MICHAEL W. BIEN – 096891
GAY C. GRUNFELD – 121944
VAN SWEARINGEN – 259809
MICHAEL FREEDMAN – 262850
SARAH P. ALEXANDER – 291080
ROSEN BIEN
GALVAN & GRUNFELD LLP
315 Montgomery Street, Tenth Floor
San Francisco, California 94104-1823
Telephone: (415) 433-6830
Facsimile: (415) 433-7104
Email: mbien@rbgg.com
ggrunfeld@rbgg.com
vswearingen@rbgg.com
mfreedman@rbgg.com
spalexander@rbgg.com

ALAN SCHLOSSER – 049957
MICAELA DAVIS – 282195
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA, INC.
39 Drumm Street
San Francisco, California 94111-4805
Telephone: (415) 621-2493
Facsimile: (415) 255-8437
Email: aschlosser@aclunc.org
mdavis@aclunc.org

JAMES EGAR – 065702
Public Defender
DONALD E. LANDIS, JR. – 149006
Assistant Public Defender
OFFICE OF THE PUBLIC DEFENDER
COUNTY OF MONTEREY
111 West Alisal Street
Salinas, California 93901-2644
Telephone: (831) 755-5806
Facsimile: (831) 755-5873
Email: EgarJS@co.monterey.ca.us
LandisDE@co.monterey.ca.us

ERIC BALABAN*
CARL TAKEI*
ACLU NATIONAL PRISON PROJECT
915 15th Street N.W., 7th Floor
Washington, D.C. 20005-2302
Telephone: (202) 393-4930
Facsimile: (202) 393-4931
Email: ebalaban@npp-aclu.org
ctakei@npp-aclu.org

*Admitted *Pro Hac Vice*

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

JESSE HERNANDEZ et al., on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

COUNTY OF MONTEREY; MONTEREY COUNTY SHERIFF'S OFFICE; CALIFORNIA FORENSIC MEDICAL GROUP, INCORPORATED, a California corporation; and DOES 1 to 20, inclusive,

Defendants.

Case No. CV 13 2354 PSG

DECLARATION OF PABLO STEWART IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

Judge: Hon. Paul S. Grewal
Date: June 3, 2014
Time: 10:00 A.M.
Crtrm.: 5, 4th Floor

Trial Date: None Set

1 I, Pablo Stewart, declare:
2 1. I am a board-certified psychiatrist and Clinical Professor in the Department
3 of Psychiatry at the University of California, San Francisco. My curriculum vitae is
4 attached hereto as **Exhibit A**. I have more than 25 years of experience in correctional
5 mental health care, including serving as the court's expert in class action cases challenging
6 the provision of mental health care to prisoners.
7 2. I have been asked to provide my opinion regarding the policies and practices
8 of the County of Monterey, the Monterey County Sheriff's Office, California Forensic
9 Medical Group ("CFMG"), and their agents as they relate to the provision of mental health
10 care to prisoners in Monterey County Jail (the "Jail").
11 3. In order to prepare this report, I have reviewed the following materials:
12 a. Plaintiffs' Second Amended Complaint
13 b. Draft Review of Mental Health Services at the Monterey County Jail,
14 Dr. Richard Hayward, Ph.D., Dec. 6, 2013
15 c. Monterey County Jail Health Care Evaluation, Dr. Mike Puisis, D.O.,
16 Nov. 29, 2013
17 d. Rule 26 Report, Michael Hackett, Dec. 9, 2013
18 e. The CFMG Staffing Plan for Monterey County
19 f. All declarations submitted by named plaintiffs in support of Plaintiffs'
20 Motion for Class Certification
21 g. Inmate Daily Count Sheets from January 1, 2013 to March 13, 2013
22 h. California Forensic Medical Group, Inc., Policy and Procedure
23 Manual, Monterey County Adult Detention Facility
24 i. Monterey County Sheriff's Office, Custody Operations, Policies and
25 Procedures
26 j. Minutes, Quality Assurance/Peer Review Committee Meeting,
27 Monterey County Jail & Juvenile Hall Medical Services, Oct. 28, 2010
28

k. Minutes, Quality Assurance/Peer Review Committee Meeting, Monterey County Jail & Juvenile Hall Medical Services, Jan. 27, 2011

l. Letter from Gay Grunfeld, Plaintiffs' counsel, to Dr. Hayward, Dec. 20, 2013

m. Initial Response to Feedback to Draft of Review of Mental Health Services at the Monterey County Jail, Dr. Hayward, Jan. 17, 2014

n. Letter from Michael Philippi, Deputy County Counsel, Monterey County, to Dr. Hayward, Jan. 13, 2014

o. Letter from Gay Grunfeld to Dr. Hayward, Feb. 11, 2014

p. Email from Susan Blitch, Senior Deputy County Counsel, Monterey County, to Dr. Hayward, Feb. 11, 2014

q. Applications by the Monterey County Sheriff's Office pursuant to California Penal Code § 4024.1

r. ADA Assessment & Review, Monterey County Jail, SZS Consulting, Nov. 30, 2013, Appendix

s. Redacted documents related to the suicide of Daniel Lariviere, including the Coroner Report, July 25, 2011; Monterey County Postmortem Examination, July 11, 2011; Toxicology Report, July 19, 2011; Monterey County, Office of the Sheriff, Crime/Incident Reports and Supplements, July 8, 2011; Safety Cell Log, July 5, 2011; Classification Inmate Intake Screening Questionnaire, July 5, 2011; Intake Health Screening form, July 5, 2011; and Pre-Booking Sheet, July 5, 2011

t. Documents (some redacted) related to the suicide of Jessie Crow, including the Coroner Report, August 30, 2010; Monterey County Postmortem Examination, August 11, 2010; Toxicology Report, August 13, 2010; and documents from Mr. Crow's medical file

u. Redacted incident reports related to the suicide of Joshua Claypole

v. Incident reports from September 1, 2012 to March 2014 involving suicide attempts

4. My opinions set forth below are based upon the documents and other evidence listed above and on my professional knowledge and my experiences working in correctional settings.

5. This case is still in a very early stage. I am informed that the parties have not yet exchanged any formal discovery. For example, I have not conducted any inspection of the Jail facilities, I have not interviewed any staff or prisoners, and I have only reviewed a small number of records for the named plaintiffs. As a result, I have not been able to form opinions regarding certain elements of the mental health care system at the Jail. For example, at the present time, I do not have access to the information necessary to form opinions regarding whether Defendants maintain appropriate medical records. I would expect to consider this and other issues not addressed in this report in the future once Plaintiffs propound discovery. Based upon the documents and information I have reviewed, however, I am able to offer the following preliminary opinions. I reserve the right to supplement or modify these opinions as more information becomes available.

6. From my preliminary review, it is my opinion that the mental health care program at the Jail is not sufficient to meet prisoners' serious mental health needs and needlessly places prisoners in the Jail at a substantial risk of serious harm. The serious, system-wide problems with the mental health care system at the Jail include the following:

- Defendants fail to staff the Jail with sufficient mental health, medical, and custody staff to deliver timely and appropriate mental health care to prisoners with serious mental illness.
- Defendants' intake processes are inadequate, in that they fail to adequately identify prisoners with mental illness booked into the Jail and also fail to appropriately continue care that prisoners were receiving in the community.
- Defendants lack an effective and timely mechanism for prisoners to request mental health care services.
- Defendants fail to appropriately and safely manage and monitor the administration of psychotropic medication.

- Defendants do not offer adequate group and individual therapy to prisoners with serious mental illness.
- Defendants lack adequate policies and practices for transferring prisoners who require higher level inpatient or crisis care to facilities that can meet prisoners' serious mental health needs.
- Defendants, pursuant to policy, house prisoners with the most serious mental illness in restrictive administrative segregation units that aggravate prisoners' mental health and deny prisoners access to programs and services in the Jail.
- Defendants lack an adequately functioning suicide prevention program; expose acutely suicidal prisoners to unnecessarily harsh conditions in safety cells that exacerbate prisoners' suicidality and inhibit prisoners from coming forward with suicidal feelings; fail to adequately observe prisoners placed on suicide watch; and have a higher than average suicide rate.
- Defendants' quality improvement program is inadequate to ensure Defendants identify and fix systemic problems.
- Additionally, the Jail is overcrowded, which magnifies the negative effects of each of the problems listed above.

7. As I discuss below, it is my opinion that, collectively and individually, these problems place all prisoners at a substantial risk of serious harm. Any prisoner, whether they enter the Jail with a diagnosed mental illness or not, may develop symptoms of mental illness while in the Jail. This is especially true given the harsh, overcrowded conditions in the Jail. And any prisoner with mental illness in the Jail is endangered by Defendants' problematic policies and practices, which do not ensure that prisoners receive timely, appropriate, and effective mental health care. Consequently, all prisoners, not just prisoners with diagnosed mental illness, are placed at great risk of serious harm by Defendants' deficient mental health care system.

Defendants' Insufficient Staffing of Mental Health Care Clinicians, Medical Clinicians, and Custody Staff Affects All Prisoners With Serious Mental Illness.

8. From the information I have reviewed, it is my opinion that the County and CFMG do not employ sufficient mental health care, medical, and custody staff to ensure prisoners receive mental health care in a timely and appropriate manner. Defendants' understaffing affects all prisoners in the Jail, especially those who have serious mental illness.

9. The number of mental health care clinicians employed at the Jail is not adequate to deliver mental health care to prisoners in the Jail. As part of the contract for CFMG to provide medical, mental health, and dental services to prisoners at the Jail, Defendants developed a staffing plan for the Jail. Pursuant to the staffing plan, CFMG employs three staff members who provide mental health services to prisoners: a Psychiatrist who works 15 hours a week, a Licensed Clinical Social Worker/Psychologist/Marriage and Family Therapist who works 20 hours a week, and a psychiatric registered nurse who works 40 hours per week. *See* Grunfeld Decl., Ex. H. According to the staffing plan, collectively there are 1.88 Full-time Equivalent ("FTE") positions for mental health care staff at the Jail.

10. Dr. Richard Hayward, Ph.D., was jointly retained by the parties to conduct an evaluation of the mental health care system at the Jail. In his draft report summarizing his findings, Dr. Hayward indicated that he was informed that CFMG employs four employees to provide mental health treatment to prisoners: Dr. Taylor Fithian, a psychiatrist who works about 25 hours a week in the Jail, Dr. Elaine Finnberg, Ph.D., a psychologist who works 20 hours per week in the Jail, Charlotte Gage, R.N., a registered nurse who works 40 hours per week at the Jail, and Kim Spano, L.M.F.T., a licensed marriage and family therapist who works 40 hours per week. *See* Grunfeld Decl., Ex. O, at 4. According to Dr. Hayward, collectively there are 3.125 FTE positions for mental health care staff at the Jail.

11. Regardless of whether the Defendants staff the Jail at the level indicated in

the staffing plan agreed to by CFMG and the County or at the level indicated in Dr. Hayward's report, the number and type of clinical staff in the Jail are not sufficient for a jail the size of Monterey County Jail. In his draft report, Dr. Hayward described a shortage of mental health care clinicians and the risks the shortage poses to prisoners. He found that CFMG needed to add an additional 0.5 FTE staffing for a mental health clinician in addition to the psychiatrist and psychologist "to provide a minimally adequate level of mental health services …" at the Jail. *See id.* Dr. Hayward found that the additional staff is necessary for Defendants to "provide mental health intake assessments, crisis intervention services, evaluations of inmates in the safety cells or the restraint chair and supportive counseling to seriously mentally ill inmate-patients housed in the administrative segregation pods." *See* Grunfeld Decl., Ex. M, at 5.

12. Dr. Hayward also identifies as a problem that there are *no* mental health care clinicians on site at the Jail on weekends and holidays. *See id.* at 2, 5. One consequence of this staffing deficiency is that prisoners who require acute psychiatric services on weekends remain in the Jail, largely untreated, until the mental health clinicians arrive on Monday. My review of the declaration for Plaintiff Brandon Mefford, a prisoner who Defendants knew suffered from serious mental illness, indicates that this is exactly what happened to him. He was identified as being in mental health crisis on a Friday afternoon at about 3:00 P.M. Over the weekend, Plaintiff Mefford was not seen by any mental health care staff and was housed in a safety cell (sometimes being placed in a restraint chair with belly chains and a helmet) or a booking cell. He was not seen by a mental health clinician until Monday. This lack of qualified mental health staff on-site on weekends poses a serious risk to prisoners who are suicidal. Any prisoners, newly booked or otherwise, who present with any mental health needs on a Friday, Saturday, or Sunday will be at risk for deterioration of his or her condition and needless suffering over the weekend without mental health care staffing. Accordingly, I agree with Dr. Hayward that the understaffing of mental health clinicians at the Jail results in inadequate mental health care services for prisoners in the Jail.

13. In order to provide minimally adequate mental health care to prisoners in the Jail, Defendants will, for the following reasons, need to add significantly more than 0.5 FTE mental health clinicians to the staff.

14. To begin with, Dr. Hayward's recommendation for additional staffing did not include a relief factor. *See* Grunfeld Decl., Ex. O, at 4. A relief factor indicates how many FTEs it takes to fill a position, taking into account the inevitable absences of employees for vacation, sickness, leave, and training. Any evaluation of staffing that does not include a relief factor necessarily underestimates the minimum amount of necessary staff.

15. More importantly, Dr. Hayward's recommendation appears to be based upon an under-estimation of the needs of prisoners for mental health care services. Dr. Hayward explained that Defendants house prisoners with the most serious mental illness in administrative segregation: A and B Pods for men, and R and S Pods for women. *See* Grunfeld Decl., Ex. M, at 6. He also explained that his staffing recommendation was based on the Jail needing to provide socialization groups to those prisoners once per week for one hour. *See* Grunfeld Decl., Ex. M, at 7. It is my opinion that one hour of structured out-of-cell time once per week for prisoners who are "not stabilized" falls far below the standard of care and is insufficient to provide adequate psychiatric therapy to prisoners who have serious mental illness. Dr. Hayward's estimate for additional needed staff does not take into account the need for significantly greater group therapy offerings necessary to meet the standard of care.

16. It is my opinion that Defendants also do not staff the Jail with sufficient medical staff, placing all prisoners, including prisoners with serious mental illness, at risk of significant harm. Dr. Mike Puisis, who evaluated the quality of medical care provided in the Jail as a joint expert for the parties, found that the staffing pattern for providing medical care in the Jail "is not capable of accomplishing all assigned duties ...." Grunfeld Decl., Ex. J, at 7; *see id.* at 3 ("Staffing is inadequate."). According to Dr. Hayward, the mental health care staff at the Jail relies heavily on medical staff for a number of critical

1 tasks, including, but not limited to, screening of prisoners with mental illness during the
2 intake process, distributing psychiatric medications, verifying prescriptions for psychiatric
3 medications, attending to prisoners in acute psychiatric distress on weekends and holidays,
4 and processing and routing requests for mental health care treatment. *See* Grunfeld Decl.,
5 Ex. M, at 1-4. The shortages of medical providers identified by Dr. Puisis would
6 necessarily have an impact on the ability of prisoners to receive timely, adequate mental
7 health care in the Jail.

8 17. It is my opinion that Defendants also do not staff the Jail with sufficient
9 custody staff to ensure the timely delivery of appropriate mental health care, which affects
10 all prisoners in the Jail. Each of the experts who reviewed staffing found that custody
11 staffing was insufficient to complete all necessary tasks. Dr. Hayward found that custody
12 staff frequently failed to make required safety checks of prisoners in safety cells twice
13 every thirty minutes, as required by Sheriff's Office and CFMG policies, a deficiency
14 possibly caused by lack of sufficient staff. *See id.* at 12. Dr. Puisis concluded that custody
15 staffing in the Jail was insufficient to adequately facilitate the provision of medical care to
16 prisoners. *See* Grunfeld Decl., Ex. J, at 3 ("Because there are limitations with respect to
17 officers transporting inmates for their scheduled appointments, officer staffing should be
18 evaluated along with medical staffing."). Michael Hackett, who evaluated the safety in the
19 Jail as a joint expert for the parties, also concluded that custody staffing at the Jail was
20 inadequate in a number of respects. *See generally* Grunfeld Decl., Ex. I, at ¶¶ 3.1-.14. In
21 addition, TRG Consulting, who produced a Jail Needs Assessment for the County and
22 Sheriff's Office in December 2011, also found that the Jail employed nowhere near enough
23 custody staff to, among other things, "provide medical care … and move inmates within
24 the facility." Second Am. Compl., Ex. B (Dkt. No. 41), at EX. 6.

25 18. These custody staffing shortages create serious problems for all prisoners.
26 For example, many of the named plaintiffs were unable, at some point during their time in
27 the Jail, to receive needed medical treatment because of the unavailability of custody staff.

28 19. In my experience, mental health care staff members in correctional settings

1 rely upon custody staff to assist in the provision of mental health care to prisoners. Among
2 other critical tasks, custody staff members escort prisoners to and from mental health care
3 treatment and monitor prisoners with mental illness in administrative segregation and in
4 safety cells. Custody staff is also responsible for supervising prisoners on the exercise
5 yard, in the day room, and for other programs and activities. The shortages of custody
6 staff identified by Drs. Puisis and Hayward and by Mr. Hackett and TRG Consulting
7 necessarily impede the delivery of mental health care and the provision of other activities.
8 It is thus my opinion that the Jail's failure to employ sufficient custody staff to ensure that
9 prisoners with mental illness receive the care that they require affects all prisoners at the
10 Jail.

11 20. Without more information regarding the incidence and acuity of mental
12 illness in the Jail population, I cannot provide a recommendation regarding the quantity of
13 additional mental health care and medical clinicians and custody staff necessary to provide
14 adequate mental health care to prisoners in the Jail. I am, however, confident that, as
15 found by Dr. Hayward, Defendants currently do not staff the Jail with sufficient mental
16 health clinicians to ensure that prisoners receive the mental health treatment they require. I
17 am also confident that Dr. Hayward's estimate—that an additional 0.5 FTE for mental
18 health clinicians would result in minimally adequate mental health care staff—is too low,
19 likely by a significant amount.

20 21. Lack of sufficient mental health, medical, and custody staff inevitably has a
21 negative impact on the quality and quantity of the mental health care delivered to
22 prisoners. An understaffed facility, and particularly one that appears to be as understaffed
23 as the Jail, is simply not capable of providing all of the mental health care services that
24 prisoners require. The problems caused by understaffing are exacerbated by the
25 overcrowding in the Jail, which I discuss below. As a result of the lack of sufficient
26 mental health, medical, and custody staff at the Jail, all prisoners with, or who may
27 develop, mental illness, are placed at serious risk of substantial harm.
28

Defendants Fail to Adequately Identify Prisoners with Mental Illness During the Intake and Booking Process, and Thereby Fail to Continue Providing the Care Prisoners Were Receiving in the Community and/or Fail to Provide Care Prisoners Require When They Arrive at the Jail.

22. One of the most important functions of a jail mental health care system is to ensure that newly booked prisoners quickly receive the mental health care services they require. For prisoners who were receiving mental health treatment up to the time of their arrest, a jail must identify the nature of the person's mental illness, the types of treatments they were receiving in the community, and ensure such treatment is continued unless a provider makes a reasonable clinical determination to discontinue or change treatment following a face-to-face assessment of the patient. For prisoners who were not receiving treatment in the community, a jail must determine whether the person suffers from mental illness and devise an appropriate treatment plan. The Jail's intake process fails to ensure that necessary mental health treatment is continued or initiated.

23. Any failure to quickly diagnose new prisoners' mental illnesses, identify their community mental health treatment (if any), and devise an appropriate treatment plan for their time in the Jail, can have devastating consequences. As is discussed more fully below, prisoners with mental illness who are introduced to a Jail environment are, for a number of reasons, at a heightened risk of suicide; any delay in identifying such prisoners and mitigating that risk can result in self-harm and attempted or completed suicide. In addition, and as is also discussed more fully below, for those prisoners who were taking psychotropic medications in the community, any interruption of medication can cause a prisoner to mentally decompensate, may result in a permanent worsening of their underlying mental illness, and may make future treatment more difficult and potentially less efficacious.

24. The intake process is also important for ensuring that prisoners are placed in appropriate jail housing. Prisoners with unstable mental illness should be placed into housing units capable of addressing their mental health needs. And prisoners who are at risk of suicide must be placed in suicide-safe housing, in which suicide hazards have been

eliminated and where there is increased observation. The Jail's intake process fails to ensure that mentally ill prisoners are appropriately housed after intake.

25. The policies and practices at the Jail for identifying newly-booked prisoners with mental illness and ensuring they receive appropriate treatment and housing are inadequate in a number of respects. Pursuant to Sheriff's Office and CFMG policy, the process of identifying prisoners with mental illness and their mental health needs occurs in three steps. First, during the booking process, custody staff completes an Intake Health Screening form for all prisoners. Second, for prisoners identified as receiving psychiatric medications, medical staff is supposed to conduct an Intake Triage Assessment immediately. And third, if medical staff refers a patient for a psychiatric evaluation, a psychiatrist is supposed to assess the prisoner within five to seven days. Each of these steps is deficient in ways that expose prisoners to substantial risk of serious harm.

26. Both the Intake Health Screening form and the custody officers who complete it are inadequate for the task. Though the form does include some questions about prisoners' mental health, Dr. Hayward found it was insufficient to capture adequate information regarding prisoners with mental illness. As Dr. Hayward explains, the form should, but does not, include questions regarding whether the prisoner has ever been hospitalized at a psychiatric facility in the past five years, whether the prisoner ever has been or is currently depressed, or has ever had mental health counseling or treatment. *See* Grunfeld Decl., Ex. M, at 2. I agree with Dr. Hayward's recommendations.

27. Dr. Puisis, in his report, concluded that the Intake Health Screening process "does not provide for accurate or appropriate medical intake screening and therefore does not protect incoming detainees from harm." Grunfeld Decl., Ex. J, at 15. He found that the "responsibilities placed upon correctional officers … are well beyond their ability to perform" and that the officers were not properly trained for the function. *Id.* He recommended that, for a jail the size of Monterey County Jail, all screening be conducted by nurses. *See id.* I agree with Dr. Puisis. Having custody staff conduct initial health care screenings is ineffective and dangerous. Prisoners with mental illness, many of whom also

have co-occurring substance abuse problems, are frequently reluctant to provide truthful information to correctional officers, especially before the charges against them have been resolved. Having non-medical, poorly-trained staff conduct initial healthcare evaluations places all prisoners, especially those with mental illness, at risk of harm.

28. At this first stage of the intake process, Dr. Puisis also observed that custody staff members make decisions regarding whether to place prisoners in sobering or safety cells. *See* Grunfeld Decl., Ex. J, at 19-20. Dr. Puisis found that the officers making these decisions "are not trained to identify persons at risk for withdrawal, to evaluate persons who appear to be intoxicated, or to make medical decisions with respect to isolation for this purpose.... The altered mental status of alcoholism or drug withdrawal can mask serious injury or other medical conditions." *Id.* at 20. Dr. Puisis recommended that these decisions should be made "by medical professionals not custody officers." *Id.* And he concluded that the current practice "places detainees at risk for harm." *Id.*

29. I agree with Dr. Puisis. As he correctly states, substance intoxication and/or withdrawal can mask serious injury or other medical conditions. These conditions also heighten the risk of suicide. It is particularly difficult to identify prisoners with mental illness in the context of substance intoxication and withdrawal. For that reason, medical and mental health screening should be conducted by properly trained medical or mental health care staff.

30. At the first step, Dr. Puisis also found that Defendants lack any policy to govern the housing of prisoners with mental illness. *See* Grunfeld Decl., Ex. J, at 13. This systematic deficiency places all prisoners at risk by increasing the likelihood (1) that a prisoner with mental illness is housed in an inappropriate setting that increases the prisoner's risk of suicide or decompensation or (2) that the prisoner with mental illness is involved in a conflict with other prisoners or staff while experiencing a behavioral disturbance secondary to his or her inadequately treated mental illness.

31. The second step of the intake process, the Intake Triage Assessment, is conducted by medical staff at the Jail. Dr. Puisis found that during the Intake Triage

Assessment, medical staff significantly under-identifies chronic diseases, including tuberculosis, hypertension, diabetes, and asthma, among newly-booked prisoners. *See* Grunfeld Decl., Ex. J, at 17-19. If medical staff similarly under-identifies prisoners with mental illness, and therefore fail to refer them to mental health care staff, it would also place prisoners at risk of harm. Dr. Hayward indicated that this does occur in the Jail. *See* Grunfeld Decl., Ex. N, at 5 (asking Dr. Hayward if there were "any prisoners who suffered from mental illness at the time of intake but who were not identified as having mental illness"); Grunfeld Decl., Ex. O, at 2 (responding that "some inmates were not identified as having a mental illness until sometime following their intake").

32. In order to reach the third step of the mental illness identification process, prisoners must be referred by medical staff to see mental health care staff. According to Dr. Hayward, mental health care staff is available for urgent mental health care referrals during the week, but are not available over the weekends or on holidays. *See* Grunfeld Decl., Ex. M, at 2. This staffing deficiency, discussed above, places all prisoners at risk. It also appears, at least with respect to the suicide of Daniel Lariviere, discussed below, that mental health evaluations do not always occur in a timely manner during the week.

33. According to Dr. Hayward, even when prisoners get to see mental health care staff for an initial evaluation, clinicians do not use any standardized mental health intake form to summarize a prisoner's "symptom and treatment history, community provider(s), prior diagnoses and medications, co-occurring disorders, substance use, [or] history of self-harm or suicidal ideation and attempts." *Id.* at 4. As I discuss further below, mental health care staff also does not utilize any comprehensive suicide risk assessment tool to evaluate prisoners' risk of suicide. These lack of standardized practices place prisoners at risk.

34. It also appears that Defendants do not identify and continue needed mental health care treatment for prisoners who were receiving care in the community. Any disruption of psychiatric medications can be dangerous for a number of reasons. First, individuals who take prescribed medication to control their mental illness often

1 decompensate if their medication is interrupted. This can lead to increased symptoms and
2 risk of suicide. Second, a disruption of prescribed psychiatric medication can actually
3 exacerbate the underlying mental illness by altering brain physiology and causing an
4 expansion of foci in the brain of the condition at issue. This is called the "kindling
5 phenomenon." Finally, because disruption of medication can cause a worsening of the
6 underlying condition, it can also make it more difficult to treat the metal illness.

7 35. For all of these reasons, it is important that Defendants minimize the
8 disruption in receipt of prescribed psychotropic medications. One of the most important
9 means for accomplishing this task is to quickly obtain outside pharmacy records for
10 prisoners to confirm their prescriptions and dosages. This process does not appear to
11 function properly, especially on weekends. Dr. Hayward found that only mental health
12 care staff members, not medical staff, initiate requests for pharmacy records for prisoners
13 with mental illness. *See id.* at 4. Because of the lack of mental health care staff on site
14 during the weekends, Defendants do not even begin the process of obtaining mental health
15 care records for prisoners booked on Fridays and weekends until the following Monday.
16 *See id.* This can result in significant disruptions in the receipt of prescribed psychotropic
17 medications, which creates the risks I describe above.

18 36. Dr. Puisis found that Defendants' policies and practices for continuing
19 medications begun prior to incarceration are fundamentally flawed. Troublingly, he found
20 that "if a detainee does not remember the name of his medication or if the health staff can
21 not verify a prescription of medication at a local pharmacy, no medication is provided even
22 when medication is medically necessary." Grunfeld Decl., Ex. J, at 23. Dr. Puisis also
23 found that Defendants lack an adequate process for physician intervention for when staff
24 cannot verify outside medical records. *See id.* at 13. He concluded that "[b]ased on chart
25 reviews, it appears that MCJ is systematically denying necessary medication to patients
26 with chronic disease." *Id.* at 23. Similar failures with respect to continuing psychiatric
27 treatment for prisoners newly-booked into the Jail would place prisoners at serious risk of
28 harm.

1 37. The problems identified by Dr. Puisis are likely caused by serious
2 deficiencies and lack of clarity in the policies regarding continuation of medications
3 prescribed prior to incarceration. There appear to be two policies that might govern the
4 provision of psychotropic medications to prisoners newly arrived at the Jail. First, CFMG
5 policy includes a list of medications that can be continued prior to being seen by a mid-
6 level provider or a physician in the sick call process. *See* Grunfeld Decl., Ex. G, at 371.
7 Psychotropic medications are not on this list of medications. This means it is critically
8 important that a process exist to ensure prisoners on psychotropic medications have
9 immediate access to a prescribing provider. This is not, however, the case. CFMG has a
10 second, more specific policy, entitled "Psychotropic Medications," which sets forth the
11 procedure for continuing psychotropic medications. *See id.* at 361. It states that "[n]o
12 psychotropic medications shall be unilaterally discontinued without consultation with the
13 facility physician or psychiatrist." *Id.* But it then explains that no prisoner will receive
14 psychotropic medications until staff requests their outside psychiatric records and they are
15 seen by a psychiatrist at the Jail. The policy only requires that the prisoner be seen by the
16 psychiatrist within 5-7 days of booking. As I read the policy, this means that, at best, even
17 a prisoner who brings his medication to the Jail and for whom the Jail immediately verifies
18 his prescriptions, will suffer, at a minimum, a five day interruption in medication. As I
19 discuss above, a five day interruption of medication can cause very serious problems. This
20 policy for continuing prescriptions for psychotropic medications begun prior to
21 incarceration places prisoners at a substantial risk of serious harm.
22 38. Defendants also appear to engage in a very dangerous detoxification process
23 for prisoners who arrive at the Jail intoxicated or with a history of drug or alcohol abuse.
24 Individuals suffering alcohol or benzodiazepine withdrawal are at increased risk of
25 seizures. Most antipsychotic medications lower the seizure threshold. Consequently, it is
26 clinically appropriate to remove a person experiencing alcohol or benzodiazepine
27 withdrawal from antipsychotic medications they are taking for up to 72 to 96 hours for
28 alcohol withdrawal and up to a week depending on the type of benzodiazepine. After that

1 time, it is safe and appropriate to restart the antipsychotic medications. As far as I am
2 aware, alcohol and benzodiazepine withdrawal present the only circumstances where, as
3 part of a detoxification process, it is clinically appropriate to temporarily remove a prisoner
4 from antipsychotic medications. There is no medical reason to remove people from
5 psychotropic medications as part of the detoxification process from opiates or
6 psychostimulants.

7 39. From my limited review, however, it appears that Defendants utilize a
8 punitive, medically contraindicated detoxification process for some prisoners that involves
9 removing them from all psychotropic medications for 90 days or longer. For example, my
10 review of the declaration for Plaintiff Gist shows that she was booked into the Jail on
11 March 15, 2012. She informed medical and custody staff that she was taking a number of
12 psychotropic medications, including Risperidone, Fluoxetine, Benztropine, and Trazodone.
13 Four days later, on March 19, 2012, her relatives brought those psychotropic medications
14 to the Jail for her. That same day, the Jail obtained pharmacy records that confirmed that
15 she was prescribed the same medications. On March 20, 2012, a psychologist at the Jail
16 consulted with Dr. Fithian about whether Plaintiff Gist should be provided with her
17 prescription medication. Dr. Fithian instructed that "due to history of alcoholism, … we
18 should hold off medicating her for now to allow her to detox from alcohol while in
19 custody." On March 27, Plaintiff Gist was again seen by the psychologist. In a progress
20 note, the psychologist wrote that "[p]rior to seeing inmate, writer conferred with
21 Dr. Fithian. It was agreed that she is to remain medication free and clean and sober for 90
22 days." It appears that mental health care staff at the Jail also refused to provide Plaintiff
23 Greim with psychiatric medications for 90 days on the basis that he suffered from alcohol
24 dependence.

25 40. There was no clinical justification for denying Plaintiffs Gist and Greim
26 psychotropic medications for 90 days because of a history of alcohol abuse. In fact, such a
27 process is medically contraindicated for the reasons I described above regarding the risks
28 of interrupting psychotropic medications. This 90-day detoxification "protocol" places

prisoners with mental illness at a substantial risk of serious harm.

41. Plaintiff Gist's experience also included examples of other problems with the intake process. Defendants did not even consider continuing her previously prescribed medications for at least five days after booking. As I discuss above, a five-day delay to determine whether to continue prescribed medications does not meet the standard of care. In addition, Plaintiff Gist did not receive a face-to-face evaluation from Dr. Fithian, the only mental health care staff with prescribing authority at the Jail, prior to discontinuing Plaintiff Gist's psychotropic medications. The standard of care for starting or stopping medication is for the prescriber to conduct a face-to-face evaluation.

42. As evidenced by the circumstances surrounding the suicide of Daniel Lariviere, which occurred in July 2011, problems with the intake process can have fatal consequences. I discuss additional problems with Mr. Lariviere's suicide below, but his tragic experience with the intake process is revealing. In short, Mr. Lariviere committed suicide approximately 72 hours after he arrived at the Jail. Upon his arrest, which took place on a Tuesday, Mr. Lariviere was placed in a safety cell in restraints without any prior consultation with mental health care staff. He remained in the safety cell for approximately 2.5 hours, and was released without approval from any mental health care staff. About 12 hours later, Mr. Lariviere was finally interviewed by custody staff for the Intake Health Screening assessment. Mr. Lariviere informed custody staff that he was under the care of a doctor for psychiatric reasons, had a history of alcohol abuse, and had recently been discharged from a psychiatric hospital. Despite this information, custody staff recommended that he be placed in the general population. Mr. Lariviere was then evaluated by medical staff, who confirmed the information Mr. Lariviere provided to custody staff and learned that Mr. Lariviere was having auditory hallucinations and had been discharged from the psychiatric hospital only four days earlier. The medical staff conducting the Intake Triage Assessment set a medical appointment for Mr. Lariviere the next day, but did not request an urgent psychiatric consultation, and instead, made an appointment with mental health staff for Friday, three days later. It is not clear whether

staff initiated the process for obtaining Mr. Lariviere's outside mental health care records, including records of any prescribed medications. For reasons unclear, Mr. Lariviere was then single-celled in an administrative segregation housing unit in a cell that contained suicide hazards. It appears that the medical appointment did not occur as scheduled. And before Mr. Lariviere's scheduled psychiatric evaluation, he committed suicide by hanging in his cell. When Mr. Lariviere committed suicide early on Friday morning, he had received no psychiatric medications and had not been evaluated by either mental health or medical staff. It is my opinion, based on the records I have reviewed, that this suicide was completely preventable. If any one of a number of things that should have happened did take place—mental health care consultations before and upon release from placement in safety cell, a mental health suicide risk evaluation prior to being placed in housing, a timely request for and review of outside medical treatment and prescription medication records, the continuation of previously prescribed medications, and a safe housing placement for a seriously mentally ill and suicidal prisoner—his suicide would have been prevented.

43. The intake process is more difficult to conduct adequately in overcrowded, understaffed facilities, like the Jail, than in jails that have adequate staff and are not overcrowded.

44. For all of the above-stated reasons, it is my opinion that the Jail's intake process for identifying and treating prisoners with mental illness is broken and places all prisoners at risk of harm.

Defendants Lack an Adequate Method for Prisoners to Request Mental Health Care Services.

45. Another important element of an adequate correctional mental health care system is a functioning, effective process for prisoners to request mental health care services and be timely seen by appropriate staff for treatment. An inadequate and unreliable health care request process places all prisoners and staff at risk. Those with mental illness are denied access to timely care and others may be harmed if prisoners with

mental illness have behavioral disturbances secondary to their untreated mental illness. In my experience, many prisoners with mental illness will underreport their mental health conditions during the intake process. As a result, it is critical to have a means for them to confidentially communicate their mental health needs at a later time. This system is also vital in suicide prevention in that prisoners will often use the system to seek help for suicidality.

46. Health requests should be collected and triaged at least twice in any 24 hours period. The system must also have in place mechanisms for the most acute patients to be seen immediately by appropriate staff after the request is triaged.

47. The current health care request process at the Jail does not provide prisoners with a reliable and effective means for requesting mental health care services and being timely seen and assessed. Pursuant to policy, the primary method prisoners have for requesting either medical or mental health care services is to fill out and submit what is called a "sick call slip." *See* Grunfeld Decl., Ex. G, at 230. According to Dr. Puisis, there are a variety of problems with the current policy and practices for triaging sick slips. The policy itself is very brief: It does not address how nurses are to evaluate health requests; it does not include a timeframe for evaluating sick call slips; it does not require vital signs for all symptomatic complains; and it does not require that sick call slips and/or the response to sick call slips be tracked. *See* Grunfeld Decl., Ex. J, at 11, 22.

48. Two additional problems identified by Dr. Puisis are particularly relevant to the delivery of mental health care. First, even though there are as many as 200 prisoners housed in segregation at any time, including two male (A and B) and two female (R and S) pods of prisoners with serious mental illness, there is no policy for how such prisoners are to obtain and submit sick call slips. *See id.* at 22. Second, though all sick call slips are evaluated by medical nurses, there is no policy regarding what is to be done with requests that raise psychiatric issues. *See id.* at 11. I have reviewed the policy and agree with Dr. Puisis' conclusions.

49. The sick call process appears to be even more dysfunctional in practice.

1 Dr. Puisis concluded from his review that the "follow up of care of health requests was not
2 consistently timely ...." Grunfeld Decl., Ex. J, at 22. Moreover, according to Dr. Puisis,
3 Defendants do not track "how many people place requests, how many are seen, or whether
4 their care was timely," and thus are "unable to evaluate [their] own performance with
5 respect to detainee access to care." *Id.* Dr. Hayward reached a similar conclusion. *See*
6 Grunfeld Decl., Ex. M, at 3 ("The current procedures lack a systematic method of auditing
7 receipt and responses to all inmate requests for health services.").

8 50. I have reviewed the declarations of all of the named plaintiffs in this action.
9 Most of these declarations describe serious problems using the sick call process to access
10 appropriate care.

11 51. In addition, Defendants do not provide a confidential place for prisoners to
12 submit sick call slips. Instead, as found by both Dr. Puisis and Dr. Hayward, prisoners
13 submit sick call slips in the same boxes into which prisoners also submit grievances
14 regarding non-medical issues. Only custody officers have keys to access the boxes and
15 collect the sick slips and grievances. As Dr. Hayward wrote, "[t]his practice requires
16 modification since current correctional healthcare standards require that inmates have
17 privacy of their healthcare requests." *Id.* at 3; *see also* Grunfeld Decl., Ex. J at 21 (Dr.
18 Puisis recommending that medical requests should be secure, confidential, and only
19 reviewed by medical staff). I agree with both Dr. Hayward and Dr. Puisis that it is
20 problematic if Defendants do not have a confidential means for prisoners to request mental
21 health care services.

22 52. These problems with the sick call process at the Jail, which deny prisoners
23 timely access to needed care, affect all prisoners, especially those with mental illness, and
24 place them at risk of serious harm.

25 **The Medication Administration and Prescription Drug Renewal Processes at the Jail**
26 **Place All Prisoners at Risk of Serious Harm.**

27 53. The proper administration of psychotropic medications prescribed for
28 prisoners with mental health issues is another critical element of an adequate mental health

care program in a correctional facility. Many psychotropic medications can cause significant and adverse side effects, including, but not limited to, extrapyramidal and metabolic syndromes and cardiac complications, which can cause unnecessary pain and be life threatening. As a result, medical and custody staff in the Jail play a very important role monitoring drug side effects, efficacy, and compliance. Staff administering medication must record their clinical impression of prisoners taking psychotropic medication, any reports of side effects, and any instances of non-compliance. It appears that Defendants do not adequately utilize the medication administration process to monitor prisoners on psychotropic medications. Dr. Puisis found that "[m]edication administration records are not used to record administration of medication at the time medication is administered. Instead, … [r]ecording medication administration is performed at a later time by virtue of evaluating the envelopes [in which the medications were packaged for prisoners] after return to the medication room which may be a few hours after starting medication administration. The nurse records an empty envelope as a successful medication administration. Envelopes which still contain medication are recorded as not given. The reason for not administering medication is recollected from memory. This is not good nursing practice. Medication administration should be documented at the time it is performed." Grunfeld Decl., Ex. J at 24-25. I agree with Dr. Puisis. The process currently in place for documenting medication distribution places prisoners at risk because it is not adequate for monitoring the side effects, efficacy, and compliance for prisoners taking psychotropic medications.

54. In addition, a number of the plaintiffs' declarations indicate significant problems renewing expiring prescriptions for medication. From these declarations, it appears that rather than scheduling prisoners for medical appointments prior to the expiration of a prescription, Jail staff, before taking any action, waits for prisoners to file sick call slips for renewal. For many of the plaintiffs, this frequently resulted in disruptions in medications. As I discussed above, any disruption in the receipt of psychotropic medications can cause serious harm to prisoners.

The Group and Individual Therapy Offered to Prisoners with Serious Mental Illness Is Not Sufficient to Adequately Treat the Mentally Ill Population in the Jail.

55. Mental health therapy is an essential component of any mental health care system. As important as it is to have an adequate psychiatric medication system, mental illness requires additional treatments besides medication.

56. Defendants offer very few opportunities for prisoners to receive mental health therapies. It appears from Dr. Hayward's draft report that the only therapy available to prisoners is individual supportive counseling and psychotherapy offered by the L.M.F.T. and group socialization/support groups run by the psychiatric nurse. Dr. Hayward does not specify how many hours of therapy the L.M.F.T. offers on weekly basis. He does indicate that prisoners who are cleared by custody staff are eligible to receive one hour of group therapy every two weeks.

57. As I discussed above, the quantity of group therapy offered at the Jail—once every other week for one hour—falls well below the standard of care for seriously mentally ill prisoners housed in restricted housing units. Individual therapy should be provided as often as clinically indicated. Because I do not know how often individual therapy is offered, I cannot draw any opinion regarding its adequacy for all mentally ill prisoners.

58. Pursuant to Defendants' policies and according to Dr. Hayward, it appears that the prisoners with the most severe mental illness may be denied access to group therapy. Dr. Hayward explained in his draft report that only prisoners who "are sufficiently stable to participate in group" therapy are permitted to participate. Grunfeld Decl., Ex. M, at 6. Plaintiffs' counsel requested clarification from Dr. Hayward regarding who determines whether a prisoner is "sufficiently stable." Dr. Hayward explained that "deputies have the responsibility to determine which inmate-patients can participate safely in groups. The deputies consider only safety issues not clinical issues." Grunfeld Decl., Ex. O, at 5. If I understand Dr. Hayward correctly, because only "stable" prisoners can participate in group therapy, the prisoners with the most severe mental illness, who are the

least stable but also the most in need of socialization and therapy, are more likely to be denied access to therapy. Moreover, custody staff, not clinical staff, makes the decisions regarding who can participate in socialization groups. This is very problematic. Custody staff members lack clinical training to determine what treatment a prisoner with serious mental illness requires. As far as I could determine from my review of the Jail and CFMG policies, there is no policy governing which prisoners custody staff should permit to participate in group therapy. Though I have not had an opportunity to observe group therapy offered at the Jail, I have serious concerns that the most seriously ill and difficult prisoners will be denied access to therapy.

59. It is considerably more difficult to offer adequate mental health therapy to prisoners in overcrowded facilities. In order to offer individual and group therapy, the facility must have sufficient staff to transport prisoners to and from the location of the therapy and confidential and adequately-sized locations that are conducive to therapy. In overcrowded facilities, like the Jail, both adequate transportation staff and adequate space to offer therapy are frequently lacking. It appears that both areas are problems at the Jail.

Defendants Lack Adequate Policies and Practices for Transferring Prisoners Who Require Higher Levels of Psychiatric Care to Facilities Licensed to Provide That Level of Care.

60. Another critical element of any adequate correctional mental health system is the ability to provide inpatient mental health care services to prisoners who require higher levels of care. Prisoners must have access to inpatient units with appropriately trained mental health care staff. Prisoners must also have access to units licensed to provide care to prisoners in acute psychiatric crisis.

61. From my review, the Jail is not licensed to provide any higher levels of care to prisoners with serious mental illness. Accordingly, Defendants must have in place adequate policies and practices for transferring prisoners to a licensed facility that can provide such care. I have not fully evaluated the processes in place at the Jail, but it appears that, in theory, Defendants utilize a mental health care unit at Natividad Medical Center ("NMC") when prisoners require higher levels of care. According to Dr. Hayward,

however, transfers to NMC do not always take place when necessary. Dr. Hayward writes that:

> The [Jail] has the capability of transporting an inmate to Natividad Medical Center for acute psychiatric services on weekends. However, review of the records indicates that this rarely occurs and most inmate-patients remain in the jail until the mental health clinicians arrive on Monday. They may be placed in a safety cell on suicide precautions for observation until they can be evaluated by a mental health clinician. The safety cells are used excessively for this purpose and inmates may remain in the safety cell over the weekend until a clinician provides evaluation and release on Mondays.

Grunfeld Decl., Ex. M at 5. I agree with Dr. Hayward that Defendants' failures to timely transfer prisoners to inpatient mental health care units when necessary is a significant problem and places prisoners with mental illness at risk of serious harm.

By Housing Prisoners With Serious Mental Illness in Administrative Segregation, Defendants Place Prisoners' Mental Health In Serious Jeopardy.

62. As discussed above, Defendants have a policy of housing the prisoners with the most serious mental illness in administrative segregation units— A and B Pods for men, R and S Pods for women. *See* Grunfeld Decl., Ex. M, at 6.[1] According to policy, prisoners in these units are locked in their cells for 23 hours per day. Grunfeld Dec., Ex. G, at 217. This policy is confirmed by named Plaintiffs who have been housed in administrative segregation in the Jail, who describe how they and other prisoners in such pods are only permitted one hour outside of their cells per day. The hour that prisoners are permitted outside of their cell is the only opportunity they have to exercise, shower, and use the telephone.

63. Prisoners with mental illness are likely to deteriorate and decompensate in segregation units under isolated conditions. This deterioration and decompensation often takes the form of acting out and other actions that may violate the rules of the correctional

[1] C, D, G, H, I, and J-Pods also are administrative segregations units. It is my understanding that Defendants house prisoners with mental illness in these units as well. However, according to Dr. Hayward, A, B, R, and S-Pods are the only administrative segregation units in which Defendants house prisoners *because of* their mental illness.

facility. In these cases, the prisoners' "bad" conduct is the direct product of their mental illness. Their illness exacerbates the psychological and behavioral reactions they have to the pain and stress of isolated confinement.

64. Scientific literature establishes the risk of harm posed to seriously mentally ill persons who are placed in solitary confinement or segregation. The recognition of this risk has led professional mental health organizations to prohibit the placement of the seriously mentally ill in such units or, if it is absolutely necessary (and only as a last resort) to confine them there, but under strict limits and with significant amounts of out-of-cell time and enhanced access to care. For example, the American Psychiatric Association ("APA") has issued a Position Statement on Segregation of Prisoners with Mental Illness stating:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for the individuals.[2]

The APA's position on this issue reflects the accepted fact that mentally ill prisoners are especially vulnerable to isolation- and stress-related regression, deterioration, and decompensating that worsen their psychiatric conditions and intensify their mental health-related symptoms and maladies (including depression, psychosis, and self-harm). I share this view.

65. Correctional professionals likewise have recognized the risk of placing mentally ill prisoners in isolated confinement. Mental health staff in a well-functioning prison or jail system is required by policy and practice to screen prisoners in advance of their possible placement in isolation to identify those who are mentally ill and to exclude

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[2] Am. Psych. Assoc., Position Statements: Segregation of Prisoners with Mental Illness (2012), *available at* http://www.psychiatry.org/advocacy--newsroom/position-statements.

them from such confinement if indicated. Moreover, they are charged with regularly monitoring isolated prisoners to identify any who may be manifesting the signs and symptoms of emerging mental illness and to remove them from these harmful environments if indicated.

66. The concerns about placing prisoners with serious mental illness in isolated conditions generally emanate from the conundrum faced by correctional staff when a prisoner with serious mental illness violates the rules of a facility. Standard correctional practice is to place prisoners who break facility rules in the isolated conditions of administrative segregation as a punishment. A consensus has been reached in mental health care and correctional communities, however, that when a prisoner who breaks the rules suffers from serious mental illness, the facility must take into account the prisoner's mental illness when devising an appropriate response to his or her rule breaking. This break from ordinary practice is necessitated by the risks that a prisoner with mental illness faces in administrative segregation.

67. Defendants' use of administrative segregation as a place to house prisoners with mental illness who have not violated any Jail rules is an extremely dangerous practice. Instead of trying to avoid placing prisoners with serious mental illness in administrative segregation unless absolutely necessary, Defendants place such prisoners in administrative segregation *because of* their serious mental illness. Thus, as a matter of policy and practice, Defendants intentionally expose prisoners with serious mental illness to the dangerous conditions of administrative segregation. This practice is far outside the accepted norms in the correctional or mental health care communities, and places prisoners at risk of grave harm.

68. Not only do Defendants place prisoners in administrative segregation because of their mental illness, Defendants have no policy governing how and when prisoners placed in administrative segregation should be transferred to less restrictive housing environments. Dr. Hayward recommended in his draft report that "the Sheriff adopt a policy of having Classification review the status of mentally ill inmates housed in

administrative segregation at least once monthly to determine if the inmate can be moved to less restrictive housing." Grunfeld Decl., Ex. M, at 9. I infer from Dr. Hayward's recommendation that such reviews do not occur monthly and may not occur at all. Failing to reevaluate prisoners with serious mental illness to transfer them out of administrative segregation as soon as possible further contributes to the risks of harm faced by such prisoners.

69. Approximately half of all suicides committed in correctional facilities take place in administrative segregation units. In fact, all three suicides since 2010 in the Jail have occurred in administrative segregation. One of the suicides occurred in A Pod, one of the housing units in which Defendants specifically place prisoners with serious, unstabilized mental illness.

70. In recognition of the risks posed to prisoners with mental illness in administrative segregation, it is the correctional standard that security checks occur twice every hour at intervals no longer than 30 minutes at unpredictable and intermittent times. Pursuant to policy, custody staff only conducts health and welfare checks of prisoners in administrative segregation once every hour. The policy also does not mandate that the security checks be conducted at intermittent and unpredictable times or that staff log their observations of prisoners. *See* Grunfeld Decl., Ex. E, at § 1106.04. It is my opinion that the inadequacies in the Defendants' policies for conducting safety checks on prisoners in administrative segregation place all prisoners, especially those with serious mental illness, at risk of serious harm.

71. It is my opinion that Defendants overuse administrative segregation units to house prisoners with mental illness. Overuse of administrative segregation is a common problem in overcrowded facilities like the Jail.

Defendants' Suicide Prevention Program Is Deficient in a Number of Respects that Significantly Increase the Likelihood of Self-Harm and Suicide For All Prisoners, Especially Those With Mental Illness.

72. The suicide rate in the Monterey County Jail is nearly twice the average suicide rate for jails throughout the country. According to the most recent data available

from the Department of Justice's Bureau of Justice Statistics, the average suicide rate in jails throughout the country was 43 suicides per 100,000 inmates in 2011.[3] From 2010 through 2013, three prisoners committed suicide in Monterey County Jail. Assuming the Jail maintained an average daily population of 1000 prisoners throughout that time period, the suicide rate for the Jail for those four years is 75 suicides per 100,000 prisoners. That rate is 74 percent above the national average for jail populations.

73. Having reviewed the Jail's suicide prevention policies, a number of documents related to completed and attempted suicides, and the declarations for the named Plaintiffs, it is not surprising that the rate of suicide in the Jail is above the national average. The suicide prevention program at the Jail has a number of serious problems that place all prisoners at risk.

74. As is discussed above, Defendants' policies and practices during the intake process for identifying prisoners with serious mental illness, including those who are at risk of suicide, are woefully inadequate. Prisoners newly booked into the Jail have a higher risk of suicide than prisoners who have been in the Jail for a longer time. Incarceration is one of the most stressful experiences people can encounter. The stress associated with arrest incarceration increases the likelihood of suicide. People often are booked into the Jail while intoxicated on drugs and alcohol; individuals experiencing acute withdrawal are at an extremely high risk for suicide. Finally, the mentally ill are overrepresented in the Jail population. As a result, Defendants' failures of suicide prevention during the intake process place prisoners at great risk of harm.

75. According to Dr. Hayward, Defendants do not utilize *any* comprehensive suicide risk assessment tool. *See* Grunfeld Decl., Ex. M, at 12. The only means by which Defendants become aware of prisoners who are at risk of suicide is when prisoners express suicidal ideation to staff or display self-harm behavior. *See id.* Dr. Hayward, as an

[3] *See* U.S. Dep't of Justice, Bureau of Justice Statistics, *Mortality in Local Jails and State Prisons, 2000-2011*, at 8, Table 3 (Aug. 2013), *available at* http://www.bjs.gov/content/pub/pdf/mljsp0011.pdf.

appendix to his report, included an example of one such form. *See id.* at Appendix A. Without a suicide assessment tool, Defendants are unable to employ suicide prevention efforts with respect to a subpopulation of prisoners at high risk of suicide—those who have any of a variety of indicia of suicidality, but who have not yet engaged in self-harm or reported their suicidal feelings to any staff members. A suicide risk assessment tool is a basic element of an adequate suicide prevention program.

76. When Jail staff members determine that a prisoner is at risk of harming him or herself, staff members place prisoners in one of the six safety cells in the Jail. The conditions in the safety cells are extraordinarily punitive. According to Plaintiffs' declarations, the safety cells, which are often referred to as "rubber rooms," are empty rooms with padded walls and floors. The safety cells have no features other than a window and a tray slot in the door and a grate in the floor through which prisoners must urinate and defecate. The safety cells have no beds, sinks, toilets (other than the grate in the floor), chairs, tables, or windows for natural light. Prisoners must sit, sleep, and eat on the same floor on which the toilet grate is located. In addition, according to Dr. Hayward, the safety cells are not sufficiently maintained and cleaned. *See id.* at 11. As a result, they frequently smell of and are sometimes covered in feces.

77. Prisoners placed in the safety cells are denied nearly all privileges and human contact. From my review of safety cell logs attached to Plaintiffs' declarations, prisoners are not provided with showers, any out of cell time, exercise, or property while in the safety cells, regardless of how long they are retained in those cells. Pursuant to policy, Defendants are supposed to provide prisoners with meals and water; from my review of Plaintiffs' declarations, it appears that this does not always happen. In addition, Jail policy explicitly permits staff to handcuff and shackle prisoners while they are in the safety cells. *See* Grunfeld Decl., Ex. E, at § 1104.06 (section improperly numbered in exhibit as 11104.06). From my review of some of the Plaintiffs' declarations, it appears that staff frequently engages in this practice.

78. As if the conditions discussed above were not sufficiently punitive,

1 Defendants frequently strip prisoners and place them naked in the safety cells. Jail policy
2 requires that prisoners placed in the safety cells "shall be allowed to retain sufficient
3 clothing or be provided with a safety smock to provide for their personal privacy unless
4 specific identified risks to the inmate's safety or to the security of the facility are
5 documented." *Id.* at § 1104.05(I) (section improperly numbered in exhibit as 1114.05).
6 However, according to Dr. Hayward, Jail staff frequently deprives prisoners of clothing or
7 a safety smock gown for many hours. *See* Grunfeld Decl., Ex. M, at 11.

8 79. It is my opinion that these conditions are overly restrictive and punitive.
9 Confining a suicidal prisoner to their cell for 24 hours a day only enhances isolation and is
10 anti-therapeutic. Under these circumstances, it is also difficult, if not impossible, to
11 accurately gauge the source of the prisoner's suicidal ideation. The punitive nature of the
12 safety cells also increases the risk of suicide in two very dangerous ways. First, the
13 conditions increase prisoners' suicidality, also increasing the risk that prisoners will follow
14 through on their suicidal feelings. Second, punitive conditions in the safety cells increase
15 the likelihood that a suicidal individual will not report feelings of suicidality in order to
16 avoid being placed in a safety cell.

17 80. These effects are very real, not hypothetical. For example, according to his
18 declaration, when Plaintiff Mefford was experiencing suicidal thoughts in January 2014,
19 he explicitly represented to mental health care staff that he was unsure whether he should
20 report his true level of suicidality because he was afraid he would be placed in a safety
21 cell. Once he was placed in the safety cell, his suicidality increased markedly and he
22 engaged in repeated acts of self-harm.

23 81. Defendants' policies and practices for observing prisoners in safety cells are
24 wholly inadequate and place prisoners at risk. Sheriff's Office policy requires that custody
25 staff members conduct and log a safety check at least twice every thirty minutes when a
26 prisoner is in a safety cell. *See* Grunfeld Decl., Ex. E, at § 1104.05(B) & (C) (section
27 improperly numbered in exhibit as 1114.05). CFMG policy requires that medical staff be
28 notified within one hour of a prisoner's placement in a safety cell, that medical staff

members check in on the prisoner at least once every six hours, and that mental health staff members evaluate a prisoner within 24 hours of placement. Grunfeld Decl., Ex. G, at 289.

82. The policies, even if followed perfectly, are problematic in a number of ways that place prisoners at risk. First, Defendants lack any policy for suicide watch. Suicide watch—where staff constantly observes an acutely suicidal prisoner—is necessary to ensure that certain, acutely suicidal prisoners do not engage in self-harm. To address this danger, some correctional systems, for example the Federal Bureau of Prisons, place all suicidal prisoners under constant observation until such time that mental health care staff determines the prisoner is no longer at risk of self-harm. The complete lack of a suicide watch policy at the Jail places prisoners at risk of serious harm.

83. Second, the custody policy for conducting safety checks of suicidal prisoners placed in safety cells does not require that the twice-every-half-hour safety checks be conducted at unpredictable and non-repeating times. Safety checks at unpredictable times are necessary to ensure that the patient cannot anticipate the amount of time they will not be observed and engage in suicidal acts.

84. Third, CFMG's policy permits a suicidal prisoner to be kept in a safety cell for up to 24 hours without any evaluation by mental health care staff. A suicidal patient should be seen prior to being placed in a safety cell to determine if they require such placement. In cases where that is not possible, the patient should be seen as soon as possible after placement in a safety cell; 24 hours is far too long for a suicidal prisoner to spend in a safety cell without being seen by mental health care staff. The lack of an adequate policy has, according to Dr. Hayward, resulted an "excessive" use of safety cells at the Jail. Grunfeld Decl., Ex. M, at 12. Dr. Hayward wrote that "[r]eview of the records indicates that many of the inmates placed on suicide watch in a safety cell reported suicidal ideation but were not acutely suicidal." *Id.*

85. Fourth, the policy does not specify what level provider is authorized to evaluate and remove a suicidal prisoner from a safety cell, nor does it specify whether evaluations must be in in-person. By potentially permitting low-level providers to admit,

1 evaluate, and discharge suicidal prisoners from safety cells, the policy places suicidal
2 prisoners at risk of serious harm.
3 86. Dr. Hayward found that Defendants do not even follow their flawed safety
4 cell policies. In his review of safety cell logs, he found "that many deputy checks were out
5 of compliance with the required frequency of two every 30 minutes. Some logs document
6 delays of an hour or more between checks." *Id.* at 12. My review of the declaration for
7 Plaintiff Mefford confirms Dr. Hayward's findings, as there were numerous times where
8 Plaintiff Mefford was in a safety cell and was not observed by staff twice every half hour.
9 87. Dr. Hayward concluded that staff's failures to perform safety checks
10 "presents an increased risk of inmate self-harm …." *Id.* I agree with his conclusion. The
11 failure to conduct safety checks on a timely basis is a hallmark of overcrowded facilities
12 like the Jail.
13 88. Dr. Hayward also found that Defendants overuse the safety cells as holding
14 cells for prisoners displaying acute mental illness while staff waits for a mental health
15 clinician to arrive. As he explains, prisoners "may be placed in a safety cell on suicide
16 precautions for observation until they can be evaluated by a mental health clinician….
17 [I]nmates may remain in the safety cell over the weekend until a clinician provides
18 evaluation and release on Mondays." Grunfeld Decl., Ex. M, at 5. Keeping prisoners in a
19 safety cell for a prolonged period of time, such as an entire weekend, without any attention
20 from mental health clinicians, can seriously harm a prisoner's mental health.
21 89. Defendants' use of restraint chairs also places prisoners at risk of serious
22 harm. Restraint chairs should only be used when a prisoner is so out of control that the
23 only means for preventing harm to self or others is to place them in a restraint chair. That
24 said, prisoners placed in restraint chairs are at significant risk of physical harm from being
25 restrained. As a result, prisoners who have been placed in a restraint chair must be
26 constantly observed. Jail policy provides that prisoners in restraint chairs must be
27 observed twice every thirty minutes, the same frequency as for prisoners in safety cells.
28 90. Though I have not yet had an opportunity to fully review Defendants' use of

restraint chairs, Defendants do not always follow their stated policy. For example, Plaintiff Mefford was placed in restraint chairs for approximately four hours and twenty minutes on December 15 and 16, 2013. Staff should have conducted a minimum of 18 checks during that time period. Instead, staff only conducted 13 checks. Moreover, during the time he was in the chair, periods of 39 and 50 minutes passed without any checks. During such long periods without observation, it was possible that Plaintiff Mefford could have suffered grave injury or even death.

91. It also appears that the physical structure of the Jail does adequately protect prisoners with mental illness from suicide. TRG Consulting found in its December 2011 assessment of the Jail that "suicide hazard elimination is not as stringent as it should be to prevent self-harm …." Second Am. Compl., Ex. B (Dkt. No. 41), at A.3. I have not yet been able to inspect the facilities at the Jail. Nonetheless, a correctional facility should have a sufficient number of cells without suicide hazards in booking and in all places where mentally ill prisoners are housed. If Defendants have not sufficiently eliminated suicide hazards at the Jail, it would increase the risk of harm to which prisoners with mental illness are exposed.

92. I have reviewed some[4] documents related to the three completed suicides since 2010. In each case, problems with the Jail's mental health and suicide prevention programs appear to have contributed to the suicides.

93. *Daniel Lariviere:* Daniel Lariviere committed suicide on July 8, 2011. Multiple failures in Defendants' mental health and suicide prevention programs preceded Mr. Lariviere's suicide. The problems with Mr. Lariviere's intake, diagnosis, and intervention, discussed above in Paragraph 42, speak to deficiencies in Defendants' suicide prevention program. Defendants' actions in the hours immediately preceding and following Mr. Lariviere's death reflect additional inadequacies that place prisoners at risk.

[4] I should note that I have only been able to review the medical file for Jessie Crow, and not for the other two prisoners who committed suicide.

1 Mr. Lariviere was ultimately housed in a single cell in I-Pod, an administrative segregation
2 housing unit. Early in the morning, sometime between 2:05 and 3:06 a.m., Mr. Lariviere
3 tied a ligature onto part of the window and hanged himself. He was found with either a t-
4 shirt or a sheet around his neck (Defendants' records are unclear) at 3:06 a.m. during an
5 hourly safety check. A deputy cut Mr. Lariviere down using a knife, began shaking him to
6 try to get a response, and then began to implement CPR. Medical staff was called, and,
7 when Mr. Lariviere did not respond, he was pronounced dead.

8 94. Defendants' supervision of Mr. Lariviere and response to his suicide were
9 problematic in a number of respects. The safety checks in administrative segregation were
10 conducted hourly, as opposed to every half hour. Moreover, the checks were not staggered
11 and unpredictable, but rather, occurred almost exactly one hour apart (at 12:10, 1:10, 2:05,
12 and 3:06 a.m.). Though Defendants maintained a log of the time at which they conducted
13 safety checks for Mr. Lariviere's unit (and presumably other units), they kept no log of
14 their observations of individual prisoners (i.e., whether the prisoner was awake or asleep,
15 standing or lying down, etc.). And rather, than start CPR immediately, the deputy shook
16 Mr. Lariviere, and only when he did not respond, did staff begin CPR. This series of
17 events highlight Defendants' inadequate policies and practices for monitoring prisoners in
18 administrative segregation, inadequate training of officers regarding how to respond to
19 medical and suicide emergencies, and lack of suicide-safe housing. Better policies,
20 practices, and training and safer housing may have been able to save Mr. Lariviere's life.

21 95. *Jesse Crow:* Jesse Crow committed suicide on August 7, 2011, by hanging
22 in his cell in D-Pod, one of the administrative segregation pods. According to the
23 Coroner's Report, Mr. Crow used a rope that he manufactured himself while in Jail that he
24 threaded through the air vent in the ceiling. He also used another rope he made in the Jail
25 to tie his cell door closed so securely that it took two deputies to pry open the door. A
26 number of elements of Mr. Crow's suicide are problematic. First, that Mr. Crow was able
27 to construct two substantial ropes, and position one of them to hang himself and the other
28 to prevent staff from opening his door, all without staff noticing indicates that staff was not

conducting effective checks of prisoners in an administrative segregation unit. In addition, Mr. Crow's ability to access the air vent in his cell demonstrates that Defendants did not adequately eliminate suicide hazards in administrative segregation; suicide resistant air vents are generally available for jails and prisons. Finally, Mr. Crow submitted one sick call slip on June 22, 2010 stating that he was depressed, and another on June 23, 2010 complaining of trouble sleeping. Mr. Crow was not seen by any mental health care staff between his complaints and the date of his suicide.

96. *Joshua Claypole:* Joshua Claypole attempted suicide on May 4, 2013 by hanging, and died a few days later at a hospital in San Jose from complications from his suicide attempt. As with the other two suicides, elements of Mr. Claypole's suicide demonstrate problems with the Jail's suicide prevention program. At the time he attempted suicide, Mr. Claypole was housed in A Pod, one of the administrative segregation housing units utilized by Defendants to house prisoners with serious mental illness. Mr. Claypole was found in his second-tier cell and had used his sheet as a noose. The cell included a set of sturdy metal braces on that wall to which the sheet had been tied, which are serious suicide hazards. When an officer initially found Mr. Claypole, rather than immediately open the cell to cut down the ligature, the officer requested back up by custody and medical staff. Staff did not open the cell and begin to assist Mr. Claypole until other custody staff arrived on the scene. Staff cut Mr. Claypole's ligature using a knife and appeared to have some difficulty doing so; this indicates that they lacked access to a cut-down tool, a much more efficient tool for such a purpose.

97. My review of incident reports involving attempted suicides also identified a number of problems with Defendants' suicide prevention program. For example, an incident report from September 2012 indicates that prisoners in the booking area have access to material (a sheet) they can use to harm themselves. An incident report from November 2012 involved a prisoner who engaged in self-harm (using fingernails and part of a prisoner ID wristband to open a self-inflicted wound) and was placed in a safety cell; that prisoner was transferred directly from the safety cell to a general population holding

cell, where the prisoner proceeded to assault another prisoner. An incident report from April 2013, in which a female prisoner ingested one ounce of Combat germicide solution, indicates that Defendants have poor control over items that can be used for self-harm. Finally, an incident report from September 2013—where a deputy, without consulting with mental health care staff or calling for backup, tased a mentally ill detainee who had threatened suicide after the prisoner refused to surrender her spork and leave her cell—demonstrates that Defendants improperly use force against prisoners who are suicidal and who have mental illness.

Defendants appear to lack an adequate quality improvement plan for identifying and fixing problems with the delivery of mental health care and especially for responding to completed and attempted suicides.

98. All adequately functioning correctional mental health systems must have a robust quality improvement process in place. A quality improvement program provides an essential forum for custody and medical staff to review performance, identify problems, and devise, implement, and evaluate solutions. A quality improvement process is particularly critical for ensuring the adequacy of a suicide prevention program. Close review of prisoners' attempted and completed suicides is necessary to understand where the suicide prevention program may have failed and to ensure such failures do not occur again.

99. According to policy, Defendants have a quality management program. Pursuant to this policy, Defendants must conduct a medical review of all in-custody deaths, including suicides, and produce written findings that must note deficiencies and include corrective action plans. *See* Grunfeld Decl., Ex. G, at 31-32. The medical reviews of in-custody deaths are then supposed to be reviewed by the Quality Management/Peer Review Committee, which consists of key members of the custody and medical staff. *See id.* at 13. According to policy, "[t]he Committee shall be responsible for identifying inappropriateness, deficiencies, and/or problems in health services delivery; developing a corrective action plan and scheduled follow-up evaluation and reporting." *Id.*

100. I have reviewed the CFMG Quality Assurance/Peer Review Committee

1 Meeting Minutes related to Jesse Crow's suicide. Mr. Crow's suicide was discussed at two
2 Quality Assurance meetings. During the first meeting, on October 28, 2010, the discussion
3 in the minutes sets forth a chronology of Mr. Crow's time at the Jail and identified two
4 problems with the care provided to Mr. Crow. First, a psychologist had dictated a note
5 about an interaction with Mr. Crow, but the note was never placed in his medical file.
6 Second, Mr. Crow complained of trouble sleeping a month and a half before he committed
7 suicide, but he was not referred for a psychiatric consultation. According to the
8 chronology, Mr. Crow was not seen by mental health care staff between the date of his
9 complaint about sleeping and the date of his suicide. There is no recommendation for
10 corrective action in the minutes.

11 101. The Quality Assurance Committee's second discussion of Mr. Crow's
12 suicide took place on January 27, 2011. This discussion was considerably shorter, and
13 only indicated that the autopsy had been reviewed and the missing transcribed progress
14 note had been posthumously placed in Mr. Crow's records. Again, there is no
15 recommendation for corrective action.

16 102. If the quality improvement program's response to Mr. Crow's suicide is
17 indicative of Defendants' current quality improvement practices, they fall far short of an
18 adequate. The Quality Improvement Committee should have examined Mr. Crow's
19 suicide more closely to determine if any areas of the Jail's suicide prevention program
20 needed to be addressed. In fact, the Committee identified two serious systematic problems
21 that may have contributed to Mr. Crow's suicide: the failure to refer him for psychiatric
22 care when he requested it shortly before his death and the improper maintenance of his
23 medical records. Nevertheless, the Committee did not propose any corrective action.

24 103. It should also be noted that, pursuant to policy, Defendants are only required
25 to review in-custody completed suicides in the Quality Assurance Committee. There is no
26 policy for reviewing suicide attempts. In my opinion, for a jail the size of Monterey
27 County Jail, the quality improvement program should review both completed and
28 attempted suicides. Though the suicide rate in the Jail is very high, there will likely not be

enough suicides in the Jail during any given time period for Defendants to remedy the problems with their suicide prevention program by only reviewing completed suicides. Attempted suicides, which generally occur at a much higher rate than completed suicides, provide another critical source of information regarding the holes in Defendants' suicide prevention program.

104. The lack of a properly functioning quality improvement program places all prisoners at risk of serious harm by decreasing the likelihood that serious deficiencies in the delivery of health care will be identified and remedied.

The Jail Is Overcrowded, Which Magnifies the Negative Effects of the Problems Discussed Above.

105. I have significant experience evaluating overcrowded correctional systems. In 2008, I was one of the testifying experts in the *Coleman v. Schwarzenegger* trial before a federal three-judge district court; the question for the court was whether overcrowding was the primary cause of deficiencies in the medical and mental health care provided to prisoners in the California Department of Corrections and Rehabilitation. I have also evaluated, testified about, and helped to manage psychiatric care in other overcrowded correctional systems, including the San Francisco County Jail, the Georgia youth corrections system, and the California Youth Authority.

106. Overcrowded facilities suffer from a number of problems: staffing shortages, insufficient treatment space, the unnecessary placement of prisoners in administrative segregation and other locked units, a marked increase in the number of prisoners experiencing psychiatric crisis, medical problems, and/or psychiatric decompensation, a reduction in programs, and overcrowded, dangerous, and chaotic housing environments. These problems work as a feedback loop. A problem in one area tends to reinforce and heighten problems in the other areas.

107. Monterey County Jail has been and continues to be an overcrowded facility. Mr. Hackett, in his report regarding the security at the Jail, wrote that "[b]y any definition, the jail population is such that the jail is overcrowded." Grunfeld Decl., Ex. I, at ¶ 1.4. As

1 evidence of overcrowding, Mr. Hackett relied not just on the fact that the Jail houses more
2 prisoners than its Board Rated Capacity—which it does, *see id.*at ¶ 1.9—but also on the
3 fact that prisoners "are housed in living areas not designed for inmate housing, inmates
4 who should by most standards be housed in medium or maximum security housing are
5 housed in les secure housing, and there are insufficient types of housing available to meet
6 classification needs," *id.* at ¶ 1.4.

7 108. Both Dr. Puisis and TRG Consulting, in their reports about the problems
8 with the Jail, highlighted the gross insufficiency of available, confidential treatment space.
9 Dr. Puisis found that none of the treatment spaces in the Jail were originally designed for
10 clinical purposes. *See* Grunfeld Decl., Ex. J, at 8. He also found that nurses frequently
11 evaluated prisoners in non-clinical, non-confidential spaces. *See id.* at 21. TRG
12 Consulting, in their December 2011 report, wrote that "[m]edical/mental health treatment
13 spaces are not adequate for the rated beds, let alone the actual number of inmates held."
14 Second Am. Compl., Ex. B (Dkt. No. 41), at EX. 3. A number of the Plaintiffs describe
15 situations in which medical and mental health staff examined them in non-clinical, non-
16 confidential settings. Examinations conducted in such circumstances, especially mental
17 health evaluations in which prisoners communicate sensitive and personal information to
18 the mental health care clinicians, are highly prone to error because of prisoners'
19 understandable reluctance to speak earnestly. The lack of sufficient confidential treatment
20 space in the Jail places prisoners at a substantial risk of serious harm by hindering their
21 ability to request and receive adequate treatment.

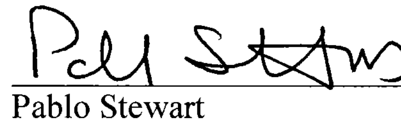
22 109. TRG Consulting also highlighted how the overcrowding in the facility
23 "forces the entire facility to operate as an indirect supervision jail. Mental health issues are
24 considerably more difficult to recognize, manage and treat in an indirect supervision
25 facility." *Id.* I agree with TRG Consulting's conclusion.

26 110. The Defendants in this case have acknowledged that the overcrowding in the
27 Jail compromises their ability to deliver effective health care. For most of the last six
28 years, the County has applied to the Superior Court for the County of Monterey for an

order to release prisoners on an accelerated basis pursuant to California Penal Code § 4024.1. In many of these applications, including one from as recently as October 2012, Dr. Fithian "advised that the excessive number of inmates housed in the Jail compromises the health of the inmates and the staff working at the facility." Grunfeld Decl., Ex. Z, at 2.

111. In my more than 25 years evaluating and working with correctional facilities, I have come across very few, if any, overcrowded facilities in which the overcrowding did not negatively affect the delivery of mental health care. In light of the problems discussed above, it is my opinion that overcrowding negatively affects the quality of mental health care in the Jail and places all prisoners, especially those with serious mental illness, at risk of serious harm.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct, and that this declaration is executed at San Francisco, California this 24TH day of April, 2014.



Pablo Stewart

Exhibit A

CURRICULUM VITAE

PABLO STEWART, M.D.
824 Ashbury Street
San Francisco, California 94117
(415) 753-0321; fax (415) 753-5479; e-mail: pab4emi@aol.com
(Updated November 2013)

EDUCATION:	University of California School of Medicine, San Francisco, California, M.D., 1982 United States Naval Academy, Annapolis, MD, B.S. 1973, Major: Chemistry
LICENSURE:	California Medical License #GO50899 Hawai'i Medical License #MD-11784 Federal Drug Enforcement Administration #BS0546981 Diplomate in Psychiatry, American Board of Psychiatry and Neurology, Certificate #32564

ACADEMIC APPOINTMENTS:

September 2006- Present	Academic Appointment: Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
July 1995 - August 2006	Academic Appointment: Associate Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1989 - June 1995	Academic Appointment: Assistant Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1986 - July 1989	Academic Appointment: Clinical Instructor, Department of Psychiatry, University of California, San Francisco, School of Medicine.

EMPLOYMENT:

December 1996- Present	Psychiatric Consultant Provide consultation to governmental and private agencies on a variety of psychiatric, forensic, substance abuse and organizational issues; extensive experience in all phases of capital litigation and correctional psychiatry.

January 1997- September 1998	Director of Clinical Services, San Francisco Target Cities Project. Overall responsibility for ensuring the quality of the clinical services provided by the various departments of the project including the Central Intake Unit, the ACCESS Project and the San Francisco Drug Court Also responsible for providing clinical in-service trainings for the staff of the Project and community agencies that requested technical assistance.
February 1996 - November 1996	Medical Director, Comprehensive Homeless Center, Department of Veterans Affairs Medical Center, San Francisco. Overall responsibility for the medical and psychiatric services at the Homeless Center.
March 1995 - January 1996	Chief, Intensive Psychiatric Community Care Program, (IPCC) Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for the IPCC, a community based case management program. Duties also include medical/psychiatric consultation to Veteran Comprehensive Homeless Center. This is a social work managed program that provides comprehensive social services to homeless veterans.
April 1991 - February 1995	Chief, Substance Abuse Inpatient Unit, (SAIU), Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for SAIU.
September 1990 - March 1991	Psychiatrist, Substance Abuse Inpatient Unit, Veterans Affairs Medical Center, San Francisco. Clinical responsibility for patients admitted to SAIU. Provide consultation to the Medical/Surgical Units regarding patients with substance abuse issues.
August 1988 - December 1989	Director, Forensic Psychiatric Services, City and County of San Francisco. Administrative and clinical responsibility for psychiatric services provided to the inmate population of San Francisco. Duties included direct clinical and administrative responsibility for the Jail Psychiatric Services and the Forensic Unit at San Francisco General Hospital.
July 1986 - August 1990	Senior Attending Psychiatrist, Forensic Unit, University of California, San Francisco General Hospital. Administrative and clinical responsibility for a 12-bed, maximum-security psychiatric ward. Clinical supervision for psychiatric residents, postdoctoral psychology fellows and medical students assigned to the ward. Liaison with Jail Psychiatric Services, City and County of San Francisco. Advise San Francisco City Attorney on issues pertaining to forensic psychiatry.

July 1985 June 1986	Chief Resident, Department of Psychiatry, University of California San Francisco General Hospital. Team leader of the Latino-focus inpatient treatment team (involving 10-12 patients with bicultural/bilingual issues); direct clinical supervision of 7 psychiatric residents and 3-6 medical students; organized weekly departmental Grand Rounds; administered and supervised departmental residents' call schedule; psychiatric consultant to hospital general medical clinic; assistant coordinator of medical student education; group seminar leader for introduction to clinical psychiatry course for UCSF second-year medical students.
July 1984 - March 1987	Physician Specialist, Westside Crisis Center, San Francisco, CA. Responsibility for Crisis Center operations during assigned shifts; admitting privileges at Mount Zion Hospital. Provided psychiatric consultation for the patients admitted to Mount Zion Hospital when requested.
April 1984 - July 1985	Psychiatric Consultant, Marin Alternative Treatment, (ACT). Provided medical and psychiatric evaluation and treatment of residential drug and alcohol clients; consultant to staff concerning medical/psychiatric issues.
August 1983 - November 1984	Physician Specialist, Mission Mental Health Crisis Center, San Francisco, CA. Clinical responsibility for Crisis Center clients; consultant to staff concerning medical/psychiatric issues.
July 1982- July 1985	Psychiatric Resident, University of California, San Francisco. Primary Therapist and Medical Consultant for the adult inpatient units at San Francisco General Hospital and San Francisco Veterans Affairs Medical Center; Medical Coordinator/Primary Therapist - Alcohol Inpatient Unit and Substance Abuse Clinic at San Francisco Veterans Affairs Medical Center; Outpatient Adult/Child Psychotherapist; Psychiatric Consultant - Adult Day Treatment Center - San Francisco Veterans Affairs Medical Center; Primary Therapist and Medial Consultant - San Francisco General Hospital Psychiatric Emergency Services; Psychiatric Consultant, Inpatient Medical/Surgical Units - San Francisco General Hospital.
June 1973 - July 1978	Infantry Officer - United States Marine Corps. Rifle Platoon Commander; Anti-tank Platoon Commander; 81mm Mortar Platoon Commander; Rifle Company Executive Officer; Rifle Company Commander; Assistant Battalion Operations Officer; Embarkation Officer; Recruitment Officer; Drug, Alcohol and Human Relations Counselor; Parachutist and Scuba Diver; Commander of a Vietnamese Refugee Camp. Received an Honorable Discharge. Highest rank attained was Captain.

HONORS AND AWARDS:

June 1995	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1994/1995.
June 1993	Selected by the class of 1996, University of California, San Francisco, School of Medicine as outstanding lecturer, academic year 1992/1993.
May 1993	Elected to Membership of Medical Honor Society, AOA, by the AOA Member of the 1993 Graduating Class of the University of California, San Francisco, School of Medicine.
May 1991	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1990-1991.
May 1990	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1989-1990.
May 1989	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1988-1989.
May 1987	Selected by the faculty and students of the University of California, San Francisco, School of Medicine as the recipient of the Henry J. Kaiser Award For Excellence in Teaching.
May 1987	Selected by the graduating class of the University of California, San Francisco, School of Medicine as Outstanding Psychiatric Resident. The award covered the period of 1 July 1985 to 30 June 1986, during which time I served as Chief Psychiatric resident, San Francisco General Hospital.
May 1985	Selected by the graduating class of the University of California, San Francisco, School of Medicine as Outstanding Psychiatric Resident.
1985	Mead-Johnson American Psychiatric Association Fellowship. One of sixteen nationwide psychiatric residents selected because of a demonstrated commitment to public sector psychiatry. Made presentation at Annual Hospital and Community Psychiatry Meeting in Montreal, Canada, in October 1985, on the “Psychiatric Aspects of the Acquired Immunodeficiency Syndrome.”

MEMBERSHIPS:

June 2000- May 2008	California Association of Drug Court Professionals.
July 1997- June 1998	President, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1996 - June 1997	President-Elect, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1995 - June 1996	Vice President, Northern California Area, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
April 1995 - April 2002	Associate Clinical Member, American Group Psychotherapy Association.
July 1992 - June 1995	Secretary-Treasurer, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1990 - June 1992	Councilor-at-large, Alumni-Faculty Association, University of California, San Francisco, School of Medicine

PUBLIC SERVICE:

June 1992	Examiner, American Board of Psychiatry and Neurology, Inc.
November 1992 - January 1994	California Tuberculosis Elimination Task Force, Institutional Control Subcommittee.
September 2000- April 2005	Editorial Advisory Board, *Juvenile Correctional Mental Health Report.*
May 2001- Present	Psychiatric and Substance Abuse Consultant, San Francisco Police Officers' Association.
January 2002- June 2003	Psychiatric Consultant, San Francisco Sheriff's Department Peer Support Program.
February 2003- April 2004	Proposition "N" (Care Not Cash) Service Providers' Advisory Committee, Department of Human Services, City and County of San Francisco.
December 2003- January 2004	Member of San Francisco Mayor-Elect Gavin Newsom's Transition Team.
February 2004- June 2004	Mayor's Homeless Coalition, San Francisco, CA.
April 2004- January 2006	Member of Human Services Commission, City and County of San Francisco.

February 2006- January 2007; April 2013- present	Vice President, Human Services Commission, City and County of San Francisco.
February 2007- March 2013	President, Human Services Commission, City and County of San Francisco.

UNIVERSITY SERVICE:

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

October 1978 - December 1980	Co-Founder and Director of the University of California, San Francisco Running Clinic. Provided free instruction to the public on proper methods of exercise and preventative health measures.

TEACHING RESPONSIBILITIES:

July 2003- Present	Facilitate weekly psychotherapy training group for residents in the Department of Psychiatry.
January 2002- January 2004	Course Coordinator of Elective Course University of California, San Francisco, School of Medicine, "Prisoner Health." This is a 1-unit course, which covers the unique health needs of prisoners.
September 2001- June 2003	Supervisor, San Mateo County Psychiatric Residency Program.
April 1999- April 2001	Lecturer, UCSF School of Pharmacy, Committee for Drug Awareness Community Outreach Project.
February 1998- June 2000	Lecturer, UCSF Student Enrichment Program.
January 1996 - November 1996	Supervisor, Psychiatry 110 students, Veterans Comprehensive Homeless Center.
March 1995- Present	Supervisor, UCSF School of Medicine, Department of Psychiatry, Substance Abuse Fellowship Program.
September 1994 - June 1999	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Drug and Alcohol Abuse." This is a 1-unit course, which covers the major aspects of drug and alcohol abuse.
August 1994 - February 2006	Supervisor, Psychiatric Continuity Clinic, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Supervise 4th Year medical students in the care of dual diagnostic patients.
February 1994 - February 2006	Consultant, Napa State Hospital Chemical Dependency Program Monthly Conference.
July 1992 - June 1994	Facilitate weekly psychiatric intern seminar, "Psychiatric Aspects of Medicine," University of California, San Francisco, School of Medicine.
July 1991- Present	Group and individual psychotherapy supervisor, Outpatient Clinic, Department of Psychiatry, University of California, San Francisco, School of Medicine.

January 1991	Lecturer, University of California, San Francisco, School of Pharmacy course, "Addictionology and Substance Abuse Prevention."
September 1990 - February 1995	Clinical supervisor, substance abuse fellows, and psychiatric residents, Substance Abuse Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - November 1996	Off ward supervisor, PGY II psychiatric residents, Psychiatric Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - June 1991	Group therapy supervisor, Psychiatric Inpatient Unit, (PIU), San Francisco Veterans Affairs Medical Center.
September 1990 - June 1994	Course coordinator, Psychiatry 110, San Francisco Veterans Affairs Medical Center.
September 1989 - November 1996	Seminar leader/lecturer, Psychiatry 100 A/B.
July 1988 - June 1992	Clinical supervisor, PGY III psychiatric residents, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project.
September 1987 - Present	Tavistock Organizational Consultant. Extensive experience as a consultant in numerous Tavistock conferences.
September 1987 - December 1993	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Alcoholism". This is a 1-unit course offered to medical students, which covers alcoholism with special emphasis on the health professional. This course is offered fall quarter each academic year.
July 1987- June 1994	Clinical supervisor/lecturer FCM 110, San Francisco General Hospital and Veterans Affairs Medical Center.
July 1986 - June 1996	Seminar leader/lecturer Psychiatry 131 A/B.
July 1986 - August 1990	Clinical supervisor, Psychology interns/fellows, San Francisco General Hospital.
July 1986 - August 1990	Clinical supervisor PGY I psychiatric residents, San Francisco General Hospital
July 1986 - August 1990	Coordinator of Medical Student Education, University of California, San Francisco General Hospital, Department of Psychiatry. Teach seminars and supervise clerkships to medical students including: Psychological Core of Medicine 100 A/B; Introduction to Clinical Psychiatry 131 A/B; Core Psychiatric Clerkship 110 and Advanced Clinical Clerkship in Psychiatry 141.01.

July 1985 – August 1990	Psychiatric Consultant to the General Medical Clinic, University of California, San Francisco General Hospital. Teach and supervise medical residents in interviewing and communication skills. Provide instruction to the clinic on the psychiatric aspects of ambulatory medical care.

COMMUNITY SERVICE AND PRISON CONDITIONS EXPERT WORK:

October 2007 -Present	Plaintiffs' expert in 2007-2010 overcrowding litigation and in opposing current efforts by defendants to terminate the injunctive relief in *Coleman v. Brown,* United States District Court, Eastern District of California, Case No. 2:90-cv-00520-LKK-JFM. The litigation involves plaintiffs' claim that overcrowding is causing unconstitutional medical and mental health care in the California state prison system. Plaintiffs won an order requiring the state to reduce its population by approximately 45,000 state prisoners. My expert opinion was cited several times in the landmark United States Supreme Court decision upholding the prison population reduction order. *See Brown v. Plata,* __ U.S. ___, 131 S. Ct. 1910, 1933 n.6, 1935, 179 L.Ed.2d 969, 992 n.6, 994 (2011).
July/August 2008	Plaintiff psychiatric expert in the case of Fred Graves, et al., plaintiffs v. Joseph Arpaio, et al., defendants (District Court, Phoenix, Arizona.) This case involved Federal oversight of the mental health treatment provided to pre-trial detainees in the Maricopa County Jails.
February 2006- December 2009	Board of Directors, Physician Foundation at California Pacific Medical Center.
June 2004- September 2012	Psychiatric Consultant, Hawaii Drug Court.
November 2003- June 2008	Organizational/Psychiatric Consultant, State of Hawaii, Department of Human Services.
June 2003- December 2004	Monitor of the psychiatric sections of the "Ayers Agreement," New Mexico Corrections Department (NMCD). This is a settlement arrived at between plaintiffs and the NMCD regarding the provision of constitutionally mandated psychiatric services for inmates placed within the Department's "Supermax" unit.
October 2002- August 2006	Juvenile Mental Health and Medical Consultant, United States Department of Justice, Civil Rights Division, Special Litigation Section.

July 1998- June 2000	Psychiatric Consultant to the Pacific Research and Training Alliance's Alcohol and Drug Disability Technical Assistance Project. This Project provides assistance to programs and communities that will have long lasting impact and permanently improve the quality of alcohol and other drug services available to individuals with disabilities.
July 1998- February 2004	Psychiatric Consultant to the National Council on Crime and Delinquency (NCCD) in its monitoring of the State of Georgia's secure juvenile detention and treatment facilities. NCCD is acting as the monitor of the agreement between the United States and Georgia to improve the quality of the juvenile justice facilities, critical mental health, medical and educational services, and treatment programs. NCCD ceased to be the monitoring agency for this project in June 1999. At that time, the Institute of Crime, Justice and Corrections at the George Washington University became the monitoring agency. The work remained unchanged.
July 1998- July 2001	Psychiatric Consultant to the San Francisco Campaign Against Drug Abuse (SF CADA).
March 1997- Present	Technical Assistance Consultant, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.
January 1996- June 2003	Psychiatric Consultant to the San Francisco Drug Court.
November 1993- June 2001	Executive Committee, Addiction Technology Transfer Center (ATTC), University of California, San Diego.
December 1992 - December 1994	Institutional Review Board, Haight Ashbury Free Clinics, Inc. Review all research protocols for the clinic per Department of Health and Human Services guidelines.
June 1991- February 2006	Chief of Psychiatric Services, Haight Ashbury Free Clinic. Overall responsibility for psychiatric services at the clinic.
December 1990 - June 1991	Medical Director, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Responsible for directing all medical and psychiatric care at the clinic.
October 1996-July 1997	Psychiatric Expert for the U.S. District Court, Northern District of California, in the case of Madrid v. Gomez, No. C90-3094-TEH. Report directly to the Special Master regarding the implementation of constitutionally mandated psychiatric care to the inmates at Pelican Bay State Prison.
April 1990 –January 2000	Psychiatric Expert for the U.S. District Court, Eastern District of California, in the case of Gates v. Deukmejian, No. C1V S-87-1636 LKK-JFM. Report directly to the court regarding implementation and monitoring of the consent decree in this case. (This case involves the provision of adequate psychiatric care to the inmates at the California Medical Facility, Vacaville).

January 1984 - December 1990	Chief of Psychiatric Services, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Direct medical/psychiatric management of project clients; consultant to staff on substance abuse issues. Special emphasis on dual diagnostic patients.
July 1981- December 1981	Medical/Psychiatric Consultant, Youth Services, Hospitality House, San Francisco, CA. Advised youth services staff on client management. Provided training on various topics related to adolescents. Facilitated weekly client support groups.

SERVICE TO ELEMENTARY AND SECONDARY EDUCATION:

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

PRESENTATIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35. The California Council of Community Mental Health Agencies Winter Conference, Key Note Presentation, "Combining funding sources and integrating treatment for addiction problems for children, adolescents and adults, as well as coordination of addiction

treatment for parents with mental health services to severely emotionally disturbed children." Newport Beach, California. (2/12/98)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

64. Pfizer Pharmaceuticals sponsored lecture tour of Hawai'i. Lectures included: Major Depressive Disorder and Substance Abuse, Treatment Strategies for Depression and Anxiety with the Substance Abusing Patient, Advances in the Field of Dual Diagnosis &

Addressing the Needs of the Patient with Multiple Substance Dependencies. Lecture sites included: Straub Hospital, Honolulu; Maui County Community Mental Health; Veterans Administration Hospital, Honolulu; Hawai'i (Big Island) County Community Mental Health; Mililani (Oahu) Physicians Center; Kahi Mohala (Oahu) Psychiatric Hospital; Hale ola Ka'u (Big Island) Residential Treatment Facility. (4/2-4/9/99)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS:

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

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

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

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