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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Larry Gann, Division Director, Health Care Services Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

PLAINTIFFS' MOTION TO ENFORCE PARAGRAPH 14 OF THE STIPULATION

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Plaintiffs hereby move the Court to exercise its inherent powers and those outlined in the Stipulation to enforce the terms of the Stipulation and order Defendants to take immediate and substantial action to remedy their failure to provide interpretation during the healthcare encounters of class members who are not fluent in English, including D/deaf class members who communicate using sign language and monolingual Spanish speakers.[1] All too often, patients are forced to pantomime or simply not participate in or fully understand critical healthcare encounters involving, among other things, mental health counseling, review and prescription of psychiatric medications, and chronic care appointments.

PROCEDURAL HISTORY

Paragraph 14 of the Stipulation provides:

> For prisoners who are not fluent in English, language interpretation for healthcare encounters shall be provided by a qualified health care practitioner who is proficient in the prisoner's language, or by a language line interpretation service.

[Doc. 1185 at 6 ¶ 14]

On July 12, 2016, Plaintiffs moved to enforce the Stipulation, noting, among other things, that Defendants refused "to monitor and document compliance" with Paragraph 14. [Doc. 1625 at 8-9] In response, Defendants contended that they were "not required to monitor" Paragraph 14. [Doc. 1644 (capitalization omitted) at 3] The Court disagreed and, on September 6, 2016, granted Plaintiffs' motion in part. [Doc. 1673 at 1-2, 8] The Court held that "Plaintiffs are entitled to timely data demonstrating Defendants' compliance" and ordered Defendants to "propose a reporting procedure to demonstrate compliance" within thirty days. [*Id.* at 2, 8]

[1] Use of the lowercase "deaf" generally is used when referring to the audiological condition of not hearing, whereas the uppercase "Deaf" is used when referring to individuals who self-identify as culturally Deaf, meaning they share the use of American Sign Language and other practices as a culture.

On October 6, 2016, Defendants proposed the following:

> To demonstrate compliance with [Paragraph 14], Defendants propose that a 'hard-stop' feature be added to eOMIS. Specifically, when a health care provider opens a new note to begin a health care encounter with an inmate, the provider will be prompted to answer the following questions before being allowed to complete the remainder of the note:
>
> 1. Are interpreter services needed for this inmate?
> 2. If so, what type of interpreter services were used for the encounter?
>
> a) Language line
>
> b) Healthcare staff was available for interpretive services
>
> c) Inmate refused interpreter services.

[Doc. 1703 at 3] Defendants stated that "a report of all inmates who required interpreter services to be seen and the type of interpretation that was used" would "be produced to Plaintiffs on a monthly basis." [*Id.*]

Plaintiffs responded that they were satisfied with this proposal, but noted that Defendants offered no information as to when the changes would be implemented. [Doc. 1755 at 21-22] The Court thereafter ordered Defendants to report whether they could make the changes within thirty days. [Doc. 1831 at 3] On February 9, 2017, Defendants reported that "[a] 'hard-stop' feature has been added to eOMIS, which requires a provider answer several questions regarding interpreter services each time a SOAPE note is opened."[2] [Doc. 1927 at 2] Defendants, however, never produced the promised monthly compliance reports. [*See* Declaration of Corene T. Kendrick ("Kendrick Decl.") ¶ 8]

On February 7, 2019, Plaintiffs sent Defendants a Notice of Substantial Non-Compliance. [Doc. 3255-1 at 108-113] Plaintiffs noted that, during visits to ASPC-

[2] "eOMIS" refers to the electronic medical record system used by Defendants. "SOAPE" note refers to the "Subjective, Objective, Assessment, Plan, and Education" sections that are a standard part of documenting every healthcare encounter. The fields for a SOAPE note are generated whenever a new encounter is opened in eOMIS.

Tucson and ASPC-Eyman in 2019, "deaf class members whose primary form of communication is American Sign Language (ASL) reported that they are not provided with sign language interpretation during healthcare encounters." [*Id.* at 108] Plaintiffs noted that "[a] review of the electronic medical record confirms deaf class members' reports," and listed several examples where sign language interpretation was not provided for healthcare encounters, including for intake assessments and mental health counseling. [*Id.* at 109-111] Plaintiffs further noted that the "hard-stop" feature that had been proposed by Defendants to demonstrate compliance was not in fact accurately identifying instances of noncompliance and was yielding internally inconsistent results:

> The electronic medical record now contains two fields related to interpreter services for specific health care encounters: "Are interpreter services needed for this inmate," and "What type of interpreter services were used for the encounters." The first field, however, does not appear to be automatically populated and can be inconsistent between different medical encounters for the same class members.

[*Id.* at 113]

This also was true for Spanish-speaking class members. In one case, "the psychologist noted that interpretation was required" during an individual counseling encounter on January 15, 2019, and "that such interpretation was provided by a health care staff member." [Doc. 3255-1 at 112] "However, when [the patient] participated in MH Group Counseling one week earlier, on January 8, the same psychologist wrote that interpretation was not needed, and there is no indication that it was provided." [*Id.*]

Defendants responded to the Notice of Substantial Non-Compliance on March 11, 2019. [Doc. 3255-1 at 125-27] Defendants first stated that they "disagree that Paragraph 14 of the Stipulation was intended to include inmates who utilize sign language as a form of communication." [*Id.* at 125] Defendants then stated that their contractor "has a national contract with LanguageLine, which provides video interpreting, including American Sign Language." [*Id.* at 126] As to the specific examples of noncompliance provided by Plaintiffs, Defendants stated only that "Plaintiffs failed to substantiate that

[the] inmate[s] . . . [are] not sufficiently fluent in English." [*Id.* at 126-27] Defendants concluded their letter by stating that they "consider this issue closed." [*Id.* at 127]

On March 20, 2019, Defendants responded to Plaintiffs' request for "[a]ll documents related to Defendants' monitoring of compliance with Paragraph 14 . . . at all ASPCs, including instructions to monitoring staff and compliance reports." [Kendrick Decl., Ex. 3 at 6] Defendants asserted, "[w]ithout waiving any objections, there are no responsive documents." [*Id.*]

The parties met-and-conferred and later mediated the dispute before Magistrate Judge Deborah M. Fine on August 28, 2019. [Doc. 3348] The parties were unable to resolve the dispute through mediation, and have been unable to resolve it since that time.

ARGUMENT

I. PARAGRAPH 14 APPLIES TO ALL CLASS MEMBERS NOT FLUENT IN ENGLISH, INCLUDING THOSE WHO USE SIGN LANGUAGE.

As an initial matter, Defendants simply are wrong when they assert "that Paragraph 14 of the Stipulation was [not] intended to include inmates who utilize sign language as a form of communication." [Doc. 3255-1 at 125] Paragraph 14 is broadly worded and covers all class members "who are not fluent in English." [Doc. 1185 at 6 ¶ 14] This includes class members who use a sign language, including American Sign Language ("ASL"), to communicate. "ASL is a visual, three-dimensional, non-linear language, and its grammar and syntax differ from the grammar and syntax of English and other spoken languages. In many cases, there is no one-to-one correspondence between signs in ASL and words in the English language." *U.S. E.E.O.C. v. UPS Supply Chain Sol'ns*, 620 F.3d 1103, 1105 (9th Cir. 2010) (internal citations omitted).

D/deaf class members uniformly report that a sign language interpreter was not provided for healthcare encounters.[3] From review of the medical record, it appears that

[3] [*See* Declaration of Amber Norris ("Norris Decl."), Ex. 1, Declaration of W.D. ("W.D. Decl.") ¶ 8 ("The only ASL interpreters I have had in medical appointments at ADC has been other prisoners who knew some fingerspelling in ASL."); *id.*, Ex. 62, Declaration of J.H. ("J.H. Decl.") ¶ 10 ("While at ADC, I was not provided a certified

staff instead often attempted to communicate through notes written in English.[4] [*See, e.g.*, Norris Decl. ¶¶ 27, 58, 70, 93, 97, 116, 122, 126, 128, 132, 134, 142, 147, 149, 157, 165, 167, 175, 192, 196, 200, 202, 204, 211, 281, 283] This includes perfunctory questions written by mental health staff ("Homicidal? Kill others?"), and an attempt to counsel a class member after the suicide of his brother ("greif [sic] is like a fart if you force it, it just might be shit"). [*Id.*, Ex. 99 at 10] As Dr. Pablo Stewart, a board-certified psychiatrist and correctional health expert, explained, such notes are "an unnecessarily awkward, stilted, and slow way to communicate and do[] not provide an appropriate or adequate medium to engage the patient in discussion of sensitive and important mental health matters."[5] [Declaration of Dr. Pablo Stewart ("Stewart Decl.") ¶ 25] Indeed, one psychologist wrote that an "evaluation proceed[ed] with written questions that [the

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ASL interpreter during important medical and mental health encounters, including medical appointments, psychiatric consults, psychologist/therapy meetings, dental procedures, and intake."); *id.*, Ex. 20, Declaration of F.L.H. ("F.L.H. Decl.") ¶ 9 (same); *id.*, Ex. 52, Declaration of G.M. ("G.M. Decl.") ¶ 25 (same); *id.*, Ex. 83, Declaration of K.P. ("K.P. Decl.") ¶¶ 15-16 ("I have never been provided an ASL interpreter for any of my healthcare encounters at ADC. During healthcare encounters at ADC, ADC has either attempted to use an unqualified fellow incarcerated person to interpret, used written English notes, or simply ignored that I could not hear and talked to me.")] The class member declarations cited in this motion were drafted with the assistance of Spanish language interpreters, a person fluent in Spanish, and sign language interpreters, as appropriate, and read to the class member in his or her language to ensure accuracy. [*See id.*, Exs. 2, 49, 53, 63, 84, 102, 126, 139, 145, 158 at 3, 165 at 4]

[4] In other cases, there is no indication in the record how, if at all, effective communication was achieved. [*See, e.g.*, Norris Decl. ¶¶ 17, 36, 38, 40, 42, 44, 48, 64, 66, 99, 101, 114, 130, 136, 138, 140, 151, 155, 171, 182, 206, 219]

[5] *See also* Anna Middleton, ed., Working with Deaf People: A Handbook for Healthcare Professionals 59 (2010) ("A busy health professional is also likely to write in a briefer manner in a written note, given the time it takes to write one, than they would be if they were explaining in speech. This means that a deaf person, particularly a sign language user, is receiving their medical information not only in a language they do not routinely use, but also in a shorter form than their hearing counterpart would receive. It is not difficult to see that this means a substandard service is being provided.") (citation omitted); G.M. Decl. ¶ 20 ("I find that often when using notes to communicate in healthcare visits, [staff] provide less information than they would provide if they could say it. The notes are short. It takes a lot less time to tell me information than to write it down. The healthcare professionals are, at times, impatient, if I need to follow up on information in the note or if I write that I do not understand."); Norris Decl., Ex. 48, Declaration of C.P. ¶ 20 ("I receive less information when it needs to be written because it takes longer to write than to speak/translate information in sign language, and the healthcare providers are in a hurry. If I do not understand a concept or a medical term in the note, the healthcare provider often does not provide a sufficient explanation for the same reasons.").

patient] answers with written one-word responses," something that even the psychologist acknowledged in the medical record did not allow her to assess "[t]hought processes." [Norris Decl. ¶ 281]

And many D/deaf people are not fluent in English—verbal or written.[6] In fact, D/deaf class members reported that they did not understand English notes written by healthcare staff. [*See, e.g.*, W.D. Decl. ¶ 10 ("The provider showed me a list of medicines on the computer screen and wrote down information on a piece of paper and showed it to me, but I did not understand what the provider wrote."); *id.* ¶ 11 ("The nurse tried to communicate with me by typing on the computer and showing me what she had typed, but I did not understand what the nurse was trying to communicate."); Norris Decl., Ex. 101, Declaration of F.L. ("F.L. Decl.") ¶ 8 ("There are certain medical terms that after reading them in English, I have no idea what they mean."); K.P. Decl. ¶¶ 14, 22 ("I did not understand a lot of the vocabulary in the medical questionnaire when I read it and had to guess. . . . In some encounters, healthcare staff wrote notes to attempt to communicate with me. Handwritten notes are not an effective way for me to communicate with medical staff because I am not fluent in reading and writing in English."); F.L.H. Decl. ¶ 8 ("[O]ut of several pages of notes the doctors write, I can usually understand just a few words.")]

It thus is critical that sign language interpretation be provided when required by Paragraph 14. *Armstrong v. Brown*, 939 F. Supp. 2d 1012, 1021 (N.D. Cal. 2013) (noting "Defendants harm deaf prisoners by forcing them to rely on inadequate and ineffective forms of communication, such as . . . written notes" and "requiring Defendants, for all deaf prisoners whose primary means of communication is sign language, to provide a

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[6] *See, e.g.*, Michele LaVigne & McCay Vernon, An Interpreter Isn't Enough: Deafness, Language, and Due Process, 2003 Wis. L. Rev. 843, 854 (2003) ("Thirty percent of deaf students leave school functionally illiterate, i.e., they read at grade level 2.8 or below."); Irene W. Leigh *et al.*, Deaf Culture 191 (2018) ("It is a well-known fact that many deaf people have low English literacy. . . . They may misunderstand instructions for medicine after they see doctors because sign language interpreters were not provided. . . . Doctors may not understand them because they do not know ASL and may not have sign language interpreters available and as a result may misdiagnose medical symptoms. This can lead to ongoing health problems based on lack of understanding.").

qualified sign language interpreter during all regularly-scheduled mental health rounds and all other encounters within the definition of the [settlement agreement]").

II. DEFENDANTS DO NOT HAVE A SYSTEM IN PLACE TO ACCURATELY DEMONSTRATE COMPLIANCE WITH PARAGRAPH 14.

Defendants do not have a system in place to accurately demonstrate compliance with Paragraph 14. First, Defendants do not accurately document whether a class member is not fluent in English and therefore requires an interpreter for healthcare encounters. Second, Defendants do not maintain a list of the healthcare practitioners who are proficient in languages other than English.

A. Defendants Do Not Accurately Document Whether Someone Requires Interpreter Services.

Defendants have conceded that they do not have a "[l]ist of all class members who are not fluent in English and their ADC numbers and primary language." [*See* Kendrick Decl., Ex. 3 at 5] Instead, for each individual healthcare encounter, medical staff enters a response to the "hard-stop" question: "Are interpreter services needed for this inmate." This has not proven to be a reliable method for documenting or determining if a person in fact requires interpreter services. In some cases, medical staff improperly state that a class member who is not fluent in English does *not* need an interpreter for a specific encounter. And a single class member can have inconsistent entries; some encounters state that the class member needs an interpreter, and other encounters state that the same class member does not need an interpreter (and, even more confusingly, some encounters state both that an interpreter is needed and that an interpreter is not needed).

1. Medical Records Improperly State That Class Members Who Are Not Fluent in English Do Not Need an Interpreter.

The medical record sometimes states that no interpreter services are needed when the class member is not fluent in English and does in fact require such services. For example, D.M. reported that he is a native Spanish speaker, has not had any formal education in English, and has a limited English vocabulary. [Norris Decl., Ex. 144,

Declaration of D.M. ("D.M. Decl.") ¶ 2] He "cannot speak, write, or read English fluently." [*Id.*] He reported that he has been provided Spanish interpreter services only once during a healthcare encounter—in 2012. [*Id.* ¶ 9] He reported that he could not communicate with the Nurse Practitioner during a chronic care appointment on September 18, 2019, because she spoke only in English, and he did not understand what was said at that appointment. [*Id.* ¶ 5] Nonetheless, the medical record states that interpreter services were not needed for the encounter. [Norris Decl. ¶ 272; *id.*, Ex. 149]

The same is true for an encounter with a psychiatrist on August 5, 2019, to discuss psychiatric medications; D.M. was not provided with an interpreter, and the medical record says one was not needed. [Norris Decl. ¶ 266; *id.*, Ex. 146] In order to communicate his concerns, D.M. "had another prisoner write down what [he] needed to say in English and practiced it before going to [the] appointment." [D.M. Decl. ¶ 8] The psychiatrist noted the following in the medical record:

> Today he says that he would like to get back on his zyprexa, that loxapine is not working, reports that, "I am having mood swings, I am happy, sad, angry, worrying, thinking, depressed, feel angry too much, and too much problem for sleep, I feeling bad, I put 2 HNR to other psychiatrist, I eat my fingers, I eat my nails, I bang the wall because I feel angry too much, I need help please, I am not crazy but I feeling bad, I am having too much problem, I don't want to do something wrong, I don't want to hurt someone, I need help please."

[Norris Decl., Ex. 146 at 1] "The verbatim quotation to what the patient was saying shows that the patient was rattling off what was written down in a staccato manner and clearly isn't fluent in English ('I feeling bad')." [Stewart Decl. ¶ 16 ("I lack the adjectives to describe how problematic this encounter is.")]

The following month, D.M. had a mental health counseling appointment, where the psychologist again spoke to D.M. only in English. [D.M. Decl. ¶ 6] As D.M. explained, "I have learned a few words like 'happy,' 'sad,' 'angry,' and 'depressed' from other prisoners, but I cannot elaborate further in English. I cannot explain to the psychologist in English why I feel those emotions, and I cannot understand anything the psychologist says that might be able to help me feel better." [*Id.*] Again, the medical record, which quotes

D.M. as saying his mood "goes happy, sad, angry, depressed . . . too much angry," states that interpreter services were not needed. [Norris Decl., Ex. 148]

Other monolingual Spanish speaking class members are incorrectly listed as not requiring interpreter services for healthcare encounters. For example:

- C.L., a native Spanish speaker with limited English language abilities, requested an interpreter for a chronic care appointment to discuss diabetes, lung problems, and high blood pressure. "The provider got another prisoner who was a porter in the health unit to serve as the Spanish interpreter for this appointment." [Norris Decl., Ex. 138, Declaration of C.L. ¶¶ 4-6, 11] The medical record states that interpreter services were not needed, and makes no reference to another incarcerated person being present or providing interpreter services. [*Id.*, Ex. 141 at 1]

- F.A.H., a native Spanish speaker who does "not speak English at all," requested an interpreter for a mental health encounter, but was not given one: "Communicating with the psychiatrist in this appointment was difficult. He seemed to understand when I said 'medicina' that I was talking about my medication but then I ended up having to 'act out' what I was experiencing with my medication—that it wasn't helping, that I still couldn't sleep well. I never understood what the psychologist told me in that appointment, and I wonder whether he understood what I was trying to communicate through gestures and acting out what was happening to me. I also wanted to be able to ask about whether the medication I am taking might cause any potential long-term harm to my liver. However, because without a Spanish interpreter I was communicating mostly by gestures in this appointment, I did not know how to ask the questions. I still do not know about any of the long-term risks of the medication I am taking, if there are any." [Norris Decl., Ex. 125, Declaration of F.A.H. ("F.A.H. Decl.") ¶¶ 8, 13; *see also id.*, Ex. 133 at 1 (medical record entry stating no interpreter services needed)]

- C.M., a native Spanish speaker with "a very limited English vocabulary," reported that she was not able to fully participate in her individual counseling session: "Ms. Contreras [Psych Associate] speaks some Spanish but is very limited in her vocabulary. I did not have an interpreter for this appointment. Ms. Contreras is aware that I speak very little English and require an interpreter. I tried to express to Ms. Contreras how I was feeling in Spanish and let her know that I had a lot of anxiety following an assault that occurred in April 2018 while I was housed in ASPC-Lewis. Following that incident, I attempted to take my own life. I did not feel that I was able to fully communicate my feelings to Ms. Contreras because of our language barrier." [Norris Decl., Ex. 165, Declaration of C.M. ¶¶ 4, 7; *see also id.*, Ex. 166 at 1 (medical record entry stating no interpreter services needed)]

Defendants' failure to comply with the requirements of Paragraph 14 is not limited to monolingual Spanish speakers. As noted above, D/deaf class members who are not fluent in English and who use sign language to communicate uniformly report that an interpreter was not provided for healthcare encounters, even when they asked for one. [*See, e.g.*, J.H. Decl. ¶ 13 (during intake process), ¶ 16 (during encounter with psych associate), ¶¶ 17-18 (after being assaulted by an incarcerated person, which resulted in

blood loss, dizziness, and his jaw being wired shut), ¶ 22 (during mental health counseling appointment), ¶ 24 (during encounter with nurse regarding flu symptoms); W.D. Decl. ¶ 8 ("I have repeatedly requested ASL interpreters for medical appointments and have been repeatedly told 'no.'"); F.L. Decl. ¶ 17 ("I was experiencing problems with my lower back relating to kidney stones. I tried to gesture [to] indicate the area that was bothering me, but I later found out that the provider misunderstood me and thought that I was experiencing pain in the middle of my back."); K.P. Decl. ¶ 40 ("Without an ASL interpreter, I could not really explain my feelings of loneliness and isolation and what it is like to be deprived constantly of language."); F.L.H. Decl. ¶ 21 ("On the Living Will form I just picked the last choice without understanding the choice or what it meant.")] In those cases, the related medical record entry says that no interpreter was needed. [*See* Norris Decl. ¶¶ 6-32 (W.D.), 56-57 (F.L.H.), 106-143 (J.H.), 163-64 (K.P.), 200-01 (F.L.)]

2. Medical Records for the Same Patient Are Contradictory, Sometimes Stating That Interpreter Services Are Needed, and Sometimes Saying That They Are Not.

The medical record for individual patients also is internally contradictory. In some cases, medical staff state that no interpreter is needed in response to the "hard-stop" question: "Are interpreter services needed for this inmate." But, in the same medical record for the same encounter, the same medical staff note that the patient was deaf and no sign language interpreter was available. For example, one Deaf patient was assaulted in July 2017 by another incarcerated person. "The punch was so severe that it dislocated [his] jaw, [his] jaw had to be wired shut, and [he] had to have surgery." [J.H. Decl. ¶ 17] He was seen by a psych associate "to assess for suicidality following [the] assault." [Norris Decl. ¶ 122; *id.*, Ex. 72] The psych associate entered "No" in response to the hard-stop question "Are interpreter services needed for this inmate," but also wrote: "as IM is deaf and **no interpreter was available**, interview was conducted with paper and pen." [*Id.* (emphasis added); *see* J.H. Decl. ¶ 18 (stating he could not express himself in writing)]

Subjective

Are interpreter services needed for this inmate*: No
What type of interpreter services were used for the encounter*:

...

Subjective Notes

IM was seen in confidential setting for 27 minutes to assess for suicidality following an assault; as IM is deaf and no interpreter was available, interview was conducted with paper and pen.

The same Deaf patient had an individual mental health counseling appointment in May 2017. The psych associate entered "No" in response to the hard-stop question "Are interpreter services needed for this inmate," but also wrote: "IM was seen for 15 minutes in confidential setting to update tx [treatment] plan; as he is hearing-impaired and **no sign language interpreter was available**, session was conducted mostly in writing." [Norris Decl. ¶ 116 (emphasis added); *id.*, Ex. 69 at 7] The psych associate noted the patient's limitations as "hearing loss, **requires a translator**," and interventions as "**provide translating services**; 1:1 counseling; HNR as needed." [*Id.*, Ex. 69 at 4 (emphasis added)] Nonetheless, interpreter services were never provided to the Deaf patient between May 2017 and January 2019, when he was released from prison. [J.H. Decl. ¶¶ 10, 22]

The records of other D/deaf patients show similar inconsistencies. For example:

- W.D. saw a nurse in September 2018. The nurse entered "No" in response to the question "Are interpreter services needed for this inmate," but also wrote: "****Patient needs sign language to communicate** . . . A&Ox3, cannot speak, uses a sign language inmate to communicate." [Norris Decl. ¶ 21 (emphasis added); *id.*, Ex. 14 at 1, 2] W.D. reported, of this encounter: "[D]uring this appointment I went to medical with a friend of mine, another prisoner who knew some ASL fingerspelling. The nurse would only allow me in the room at first, but after the nurse and I tried to communicate and could not understand each other, the nurse eventually let my friend come in to help us communicate."[7] [W.D. Decl. ¶ 12]

[7] Other D/deaf class members reported being forced to rely on incarcerated people not fluent in ASL to try to facilitate communication during healthcare encounters. [*See, e.g.*, J.H. Decl. ¶ 14; K.P. Decl. ¶¶ 17-21, 26-29] That does not comply with the Stipulation. *See also* U.S. Dep't of Justice, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455, 41,462 (June 18, 2002) (noting that people "may feel uncomfortable revealing or describing sensitive,

- F.L. saw an RN in November 2019, in response to a Health Needs Request asking for a sign language interpreter for a dental appointment. [Norris Decl., Ex. 113 at 1] The RN entered "No" to the question "Are interpreter services needed for this inmate," but also wrote, "DEAF **REQUIRES SIGN LANGUAGE INTREPRETER** [sic]; NO TTY MACHINE AVAILABLE AT THIS TIME. ABLE TO COMMUNICATE VIA WRITTEN NOTES AND PER IM DEPUTY WARREN ASSIGNED IM FLORES TO INTREPRET [sic] FOR THIS PATIENT," and "IM IS DEAF REQUIRES LANGUAGE INTREPRETER [sic]." [*Id.* ¶ 202 (emphasis added); *id.*, Ex. 113 at 3]

And medical records also are inconsistent between different healthcare encounters for the same class member. For example, medical staff wrote on February 20, 2018, that interpreter services were needed for G.M., noting that "Patient uses sign language to communicate." [Norris Decl. ¶ 95; *id.*, Ex. 58 at 1] But medical staff wrote that no interpreter services were needed for encounters with G.M. on February 22, 2018; May 17, 2018; January 10, 2019; and June 5, 2019. [*Id.* ¶¶ 97-102; *id.*, Exs. 59 at 1, 60 at 1, 61 at 1] And K.P., another Deaf class member, had healthcare encounters on February 8, 2020; February 27, 2020; March 5, 2020 (twice); and March 7, 2020, with confusing and inconsistent entries in the medical record:

	Are interpreter services needed for this inmate*:	What type of interpreter services were used for the encounter*:	Subjective Notes (excerpt):
February 8 (Nurse - Sick Call - Scheduled)	No	--	IM is deaf, uses sign language, communicated with IM through writing on pieces of paper back and fourth [sic].
February 27 (Nurse - Sick Call - Scheduled)	Yes	Inmate Refused Interpreter Services	IM IS DEAF. UNABLE TO PULL UP ASL INTERPRETER, IM REQUESTED TO JUST WRITE ON PAPER TO COMMUNICATE
March 5 (MH - Non-Clinical Contact Note)	No	--	Inmate communicated with COII Jones and he denied wanting to talk with mental health. He was informed that his brother hanged himself on graveyard shift Wednesday morning.
March 5 (Nurse - Treatment Call)	No	--	ASL Interpreter 356204 Lynette
March 7 (Nurse - Treatment Call)	Yes	Language Line	ASL interpreter Tina 248645

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confidential, or potentially embarrassing medical . . . information to" friends and community members); Stewart Decl. ¶¶ 18-19 (same).

[Norris Decl. ¶¶ 165-174; *id.*, Exs. 94 at 1, 95 at 1, 96 at 1, 97 at 1, 98 at 1][8]

B. Defendants Do Not Assess or Document Whether Qualified Healthcare Practitioners Are Proficient in Any Non-English Language.

Under the Stipulation, if a healthcare practitioner provides interpreter services for a specific healthcare encounter, that practitioner must be "proficient in the prisoner's language." [Doc. 1185 at 6 ¶ 14] Defendants do not have a system in place to demonstrate compliance with that requirement.

First, Defendants do not record the name of the healthcare practitioner providing interpreter services during a specific healthcare encounter. [*See, e.g.*, Norris Decl. ¶¶ 15 (W.D.), 19 (W.D.), 54 (F.L.H.), 62 (F.L.H.), 95 (G.M.), 112 (J.H.), 151 (K.P.)][9] Therefore, it is impossible to check whether a specific practitioner in fact is proficient in the relevant language. Second, even if the identity of the practitioner providing interpreter services was known, there is no way to determine whether he or she in fact was qualified to provide such services under the standard set forth in Paragraph 14. This is because Defendants, by their own admission, do not maintain a "[l]ist of all qualified health care practitioners who are proficient in any non-English language." [*See* Kendrick Decl., Ex. 3, Letter from Richard M. Valenti to Corene Kendrick, Plaintiffs' Supplemental Document Requests 82, 98, 99, 101, and 103-111 at 2-3 (Mar. 20, 2019); Kendrick Decl., Ex. 4, Letter from Richard M. Valenti to Corene Kendrick, Plaintiffs' Supplemental Document Requests 101, 104, 105, and 112 at 1-2 (Apr. 19, 2019)]

This is a significant problem. Spanish-speaking class members report that practitioners sometimes try to communicate with them in Spanish, but the staff member is

[8] References to "pull[ing] up" an interpreter and the listing of ASL interpreter numbers suggest that Defendants may now be providing video remote interpretation for some encounters. If that is true, it is a welcome and overdue development. But, as seen in the table above, interpretation is not consistently provided and the medical record remains unreliable, making it impossible to accurately evaluate compliance with Paragraph 14.

[9] Although the medical record states that "Healthcare Staff Used for Interpreter Services" for these encounters, the class members report that no interpretation in fact was provided by staff or anyone else. [*See* W.D. Decl. ¶¶ 13, 15; F.L.H. Decl. ¶¶ 16, 19; G.M. Decl. ¶ 25; J.H. Decl. ¶ 10]

not proficient in the language and therefore neither the patient nor healthcare staff is able to fully understand what is going on. For example:[10]

- "On September 4, 2019, I had a mental health counseling appointment. . . . I asked the psychologist if we could use the telephonic Spanish interpreter because my English skills are not good. The psychologist told me she could understand me in Spanish, and while it did seem like she understood what I was saying during the appointment, she only spoke English back to me and I didn't understand what she was saying. I didn't understand what was going on during the appointment, and I was frustrated that I was unable to ask questions I had about my medication for depression and insomnia. I wanted to ask her whether these medications might be bad for my liver, because I already have Hepatitis C. Because I was not able to understand the psychologist or communicate well in the appointment due to the lack of a Spanish interpreter, I was not able to resolve these questions concerning my healthcare." [F.A.H. Decl. ¶ 12]

- "On April 23, 2019, I saw Nurse Practitioner (NP) Clarisse Ngueha-nana, who claimed to be able to conduct my appointment in Spanish. Yet, NP Ngueha-nana spoke to me in mostly English and limited Spanish during this encounter. Because I do not know English, I was only able to speak with NP Ngueha-nana in Spanish. It became apparent that NP Ngueha-nana did not speak Spanish well and was not understanding the questions I was asking. For example, I asked NP Ngueha-nana why she was prescribing me medication for hemorrhoids when it was my stomach that was the problem. She was not able to respond to my question." [Norris Decl., Ex. 158, Declaration of J.F.B. ¶ 11]

III. RELIEF REQUESTED

Because Defendants do not have an accurate system in place to demonstrate compliance with Paragraph 14 of the Stipulation, the Court should order them to develop such a system. [Doc. 1185 at 14-15 ¶ 36 ("In the event the Court subsequently determines that the Defendants' plan did not remedy the deficiencies, the Court shall retain the power to enforce this Stipulation through all remedies provided by law" and "shall consider whether to require Defendants to submit a revised plan")] The system should include the three components listed below. *Armstrong v. Davis*, 275 F.3d 849, 873 (9th Cir. 2001), *abrogated on other grounds by Johnson v. California*, 543 U.S. 499 (2005) (holding that "the court is entitled to give some guidance to the [defendant]," including by "set[ing] clear objectives for it to attempt to attain, and, in most circumstances, general methods

[10] In these examples, the medical record states that interpreter services were *not* needed and there is no reference to the fact that staff attempted to communicate in Spanish. [Norris Decl. ¶¶ 244 (F.A.H.), 297 (J.F.B); *id.*, Exs. 134 (F.A.H), 161 (J.F.B.)]

whereby it would attain them"); *Brown v. Plata*, 563 U.S. 493, 542-43 (2011) (noting that a court "retains the authority, and the responsibility, to make further amendments to the existing order or any modified decree it may enter as warranted by the exercise of its sound discretion" and that "[e]xperience may teach the necessity for modification or amendment of an earlier decree").

First, Defendants must develop a process to promptly identify all class members "who are not fluent in English" (Doc. 1185 at 6 ¶ 14) and their primary language.[11] This first should be assessed during intake, as is "standard practice in functional correctional health care systems."[12] Stewart Decl. ¶ 20; *see also* U.S. Dep't of Justice, Appendix A, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455, 41,469 (June 18, 2002) ("U.S. Dep't of Justice Guidance") ("Intake/Orientation plays a critical role . . . in the system's identification of LEP prisoners"); Declaration of Rita K. Lomio ("Lomio Decl."), Ex. 2, U.S. Dep't of Justice, Planning Tool: Considerations for Creation of a Language Assistance Policy and Implementation Plan for Addressing Limited English Proficiency in a Department of Corrections 10-11 (Mar. 2006) ("U.S. Dep't of Justice Planning Tool") (discussing

[11] This includes people who are deaf and communicate through sign language. *See Pierce v. District of Columbia*, 128 F. Supp. 3d 250, 272 (D.D.C. 2015) (holding that "prison officials have an affirmative duty to assess the potential accommodation needs of inmates with known disabilities who are taken into custody and to provide the accommodations that are necessary for those inmates to access the prison's programs and services, without regard to whether or not the disabled individual has made a specific request for accommodation and without relying solely on the assumptions of prison officials regarding that individual's needs").

[12] *See, e.g.*, *Jones v. Gusman*, 296 F.R.D. 416, 454 (E.D. La. 2013) (finding that Defendant "does not keep a record, whether through intake classification or through some other process, of inmates that do not speak English" and approving settlement that required identification at intake of people who had limited English proficiency and what language(s) they speak); Declaration of Rita K. Lomio, Ex. 1, Consent Judgment § IV.F.1.a(3), *Jones v. Gusman*, No. 12-CV-859 (E.D. La. June 6, 2013) (requiring Orleans Parish Prison to, "[a]t intake and classification, identify and assess demographic data, specifically including the number of LEP [limited English proficiency] individuals at OPP on a monthly basis, and the language(s) they speak").

assessment and evaluation of language on intake).[13] There also should be a mechanism to identify at a later time class members who are not fluent in English, including if they state that they are not able to fully understand what is being said, or are not able to fully respond in English, during a healthcare encounter. [Stewart Decl. ¶ 20] Whether a class member is not fluent in English, and their primary language, should be documented and made readily available to healthcare staff through eOMIS. *See* U.S. Dep't of Justice Guidance at 41,469 ("Each prisoner's LEP status, and the language he or she speaks, should be placed in his or her file."). Class members should be informed how to request interpreter services, and healthcare staff should be trained on their obligations in securing and documenting in the medical record interpreter services.

Second, Defendants must develop a process to identify, evaluate, and train "qualified health care practitioner[s] who [are] proficient" in languages other than English. [Doc. 1185 at 6 ¶ 14] This will allow the parties to determine whether interpreter services are being provided by *qualified* healthcare practitioners. *See* U.S. Dep't of Justice Planning Tool at 9 (recommending "[a]ssessment and training for bilingual direct service staff"); *Jones v. Gusman*, 296 F.R.D. 416, 454 (E.D. La. 2013) (finding that Orleans Parish Prison "does not keep a record or otherwise identify staff members who are bilingual" and approving settlement that required assessment of bilingual staff and a list of such staff); Lomio Decl., Ex. 1, Consent Judgment § IV.F.1.a(5)-(6), *Jones v. Gusman*, No. 12-CV-859 (E.D. La. June 6, 2013) (requiring Orleans Parish Prison to "[r]egularly assess the proficiency and qualifications of bilingual

[13] Paragraph 14 overlaps with Defendants' responsibilities to people with limited English proficiency under Title VI. *United States v. Maricopa County*, 915 F. Supp. 2d 1073, 1079 (D. Ariz. 2012) ("[L]ongstanding case law, federal regulations and agency interpretation . . . hold language-based discrimination constitutes a form of national origin discrimination under Title VI"); U.S. Dep't of Justice Guidance at 41,466 ("The requirements of the Title VI regulations, as clarified by this Guidance, supplement, but do not supplant, constitutional and other statutory or regulatory provisions that may require LEP services."). For that reason, Defendants should take advantage of the free language access technical assistance provided to prison administrators by the U.S. Department of Justice. [*See* Lomio Decl. ¶ 3]

staff to become an [Orleans Parish Prison] Authorized Interpreter ('OPPAI')" and "[c]reate and maintain an OPPAI list").

Third, Defendants must develop an automated process to evaluate whether, for each month, "language interpretation for healthcare encounters [for all class members not fluent in English] [was] provided by a qualified health care practitioner who is proficient in the prisoner's language, or by a language line interpretation service." [Doc. 1185 at 6 ¶ 14] This requires running reports of all healthcare encounters for class members who are not fluent in English and determining whether appropriate interpretation in fact was provided. Defendants should report the overall compliance numbers, by prison and yard, on a monthly basis, and also provide Plaintiffs with the underlying reports, including the ADC numbers of the relevant class members and all encounters marked either compliant or noncompliant in a given month.

CONCLUSION

The Court should order Defendants to develop an accurate system to demonstrate compliance with Paragraph 14 of the Stipulation.

Respectfully submitted this 12th day of June 2020.

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CERTIFICATE OF SERVICE

I hereby certify that on June 12, 2020, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

David Shinn, Director, Arizona Department of Corrections; and Larry Gann, Division Director, Health Care Services Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

ORDER

This Court, having reviewed Plaintiffs' Motion to Enforce Paragraph 14 of the Stipulation, and all briefing and exhibits so related, hereby **GRANTS** Plaintiffs' Motion.

The Court hereby FINDS that Paragraph 14, by its plain terms, requires provision of interpreter services for all class members who are not fluent in English, including those who use sign language. The Court FURTHER FINDS that Defendants do not have a system in place to accurately or reliably demonstrate compliance with Paragraph 14.

IT IS THEREFORE ORDERED that Defendants shall, within 30 days, submit a proposed plan to implement such a system as soon as practicable. The plan must include detailed provisions (1) to promptly identify all class members who are not fluent in

English, along with their primary language, at intake and at later times; (2) to inform class members how to request interpreter services; (3) to train healthcare staff on their obligations in securing and documenting interpreter services; (4) to ensure that for all deaf class members whose primary means of communication is sign language, that they are provided a qualified sign language interpreter during all healthcare encounters; (5) to identify, evaluate, and train qualified healthcare practitioners who are proficient in languages other than English; and (6) to evaluate, on a monthly basis, whether Paragraph 14 has been complied with at each prison and yard, and to produce to Plaintiffs, for each month, all underlying compliance documents by the 15th of the following month. The plan must include the date(s) on which each provision has been or will be fully implemented.

IT IS FURTHER ORDERED that Plaintiffs shall, within 14 days of the filing of Defendants' proposed plan, submit a response to the plan.

The Court will evaluate the adequacy of the plan and issue further relief as appropriate.

SO ORDERED.

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Larry Gann, Division Director, Health Care Services Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF CORENE T. KENDRICK IN SUPPORT OF PLAINTIFFS' MOTION TO ENFORCE PARAGRAPH 14 OF THE STIPULATION

I, Corene T. Kendrick, declare:

1. I am an attorney licensed to practice before the courts of the State of California, and admitted to this Court *pro hac vice*. I am a staff attorney at the Prison Law Office, and an attorney of record to the plaintiff class in this litigation. If called as a witness, I could and would testify competently to the facts stated herein, all of which are within my personal knowledge.

2. I have been counsel of record in this case since its filing in March 2012. In July 2015, Plaintiffs' counsel notified Counsel for Defendants that Defendants were using a flawed methodology to measure compliance with the requirements of Paragraph 14 of the Stipulation, which requires that for incarcerated people "who are not fluent in English, language interpretation for healthcare encounters shall be provided by a qualified health care practitioner who is proficient in the prisoner's language, or by a language line interpretation service." [*See* Doc. 1561-1 at 6-7] Specifically, Defendants' practice was to review the log of all appointments at which the language line was actually utilized, which unsurprisingly resulted in findings of 100% compliance, and failed to capture the universe of health care encounters when the line was ***not*** used, including when d/Deaf patients had health care encounters. [*Id*. at 6] When Plaintiffs' counsel spot-checked medical records of nine non-English speaking individuals listed in the ASPC-Florence language logs, we found numerous other health care encounters for those same patients in which there were no records of interpretation (and which were not recorded on the language line log); depending upon which way the nine class members' health care records were analyzed, Defendants' rate of compliance with Paragraph 14 was either 11% (using the method of finding the entire patient record noncompliant if there is one or more encounters during the period without an interpreter) or 31% (adding up all health care encounters of the nine class members and calculating what percentage of those encounters had interpretation). [Doc. 1561-2 at 19-20, 62-66] Only one of the nine class members in fact had interpretation at all of his encounters.

3. Rather than address our concerns, Defendants instead unilaterally decided to stop monitoring compliance with Paragraph 14 and took the position that the Stipulation's requirement "does not require the use of language interpreters to be measured or reported." [*See* Doc. 1626-1 at Ex. 2 at 8-9 (filed under seal at Doc. 1629); *see also* Doc. 1626-1 at 13 (12/1/15 Letter from Assistant Attorney General stating that "Defendants' [sic] disagree and take the position that items not expressly required to be monitored by one of the 112 performance measures are not required to be monitored.")]

4. On October 15, 2015, I sent Defendants' Counsel a Notice of Noncompliance that, among other things, reiterated our concern that Defendants were using an invalid methodology to measure compliance with Paragraph 14, and explained how this interpretation requirement could be measured and quantified accurately. [Doc. 1561-2 at 19-20, 62-66] Defendants' counsel asserted in response in a letter dated December 1, 2015, that "some inmates are dishonest about the languages they speak," and reiterated their position that Defendants "are not required to monitor items not contained in the performance measures." [Doc. 1626-1 at 13]

5. In an attempt to avoid litigation and Court involvement in the matter, the parties began a process in March 2016 to develop and revise Defendants' Monitoring Guide designed to assist ADC monitors who evaluate compliance with the Stipulation's requirements and Performance Measures. Unfortunately, in mid-April after a series of weekly telephonic meet-and-confers, Defendants unilaterally announced that they would no longer participate in these meetings. At that time, the parties had not yet addressed how Paragraph 14 should be monitored, and it was not in the draft of the Monitoring Guide. [*See* Doc. 1626-1 at 77]

6. On July 12, 2016, Plaintiffs moved to enforce the Stipulation regarding the numerous deficiencies in monitoring methodology across the board, including in monitoring compliance with Paragraph 14. [Doc. 1625 at 11-12] After briefing, the Court ordered Defendants to "propose a reporting procedure to demonstrate compliance" for Paragraph 14 within thirty days of its September 6, 2016 order. [Doc. 1673 at 2, 8]

7. In October 2016, Defendants indicated that they would add a "hard-stop" feature to eOMIS so that health care staff would have to indicate whether interpreter services were needed, and if so, how they were provided. [Doc. 1703 at 2] "Hard-stop" apparently meant that the mental health staff would have to enter whether interpreter services were needed before entering additional information in a specific encounter record. Defendants indicated that they would "generate a report of all inmates who required interpreter services to be seen and the type of interpretation," and the "report will then be produced to Plaintiffs on a monthly basis." [Doc. 1703 at 2] Defendants ultimately added this "hard-stop" feature to eOMIS in February 2017. [Doc. 1927 at 2]

8. Despite their representation to the Court in 2017 that they would provide the monthly interpretation compliance report to Plaintiffs' counsel, Defendants have never done so. And in fact, as detailed below in paragraphs 11 and 18, below, when we requested this compliance report (RFP 110), Defendants asserted that no responsive reports or documents existed.

9. For a year and a half, Plaintiffs' counsel has asked for documents associated with monitoring of Paragraph 14, and Defendants have refused to provide them, or have asserted that these documents do not exist.

10. On January 17, 2019, as part of our monthly request for documents to monitor compliance with the Stipulation,[1] Plaintiffs' counsel requested reports and documents related to Paragraph 14 and people who are d/Deaf. Specifically, we requested the following documents, and that if no such documents existed, that Defendants so indicate:

RFP 99: List of all class members who are deaf and their ADC numbers.

[1] The parties agreed in March 2015, after the Court's approval of the Stipulation, that our practice would be that Plaintiffs' counsel submit the monthly request in the middle of the month, and Defendants produce responsive documents within 30 days, at the same time the CGAR reports are supposed to be ready on the 15th of each month. Defendants more often than not do not comply with the agreed-upon 30-day production schedule.

RFP 100: List of all class members whose primary form of communication is American Sign Language (ASL) or another sign language and their ADC numbers.

RFP 101: All documents regarding provision of sign language interpretation during medical, dental, and mental health encounters at all ASPCs, including (1) policies, procedures, and orders regarding the use of sign language interpreters at such encounters; (2) contract(s) for in-person and video remote interpretation; (3) location of computers used for video remote interpretation; and (4) log of use of sign language interpretation for the past three years.

11. On February 14, 2019, we requested the following reports and documents related to Defendants' compliance with Paragraph 14, and again for each request, asked that if there were no responsive documents, that Defendants so indicate:

RFP 104: List of all qualified health care practitioners who are proficient in American Sign Language, and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s).

RFP 105: List of all qualified health care practitioners who are proficient in any non-English language (other than American Sign Language), and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s).

RFP 106: All HNRs and grievances in which a class member requested an interpreter for a healthcare encounter and the responses to the HNRs and grievances since January 1, 2018.

RFP 107: All Form 108-1s for all deaf people who were in ADC custody at any time since January 1, 2017.[2]

RFP 108: List of all class members who are not fluent in English and their ADC numbers and primary language.

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[2] Section 5.3.3 of Department Order 108: Americans with Disabilities Act Compliance (May 9, 2014), makes reference to a provider or Nursing Supervisor completing a "Functional Assessment, Form 108-1," but it is not clear whether this form contains information regarding necessary accommodations for effective communication, including sign language interpretation. We have not seen the form in the electronic medical record of deaf class members.

RFP 109: All documents regarding provision of language interpretation during healthcare encounters at all ASPCs, including policies, procedures, and orders regarding assessment of language fluency and the use of interpreters at such encounters.

RFP 110: All documents related to Defendants' monitoring of compliance with Paragraph 14 of the Stipulation at all ASPCs, including instructions to monitoring staff and compliance reports.

RFP 111: All ADA requests for sign language interpreters during healthcare encounters submitted by a class member or another person on behalf of a class member and the responses to the ADA requests since January 1, 2018.

12. Attached hereto as **Exhibit 1** is a true and correct copy of a letter from Richard M. Valenti, Counsel for Defendants, addressed to me, dated March 6, 2019.

13. With regard to ***RFP 99*** ("List of all class members who are deaf and their ADC numbers"), he produced a list of class members classified as "Deaf nonspeaking, not elsewhere classified." [Ex. 1 at 6, citing to ADCM1561791] After receiving this document, I reviewed it and found that it was woefully incomplete, as it failed to list several d/Deaf class members with whom my office and co-counsel from the Arizona Center for Disability Law had been communicating.

14. In his March 6, 2019 letter, in addition to asserting boilerplate objections, Mr. Valenti asserts that there are no responsive documents to ***RFP 100*** ("List of all class members whose primary form of communication is American Sign Language (ASL) or another sign language and their ADC numbers"), and subparts (3) and (4) of ***RFP 101***. [*Id*. at 6-7] With regard to ***RFP 101***, subpart (1) ("policies, procedures, and orders regarding the use of sign language interpreters at such encounters"), he indicated that Department Order 108 (Americans With Disabilities Act Compliance) was the only responsive document, and for RFP 101, subpart (2) ("contract(s) for in-person and video remote interpretation"), he asserted that Corizon's national contract with Language Line included American Sign Language. [*Id*. at 7]

15. On March 6, 2019, shortly after receiving Mr. Valenti's letter, I had a previously scheduled telephonic meet-and-confer with Timothy Bojanowski, counsel for Defendants, regarding their ongoing failure to produce documents. Attached hereto as **Exhibit 2** is a true and correct copy of a letter that I sent Mr. Bojanowski on March 7, 2019, memorializing our discussion. With regard to ***RFP 99***, we discussed that Corizon used more than one diagnosis code for people who are deaf / hard of hearing. My letter provided Defendants with additional ICD-10 codes commonly used in audiology, so that they could provide an updated list by March 13, 2019.[3] [Ex. 2 at 2] With regard to ***RFP 101 (2)***, we requested a copy of the Corizon/Language Line contract to confirm that it included American Sign Language. [*Id*.]

16. On March 13, 2019, Plaintiffs' counsel submitted another request for documents related to Paragraph 14:

RFP 112: All billing documents from Language Line to Corizon for interpreter services rendered at all ASPCs from January 1, 2018 to the present.

17. Attached hereto as **Exhibit 3** is a letter from Mr. Valenti, addressed to me, dated March 20, 2019. He provided an updated list responsive to ***RFP 99*** with his letter. [Ex. 3 at 2, citing to ADCM1564103-107] In addition to boilerplate objections, he asserted that no responsive lists existed in response to ***RFP 104*** ("List of all qualified health care practitioners who are proficient in American Sign Language, and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s)"); ***RFP 105*** ("List of all qualified health care practitioners who are proficient in any non-English language (other than American Sign Language), and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s)"); and

[3] ICD-10 stands for International Classification of Diseases, 10th Revision, and is provided by the Centers for Medicare and Medicaid Services and the National Center for Health Statistics, for medical coding and reporting in the United States. *See generally* U.S. Centers for Disease Control & Prevention, National Center for Health Statistics, *Int'l Classification of Diseases-Tenth Revision, Clinical Modification*, at https://www.cdc.gov/nchs/icd/icd10cm.htm (last checked June 4, 2020).

RFP 108 ("List of all class members who are not fluent in English and their ADC numbers and primary language"). [*Id*. at 3-4, 5]

18. Mr. Valenti also asserted that there were no responsive documents to ***RFP 110*** ("All documents related to Defendants' monitoring of compliance with Paragraph 14 of the Stipulation at all ASPCs, including instructions to monitoring staff and compliance reports"), which related to the monthly report that Defendants had represented to the Court would be used to monitor compliance and provided monthly to Plaintiffs' counsel (*see* ¶ 7 above). [Ex. 3 at 6] He simply asserted boilerplate objections to ***RFP 106*** ("All HNRs and grievances in which a class member requested an interpreter for a healthcare encounter and the responses to the HNRs and grievances since January 1, 2018"); ***RFP 107*** ("All Form 108-1s for all deaf people who were in ADC custody at any time since January 1, 2017"); and ***RFP 111*** ("All ADA requests for sign language interpreters during healthcare encounters submitted by a class member or another person on behalf of a class member and the responses to the ADA requests since January 1, 2018"). [*Id.* at 4-5, 7]

19. Attached hereto as **Exhibit 4** is a letter from Mr. Valenti to me, dated April 19, 2019. With regard to ***RFP 101***, Mr. Valenti stated that Corizon would not provide the Language Line contract, and with regard to ***RFP 112***, they would not provide any interpreter billing documents. [*Id*. at 1] Mr. Valenti confirmed that Corizon did not have any responsive documents to ***RFP 104*** and ***RFP 105***.

I declare under penalty of perjury that the foregoing is true and correct.

Executed June 8, 2020, in San Francisco, California.

s/ Corene T. Kendrick
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CERTIFICATE OF SERVICE

I hereby certify that on June 12, 2020, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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Attorneys for Defendants

s/ D. Freouf

Index of Exhibits to the
Declaration of Corene T. Kendrick

Exhibit	Description
1	A true and correct copy of a letter from Richard M. Valenti to Corene Kendrick, dated March 6, 2019
2	A true and correct copy of a letter from Corene Kendrick to Timothy Bojanowski, dated March 7, 2019
3	A true and correct copy of a letter from Richard M. Valenti to Corene Kendrick, dated March 20, 2019
4	A true and correct copy of a letter from Richard M. Valenti to Corene Kendrick, dated April 19, 2019

Exhibit 1

STRUCK LOVE BOJANOWSKI & ACEDO, PLC

Richard M. Valenti
480.420.1615
rvalenti@strucklove.com

March 6, 2019

VIA EMAIL ONLY
Corene Kendrick
PRISON LAW OFFICE
General Delivery
San Quentin, CA 94964

Re: Parsons v. Ryan
Plaintiffs' Outstanding Document Requests

Dear Corene:

This is a response to your March 1, 2019 letter regarding outstanding document production requests.

Mortality Reviews and Psychological Autopsies

To the extent that Plaintiffs request the medical records of any of the inmates listed in Attachment A, as Defendants have explained previously, Plaintiffs' counsel have access to deceased medical records through eOMIS. Because Plaintiffs have access to those records, Defendants will not be producing paper or electronic copies of deceased medical records. *See* pages 1-2 of April 13, 2018 Richard Valenti letter to Corene Kendrick.

As to inmate Jorge Montes-Beltran (323912), per the ADC announcement on its website, he was in the custody of the United States Marshal's Service since August 2018. *See* https://corrections.az.gov/article/inmate-death-notification-montes-beltran.Because inmate Montes-Beltran did not die while in the custody of ADC, Defendants will not be producing this mortality review. *See* ¶¶ 3, 29 of Doc. 1185. As to inmate Harvey Gass (159737), at the time of his death he was housed at a private prison in Florence. Consequently, Defendants will not be producing this mortality review. *See* ¶¶ 3, 29 of Doc. 1185.

Defendants produced the mortality review of Adalberto Olivas (275449) on April 6, 2018. *See* ADCM1496679-1496682. Defendants produced the mortality reviews of inmates Rick Miller (035695), Kenneth Price (211005), Aaron Salter (284794), Morgan Schuller (317526), and Joseph Thompson (296182) on March 5, 2019. *See* ADM1560851-1560879.

Produced herewith are the following mortality reviews and, if applicable, psychological autopsies:

1) Jose Hernandez (166739)
2) John Knox (042475)
3) Vincent Cortez (154121)
4) Gilbert Lopez (037963)
5) William Green (295448)
6) Francisco Montez (029453)
7) Richard Munguia (090192)
8) Victor Martinez (280392)
9) Tiffany Everest (276797)
10) Hector Hurtado (312361)
11) Cody Williams (116387)
12) Lance Beier (040815)
13) Damian Gonzalez (291876)
14) William Jobe (062720)
15) Kevin Barnes (047677)
16) Andrew Salinas (266335)
17) Linda Woods (208394)
18) Jason Scherer (310401)
19) James Slovekosky (122147)
20) Carlos Carrillo (172834)
21) Pedro Gonzalez (235043)

See ADCM1561792-1562003.

The following mortality reviews and psychological autopsies (if applicable) have not been finalized by ADC:

1) Gabriel Cruz (197177)
2) Joseph Stuart (281867)
3) Bruce Johannes (082267)
4) Rosario Hernandez (055050)

5) Christopher Cecil (064179)
6) Tyrone Nez (207542)
7) Jose Cruz (208380)
8) Donald Sowell (066847)
9) Manuel Frajio (240972)
10) Freddie Ford (121707)
11) Raymond Hernandez (188890)
12) Gregory Valenzuela (304312)
13) Joseph Shreve (309533)
14) James Harrod (136270)
15) Lisa Langeneckert (278225)
16) Richard Washington (039492)
17) Martin Torres (158092)
18) Steven Johnson (050856)
19) Matthew Ariens (290460)
20) Lawrence Dawson (065408)

Request 94: List of all class members and ADC numbers who were treated for scabies at ASPC-Tucson and ASPC-Douglas in 2018.

Defendants' Response:
Defendants object to this request as it seeks information that is irrelevant to the Stipulation and the Performance Measures. Furthermore, the request is overbroad and exceeds the scope of the Stipulation and the Performance Measures. Neither the Stipulation nor any of the Performance Measures impose any monitoring requirements, reporting obligations, or any other conditions with respect to the treatment of scabies at any facility. The request is also vague and ambiguous as to the terms "list" and "treated"; as a result the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A).

The list Plaintiffs request requires the creation of documents by Defendants, which, pursuant to Fed.R.Civ.P. 34, Defendants are not required to do. *See Goolsby v. Carrasco*, No. 1:09–cv–01650 JLT (PC), 2011 WL 2636099, at *8 (E.D. Cal. July 5, 2011) (document request that would require the defendant to create a roster of employees is not a proper request under Fed. R. Civ. P. 34(a)); *Robinson v. Adams*, No. 1:08–cv–01380–AWI–SMS PC, 2011 WL 2118753, at *20 (E.D. Cal. May 27, 2011) (defendant is not required to create a document in response to a request for production).

Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added). Finally, refer to Ashlee Hesman's November 8 and November 16, 2018 letters to Corene Kendrick regarding the scabies outbreaks at ASPC-Tucson and ASPC-Douglas.

Without waiving any objections, on March 5, 2019, Defendants produced the housing rosters for ASPC-Douglas/Mohave Unit. *See* ADCM1561749-1561782.

Request 95: For each applicable Arizona State prison complex, the log of all class members (and their ADC numbers) who are currently subjected to involuntary medication.

Defendants' Response:
Defendants object to this request as it seeks information that is irrelevant to the Stipulation and the Performance Measures. Furthermore, the request is overbroad and exceeds the scope of the Stipulation and the Performance Measures. Neither the Stipulation nor any of the Performance Measures impose any monitoring requirements, reporting obligations, or any other conditions with respect to the administration of involuntary medication. The request is also vague and ambiguous as to the term "log", and the phrases "currently subjected to" and "involuntary medication"; as a result the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. S*ee* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added).

Without waiving any objections, on March 5, 2019, Defendants produced PMRB logs for each of the seven corridor facilities (Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, and Yuma). *See* ADCM1561783-1561789.

Request 97: The revised powerpoint and employee orientation book of nursing NETs used with the onboarding and training of nursing staff.

Defendants' Response:
Defendants object to this request as outside the scope of the Stipulation and the Performance Measures. Defendants also object to this request as vague and ambiguous with respect to the phrase "revised", because it fails to specify what version (including the effective date) of the documents that are requested. Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added).

Without waiving any objections, Defendants have made multiple requests to Corizon and are awaiting a response.

Request 98: For each ASPC, as of October 1, 2018 and November 1, 2018, the current backlog of chronic care provider appointments and specaility [sic] care apointments [sic].

Defendants' Response:
Defendants object to this request as outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the terms "current" and "backlog"; as a result the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added).

Without waiving any objections, Defendants have made multiple requests to Corizon and are awaiting a response.

Request 99: List of all class members who are deaf and their ADC numbers. If no such list exists, please so indicate.

Defendants' Response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the term "deaf"; as a result the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Furthermore, the list Plaintiffs request requires the creation of documents by Defendants, which, pursuant to Fed.R.Civ.P. 34,

Defendants are not required to do. *See Goolsby v. Carrasco*, No. 1:09–cv–01650 JLT (PC), 2011 WL 2636099, at *8 (E.D. Cal. July 5, 2011) (document request that would require the defendant to create a roster of employees is not a proper request under Fed. R. Civ. P. 34(a)); *Robinson v. Adams*, No. 1:08–cv–01380–AWI–SMS PC, 2011 WL 2118753, at *20 (E.D. Cal. May 27, 2011) (defendant is not required to create a document in response to a request for production). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added).

Without waiving any objections, as a one-time accommodation, on March 5, 2019, Defendants produced a list of inmates who are classified as "Deaf nonspeaking, not elsewhere classified". *See* ADCM1561791. This list is not a record that is maintained in the ordinary course of business by ADC.

Request 100: List of all class members whose primary form of communication is American Sign Language (ASL) or another sign language and their ADC numbers. If no such list exists, please so indicate.

Defendants' response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the terms "primary", "communication", and "sign language"; as a result the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Furthermore, the list Plaintiffs request requires the creation of documents by Defendants, which, pursuant to Fed.R.Civ.P. 34, Defendants are not required to do. *See Goolsby v. Carrasco*, No. 1:09–cv–01650 JLT (PC), 2011 WL 2636099, at *8 (E.D. Cal. July 5, 2011) (document request that would require the defendant to create a roster of employees is not a proper request under Fed. R. Civ. P. 34(a)); *Robinson v. Adams*, No. 1:08–cv–01380–AWI–SMS PC, 2011 WL 2118753, at *20 (E.D. Cal. May 27, 2011) (defendant is not required to create a document in response to a request for production). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added).

Without waiving any objections, no responsive list exists.

Request 101: All documents regarding provision of sign language interpretation during medical, dental, and mental health encounters at all ASPCs, including (1) policies, procedures, and orders regarding the use of sign language interpreters at such encounters; (2) contract(s) for in-person and video remote interpretation; (3) location of computers used for video remote interpretation; (4) and log of use of sign language interpretation for the past three years. If no such documents exist, please so indicate.

Defendants' response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the terms "log", "provision", "encounters", and "sign language"; as a result the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added).

Without waiving any objections, as to subpart one, see Department Order 108 (Americans with Disabilities Act Compliance), which is available on the ADC website. *See* https://corrections.az.gov/sites/default/files/policies/100/0108_010119.pdf. As to subpart two, without waiving any objections, according to Corizon, Corizon has a national contract with LanguageLine, which provides video interpreting; it includes American Sign Language. As to subpart three, without waiving any objections, there are no responsive documents that exist. As to subpart four, without waiving any objections, according to Corizon, logs of sign language interpretation are not currently maintained; therefore, no responsive documents exist.

Request 102: All documents supporting the following statements in the January 17, 2019 letter from Tim Bojanowski to Corene Kendrick. For each statement, if no supporting documents exist, please so indicate.

> 1) "[A]ll complexes are instructed on a continuing basis that providers must ensure their contacts are confidential when the inmate agrees to leave the cell for the same."

2) "When review of records by the monitors indicates that a confidential setting was not indeed confidential, that encounter is not given credit and the situation is addressed in out-briefs."

3) "Dr. Calcote distributed a memo after the Lewis tour reinforcing this expectation."

4) "Dr. Taylor confirmed that, for monitoring purposes, patient encounters in which an officer is present or within earshot are not counted as satisfying the Stipulation's requirement that the patient be "seen by mental health staff" in a confidential setting unless they are being seen cell front due to their refusal to be seen in a confidential setting."

5) "[T]he Lewis HNR log documents for the last six months show that for inmates on watch, the number of HNR submissions per month was consistently one to two HNRs."

6) "Moreover, the eight HNRs submitted by inmates on watch in the last six months were appropriately triaged and the inmates were seen on time." Please provide legible copies of the 8 HNRs.

Defendants' response:
Defendants object to this request as outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the phrase "all documents supporting"; as a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (emphasis added).

As to subpart one, without waiving any objections, on March 5, 2019, Defendants produced a December 7, 2018 memorandum by Dr. Calcote. *See* ADCM1561790. Other than that memorandum, there are no responsive documents, since the continuous instruction regarding confidentiality during inmate contacts is done verbally at monthly out-briefs at the seven corridor facilities.

As to subpart two, Defendants further object because this information is already in Plaintiffs' counsel's possession. Plaintiffs' counsel can look at the CGARs, identify non-compliant findings in the Performance Measures that require a confidential contact, and then review the relevant notes in eOMIS. Also, refer to Dr. Calcote's December 7, 2018 memorandum. ADCM1561790.

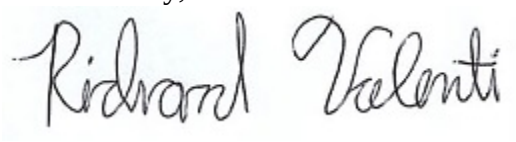
As to subpart three, without waiving any objections, see Dr. Calcote's December 7, 2018 memorandum. ADCM1561790.

As to subpart four, without waiving any objections, see response to subpart two.

As to subpart five, without waiving any objections, there are no responsive documents to this request.

As to subpart six; without waiving any objections, the ADC numbers and the dates of the eight HNRs are 231701 (6/21/18), 287357 (7/14/18), 323386 (8/16/18), 105041 (8/30/18), 86611 (9/16/18), 218972 (10/15/18), 86611 (11/1/18), and 86611 (11/22/18). Plaintiffs can access the HNRs in eOMIS to determine if the inmates were appropriately triaged and if the inmates were seen on time.

Sincerely,



Richard M. Valenti

RMV/eap
cc: Counsel of record

Exhibit 2

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

VIA EMAIL ONLY

March 7, 2019

Mr. Timothy Bojanowski
Struck, Love, Bojanowski & Acedo
3100 West Ray Road, Suite 300
Chandler, AZ 85226
tbojanowski@strucklove.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
Outstanding Document Productions

Dear Tim:

Thank you for a productive phone call yesterday regarding Defendants' outstanding document productions. I write to memorialize our discussion; please let me know if anything does not comport with your notes from the call.

Prior to the call you provided documents that you stated were responsive to **Requests Nos. 94, 95, 99, and 102**. You also provided the mortality reviews and psychological autopsies of many of the class members who died in 2017 and 2018. We are concerned that many of the reviews were completed six to nine months ago, and hope that in the future your productions will be more timely and occur as the reviews and autopsies are finalized by the Monitoring Bureau.

Richie Valenti's March 6, 2019 letter stated, and you confirmed on the call, that with regard to **Requests 97 and 98**, you have asked Corizon on a weekly basis for those documents, and would continue to do so. I asked whether you were asking Corizon on a weekly basis for documents responsive to **Standing Request No. 82** ("For all ten Arizona State Prison Complexes for the previous 90 days, a list of (1) all pending requests for specialty referral pending Utilization Management review, and (2) all pending specialty appointments"), which we originally requested on January 15, 2018; you stated that you did not think so, but you would ask Corizon's attorneys to start producing these reports. I observed that this is a report that Corizon is easily capable of creating, as we request this report prior to institution tours. You also confirmed that ADC has taken no steps to other than asking for the documents to force Corizon to produce the reports pursuant to the requirements of the contract between ADC and Corizon. This afternoon, you provided documents responsive to Reuqest No. 97. **Please provide documents responsive to**

Requests 82 and 98 without further delay; and ensure that documents responsive to Request 82 are provided on a monthly basis in the future.

With regard to **Request No. 99** ("List of all class members who are deaf and their ADC numbers"), you stated that ADC does not track or maintain this information. We noted that the document that you produced did not list individuals whom we know are deaf. You indicated that Corizon created this list by running one diagnosis code ("Deaf, nonspeaking, not elsewhere classified (H91.3)"), but agreed that Corizon uses more than one diagnosis code for people who are deaf/hard of hearing. You also confirmed that this information is not maintained or tracked by ADC. You agreed that you would speak with Ms. Guzman and have Corizon run a report with additional diagnosis codes tied to deafness, and **you would supplement this response by March 13, 2019.** Attached is a document that lists common ICD-10 codes used in audiology. We suggest that the search look at ICD-10 diagnosis codes H90, H91.0-91.3, H91.9, H93.01, Q16, and those subcodes therein.

Mr. Valenti's letter stated, and you confirmed on our call, that no information is maintained by ADC or Corizon that is responsive to **Request No. 100** ("List of all class members whose primary form of communication is American Sign Language (ASL) or another sign language and their ADC numbers"). With regard to **Request No. 101** ("All documents regarding provision of sign language interpretation during medical, dental, and mental health encounters at all ASPCs, including (1) policies, procedures, and orders regarding the use of sign language interpreters at such encounters; (2) contract(s) for in-person and video remote interpretation; (3) location of computers used for video remote interpretation; (4) and log of use of sign language interpretation for the past three years"), Mr. Valenti's letter pointed to DO 108 as responsive to the request for all "policies, procedures, and orders," and stated that Corizon has a "national contract with LanguageLine, which provides video interpreting; it includes American Sign Language." **However, you did not produce any documents showing that such a contract exists**. Similarly, Mr. Valenti's letter asserted, and you confirmed on the call, that there is no written record showing where Video Remote Interpreting computers are located, nor does Corizon maintain any logs regarding the use of sign language interpreters in heath care encounters. Again, you stated that ADC does not track this information.

With respect to **Request No. 95** ("For each applicable Arizona State prison complex, the log of all class members (and their ADC numbers) who are currently subjected to involuntary medication"), the document you produced (ADCM1561783-1561789) is undated, and on our call you were unable to state the effective date of the document. **Please state the date this document was prepared, and confirm that it lists all ADC prisoners who were subject to an involuntary medication order as of that date.**

With respect to **Request No. 102** (requesting all documents supporting six enumerated statements in the January 17, 2019 letter from Tim Bojanowski to Corene Kendrick), you produced a one-page memo from Lynn Calcote (ADCM1561790). On our call you confirmed that this is the only document responsive to this Request, and that Defendants are not withholding any responsive documents based upon the objections asserted on pp. 8-9 of Richard Valenti's March 6, 2019 letter.

Thank you for your attention to these matters.

Sincerely,

Corene Kendrick, Staff Attorney

ASHA
Audiology
The Largest Association of Audiology Professionals

2019 ICD-10-CM Diagnosis Codes

RELATED TO HEARING AND VESTIBULAR DISORDERS

1st Edition

October 1, 2018

General Information

This ASHA document provides a listing of the *2019 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* codes related to hearing and vestibular disorders. This document is **not** a comprehensive list and a number of codes are included for information purposes only. Entries with only three or four digits may require coding to a higher degree of specificity than indicated here. However, in general, audiology related diagnoses are listed to their highest level of specificity.

For the most up-to-date information on ICD coding, go to ASHA's Billing and Reimbursement website at www.asha.org/Practice/reimbursement/coding/ICD-10/.

A listing of new ICD-10-CM codes effective October 1, 2018, is available at www.asha.org/Practice/reimbursement/coding/New-and-Revised-ICD-10-CM-Codes-for-Audiology/.

For additional information, contact the health care education and policy team at reimbursement@asha.org.

Table of Contents

ICD-10-CM Diagnosis Codes

Overview

On October 1, 2015, the **International Classification of Diseases, 10th Revision (ICD-10)** replaced ICD-9 (9th Revision) as the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The **ICD** is also used to code and classify mortality data from death certificates.

ICD-10 includes the ICD-10-CM (clinical modification) and ICD-10-PCS (procedure coding system). The ICD-10 is owned by the World Health Organization (WHO). The clinical modification was developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings. The procedure coding system (ICD-10-PCS) was developed by the Centers for Medicare and Medicaid Services for use in the U.S. for inpatient hospital settings only. **This product only includes audiology related ICD-10-CM codes.**

Scope

The intent of ICD-10-CM is to standardize disease and procedure classification throughout the United States and to gather data about basic health statistics.

Purpose

HIPAA legislation requires the ICD-10-CM to be used for health services billing and record keeping. The effective implementation date for ICD-10-CM (and ICD-10-PCS) was October 1, 2015.

Relation to Professional Scope of Practice

The audiologist practicing in a health care setting, especially a hospital, may have to code delivery of services according to the ICD-10-CM. Audiologists whose services may be billed to third-party payers may also be required to report ICD-10-CM codes.

Official ICD-10-CM Websites

- National Center for Health Statistics: www.cdc.gov/nchs/icd/icd10.htm
- Centers for Medicare and Medicaid Services: www.cms.gov/ICD10/
- ICD-10-CM Official Guidelines for Coding and Reporting: www.cdc.gov/nchs/icd/data/10cmguidelines-FY2019-final.pdf

ASHA Resources

- ICD-10-CM Diagnosis Codes for Audiology and Speech-Language Pathology: www.asha.org/Practice/reimbursement/coding/ICD-10/
- ICD-10-CM Coding FAQs for Audiologists and SLPs: www.asha.org/Practice/reimbursement/coding/ICD-10-CM-Coding-FAQs-for-Audiologists-and-SLPs/
- Coding Normal Results: www.asha.org/practice/reimbursement/coding/normalresults/
- Coding to the Highest Degree of Specificity: www.asha.org/practice/reimbursement/coding/codespecificity/

Instructional Notations

The following instructional notations are from the published *ICD-10-CM Tabular List of Diseases and Injuries* (www.cdc.gov/nchs/icd/icd10cm.htm).

Includes
The word 'Includes' appears immediately under certain categories to further define, or give examples of, the content of the category.

Excludes Notes
The ICD-10-CM has two types of excludes notes. Each note has a different definition for use but they are both similar in that they indicate that codes excluded from each other are independent of each other.

Excludes1
A type 1 Excludes note is a pure excludes. It means 'NOT CODED HERE!' An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. **(ASHA Note: In other words, never report the listed codes together)**

Excludes2 (Can use the listed codes together)
A type 2 excludes note represents 'Not included here'. An excludes2 note indicates that the condition excluded is not part of the condition it is excluded from but a patient may have both conditions at the same time. When an Excludes2 note appears under a code it is acceptable to use both the code and the excluded code together. **(ASHA Note: In other words, codes can be listed together)**

Code First/Use Additional Code notes (etiology/manifestation paired codes)
Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists there is a 'use additional code' note at the etiology code, and a 'code first' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, 'in diseases classified elsewhere.' Codes with this title area component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. 'In diseases classified elsewhere' codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

Code Also
A code also note instructs that 2 codes may be required to fully describe a condition but the sequencing of the two codes is discretionary, depending on the severity of the conditions and the reason for the encounter.

7th characters and placeholder X
For codes less than 6 characters that require a 7th character a placeholder X should be assigned for all characters less than 6. The 7th character must always be the 7th character of a code.

ASHA Note: Certain ICD-10-CM categories have applicable 7th characters. The seventh character of ICD-10 is often a required character in codes involving, for example, injuries and poisonings (Chapter 19, S00-T88). The purpose of the 7th character is to communicate to the payer the "type of encounter" such as initial (A), subsequent (D), or sequela (S). Any codes requiring a 7th character will be clearly indicated. Not all codes require a 7th character.

ICD-10-CM Tabular List of Diseases and Injuries

Related to hearing and vestibular disorders

Note: This is **not** a comprehensive list and a number of codes are included for information purposes only. Some categories of codes (e.g., specific ear diseases) may be more extensive, contain additional instructional notes, and may also require coding to a higher degree of specificity than indicated here. However, in general, audiology related diagnoses are listed to their highest level of specificity. For a full list of ICD-10-CM codes, descriptors, and instructions, see the official ICD-10-CM publication at www.cdc.gov/nchs/icd/icd10cm.htm.

Ch. 6: Diseases of the nervous system (G00-G99)

Other disorders of the nervous system (G89-G99)

G96 Other disorders of central nervous system

G96.0 Cerebrospinal fluid leak

Excludes1: cerebrospinal fluid leak from spinal puncture (G97.0)

Ch. 8: Diseases of the ear and mastoid process (H60-H95)

Note: Use an external cause code following the code for the ear condition, if applicable, to identify the cause of the ear condition

Excludes2: certain conditions originating in the perinatal period (P04-P96)

certain infectious and parasitic diseases (A00-B99)

complications of pregnancy, childbirth and the puerperium (O00-O9A)

congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)

endocrine, nutritional and metabolic diseases (E00-E88)

injury, poisoning and certain other consequences of external causes (S00-T88)

neoplasms (C00-D49)

symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

This chapter contains the following blocks:

H60-H62: Diseases of external ear

H65-H75: Diseases of middle ear and mastoid

H80-H83: Diseases of inner ear

H90-H94: Other disorders of ear

H95: Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified

Diseases of external ear (H60-H62)

H60 Otitis externa

H60.0 Abscess of external ear
Boil of external ear
Carbuncle of auricle or external auditory canal
Furuncle of external ear

H60.00 Abscess of external ear, unspecified ear

H60.01 Abscess of right external ear

H60.02 Abscess of left external ear

H60.03 Abscess of external ear, bilateral

H60.1 Cellulitis of external ear
Cellulitis of auricle
Cellulitis of external auditory canal

H60.10 Cellulitis of external ear, unspecified ear

H60.11 Cellulitis of right external ear

H60.12 Cellulitis of left external ear

H60.13 Cellulitis of external ear, bilateral

H60.2 Malignant otitis externa

H60.20 Malignant otitis externa, unspecified ear

H60.21 Malignant otitis externa, right ear

H60.22 Malignant otitis externa, left ear

H60.23 Malignant otitis externa, bilateral

H60.3 Other infective otitis externa

H60.31 Diffuse otitis externa

H60.311 Diffuse otitis externa, right ear

H60.312 Diffuse otitis externa, left ear

H60.313 Diffuse otitis externa, bilateral

H60.319 Diffuse otitis externa, unspecified ear

H60.32 Hemorrhagic otitis externa

H60.321 Hemorrhagic otitis externa, right ear

H60.322 Hemorrhagic otitis externa, left ear

H60.323 Hemorrhagic otitis externa, bilateral

H60.329 Hemorrhagic otitis externa, unspecified ear

H60.33 Swimmer's ear

H60.331 Swimmer's ear, right ear

H60.332 Swimmer's ear, left ear

H60.333 Swimmer's ear, bilateral

H60.339 Swimmer's ear, unspecified ear

H60.39 Other infective otitis externa

H60.391 Other infective otitis externa, right ear

H60.392 Other infective otitis externa, left ear

H60.393 Other infective otitis externa, bilateral

H60.399 Other infective otitis externa, unspecified ear

H60.4 Cholesteatoma of external ear
Keratosis obturans of external ear (canal)

Excludes2: cholesteatoma of middle ear (H71.-)
recurrent cholesteatoma of postmastoidectomy cavity (H95.0-)

H60.40 Cholesteatoma of external ear, unspecified ear

H60.41 Cholesteatoma of right external ear

H60.42 Cholesteatoma of left external ear

H60.43 Cholesteatoma of external ear, bilateral

❖ **H60.5** Acute noninfective otitis externa

❖ **H60.6** Unspecified chronic otitis externa

❖ **H60.8** Other otitis externa

❖ **H60.9** Unspecified otitis externa

H61 Other disorders of external ear

H61.0 Chondritis and perichondritis of external ear
Chondrodermatitis nodularis chronica helicis
Perichondritis of auricle
Perichondritis of pinna

H61.00 Unspecified perichondritis of external ear

H61.001 Unspecified perichondritis of right external ear

H61.002 Unspecified perichondritis of left external ear

H61.003 Unspecified perichondritis of external ear, bilateral

H61.009 Unspecified perichondritis of external ear, unspecified ear

H61.01 Acute perichondritis of external ear

H61.011 Acute perichondritis of right external ear

H61.012 Acute perichondritis of left external ear

H61.013 Acute perichondritis of external ear, bilateral

H61.019 Acute perichondritis of external ear, unspecified ear

H61.02 Chronic perichondritis of external ear

H61.021 Chronic perichondritis of right external ear

H61.022 Chronic perichondritis of left external ear

H61.023 Chronic perichondritis of external ear, bilateral

H61.029 Chronic perichondritis of external ear, unspecified ear

H61.03 Chondritis of external ear
Chondritis of auricle
Chondritis of pinna

H61.031 Chondritis of right external ear

H61.032 Chondritis of left external ear

H61.033 Chondritis of external ear, bilateral

H61.039 Chondritis of external ear, unspecified ear

H61.1 Noninfective disorders of pinna

Excludes2: cauliflower ear (M95.1-)
gouty tophi of ear (M1A-)

H61.10 Unspecified noninfective disorders of pinna
Disorder of pinna NOS

H61.101 Unspecified noninfective disorders of pinna, right ear

H61.102 Unspecified noninfective disorders of pinna, left ear

H61.103 Unspecified noninfective disorders of pinna, bilateral

H61.109 Unspecified noninfective disorders of pinna, unspecified ear

H61.11 Acquired deformity of pinna
Acquired deformity of auricle

Excludes2: cauliflower ear (M95.1-)

H61.111 Acquired deformity of pinna, right ear

H61.112 Acquired deformity of pinna, left ear

H61.113 Acquired deformity of pinna, bilateral

H61.119 Acquired deformity of pinna, unspecified ear

H61.12 Hematoma of pinna
Hematoma of auricle

H61.121 Hematoma of pinna, right ear

H61.122 Hematoma of pinna, left ear

H61.123 Hematoma of pinna, bilateral

H61.129 Hematoma of pinna, unspecified ear

H61.19 Other noninfective disorders of pinna

H61.191 Noninfective disorders of pinna, right ear

H61.192 Noninfective disorders of pinna, left ear

H61.193 Noninfective disorders of pinna, bilateral

H61.199 Noninfective disorders of pinna, unspecified ear

H61.2 Impacted cerumen
Wax in ear

H61.20 Impacted cerumen, unspecified ear

H61.21 Impacted cerumen, right ear

H61.22 Impacted cerumen, left ear

H61.23 Impacted cerumen, bilateral

H61.3 Acquired stenosis of external ear canal
Collapse of external ear canal

Excludes1: postprocedural stenosis of external ear canal (H95.81-)

H61.30 Acquired stenosis of external ear canal, unspecified

H61.301 Acquired stenosis of right external ear canal, unspecified

H61.302 Acquired stenosis of left external ear canal, unspecified

H61.303 Acquired stenosis of external ear canal, unspecified, bilateral

H61.309 Acquired stenosis of external ear canal, unspecified, unspecified ear

H61.31 Acquired stenosis of external ear canal secondary to trauma

H61.311 Acquired stenosis of right external ear canal secondary to trauma

H61.312 Acquired stenosis of left external ear canal secondary to trauma

H61.313 Acquired stenosis of external ear canal secondary to trauma, bilateral

H61.319 Acquired stenosis of external ear canal secondary to trauma, unspecified ear

H61.32 Acquired stenosis of external ear canal secondary to inflammation and infection

H61.321 Acquired stenosis of right external ear canal secondary to inflammation and infection

H61.322 Acquired stenosis of left external ear canal secondary to inflammation and infection

H61.323 Acquired stenosis of external ear canal secondary to inflammation and infection, bilateral

H61.329 Acquired stenosis of external ear canal secondary to inflammation and infection, unspecified ear

H61.39 Other acquired stenosis of external ear canal

H61.391 Other acquired stenosis of right external ear canal

H61.392 Other acquired stenosis of left external ear canal

H61.393 Other acquired stenosis of external ear canal, bilateral

H61.399 Other acquired stenosis of external ear canal, unspecified ear

H61.8 Other specified disorders of external ear

H61.81 Exostosis of external canal

H61.811 Exostosis of right external canal

H61.812 Exostosis of left external canal

H61.813 Exostosis of external canal, bilateral

H61.819 Exostosis of external canal, unspecified ear

H61.89 Other specified disorders of external ear

H61.891 Other specified disorders of right external ear

H61.892 Other specified disorders of left external ear

H61.893 Other specified disorders of external ear, bilateral

H61.899 Other specified disorders of external ear, unspecified ear

H61.9 Disorder of external ear, unspecified

H61.90 Disorder of external ear, unspecified, unspecified ear

H61.91 Disorder of right external ear, unspecified

H61.92 Disorder of left external ear, unspecified

H61.93 Disorder of external ear, unspecified, bilateral

❖ **H62** Disorders of external ear in diseases classified elsewhere

Diseases of middle ear and mastoid (H65-H75)

H65 Nonsuppurative otitis media

Includes: nonsuppurative otitis media with myringitis

Use additional code for any associated perforated tympanic membrane (H72.-)

Use additional code to identify:
exposure to environmental tobacco smoke (Z77.22)
exposure to tobacco smoke in the perinatal period (P96.81)
history of tobacco use (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31)
tobacco dependence (F17.-)
tobacco use (Z72.0)

H65.0 Acute serous otitis media
Acute and subacute secretory otitis

H65.00 Acute serous otitis media, unspecified ear

H65.01 Acute serous otitis media, right ear

H65.02 Acute serous otitis media, left ear

H65.03 Acute serous otitis media, bilateral

H65.04 Acute serous otitis media, recurrent, right ear

H65.05 Acute serous otitis media, recurrent, left ear

H65.06 Acute serous otitis media, recurrent, bilateral

H65.07 Acute serous otitis media, recurrent, unspecified ear

H65.1 Other acute nonsuppurative otitis media

Excludes1: otitic barotrauma (T70.0)
otitis media (acute) NOS (H66.9)

H65.11 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous)

H65.111 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), right ear

H65.112 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), left ear

H65.113 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), bilateral

H65.114 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), recurrent, right ear

H65.115 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), recurrent, left ear

H65.116 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), recurrent, bilateral

H65.117 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), recurrent, unspecified ear

H65.119 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), unspecified ear

H65.19 Other acute nonsuppurative otitis media
Acute and subacute mucoid otitis media
Acute and subacute nonsuppurative otitis media NOS
Acute and subacute sanguinous otitis media
Acute and subacute seromucinous otitis media

H65.191 Other acute nonsuppurative otitis media, right ear

H65.192 Other acute nonsuppurative otitis media, left ear

H65.193 Other acute nonsuppurative otitis media, bilateral

H65.194 Other acute nonsuppurative otitis media, recurrent, right ear

H65.195 Other acute nonsuppurative otitis media, recurrent, left ear

H65.196 Other acute nonsuppurative otitis media, recurrent, bilateral

H65.197 Other acute nonsuppurative otitis media recurrent, unspecified ear

H65.199 Other acute nonsuppurative otitis media, unspecified ear

H65.2 Chronic serous otitis media
Chronic tubotympanal catarrh

H65.20 Chronic serous otitis media, unspecified ear

H65.21 Chronic serous otitis media, right ear

H65.22 Chronic serous otitis media, left ear

H65.23 Chronic serous otitis media, bilateral

H65.3 Chronic mucoid otitis media
Chronic mucinous otitis media
Chronic secretory otitis media
Chronic transudative otitis media
Glue ear

Excludes1: adhesive middle ear disease (H74.1)

H65.30 Chronic mucoid otitis media, unspecified ear

H65.31 Chronic mucoid otitis media, right ear

H65.32 Chronic mucoid otitis media, left ear

H65.33 Chronic mucoid otitis media, bilateral

H65.4 Other chronic nonsuppurative otitis media

H65.41 Chronic allergic otitis media

H65.411 Chronic allergic otitis media, right ear

H65.412 Chronic allergic otitis media, left ear

H65.413 Chronic allergic otitis media, bilateral

H65.419 Chronic allergic otitis media, unspecified ear

H65.49 Other chronic nonsuppurative otitis media
Chronic exudative otitis media
Chronic nonsuppurative otitis media NOS
Chronic otitis media with effusion (nonpurulent)
Chronic seromucinous otitis media

H65.491 Other chronic nonsuppurative otitis media, right ear

H65.492 Other chronic nonsuppurative otitis media, left ear

H65.493 Other chronic nonsuppurative otitis media, bilateral

H65.499 Other chronic nonsuppurative otitis media, unspecified ear

H65.9 Unspecified nonsuppurative otitis media
Allergic otitis media NOS
Catarrhal otitis media NOS
Exudative otitis media NOS
Mucoid otitis media NOS
Otitis media with effusion (nonpurulent) NOS
Secretory otitis media NOS
Seromucinous otitis media NOS
Serous otitis media NOS
Transudative otitis media NOS

H65.90 Unspecified nonsuppurative otitis media, unspecified ear

H65.91 Unspecified nonsuppurative otitis media, right ear

H65.92 Unspecified nonsuppurative otitis media, left ear

H65.93 Unspecified nonsuppurative otitis media, bilateral

H66 Suppurative and unspecified otitis media

Includes: suppurative and unspecified otitis media with myringitis

Use additional code for any associated perforated tympanic membrane (H72.-)

Use additional code to identify:
exposure to environmental tobacco smoke (Z77.22)
exposure to tobacco smoke in the perinatal period (P96.81)
history of tobacco use (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31)
tobacco dependence (F17.-)
tobacco use (Z72.0)

H66.0 Acute suppurative otitis media

H66.00 Acute suppurative otitis media without spontaneous rupture of ear drum

H66.001 Acute suppurative otitis media without spontaneous rupture of ear drum, right ear

H66.002 Acute suppurative otitis media without spontaneous rupture of ear drum, left ear

H66.003 Acute suppurative otitis media without spontaneous rupture of ear drum, bilateral

H66.004 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear

H66.005 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, left ear

H66.006 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, bilateral

H66.007 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, unspecified ear

H66.009 Acute suppurative otitis media without spontaneous rupture of ear drum, unspecified ear

H66.01 Acute suppurative otitis media with spontaneous rupture of ear drum

H66.011 Acute suppurative otitis media with spontaneous rupture of ear drum, right ear

H66.012 Acute suppurative otitis media with spontaneous rupture of ear drum, left ear

H66.013 Acute suppurative otitis media with spontaneous rupture of ear drum, bilateral

H66.014 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, right ear

H66.015 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, left ear

H66.016 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, bilateral

H66.017 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, unspecified ear

H66.019 Acute suppurative otitis media with spontaneous rupture of ear drum, unspecified ear

H66.1 Chronic tubotympanic suppurative otitis media
Benign chronic suppurative otitis media
Chronic tubotympanic disease

Use additional code for any associated perforated tympanic membrane (H72.-)

H66.10 Chronic tubotympanic suppurative otitis media, unspecified

H66.11 Chronic tubotympanic suppurative otitis media, right ear

H66.12 Chronic tubotympanic suppurative otitis media, left ear

H66.13 Chronic tubotympanic suppurative otitis media, bilateral

H66.2 Chronic atticoantral suppurative otitis media
Chronic atticoantral disease

H66.20 Chronic atticoantral suppurative otitis media, unspecified ear

H66.21 Chronic atticoantral suppurative otitis media, right ear

H66.22 Chronic atticoantral suppurative otitis media, left ear

H66.23 Chronic atticoantral suppurative otitis media, bilateral

H66.3 Other chronic suppurative otitis media
Chronic suppurative otitis media NOS

Use additional code for any associated perforated tympanic membrane (H72.-)

Excludes1: tuberculous otitis media (A18.6)

H66.3X Other chronic suppurative otitis media

H66.3X1 Other chronic suppurative otitis media, right ear

H66.3X2 Other chronic suppurative otitis media, left ear

H66.3X3 Other chronic suppurative otitis media, bilateral

H66.3X9 Other chronic suppurative otitis media, unspecified ear

H66.4 Suppurative otitis media, unspecified
Purulent otitis media NOS

Use additional code for any associated perforated tympanic membrane (H72.-)

H66.40 Suppurative otitis media, unspecified, unspecified ear

H66.41 Suppurative otitis media, unspecified, right ear

H66.42 Suppurative otitis media, unspecified, left ear

H66.43 Suppurative otitis media, unspecified, bilateral

H66.9 Otitis media, unspecified
Otitis media NOS
Acute otitis media NOS
Chronic otitis media NOS

Use additional code for any associated perforated tympanic membrane (H72.-)

H66.90 Otitis media, unspecified, unspecified ear

H66.91 Otitis media, unspecified, right ear

H66.92 Otitis media, unspecified, left ear

H66.93 Otitis media, unspecified, bilateral

H67 Otitis media in diseases classified elsewhere

Code first underlying disease, such as:
viral disease NEC (B00-B34)

Use additional code for any associated perforated tympanic membrane (H72.-)

Excludes1: otitis media in:
influenza (J09.X9, J10.83, J11.83)
measles (B05.3)
scarlet fever (A38.0)

tuberculosis (A18.6)

H67.1 Otitis media in diseases classified elsewhere, right ear

H67.2 Otitis media in diseases classified elsewhere, left ear

H67.3 Otitis media in diseases classified elsewhere, bilateral

H67.9 Otitis media in diseases classified elsewhere, unspecified ear

H68 Eustachian salpingitis and obstruction

H68.0 Eustachian salpingitis

H68.00 Unspecified Eustachian salpingitis

H68.001 Unspecified Eustachian salpingitis, right ear

H68.002 Unspecified Eustachian salpingitis, left ear

H68.003 Unspecified Eustachian salpingitis, bilateral

H68.009 Unspecified Eustachian salpingitis, unspecified ear

H68.01 Acute Eustachian salpingitis

H68.011 Acute Eustachian salpingitis, right ear

H68.012 Acute Eustachian salpingitis, left ear

H68.013 Acute Eustachian salpingitis, bilateral

H68.019 Acute Eustachian salpingitis, unspecified ear

H68.02 Chronic Eustachian salpingitis

H68.021 Chronic Eustachian salpingitis, right ear

H68.022 Chronic Eustachian salpingitis, left ear

H68.023 Chronic Eustachian salpingitis, bilateral

H68.029 Chronic Eustachian salpingitis, unspecified ear

H68.1 Obstruction of Eustachian tube
Stenosis of Eustachian tube
Stricture of Eustachian tube

H68.10 Unspecified obstruction of Eustachian tube

H68.101 Unspecified obstruction of Eustachian tube, right ear

H68.102 Unspecified obstruction of Eustachian tube, left ear

H68.103 Unspecified obstruction of Eustachian tube, bilateral

H68.109 Unspecified obstruction of Eustachian tube, unspecified ear

H68.11 Osseous obstruction of Eustachian tube

H68.111 Osseous obstruction of Eustachian tube, right ear

H68.112 Osseous obstruction of Eustachian tube, left ear

H68.113 Osseous obstruction of Eustachian tube, bilateral

H68.119 Osseous obstruction of Eustachian tube, unspecified ear

H68.12 Intrinsic cartilagenous obstruction of Eustachian tube

H68.121 Intrinsic cartilagenous obstruction of Eustachian tube, right ear

H68.122 Intrinsic cartilagenous obstruction of Eustachian tube, left ear

H68.123 Intrinsic cartilagenous obstruction of Eustachian tube, bilateral

H68.129 Intrinsic cartilagenous obstruction of Eustachian tube, unspecified ear

H68.13 Extrinsic cartilagenous obstruction of Eustachian tube
Compression of Eustachian tube

H68.131 Extrinsic cartilagenous obstruction of Eustachian tube, right ear

H68.132 Extrinsic cartilagenous obstruction of Eustachian tube, left ear

H68.133 Extrinsic cartilagenous obstruction of Eustachian tube, bilateral

H68.139 Extrinsic cartilagenous obstruction of Eustachian tube, unspecified ear

H69 Other and unspecified disorders of Eustachian tube

H69.0 Patulous Eustachian tube

H69.00 Patulous Eustachian tube, unspecified ear

H69.01 Patulous Eustachian tube, right ear

H69.02 Patulous Eustachian tube, left ear

H69.03 Patulous Eustachian tube, bilateral

H69.8 Other specified disorders of Eustachian tube

H69.80 Other specified disorders of Eustachian tube, unspecified ear

H69.81 Other specified disorders of Eustachian tube, right ear

H69.82 Other specified disorders of Eustachian tube, left ear

H69.83 Other specified disorders of Eustachian tube, bilateral

H69.9 Unspecified Eustachian tube disorder

H69.90 Unspecified Eustachian tube disorder, unspecified ear

H69.91 Unspecified Eustachian tube disorder, right ear

H69.92 Unspecified Eustachian tube disorder, left ear

H69.93 Unspecified Eustachian tube disorder, bilateral

H70 Mastoiditis and related conditions

H70.0 Acute mastoiditis
Abscess of mastoid
Empyema of mastoid

H70.00 Acute mastoiditis without complications

H70.001 Acute mastoiditis without complications, right ear

H70.002 Acute mastoiditis without complications, left ear

H70.003 Acute mastoiditis without complications, bilateral

H70.009 Acute mastoiditis without complications, unspecified ear

H70.01 Subperiosteal abscess of mastoid

H70.011 Subperiosteal abscess of mastoid, right ear

H70.012 Subperiosteal abscess of mastoid, left ear

H70.013 Subperiosteal abscess of mastoid, bilateral

H70.019 Subperiosteal abscess of mastoid, unspecified ear

H70.09 Acute mastoiditis with other complications

H70.091 Acute mastoiditis with other complications, right ear

H70.092 Acute mastoiditis with other complications, left ear

H70.093 Acute mastoiditis with other complications, bilateral

H70.099 Acute mastoiditis with other complications, unspecified ear

H70.1 Chronic mastoiditis
Caries of mastoid
Fistula of mastoid

Excludes1: tuberculous mastoiditis (A18.03)

H70.10 Chronic mastoiditis, unspecified ear

H70.11 Chronic mastoiditis, right ear

H70.12 Chronic mastoiditis, left ear

H70.13 Chronic mastoiditis, bilateral

H70.2 Petrositis
Inflammation of petrous bone

H70.20 Unspecified petrositis

H70.201 Unspecified petrositis, right ear

H70.202 Unspecified petrositis, left ear

H70.203 Unspecified petrositis, bilateral

H70.209 Unspecified petrositis, unspecified ear

H70.21 Acute petrositis

H70.211 Acute petrositis, right ear

H70.212 Acute petrositis, left ear

H70.213 Acute petrositis, bilateral

H70.219 Acute petrositis, unspecified ear

H70.22 Chronic petrositis

H70.221 Chronic petrositis, right ear

H70.222 Chronic petrositis, left ear

H70.223 Chronic petrositis, bilateral

H70.229 Chronic petrositis, unspecified ear

H70.8 Other mastoiditis and related conditions

Excludes1: preauricular sinus and cyst (Q18.1)
sinus, fistula, and cyst of branchial cleft (Q18.0)

H70.81 Postauricular fistula

H70.811 Postauricular fistula, right ear

H70.812 Postauricular fistula, left ear

H70.813 Postauricular fistula, bilateral

H70.819 Postauricular fistula, unspecified ear

H70.89 Other mastoiditis and related conditions

H70.891 Other mastoiditis and related conditions, right ear

H70.892 Other mastoiditis and related conditions, left ear

H70.893 Other mastoiditis and related conditions, bilateral

H70.899 Other mastoiditis and related conditions, unspecified ear

H70.9 Unspecified mastoiditis

H70.90 Unspecified mastoiditis, unspecified ear

H70.91 Unspecified mastoiditis, right ear

H70.92 Unspecified mastoiditis, left ear

H70.93 Unspecified mastoiditis, bilateral

H71.2 Cholesteatoma of mastoid

H71.20 Cholesteatoma of mastoid, unspecified ear

H71.21 Cholesteatoma of mastoid, right ear

H71.22 Cholesteatoma of mastoid, left ear

H71.23 Cholesteatoma of mastoid, bilateral

H71.3 Diffuse cholesteatosis

H71.30 Diffuse cholesteatosis, unspecified ear

H71.31 Diffuse cholesteatosis, right ear

H71.32 Diffuse cholesteatosis, left ear

H71.33 Diffuse cholesteatosis, bilateral

H71.9 Unspecified cholesteatoma

H71.90 Unspecified cholesteatoma, unspecified ear

H71.91 Unspecified cholesteatoma, right ear

H71.92 Unspecified cholesteatoma, left ear

H71.93 Unspecified cholesteatoma, bilateral

H72 Perforation of tympanic membrane

Includes: persistent post-traumatic perforation of ear drum
postinflammatory perforation of ear drum

Code first any associated otitis media (H65.-, H66.1-, H66.2-, H66.3-, H66.4-, H66.9-, H67.-)

Excludes1: acute suppurative otitis media with rupture of the tympanic membrane (H66.01-)
traumatic rupture of ear drum (S09.2-)

H72.0 Central perforation of tympanic membrane

H72.00 Central perforation of tympanic membrane, unspecified ear

H72.01 Central perforation of tympanic membrane, right ear

H72.02 Central perforation of tympanic membrane, left ear

H72.03 Central perforation of tympanic membrane, bilateral

H72.1 Attic perforation of tympanic membrane
Perforation of pars flaccida

H72.10 Attic perforation of tympanic membrane, unspecified ear

H72.11 Attic perforation of tympanic membrane, right ear

H72.12 Attic perforation of tympanic membrane, left ear

H72.13 Attic perforation of tympanic membrane, bilateral

H72.2 Other marginal perforations of tympanic membrane

H72.2X Other marginal perforations of tympanic membrane

H72.2X1 Other marginal perforations of tympanic membrane, right ear

H72.2X2 Other marginal perforations of tympanic membrane, left ear

H72.2X3 Other marginal perforations of tympanic membrane, bilateral

H72.2X9 Other marginal perforations of tympanic membrane, unspecified ear

H72.8 Other perforations of tympanic membrane

H72.81 Multiple perforations of tympanic membrane

H72.811 Multiple perforations of tympanic membrane, right ear

H72.812 Multiple perforations of tympanic membrane, left ear

H72.813 Multiple perforations of tympanic membrane, bilateral

H72.819 Multiple perforations of tympanic membrane, unspecified ear

H72.82 Total perforations of tympanic membrane

H72.821 Total perforations of tympanic membrane, right ear

H72.822 Total perforations of tympanic membrane, left ear

H72.823 Total perforations of tympanic membrane, bilateral

H72.829 Total perforations of tympanic membrane, unspecified ear

H72.9 Unspecified perforation of tympanic membrane

H72.90 Unspecified perforation of tympanic membrane, unspecified ear

H72.91 Unspecified perforation of tympanic membrane, right ear

H72.92 Unspecified perforation of tympanic membrane, left ear

H72.93 Unspecified perforation of tympanic membrane, bilateral

H73 Other disorders of tympanic membrane

H73.0 Acute myringitis

Excludes1: acute myringitis with otitis media (H65, H66)

H73.00 Unspecified acute myringitis
Acute tympanitis NOS

H73.001 Acute myringitis, right ear

H73.002 Acute myringitis, left ear

H73.003 Acute myringitis, bilateral

H73.009 Acute myringitis, unspecified ear

H73.01 Bullous myringitis

H73.011 Bullous myringitis, right ear

H73.012 Bullous myringitis, left ear

H73.013 Bullous myringitis, bilateral

H73.019 Bullous myringitis, unspecified ear

H73.09 Other acute myringitis

H73.091 Other acute myringitis, right ear

H73.092 Other acute myringitis, left ear

H73.093 Other acute myringitis, bilateral

H73.099 Other acute myringitis, unspecified ear

H73.1 Chronic myringitis
Chronic tympanitis

Excludes1: chronic myringitis with otitis media (H65, H66)

H73.10 Chronic myringitis, unspecified ear

H73.11 Chronic myringitis, right ear

H73.12 Chronic myringitis, left ear

H73.13 Chronic myringitis, bilateral

H73.2 Unspecified myringitis

H73.20 Unspecified myringitis, unspecified ear

H73.21 Unspecified myringitis, right ear

H73.22 Unspecified myringitis, left ear

H73.23 Unspecified myringitis, bilateral

H73.8 Other specified disorders of tympanic membrane

H73.81 Atrophic flaccid tympanic membrane

H73.811 Atrophic flaccid tympanic membrane, right ear

H73.812 Atrophic flaccid tympanic membrane, left ear

H73.813 Atrophic flaccid tympanic membrane, bilateral

H73.819 Atrophic flaccid tympanic membrane, unspecified ear

H73.82 Atrophic nonflaccid tympanic membrane

H73.821 Atrophic nonflaccid tympanic membrane, right ear

H73.822 Atrophic nonflaccid tympanic membrane, left ear

H73.823 Atrophic nonflaccid tympanic membrane, bilateral

H73.829 Atrophic nonflaccid tympanic membrane, unspecified ear

H73.89 Other specified disorders of tympanic membrane

H73.891 Other specified disorders of tympanic membrane, right ear

H73.892 Other specified disorders of tympanic membrane, left ear

H73.893 Other specified disorders of tympanic membrane, bilateral

H73.899 Other specified disorders of tympanic membrane, unspecified ear

H73.9 Unspecified disorder of tympanic membrane

H73.90 Unspecified disorder of tympanic membrane, unspecified ear

H73.91 Unspecified disorder of tympanic membrane, right ear

H73.92 Unspecified disorder of tympanic membrane, left ear

H73.93 Unspecified disorder of tympanic membrane, bilateral

H74 Other disorders of middle ear mastoid

Excludes2: mastoiditis (H70.-)

H74.0 Tympanosclerosis

H74.01 Tympanosclerosis, right ear

H74.02 Tympanosclerosis, left ear

H74.03 Tympanosclerosis, bilateral

H74.09 Tympanosclerosis, unspecified ear

H74.1 Adhesive middle ear disease
Adhesive otitis

Excludes1: glue ear (H65.3-)

H74.11 Adhesive right middle ear disease

H74.12 Adhesive left middle ear disease

H74.13 Adhesive middle ear disease, bilateral

H74.19 Adhesive middle ear disease, unspecified ear

H74.2 Discontinuity and dislocation of ear ossicles

H74.20 Discontinuity and dislocation of ear ossicles, unspecified ear

H74.21 Discontinuity and dislocation of right ear ossicles

H74.22 Discontinuity and dislocation of left ear ossicles

H74.23 Discontinuity and dislocation of ear ossicles, bilateral

H74.3 Other acquired abnormalities of ear ossicles

H74.31 Ankylosis of ear ossicles

H74.311 Ankylosis of ear ossicles, right ear

H74.312 Ankylosis of ear ossicles, left ear

H74.313 Ankylosis of ear ossicles, bilateral

H74.319 Ankylosis of ear ossicles, unspecified ear

H74.32 Partial loss of ear ossicles

H74.321 Partial loss of ear ossicles, right ear

H74.322 Partial loss of ear ossicles, left ear

H74.323 Partial loss of ear ossicles, bilateral

H74.329 Partial loss of ear ossicles, unspecified ear

H74.39 Other acquired abnormalities of ear ossicles

H74.391 Other acquired abnormalities of right ear ossicles

H74.392 Other acquired abnormalities of left ear ossicles

H74.393 Other acquired abnormalities of ear ossicles, bilateral

H74.399 Other acquired abnormalities of ear ossicles, unspecified ear

H74.4 Polyp of middle ear

H74.40 Polyp of middle ear, unspecified ear

H74.41 Polyp of right middle ear

H74.42 Polyp of left middle ear

H74.43 Polyp of middle ear, bilateral

H74.8 Other specified disorders of middle ear and mastoid

H74.8X Other specified disorders of middle ear and mastoid

H74.8X1 Other specified disorders of right middle ear and mastoid

H74.8X2 Other specified disorders of left middle ear and mastoid

H74.8X3 Other specified disorders of middle ear and mastoid, bilateral

H74.8X9 Other specified disorders of middle ear and mastoid, unspecified ear

H74.9 Unspecified disorder of middle ear and mastoid

H74.90 Unspecified disorder of middle ear and mastoid, unspecified ear

H74.91 Unspecified disorder of right middle ear and mastoid

H74.92 Unspecified disorder of left middle ear and mastoid

H74.93 Unspecified disorder of middle ear and mastoid, bilateral

H75 Other disorders of middle ear and mastoid in diseases classified elsewhere

Code first underlying disease

H75.0 Mastoiditis in infectious and parasitic diseases classified elsewhere

Excludes1: mastoiditis (in):
syphilis (A52.77)
tuberculosis (A18.03)

H75.00 Mastoiditis in infectious and parasitic diseases classified elsewhere, unspecified ear

H75.01 Mastoiditis in infectious and parasitic diseases classified elsewhere, right ear

H75.02 Mastoiditis in infectious and parasitic diseases classified elsewhere, left ear

H75.03 Mastoiditis in infectious and parasitic diseases classified elsewhere, bilateral

H75.8 Other specified disorders of middle ear and mastoid in diseases classified elsewhere

H75.80 Other specified disorders of middle ear and mastoid in diseases classified elsewhere, unspecified ear

H75.81 Other specified disorders of right middle ear and mastoid in diseases classified elsewhere

H75.82 Other specified disorders of left middle ear and mastoid in diseases classified elsewhere

H75.83 Other specified disorders of middle ear and mastoid in diseases classified elsewhere, bilateral

Diseases of inner ear (H80-H83)

H80 Otosclerosis

Includes: Otospongiosis

H80.0 Otosclerosis involving oval window, nonobliterative

H80.00 Otosclerosis involving oval window, nonobliterative, unspecified ear

H80.01 Otosclerosis involving oval window, nonobliterative, right ear

H80.02 Otosclerosis involving oval window, nonobliterative, left ear

H80.03 Otosclerosis involving oval window, nonobliterative, bilateral

H80.1 Otosclerosis involving oval window, obliterative

H80.10 Otosclerosis involving oval window, obliterative, unspecified ear

H80.11 Otosclerosis involving oval window, obliterative, right ear

H80.12 Otosclerosis involving oval window, obliterative, left ear

H80.13 Otosclerosis involving oval window, obliterative, bilateral

H80.2 Cochlear otosclerosis
Otosclerosis involving otic capsule
Otosclerosis involving round window

H80.20 Cochlear otosclerosis, unspecified ear

H80.21 Cochlear otosclerosis, right ear

H80.22 Cochlear otosclerosis, left ear

H80.23 Cochlear otosclerosis, bilateral

H80.8 Other otosclerosis

H80.80 Other otosclerosis, unspecified ear

H80.81 Other otosclerosis, right ear

H80.82 Other otosclerosis, left ear

H80.83 Other otosclerosis, bilateral

H80.9 Unspecified otosclerosis

H80.90 Unspecified otosclerosis, unspecified ear

H80.91 Unspecified otosclerosis, right ear

H80.92 Unspecified otosclerosis, left ear

H80.93 Unspecified otosclerosis, bilateral

H81 Disorders of vestibular function

Excludes1: epidemic vertigo (A88.1)
vertigo NOS (R42)

H81.0 Ménière's disease
Labyrinthine hydrops
Ménière's syndrome or vertigo

- **H81.01** Ménière's disease, right ear
- **H81.02** Ménière's disease, left ear
- **H81.03** Ménière's disease, bilateral
- **H81.09** Ménière's disease, unspecified ear

H81.1 Benign paroxysmal vertigo

- ✓ **H81.10** Benign paroxysmal vertigo, unspecified ear
- ✓ **H81.11** Benign paroxysmal vertigo, right ear
- ✓ **H81.12** Benign paroxysmal vertigo, left ear
- ✓ **H81.13** Benign paroxysmal vertigo, bilateral

H81.2 Vestibular neuronitis

- **H81.20** Vestibular neuronitis, unspecified ear
- **H81.21** Vestibular neuronitis, right ear
- **H81.22** Vestibular neuronitis, left ear
- **H81.23** Vestibular neuronitis, bilateral

H81.3 Other peripheral vertigo

- **H81.31** Aural vertigo
  - **H81.311** Aural vertigo, right ear
  - **H81.312** Aural vertigo, left ear
  - **H81.313** Aural vertigo, bilateral
  - **H81.319** Aural vertigo, unspecified ear
- **H81.39** Other peripheral vertigo
  Lermoyez' syndrome
  Otogenic vertigo
  Peripheral vertigo NOS
  - ✓ **H81.391** Other peripheral vertigo, right ear
  - ✓ **H81.392** Other peripheral vertigo, left ear
  - ✓ **H81.393** Other peripheral vertigo, bilateral
  - ✓ **H81.399** Other peripheral vertigo, unspecified ear

H81.4 Vertigo of central origin
Central positional nystagmus

- **H81.41** Vertigo of central origin, right ear
- **H81.42** Vertigo of central origin, left ear
- **H81.43** Vertigo of central origin, bilateral
- **H81.49** Vertigo of central origin, unspecified ear

H81.8 Other disorders of vestibular function

H81.8X Other disorders of vestibular function

✓ **H81.8X1** Other disorders of vestibular function, right ear

✓ **H81.8X2** Other disorders of vestibular function, left ear

✓ **H81.8X3** Other disorders of vestibular function, bilateral

✓ **H81.8X9** Other disorders of vestibular function, unspecified ear

H81.9 Unspecified disorder of vestibular function
Vertiginous syndrome NOS

H81.90 Unspecified disorder of vestibular function, unspecified ear

H81.91 Unspecified disorder of vestibular function, right ear

H81.92 Unspecified disorder of vestibular function, left ear

H81.93 Unspecified disorder of vestibular function, bilateral

H82 Vertiginous syndromes in diseases classified elsewhere

Code first underlying disease

Excludes1: epidemic vertigo (A88.1)

H82.1 Vertiginous syndromes in diseases classified elsewhere, right ear

H82.2 Vertiginous syndromes in diseases classified elsewhere, left ear

H82.3 Vertiginous syndromes in diseases classified elsewhere, bilateral

H82.9 Vertiginous syndromes in diseases classified elsewhere, unspecified ear

H83 Other diseases of inner ear

H83.0 Labyrinthitis

H83.01 Labyrinthitis, right ear

H83.02 Labyrinthitis, left ear

H83.03 Labyrinthitis, bilateral

H83.09 Labyrinthitis, unspecified ear

H83.1 Labyrinthine fistula

H83.11 Labyrinthine fistula, right ear

H83.12 Labyrinthine fistula, left ear

H83.13 Labyrinthine fistula, bilateral

H83.19 Labyrinthine fistula, unspecified ear

H83.2 Labyrinthine dysfunction
Labyrinthine hypersensitivity
Labyrinthine hypofunction
Labyrinthine loss of function

H83.2X Labyrinthine dysfunction

H83.2X1 Labyrinthine dysfunction, right ear

H83.2X2 Labyrinthine dysfunction, left ear

H83.2X3 Labyrinthine dysfunction, bilateral

H83.2X9 Labyrinthine dysfunction, unspecified ear

H83.3 Noise effects on inner ear
Acoustic trauma of inner ear
Noise-induced hearing loss of inner ear

H83.3X Noise effects on inner ear

✓ **H83.3X1** Noise effects on right inner ear

✓ **H83.3X2** Noise effects on left inner ear

✓ **H83.3X3** Noise effects on inner ear, bilateral

✓ **H83.3X9** Noise effects on inner ear, unspecified ear

H83.8 Other specified diseases of inner ear

H83.8X Other specified diseases of inner ear

H83.8X1 Other specified diseases of right inner ear

H83.8X2 Other specified diseases of left inner ear

H83.8X3 Other specified diseases of inner ear, bilateral

H83.8X9 Other specified diseases of inner ear, unspecified ear

H83.9 Unspecified disease of inner ear

H83.90 Unspecified disease of inner ear, unspecified ear

H83.91 Unspecified disease of right inner ear

H83.92 Unspecified disease of left inner ear

H83.93 Unspecified disease of inner ear, bilateral

Other disorders of ear (H90-H94)

H90 Conductive and sensorineural hearing loss

Excludes1: deaf nonspeaking NEC (H91.3)
deafness NOS (H91.9-)
hearing loss NOS (H91.9-)
noise-induced hearing loss (H83.3-)
ototoxic hearing loss (H91.0-)
sudden (idiopathic) hearing loss (H91.2-)

✓ **H90.0** Conductive hearing loss, bilateral

H90.1 Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side

✓ **H90.11** Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side

✓ **H90.12** Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side

H90.2 Conductive hearing loss, unspecified
Conductive deafness NOS

✓ **H90.3** Sensorineural hearing loss, bilateral

H90.4 Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side

✓ **H90.41** Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side

✓ **H90.42** Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side

H90.5 Unspecified sensorineural hearing loss
Central hearing loss NOS
Congenital deafness NOS
Neural hearing loss NOS
Perceptive hearing loss NOS
Sensorineural deafness NOS
Sensory hearing loss NOS

Excludes1: abnormal auditory perception (H93.2-)
psychogenic deafness (F44.6)

✓ **H90.6** Mixed conductive and sensorineural hearing loss, bilateral

H90.7 Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side

✓ **H90.71** Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side

✓ **H90.72** Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side

H90.8 Mixed conductive and sensorineural hearing loss, unspecified

H90.A Conductive and sensorineural hearing loss with restricted hearing on the contralateral side

Use 2 codes from the H90.A- series to report **different types of hearing loss in each ear**. See also: bit.ly/2jgM1DL

H90.A1 Conductive hearing loss, unilateral, with restricted hearing on the contralateral side

✓ **H90.A11** Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side

✓ **H90.A12** Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side

H90.A2 Sensorineural hearing loss, unilateral, with restricted hearing on the contralateral side

✓ **H90.A21** Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side

✓ **H90.A22** Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side

H90.A3 Mixed conductive and sensorineural hearing loss, unilateral with restricted hearing on the contralateral side

✓ **H90.A31** Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side

✓ **H90.A32** Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side

H91 Other and unspecified hearing loss

Excludes1: abnormal auditory perception (H93.2-)
hearing loss as classified in H90.-
impacted cerumen (H61.2-)
noise-induced hearing loss (H83.3-)
psychogenic deafness (F44.6)
transient ischemic deafness (H93.01-)

H91.0 Ototoxic hearing loss

Code first poisoning due to drug or toxin, if applicable (T36-T65 with fifth or sixth character 1-4 or 6)

Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

- ✓ **H91.01** Ototoxic hearing loss, right ear
- ✓ **H91.02** Ototoxic hearing loss, left ear
- ✓ **H91.03** Ototoxic hearing loss, bilateral
- ✓ **H91.09** Ototoxic hearing loss, unspecified ear

Ototoxic hearing loss: Code **first** when hearing loss is due to an adverse effect of a **properly administered drug.** Code the drug giving rise to the adverse effect second.

Code the hearing loss **second** when it is due to poisoning from a drug or toxin.

Consult the medical record or physician for the appropriate code for the drug or toxin in section T36-T65.

H91.1 Presbycusis
Presbyacusia

- ✓ **H91.10** Presbycusis, unspecified ear
- ✓ **H91.11** Presbycusis, right ear
- ✓ **H91.12** Presbycusis, left ear
- ✓ **H91.13** Presbycusis, bilateral

H91.2 Sudden idiopathic hearing loss
Sudden hearing loss NOS

- ✓ **H91.20** Sudden idiopathic hearing loss, unspecified ear
- ✓ **H91.21** Sudden idiopathic hearing loss, right ear
- ✓ **H91.22** Sudden idiopathic hearing loss, left ear
- ✓ **H91.23** Sudden idiopathic hearing loss, bilateral

✓ **H91.3** Deaf nonspeaking, not elsewhere classified

H91.8 Other specified hearing loss

H91.8X Other specified hearing loss

- ✓ **H91.8X1** Other specified hearing loss, right ear
- ✓ **H91.8X2** Other specified hearing loss, left ear
- ✓ **H91.8X3** Other specified hearing loss, bilateral
- ✓ **H91.8X9** Other specified hearing loss, unspecified ear

H91.9 Unspecified hearing loss
Deafness NOS
High frequency deafness
Low frequency deafness

H91.90 Unspecified hearing loss, unspecified ear

Unspecified hearing loss codes: Try to limit the use of these and other "unspecified" codes to cases where the type or laterality of hearing loss has not yet been determined, such as in newborn diagnostics.

H91.91 Unspecified hearing loss, right ear

H91.92 Unspecified hearing loss, left ear

H91.93 Unspecified hearing loss, bilateral

H92 Otalgia and effusion of ear

H92.0 Otalgia

H92.01 Otalgia, right ear

H92.02 Otalgia, left ear

H92.03 Otalgia, bilateral

H92.09 Otalgia, unspecified ear

H92.1 Otorrhea

Excludes1: leakage of cerebrospinal fluid through ear (G96.0)

H92.10 Otorrhea, unspecified ear

H92.11 Otorrhea, right ear

H92.12 Otorrhea, left ear

H92.13 Otorrhea, bilateral

H92.2 Otorrhagia

Excludes1: traumatic otorrhagia - code to injury

H92.20 Otorrhagia, unspecified ear

H92.21 Otorrhagia, right ear

H92.22 Otorrhagia, left ear

H92.23 Otorrhagia, bilateral

H93 Other disorders of ear, not elsewhere classified

H93.0 Degenerative and vascular disorders of ear

Excludes1: presbycusis (H91.1)

H93.01 Transient ischemic deafness

H93.011 Transient ischemic deafness, right ear

H93.012 Transient ischemic deafness, left ear

H93.013 Transient ischemic deafness, bilateral

H93.019 Transient ischemic deafness, unspecified ear

H93.09 Unspecified degenerative and vascular disorders of ear

H93.091 Unspecified degenerative and vascular disorders of right ear

H93.092 Unspecified degenerative and vascular disorders of left ear

H93.093 Unspecified degenerative and vascular disorders of ear, bilateral

H93.099 Unspecified degenerative and vascular disorders of unspecified ear

H93.1 Tinnitus

- ✓ **H93.11** Tinnitus, right ear
- ✓ **H93.12** Tinnitus, left ear
- ✓ **H93.13** Tinnitus, bilateral
- ✓ **H93.19** Tinnitus, unspecified ear

H93.A Pulsatile tinnitus

- ✓ **H93.A1** Pulsatile tinnitus, right ear
- ✓ **H93.A2** Pulsatile tinnitus, left ear
- ✓ **H93.A3** Pulsatile tinnitus, bilateral
- ✓ **H93.A1** Pulsatile tinnitus, unspecified ear

H93.2 Other abnormal auditory perceptions

Excludes2: auditory hallucinations (R44.0)

H93.21 Auditory recruitment

- ✓ **H93.211** Auditory recruitment, right ear
- ✓ **H93.212** Auditory recruitment, left ear
- ✓ **H93.213** Auditory recruitment, bilateral
- ✓ **H93.219** Auditory recruitment, unspecified ear

H93.22 Diplacusis

- ✓ **H93.221** Diplacusis, right ear
- ✓ **H93.222** Diplacusis, left ear
- ✓ **H93.223** Diplacusis, bilateral
- ✓ **H93.229** Diplacusis, unspecified ear

H93.23 Hyperacusis

- ✓ **H93.231** Hyperacusis, right ear
- ✓ **H93.232** Hyperacusis, left ear
- ✓ **H93.233** Hyperacusis, bilateral
- ✓ **H93.239** Hyperacusis, unspecified ear

H93.24 Temporary auditory threshold shift

- ✓ **H93.241** Temporary auditory threshold shift, right ear
- ✓ **H93.242** Temporary auditory threshold shift, left ear
- ✓ **H93.243** Temporary auditory threshold shift, bilateral
- ✓ **H93.249** Temporary auditory threshold shift, unspecified ear

✓ **H93.25** Central auditory processing disorder
Congenital auditory imperception
Word deafness

Excludes1: mixed receptive-expressive language disorder (F80.2)

H93.29 Other abnormal auditory perceptions

- ✓ **H93.291** Other abnormal auditory perceptions, right ear
- ✓ **H93.292** Other abnormal auditory perceptions, left ear
- ✓ **H93.293** Other abnormal auditory perceptions, bilateral
- ✓ **H93.299** Other abnormal auditory perceptions, unspecified ear

H93.3 Disorders of acoustic nerve
Disorder of 8th cranial nerve

Excludes1: acoustic neuroma (D33.3)
syphilitic acoustic neuritis (A52.15)

H93.3X Disorders of acoustic nerve

- **H93.3X1** Disorders of right acoustic nerve
- **H93.3X2** Disorders of left acoustic nerve
- **H93.3X3** Disorders of bilateral acoustic nerves
- **H93.3X9** Disorders of unspecified acoustic nerve

H93.8 Other specified disorders of ear

H93.8X Other specified disorders of ear

- **H93.8X1** Other specified disorders of right ear
- **H93.8X2** Other specified disorders of left ear
- **H93.8X3** Other specified disorders of ear, bilateral
- **H93.8X9** Other specified disorders of ear, unspecified ear

H93.9 Unspecified disorder of ear

- **H93.90** Unspecified disorder of ear, unspecified ear
- **H93.91** Unspecified disorder of right ear
- **H93.92** Unspecified disorder of left ear
- **H93.93** Unspecified disorder of ear, bilateral

H94 Other disorders of ear in diseases classified elsewhere

H94.0 Acoustic neuritis in infectious and parasitic diseases classified elsewhere

Code first underlying disease, such as: parasitic disease (B65-B89)

Excludes1: acoustic neuritis (in):
herpes zoster (B02.29)
syphilis (A52.15)

- **H94.00** Acoustic neuritis in infectious and parasitic diseases classified elsewhere, unspecified ear
- **H94.01** Acoustic neuritis in infectious and parasitic diseases classified elsewhere, right ear
- **H94.02** Acoustic neuritis in infectious and parasitic diseases classified elsewhere, left ear
- **H94.03** Acoustic neuritis in infectious and parasitic diseases classified elsewhere, bilateral

H94.8 Other specified disorders of ear in diseases classified elsewhere

Code first underlying disease, such as: congenital syphilis (A50.0)

Excludes1: aural myiasis (B87.4)
syphilitic labyrinthitis (A52.79)

H94.80 Other specified disorders of ear in diseases classified elsewhere, unspecified ear

H94.81 Other specified disorders of right ear in diseases classified elsewhere

H94.82 Other specified disorders of left ear in diseases classified elsewhere

H94.83 Other specified disorders of ear in diseases classified elsewhere, bilateral

Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified (H95)

H95 Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified

- ❖ **H95.0** Recurrent cholesteatoma of postmastoidectomy cavity
- ❖ **H95.1** Other disorders of ear and mastoid process following mastoidectomy
- ❖ **H95.2** Intraoperative hemorrhage and hematoma of ear and mastoid process complicating a procedure
- ❖ **H95.3** Accidental puncture and laceration of ear and mastoid process during a procedure
- ❖ **H95.4** Postprocedural hemorrhage of ear and mastoid process following a procedure
- ❖ **H95.5** Postprocedural hematoma and seroma of ear and mastoid process following a procedure
- ❖ **H95.8** Other intraoperative and postprocedural complications and disorders of the ear and mastoid process, not elsewhere classified

Ch. 17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)

Note: Codes from this chapter are not for use on maternal or fetal records

Excludes2: inborn errors of metabolism (E70-E88)

Congenital malformations of eye, ear, face and neck (Q10-Q18)

Excludes2: cleft lip and cleft palate (Q35-Q37)
congenital malformation of cervical spine (Q05.0, Q05.5, Q67.5, Q76.0-Q76.4)
congenital malformation of larynx (Q31.-)
congenital malformation of lip NEC (Q38.0)
congenital malformation of nose (Q30.-)
congenital malformation of parathyroid gland (Q89.2)
congenital malformation of thyroid gland (Q89.2)

Q16 Congenital malformations of ear causing impairment of hearing

Excludes1: congenital deafness (H90.-)

Q16.0 Congenital absence of (ear) auricle

Q16.1 Congenital absence, atresia and stricture of auditory canal (external)
Congenital atresia or stricture of osseous meatus

Q16.2 Absence of eustachian tube

Q16.3 Congenital malformation of ear ossicles
Congenital fusion of ear ossicles

Q16.4 Other congenital malformations of middle ear
Congenital malformation of middle ear NOS

Q16.5 Congenital malformation of inner ear
Congenital anomaly of membranous labyrinth
Congenital anomaly of organ of Corti

Q16.9 Congenital malformation of ear causing impairment of hearing, unspecified
Congenital absence of ear NOS

Q17 Other congenital malformations of ear

Excludes1: congenital malformations of ear with impairment of hearing (Q16.0-Q16.9)
preauricular sinus (Q18.1)

Q17.0 Accessory auricle
Accessory tragus
Polyotia
Preauricular appendage or tag
Supernumerary ear
Supernumerary lobule

Q17.1 Macrotia

Q17.2 Microtia

Q17.3 Other misshapen ear
Pointed ear

Q17.4 Misplaced ear
Low-set ears

Excludes1: cervical auricle (Q18.2)

Q17.5 Prominent ear
Bat ear

Q17.8 Other specified congenital malformations of ear
Congenital absence of lobe of ear

Q17.9 Congenital malformation of ear, unspecified
Congenital anomaly of ear NOS

Ch. 18: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

Note: This chapter includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded.

Signs and symptoms that point rather definitely to a given diagnosis have been assigned to a category in other chapters of the classification. In general, categories in this chapter include the less well-defined conditions and symptoms that, without the necessary study of the case to establish a final diagnosis, point perhaps equally to two or more diseases or to two or more systems of the body. Practically all categories in the chapter could be designated 'not otherwise specified', 'unknown etiology' or 'transient'. The Alphabetical Index should be consulted to determine which symptoms and signs are to be allocated here and which to other chapters. The residual subcategories, numbered .8, are generally provided for other relevant symptoms that cannot be allocated elsewhere in the classification.

The conditions and signs or symptoms included in categories R00-R94 consist of:

(a) cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated;

(b) signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined;

(c) provisional diagnosis in a patient who failed to return for further investigation or care;

(d) cases referred elsewhere for investigation or treatment before the diagnosis was made;

(e) cases in which a more precise diagnosis was not available for any other reason;

(f) certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right.

Excludes2: abnormal findings on antenatal screening of mother (O28.-)
certain conditions originating in the perinatal period (P04-P96)
signs and symptoms classified in the body system chapters
signs and symptoms of breast (N63, N64.5)

Symptoms and signs involving cognition, perception, emotional state and behavior (R40-R46)

Excludes2: symptoms and signs constituting part of a pattern of mental disorder (F01-F99)

✓ **R42** Dizziness and giddiness
Light-headedness
Vertigo NOS

Excludes1: vertiginous syndromes (H81.-)
vertigo from infrasound (T75.23)

R44 Other symptoms and signs involving general sensations and perceptions

Excludes1: alcoholic hallucinations (F1.5)
hallucinations in drug psychosis (F11-F19 with .5)
hallucinations in mood disorders with psychotic symptoms (F30.2, F31.5, F32.3, F33.3)
hallucinations in schizophrenia, schizotypal and delusional disorders (F20-F29)

Excludes2: disturbances of skin sensation (R20.-)

R44.0 Auditory hallucinations

Abnormal findings on diagnostic imaging and in function studies, without diagnosis (R90-R94)

R94 Abnormal results of function studies

R94.0 Abnormal results of function studies of central nervous system

R94.01 Abnormal electroencephalogram [EEG]

R94.02 Abnormal brain scan

R94.09 Abnormal results of other function studies of central nervous system

R94.1 Abnormal results of function studies of peripheral nervous system and special senses

R94.12 Abnormal results of function studies of ear and other special senses

✓ **R94.120** Abnormal auditory function study

✓ **R94.121** Abnormal vestibular function study

✓ **R94.128** Abnormal results of other function studies of ear and other special senses

Ch. 19: Injury, poisoning and certain other consequences of external causes (S00-T88)

Note: Use secondary code(s) from Chapter 20, External causes of morbidity, to indicate cause of injury. Codes within the T section that include the external cause do not require an additional external cause code

Use additional code to identify any retained foreign body, if applicable (Z18.-)

Excludes1: birth trauma (P10-P15)
obstetric trauma (O70-O71)

This chapter contains the following blocks:

S00-S09: Injuries to the head

T15-T19: Effects of foreign body entering through natural orifice

T36-T50: Poisoning by, adverse effect of and underdosing of drugs, medicaments and biological substances

T51-T65: Toxic effects of substances chiefly nonmedicinal as to source

Note: The chapter uses the S-section for coding different types of injuries related to single body regions and the T-section to cover injuries to unspecified body regions as well as poisoning and certain other consequences of external causes.

Injuries to the head (S00-S09)

Includes: injuries of ear
injuries of eye
injuries of face [any part]
injuries of gum
injuries of jaw

injuries of oral cavity
injuries of palate
injuries of periocular area
injuries of scalp
injuries of temporomandibular joint area
injuries of tongue
injuries of tooth

Excludes2: burns and corrosions (T20-T32)
effects of foreign body in ear (T16)
effects of foreign body in larynx (T17.3)
effects of foreign body in mouth NOS (T18.0)
effects of foreign body in nose (T17.0-T17.1)
effects of foreign body in pharynx (T17.2)
effects of foreign body on external eye (T15.-)
frostbite (T33-T34)

S00 Superficial injury of head

Excludes1: diffuse cerebral contusion (S06.2-)
focal cerebral contusion (S06.3-)
injury of eye and orbit (S05.-)
open wound of head (S01.-)

The appropriate 7th character is to be added to each code from category S00
A - initial encounter
D - subsequent encounter
S - sequela

S00.4 Superficial injury of ear

S00.41 Abrasion of ear

S00.43 Contusion of ear
Bruise of ear
Hematoma of ear

S00.44 External constriction of ear

S00.45 Superficial foreign body of ear
Splinter in the ear

S01 Open wound of head

Code also any associated:
injury of cranial nerve (SO4.-)
injury of muscle and tendon of head (S09.1-)
intracranial injury (S06.-)
wound infection

Excludes1: open skull fracture (S02.- with 7th character B)

Excludes2: injury of eye and orbit (S05.-)
traumatic amputation of part of head (S08.-)

The appropriate 7th character is to be added to each code from category S01
A - initial encounter

D - subsequent encounter
S - sequela

❖ **S01.3** Open wound of ear

S08 Avulsion and traumatic amputation of part of head
An amputation not identified as partial or complete should be coded to complete

The appropriate 7th character is to be added to each code from category S08
A - initial encounter
D - subsequent encounter
S - sequela

❖ **S08.1** Traumatic amputation of ear

S09 Other and unspecified injuries of head

The appropriate 7th character is to be added to each code from category S09
A - initial encounter
D - subsequent encounter
S - sequela

❖ **S09.2** Traumatic rupture of ear drum

Excludes1: traumatic rupture of ear drum due to blast injury (S09.31-)

❖ **S09.3** Other specified and unspecified injury of middle and inner ear

Excludes1: injury to ear NOS (S09.91-)

Excludes2: injury to external ear (S00.4-, S01.3-, S08.1-)

S09.9 Unspecified injury of face and heat
Head injury NOS

Excludes1: brain injury NOS (S06.9-)
head injury NOS with loss of consciousness (S06.9-)
intracranial injury NOS (S06.9-)

S09.91 Unspecified injury of ear
Injury of ear NOS

Injury, poisoning and certain other consequences of external causes (T07-T88)

Effects of foreign body entering through natural orifice (T15-T19)

Excludes2: foreign body accidentally left in operation wound (T81.5-)
foreign body in penetrating wound - See open wound by body region
residual foreign body in soft tissue (M79.5)
splinter, without open wound - See superficial injury by body region

T16 Foreign body in ear

Includes: foreign body in auditory canal

The appropriate 7th character is to be added to each code from category T16
A - initial encounter
D - subsequent encounter
S - sequela

T16.1 Foreign body in right ear

T16.2 Foreign body in left ear

T16.9 Foreign body in ear, unspecified ear

Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)

Includes: adverse effect of correct substance properly administered
poisoning by overdose of substance
poisoning by wrong substance given or taken in error
underdosing by (inadvertently) (deliberately) taking less substance than prescribed or instructed

Code first, for adverse effects, the nature of the adverse effect, such as:
adverse effect NOS (T88.7)
aspirin gastritis (K29.-)
blood disorders (D56-D76)
contact dermatitis (L23-L25)
dermatitis due to substances taken internally (L27.-)
nephropathy (N14.0-N14.2)

Code the hearing loss or vestibular effects first (eg, H91.0- series for ototoxic hearing loss). Code the drug or toxin giving rise to the **adverse effect** second.

Note: The drug giving rise to the adverse effect should be identified by use of codes from categories T36-T50 with fifth or sixth character 5.

Use additional code(s) to specify:
manifestations of poisoning
underdosing or failure in dosage during medical and surgical care (Y63.6, Y63.8-Y63.9)
underdosing of medication regimen (Z91.12-, Z91.13-)

Excludes1: toxic reaction to local anesthesia in pregnancy (O29.3-)

Excludes2: abuse and dependence of psychoactive substances (F10-F19)
abuse of non-dependence-producing substances (F55.-)
drug reaction and poisoning affecting newborn (P00-P96)
pathological drug intoxication (inebriation) (F10-F19)

T36 Poisoning by, adverse effect of and underdosing of systemic antibiotics

Excludes1: antineoplastic antibiotics (T45.1-)
locally applied antibiotic NEC (T49.0)
topically used antibiotic for ear, nose and throat (T49.6)
topically used antibiotic for eye (T49.5)

The appropriate 7th character is to be added to each code from category T36
A - initial encounter
D - subsequent encounter
S - sequela

T36.0 Poisoning by, adverse effect of and underdosing of penicillins

T36.0X Poisoning by, adverse effect of and underdosing of penicillins

T36.0X1 Poisoning by penicillins, accidental (unintentional)
Poisoning by penicillins NOS

T36.0X2 Poisoning by penicillins, intentional self-harm

T36.0X3 Poisoning by penicillins, assault

T36.0X4 Poisoning by penicillins, undetermined

T36.0X5 Adverse effect of penicillins

T36.0X6 Underdosing of penicillins

❖ **T36.2** Poisoning by, adverse effect of and underdosing of chloramphenicol group

T36.3 Poisoning by, adverse effect of and underdosing of macrolides

T36.3X Poisoning by, adverse effect of and underdosing of macrolides

T36.3X1 Poisoning by macrolides, accidental (unintentional)
Poisoning by macrolides NOS

T36.3X2 Poisoning by macrolides, intentional self-harm

T36.3X3 Poisoning by macrolides, assault

T36.3X4 Poisoning by macrolides, undetermined

T36.3X5 Adverse effect of macrolides

T36.3X6 Underdosing of macrolides

❖ **T36.4** Poisoning by, adverse effect of and underdosing of tetracyclines

T36.5 Poisoning by, adverse effect of and underdosing of aminoglycosides
Poisoning by, adverse effect of and underdosing of streptomycin

T36.5X Poisoning by, adverse effect of and underdosing of aminoglycosides

T36.5X1 Poisoning by aminoglycosides, accidental (unintentional)
Poisoning by aminoglycosides NOS

T36.5X2 Poisoning by aminoglycosides, intentional self-harm

T36.5X3 Poisoning by aminoglycosides, assault

T36.5X4 Poisoning by aminoglycosides, undetermined

T36.5X5 Adverse effect of aminoglycosides

T36.5X6 Underdosing of aminoglycosides

T36.6 Poisoning by, adverse effect of and underdosing of rifampicins

T36.6X Poisoning by, adverse effect of and underdosing of rifampicins

T36.6X1 Poisoning by rifampicins, accidental (unintentional)
Poisoning by rifampicins NOS

T36.6X2 Poisoning by rifampicins, intentional self-harm

T36.6X3 Poisoning by rifampicins, assault

T36.6X4 Poisoning by rifampicins, undetermined

T36.6X5 Adverse effect of rifampicins

T36.6X6 Underdosing of rifampicins

❖ **T36.7** Poisoning by, adverse effect of and underdosing of antifungal antibiotics, systemically used

❖ **T36.8** Poisoning by, adverse effect of and underdosing of other systemic antibiotics

❖ **T36.9** Poisoning by, adverse effect of and underdosing of unspecified systemic antibiotic

T37 Poisoning by, adverse effect of and underdosing of other systemic anti-infectives and antiparasitics

Excludes1: anti-infectives topically used for ear, nose and throat (T49.6-)
anti-infectives topically used for eye (T49.5-)
locally applied anti-infectives NEC (T49.0-)

The appropriate 7th character is to be added to each code from category T37
A - initial encounter
D - subsequent encounter
S - sequela

T37.2 Poisoning by, adverse effect of and underdosing of antimalarials and drugs acting on other blood protozoa

Excludes1: hydroxyquinoline derivatives (T37.8-)

T37.2X Poisoning by, adverse effect of and underdosing of antimalarials and drugs acting on other blood protozoa

T37.2X1 Poisoning by antimalarials and drugs acting on other blood protozoa, accidental (unintentional)
Poisoning by antimalarials and drugs acting on other blood protozoa NOS

T37.2X2 Poisoning by antimalarials and drugs acting on other blood protozoa, intentional selfharm

T37.2X3 Poisoning by antimalarials and drugs acting on other blood protozoa, assault

T37.2X4 Poisoning by antimalarials and drugs acting on other blood protozoa, undetermined

T37.2X5 Adverse effect of antimalarials and drugs acting on other blood protozoa

T37.2X6 Underdosing of antimalarials and drugs acting on other blood protozoa

T39 Poisoning by, adverse effect of and underdosing of nonopioid analgesics, antipyretics and antirheumatics

The appropriate 7th character is to be added to each code from category T39
A - initial encounter
D - subsequent encounter
S - sequela

T39.0 Poisoning by, adverse effect of and underdosing of salicylates

T39.01 Poisoning by, adverse effect of and underdosing of aspirin
Poisoning by, adverse effect of and underdosing of acetylsalicylic acid

T39.011 Poisoning by aspirin, accidental (unintentional)

T39.012 Poisoning by aspirin, intentional self-harm

T39.013 Poisoning by aspirin, assault

T39.014 Poisoning by aspirin, undetermined

T39.015 Adverse effect of aspirin

T39.016 Underdosing of aspirin

T39.09 Poisoning by, adverse effect of and underdosing of other salicylates

T39.091 Poisoning by salicylates, accidental (unintentional)
Poisoning by salicylates NOS

T39.092 Poisoning by salicylates, intentional self-harm

T39.093 Poisoning by salicylates, assault

T39.094 Poisoning by salicylates, undetermined

T39.095 Adverse effect of salicylates

T39.096 Underdosing of salicylates

❖ **T39.1** Poisoning by, adverse effect of and underdosing of 4-Aminophenol derivatives

❖ **T39.2** Poisoning by, adverse effect of and underdosing of pyrazolone derivatives

T39.3 Poisoning by, adverse effect of and underdosing of other nonsteroidal anti-inflammatory drugs [NSAID]

T39.31 Poisoning by, adverse effect of and underdosing of propionic acid derivatives
Poisoning by, adverse effect of and underdosing of fenoprofen
Poisoning by, adverse effect of and underdosing of flurbiprofen
Poisoning by, adverse effect of and underdosing of ibuprofen
Poisoning by, adverse effect of and underdosing of ketoprofen
Poisoning by, adverse effect of and underdosing of naproxen
Poisoning by, adverse effect of and underdosing of oxaprozin

T39.311 Poisoning by propionic acid derivatives, accidental (unintentional)

T39.312 Poisoning by propionic acid derivatives, intentional self-harm

T39.313 Poisoning by propionic acid derivatives, assault

T39.314 Poisoning by propionic acid derivatives, undetermined

T39.315 Adverse effect of propionic acid derivatives

T39.316 Underdosing of propionic acid derivatives

T39.39 Poisoning by, adverse effect of and underdosing of other nonsteroidal anti-inflammatory drugs [NSAID]

T39.391 Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], accidental (unintentional)
Poisoning by other nonsteroidal anti-inflammatory drugs NOS

T39.392 Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], intentional self-harm

T39.393 Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], assault

T39.394 Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], undetermined

T39.395 Adverse effect of other nonsteroidal anti-inflammatory drugs [NSAID]

T39.396 Underdosing of other nonsteroidal anti-inflammatory drugs [NSAID]

❖ **T39.4** Poisoning by, adverse effect of and underdosing of antirheumatics, not elsewhere classified

❖ **T39.8** Poisoning by, adverse effect of and underdosing of other nonopioid analgesics and antipyretics, not elsewhere classified

❖ **T39.9** Poisoning by, adverse effect of and underdosing of unspecified nonopioid analgesic, antipyretic and antirheumatic

T40 Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics [hallucinogens]

Excludes2: drug dependence and related mental and behavioral disorders due to psychoactive substance use (F10.- F19.-)

The appropriate 7th character is to be added to each code from category T40
A - initial encounter
D - subsequent encounter
S - sequela

T40.3 Poisoning by, adverse effect of and underdosing of methadone

T40.3X Poisoning by, adverse effect of and underdosing of methadone

T40.3X1 Poisoning by methadone, accidental (unintentional)
Poisoning by methadone NOS

T40.3X2 Poisoning by methadone, intentional self-harm

T40.3X3 Poisoning by methadone, assault

T40.3X4 Poisoning by methadone, undetermined

T40.3X5 Adverse effect of methadone

T40.3X6 Underdosing of methadone

T45 Poisoning by, adverse effect of and underdosing of primarily systemic and hematological agents, not elsewhere classified

The appropriate 7th character is to be added to each code from category T45
A - initial encounter
D - subsequent encounter
S - sequela

T45.1 Poisoning by, adverse effect of and underdosing of antineoplastic and immunosuppressive drugs

Excludes1: poisoning by, adverse effect of and underdosing of tamoxifen (T38.6)

T45.1X Poisoning by, adverse effect of and underdosing of antineoplastic and immunosuppressive drugs

T45.1X1 Poisoning by antineoplastic and immunosuppressive drugs, accidental (unintentional)
Poisoning by antineoplastic and immunosuppressive drugs NOS

T45.1X2 Poisoning by antineoplastic and immunosuppressive drugs, intentional self-harm

T45.1X3 Poisoning by antineoplastic and immunosuppressive drugs, assault

T45.1X4 Poisoning by antineoplastic and immunosuppressive drugs, undetermined

T45.1X5 Adverse effect of antineoplastic and immunosuppressive drugs

T45.1X6 Underdosing of antineoplastic and immunosuppressive drugs

T50 Poisoning by, adverse effect of and underdosing of diuretics and other and unspecified drugs, medicaments and biological substances

The appropriate 7th character is to be added to each code from category T50
A - initial encounter
D - subsequent encounter
S - sequela

T50.1 Poisoning by, adverse effect of and underdosing of loop [high-ceiling] diuretics

T50.1X Poisoning by, adverse effect of and underdosing of loop [high-ceiling] diuretics

T50.1X1 Poisoning by loop [high-ceiling] diuretics, accidental (unintentional)
Poisoning by loop [high-ceiling] diuretics NOS

T50.1X2 Poisoning by loop [high-ceiling] diuretics, intentional self-harm

T50.1X3 Poisoning by loop [high-ceiling] diuretics, assault

T50.1X4 Poisoning by loop [high-ceiling] diuretics, undetermined

T50.1X5 Adverse effect of loop [high-ceiling] diuretics

T50.1X6 Underdosing of loop [high-ceiling] diuretics

Toxic effects of substances chiefly nonmedicinal as to source (T51-T65)

Note: When no intent is indicated code to accidental. Undetermined intent is only for use when there is specific documentation in the record that the intent of the toxic effect cannot be determined.

Use additional code(s):
for all associated manifestations of toxic effect, such as:
respiratory conditions due to external agents (J60-J70)
personal history of foreign body fully removed (Z87.821)
to identify any retained foreign body, if applicable (Z18.-)

Excludes1: contact with and (suspected) exposure to toxic substances (Z77.-)

T52 Toxic effect of organic solvents

Excludes1: halogen derivatives of aliphatic and aromatic hydrocarbons (T53.-)

The appropriate 7th character is to be added to each code from category T52
A - initial encounter
D - subsequent encounter
S - sequela

T52.1 Toxic effects of benzene

Excludes1: homologues of benzene (T52.2)
nitroderivatives and aminoderivatives of benzene and its homologues (T65.3)

T52.1X Toxic effects of benzene

T52.1X1 Toxic effect of benzene, accidental (unintentional)

Toxic effects of benzene NOS

T52.1X2 Toxic effect of benzene, intentional self-harm

T52.1X3 Toxic effect of benzene, assault

T52.1X4 Toxic effect of benzene, undetermined

T52.2 Toxic effects of homologues of benzene
Toxic effects of toluene [methylbenzene]
Toxic effects of xylene [dimethylbenzene]

T52.2X Toxic effects of homologues of benzene

T52.2X1 Toxic effect of homologues of benzene, accidental (unintentional)
Toxic effects of homologues of benzene NOS

T52.2X2 Toxic effect of homologues of benzene, intentional self-harm

T52.2X3 Toxic effect of homologues of benzene, assault

T52.2X4 Toxic effect of homologues of benzene, undetermined

T52.8 Toxic effects of other organic solvents

T52.8X Toxic effects of other organic solvents

T52.8X1 Toxic effect of other organic solvents, accidental (unintentional)
Toxic effects of other organic solvents NOS

T52.8X2 Toxic effect of other organic solvents, intentional self-harm

T52.8X3 Toxic effect of other organic solvents, assault

T52.8X4 Toxic effect of other organic solvents, undetermined

T52.9 Toxic effects of unspecified organic solvent

T52.91 Toxic effect of unspecified organic solvent, accidental (unintentional)

T52.92 Toxic effect of unspecified organic solvent, intentional self-harm

T52.93 Toxic effect of unspecified organic solvent, assault

T52.94 Toxic effect of unspecified organic solvent, undetermined

T56 Toxic effect of metals

Includes: toxic effects of fumes and vapors of metals
toxic effects of metals from all sources, except medicinal substances

Use additional code to identify any retained metal foreign body, if applicable (Z18.0-, T18.1-)

Excludes1: arsenic and its compounds (T57.0)
manganese and its compounds (T57.2)

The appropriate 7th character is to be added to each code from category T56
A - initial encounter
D - subsequent encounter
S - sequela

T56.0 Toxic effects of lead and its compounds

T56.0X Toxic effects of lead and its compounds

T56.0X1 Toxic effect of lead and its compounds, accidental (unintentional)
Toxic effects of lead and its compounds NOS

T56.0X2 Toxic effect of lead and its compounds, intentional self-harm

T56.0X3 Toxic effect of lead and its compounds, assault

T56.0X4 Toxic effect of lead and its compounds, undetermined

T56.1 Toxic effects of mercury and its compounds

T56.1X Toxic effects of mercury and its compounds

T56.1X1 Toxic effect of mercury and its compounds, accidental (unintentional)
Toxic effects of mercury and its compounds NOS

T56.1X2 Toxic effect of mercury and its compounds, intentional self-harm

T56.1X3 Toxic effect of mercury and its compounds, assault

T56.1X4 Toxic effect of mercury and its compounds, undetermined

T56.8 Toxic effects of other metals

T56.81 Toxic effect of thallium

T56.811 Toxic effect of thallium, accidental (unintentional)
Toxic effect of thallium NOS

T56.812 Toxic effect of thallium, intentional self-harm

T56.813 Toxic effect of thallium, assault

T56.814 Toxic effect of thallium, undetermined

T56.89 Toxic effects of other metals

T56.891 Toxic effect of other metals, accidental (unintentional)
Toxic effects of other metals NOS

T56.892 Toxic effect of other metals, intentional self-harm

T56.893 Toxic effect of other metals, assault

T56.894 Toxic effect of other metals, undetermined

T56.9 Toxic effects of unspecified metal

T56.91 Toxic effect of unspecified metal, accidental (unintentional)

T56.92 Toxic effect of unspecified metal, intentional self-harm

T56.93 Toxic effect of unspecified metal, assault

T56.94 Toxic effect of unspecified metal, undetermined

T57 Toxic effect of other inorganic substances

The appropriate 7th character is to be added to each code from category T57
A - initial encounter
D - subsequent encounter
S - sequela

T57.0 Toxic effect of arsenic and its compounds

T57.0X Toxic effect of arsenic and its compounds

T57.0X1 Toxic effect of arsenic and its compounds, accidental (unintentional)
Toxic effect of arsenic and its compounds NOS

T57.0X2 Toxic effect of arsenic and its compounds, intentional self-harm

T57.0X3 Toxic effect of arsenic and its compounds, assault

T57.0X4 Toxic effect of arsenic and its compounds, undetermined

T57.2 Toxic effect of manganese and its compounds

T57.2X Toxic effect of manganese and its compounds

T57.2X1 Toxic effect of manganese and its compounds, accidental (unintentional)
Toxic effect of manganese and its compounds NOS

T57.2X2 Toxic effect of manganese and its compounds, intentional self-harm

T57.2X3 Toxic effect of manganese and its compounds, assault

T57.2X4 Toxic effect of manganese and its compounds, undetermined

T58 Toxic effect of carbon monoxide

Includes: asphyxiation from carbon monoxide
toxic effect of carbon monoxide from all sources

The appropriate 7th character is to be added to each code from category T58
A - initial encounter
D - subsequent encounter
S - sequela

T58.0 Toxic effect of carbon monoxide from motor vehicle exhaust
Toxic effect of exhaust gas from gas engine
Toxic effect of exhaust gas from motor pump

T58.01 Toxic effect of carbon monoxide from motor vehicle exhaust, accidental (unintentional)

T58.02 Toxic effect of carbon monoxide from motor vehicle exhaust, intentional self-harm

T58.03 Toxic effect of carbon monoxide from motor vehicle exhaust, assault

T58.04 Toxic effect of carbon monoxide from motor vehicle exhaust, undetermined

T58.1 Toxic effect of carbon monoxide from utility gas
Toxic effect of acetylene
Toxic effect of gas NOS used for lighting, heating, cooking
Toxic effect of water gas

T58.11 Toxic effect of carbon monoxide from utility gas, accidental (unintentional)

T58.12 Toxic effect of carbon monoxide from utility gas, intentional self-harm

T58.13 Toxic effect of carbon monoxide from utility gas, assault

T58.14 Toxic effect of carbon monoxide from utility gas, undetermined

T58.2 Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels
Toxic effect of carbon monoxide from incomplete combustion of coal, coke, kerosene, wood

T58.2X Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels

T58.2X1 Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels,accidental (unintentional)

T58.2X2 Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels,intentional self-harm

T58.2X3 Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels, assault

T58.2X4 Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels,undetermined

T58.8 Toxic effect of carbon monoxide from other source
Toxic effect of carbon monoxide from blast furnace gas
Toxic effect of carbon monoxide from fuels in industrial use
Toxic effect of carbon monoxide from kiln vapor

T58.8X Toxic effect of carbon monoxide from other source

T58.8X1 Toxic effect of carbon monoxide from other source, accidental (unintentional)

T58.8X2 Toxic effect of carbon monoxide from other source, intentional self-harm

T58.8X3 Toxic effect of carbon monoxide from other source, assault

T58.8X4 Toxic effect of carbon monoxide from other source, undetermined

T58.9 Toxic effect of carbon monoxide from unspecified source

T58.91 Toxic effect of carbon monoxide from unspecified source, accidental (unintentional)

T58.92 Toxic effect of carbon monoxide from unspecified source, intentional self-harm

T58.93 Toxic effect of carbon monoxide from unspecified source, assault

T58.94 Toxic effect of carbon monoxide from unspecified source, undetermined

Ch. 20: External causes of morbidity (V00-Y99)

Note: This chapter permits the classification of environmental events and circumstances as the cause of injury, and other adverse effects. Where a code from this section is applicable, it is intended that it shall be used secondary to a code from another chapter of the Classification indicating the nature of the condition. Most often, the condition will be classifiable to Chapter 19, Injury, poisoning and certain other consequences of external causes (S00-T88). Other conditions that may be stated to be due to external causes are classified in Chapters 1 to 18. For these conditions, codes from Chapter 20 should be used to provide additional information as to the cause of the condition.

ASHA Note: There is no national requirement for external cause code reporting. Mandatory reporting is subject to state-based mandates or payer requirements. However, providers are encouraged to voluntarily report.

ASHA Note: External cause codes are not listed in this product due to the volume of available codes in Chapter 20. For a complete listing of codes, see the official ICD-10 list at www.cdc.gov/nchs/icd/icd10cm.htm.

Ch. 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Note: Z codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed. Categories Z00-Z99 are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories A00-Y89 are recorded as 'diagnoses' or 'problems'. This can arise in two main ways:

a. When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.

b. When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

Verify use of **Z codes** with payers or your facility.

Persons encountering health services for examinations (Z00-Z13)

Note: Nonspecific abnormal findings disclosed at the time of these examinations are classified to categories R70-R94.

Excludes1: examinations related to pregnancy and reproduction (Z30-Z36, Z39.-)

Z00 Encounter for general examination without complaint, suspected or reported diagnosis

Excludes1: encounter for examination for administrative purposes (Z02.-)

Excludes2: encounter for pre-procedural examinations (Z01.81-)
special screening examinations (Z11-Z13)

Z00.1 Encounter for newborn, infant and child health examinations

Z00.11 Newborn health examination
Health check for child under 29 days old

Use additional code to identify any abnormal findings

Excludes1: health check for child over 28 days old (Z00.12-)

Z00.110 Health examination for newborn under 8 days old
Health check for newborn under 8 days old

Z00.111 Health examination for newborn 8 to 28 days old
Health check for newborn 8 to 28 days old
Newborn weight check

Z00.12 Encounter for routine child health examination
Health check (routine) for child over 28 days old
Immunizations appropriate for age
Routine developmental screening of infant or child
Routine vision and hearing testing

Excludes1: health check for child under 29 days old (Z00.11-)
health supervision of foundling or other healthy infant or child (Z76.1-Z76.2)
newborn health examination (Z00.11-)

Z00.121 Encounter for routine child health examination with abnormal findings

Use additional code to identify abnormal findings

Z00.129 Encounter for routine child health examination without abnormal findings
Encounter for routine child health examination NOS

Z01 Encounter for other special examination without complaint, suspected or reported diagnosis

Includes: routine examination of specific system

Note: Codes from category Z01 represent the reason for the encounter. A separate procedure code is required to identify any examinations or procedures performed

Excludes1: encounter for examination for administrative purposes (Z02.-)
encounter for examination for suspected conditions, proven not to exist (Z03.-)
encounter for laboratory and radiologic examinations as a component of general medical examinations(Z00.0-)
encounter for laboratory, radiologic and imaging examinations for sign(s) and symptom(s) - code to the sign(s) or symptom(s)

Excludes2: screening examinations (Z11-Z13)

Z01.1 Encounter for examination of ears and hearing

Z01.10 Encounter for examination of ears and hearing without abnormal findings
Encounter for examination of ears and hearing NOS

Z01.11 Encounter for examination of ears and hearing with abnormal findings

Z01.110 Encounter for hearing examination following failed hearing screening

Z01.118 Encounter for examination of ears and hearing with other abnormal findings

Use additional code to identify abnormal findings

Z01.12 Encounter for hearing conservation and treatment

Z01.8 Encounter for other specified special examinations

Z01.81 Encounter for preprocedural examinations
Encounter for preoperative examinations
Encounter for radiological and imaging examinations as part of preprocedural examination

Z01.818 Encounter for other preprocedural examination
Encounter for preprocedural examination NOS
Encounter for examinations prior to antineoplastic chemotherapy

Z02 Encounter for administrative examination

Z02.0 Encounter for examination for admission to educational institution
Encounter for examination for admission to preschool (education)
Encounter for examination for re-admission to school following illness or medical treatment

Z02.1 Encounter for pre-employment examination

Z02.2 Encounter for examination for admission to residential institution

Excludes1: examination for admission to prison (Z02.89)

Z02.3 Encounter for examination for recruitment to armed forces

Z02.4 Encounter for examination for driving license

Z02.5 Encounter for examination for participation in sport

Excludes1: blood-alcohol and blood-drug test (Z02.83)

Z02.6 Encounter for examination for insurance purposes

Z02.7 Encounter for issue of medical certificate

Excludes1: encounter for general medical examination (Z00-Z01, Z02.0-Z02.6, Z02.8-Z02.9)

Z02.71 Encounter for disability determination
Encounter for issue of medical certificate of incapacity
Encounter for issue of medical certificate of invalidity

Z02.79 Encounter for issue of other medical certificate

Z04 Encounter for examination and observation for other reasons

Includes: encounter for examination for medicolegal reasons
This category is to be used when a person without a diagnosis is suspected of having an abnormal condition, without signs or symptoms, which requires study, but after examination and observation, is ruled-out. This category is also for use for administrative and legal observation status.

Z04.1 Encounter for examination and observation following transport accident

Excludes1: encounter for examination and observation following work accident (Z04.2)

Z04.2 Encounter for examination and observation following work accident

Z04.3 Encounter for examination and observation following other accident

Z04.8 Encounter for examination and observation for other specified reasons
Encounter for examination and observation for request for expert evidence

Z04.9 Encounter for examination and observation for unspecified reason
Encounter for observation NOS

❖ **Z05** Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out
This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition, but without signs or symptoms, and which, after examination and observation, is ruled out.

Z13 Encounter for screening for other diseases and disorders
Screening is the testing for disease or disease precursors in asymptomatic individuals so that early detection and treatment can be provided for those who test positive for the disease.

Excludes1: encounter for diagnostic examination-code to sign or symptom

Z13.4 Encounter for screening for certain developmental disorders in childhood
Encounter for development testing of infant or child
Encounter for screening for developmental handicaps in early childhood

Excludes2: encounter for routine child health examination (Z00.12-)

New **Z13.40** Encounter for screening for unspecified developmental delays

New **Z13.41** Encounter for autism screening

New **Z13.42** Encounter for screening for global developmental delays (milestones)
Encounter for screening for developmental handicaps in early childhood

New **Z13.49** Encounter for screening for other developmental delays

Z13.5 Encounter for screening for eye and ear disorders

Excludes2: encounter for general hearing examination (Z01.1-)
encounter for general vision examination (Z01.0-)

Z13.8 Encounter for screening for other specified diseases and disorders

Excludes2: screening for malignant neoplasms (Z12.-)

Z13.85 Encounter for screening for nervous system disorders

Z13.850 Encounter for screening for traumatic brain injury

Encounters for other specific health care (Z40-Z53)

Categories Z40-Z53 are intended for use to indicate a reason for care. They may be used for patients who have already been treated for a disease or injury, but who are receiving aftercare or prophylactic care, or care to consolidate the treatment, or to deal with a residual state

Excludes2: follow-up examination for medical surveillance after treatment (Z08-Z09)

Z44 Encounter for fitting and adjustment of external prosthetic device

Includes: removal or replacement of external prosthetic device

Excludes1: malfunction or other complications of device - see Alphabetical Index
presence of prosthetic device (Z97.-)

Z44.8 Encounter for fitting and adjustment of other external prosthetic devices

Z44.9 Encounter for fitting and adjustment of unspecified external prosthetic device

Z45 Encounter for adjustment and management of implanted device

Includes: removal or replacement of implanted device

Excludes1: malfunction or other complications of device

Excludes2: encounter for fitting and adjustment of non-implanted device (Z46.-)

Z45.3 Encounter for adjustment and management of implanted devices of the special senses

Z45.32 Encounter for adjustment and management of implanted hearing device

Excludes1: Encounter for fitting and adjustment of hearing aide (Z46.1)

Z45.320 Encounter for adjustment and management of bone conduction device

Z45.321 Encounter for adjustment and management of cochlear device

Z45.328 Encounter for adjustment and management of other implanted hearing device

Z46 Encounter for fitting and adjustment of other devices

Includes: removal or replacement of other device

Excludes1: malfunction or other complications of device - see Alphabetical Index

Excludes2: encounter for fitting and management of implanted devices (Z45.-)
issue of repeat prescription only (Z76.0)
presence of prosthetic and other devices (Z95-Z97)

Z46.1 Encounter for fitting and adjustment of hearing aid

Excludes1: encounter for adjustment and management of implanted hearing device (Z45.32-)

Z51 Encounter for other aftercare

Z51.8 Encounter for other specified aftercare

Excludes1: holiday relief care (Z75.5)

Z51.89 Encounter for other specified aftercare

Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)

Z57 Occupational exposure to risk factors

Z57.0 Occupational exposure to noise

Persons encountering health services in other circumstances (Z69-Z76)

Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classifiable

Excludes2: contraceptive or procreation counseling (Z30-Z31)
sex counseling (Z70.-)

Z71.0 Person encountering health services to consult on behalf of another person
Person encountering health services to seek advice or treatment for non-attending third party

Excludes2: anxiety (normal) about sick person in family (Z63.7)
expectant (adoptive) parent(s) pre-birth pediatrician visit (Z76.81)

Z71.1 Person with feared health complaint in whom no diagnosis is made
Person encountering health services with feared condition which was not demonstrated
Person encountering health services in which problem was normal state
'Worried well'

Excludes1: medical observation for suspected diseases and conditions proven not to exist (Z03.-)

Z71.2 Person consulting for explanation of examination or test findings

Z72 Problems related to lifestyle

Excludes2: problems related to life-management difficulty (Z73.-)
problems related to socioeconomic and psychosocial circumstances (Z55-Z65)

Z72.0 Tobacco use
Tobacco use NOS

Excludes1: history of tobacco dependence (Z87.891)
nicotine dependence (F17.2-)
tobacco dependence (F17.2-)
tobacco use during pregnancy (O99.33-)

Z73 Problems related to life management difficulty

Excludes2: problems related to socioeconomic and psychosocial circumstances (Z55-Z65)

Z73.8 Other problems related to life management difficulty

Z73.82 Dual sensory impairment

Z76 Persons encountering health services in other circumstances

Z76.5 Malingerer [conscious simulation]
Person feigning illness (with obvious motivation)

Excludes 1: factitious patient (F68.1-)
peregrinating patient (F68.1-)

Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z77-Z99)

Code also any follow-up examination (Z08-Z09)

Z77 Other contact with and (suspected) exposures hazardous to health

Z77.1 Contact with and (suspected) exposure to environmental pollution and hazards in the physical environment

Z77.12 Contact with and (suspected) exposure to hazards in the physical environment

Z77.122 Contact with and (suspected) exposure to noise

❖ **Z79** Long term (current) drug therapy

❖ **Z80** Family history of primary malignant neoplasm

❖ **Z81** Family history of mental and behavioral disorders

Z82 Family history of certain disabilities and chronic diseases (leading to disablement)

Z82.2 Family history of deafness and hearing loss
Conditions classifiable to H90-H91

Z83 Family history of other specific disorders

Excludes2: contact with and (suspected) exposure to communicable disease in the family (Z20.-)

Z83.5 Family history of eye and ear disorders
Conditions classifiable to H00-H53, H55-H83, H92-H95

Excludes2: family history of blindness and visual loss (Z82.1)
family history of deafness and hearing loss (Z82.2)

Z83.52 Family history of ear disorders
Conditions classifiable to H60-H83, H92-H95

Excludes2: family history of deafness and hearing loss (Z82.2)

Z86 Personal history of certain other diseases

Code first any follow-up examination after treatment (Z09)

Z86.5 Personal history of mental and behavioral disorders
Conditions classifiable to F40-F59

Z86.51 Personal history of combat and operational stress reaction

Z86.59 Personal history of other mental and behavioral disorders

Z86.6 Personal history of diseases of the nervous system and sense organs

Conditions classifiable to G00-G99, H00-H95

Z86.61 Personal history of infections of the central nervous system
Personal history of encephalitis
Personal history of meningitis

Z86.69 Personal history of other diseases of the nervous system and sense organs

Z87 Personal history of other diseases and conditions

Code first any follow-up examination after treatment (Z09)

Z87.7 Personal history of (corrected) congenital malformations
Conditions classifiable to Q00-Q89 that have been repaired or corrected

Z87.72 Personal history of (corrected) congenital malformations of nervous system and sense organs

Z87.721 Personal history of (corrected) congenital malformations of ear

Z87.73 Personal history of (corrected) congenital malformations of digestive system

Z87.730 Personal history of (corrected) cleft lip and palate

Z87.79 Personal history of other (corrected) congenital malformations

Z87.790 Personal history of (corrected) congenital malformations of face and neck

Z87.8 Personal history of other specified conditions

Excludes2: personal history of self harm (Z91.5)

Z87.82 Personal history of other (healed) physical injury and trauma
Conditions classifiable to S00-T88, except traumatic fractures

Z87.820 Personal history of traumatic brain injury

Excludes1: personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits (Z86.73)

Z87.89 Personal history of other specified conditions

Z87.891 Personal history of nicotine dependence

Excludes1: current nicotine dependence (F17.2-)

Z90 Acquired absence of organs, not elsewhere classified

Includes: postprocedural or post-traumatic loss of body part NEC

Excludes1: congenital absence

Z90.0 Acquired absence of part of head and neck

Z90.09 Acquired absence of other part of head and neck
Acquired absence of nose

Excludes2: teeth (K08.1)

Z92 Personal history of medical treatment

Excludes2: postprocedural states (Z98.-)

Z92.2 Personal history of drug therapy

Excludes2: long term (current) drug therapy (Z79.-)

Z92.21 Personal history of antineoplastic chemotherapy

Z92.22 Personal history of monoclonal drug therapy

Z92.23 Personal history of estrogen therapy

Z92.24 Personal history of steroid therapy

Z92.240 Personal history of inhaled steroid therapy

Z92.241 Personal history of systemic steroid therapy
Personal history of steroid therapy NOS

Z92.25 Personal history of immunosupression therapy

Excludes2: personal history of steroid therapy (Z92.24)

Z92.29 Personal history of other drug therapy

Z92.3 Personal history of irradiation
Personal history of exposure to therapeutic radiation

Excludes1: exposure to radiation in the physical environment (Z77.12)
occupational exposure to radiation (Z57.1)

Z96 Presence of other functional implants

Excludes2: complications of internal prosthetic devices, implants and grafts (T82-T85)
fitting and adjustment of prosthetic and other devices (Z44-Z46)

Z96.2 Presence of otological and audiological implants

Z96.20 Presence of otological and audiological implant, unspecified

Z96.21 Cochlear implant status

Z96.22 Myringotomy tube(s) status

Z96.29 Presence of other otological and audiological implants
Presence of bone-conduction hearing device
Presence of eustachian tube stent
Stapes replacement

Z97 Presence of other devices

Excludes1: complications of internal prosthetic devices, implants and grafts (T82-T85)
fitting and adjustment of prosthetic and other devices (Z44-Z46)

Excludes2: presence of cerebrospinal fluid drainage device (Z98.2)

Z97.4 Presence of external hearing-aid

ICD-10-PCS (Procedure Coding System) for Audiologists

ICD-10 includes the ICD-10-CM (clinical modification) and ICD-10-PCS (procedure coding system). The clinical modification was developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings. The procedure coding system (ICD-10-PCS) was developed by the Centers for Medicare and Medicaid Services for use in the U.S. for inpatient hospital settings only. ASHA's resources focus mostly on ICD-10-CM. You may want to check with your facility on use of ICD-10-PCS.

The ICD-10-PCS is a procedure classification published by the United States for classifying procedures performed in hospital inpatient health care settings only.

CMS provides the following link for information about ICD-10-PCS at www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-PCS.html.

The CMS guidelines for ICD-10-PCS, found on the CMS webpage, are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-PCS itself.

The instructions and conventions of the classification take precedence over guidelines.

The 2019 Code Tables and Index are the actual codes used in ICD-10-PCS. Audiology related codes are found in section **F - Physical Rehabilitation and Diagnostic Audiology**.

Exhibit 3

STRUCK LOVE BOJANOWSKI & ACEDO, PLC

Richard M. Valenti
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March 20, 2019

VIA EMAIL ONLY
Corene Kendrick
PRISON LAW OFFICE
General Delivery
San Quentin, CA 94964

Re: ***Parsons v. Ryan***
Plaintiffs' Supplemental Document Requests 82, 98, 99, 101, and 103-111

Dear Corene:

Below are Defendants' responses to Plaintiffs' Supplemental Document Requests 103-111, and Defendants' supplemental responses to Plaintiffs' Supplemental Document Requests 82, 98, 99, and 101.

Request 82: For all ten Arizona State Prison Complexes for the previous 90 days, a list of (1) all pending requests for specialty referral pending Utilization Management review, and (2) all pending specialty appointments.

Defendants' supplemental response:
On March 12 and March 15, 2019, Defendants produced responsive documents for the October 1, 2017 to March 13, 2019 time period. *See* ADCM1564051-1564067 and ADCM1564078-1564102. Going forward, Defendants will produce responsive documents on a quarterly basis (i.e., every 90 days).

Request 98: For each ASPC, as of October 1, 2018 and November 1, 2018, the current backlog of chronic care provider appointments and specialty care appointments.

Defendants' supplemental response:
Produced herewith are Corizon tables, which are responsive to the request. *See* ADCM1564108. According to Corizon, as to specialty care, optometry is the only specialty care that Corizon currently tracks. As to the October 2018 table, per Corizon, the

numbers for all facilities except Lewis are as of October 1, 2018. The numbers for Lewis as of October 1, 2018 are not available. The numbers for Lewis are as of October 15, 2018. As to the November 2018 table, per Corizon, the numbers for all facilities are as of November 1, 2018.

Request 99: List of all class members who are deaf and their ADC numbers. If no such list exists, please so indicate.

Defendants' supplemental response:
Defendants reiterate their previous response and objections. *See* pages 5-6 of Richard Valenti's March 6, 2019 letter to Corene Kendrick. Without waiving any previous objections, see the March 2019 Arizona Deaf Patients List that was produced on March 18, 2019, which Corizon had run with additional diagnosis codes requested by Plaintiffs' counsel. *See* ADCM1564103-1564107.

Request 101: All documents regarding provision of sign language interpretation during medical, dental, and mental health encounters at all ASPCs, including (1) policies, procedures, and orders regarding the use of sign language interpreters at such encounters; (2) contract(s) for in-person and video remote interpretation; (3) location of computers used for video remote interpretation; (4) and log of use of sign language interpretation for the past three years. If no such documents exist, please so indicate.

Defendant's supplemental response:
Defendants reiterate their previous response and objections. *See* page 7 of Richard Valenti's March 6, 2019 letter to Corene Kendrick. Without waiving any previous objections, as to subpart two, Defendants are following up with Corizon regarding the LanguageLine contract.

Request 103: The most recent version of the ADC Health Services Monitoring Bureau's Monitoring Guide.

Defendants' response:
Plaintiffs' counsel already have the most recent version of the Monitoring Guide, which is dated February 7, 2018.

Request 104: List of all qualified health care practitioners who are proficient in American Sign Language, and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s). If no such list or documentation exists, please so indicate.

Defendants' response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the terms "qualified", "health care practitioners", "proficient", and the phrase "documentation establishing proficiency". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Furthermore, the list Plaintiffs request requires the creation of documents by Defendants, which, pursuant to Fed.R.Civ.P. 34, Defendants are not required to do. *See* Goolsby v. Carrasco, No. 1:09–cv–01650 JLT (PC), 2011 WL 2636099, at *8 (E.D. Cal. July 5, 2011) (document request that would require the defendant to create a roster of employees is not a proper request under Fed. R. Civ. P. 34(a)); Robinson v. Adams, No. 1:08–cv– 01380–AWI–SMS PC, 2011 WL 2118753, at *20 (E.D. Cal. May 27, 2011) (defendant is not required to create a document in response to a request for production). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")(emphasis added).

Without waiving any objections, no responsive list exists. As to subparts 1 and 2, ADC does not have responsive documents; Defendants are awaiting Corizon's response concerning responsive documents and will supplement.

Request 105:
List of all qualified health care practitioners who are proficient in any non-English language (other than American Sign Language), and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s). If no such list or documentation exists, please so indicate.

Defendants' response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the terms "qualified", "health care practitioners", "proficient", and the phrase "documentation establishing proficiency". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Furthermore, the list Plaintiffs request requires the creation of documents by Defendants, which, pursuant to Fed.R.Civ.P. 34, Defendants are not required to do. *See* Goolsby v. Carrasco, No. 1:09–cv–01650 JLT (PC), 2011 WL 2636099, at *8 (E.D. Cal. July 5, 2011) (document request that would require the defendant to create a roster of employees is not a proper request under Fed. R. Civ. P. 34(a)); Robinson v. Adams, No. 1:08–cv– 01380–AWI–SMS PC,

2011 WL 2118753, at *20 (E.D. Cal. May 27, 2011) (defendant is not required to create a document in response to a request for production). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")(emphasis added).

Without waiving any objections, no responsive list exists. As to subparts 1 and 2, ADC does not have responsive documents; Defendants are awaiting Corizon's response concerning responsive documents and will supplement.

Request 106: All HNRs and grievances in which a class member requested an interpreter for a healthcare encounter and the responses to the HNRs and grievances since January 1, 2018.

Defendants' response:
Defendants object to this request as outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the terms "grievances", "responses", "healthcare encounter", and "interpreter". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). The request is unduly burdensome as it would require Defendants to do a manual review of all HNRs and grievances and their responses for all class members for the specified time period to identify all documents that involve a request for an interpreter for a health encounter. Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")(emphasis added).

Request 107: All Form 108-1s for all deaf people who were in ADC custody at any time since January 1, 2017.

Defendants' response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the term "deaf". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Defendants further object to the Plaintiffs' request to the extent it requests information related to inmates who are not in ADC custody. Under the Stipulation, class members are limited to "[a]ll prisoners who are now,

or will in the future be, subjected to the medical, mental health, and dental care policies and practices of the ADC." *See* ¶ 3 of Dkt. 1185. Inmates who are not in ADC custody are not class members, and any information related to those inmates is irrelevant and beyond the scope of the Stipulation. Furthermore, this request is unduly burdensome. It would require Defendants to manually review the eOMIS records of every class member for the requested time period to verify if there is a 108-1 form in their file. Defendants would then have to review every 108-1 form to determine if it documented hearing impairment, since a 108-1 form is a functional assessment that documents a variety of issues (e.g., allergies). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")(emphasis added).

Request 108: List of all class members who are not fluent in English and their ADC numbers and primary language. If no such list exists, please so indicate.

Defendants' response:
Defendants object to this request as vague and ambiguous as to the terms "fluent" and "primary language". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Furthermore, the list Plaintiffs request requires the creation of documents by Defendants, which, pursuant to Fed.R.Civ.P. 34, Defendants are not required to do. *See Goolsby v. Carrasco*, No. 1:09–cv–01650 JLT (PC), 2011 WL 2636099, at *8 (E.D. Cal. July 5, 2011) (document request that would require the defendant to create a roster of employees is not a proper request under Fed. R. Civ. P. 34(a)); *Robinson v. Adams*, No. 1:08–cv–01380–AWI–SMS PC, 2011 WL 2118753, at *20 (E.D. Cal. May 27, 2011) (defendant is not required to create a document in response to a request for production). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")**(**emphasis added).

Without waiving any objections, no responsive list exists.

Request 109: All documents regarding provision of language interpretation during healthcare encounters at all ASPCs, including policies, procedures, and orders regarding assessment of language fluency and the use of interpreters at such encounters. If no such documents exist, please so indicate.

Defendants' response:
Defendants object to this request as irrelevant, overly broad, and outside the scope of the Stipulation and the Performance Measures. The requests fails to specify a timeframe. The request is also vague and ambiguous as to the terms "language interpretation", "healthcare encounters", "interpreters"; and the phrases "documents regarding provision of" and "regarding assessment of language fluency". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")(emphasis added).

Without waiving any objections, see ADC Department Order 1101 and the Health Services Technical Manual, which are available on ADC's website. Furthermore, Plaintiffs' counsel have access to eOMIS records of class members and can review what interpreter services were provided during a healthcare encounter.

Request 110: All documents related to Defendants' monitoring of compliance with Paragraph 14 of the Stipulation at all ASPCs, including instructions to monitoring staff and compliance reports. If no such documents exist, please so indicate.

Defendants' response:
Defendants object to this request as overly broad. The request is also vague and ambiguous as to the terms "compliance reports", and "monitoring staff", and the phrase "all documents related to". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). The request also fails to specify a timeframe. Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")(emphasis added).

Without waiving any objections, there are no responsive documents.

Request 111: All ADA requests for sign language interpreters during healthcare encounters submitted by a class member or another person on behalf of a class member and the responses to the ADA requests since January 1, 2018.

Defendants' response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the terms "ADA requests", "sign language", "interpreters", and "healthcare encounters", and the phrases "or another person on behalf of a class member" and "responses to the ADA requests". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). The request is also unduly burdensome, as it would require Defendants to manually review an indeterminable number of documents that involve requests for a sign language interpreter and the responses to those requests. Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.")(emphasis added).

Sincerely,

Richard M. Valenti

RMV/eap
cc: Counsel of record

Exhibit 4

STRUCK LOVE BOJANOWSKI & ACEDO, PLC

Richard M. Valenti
480.420.1615
rvalenti@strucklove.com

April 19, 2019

VIA EMAIL ONLY
Corene Kendrick
PRISON LAW OFFICE
General Delivery
San Quentin, CA 94964

Re: ***Parsons v. Ryan***
Plaintiffs' Supplemental Document Requests 101, 104, 105, and 112

Dear Corene:

Below is Defendants' response to Plaintiffs' Supplemental Document Request 112 identified in Plaintiffs' March 15, 2019 Monthly Request for Documents, and Defendants' supplemental responses to Plaintiffs' Supplemental Document Requests 101, 104, and 105.

Request 101: All documents regarding provision of sign language interpretation during medical, dental, and mental health encounters at all ASPCs, including (1) policies, procedures, and orders regarding the use of sign language interpreters at such encounters; (2) contract(s) for in-person and video remote interpretation; (3) location of computers used for video remote interpretation; (4) and log of use of sign language interpretation for the past three years. If no such documents exist, please so indicate.

Defendants' supplemental response:
Defendants reiterate their previous response and objections. *See* page 7 of Richard Valenti's March 6, 2019 letter to Corene Kendrick. As to subpart two, without waiving any objections, Corizon objects to producing the LanguageLine contract.

Request 104: List of all qualified health care practitioners who are proficient in American Sign Language, and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s). If no such list or documentation exists, please so indicate.

Defendants' supplemental response:
Defendants reiterate their previous response and objections. *See* pages 2-3 of Richard Valenti's March 20, 2019 letter to Corene Kendrick. As to subparts one and two, without waiving any objections, per Corizon there are no responsive documents.

Request 105:
List of all qualified health care practitioners who are proficient in any non-English language (other than American Sign Language), and, for each, (1) all documentation establishing proficiency, and (2) work schedule(s) and location(s). If no such list or documentation exists, please so indicate.

Defendants' supplemental response:
Defendants reiterate their previous response and objections. *See* pages 3-4 of Richard Valenti's March 20, 2019 letter to Corene Kendrick. As to subparts one and two, without waiving any objections, per Corizon there are no responsive documents.

Request 112: All billing documents from Language Line to Corizon for interpreter services rendered at all ASPCs from January 1, 2018 to the present.

Defendants' response:
Defendants object to this request as irrelevant and outside the scope of the Stipulation and the Performance Measures. The request is also vague and ambiguous as to the term "billing documents" and the phrase "interpreter services rendered". As a result, the request fails to describe the documents sought with requisite particularity. *See* Fed. R. Civ. P. 26 (b)(1)(A). Based on the foregoing, the burden of identifying and producing documents responsive to this request substantially outweighs any likely benefit of production. *See* Fed. R. Civ. P. 26(b)(1); ¶ 29 of Dkt. 1185 ("The parties shall cooperate so that plaintiffs' counsel has reasonable access to **information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants**.") (Emphasis added.) Furthermore, Corizon objects to producing any responsive documents.

Sincerely,

Richard M. Valenti

RMV/eap
cc: Counsel of record

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[ADDITIONAL COUNSEL LISTED BELOW]

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Larry Gann, Division Director, Health Care Services Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF RITA K. LOMIO IN SUPPORT OF PLAINTIFFS' MOTION TO ENFORCE PARAGRAPH 14 OF THE STIPULATION

I, Rita K. Lomio, declare:

1. I am an attorney licensed to practice before the courts of the State of California, and admitted to this Court *pro hac vice*. I am a staff attorney at the Prison Law Office, and an attorney of record to the plaintiff class in this litigation. If called as a witness, I could and would testify competently to the facts stated herein, all of which are within my personal knowledge.

2. On May 31, 2020, I visited the website of the United States District Court for the Eastern District of Louisiana. I downloaded a copy of the Consent Judgment dated June 6, 2013, on the "Cases of Interest" webpage entitled, "Orleans Parish Prison Consent Judgment, 12-cv-859, Jones v. Gusman," available at http://www.laed.uscourts.gov/case-information/mdl-mass-class-action/oppconsent. A true and correct copy of the Consent Judgment is attached hereto as **Exhibit 1**.

3. On June 1, 2020, I spoke with an attorney with the Federal Coordination and Compliance Section ("FCS") of the U.S. Department of Justice, Civil Rights Division. She said that the FCS provides, upon request, language access technical assistance to prison administrators, including through trainings and consultation. She said that such assistance is provided free of charge.

4. On June 8, 2020, I visited the website LEP.gov, which is maintained by the FCS. I downloaded a copy of the Planning Tool: Considerations for Creation of a Language Assistance Policy and Implementation Plan for Addressing Limited English Proficiency in a Department of Corrections, available at https://www.lep.gov/sites/lep/files/resources/LEP_Corrections_Planning_Tool.doc. A true and correct copy of the Planning Tool is attached hereto as **Exhibit 2**.

I declare under penalty of perjury that the foregoing is true and correct.

Executed June 12, 2020, in Berkeley, California.

s/ Rita K. Lomio
Rita K. Lomio

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CERTIFICATE OF SERVICE

I hereby certify that on June 12, 2020, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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Attorneys for Defendants

s/ D. Freouf

Index of Exhibits to the
Declaration of Rita K. Lomio

Exhibit	Description
1	A true and correct copy of the Consent Judgment, dated June 6, 2013, from the "Cases of Interest" webpage entitled, "Orleans Parish Prison Consent Judgment, 12-cv-859, Jones v. Gusman" (E.D. La.)
2	A true and correct copy of Planning Tool: Considerations for Creation of a Language Assistance Policy and Implementation Plan for Addressing Limited English Proficiency in a Department of Corrections (LEP.gov)

EXHIBIT 1

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

LASHAWN JONES, *et al.*, and THE UNITED STATES OF AMERICA, PLAINTIFFS, v. MARLIN GUSMAN, Sheriff, DEFENDANT.	Civil Action No. 2:12-cv-00859 Section I Judge Lance M. Africk Magistrate Judge Chasez

CONSENT JUDGMENT

TABLE OF CONTENTS

I. PARTIES

This Consent Judgment ("Agreement") is entered among and between the Plaintiff class; United States of America, acting through the United States Department of Justice; and the Orleans Parish Sheriff (in his official capacity).

II. INTRODUCTION

1. The purpose of this Agreement is to address the constitutional violations alleged in this matter, as well as the violations alleged in the findings letter issued by the United States on September 11, 2009. The Orleans Parish Prison ("OPP") is an integral part of the public safety system in New Orleans, Louisiana. Through the provisions of this Agreement, the Parties seek to ensure that the conditions in OPP protect the constitutional rights of prisoners confined there. By ensuring that the conditions in OPP are constitutional, the Sheriff will also provide for the safety of staff and promote public safety in the community.

2. Plaintiffs are the settlement class (*Jones* and *JJ* Plaintiffs) and the United States. The Parties agree to a settlement class comprised of all individuals who are now or will be imprisoned in OPP.

3. Defendant is the Orleans Parish Sheriff (in his official capacity) and each of his successors in office (the "Defendant"). Defendant shall ensure that the Orleans Parish Sheriff's Office ("OPSO") will take all actions necessary to comply with the provisions of this Agreement.

4. As indicated in Section XII of this Agreement, the Parties consent to a finding that this Agreement complies in all respects with the provisions of the Prison Litigation Reform Act, 18 U.S.C. § 3626(a).

5. OPP is a parish-wide correctional facility in New Orleans, Louisiana. OPSO is responsible for providing care, custody, and control of prisoners. The Parties recognize that the conditions in OPP and the treatment of prisoners confined there have an impact on whether prisoners will be successfully re-integrated on release, whether released prisoners will re-offend, and on the public confidence in the criminal justice system.

6. OPSO has taken steps to address concerns at OPP. OPSO has in place certain policies, practices, and procedures, and has plans to adopt certain other policies, practices, and procedures. This Consent Judgment is based on these policies, practices, and procedures, and contemplates that the dispute between the Parties will be resolved by the continued development and implementation of these measures.

III. DEFINITIONS

1. "OPSO" refers to the Orleans Parish Sheriff's Office, which is responsible for all corrections and security functions at the Facility.

2. "OPP" or "Facility" or "Jail" refers to the Orleans Parish Prison, and shall include the Temporary Detention Center ("TDC"), Templeman V, Conchetta, the FEMA-supplied windowless canvas-tents ("The Tents"), the original Orleans Parish Prison Jail, and the Broad Street work-release facility, as well as any facility that is built, leased, or otherwise used, to replace or supplement the current OPP or any part of OPP.

3. "DOJ" refers to the United States Department of Justice, which represents the United States in this matter.

4. "SPLC" refers to the Southern Poverty Law Center, which represents the Plaintiff class in this matter. Should SPLC cease to represent the Plaintiff class, "Plaintiffs' counsel" will be substituted for "SPLC."

5. "Assessment factors" refers to the evaluation or estimate of the levels of risk for suicide and self-injurious behavior requiring intervention.

6. "Bilingual staff" means a staff person who has demonstrated and verified proficiency, pursuant to generally accepted objective criteria, in both spoken English and at least one other language as authorized by OPP. Bilingual staff must be routinely assessed and serve as bilingual employees on behalf of OPP.

7. Consistent with, or in accordance with, the term "generally accepted correctional standards" shall mean those industry standards accepted by correctional professionals or organizations in the relevant subject area, as agreed to by the Parties (e.g., the NCCHC or ACA).

8. "Days" are measured in calendar days; weekend days are included.

9. "Describe" means provide a clear and detailed description of anything done, seen, or heard.

10. "District Attorney" or "DA's Office" refers to the Orleans Parish District Attorney's Office.

11. "Document" when used in this Agreement as a verb means completing a report, either in hard copy or in electronic format.

12. "Effective Date" means the date the Court enters a definitive judgment regarding the amount of funding needed to ensure compliance with the signed Agreement that has been entered as an order by the Court.

13. "EIS" means the Early Intervention System, which is a system to collect and analyze data regarding uses of force and is used to identify the need for corrective action, including changes to training protocols and policy or retraining or disciplining individual officers or groups of officers.

14. "Emergency maintenance needs" means items that affect building security, or which may cause imminent danger to the life, safety, or health of prisoners.

15. "Good cause" means fair and honest reasons, regulated by good faith on the part of either party, that are not arbitrary, capricious, trivial, or pretextual.

16. "IAD" refers to the Internal Affairs Division.

17. "Include", "includes", or "including" means "include, but not be limited to" or "including, but not limited to."

18. "Interdisciplinary Team" refers to a team consisting of treatment staff from various disciplines, including medical, nursing, and mental health, and one or more members from security.

19. "Limited English Proficient" or "LEP" refers to a person who does not speak English as his/her primary language and has a limited ability to read, write, speak, or understand English. LEP individuals may be competent in certain types of communication (e.g., speaking or understanding), but still be LEP for other purposes (e.g., reading or writing).

20. "Monitor" means an individual and his or her team of professionals, all of whom are selected by the Parties to oversee implementation of the Agreement.

21. "NOPRS" means City of New Orleans PreTrial Release Services.

22. "Prisoners" or "Prisoner" is construed broadly to refer to one or more individuals detained at, or otherwise housed, held, in the custody of, or confined at OPP, based on arrests, detainers, criminal charges, civil contempt charges, or convictions.

23. "Psychotropic medication" means any medication used to affect mental activity, perception, behavior, or mood.

24. "Qualified Health Care Professional" means an individual who has received instruction and supervision in identifying and interacting with individuals in need of health care services.

25. "Qualified Medical Professional" means a licensed physician, licensed physician assistant, or a licensed nurse practitioner, who is currently licensed by the State of Louisiana to deliver those health care services he or she has undertaken to provide.

26. "Qualified Medical Staff" refers to Qualified Medical Professionals and Qualified Nursing Staff.

27. "Qualified Mental Health Professional" refers to an individual with a minimum of masters-level education and training in psychiatry, psychology, counseling, social work, or psychiatric nursing, who is currently licensed by the State of Louisiana to deliver those mental health services he or she has undertaken to provide.

28. "Qualified Nursing Staff" means registered nurses and licensed practical nurses currently licensed by the State of Louisiana to deliver those health care services he or she has undertaken to provide.

29. "Reportable incidents" refers to any incident that involves a Level 1 or 2 rule violation, a prisoner death or serious injury, serious suicide attempt, sexual threats, a cell extraction, a use of force or restraint, a medical emergency, escapes and escape attempts, and fires.

30. "Serious injury" means any injury requiring hospitalization and/or follow-up medical care.

31. "Serious suicide attempt" means a suicide attempt that is considered to be either potentially life-threatening or that requires hospitalization. Even if caught in the early stages of the attempt, if the injury resulting from the attempted act could be life threatening, the suicide attempt is "serious" and is reportable under this Agreement.

32. "Special Management Units" mean those housing units of the Facility designated for prisoners in administrative or disciplinary segregation, in protective custody, on suicide precautions, with mental illness, or who are youth age 17 and below.

33. "Staff Members" includes all employees, including correctional officers, who have contact with prisoners.

34. "Suicide Attempt" means any serious effort to commit an act of self-harm that can result in death and involves a definite risk.

35. "Suicide Precautions" means any level of watch, observation, or measures to prevent suicide or self-harm.

36. "Train" means to instruct in skills to a level that the trainee has demonstrated proficiency by testing to implement those skills as and when called for. "Trained" means proficient in the skills.

37. "Threshold" or "threshold event" means requiring a certain level of intervention due to a serious event or a number of serious events. This term is further explained in Appendix A and Appendix B.

38. "Triggers" or "triggering event" means an event or events, like a suicide or serious suicide attempt that causes the Facility to self-assess. This term is further explained in Appendix A and Appendix B.

39. "Use of force" means the application of physical or mechanical measures to compel compliance. "Use of force" shall include all force to compel compliance except force resulting from complaints of minor discomfort from un-resisted handcuffing or un-resisted shackling of prisoners for movement purposes.

40. "Vital Documents" means paper or electronic written material that contains information that is critical for accessing OPP's programs, services, or activities, or is required by law. Vital documents may include grievance forms, notification to prisoners (such as rule violations, transfers, and grievance responses), prisoner handbooks, sick call forms, and request for service forms.

41. "Youth" and "youthful prisoner" shall mean any person in OPSO custody who is age 17 or younger, or who is housed in OPP as a "transfer" youth being tried as an adult.

42. Throughout this Agreement, the following terms are used when discussing compliance: substantial compliance, partial compliance, and non-compliance. "Substantial Compliance" indicates that Defendant has achieved compliance with most or all components of the relevant provision of the Agreement. "Partial Compliance" indicates that Defendant achieved compliance on some of the components of the relevant provision of the Agreement, but significant work remains. "Non-compliance" indicates that Defendant has not met most or all of the components of the Agreement.

IV. SUBSTANTIVE PROVISIONS

A. PROTECTION FROM HARM

Consistent with constitutional standards, Defendant shall provide prisoners with a safe and secure environment and ensure their reasonable safety from harm. OPSO shall take all reasonable measures to ensure that during the course of incarceration, prisoners are not subjected to unnecessary or excessive force by OPSO staff and are protected from violence by other prisoners.

1. Use of Force Policies and Procedures

   a. OPSO shall develop, implement, and maintain comprehensive policies and procedures (in accordance with generally accepted correctional standards) relating to the use of force with particular emphasis regarding permissible and impermissible uses of force.

   b. OPSO shall develop and implement a single, uniform reporting system under a Use of Force Reporting policy. OPSO reportable force shall be divided into two levels, as further specified in policy: Level 1 uses of force will include all serious

uses of force (i.e., the use of force leads to injuries that are extensive, serious or visible in nature, including black eyes, lacerations, injuries to the mouth or head, multiple bruises, injuries to the genitals, etc.), injuries requiring hospitalization, staff misconduct, and occasions when use of force reports are inconsistent, conflicting, or otherwise suspicious. Level 2 uses of force will include all escort or control holds used to overcome resistance that are not covered by the definition of Level 1 uses of force.

c. OPSO shall assess, annually, all data collected regarding uses of force and make any necessary changes to use of force policies or procedures to ensure that unnecessary or excessive use of force is not used in OPP. The review and recommendations will be documented and provided to the Monitor, DOJ, and SPLC.

2. Use of Force Training

a. OPSO shall ensure that all correctional officers are knowledgeable of and have the knowledge, skills, and abilities to comply with use of force policies and procedures. At a minimum, OPSO shall provide correctional officers with pre-service and annual in-service training in use of force, defensive tactics, and use of force policies and procedures. The training will include the following:

(1) instruction on what constitutes excessive force;

(2) de-escalation tactics; and

(3) management of prisoners with mental illness to limit the need for using force.

b. OPSO shall ensure that officers are aware of any change to policies and practices throughout their employment with OPP. At a minimum, OPSO shall provide pre-service and annual in-service use of force training that prohibits:

(1) use of force as a response to verbal insults or prisoner threats where there is no immediate threat to the safety or security of the institution, prisoners, staff, or visitors;

(2) use of force as a response to prisoners' failure to follow instructions where there is no immediate threat to the safety or security of the institution, prisoners, staff, or visitors;

(3) use of force against a prisoner after the prisoner has ceased to offer resistance and is under control;

(4) use of force as punishment or retaliation; and

(5) use of force involving kicking, striking, hitting, or punching a non-combative prisoner.

c. OPSO shall randomly test five percent of the correctional officer staff on an annual basis to determine their knowledge of the use of force policies and procedures. The testing instrument and policies shall be approved by the Monitor. The results of these assessments shall be evaluated to determine the need for changes in training practices. The review and conclusions will be documented and provided to the Monitor.

3. Use of Force Reporting

a. Failure to report a use of force incident by any staff member engaging in the use of force or witnessing the use of force shall be grounds for discipline, up to and including termination.

b. OPSO shall ensure that sufficient information is collected on uses of force to assess whether staff members complied with policy; whether corrective action is necessary including training or discipline; the effectiveness of training and policies; and whether the conditions in OPP comply with this Agreement. At a minimum, OPSO will ensure that officers using or observing a Level 1 use of force shall complete a use of force report that will:

(1) include the names of all staff, prisoner(s), or other visual or oral witness(es);

(2) contain an accurate and specific account of the events leading to the use of force;

(3) describe the level of resistance and the type and level of force used, consistent with OPP use of force policy and procedure, as well as the precise actions taken by OPSO staff in response to the incident;

(4) describe the weapon or instrument(s) of restraint, if any, and the manner of such use;

(5) be accompanied by a prisoner disciplinary report, if it exists, pertaining to the events or prisoner activity that prompted the use of force incident;

(6) describe the nature and extent of injuries sustained by anyone involved in the incident;

(7) contain the date and time when medical attention, if any, was requested and actually provided;

(8) describe any attempts the staff took to de-escalate prior to the use of force;

(9) include an individual written account of the use of force from every staff member who witnessed the use of force;

(10) include photographs taken promptly, but no later than two hours after a use of force incident, of all injuries sustained, or as evidence that no injuries were sustained, by prisoners and staff involved in the use of force incident;

(11) document whether the use of force was digitally or otherwise recorded. If the use of force is not digitally or otherwise recorded, the reporting officer and/or watch commander will provide an explanation as to why it was not recorded; and

(12) include a statement about the incident from the prisoner(s) against whom force was used.

c. All officers using a Level 2 use of force shall complete a use of force report that will:

(1) include the names of staff, prisoner(s), or other visual or oral witness(es);

(2) contain an accurate and specific account of the events leading to the use of force;

(3) describe the level of resistance and the type and level of force used, consistent with OPP use of force policy and procedure, as well as the precise actions taken by OPSO staff in response to the incident;

(4) describe the weapon or instrument(s) of restraint, if any, and the manner of such use;

(5) be accompanied by a prisoner disciplinary report, if it exists, pertaining to the events or prisoner activity that prompted the use of force incident;

(6) describe the nature and extent of injuries sustained by anyone involved in the incident;

(7) contain the date and time when medical attention, if any, was requested and actually provided; and

(8) describe any attempts the staff took to de-escalate prior to the use of force;

d. OPSO shall require correctional officers to notify the watch commander as soon as practical of any use of force incident or allegation of use of force. When notified, the watch commander will respond to the scene of all Level 1 uses of force. When arriving on the scene, the watch commander shall:

(1) ensure the safety of everyone involved in or proximate to the incident;

(2) determine if any prisoner or correctional officer is injured and ensure that necessary medical care is provided;

(3) ensure that personnel and witnesses are identified, separated, and advised that communications with other witnesses or correctional officers regarding the incident are prohibited;

(4) ensure that witness and subject statements are taken from both staff and prisoner(s) outside of the presence of other prisoners and staff;

(5) ensure that the supervisor's use of force report is forwarded to IAD for investigation if, upon the supervisor's review, a violation of law or policy is suspected. The determination of what type of investigation is needed will be based on the degree of the force used consistent with the terms of this Agreement;

(6) If the watch commander is not involved in the use of force incident, the watch commander shall review all submitted use of force reports within 36 hours of the end of the incident, and shall specify his findings as to completeness and procedural errors. If the watch commander believes that the use of force may have been unnecessary or excessive, he shall immediately contact IAD for investigation consideration and shall notify the warden or assistant warden; and

(7) All Level 1 use of force reports, whether or not the force is believed by any party to be unnecessary or excessive, shall be sent to IAD for review. IAD shall develop and submit to the Monitor within 90 days of the Effective Date clear criteria to identify use of force incidents that warrant a full investigation, including injuries that are extensive or serious, visible in nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.), injuries requiring hospitalization, staff misconduct (including inappropriate relationships with prisoners), and occasions when use of force reports are inconsistent, conflicting, or otherwise suspicious.

e. Ensure that a first-line supervisor is present during all pre-planned uses of force, such as cell extractions.

f. Within 36 hours, exclusive of weekends and holidays, of receiving the report and review from the shift commander, in order to determine the appropriateness of the

force used and whether policy was followed, the Warden or Assistant Warden shall review all use of force reports and supervisory reviews including:

(1) the incident report associated with the use of force;

(2) any medical documentation of injuries and any further medical care;

(3) the prisoner disciplinary report associated with the use of force; and

(4) the Warden or Assistant Warden shall complete a written report or written statement of specific findings and determinations of the appropriateness of force.

g. Provide the Monitor a periodic report detailing use of force by staff. These periodic reports shall be provided to the Monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement. Each report will include the following information:

(1) a brief summary of all uses of force, by type;

(2) date that force was used;

(3) identity of staff members involved in using force;

(4) identity of prisoners against whom force was used;

(5) a brief summary of all uses of force resulting in injuries;

(6) number of planned and unplanned uses of force;

(7) a summary of all in-custody deaths related to use of force, including the identity of the decedent and the circumstances of the death; and

(8) a listing of serious injuries requiring hospitalization.

h. OPSO shall conduct, annually, a review of the use of force reporting system to ensure that it has been effective in reducing unnecessary or excessive uses of force. OPSO will document its review and conclusions and provide them to the Monitor, SPLC, and DOJ.

4. Early Intervention System ("EIS")

a. OPSO shall develop, within 120 days of the Effective Date, a computerized relational database ("EIS") that will document and track staff members who are involved in use of force incidents and any complaints related to the inappropriate or excessive use of force, in order to alert OPSO management to any potential

problematic policies or supervision lapses or need for retraining or discipline. The Chief of Operations Deputy, supervisors, and investigative staff shall have access to this information and shall review on a regular basis, but not less than quarterly, system reports to evaluate individual staff, supervisor, and housing area activity. OPSO will use the EIS as a tool for correcting inappropriate staff behavior before it escalates to more serious misconduct.

b. Within 120 days of the Effective Date, OPSO senior management shall use EIS information to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level. IAD will manage and administer EIS systems. The Special Operations Division ("SOD") will have access to the EIS. IAD will conduct quarterly audits of the EIS to ensure that analysis and intervention is taken according to the process described below. Command staff shall review the data collected by the EIS on at least a quarterly basis to identify potential patterns or trends resulting in harm to prisoners. The Use of Force Review Board will periodically review information collected regarding uses of force in order to identify the need for corrective action, including changes to training protocols and policy or retraining or disciplining individual staff or staff members. Through comparison of the operation of this system to changes in the conditions in OPP, OPSO will assess whether the mechanism is effective at addressing the requirements of this Agreement.

c. OPSO shall provide, within 180 days of the implementation date of its EIS, to SPLC, DOJ, and the Monitor, a list of all staff members identified through the EIS and corrective action taken.

d. The EIS protocol shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit.

e. On an annual basis, OPSO shall review the EIS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline. This assessment will be based in part on the number and severity of harm and injury identified through data collected pursuant to this Agreement. OPSO will document its review and conclusions and provide them to the Monitor, who shall forward this document to DOJ and SPLC.

5. Safety and Supervision

Recognizing that some danger is inherent in a jail setting, OPSO shall take all reasonable measures to ensure that prisoners are not subjected to harm or the risk of harm. At a minimum, OPSO shall do the following:

a. Maintain security policies, procedures, and practices to provide a reasonably safe and secure environment for prisoners and staff in accordance with this Agreement.

b. Maintain policies, procedures, and practices to ensure the adequate supervision of prisoner work areas and trustees.

c. Maintain policies and procedures regarding care for and housing of protective custody prisoners and prisoners requesting protection from harm.

d. Continue to ensure that correctional officers conduct appropriate rounds at least once during every 30-minute period, at irregular times, inside each general population housing unit and at least once during every 15-minute period of special management prisoners, or more often if necessary. All security rounds shall be documented on forms or logs that do not contain pre-printed rounding times. In the alternative, OPSO may provide direct supervision of prisoners by posting a correctional officer inside the day room area of a housing unit to conduct surveillance.

e. Staff shall provide direct supervision in housing units that are designed for this type of supervision. Video surveillance may be used to supplement, but must not be used to replace, rounds by correctional officers.

f. Increase the use of overhead video surveillance and recording cameras to provide adequate coverage throughout the common areas of the Jail, including the Intake Processing Center, all divisions' intake areas, mental health units, special management units, prisoner housing units, and in the divisions' common areas.

g. Continue to ensure that correctional officers, who are transferred from one division to another, are required to attend training on division-specific post orders before working on the unit.

h. Continue to ensure that correctional officers assigned to special management units, which include youth tiers, mental health tiers, disciplinary segregation, and protective custody, receive eight hours of specialized training regarding such units on prisoner safety and security on at least an annual basis.

i. Continue to ensure that supervisors conduct daily rounds on each shift in the prisoner housing units, and document the results of their rounds.

j. Continue to ensure that staff conduct daily inspections of cells and common areas of the housing units to protect prisoners from unreasonable harm or unreasonable risk of harm.

k. Continue to ensure that staff conduct random monthly shakedowns of cells and common areas so that prisoners do not possess or have access to dangerous contraband.

l. Provide the Monitor a periodic report of safety and supervision at the Facility. These periodic reports shall be provided to the monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement. Each report will provide the following information:

(1) a listing of special management prisoners, their housing assignments, the basis for them being placed in the specialized housing unit, and the date placed in the unit; and

(2) a listing of all contraband, including weapons seized, the type of contraband, date of seizure, location, and shift of seizure.

6. Security Staffing

a. OPSO shall ensure that correctional staffing and supervision is sufficient to adequately supervise prisoners, fulfill the terms of this Agreement, and allow for the safe operation of the Facility, consistent with constitutional standards. OPSO shall achieve adequate correctional officer staffing in the following manner:

(1) Within 90 days of the Effective Date, develop a staffing plan that will identify all posts and positions, the adequate number and qualification of staff to cover each post and position, adequate shift relief, and coverage for vacations. The staffing plan will ensure that there is adequate coverage inside each housing and specialized housing areas and to accompany prisoners for court, visits and legal visits, and other operations of OPP and to comply with all provisions of this Agreement. OPSO will provide its plan to the Monitor, SPLC, and DOJ for approval. The Monitor, SPLC, or DOJ will have 60 days to raise any objections and recommend revisions to the staffing plan.

(2) Within 120 days before the opening of any new facility, submit a staffing plan consistent with subsection (1) above.

(3) Within 90 days after completion of the staffing study, OPSO shall recruit and hire a full-time professional corrections administrator to analyze and review OPP operations. The professional corrections administrator shall report directly to the Sheriff and shall have responsibilities to be determined by the Sheriff. The professional corrections administrator shall have at least the following qualifications: (a) a bachelor's degree in criminal justice or other closely related field; (b) five years of experience in supervising a large correctional facility; and (c) knowledge of and experience in applying modern correctional standards, maintained through

regular participation in corrections-related conferences or other continuing education.

(4) Provide the Monitor a periodic report on staffing levels at the Facility. These periodic reports shall be provided to the Monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement Each report will include the following information:

i. a listing of each post and position needed;

ii. the number of hours needed for each post and position;

iii. a listing of staff hired and positions filled;

iv. a listing of staff working overtime and the amount of overtime worked by each staff member;

v. a listing of supervisors working overtime; and

vi. a listing of and types of critical incidents reported.

b. Review the periodic report to determine whether staffing is adequate to meet the requirements of this Agreement. OPSO shall make recommendations regarding staffing based on this review. The review and recommendations will be documented and provided to the Monitor.

7. Incidents and Referrals

a. OPSO shall develop and implement policies that ensure that Facility watch commanders have knowledge of reportable incidents in OPP to take action in a timely manner to prevent harm to prisoners or take other corrective action. At a minimum, OPSO shall do the following:

b. Continue to ensure that Facility watch commanders document all reportable incidents by the end of their shift, but no later than 24 hours after the incident, including prisoner fights, rule violations, prisoner injuries, suicide attempts, cell extractions, medical emergencies, found contraband, vandalism, escapes and escape attempts, and fires.

c. Continue to ensure that Facility watch commanders report all suicides and deaths no later than one hour after the incident, to a supervisor, IAD, the Special Operations Division, and medical and mental health staff.

d. Provide formal pre-service and annual in-service training on proper incident reporting policies and procedures.

e. Implement a policy providing that it is a disciplinary infraction for staff to fail to report any reportable incident that occurred on his or her shift. Failure to formally report any observed prisoner injury may result in staff discipline, up to and including termination.

f. Maintain a system to track all reportable incidents that, at a minimum, includes the following information:

(1) tracking number;

(2) the prisoner(s) name;

(3) housing classification and location;

(4) date and time;

(5) type of incident;

(6) injuries to staff or prisoner;

(7) medical care;

(8) primary and secondary staff involved;

(9) reviewing supervisor;

(10) external reviews and results;

(11) corrective action taken; and

(12) administrative sign-off.

e. Ensure that incident reports and prisoner grievances are screened for allegations of staff misconduct, and, if the incident or allegation meets established criteria in accordance with this Agreement, it is referred for investigation.

f. Provide the Monitor a periodic data report of incidents at the Facility. These periodic reports shall be provided to the Monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement.

g. The report will include the following information:

(1) a brief summary of all reportable incidents, by type and date;

(2) a description of all suicides and in-custody deaths, including the date, name of prisoner, and housing unit;

(3) number of prisoner grievances screened for allegations of misconduct; and

(4) number of grievances referred to IAD or SOD for investigation.

h. Conduct internal reviews of the periodic reports to determine whether the incident reporting system is ensuring that the constitutional rights of prisoners are respected. Review the quarterly report to determine whether the incident reporting system is meeting the requirements of this Agreement. OPSO shall make recommendations regarding the reporting system or other necessary changes in policy or staffing based on this review. The review and recommendations will be documented and provided to the Monitor.

8. Investigations

OPSO shall ensure that it has sufficient staff to identify, investigate, and make recommendations correcting misconduct that has or may lead to a violation of the Constitution. At a minimum, OPSO shall:

a. Maintain implementation of comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct, sexual assaults, and physical assaults of prisoners resulting in serious injury, in accordance with this Agreement. Investigations shall:

(1) be conducted by persons who do not have conflicts of interest that bear on the partiality of the investigation;

(2) include timely, thorough, and documented interviews of all relevant staff and prisoners who were involved in or who witnessed the incident in question, to the extent practicable; and

(3) include all supporting evidence, including logs, witness and participant statements, references to policies and procedures relevant to the incident, physical evidence, and video or audio recordings.

b. Continue to provide SOD and IAD staff with pre-service and annual in-service training on appropriate investigation policies and procedures, the investigation tracking process, investigatory interviewing techniques, and confidentiality requirements.

c. Ensure that any investigative report indicating possible criminal behavior will be referred to IAD/SOD and then referred to the Orleans Parish District Attorney's Office, if appropriate.

d. Provide the Monitor a periodic report of investigations conducted at the Facility. These periodic reports shall be provided to theMonitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement.

e. The report will include the following information:

(1) a brief summary of all completed investigations, by type and date;

(2) a listing of investigations referred for administrative investigation;

(3) a listing of all investigations referred to an appropriate law enforcement agency and the name of the agency; and

(4) a listing of all staff suspended, terminated, arrested, or reassigned because of misconduct or violations of policy and procedures. This list must also contain the specific misconduct and/or violation.

f. OPSO shall review the periodic report to determine whether the investigation system is meeting the requirements of this Agreement and make recommendations regarding the investigation system or other necessary changes in policy based on this review. The review and recommendations will be documented and provided to the Monitor.

9. Pretrial Placement in Alternative Settings:

a. OPSO shall maintain its role of providing space and security to facilitate interviews conducted pursuant to the City's pretrial release program, which is intended to ensure placement in the least restrictive appropriate placement consistent with public safety.

b. OPSO shall create a system to ensure that it does not unlawfully confine prisoners whose sole detainer is by Immigration and Customs Enforcement ("ICE"), where the detainer has expired.

10. Custodial Placement within OPP

a. OPP shall implement an objective and validated classification system that assigns prisoners to housing units by security levels, among other valid factors, in order to protect prisoners from unreasonable risk of harm. The system shall include: consideration of a prisoner's security needs, severity of the current charge, types of prior commitments, suicide risk, history of escape attempts, history of violence, gang affiliations, and special needs, including mental illness, gender identity, age, and education requirements. OPSO shall anticipate periods of unusual intake volume and schedule sufficient classification staff to classify prisoners within 24 hours of booking and perform prisoner reclassifications, assist eligible DOC

prisoners with re-entry assistance (release preparation), among other duties related to case management.

b. Prohibit classifications based solely on race, color, national origin, or ethnicity.

c. Ensure that the classification staff has sufficient access to current information regarding cell availability in each division.

d. Continue to update the classification system to include information on each prisoner's history at OPSO.

e. Continue competency-based training and access to all supervisors on the full capabilities of the OPSO classification and prisoner tracking system.

f. Conduct internal and external review and validation of the classification and prisoner tracking system on at least an annual basis.

g. Provide the Monitor a periodic report on classification at the Facility. These periodic reports shall be provided to the Monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement. Each report will include the following information:

(1) number of prisoner-on-prisoner assaults;

(2) number of assaults against prisoners with mental illness;

(3) number of prisoners who report having gang affiliations;

(4) most serious offense leading to incarceration;

(5) number of prisoners classified in each security level;

(6) number of prisoners placed in protective custody; and

(7) number of misconduct complaints.

h. OPSO shall review the periodic data report and make recommendations regarding proper placement consistent with this Agreement or other necessary changes in policy based on this review. The review and recommendations will be documented and provided to the Monitor.

11. Prisoner Grievance Process

a. OPSO shall ensure that prisoners have a mechanism to express their grievances, resolve disputes, and ensure that concerns regarding their constitutional rights are addressed. OPSO shall, at a minimum, do the following:

(1) Continue to maintain policies and procedures to ensure that prisoners have access to an adequate grievance process and to ensure that grievances may be reported and filed confidentially, without requiring the intervention of a correctional officer. The policies and procedures should be applicable and standardized across all the Facility divisions.

(2) Ensure that each grievance receives appropriate follow-up, including providing a timely written response and tracking implementation of resolutions.

(3) Ensure that grievance forms are available on all units and are available in Spanish and Vietnamese and that there is adequate opportunity for illiterate prisoners and prisoners who have physical or cognitive disabilities or language barriers to access the grievance system.

(4) Separate the process of "requests to staff" from the grievance process and prioritize grievances that raise issues regarding prisoner safety or health.

(5) Ensure that prisoner grievances are screened for allegations of staff misconduct and, if an incident or allegation warrants per this Agreement, that it is referred for investigation.

(6) A member of the management staff shall review the grievance tracking system quarterly to identify areas of concerns. These reviews and any recommendations will be documented and provided to the Monitor.

12. Sexual Abuse

OPSO will develop and implement policies, protocols, trainings, and audits, consistent with the requirements of the Prison Rape Elimination Act of 2003, 42 U.S.C. § 15601, et seq., and its implementation of regulations, including but not limited to, preventing, detecting, reporting, investigating, and collecting sexual abuse data, including prisoner-on-prisoner and staff-on-prisoner sexual abuse, sexual harassment, and sexual touching.

13. Access to Information

OPSO will ensure that all newly admitted prisoners receive information, through an inmate handbook and, at the discretion of the Jail, an orientation video, regarding the following topics: understanding Facility disciplinary process and rules and regulations; reporting misconduct; reporting sexual abuse or assault; accessing medical and mental health care; emergency procedures; and sending and receiving mail; understanding the visitation process; and accessing the grievance process.

B. MENTAL HEALTH CARE

OPSO shall ensure constitutionally adequate intake, assessment, treatment, and monitoring of prisoners' mental health needs, including but not limited to, protecting the safety of and giving priority access to prisoners at risk for self-injurious behavior or suicide. OPSO shall assess, on an annual or more frequent basis, whether the mental health services at OPP comply with the Constitution. In order to provide mental health services to prisoners, OPSO, at a minimum, shall:

1. Screening and Assessment

   a. Develop and maintain comprehensive policies and procedures for appropriate screening and assessment of prisoners with mental illness. These policies should include definitions of emergent, urgent, and routine mental health needs, as well as timeframes for the provision of services for each category of mental health needs.

   b. Develop and implement an appropriate screening instrument that identifies mental health needs, and ensures timely access to a mental health professional when presenting symptoms require such care. The screening instrument should include the factors described in Appendix B. The screening instrument will be validated by a qualified professional approved by the Monitor within 180 days of the Effective Date and every 12 months thereafter, if necessary.

   c. Ensure that all prisoners are screened by Qualified Medical Staff upon arrival to OPP, but no later than within eight hours, to identify a prisoner's risk for suicide or self-injurious behavior. No prisoner shall be held in isolation prior to an evaluation by medical staff.

   d. Implement a triage policy that utilizes the screening and assessment procedures to ensure that prisoners with emergent and urgent mental health needs are prioritized for services.

   e. Develop and implement protocols, commensurate with the level of risk of suicide or self-harm, to ensure that prisoners are protected from identified risks for suicide or self-injurious behavior. The protocols shall also require that a Qualified Mental Health Professional perform a mental health assessment, based on the prisoner's risk.

   f. For prisoners with emergent or urgent mental health needs, search the prisoner and monitor with constant supervision until the prisoner is transferred to a Qualified Mental Health Professional for assessment.

   g. Ensure that a Qualified Mental Health Professional conducts appropriate mental health assessments within the following periods from the initial screen or other identification of need:

(1) 14 days, or sooner, if medically necessary, for prisoners with routine mental health needs;

(2) 48 hours, or sooner, if medically necessary, for prisoners with urgent mental health needs; and

(3) immediately, but no later than two hours, for prisoners with emergent mental health needs.

h. Ensure that a Qualified Mental Health Professional performs a mental health assessment no later than the next working day following any adverse triggering event (i.e., any suicide attempt, any suicide ideation, orany aggression to self resulting in serious injury).

i. Ensure that a Qualified Mental Health Professional, as part of the prisoner's interdisciplinary treatment team, maintains a risk profile for each prisoner on the mental health case load based on the Assessment Factors identified in Appendix B, and develops and implements a treatment plan to minimize the risk of harm to each of these prisoners.

j. Ensure adequate and timely treatment for prisoners, whose assessments reveal mental illness and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate.

k. Ensure crisis services are available to manage psychiatric emergencies. Such services include licensed in-patient psychiatric care, when clinically appropriate.

l. On an annual basis, assess the process for screening prisoners for mental health needs to determine whether prisoners are being appropriately identified for care. Based on this assessment, OPSO shall recommend changes to the screening system. The assessment and recommendations will be documented and provided to the Monitor.

2. Treatment

a. Review, revise, and supplement its existing policies in order to implement a policy for the delivery of mental health services that includes a continuum of services, provides for necessary and appropriate mental health staff, includes a treatment plan for prisoners with serious mental illness, and collects data and contains mechanisms sufficient to measure whether care is being provided in a manner consistent with the Constitution.

b. Ensure that treatment plans adequately address prisoners' serious mental health needs and that the treatment plans contain interventions specifically tailored to the prisoner's diagnoses and problems.

c. Provide group or individual therapy services by an appropriately licensed provider where necessary for prisoners with mental health needs.

d. Ensure that mental health evaluations that are done as part of the disciplinary process include recommendations based on the prisoner's mental health status.

e. Ensure that prisoners receive psychotropic medications in a timely manner and that prisoners have proper diagnoses and/or indications for each psychotropic medication they receive.

f. Ensure that psychotropic medications are administered in a clinically appropriate manner as to prevent misuse, overdose, theft, or violence related to the medication.

g. Ensure that prescriptions for psychotropic medications are reviewed by a Qualified Mental Health Professional on a regular, timely basis and prisoners are properly monitored.

h. Ensure that standards are established for the frequency of review and associated charting of psychotropic medication monitoring, including monitoring for metabolic effects of second generation psychotropic medications.

3. Counseling

a. OPSO shall develop and implement policies and procedures for prisoner counseling in the areas of general mental health/therapy, sexual-abuse counseling, and alcohol and drug counseling. This should, at a minimum, include some provision for individual services.

b. Within 180 days of the Effective Date, and quarterly thereafter, report all prisoner counseling services to the Monitor, which should include:

(1) the number of prisoners who report having participated in general mental health/therapy counseling at OPP;

(2) the number of prisoners who report having participated in alcohol and drug counseling services at OPP;

(3) the number of prisoners who report having participated in sexual-abuse counseling at OPP; and

(4) the number of cases with an appropriately licensed practitioner and related one-to-one counseling at OPP.

4. Suicide Prevention Training Program

a. OPSO shall ensure that all staff who supervise prisoners have the adequate knowledge, skill, and ability to address the needs of prisoners at risk for suicide. Within 180 days of the Effective Date, OPSO shall review and revise its current suicide prevention training curriculum to include the following topics:

(1) suicide prevention policies and procedures (as revised consistent with this Agreement);

(2) analysis of facility environments and why they may contribute to suicidal behavior;

(3) potential predisposing factors to suicide;

(4) high-risk suicide periods;

(5) warning signs and symptoms of suicidal behavior;

(6) case studies of recent suicides and serious suicide attempts;

(7) mock demonstrations regarding the proper response to a suicide attempt;

(8) differentiating suicidal and self-injurious behavior; and

(9) the proper use of emergency equipment.

b. Ensure that all correctional, medical, and mental health staff are trained on the suicide screening instrument and the medical intake tool.

c. Ensure that multi-disciplinary in-service training is completed annually by all correctional, medical, and mental health staff, to include training on updated policies, procedures, and techniques. The training will be reviewed and approved by the Monitor.

d. Ensure that staff are trained in observing prisoners on suicide watch and step-down unit status.

e. Ensure that all staff that have contact with prisoners are certified in cardiopulmonary resuscitation ("CPR").

f. Ensure that an emergency response bag, which includes a first aid kit and emergency rescue tool, is in close proximity to all housing units. All staff that has

contact with prisoners shall know the location of this emergency response bag and be trained to use its contents.

g. Randomly test five percent of relevant staff on an annual basis to determine their knowledge of suicide prevention policies. The testing instrument and policies shall be approved by the Monitor. The results of these assessments shall be evaluated to determine the need for changes in training practices. The review and conclusions will be documented and provided to the Monitor.

5. Suicide Precautions

a. OPSO shall implement a policy to ensure that prisoners at risk of self-harm are identified, protected, and treated in a manner consistent with the Constitution.

b. Ensure that suicide prevention procedures include provisions for constant direct supervision of current suicidal prisoners and close supervision of special needs prisoners with lower levels of risk (at a minimum, 15 minute checks). Correctional officers shall document their checks in a format that does not have pre-printed times.

c. Ensure that prisoners on suicide watch are immediately searched and monitored with constant direct supervision until a Qualified Mental Health Professional conducts a suicide risk assessment, determines the degree of risk, and specifies the appropriate degree of supervision.

d. Ensure that all prisoners discharged from suicide precautions receive a follow-up assessment within three to eight working days after discharge, as clinically appropriate, in accordance with a treatment plan developed by a Qualified Mental Health Care Professional. Upon discharge, the Qualified Mental Health Care Professional shall conduct a documented in-person assessment regarding the clinically appropriate follow-up intervals.

e. Implement a step-down program providing clinically appropriate transition for prisoners discharged from suicide precautions.

f. Develop and implement policies and procedures for suicide precautions that set forth the conditions of the watch, incorporating a requirement of an individualized clinical determination of allowable clothing, property, and utensils. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergency circumstances or when security considerations require.

g. Ensure that cells designated by OPSO for housing suicidal prisoners are retrofitted to render them suicide-resistant (e.g., eliminating bed frames/holes, sprinkler heads, water faucet lips, and unshielded lighting or electrical sockets).

h. Ensure that every suicide or serious suicide attempt is investigated by appropriate mental health and correctional staff, and that the results of the investigation are provided to the Sheriff and the Monitor.

i. Direct observation orders for inmates placed on suicide watch shall be individualized by the ordering clinician based upon the clinical needs of each inmate, and shall not be more restrictive than is deemed necessary by the ordering clinician to ensure the safety and well being of the inmate.

j. Provide the Monitor a periodic report on suicide and self-harm at the Facility. These periodic reports shall be provided to the monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement. The report will include the following:

(1) all suicides;

(2) all serious suicide or self-harm attempts; and

(3) all uses of restraints to respond to or prevent a suicide attempt.

k. Assess the periodic report to determine whether prisoners are being appropriately identified for risk of self-harm, protected, and treated. Based on this assessment, OPSO shall document recommended changes to policies and procedures and provide these to the Monitor.

6. Use of Restraints

a. OPSO shall prevent the unnecessary or excessive use of physical or chemical restraints on prisoners with mental illness.

b. Maintain comprehensive policies and procedures for the use of restraints for prisoners with mental illness consistent with the Constitution.

c. Ensure that approval by a Qualified Medical or Mental Health Professional is received and documented prior to the use of restraints on prisoners living with mental illness or requiring suicide precautions.

d. Ensure that restrained prisoners with mental illnesses are monitored at least every 15 minutes by Custody Staff to assess their physical condition.

e. Ensure that Qualified Medical or Mental Health Staff document the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on restrained prisoners.

f. Provide the Monitor a periodic report of restraint use at the Facility. These periodic reports shall be provided to the monitor within four months of the

Effective Date; and every six months thereafter until termination of this Agreement. Each report shall include:

(1) A list of prisoners whom were restrained;

(2) A list of any self-injurious behavior observed or discovered while restrained; and

(3) A list of any prisoners whom were placed in restraints on three or more occasions in a thirty (30) day period or whom were kept in restraints for a period exceeding twenty-four (24) hours.

g. Assess the periodic report to determine whether restraints are being used appropriately on prisoners with mental illness. Based on this assessment, OPSO shall document recommended changes to policies and procedures and provide these to the Monitor.

7. Detoxification and Training

a. OPSO shall ensure that all staff who supervise prisoners have the knowledge, skills, and abilities to identify and respond to detoxifying prisoners. Within 180 days of the Effective Date, OPSO shall institute an annual in-service detoxification training program for Qualified Medical and Mental Health Staff and for correctional staff. The detoxification training program shall include:

(1) annual staff training on alcohol and drug abuse withdrawal;

(2) training of Qualified Medical and Mental Health Staff on treatment of alcohol and drug abuse conducted by the Chief Medical Officer or his or her delegate;

(3) oversight of the training of correctional staff, including booking and housing unit officers, on the policies and procedures of the detoxification unit, by the Chief Medical Officer or his or her delegate;

(4) training on drug and alcohol withdrawal by Qualified Medical and Mental Health Staff;

(5) training of Qualified Medical and Mental Health Staff in providing prisoners with timely access to a Qualified Mental Health Professional, including psychiatrists, as clinically appropriate; and

(6) training of Qualified Medical and Mental Health Staff on the use and treatment of withdrawals, where medically appropriate.

b. Provide medical screenings to determine the degree of risk for potentially life-threatening withdrawal from alcohol, benzodiazepines, and other substances, in accordance with Appendix B.

c. Ensure that the nursing staff complete assessments of prisoners in detoxification on an individualized schedule, ordered by a Qualified Medical or Mental Health Professional, as clinically appropriate, to include observations and vital signs, including blood pressure.

d. Annually, conduct a review of whether the detoxification training program has been effective in identifying concerns regarding policy, training, or the proper identification of and response to detoxifying prisoners. OPSO will document this review and provide its conclusions to the Monitor.

8. Medical and Mental Health Staffing

a. OPSO shall ensure that medical and mental health staffing is sufficient to provide adequate care for prisoners' serious medical and mental health needs, fulfill constitutional mandates and the terms of this Agreement, and allow for the adequate operation of the Facility, consistent with constitutional standards.

b. Within 90 days of the Effective Date, OPSO shall conduct a comprehensive staffing plan and/or analysis to determine the medical and mental health staffing levels necessary to provide adequate care for prisoners' mental health needs and to carry out the requirements of this Agreement. Upon completion of the staffing plan and/or analysis, OPSO shall provide its findings to the Monitor, SPLC, and DOJ for review. The Monitor, SPLC, and DOJ will have 60 days to raise any objections and recommend revisions to the staffing plan.

9. Risk Management

a. OPSO shall develop, implement, and maintain a system to ensure that trends and incidents involving avoidable suicides and self-injurious behavior are identified and corrected in a timely manner. Within 90 days of the Effective Date, OPSO shall develop and implement a risk management system that identifies levels of risk for suicide and self-injurious behavior and requires intervention at the individual and system levels to prevent or minimize harm to prisoners, based on the triggers and thresholds set forth in Appendix B.

b. The risk management system shall include the following processes to supplement the mental health screening and assessment processes: incident reporting, data collection, and data aggregation to capture sufficient information to formulate a reliable risk assessment at the individual and system levels; identification of at-risk prisoners in need of clinical treatment or assessment by the Interdisciplinary Team or the Mental Health Committee; and development and implementation of interventions that minimize and prevent harm in response to identified patterns and trends.

c. OPSO shall develop and implement an Interdisciplinary Team, which utilizes intake screening, health assessment, and triggering event information for formulating treatment plans. The Interdisciplinary Team shall:

(1) include the Medical and Nursing directors, one or more members of the psychiatry staff, counseling staff, social services staff, and security staff, and other members as clinical circumstances dictate;

(2) conduct interdisciplinary treatment rounds, on a weekly basis, during which targeted patients are reviewed based upon screening and assessment factors, as well as triggering events; and

(3) provide individualized treatment plans based, in part, on screening and assessment factors, to all mental health patients seen by various providers.

d. OPSO shall develop and implement a Mental Health Review Committee that will, on a monthly basis, review mental health statistics including, but not limited to, risk management triggers and trends at both the individual and system levels. The Mental Health Review Committee shall:

(1) include the Medical and Nursing Director, one or more members of the psychiatry staff and social services staff, the Health Services Administrator, the Warden of the facility housing the Acute Psychiatric Unit, and the Risk Manager.

(2) identify at-risk patients in need of mental health case management who may require intervention from and referral to the Interdisciplinary Team, the OPSO administration, or other providers.

(3) conduct department-wide analyses and validation of both the mental health and self-harm screening and assessment processes and tools, review the quality of screenings and assessments and the timeliness and appropriateness of care provided, and make recommendations on changes and corrective actions;

(4) analyze individual and aggregate mental health data and identify trends and triggers that indicate risk of harm;

(5) review data on mental health appointments, including the number of appointments and wait times before care is received; and

(6) review policies, training, and staffing and recommend changes, supplemental training, or corrective actions.

e. OPSO shall develop and implement a Quality Improvement and Morbidity and Mortality Review Committee that will review, on at least a quarterly basis, risk management triggers and trends and quality improvement reports in order to improve care on a Jail-wide basis.

(1) The Quality Improvement Committee shall include the Medical Director, the Director of Psychiatry, the Chief Deputy, the Risk Manager, and the Director of Training. The Quality Improvement Committee shall review and analyze activities and conclusions of the Mental Health Review Committee and pursue Jail-wide corrective actions.

(2) The Quality Improvement Committee shall:

i. monitor all risk management activities of the facilities through the review of risk data, identification of individual and systemic trends, and recommendation and monitored implementation of investigation or corrective action; and

ii. generate reports of risk data analyzed and corrective actions taken.

(3) The Morbidity and Mortality Review Committee shall include one or more members of Jail operations, the medical department, the mental health department, related clinical disciplines, corrections, and the Risk Manager. The Morbidity and Mortality Review Committee shall:

i. review suicides and serious suicide attempts in a morbidity and mortality capacity;

ii. outline the factors involved in each case, including the individual circumstances, identification of predisposing factors, documentation, medical and security procedures and training, and perform a psychological autopsy and morbidity report;

iii. recommend changes to medical and security policies and procedures;

iv. develop a written plan, with a timetable, for corrective actions; and

v. ensure a final mortality review report is completed within 30 days of a suicide or suicide attempt.

f. OPSO shall review mortality and morbidity reports quarterly to determine whether the risk management system is ensuring compliance with the terms of this Agreement. OPSO shall make recommendations regarding the risk management system or other necessary changes in policy based on this review. The review and recommendations will be documented and provided to the Monitor.

C. MEDICAL CARE

OPSO shall ensure constitutionally adequate treatment of prisoners' medical needs. OPSO shall prevent unnecessary risks to prisoners and ensure proper medication administration practices. OPSO shall assess on an annual or more frequent basis whether the medical services at OPP comply with the Constitution. At a minimum, OPSO shall:

1. Quality Management of Medication Administration

   a. Within 120 days of the Effective Date, ensure that medical and mental health staff are trained on proper medication administration practices, including appropriately labeling containers and contemporaneously recording medication administration;

   b. Ensure that physicians provide a systematic review of the use of medication to ensure that each prisoner's prescribed regimen continues to be appropriate and effective for his or her condition;

   c. Maintain medication administration protocols that provide adequate direction on how to take medications, describe the names of the medications, how frequently to take medications, and identify how prisoners taking such medications are monitored; and

   d. Maintain medication administration protocols that prevent misuse, overdose, theft, or violence related to medication.

2. Health Care Delivered

   a. Provide the Monitor a periodic report on health care at the Facility. These periodic reports shall be provided to the Monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement. Each report will include:

      (1) number of prisoners transferred to the emergency room for medical treatment related to medication errors;

      (2) number of prisoners taken to the infirmary for non-emergency treatment related to medication errors;

      (3) number of prisoners prescribed psychotropic medications;

      (4) number of prisoners prescribed "keep on person" medications; and

      (5) occurrences of medication variances.

   b. Review the periodic health care delivery reports to determine whether the medication administration protocols and requirements of this Agreement are

followed. OPSO shall make recommendations regarding the medication administration process, or other necessary changes in policy, based on this review. The review and recommendations will be documented and provided to the Monitor.

3. Release and Transfer

a. OPSO shall notify Qualified Medical or Mental Health staff regarding the release of prisoners with serious medical and/or mental health needs from OPSO custody, as soon as such information is available.

b. When Qualified Medical or Mental Health staff are notified of the release of prisoners with serious medical and/or mental health needs from OPSO custody, OPSO shall provide these prisoners with at least a seven-day supply of appropriate prescription medication, unless a different amount is necessary and medically appropriate to serve as a bridge until prisoners can reasonably arrange for continuity of care in the community.

c. For all other prisoners with serious medical and/or mental health needs who are released from OPSO custody without advance notice, OPSO shall provide the prisoner a prescription for his or her medications, printed instructions regarding prescription medications, and resources indicating where prescriptions may be filled in the community.

d. For prisoners who are being transferred to another facility, OPSO shall prepare and send with a transferring prisoner, a transition summary detailing major health problems and listing current medications and dosages, as well as medication history while at the Facility. OPSO shall also supply sufficient medication for the period of transit for prisoners who are being transferred to another correctional facility or other institution, in the amount required by the receiving agency.

D. SANITATION AND ENVIRONMENTAL CONDITIONS

Defendant shall ensure that prisoners are provided with constitutionally adequate sanitation and environmental conditions. To provide prisoners safe living conditions, OPSO, at a minimum, shall:

1. Sanitation and Environmental Conditions

a. OPSO shall provide oversight and supervision of routine cleaning of housing units, showers, and medical areas. Such oversight and supervision will include meaningful inspection processes and documentation, as well as establish routine cleaning requirements for toilets, showers, and housing units to be documented at least once a week but to occur more frequently.

b. Continue the preventive maintenance plan to respond to routine and emergency maintenance needs, including ensuring that showers, toilets, and sink units are adequately installed and maintained. Work orders will be submitted within 48 hours of identified deficiencies, or within 24 hours in the case of emergency maintenance needs.

c. Maintain adequate ventilation throughout OPSO facilities to ensure that prisoners receive adequate air flow and reasonable levels of heating and cooling. Maintenance staff shall review and assess compliance with this requirement, as necessary, but no less than twice annually.

d. Ensure adequate lighting in all prisoner housing units and prompt replacement and repair of malfunctioning lighting fixtures in living areas within five days, unless the item must be specially ordered.

e. Ensure adequate pest control throughout the housing units, including routine pest control spraying on at least a quarterly basis and additional spraying as needed.

f. Ensure that any prisoner or staff assigned to clean a biohazardous area is properly trained in universal precautions, outfitted with protective materials, and properly supervised.

g. Ensure the use of cleaning chemicals that sufficiently destroy the pathogens and organisms in biohazard spills.

h. Maintain an infection control plan that addresses contact, blood borne, and airborne hazards and infections. The plan shall include provisions for the identification, treatment, and control of Methicillin-Resistant Staphylococcus Aureus ("MRSA") at the Facility.

2. Environmental Control

a. OPSO shall ensure that broken or missing electrical panels are repaired within 30 days of identified deficiencies, unless the item needs to be specially ordered.

b. Develop and implement a system for maintenance and timely repair of electrical panels, devices, and exposed electrical wires.

3. Food Service

a. OPSO shall ensure that food service staff, including prisoner staff, continues to receive in-service annual training in the areas of food safety, safe food handling procedures, and proper hygiene, to reduce the risk of food contamination and food-borne illnesses.

b. Ensure that dishes and utensils, food preparation and storage areas, and vehicles and containers used to transport food are appropriately cleaned and sanitized on a daily basis.

c. Check and record on a daily basis the temperatures in the refrigerators, coolers, walk-in refrigerators, the dishwasher water, and all other kitchen equipment with a temperature monitor, to ensure proper maintenance of food service equipment.

4. Sanitation and Environmental Conditions Reporting

a. Provide the Monitor a periodic report on sanitation and environmental conditions in the Facility. These periodic reports shall be provided to the Monitor within four months of the Effective Date; and every six months thereafter until termination of this Agreement. The report will include:

(1) number and type of violations reported by health and sanitation inspectors;

(2) number and type of violations of state standards;

(3) number of prisoner grievances filed regarding the environmental conditions at the Facility;

(4) number of inoperative plumbing fixtures, light fixtures, HVAC systems, fire protection systems, and security systems that have not been repaired within 30 days of discovery;

(5) number of prisoner-occupied areas with significant vandalism, broken furnishings, or excessive clutter;

(6) occurrences of insects and rodents in the housing units and dining halls; and

(7) occurrences of poor air circulation in housing units.

b. Review the periodic sanitation and environmental conditions reports to determine whether the prisoner grievances and violations reported by health, sanitation, or state inspectors are addressed, ensuring that the requirements of this Agreement are met. OPSO shall make recommendations regarding the sanitation and environmental conditions, or other necessary changes in policy, based on this review. The review and recommendations will be documented and provided to the Monitor.

E. FIRE AND LIFE SAFETY

OPSO shall ensure that the Facility's emergency preparedness and fire and life safety equipment are consistent with constitutional standards. To protect prisoners from fires and related hazards, OPSO, at a minimum, shall:

1. Fire and Life Safety

   a. Ensure that necessary fire and life safety equipment is properly maintained and inspected at least quarterly. These inspections must be documented.

   b. Ensure that a qualified fire safety officer conducts a monthly inspection of the facilities for compliance with fire and life safety standards (e.g., fire escapes, sprinkler heads, smoke detectors, etc.).

   c. Ensure that comprehensive fire drills are conducted every six months. OPSO shall document these drills, including start and stop times and the number and location of prisoners who were moved as part of the drills.

   d. Provide competency-based training to staff on proper fire and emergency practices and procedures at least annually.

   e. Within 120 days of the Effective Date, ensure that emergency keys are appropriately marked and identifiable by touch and consistently stored in a quickly accessible location, and that staff are adequately trained in use of the emergency keys.

2. Fire and Life Safety Reporting

   a. Provide the Monitor a periodic report on fire and life safety conditions at the Facility. These periodic reports shall be provided to the Monitor within four months of the Effective Date and every six months thereafter until termination of this Agreement. Each report shall include:

      (1) number and type of violations reported by fire and life safety inspectors;

      (2) fire code violations during annual fire inspections; and

      (3) occurrences of hazardous clutter in housing units that could lead to a fire.

   b. Review the periodic fire and life safety reports to determine whether the violations reported by fire and life safety inspectors are addressed, ensuring the requirements of this Agreement are being met. OPSO shall make recommendations regarding the fire and life safety conditions, or other necessary changes in policy, based on this review. The review and recommendations will be documented and provided to the Monitor.

F. LANGUAGE ASSISTANCE

1. Timely and Meaningful Access to Services

   a. OPP shall ensure effective communication with, and provide timely and meaningful access to services at OPP to all prisoners at OPP, regardless of their national origin or limited ability to speak, read, write, or understand English. To achieve this outcome, OPP shall:

      (1) Develop and implement a comprehensive language assistance plan and policy that complies, at a minimum, with Title VI of the Civil Rights Act of 1964, as amended, (42 U.S.C. § 2000d et seq.) and other applicable law;

      (2) Ensure that all OPP personnel take reasonable steps to provide timely, meaningful language assistance services to Limited English Proficient ("LEP") prisoners;

      (3) At intake and classification, identify and assess demographic data, specifically including the number of LEP individuals at OPP on a monthly basis, and the language(s) they speak;

      (4) Use collected demographic information to develop and implement hiring goals for bilingual staff that meet the needs of the current monthly average population of LEP prisoners;

      (5) Regularly assess the proficiency and qualifications of bilingual staff to become an OPP Authorized Interpreter ("OPPAI");

      (6) Create and maintain an OPPAI list and provide that list to the classification and intake staff; and

      (7) Ensure that while at OPP, LEP prisoners are not asked to sign or initial documents in English without the benefit of a written translation from an OPPAI.

2. Language Assistance Policies and Procedures

   a. OPP shall develop and implement written policies, procedures and protocols for documenting, processing, and tracking of individuals held for up to 48 hours for the U.S. Department of Homeland Security ("DHS");

   b. Policies, procedures, and protocols for processing 48-hour holds for DHS will:

      (1) Clearly delineate when a 48-hour hold is deemed to begin and end;

(2) Ensure that, if necessary, an OPPAI communicates verbally with the OPP prisoner about when the 48-hour period begins and is expected to end;

(3) Provide a mechanism for the prisoner's family member and attorney to be informed of the 48-hour hold time period, using, as needed, an OPPAI or telephonic interpretation service;

(4) Create an automated tracking method, not reliant on human memory or paper documentation, to trigger notification to DHS and to ensure that the 48-hour time period is not exceeded.

(5) Ensure that telephone services have recorded instructions in English and Spanish;

(6) Ensure that signs providing instructions to OPP prisoners or their families are translated into Spanish and posted;

(7) Provide Spanish translations of vital documents that are subject to dissemination to OPP prisoners or their family members. Such vital documents include, but are not limited to:

i. grievance forms;

ii. sick call forms;

iii. OPP inmate handbooks;

iv. Prisoner Notifications (e.g., rule violations, transfers, and grievance responses) and

v. "Request for Services" forms.

(8) Ensure that Spanish-speaking LEP prisoners obtain the Spanish language translations of forms provided by DHS; and

(9) Provide its language assistance plan and related policies to all staff within 180 days of the Effective Date of this Agreement.

3. Language Assistance Training

a. Within 180 days of the Effective Date, OPP shall provide at least eight hours of LEP training to all corrections and medical and mental health staff who may regularly interact with LEP prisoners.

(1) LEP training to OPP staff shall include:

i. OPP's LEP plan and policies, and the requirements of Title VI and this Agreement;
ii. how to access OPP-authorized, telephonic and in-person OPPAIs; and
iii. basic commands and statements in Spanish for OPP staff.

(2) OPP shall translate the language assistance plan and policy into Spanish, and other languages as appropriate, and post the English and translated versions in a public area of the OPP facilities, as well as online.

(3) OPP shall make its language assistance plan available to the public.

4. Bilingual Staff

(1) OPP shall ensure that adequate bilingual staff are posted in housing units where DHS detainees and other LEP prisoners may be housed.

(2) OPP shall ensure that an appropriate number of bilingual staff are available to translate or interpret for prisoners and other OPP staff. The appropriate number of bilingual staff will be determined based on a staffing assessment by OPP.

G. YOUTHFUL PRISONERS

Consistent with the Prison Rape Elimination Act of 2003, 42.U.S.C. § 15601, et seq., and its implementation of regulations, a youthful prisoner shall not be placed in a housing unit in which the youthful prisoner will have sight, sound, or physical contact with any adult prisoner through use of a shared dayroom or other common space, shower area, or sleeping quarters. In areas outside of housing units, OPSO shall either: maintain sight and sound separation between youthful prisoners and adult prisoners, or provide direct staff supervision when youthful prisoners and adult prisoners have sight, sound, or physical contact. OPP shall ensure that youthful prisoners in protective custody status shall have no contact with, or access to or from, non-protective custody prisoners. OPP will develop policies for the provision of developmentally appropriate mental health and programming services.

V. FUNDING

A. The Court shall determine the initial funding needed to ensure constitutional conditions of confinement at OPP, in accordance with the terms of this Agreement, and the source(s) responsible for providing that funding at an evidentiary hearing ("funding trial"). Defendant, third-party Defendant City of New Orleans ("City"), and Plaintiffs shall have the right to participate fully in the funding trial, including producing expert testimony and analysis regarding the cost of implementing this Agreement.

B. Defendant shall be responsible for implementation of this Agreement upon a definitive judgment with regard to initial funding for this Agreement.

C. Once the funding is determined pursuant to Paragraph A, the funding amount thereafter may be adjusted on an annual basis to account for changes in the size of the prison population, inflation, or other operating costs. If Defendant and the City are unable to agree upon such adjustments to the annual budget, the Monitor will intervene and resolve the dispute. If the Monitor cannot resolve the dispute within 45 days, the dispute will be submitted to the district judge for resolution. Defendant, the City, and Plaintiffs agree to work in good faith to determine available cost-savings measures that may result from the ongoing implementation of this Agreement or otherwise.

D. Defendant will provide an annual budget for the expenditure of the funds for operation of OPP and an annual audited financial statement to the Monitor, the City, and Plaintiffs. The Monitor will assist in conducting oversight to ensure that funds for implementing this Agreement are allocated to achieve compliance with this Agreement.

VI. THE NEW JAIL FACILITY

A. The Parties anticipate that Defendant will build a new jail facility or facilities that will replace or supplement the current facility located at 2800 Gravier Street, New Orleans, Louisiana. This Agreement shall apply to any new jail facility.

B. Defendant shall obtain the services of a qualified professional to evaluate, design, plan, oversee, and implement the construction of any new facility. At each major stage of the facility construction, Defendant shall provide the Monitor with copies of design documents.

C. Defendant shall consult with a qualified corrections expert as to the required services and staffing levels needed for any replacement facility. OPSO shall complete a staffing study to ensure that any new facility is adequately staffed to provide prisoners with reasonable safety.

D. Defendant will ensure that the new jail facility will be built in accordance with: (1) the American Correctional Association's standards in effect at the time of construction; (2) the American with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12101-12213, including changes made by the ADA Amendments of 2008 (P.L. 110-325) and 47 U.S.C.

§§ 225-661, and the regulations thereunder; and (3) all applicable fire codes and regulations.

VII. COMPLIANCE AND QUALITY IMPROVEMENT

A. Within 120 days of the Effective Date, OPSO shall revise and/or develop its policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. OPSO shall revise and/or develop, as necessary, other written documents, such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. OPSO shall send pertinent newly-drafted and revised policies and procedures to the Monitor as they are promulgated. The Monitor will provide comments on the policies to OPSO, SPLC, and DOJ within 30 days. OPSO, SPLC, and DOJ may provide comments on the Monitor's comments within 15 days. At that point, the Monitor will consider the Parties' comments, mediate any disputes, and approve the policies with any changes within 30 days. If either party disagrees with the Monitor, they may bring the dispute to the Court. OPSO shall provide initial and in-service training to all Facility staff with respect to newly implemented or revised policies and procedures. OPSO shall document employee review and training in new or revised policies and procedures.

II. Within 180 days of the Effective Date, Defendant shall develop and implement written quality improvement policies and procedures adequate to identify serious deficiencies in protection from harm, prisoner suicide prevention, detoxification, mental health care, environmental health, and fire and life safety in order to assess and ensure compliance with the terms of this Agreement on an ongoing basis. Within 90 days after identifying serious deficiencies, OPSO shall develop and implement policies and procedures to address problems that are uncovered during the course of quality improvement activities. These policies and procedures shall include the development and implementation of corrective action plans, as necessary, within 30 days of each biannual review.

I. The Parties agree that OPSO will hire and retain, or reassign a current OPSO employee for the duration of this Agreement, to serve as a full-time OPSO Compliance Coordinator. The Compliance Coordinator will serve as a liaison between the Parties and the Monitor and will assist with OPSO's compliance with this Agreement. At a minimum, the Compliance Coordinator will: coordinate OPSO's compliance and implementation activities; facilitate the provision of data, documents, materials, and access to OPSO's personnel to the Monitor, SPLC, DOJ, and the public, as needed; ensure that all documents and records are maintained as provided in this Agreement; and assist in assigning compliance tasks to OPSO personnel, as directed by the Sheriff or his or her designee. The Compliance Coordinator will take primary responsibility for collecting information the Monitor requires to carry out the duties assigned to the Monitor.

J. On a bi-annual basis, OPSO will provide the public with a self-assessment in which areas of significant improvement or areas still undergoing improvement are presented either through use of the OPSO website or through issuance of a public statement or report.

VIII. REPORTING REQUIREMENTS AND RIGHT OF ACCESS

A. OPSO shall submit periodic compliance reports to the Monitor. These periodic reports shall be provided to the Monitor within four months from the date of a definitive judgment on funding; and every six months thereafter until termination of this Agreement. Each compliance report shall describe the actions Defendant has taken during the reporting period to implement this Agreement and shall make specific reference to the Agreement provisions being implemented. The report shall also summarize audits and continuous improvement and quality assurance activities, and contain findings and recommendations that would be used to track and trend data compiled at the Facility. The report shall also capture data that is tracked and monitored under the reporting provisions of the following provisions: Use of Force; Suicide Prevention; Health Care Delivered; Sanitation and Environmental Conditions; and Fire and Life Safety.

B. OPSO shall, within 24 hours, notify the Monitor upon the death of any prisoner. The Monitor shall forward any such notifications to SPLC and DOJ upon receipt. OPSO shall forward to the Monitor incident reports and medical and/or mental health reports related to deaths, autopsies, and/or death summaries of prisoners, as well as all final SOD and IAD reports that involve prisoners. The Monitor shall forward any such reports to SPLC and DOJ upon receipt.

C. Defendant shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Monitor within seven days of request for inspection and copying. In addition, Defendant shall maintain and provide, upon request, all records or other documents to verify that they have taken the actions described in their compliance reports (e.g., census summaries, policies, procedures, protocols, training materials, investigations, incident reports, tier logs, or use of force reports).

D. SPLC, DOJ, and their attorneys, consultants, and agents, shall have unrestricted access to the Facility, prisoners, staff, and documents, as reasonably necessary to address issues affected by this Agreement. SPLC and DOJ shall provide at least seven days' notice and disclose the names of each individual to participate in the visit, each individual's role, and the purpose of the visit. SPLC shall not have to provide seven days' notice for regular attorneys' visits.

E. Within 30 days of receipt of written questions from SPLC or DOJ concerning Defendant's compliance with the requirements of this Agreement, Defendant shall provide the requester with written answers and any requested documents.

IX. MONITORING

A. Monitor Selection: The Parties will jointly select a Monitor to oversee implementation of the Agreement. Should the monitor position become vacant and the Parties are unable to

agree on a replacement, the Parties shall recommend candidates to the Court, and the Court will appoint the Monitor from the names submitted by the Parties. Neither party, nor any employee or agent of either party, shall have any supervisory authority over the Monitor's activities, reports, findings, or recommendations. Allocation of the cost for the Monitor's fees and expenses shall be determined by the Court. Should all the Parties agree that the Monitor is not fulfilling his or her duties in accordance with this Agreement, the Parties may petition the Court for the Monitor's immediate removal and replacement. One party may unilaterally petition the Court for the Monitor's removal for good cause, and the other Parties will have the opportunity to respond to the petition.

B. Good cause for the purposes of this Agreement shall mean, but not be limited to: gross neglect of duties; willful misconduct; inappropriate personal relationship with Defendant or any OPSO employee; conflicts of interest; or any criminal conduct during the pendency of this Agreement.

C. Monitor Qualifications: The Monitor and his or her staff shall have appropriate experience and education or training related to the subject areas covered in this Agreement. The Parties reserve the right to object for good cause to any member of the Monitor's staff.

D. Monitor Access: The Monitor shall have full and complete access to the Facility, all Facility records, prisoners' medical and mental health records, staff, and prisoners. OPSO shall direct all employees to cooperate fully with the Monitor. All information obtained by the Monitor shall be maintained in a confidential manner.

E. Monitor Ex Parte Communications: The Monitor shall be permitted to initiate and receive ex parte communications with all Parties.

F. Monitor Distribution of OPSO Documents, Reports, and Assessments: Within seven days of receipt, the Monitor shall distribute all OPSO assessments and reports to SPLC, DOJ, and the City. The Monitor also shall provide any OPSO compliance-related documents within seven days to DOJ, SPLC, and the City upon request.

G. Limitations on Public Disclosures by the Monitor: Except as required or authorized by the terms of this Agreement or the Parties acting together, the Monitor shall not make any public or press statements (at a conference or otherwise) or issue findings with regard to any act or omission of Defendant or Defendant's agents, representatives or employees, or disclose information provided to the Monitor pursuant to this Agreement. The Monitor shall not testify in any other litigation or proceeding with regard to any act or omission of Defendant or any of Defendant's agents, representatives, or employees related to this Agreement, nor testify regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement, nor serve as a non-testifying expert regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement. Unless such conflict is waived by all Parties, the Monitor shall not accept employment or provide consulting services that would present a conflict of interest with the Monitor's responsibilities under this Agreement, including

being retained (on a paid or unpaid basis) by any current or future litigant or claimant, or such litigant's or claimant's attorney, in connection with a claim or suit against Defendant, Defendant's departments, officers, agents, or employees. The Monitor is not a State/County or local agency or an agent thereof, and accordingly, the records maintained by the Monitor shall not be deemed public records subject to public inspection. Neither the Monitor nor any person or entity hired or otherwise retained by the Monitor to assist in furthering any provision of this Agreement, shall be liable for any claim, lawsuit, or demand arising out of the Monitor's performance pursuant to this Agreement. This provision does not apply to any proceeding before a court related to performance of contracts or subcontracts for monitoring this Agreement.

H. Monitor's Reports: The Monitor shall file with the Court and provide the Parties with reports describing the steps taken by Defendant to implement this Agreement and evaluate the extent to which Defendant has complied with each substantive provision of the Agreement. The Monitor shall issue an initial report 120 days after the Effective Date, and then every 180 days thereafter. The reports shall be provided to the Parties in draft form for comment at least 14 days prior to their issuance. The Monitor shall consider the Parties' responses and make appropriate changes, if any, before issuing the report. These reports shall be written with due regard for the privacy interests of individual prisoners and staff and the interest of Defendant in protecting against disclosure of information not permitted by this Agreement.

I. Reports issued by the Monitor shall not be admissible against Defendant in any proceeding other than a proceeding related to the enforcement of this Agreement initiated and handled exclusively by Defendant, SPLC, or DOJ.

J. Compliance Assessments: In the Monitor's report, the Monitor shall evaluate the status of compliance for each relevant provision of the Agreement using the following standards: (1) Substantial Compliance; (2) Partial Compliance, and (3) Non-compliance. In order to assess compliance, the Monitor shall review a sufficient number of pertinent documents to accurately assess current conditions, interview all necessary staff, and interview a sufficient number of prisoners to accurately assess current conditions. The Monitor shall be responsible for independently verifying representations from Defendant regarding progress toward compliance, and examining supporting documentation. Each Monitor report shall describe the steps taken by each member of the monitoring team to analyze conditions and assess compliance, including documents reviewed and individuals interviewed, and the factual basis for each of the Monitor's findings.

K. Technical Assistance by the Monitor: The Monitor shall provide Defendant with technical assistance as requested by Defendant. Technical assistance should be reasonable and should not interfere with the Monitor's ability to assess compliance.

X. ENFORCEMENT

A. The Court shall retain jurisdiction over the implementation of this Agreement at the existing OPP or any other facility used to replace or supplement OPP for all purposes.

B. During the period that the Agreement is in force, if the Monitor, SPLC, or DOJ determines that Defendant has not made material progress toward Substantial Compliance with a significant obligation under the Agreement, and such failure constitutes a violation of prisoners' constitutional rights, SPLC or DOJ may initiate contempt or enforcement proceedings against Defendant for an alleged failure to fulfill an obligation under Sections IV through X of this Agreement in Court.

C. Before taking judicial action to initiate contempt or other enforcement proceedings, SPLC or DOJ shall give Defendant written notice of its intent to initiate such proceedings, and the Parties shall engage in good-faith discussions to resolve the dispute and may petition the Court for a status conference to assist in resolution.

D. Defendant shall have 30 days from the date of such notice to cure the failure (or such additional time as is reasonable due to the nature of the issue and agreed upon by the Parties) and provide the complaining party with sufficient proof of its cure. At the end of the 30-day period (or such additional time as is reasonable due to the nature of the issue and agreed upon by the Parties), in the event that the complaining party determines that the failure has not been cured, that party may initiate contempt proceedings without further notice. The Parties commit to work in good faith with Defendant to avoid enforcement actions.

E. In case of an emergency posing an immediate threat to the health or safety of any prisoner or staff member at OPP, however, DOJ or SPLC may omit the notice and cure requirements herein and seek enforcement of the Agreement.

XI. CONSTRUCTION, IMPLEMENTATION, AND TERMINATION

A. Defendant shall implement all reforms, as designated within the provisions of this Agreement, that are necessary to effectuate this Agreement. The implementation of this Agreement will begin immediately upon the Effective Date.

B. Except where otherwise agreed to under a specific provision of this Agreement, Defendant shall implement all provisions of this Agreement within 180 days of the Effective Date.

C. This Agreement shall terminate when Defendant has achieved Substantial Compliance with each provision of the Agreement and has maintained Substantial Compliance with the Agreement for a period of two years.

D. If any unforeseen circumstance occurs that causes a failure to timely carry out any requirements of this Agreement, Defendant shall notify DOJ and SPLC in writing within

seven days after Defendant becomes aware of the unforeseen circumstance and its impact on the Defendant's ability to perform under the Agreement. The notice shall describe the cause of the failure to perform and the measures taken to prevent or minimize the failure. Defendant shall implement all reasonable measures to avoid or minimize any such failure.

E. This Agreement shall constitute the entire integrated Agreement of the Parties. No prior or contemporaneous communications, oral or written, will be relevant or admissible for purposes of determining the meaning of any provisions herein, in this litigation, or in any other proceeding.

F. The Agreement shall be applicable to, and binding upon, all Parties, their officers, agents, employees, assigns, and their successors in office.

G. Failure by any party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein, shall not be construed as a waiver of the party's right to enforce other deadlines or provisions of this Agreement.

H. If any provision of this Agreement is declared invalid for any reason by a court of competent jurisdiction, said finding shall not affect the remaining provisions of this Agreement.

XII. STIPULATION PURSUANT TO THE PRISON LITIGATION REFORM ACT, 18 U.S.C. § 3626

The Parties stipulate that this Agreement complies in all respects with the provisions of 18 U.S.C. § 3626(a). The Parties further stipulate and agree and the Court finds that the prospective relief in this Agreement is narrowly drawn, extends no further than necessary to correct the violations of federal rights as alleged by Plaintiffs in the Complaints, is the least intrusive means necessary to correct these violations, and will not have an adverse impact on public safety or the operation of a criminal justice system. Accordingly, the Parties agree and represent that the Agreement complies in all respects with the provisions of 18 U.S.C. § 3626(a). Any admission made for purposes of this Agreement is not admissible if presented by Third Parties in another proceeding.

So ORDERED this 6th day of June, 2013

LANCE M. AFRICK
UNITED STATES DISTRICT JUDGE

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APPENDIX A
Criteria that Trigger Referral for Investigation

Trigger Events Occurring in OPP	Thresholds Reached at OPP
1. Existence of resulting injuries that are extensive or serious 2. Existence of resulting injuries involving fractures or head trauma 3. Existence of resulting injuries that require treatment at outside hospitals 4. Reports of events by staff and inmates that are materially inconsistent 5. Failure to report or report accurately the use of force 6. Retaliation against an inmate or other staff member for reporting the use of excessive or inappropriate force 7. Interfered or failed to cooperate with an investigation regarding a use of force	1. Two or more use of force incidents or complaints in a 30-day period. 2. Inmate death resulting from a use of force 3. Officer arrested for suspected misconduct related to a use of force
8. Sexual conduct with an inmate	

APPENDIX B

Screening and Assessment Factors, Triggers, and Thresholds

Screening Factors	Assessment Factors	Trigger Events Occurring in Orleans Parish Prison	Thresholds Reached in Orleans Parish Prison
History, Ideation, and Observation			
Intake screening shall inquire as to the following: 1. Past suicidal ideation and/or attempts 2. Current suicidal ideation, threat, or plan 3. Prior mental health treatment or hospitalization 4. Recent significant loss - such as the death of a family member or close friend 5. History of suicidal behavior by family members and close friends 6. Suicide risk during any prior confinement 7. Any observations of the transporting officer, court, transferring agency, or similar individuals, regarding the prisoner's potential suicidal risk	Any of the following: 1. Suicide risk screening indicates moderate or high risk 2. Any suicide attempt in the past 3. Any suicidal ideations, with intent/plan within the past 30 days 4. Any command hallucinations to harm self within the past 30 days 5. Any combination of the following: a) Suicidal ideations within the past year with or without intent/plan b) Suicidal gestures (current and/or within past year) c) One or more of the following diagnoses: i) Bipolar Disorder, Depressed ii) Major Depression With or Without Psychotic Features iii) Schizophrenia iv) Schizoaffective Disorder v) Any diagnosis within the Pervasive Developmental Disorder Spectrum vi) Any other factor(s) determined by the Interdisciplinary Team (IDT) as contributing to suicide risk (e.g., recent loss, family history of suicide, etc.) 6. Any history of self-injurious behavior (SIB) resulting in injury requiring medical attention within the past year	1. Any suicide attempt 2. Any suicide ideation, with or without a plan 3. Any aggression to self resulting in major injury	1. Any suicide 2. Any suicide attempt resulting in outside medical treatment 3. Two or more episodes of suicidal ideation/attempts within 14 consecutive days 4. Four or more episodes of suicidal ideations/ attempts within 30 consecutive days

Detoxification and Use of Illicit Substances			
Intake screening shall inquire as to the following: 1. Substance(s) or medications used 2. Amount 3. Time of last use 4. History of use 5. Any physical observations, such as shaking, seizing, hallucinating, history of drug withdrawal symptoms, such as agitation, tremors, seizures, hallucinations, and D.T.'s (delirium tremens)	Any of the following: 1. Immediate history of substance use disorder. 2. History of substance use disorder within the past year. 3. Any degree of risk for potentially life-threatening withdrawal from alcohol, benzodiazepines, opiates, opioid derivatives, and other substances. 4. Vital signs appearing abnormal, when measuring body temperature, pulse rate, blood pressure, and respirations. 5. CIWA-AR score of 10 or over.	1. Any incident of an individual testing positive for illicit substance (street drug) use 2. Use of benzodiazepines (continuous for more than 60 days) in an individual with past history of substance use disorder 3. Any suicide attempt 4. Any suicidal ideation, with or without a plan 5. Any aggression to self resulting in major injury	1. Two or more incidents of illicit use in 7 consecutive days 2. Four or more incidents of illicit use in 30 consecutive days

EXHIBIT 2

PLANNING TOOL:
CONSIDERATIONS FOR CREATION OF A LANGUAGE ASSISTANCE POLICY AND IMPLEMENTATION PLAN FOR ADDRESSING LIMITED ENGLISH PROFICIENCY IN A DEPARTMENT OF CORRECTIONS

I. INTRODUCTION AND BACKGROUND

A. POLICY STATEMENT

Departments may want to consider creating a short policy statement that sets the tone and goal on language access in the agency. An example of what such a statement could potentially include is the following:

It is the policy of the _____ Department of Corrections [Sheriff's Department/Jail] ("the Department") to take reasonable steps to provide meaningful access to limited English proficient (LEP) individuals incarcerated, detained, or otherwise encountering Department facilities, programs, and activities. The policy is to ensure that language will not prevent staff from communicating effectively with LEP inmates, detainees, and others to ensure safe and orderly operations, and that limited English proficiency will not prevent inmates, detainees, or parolees from accessing important programs and information; understanding rules, participating in proceedings; or gaining eligibility for parole, probation, treatment programs, alternatives to revocation, or classifications.

B. WHO IS LIMITED ENGLISH PROFICIENT (LEP)?

LEP individuals do not speak English as their primary language and have a limited ability to read, write, speak, or understand English.

- Many LEP persons are in the process of learning English and may read, write, speak, and/or understand some English, but not proficiently.
- LEP status may be context-specific – an individual may have sufficient English language skills to communicate basic information (name, address etc.) but may not have sufficient skills to communicate detailed information (*e.g.*, medical information, eyewitness accounts, information elicited in an interrogation, etc.) in English.

C. BACKGROUND

- Federal law prohibits national origin discrimination and requires meaningful access to LEP persons, including inmates, in federal and federally assisted programs and activities.
- The task of maintaining order, ensuring a safe and secure correctional institution, and meeting corrections goals becomes extremely difficult when language barriers are not addressed.

D. PLANNING DOCUMENTS

Corrections officials have several planning documents they could choose to create.

- A general Policy could include the brief policy statement, as well as background information and as many specifics as appropriate for the agency. This policy statement could be the overarching document from which a management plan would flow.

- An Implementation Plan for managers could identify operational and management strategies and planning options for implementing the Policy. The Plan could be attached to the Policy once developed.

- Shorter directives [substitute policy guidance, general orders, or other types of direct communication with staff and managers regarding protocols and procedures, as appropriate for your Department] could be created to flow from the Plan. These directives could set forth clear expectations and procedures for staff and managers on how and when to access language service options. Where appropriate, different directives might be issued to cover different types of encounters, such as healthcare, discipline, intake, etc., so that staff responsible for the particular area have information specific to their duties.

- Language resource lists, signs, instructions on internal websites, training, videos, and other tips and tools could be created to help staff understand how and when to access and provide language assistance.

E. FRAMEWORK FOR DECIDING WHEN LANGUAGE SERVICES ARE NEEDED

The U.S. Department of Justice Limited English Proficiency Guidance for Recipients (DOJ LEP Guidance, or Guidance) sets forth a four-factor analysis for agencies to review when determining steps to take to communicate effectively with LEP individuals. The Guidance also provides examples of application of that analysis in corrections, particularly in Section B of the Appendix. (http://www.usdoj.gov/crt/cor/lep/DOJFinLEPFRJun182002.pdf) Additional information and technical assistance tools can be found at http://www.lep.gov and could also be attached to an agency's Policy as reference tools.

Four-factor analysis:

1. The number or proportion of LEP persons or inmates in the Department overall and those that would be eligible, but for limited English proficiency or English proficiency prerequisites, for different aspects of the Department's and facilities' programs and activities, and the specific language needs of those individuals.
2. The frequency of contact that the different aspects of the agencies' programs and activities have with LEP persons, or would have if LEP persons were allowed access to those programs and activities.
3. The nature and importance of the various aspects of the Department's and facilities' programs and activities; and
4. The resources available to the Department, and costs associated with different language service options.

Departments should consider the extent that past use of English proficiency prerequisites has resulted in low numbers of LEP individuals in certain programs or facilities. In such instances, the number and proportion of LEP persons may not be representative of the eligible LEP population if meaningful access were provided. If this is the case, the Department should not rely on artificially low numbers of LEP persons encountered in those programs or facilities to limit language service options. The Department should take reasonable steps to ensure meaningful access to those and other programs, as detailed in the Policy and in the Plan.

As the DOJ LEP Guidance notes, the meaningful access requirement applies to all LEP persons encountered by the Department (whether adult inmates, detainees, juveniles, or persons involved in community corrections programs). Additional constitutional, federal or state statutory, or other requirements may apply to with regard to language services as well (such as in the case of LEP juveniles

when greater rights to educational opportunities may be implicated), and should be coordinated with the Language Assistance Plan, where appropriate.

F. APPLICATION OF THE FOUR FACTORS

- The Department's Policy and/or Plan might include discussion of the four factors as applied to the Department. For example, breaking down the numbers and percentages of LEP inmates overall and in each facility, noting any trends or other information helpful to describe the linguistic characteristics of the inmate population, setting forth the nature and importance of particular types of encounters (see below for more detailed information on this point), and discussing resources available and costs associated with providing language services.

- The Policy could then reflect language service options and determinations by the Department of important areas for the provision of language services, based on the four-factor analysis. The Language Assistance Implementation Plan could provide detailed information on the protocols for accessing language services, translating vital documents, training, monitoring, and other specifics to implement the Policy.

II. DEFINITIIONS

- **Primary Language** – The language in which an individual is most effectively able to communicate.

- **Interpretation** – The act of listening to a communication in one language and orally converting it into another language, while retaining the same meaning. Interpreting is a sophisticated skill needing practice and training, and should not be confused with simple bilingualism. Even the most proficient bilingual individuals may require additional training and instruction prior to serving as interpreters. Qualified interpreters are generally required to have undergone rigorous and specialized training.

- **Translation** – The replacement of written text from one language into an equivalent written text in another language. Translation also requires special knowledge and skills.

- **Bilingual** – The ability to speak two languages fluently and to communicate directly and accurately in both English and another language.

- **Direct Communication** – Monolingual communication in a language other than English between a qualified bilingual Department employee or other bilingual person and an LEP individual (*e.g.*, Spanish to Spanish).

III. CONSIDER WHETHER THE DEPARTMENT SHOULD DESIGNATE A DEPARTMENT-LEVEL LEP COORDINATOR and FACILITY LEP MONITORS

A. LEP COORDINATOR – If a Department decides to assign an LEP Coordinator who reports to the head of the agency or some other high-ranking official, some of the responsibilities of that position could be, for example, to:

- Coordinate identification of language service needs and strategies for responding to those needs.

- Ensure identification and securing of existing and needed resources (in-house, new hires contract, resource sharing with other agencies, volunteers, or other) to provide oral and written language services.
- Identify and develop or recommend Directives/general orders to implement the Plan.
- Identify criteria for designation of languages for initial round of translation, based on demographic data and usage projections;
- Create systems to distribute translated documents, post electronically, and maintain supply;
- Identify training needs and provide for training to facility LEP Monitors, staff, and managers needing to use language services, as well as language service providers.
- Establish protocols for ensuring quality, timeliness, cost-effectiveness, and appropriate levels of confidentiality in translations, interpretation, and bilingual staff communications.
- Identify and implement a system for receiving and responding to complaints by staff, inmates, or others of ineffective language assistance measures.
- Exchange promising practices information with other departments, law enforcement, and other organizations, and amongst facilities.
- Establish a system to coordinate with the courts and jail so that inmate language needs are identified and responded to as early as possible.
- Review the progress of the Department and facilities in providing meaningful access to LEP persons, develop reports, and modify [recommend modification to] the Plan and implementing Directives/orders, as appropriate.

The Plan and Directives should set forth the name and contact information of the LEP Coordinator, if the Department chooses to assign one.

B. FACILITY LEP MONITORS – In addition, some Departments may choose to assign LEP Monitors at the facility-level. If so, LEP Facility Monitor duties could be, for example, to:

- Work with the LEP Coordinator to identify needs and strategies for meeting those needs so that staff will have access to appropriate language services in their interactions with inmates.
- Ensure the facility's compliance with the LEP Policy and Plan, including any Directives/orders.
- Provide training to facility staff on implementation of LEP Plan and Directives.
- Establish and maintain the facility's language assistance resource list, ensuring competency; revise the list as needed.
- Maintain data on selected interactions with LEP persons and provide reports to management and the LEP Coordinator, as appropriate.

The Plan and Directives should set forth the name and contact information of the Facility Monitors, if the Department chooses to assign them.

IV. LANGUAGE ASSISTANCE OPTIONS

In general, the following options should be considered in planning for providing language services:

A. ORAL LANGUAGE SERVICES

1. Direct Communication with LEP Individuals by Bilingual Staff

- Often, the most efficient and cost-effective method for communicating with LEP individuals is direct communication through qualified bilingual employees fluent both in English and the LEP person's language.

- Consider taking the following steps to ensure accurate communications:

    - Creating written standards and adopting assessments for qualifying Department employees as bilingual.
    - Assessing fluency in both languages and in the terminology used by the Department prior to designating a staff member as bilingual. A person may be able to convey simple instructions or hold conversations in an LEP individual's primary language, but not be sufficiently proficient in that language to perform more complicated tasks such as conducting interrogations, taking statements, collecting evidence, or conveying rights or responsibilities. These individuals are not yet "bilingual."
    - Providing initial and periodic training to bilingual employees on their role in direct bilingual communication, code of conduct for bilingual communications, and law enforcement terminology in other languages.

- Consider taking the following steps to improve effective utilization of bilingual officers:
    - Maintaining a directory of all qualified bilingual employees, including a list of the non-English language(s) they speak and their contact information, assignments, shifts, etc.
    - Recruiting bilingual staff and considering pay differentials or other forms of recognition for employees who do "double duty" as qualified bilingual employees.
    - Considering bilingual capabilities and language assistance needs of the inmate population and other communities encountered by the department.

2. Interpretation

When language services are needed, the Department should use qualified interpretation services when a non-bilingual employee/correctional officer needs to communicate with an LEP person or *vice versa*, when qualified bilingual employees are unavailable or *en route*, and when available bilingual employees lack the skills, rank, or assignment to provide direct communication services.

a. Options to consider include:

- Staff interpreters (trained and qualified) who are employed by the Department exclusively to perform interpretation services.

- Contract in-person interpreters, such as state and federal court interpreters, among others.

- Contract telephonic interpreters who provide interpretation according to Department guidelines. The language assistance implementation plan could set

forth telephonic interpretation options, and how to access them, including use of telephonic or radio equipment to:

- Access employees, interpreters from other agencies, or others who have been qualified as interpreters by the Department.

- Access commercial telephonic interpretation services. The Plan will set forth information on access codes and assurances of quality control for such services.

- Interpreters from other agencies with which the Department has a resource-sharing or other formal arrangement to interpret according to Departmental guidelines.

- Interpreters who also serve as bilingual sworn correctional officers or employees and have undergone training and passed Departmental language proficiency assessments and rigorous training to serve dual roles as officers/civilian employees and interpreters.

  - A bilingual person may be sufficiently proficient in English and a foreign language to have direct monolingual conversations in that foreign language with an LEP individual, but not sufficiently proficient to convert orally what is said in the foreign language back into English. Likewise, the person may be perfectly fluent in both languages, but unskilled in interpreting and untrained in the various modes of interpretation and appropriate use of those modes (simultaneous, consecutive, sight).

  - Consider creating written standards for assessing and qualifying bilingual Department employees as interpreters, and provide or secure training for qualified employees on the role of a Department interpreter, the modes of interpretation, the code of conduct for interpretation, and the use of law enforcement terminology in other languages.

- Volunteer interpreters who have undergone training and meet Departmental language proficiency standards, and have formal arrangements with the Department to perform interpretation services.

- Inmates, their family members, or unqualified volunteers should not be used for interpretation, especially for communications involving medical, psychological, or other privileged information, investigations and disciplinary procedures, collection of evidence, or other sensitive situations, except temporarily in unforeseen, emergency circumstances while awaiting professional interpretation or bilingual correctional officers.

b. Choosing Between Telephonic and In-Person Interpretation

- When interpretation is needed, in-person interpreters may be preferred (Department employees or contract) for lengthy interactions and interactions with significant potential consequences to the LEP person, such as disciplinary or grievance proceeding, parole hearings, interrogations, medical and mental health appointments.
- In general, when interpretation is needed, telephonic interpretation services are most appropriate for brief encounters, situations in which no qualified in-person interpreter is available, while awaiting a qualified in-person interpreter, and during telephone conversations with LEP persons.

B. WRITTEN LANGUAGE SERVICES

1. General Forms and Documents.

Using the four-factor analysis, the Department should translate the vital written materials into languages of frequently–encountered LEP groups (considering literacy of LEP populations in their language). Vital information from those documents should be interpreted when translations are not available for LEP or when oral communication is more effective, such as in the case of LEP individuals whose primary language is traditionally an oral one.

The Plan could set forth the documents to be translated, including languages and timeframes for such translations. For instance, the Department could consider the following format and types of documents for translations of general materials:

FORMS/DOCUMENTS – fill in appropriate identifying information	Languages	Timeframe
Intake and evaluation forms:		
Inmate orientation or rule book materials		
Documents relating to classification:		
Inmate medical consent, treatment requests, or other health care-related forms:		
Documents relating to disciplinary or administrative proceedings:		
Inmate waiver forms:		
Inmate complaint or grievance forms:		

Inmate forms for participation in counseling, vocational, work, or educational programs:		
Inmate request forms, such as those relating to diet or religion:		
Visitation forms for family and public visitors:		
Notices and posters containing important information and/or rules:		
Community corrections documents, such as notices of alleged violations, sentencing/release orders, conditions of parole, victim impact statement questionnaires, grievance procedures, etc.:		

- **Obtaining Translations:** The Plan could set forth the procedures for obtaining the initial translations, and directives could tell staff how and when to access these translations, as well as how to request additional translations.

- **Quality Control:** The Plan could set forth a quality control protocol, such as assuring initial translations and second checks by qualified individuals.

- **Updating:** The Plan could set forth steps to consider demographic changes, new information/documents, or modifications to exiting documents, leading to the need for additional translations.

2. Written Documents Containing Information Specific to Particular Inmates

a. The Department should take reasonable steps to ensure document translation and meaningful communication.
b. The more significant the communication to the LEP person, the greater the need to ensure competent and timely translations.
c. When translations are not possible or reasonable, important information should be conveyed verbally in the relevant language. Taglines or signage in the appropriate languages could inform individuals how to receive oral language assistance to understand the contents of document.
d. The department should take care to provide translation of important information consistent with this policy to the extent such written communication would be made available to English proficient inmates. For example, the following types of documents might be considered for this approach:

1. Medical prescriptions and orders.
2. Disciplinary notices, rulings, findings, etc.
3. Parole and probation decisions/findings.

4. The content of forms filled out by LEP inmates.

e. The Plan and/or implementing Directives should set forth qualified translation services (not inmates) to provide translations of documents containing information specific to a particular LEP inmate or group of inmates. They should also include quality control/second check measures and measures to ensure confidentiality and the avoidance of conflicts of interest. Further, they could include information on what to do when translations are not feasible or reasonable and oral communication of the information is more appropriate.

C. DECIDING WHICH LANGUAGE SERVICE OPTIONS TO USE

1. Fact-dependent decision.

The types of language assistance resources the Department decides to use will depend on the four-factor analysis and may be different in different types of activities and at each facility. For instance, direct services in a non-English language by bilingual staff or hiring a staff interpreter may be cost-effective ways to respond to many language needs where there are large numbers of LEP speakers of a particular language. For more rarely-encountered languages, telephonic or contract interpretation may be a preferred option.

2. Quality Control

The Plan and Directives flowing from the Policy should include, where appropriate, consideration of strategies to ensure quality control measures such as:

- Assessment and training for bilingual direct service staff.
- Interpreter quality control, ensuring that individuals used as interpreters are trained in the skill of interpreting (role, code of conduct, modes of interpretation, expectations of confidentiality, specialized terminology, etc.), are able accurately to convey information, including special terminology, in the appropriate languages, and are evaluated and monitored.
- Second-check systems for translations.
- Training and continuing skills improvement on all of the above.
- Limiting use of inmates and visitors to interpret to unforeseeable emergencies while awaiting proper interpretation or to situations in which the Policy and four-factor analysis would not result in the need for the Department to provide language services.
- Limiting use of inmates to translate written documents to general forms and other documents that are not specific to a particular inmate and do not contain any personal or confidential information, and assuring professional quality control.

V. PERSONNEL/HUMAN RESOURCE PLANNING

The Language Assistance Plan for management could include planning on personnel and human resource matters, such as:

- Consideration of language needs and inclusion of second language skills in recruitment, hiring, and promotion plans and criteria.
- Consideration of pay differentials for bilingual/interpreter staff.
- Tracking composition of staff by language ability.
- Promoting language sensitive deployment of bilingual staff and interpreters to match skills with needs.

- Providing training opportunities to improve existing language skills for staff.

The Plan should include name and contact information for persons responsible for implementing these measures, as appropriate.

VI. APPLICATION IN CONTRACTED FACILITIES

As discussed in Section B of the Appendix to the DOJ LEP guidance, Departments receiving federal financial assistance are ultimately responsible for ensuring that LEP inmates have meaningful access within a prison run by a private or other entity with which the department has entered into a contract. The management plan should consider whether to provide the staff and materials necessary to meet language services needs or to require the entity with which there is a contract to provide the services as part of the contract. Contracts and directives can provide specific information on responsibilities assigned.

VII. SPECIFIC ENCOUNTERS THAT MAY CALL FOR SPECIFIC POLICIES, PLANNING, AND DIRECTIVES

As noted in Section B of the Appendix to the DOJ LEP Guidance, a Department may find, after conducting the four-factor analysis, that there are specific types of encounters with LEP persons, or specific programs or activities, that need particular attention for planning purposes and for providing instructions to staff.

Examples of some of those activities and encounters which could be considered for prioritized attention and planning include:

A. INTAKE

1. Assessment and Evaluation.

The Department could consider the following steps in determining an LEP inmate's primary language and literacy level:

- Identifying LEP persons and their primary language at initial assessment:
  - Using language identification cards or other effective means to determine the inmate's primary language.
  - Considering the language the person spoke at home.
  - Considering whether there was a need for an interpreter in court or jail.
  - Using a bilingual person or interpreter proficient in the inmate's language to conduct the initial intake.

- Using a more thorough evaluation. Because initial screenings may be over-inclusive (*e.g.*, a person may speak a particular language at home but still be fluent in English) or under-inclusive (an inmate may be able to answer simple questions and understand simple instructions, but not be proficient enough in English to communicate, for instance, in a medical situation), a more thorough evaluation using a language assessment tool can assist in identifying the language proficiency level, orally and in writing, and therefore the language services needs of the particular inmate.

- Including information in the Plan regarding identification and assessments, including identifying responsible officials, as appropriate.

- Issuing directives to staff involved in intake to provide specific instructions for implementing the Plan.

- Setting forth, in the Plan and Directives, staff responsible and mechanisms for ensuring that each LEP inmate's language assistance requirements are in the inmate file and in inmate and institutional databases.

2. Orientation.

Consider how inmates will receive information they understand regarding the following:

- Institution rules and regulations.
- Notice to inmates on programs or services available and how to request them, including educational, vocational, training, medical, substance abuse, accommodations, religious services, or therapy.
- Language services available to LEP inmates.
- Written materials available to LEP inmates.

The Plan could set forth implementation strategies and responsible officials, while the Directives could provide specific instructions for staff involved in orientation.

B. CLASSIFICATION

Consider taking steps to avoid the following:

- Classifying or housing an inmate to his or her detriment due to limited English proficiency.

- Disqualifying in inmate, because of limited English proficiency, from important programs or services, including, for example, alternatives to incarceration and educational or treatment programs necessary to improve classification or obtain parole (*e.g.*, the Department will not exclude a LEP person from a treatment program based on English proficiency prerequisites).

Consider including in the Plan and any Directives information about how the above can be avoided and who is responsible.

C. HEALTH CARE, MEDICAL (INCLUDING MENTAL HEALTH AND DENTAL)

Consider the following:

- Using bilingual medical staff or interpreters (staff or contract) with specialized training in medical terminology.
- Translating or interpreting vital medical forms, notices, procedures, diagnoses, conclusions, and instructions available to non-LEP inmates.
- Assuring privacy and confidentiality according to system guidelines applicable to English proficient inmates.
- Including in the Plan and appropriate Directives what steps will be instituted in terms of the provision of language assistance in the health care (including mental health and dental) setting, and who is responsible.

D. ADMINISTRATIVE ACTIONS – DISCIPLINE, PAROLE, HEARINGS, ALTERNATIVES TO REVOCATION, PROGRAM REVIEW

Consider the following:

- Providing interpretation and translations so that the LEP person has a meaningful opportunity to understand and participate effectively in the proceedings.
- Translating or interpreting materials or findings made available to non-LEP inmates.
- Not using other inmates to provide translations or interpretation in this context.
- Providing LEP persons with the same parole opportunities and alternatives to revocation as similarly-situated English proficient persons.
- Including in the Plan and appropriate Directives what steps will be instituted in terms of the provision of language assistance in the discipline, parole, hearings, alternatives to revocation, and program review settings, and who is responsible.

E. ELIGIBILITY FOR INSTITUTIONAL PROGRAMS AND SERVICES

Consider the following:

- Taking reasonable steps to ensure that job training and educational programs, or reasonable alternatives (offering same or similar opportunities), are available to LEP inmates;
- Avoiding situations in which inability to participate in programs due to LEP status adversely impacts LEP inmates.
- Avoiding situations in which treatment programs and programs necessary to be eligible for parole or preferable classifications should are withheld on account of limited English proficiency.
- The role of English-as-a-Second Language in planning. Teaching English is an important strategy for ensuring access (as well as opportunity) in the long run. However, it is not a language access plan. The Department will not delay access to important programs (particularly those that would improve chances of parole, probation, or classifications) until an LEP person learns English well enough to participate without language assistance.
- Including in the Plan and appropriate Directives what steps will be instituted in terms of the provision of language assistance regarding eligibility for institutional programs and services, and who is responsible.

F. COMMUNITY CORRECTIONS PROGRAMS AND SERVICES

Consider the following with regard to the provision of language services to provide access to:

- Explanations of conditions of probation/release.
- Development of case plans.
- Setting up referrals for services.
- Supervision contacts.
- Outlining violations of probations/parole and recommendations.
- Interviews with the offender, victim, family members, or others.
- Treatment and other types of programs that allow offenders to remain safely in the community.
- Contracted community-based programming and supervision.

G. VISITATION

Consider the following:

- Providing translated visitation forms for inmates and visitors in most frequently-encountered languages;
- Posting visitation rules in most frequently encountered languages of LEP visitors.
- Ensuring that staff knows how to handle situations involving LEP visitors.
- Including in the Plan and appropriate Directives what steps will be instituted in terms of the provision of language assistance in the context of visitations, and who is responsible.

H. JUVENILE FACILITIES

- Departments responsible for juvenile facilities and programs, and those facilities and programs, should consider any additional language assistance needs that may be raised by the status of juveniles, such as, for example: mandatory education requirements; differences between adult and juvenile programs; and parental contact and information issues (including communications with LEP parents), etc.

VIII. TRAINING

Training is critical so that staff understand how to access language services, and so that those staff involved in actually providing the language services are competent to do so. Consider the following:

- Initial and periodic training for staff coming into contact with LEP persons, as well as managers and those in charge of classifications, program, treatment eligibility, medical, disciplinary, or any other aspect of this policy, on the Policy, Plan, and Directives.
- Including training on the Policy and implementing Plans, Directives, and tools in new employee orientation.
- Providing training to staff, contract interpreters, shared interpreter resources from other agencies, and community volunteers who may provide oral or written language assistance services for LEP persons on how and when it is appropriate for them to do so, confidentiality and conflict of interest requirements, necessary terminology, language skills development, and other important guidelines.
- Including in the Plan and appropriate Directives what steps will be instituted in terms of staff training, and who is responsible.

IX. LEP PROGRAM MATERIAL

Consider keeping updated copies of the LEP Policy, the Plan, Directives (or the equivalent), training opportunities, and other information and tools for ensuring language access in a central location and distributing or otherwise making them easily accessible.

X. FACILITY LANGUAGE ASSISTANCE RESOURCE LISTS

Consider creating and distributing facility language assistance resource lists, such as, for example:

- Instructions for handling emergency situations, including radio protocols for accessing language services.
- Procedures for providing language assistance, including instructions on how to work with interpreters.
- Location of language identification flash cards.
- Contact, shift, and language information for staff interpreters.
- Contact, on-call availability, and language information for contract interpreters.
- Contact numbers and language information for telephonic interpretation.

- Contact, shift, and language information for bilingual staff and officers.
- Contact, availability, and language information on community volunteers whose qualifications have been evaluated and who have been trained in confidentiality issues.
- Location and list of translated materials available for inmates and visitors.
- For obtaining additional written translations, instructions for identifying appropriate translator and ensuring quality control.

Consider including in the Plan and/or Directives a timeframe and identification of who is responsible for maintaining and distributing such resources.

XI. SIGNS IN INMATE, VISITOR, AND STAFF AREAS

Consider:

- Posting signs in inmate and visitor areas that detail important information in languages most frequently encountered.
- Posting signs in staff areas on how staff can access language services.
- Including in the Plan and/or Directives a timeframe and identification of who is responsible for posting such signs.

XII. MONITORING

Consider the following:

- Setting forth clear expectations for staff and managers regarding language assistance.
- Implementing a system to monitor effectiveness of the Plan and its implementation.
- Seeking feedback on the quality and effectiveness of the language service resources available and utilized by staff.
- Reviewing programs, the linguistic demographics of the inmate population, and the language resources available in an ongoing fashion, and more formally at least once per year (or as appropriate), and make adjustments as necessary and appropriate to ensure meaningful access and to reflect improved approaches to providing language access.
- Including in the Plan and/or Directives information on how monitoring will take place and who is responsible for it.

Departments of Corrections, Jails, and Sheriff's Departments are encouraged to copy this document and modify it as appropriate to meet the needs of the particular Department or facility. Additional information and tools can be found at http://www.lep.gov. Comments and recommendations are welcome. Please send them to: Coordination and Review Section, LEP Initiative, Civil Rights Division, U.S. Department of Justice, 950 Pennsylvania Ave., NW, NYA Bldg., Washington, DC 20530

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Larry Gann, Division Director, Health Care Services Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

EXPERT DECLARATION OF PABLO STEWART, M.D.

I, PABLO STEWART, M.D., do hereby declare:

1. I am a physician licensed to practice in California and Hawai'i, and a board-certified psychiatrist, with a specialty in clinical and forensic psychiatry. My background and experience as relevant to my expert testimony in this proceeding have previously been provided to the Court (*see* Doc. 1538-1 at 3-6), and my current CV is attached as **Exhibit 1**. I submit this declaration in support of Plaintiffs' Motion to Enforce Paragraph 14 of the Stipulation. I am competent to testify to the matters set forth in this declaration and if called to do so, would and could so testify.

2. I have been retained by plaintiffs' attorneys in the *Parsons* case as an expert on prison psychiatry and the provision of mental health services. Plaintiffs asked me to analyze ADC's policies and practices regarding provision of interpreters in group mental health care and in other health care encounters. Prior to rendering this opinion, I reviewed class members' medical records, their declarations, and reports cited herein.

OPINIONS

Effective Communication in Health Care Encounters

3. The Stipulation requires that "[f]or prisoners who are not fluent in English, language interpretation for healthcare encounters shall be provided by a qualified health care practitioner who is proficient in the prisoner's language, or by a language line interpretation service." Doc. 1185 ¶ 14. In the past, I described the problems with ADC not having interpretation for mental health encounters, or using correctional officers to translate during mental health treatment. I noted in my November 2013 report,

> Accurate mental health diagnosis and effective mental health treatment require accurate communication between the patient and the provider. The patient must be able to describe his or her emotional or cognitive state, and the provider must be able to observe often subtle cues in the patient's speech. It goes without saying that such communication requires a common language.
>
> [. . .] I am concerned that ADC has no system for providing effective, qualified, confidential interpretation for mental health diagnosis and treatment.
>
> [. . .] [A] mental health provider must make very subtle assessments, such as whether a patient is paranoid or attending to internal stimuli, and whether

> his or her thoughts are tangential. This requires an interpreter who not only is fluent in both languages, but is also specifically trained in interpretation, including specialized psychiatric vocabulary.

See 11/8/13 Report at 49-51 (filed under seal at Doc. 947-1 and 956).

4. I am familiar with the current provision of mental health services within ADC, as within the past 18 months I have joined Plaintiffs' counsel in touring Arizona State Prison Complex (ASPC)-Eyman, ASPC-Tucson, ASPC-Lewis, and ASPC-Phoenix. On each of these tours, I visited most or all of the key mental health programs in the institution, visited all mental health/suicide watch units, visited segregated units including maximum custody and detention units, interviewed key staff members and clinical leadership, and interviewed class members participating in various mental health programs. On each tour, we also requested documents and information relevant to the operations of the mental health programs at that institution.

5. In conducting my interviews of mentally ill class members, often housed in special housing units or watch units, I found many people displaying severe and disabling mental health conditions. While at each prison, I encountered class members who were so profoundly mentally ill or psychotic that pursuant to my ethical obligation as a physician, I brought them to the immediate attention of ADC officials, Defendants' counsel, and health care staff and officials at the institutions. [*See, e.g.*, Doc. 3255-1 at 19-20 (1/29/19 letter from Plaintiffs' counsel to Defendants describing patients at ASPC-Phoenix who I had identified as being in urgent need of mental health care)]

6. I stress the severity of the mental illnesses I observed, as well as the fragility of the mentally ill prisoners I encountered on these tours, because their precarious mental health conditions highlight the high stakes when they are seen by mental health staff on daily or weekly encounters. For better or worse, ADC has been entrusted with the care of many or most of the most profoundly mentally ill people in the State of Arizona, people who struggle with debilitating chronic mental health conditions who in an earlier era might have been confined to state mental hospitals. These people with mental illness are

particularly vulnerable to the harsh, stressful, chaotic, and violent conditions that prevail in ADC today, and are most at risk of self-harm and suicide.

7. I am fluent in Spanish; I have spoken it from childhood. When I visit prisons and tour mental health units and watch areas, I affirmatively seek out monolingual Spanish speakers. To a person, they will report suicidal thoughts or auditory or visual hallucinations, but when I review their medical records, there is nothing recorded that reflects that. That is of significant concern. It may be that they were not able to express their thoughts to mental health staff in a language (Spanish) that they understood. Indeed, these class members often report to me that to the extent health care staff speak Spanish, it's "tourist Spanish," and to the extent that the patients speak any English, it's "street English" or "prison English." As I detail below, effective communication is critical to establishing a durable provider-patient relationship, and it is impossible to establish such a relationship when there is a breakdown in language and nuance.

8. One of the first things mental health staff should do before commencing any encounter is ensure that they are able to effectively communicate with their patient. If they cannot do so, the encounter is largely meaningless. This is a fundamental component of providing care, and the burden should be on the staff to ensure that they are communicating fully and effectively with the patient.

9. It is an understatement to say that I am concerned when ADC admits that, more than six years after my 2013 report detailed why not providing interpretation for mental health services was deeply problematic, the Department continues not to have a reliable system in place to identify and track the class members who require an interpreter in health care encounters, nor does it have a way of tracking which staff are bilingual, as also was true in November 2013. That is simply unacceptable.

10. It is a bedrock principle of medicine that effective communication between health care staff and patients is essential to safe, quality care. A good summary of why this is the case is available in a recent white paper by the Joint Commission International, which sets evidence-based guidelines and standards for safety and quality of care in health

care services. *See* Joint Commission Int'l, *Communicating Clearly and Effectively to Patients: How to Overcome Common Communication Challenges in Health Care*, 2018, available at https://www.jointcommissioninternational.org/assets/3/7/JCI-WP-Communicating-Clearly-FINAL_%281%29.PDF, and attached hereto as **Exhibit 2**. This report describes a study that the Joint Commission conducted comparing outcomes of patients with limited English proficiency in U.S. hospitals, versus patients who were fluent in English. *Id*. at 6. The study found that almost 50% of the patients with limited English proficiency suffered some degree of physical harm, but less than 30% of the patients fluent in English suffered such harm. *Id*. "The rate at which patients with limited English proficiency suffered permanent or severe harm or death was 3.7%, compared with 1.4% of the patients who spoke English well." *Id.*, citing Divi, Koss, Schmaltz, Loeb, *Language proficiency and adverse events in US hospitals: A pilot study*, Int'l J. of Quality Health Care, April 2007;19(2):60-7.

11. It is important not only for the patient to provide information, but for the patient to receive information, and the parties can't do this in a superficial manner. When a provider (whether it be a medical or mental health provider) is trying to provide patient education, or the diagnoses and treatment modalities and options to the patient, the provider cannot engage the patient in the treatment process if the parties cannot fully and effectively communicate in a common language.

12. With regard to mental health care in particular, a recent study published in *Clinical Psychological Science* found clear and consistent differences in the use of language by those with depression, anxiety, and suicidal ideation. *See* Al-Mosaiwi and Johnstone, *In an Absolute State: Elevated Use of Absolutist Words Is a Marker Specific to Anxiety, Depression, and Suicidal Ideation*, Clinical Psychological Science, 2018, 6(4), 529–542, at https://journals.sagepub.com/doi/pdf/10.1177/2167702617747074 and attached as **Exhibit 3**. Scientists, psychologists, and psychiatrists have long observed that major depression changes the way people speak and write (sometimes referred to as "the language of depression"), most past studies of this relied upon mental health encounter

notes, while this study used computerized textual analysis of thousands of posts on 64 different online mental health fora/support groups. The computerized analysis was able to spot linguistic features including classes of words, lexical diversity, lengths of sentences, and grammatical patterns. The study confirmed what those of us who regularly see people with these conditions recognize: that there are differences in the use of language, both in terms of content and style. With regard to content, people with depression, anxiety, and suicidal thoughts are much more likely to use negative adjectives and adverbs, and first person pronouns (*e.g.*, "I," "me," "myself") instead of third-person or collective pronouns (*e.g.* "we," "us," "they"). In terms of style (how people express themselves), the use of absolutist words (conveying absolute magnitudes, *e.g.*, "always," "nothing," or "completely") was found to occur quite frequently in people with depression, given their tendency to have a more rigid, black and white view of the world. The study found that the prevalence of absolutist words (compared to control fora) was 50% greater for people with anxiety or depression, and 80% higher for people experiencing suicidal ideation.

13. The practical implication of this is clear when the primary language of the health care provider and the patient are different. A mental health provider needs to evaluate the severity of the symptoms, especially for those patients with suicidal or homicidal thoughts, or people experiencing auditory or visual hallucinations. Using as an example a patient whose primary language is Spanish and a provider whose primary language is English, even patients with some ability to converse in English will not be able to articulate and express the nuances of their current mental state the way they could if they were speaking in their native tongue of Spanish. Similarly, a provider who may speak some Spanish is not going to understand or know the nuances and phrasing by Spanish-speaking patients that may signal the degree of mental health distress, or be able to pick up on the subtleties of the Spanish language's adjectives and verb tenses.

14. One example of this that I saw was a Spanish-speaking patient who had a mental health counseling appointment, where the psychologist spoke to the patient only in English. Declaration of Amber Norris, Ex. 144, ¶ 6. As the patient explained in his

declaration, "I have learned a few words like 'happy,' 'sad,' 'angry,' and 'depressed' from other prisoners, but I cannot elaborate further in English. I cannot explain to the psychologist in English why I feel those emotions, and I cannot understand anything the psychologist says that might be able to help me feel better." *Id.* But the electronic medical record for an encounter states that interpreter services were not needed for the encounter, even though the psychologist directly quotes the patient as saying his mood as "goes happy, sad, angry, depressed...too much angry," (*id*., Ex. 148 at 1), which on the face of that quote shows the patient's limited range of ability to fully articulate his emotions in English, and the lack of nuance in the encounter.

15. This same class member also reported that a month earlier, he "had another prisoner write down what [he] needed to say in English and practiced it before going to [the] appointment." *Id*. Ex. 144, at ¶ 8. The psychiatrist noted the following in the electronic medical record:

> Today he says that he would like to get back on his zyprexa, that loxapine is not working, reports that, "I am having mood swings, I am happy, sad, angry, worrying, thinking, depressed, feel angry too much, and too much problem for sleep, I feeling bad, I put 2 HNR to other psychiatrist, I eat my fingers, I eat my nails, I bang the wall because I feel angry too much, I need help please, I am not crazy but I feeling bad, I am having too much problem, I don't want to do something wrong, I don't want to hurt someone, I need help please."

Id., Ex. 146 at 1.

16. The verbatim quotation to what the patient was saying shows that the patient was rattling off what was written down in a staccato manner and clearly isn't fluent in English ("I feeling bad"). I lack the adjectives to describe how problematic this encounter is. It is beyond comprehension that this could be seen as a nuanced exchange of information that would allow the psychiatrist to make an accurate diagnosis and treatment plan. The obligation of the psychiatrist when he or she heard the patient saying these things was to immediately pause the encounter, and secure a Spanish language interpreter to make sure they were really understanding each other. What the patient is describing ("I eat my fingers," "I bang the wall," "I don't want to hurt someone") are very serious

symptoms that needed to be thoroughly explored in a therapeutic milieu. Does "eat my fingers" mean that the patient is anxiously biting their nails, or that they are in fact chewing off parts of their fingers? Without a common language, it is impossible to know.

17. It appears that the only steps ADC and its contractors have taken to address interpretation problems in health care encounters since this case was settled, is to add a field to eOMIS that requires health care staff to answer a question regarding the need for interpreter services for a particular patient when the staff open a SOAPE note in the electronic health record system. However, I reviewed health care records for class members that showed internally inconsistent results, including staff indicating "No" in response to the question "Are interpreter services needed for this inmate," and then in the text of the medical record entry noting that the individual did in fact require an interpreter. Other examples included encounters on different days between the health care staff and the same patient, with one day's entry indicating the patient needed interpreter services, and a different day's entry indicating, without explanation, that no interpreter services were needed. These failures and discrepancies in documentation do not serve the critical goal of Paragraph 14, which is to ensure effective communication in health care encounters.

18. In another case, mental health care staff documented that an interpreter was not needed, but later quoted the patient as saying "everything is more better" and that "[s]taff used to translate briefly to clarify with him. He does speak English but with a heavy accent." *Id.*, Ex. 152 at 7. The quoted language alone suggests that the issue is not one of accent but one of lack of proficiency in the language in which the encounter is being conducted. It also is not clear what staff was asked to help "clarify" matters, as the staff person's identity does not appear to be recorded in the health care record. Paragraph 14 properly disallows custody staff from providing interpretation services during health care encounters. The use of corrections officers as interpreters in health care encounters in prison and jail settings is highly inappropriate for a number of reasons. As a threshold matter, using custody staff necessarily results in inappropriate disclosure of confidential

patient health information. The presence of custody staff may cause patients to self-censor or alter their communications with the provider, depriving the provider of critically important information. For example, if a patient is bothered by intrusive flashbacks to past trauma or the facts of their commitment offense, they may be unlikely to disclose that to the mental health provider in the presence of a corrections officer for fear that the information could get out or be used against them. Or if a patient has a medical condition that, if widely known, could subject them to physical or psychological abuse (for example, HIV positive), he is unlikely to want to discuss it in the presence of an officer.

19. Similarly, using other incarcerated people as interpreters introduces these same concerns regarding patient confidentiality and safety.

20. It is my opinion that ADC and its contractor must develop a process to promptly identify all people for whom English is not their first language, and identify their primary language. This should include people who are deaf and who communicate through sign language. Such identification should occur at intake to ADC custody. This is a standard practice in functional correctional health care systems. ADC and its contractor also must create a system by which patients can later report to health care staff that they need interpreters, so that this information is available when scheduling appointments. This is relevant for when patients who may speak and understand some English, but when confronted with a complicated health care encounter where they are trying to understand complex medical language, or who are attempting to articulate their emotional state, they realize that they need an interpreter to fully communicate with the health care providers so that they can express themselves in their primary language.

The Failure to Provide Sign Language Interpretation in Health Care Encounters

21. I was very concerned when I learned of ADC's practice not to provide sign language interpreters ("SLIs") to deaf prisoners whose primary language is American Sign Language (or other sign languages such as Pigdin Signed English or Signed Exact English) for any health care encounter, including and not limited to mental health encounters. ADC's failure to ensure effective communication for deaf people is contrary

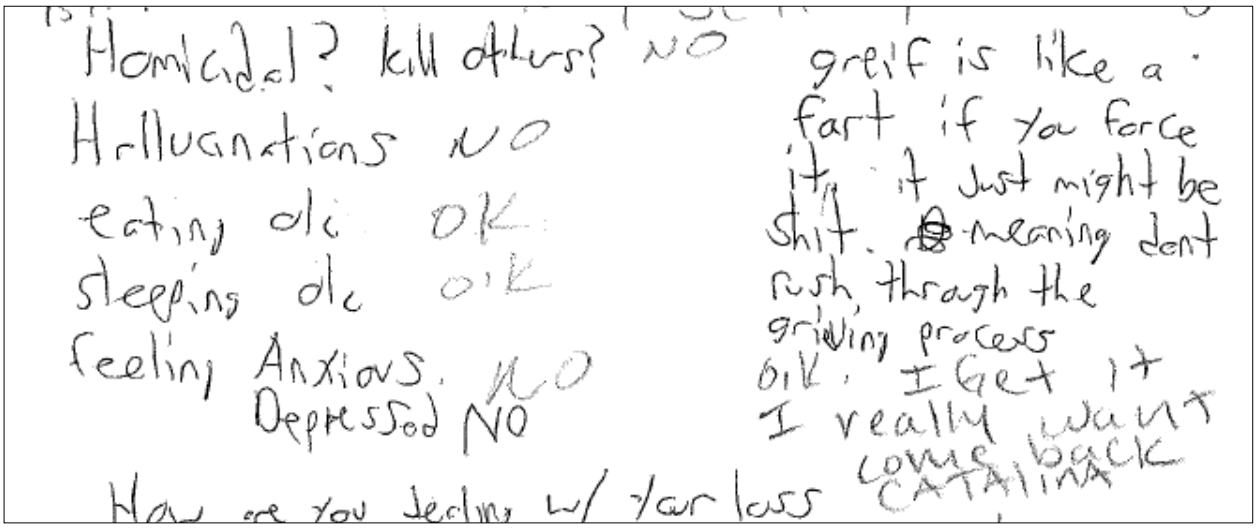
not only to Paragraph 14, but also to basic standards of effective communication in the provision of health care as detailed above. Defendants' failure to provide sign language interpretation to deaf people unnecessarily places these class members with disabilities at a significantly higher risk of serious and permanent injury than hearing class members who can communicate freely with health care staff, including mental health staff. Finally, it is well-understood by health care providers, hospitals, and clinics in the community that under the Americans with Disabilities Act, they must utilize SLIs to communicate with deaf patients.

22. I am aware that class members who are deaf and use sign language as their primary form of communication report that instead of having SLIs available for health care encounters, they are forced to attempt to communicate with health care staff by using other incarcerated people who may know a few signs as a go-between, by written notes in English, pantomiming, or lip-reading. A head-shake, "thumbs up," "thumbs down," or finger-spelling simply is not adequate to assess if a person is suicidal. With regard to written notes, given the fact that English is not the first language of most deaf people, and many if not most have limited reading / writing skills in English, this is patently inadequate for a provider to determine if patients exhibit possible signs and symptoms of a serious mental or medical condition and to provide patient education to a patient. Furthermore, research has shown that when health care providers have to rely upon written notes to communicate with deaf patients, the health care staff often write terser versions of what they would normally tell a patient, or use health care jargon. *See* Anna Middleton, ed., Working with Deaf People: A Handbook for Healthcare Professionals 59 (2010) ("A busy health professional is also likely to write in a briefer manner in a written note, given the time it takes to write one, than they would be if they were explaining in speech. This means that a deaf person, particularly a sign language user, is receiving their medical information not only in a language they do not routinely use, but also in a shorter form than their hearing counterpart would receive. It is not difficult to see that this means a substandard service is being provided."). Finally, "[l]ip-reading is difficult to do clearly,

as identical lip-patterns are often used with words which incorporate different sounds from the throat; these may be invisible to the viewer." *Id*. at 53.

23. I find it profoundly disturbing that health care leadership at ADC and their previous and current vendors are so cavalier about effective communication in health care encounters with deaf patients, a particularly isolated and vulnerable population in prison, especially when monitoring the stability and mental health of people with serious mental illness, who are incarcerated in segregated housing, and/or on suicide watch.

24. I reviewed documents from the medical records of several deaf or hearing impaired class members, as well as the declarations of deaf class members. Norris Dec. Exs. 1, 20, 52, 62, 83, 101. The documents show how deaf class members have gone for months – if not years – unable to communicate in a meaningful manner with health care staff without a sign language interpreter present. For example, one deaf class member reported that when he met with mental health staff, and had to use notes, "[w]ithout an ASL interpreter, I could not really explain my feelings of loneliness and isolation and what it is like to be deprived constantly of language." Norris Dec., Ex. 83 ¶ 40. I was appalled to see the written exchange between a psych associate and this patient when he was placed on watch after he passed out and a day after his brother committed suicide:



Id. Ex. 99 at 10.

25. Holding aside the substance of the encounter ("greif [sic] is like a fart"), this illustrates the concerns described in Paragraph 22 that the health care staff often write terser versions of what they would normally verbalize to a hearing patient. It also is an unnecessarily awkward, stilted, and slow way to communicate and does not provide an appropriate or adequate medium to engage the patient in discussion of sensitive and important mental health matters.

26. Another deaf class member reported that without an SLI in a mental health encounter, "I wanted to discuss my anxiety but I had a hard time discussing it with just pen and paper." Norris Dec. Ex. 62 ¶ 16. These patients are trying to report significant mental health issues, that if unaddressed can lead to an increased risk of self-harm or suicide. Asking a deaf person experiencing mental health issues to write down in a language they are not fluent in is unreliable and totally puts the burden of achieving effective communication on the patient. These deaf people are already burdened enough by being incarcerated, and by being in a setting where they are completely isolated from meaningful human interaction due to their disability, and it is absurd to expect that they will be able to meaningfully engage with treatment staff.

27. I was deeply alarmed to review the medical records for another patient described by medical staff in the medical record as "deaf/mute." Norris Decl., Exs. 154-155. In an individual counseling session on February 18, 2020, the mental health practitioner wrote that "Pt. responds with head shakes, head nods, or in writing." *Id.* Ex. 154 at 1. I cannot fathom how a meaningful mental health counseling encounter can be conducted in such a manner. That same deaf patient also had an individual counseling session on June 3, 2019. The psychologist wrote: "Pt. is mute and therefore the evaluation proceed with written questions that he answers with written one-word responses," and "Thought processes cannot be assessed due to pt. being mute but his written responses suggest he is logical in his thought processes." *Id.* at 153 at 1. The fact that the psychologist admitted that she could not assess "[t]hought processes" due to the manner of communication is telling. In that case, the psychologist should immediately

have obtained interpretation services and, if one was not available, rescheduled the encounter for a time when one was available. One-word responses simply are not appropriate for this type of encounter, which is meant to evaluate the patient's well-being and to provide talk therapy.

28. These barriers to effective communication by deaf class members are not limited to mental health encounters. The examples detailed in the medical records and declarations of deaf class members filed with Plaintiffs' motion confirm that deaf patients seeking care for medical concerns are similarly stymied in their ability to communicate with health care staff, which puts these people with disabilities at disproportionate risk of serious harm. Norris Dec. Exs. 1, 20, 48, 52, 62, 83, 101. These cases are clear examples of the need for SLIs to allow deaf class members who sign the opportunity for meaningful communication with health care staff. Without these interpreters, deaf people cannot communicate effectively, and their risk of physical or psychological harm is significantly greater than prisoners who can communicate verbally.

Failure to Provide Spanish Interpretation in Group Mental Health Encounters

29. As noted above in paragraph 3, I have discussed in past reports to the Court, the serious risk of harm to Spanish-speaking persons with serious mental health conditions who did not have Spanish interpretation services in one-on-one mental health encounters, or while on suicide watch. It also has come to my attention that group mental health programming provided to people in certain designated mental health units fail to provide language interpretation for people who are not fluent in English, primarily Spanish speakers.[1]

30. The people who are participating in ADC's mental health groups are doing so because they have been designated as seriously mentally ill, and live in special mental

[1] One class member has reported that in February 2020, a bilingual mental health aide began a support group for Spanish speaking patients at ASPC-Tucson Rincon Mental Health Unit, but was suspended in April 2020. Norris Dec. Ex. 165 ¶ 11. This is an excellent development, and one that I recommend below, but it needs to be implemented at all prisons, and not be dependent upon one staff person

health housing units, for example at Tucson-Rincon Mental Health Unit, Phoenix-Baker Unit and Phoenix-Flamenco Unit, or Florence-Kasson Mental Health Unit.

31. Group mental health care programs are an important component of the treatment modality for these populations. They are an incredibly effective tool because it is not just a one-on-one therapy session, but rather the individual has a whole group of other people who give feedback and point things out, and the patient can hear about others' experiences and not feel so isolated or alone. It is powerful for people to get feedback from their peers. It is frustrating and a waste of peoples' time if they are sitting in a group where they don't understand the language. In fact, it is counterproductive as they likely will feel only further isolated, frustrated, dismissed, marginalized, and alone.

32. By way of background, for many years I oversaw individual and group mental health services provided at a 12-bed psychiatric ward located at San Francisco General Hospital and as a liaison with the Jail Psychiatric Services of the City and County of San Francisco,[2] and for decades while a clinical professor of psychiatry at University of California, San Francisco School of Medicine, I supervised fourth-year medical students who led mental health group services to dually diagnosed patients at the Haight-Ashbury Free Clinic.

33. There are several ways mental health staff can ensure that non-English speakers are able to participate in a meaningful manner in group mental health sessions. As a threshold matter, ADC should track which patients assigned to group mental health sessions are not fluent in English. One approach to ensuring effective communication during these group sessions would be to have separate sessions for all of the Spanish speakers, led by mental health clinical staff who are appropriately trained, and fluent in Spanish. One advantage of this approach is that it could lead to more culturally-sensitive and appropriate care, given the dynamics and background of the group.[3]

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[2] At the time, mental health care in the San Francisco jails was subject to a consent decree in *Stone v. City and County of San Francisco*, 968 F.2d 850 (9th Cir. 1992).

[3] Likewise, if Defendants would track all deaf and hard of hearing class members who use sign language to communicate, ADC could theoretically incarcerate them

34. If there are not enough Spanish speakers at the unit to warrant a separate Spanish-language group, then simultaneous interpretation services should be provided during the group session. Simultaneous interpretation could be done unobtrusively in one of two ways. The first method would be to have a Spanish interpreter sitting near the one class member to interpret what others are saying in English, and anything the class member might want to say to the group. The other approach would be what I have done when facilitating group sessions with participants who do not all speak the same language – say a sentence or two in English, pause, and then either the provider (if fluent) or the interpreter repeats the same sentence in Spanish, and translates what the participants are saying in a similar fashion. While it may slow down the flow of the conversation, this approach allows everyone to participate, and actually by going slower, gives everyone more time to reflect upon what others are saying.

I declare under penalty of perjury that the foregoing is true and correct.

Executed June 10 2020, in Honolulu, Hawai'i.

Pablo Stewart, M.D.

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together to the extent possible, and hold separate group mental health sessions for the deaf people, led with the assistance of an in-person SLI. At the very least, either a live SLI or remote interpreter (via video remote interpretation) must be provided to ensure effective communication and participation in group sessions.

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CERTIFICATE OF SERVICE

I hereby certify that on June 12, 2020, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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Index of Exhibits to Declaration of Pablo Stewart

Exhibit	**Description**
1	Curriculum vitae of Pablo Stewart, M.D. (updated June 2019)
2	Joint Commission Int'l, *Communicating Clearly and Effectively to Patients: How to Overcome Common Communication Challenges in Health Care*, 2018, available at https://www.jointcommissioninternational.org/assets/3/7/JCI-WP-Communicating-Clearly-FINAL_%281%29.PDF
3	Al-Mosaiwi and Johnstone, *In an Absolute State: Elevated Use of Absolutist Words Is a Marker Specific to Anxiety, Depression, and Suicidal Ideation*, Clinical Psychological Science, 2018, 6(4), available at https://journals.sagepub.com/doi/pdf/10.1177/2167702617747074

Exhibit 1

CURRICULUM VITAE

PABLO STEWART, M.D.
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Honolulu, HI 96815
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e-mail: pablo.stewart.md@gmail.com
(Updated June 2019)

EDUCATION:

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

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

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

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

LICENSURE:

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

ACADEMIC APPOINTMENTS:

July 1, 2019-Present	Clinical Professor/Psychiatrist, University Health Partners (UHP), University of Hawaii, John A. Burns School of Medicine.
February 22, 2018-February 22, 2019	Academic Appointment: Clinical Professor, Department of Psychiatry, University of Hawaii, John A. Burns School of Medicine.
September 2006-Present	Academic Appointment: Clinical Professor, Department of Psychiatry, University of California, San Francisco. School of Medicine.
July 1995 - August 2006	Academic Appointment: Associate Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1989 - June 1995	Academic Appointment: Assistant Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.

August 1986 - July 1989	Academic Appointment: Clinical Instructor, Department of Psychiatry, University of California, San Francisco, School of Medicine.

EMPLOYMENT:

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 -	Senior Attending Psychiatrist, Forensic Unit, University of

August 1990	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;

Officer in Charge of a Vietnamese Refugee Camp. Received an Honorable Discharge. Highest rank attained was Captain.

HONORS AND AWARDS:

June 2015	Recognized by the Psychiatry Residents Association of the University of California, San Francisco, School of Medicine, Department of Psychiatry for "Excellence in Teaching" for the academic year 2014-2015.
June 1995	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1994/1995.
June 1993	Selected by the class of 1996, University of California, San Francisco, School of Medicine as outstanding lecturer, academic year 1992/1993.
May 1993	Elected to Membership of Medical Honor Society, AOA, by the AOA Member of the 1993 Graduating Class of the University of California, San Francisco, School of Medicine.
May 1991	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1990-1991.
May 1990	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1989-1990.
May 1989	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1988-1989.
May 1987	Selected by the faculty and students 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- September 2010	Psychiatric and Substance Abuse Consultant, San Francisco Police Officers' Association.
January 2002- June 2003	Psychiatric Consultant, San Francisco Sheriff's Department Peer Support Program.
February 2003- April 2004	Proposition "N" (Care Not Cash) Service Providers' Advisory Committee, Department of Human Services, City and County of San Francisco.
December 2003- January 2004	Member of San Francisco Mayor-Elect Gavin Newsom's Transition Team.
February 2004- June 2004	Mayor's Homeless Coalition, San Francisco, CA.

April 2004- January 2006; February 2017- October 2018	Member of Human Services Commission, City and County of San Francisco.
February 2006- January 2007; April 2013- January 2015	Vice President, Human Services Commission, City and County of San Francisco.
February 2007- March 2013; February 2015- 2017	President, Human Services Commission, City and County of San Francisco.

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:

December 2018- May 2019	Lecturer, Department of Psychiatry, JABSOM, University of Hawaii.
September 2016- June 2018	Evidence-Based Inquiry Facilitator for the *Bridges Curriculum*, University of California, San Francisco, School of Medicine.
August 2014- June 2018	Small Group Facilitator, Foundations of Patient Care, University of California, San Francisco, School of Medicine.
July 2003- June 2018	Facilitate weekly psychotherapy training group for residents in the Department of Psychiatry.
January 2002- January 2004	Course Coordinator of Elective Course University of California, San Francisco, School of Medicine, "Prisoner Health." This is a 1-unit course, which covers the unique health needs of prisoners.
September 2001- June 2003	Supervisor, San Mateo County Psychiatric Residency Program.
April 1999- April 2001	Lecturer, UCSF School of Pharmacy, Committee for Drug Awareness Community Outreach Project.
February 1998- June 2000	Lecturer, UCSF Student Enrichment Program.
January 1996 - November 1996	Supervisor, Psychiatry 110 students, Veterans Comprehensive Homeless Center.
September 1990- December 2002	Supervisor, UCSF School of Medicine, Department of Psychiatry, Substance Abuse Fellowship Program.
September 1994 - June 1999	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Drug and Alcohol Abuse." This is a 1-unit course, which covers the major aspects of drug and alcohol abuse.
August 1994 -	Supervisor, Psychiatric Continuity Clinic, Haight Ashbury

February 2006	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:

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

	LKK-JFM. The litigation involves plaintiffs' claim that overcrowding is causing unconstitutional medical and mental health care in the California state prison system. Plaintiffs won an order requiring the state to reduce its population by approximately 45,000 state prisoners. My expert opinion was cited several times in the landmark United States Supreme Court decision upholding the prison population reduction order. *See Brown v. Plata,* __ U.S. ___, 131 S. Ct. 1910, 1933 n.6, 1935, 179 L.Ed.2d 969, 992 n.6, 994 (2011).
July/August 2008-Present	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-	Psychiatric Consultant to the San Francisco Campaign

July 2001	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 -	Baseball, Basketball and Volleyball Coach, Convent of the

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

PRESENTATIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35. The California Council of Community Mental Health Agencies Winter Conference, 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)

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

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

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

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

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

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

PUBLICATIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit 2

Joint Commission International

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Communicating Clearly and Effectively to Patients

How to Overcome Common Communication Challenges in Health Care

A White Paper by Joint Commission International

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Executive Summary

Effective communication between health care providers and patients and their families is essential to safe, quality care. Studies have clearly shown that poor or missing communication between providers and patients can lead to patient harm or even death. This white paper from Joint Commission International provides a high-level overview of common communication challenges and shortcomings, including the following:

- Inadequate handovers or transitions of care
- Poor discharge planning and inadequate or unclear patient instructions
- Language problems such as limited English proficiency, literacy, and health literacy of patients
- Cultural barriers and misunderstandings
- Age-related challenges
- Errors in test results and medical orders

The white paper then identifies solutions to improve these common health care communication problems, offering tools, tips, and strategies. The white paper concludes with how Joint Commission International standards address these challenges with evidence-based best practices that lead to improved health care communication and thereby better patient outcomes.

Communicating Clearly and Effectively to Patients

How to Overcome Common Communication Challenges in Health Care

While much has been written about the doctor-patient relationship, modern health care has fostered relationships with numerous providers for many patients. A patient receiving care for one or more medical conditions may communicate regularly with several different health care providers located in multiple settings. Hospitalized patients may encounter two to three different shifts of staff each day, as well as various physicians, nurses, and teams making rounds and other staff administering tests or providing treatment. In ambulatory settings in various locations, a patient may see a primary care provider as well as different specialists, along with staff associated with each of them.

As a result, a patient often must piece together communications of varying quality to assemble a picture of his or her health status—a picture that still likely lacks the proper context, completeness, and accuracy. In some cases, this unclear picture can result in serious problems. Inadequate communication can lead to malpractice claims, patient harm, and/or death. Communication failures in United States hospitals and medical practices were responsible at least in part for 30% of all malpractice claims, resulting in 1,744 deaths and $1.7 billion in malpractice costs over five years, according to the Risk Management Foundation of the Harvard Medical Institutions.[1] Of Massachusetts General Hospital residents surveyed by Kitch and colleagues, 59% reported that one or more of their patients had been harmed during the residents' most recent clinical duty due to problematic and ineffective communication.[2]

Ineffective communication has become such a major concern that both The Joint Commission and Joint Commission International (JCI) have incorporated recommendations relating to communications into National Patient Safety Goals (NPSGs) and International Patient Safety Goals (IPSGs) respectively to address the problem.[3,4] All U.S. and internationally accredited health care organizations are expected to comply with these goals, which address aspects of communication including correct patient identification, proper handoff communication among caregivers, the safe use of high-alert medications, and more. In addition to these goals, Joint Commission and JCI hospital standards, recommendations and tools assist health care organizations wishing to improve their communications. These evidence-based solutions have worked well for many organizations.

Common communication shortcomings or challenges

Throughout the care process, patients and their families expect to receive sufficient information to understand the goals of their care and to make knowledgeable decisions. At the end of a hospital stay or when a caregiver transfers the care of a patient to another provider, a thorough summary of this information is generally given to the patient, including discharge and follow-up care instructions. However, every patient has different learning capacities and literacy skills, often relating to language preferences, cultural backgrounds, and age differences. In addition, health care providers often work according to varying standards and cultural norms, leading to substandard communication and mistakes that could have been avoided.

The factors highlighted in the following paragraphs are common contributors to communication lapses that can lead to suboptimal patient health outcomes. All these factors are affected by the pressure of working in a sometimes understaffed, fast-paced care health care environment, which contributes to errors caused by multitasking, interruptions or distractions, memory lapses, fatigue, stress and sleep deprivation—all potentially compromising the safety of patients.

1. Inadequate handovers. Inadequate handover communication, also referred to as handoff communications or transitions of care, is a major factor contributing to adverse events, including sentinel events causing significant harm or death to patients. These handovers occur between health care practitioners (for example, physician to physician, physician to nurse, nurse to nurse, and so on); between different levels or locations of care in the same hospital (for example, emergency department to surgery); between providers at two different organizations (for example, hospital to home care); and between health care practitioners and the patient and family (for example, at discharge).[5]

Joint Commission data indicate inadequate handovers are a factor in 80% of all adverse events, which include wrong-site, wrong-procedure, or wrong-patient surgeries; treatment delays; medication errors; and falls. Research indicates that only 8% of medical schools "teach how to hand off patients in formal didactic session."[6] Factors contributing to inadequate handovers include incomplete patient assessment or medical record review, a culture that does not support open communication among team members, problems related to illegible handwriting, and confusion caused by abbreviations. In addition, a lack of standardized procedures explaining how to do effective transitions within an organization—and the failure of leadership to develop standards and train staff to use them—contribute to inadequate handoffs as well.

2. Inadequate discharge planning or instructions. Discharging a patient without a well-considered plan can lead to readmission, lack of adherence to the plan, and difficulty with managing medications and follow-up treatments. A common mistake by providers is giving patients information including complex and unfamiliar terminology shortly before discharge, without taking the time to explain it and make sure the patient understands it. Providers working in understaffed organizations can find themselves under pressure to discharge patients "quicker and sicker" without a detailed discharge plan.

3. Limited English proficiency as well as literacy and health literacy deficiencies. A Joint Commission study of patients with limited English proficiency in U.S. hospitals examined the characteristics—impact, type, and causes—of adverse events experienced by these patients versus patients who could communicate well in English. Some degree of physical harm occurred to 49.2% of the patients with limited English proficiency, but to only 29.5% of the patients who spoke English well. Among those who suffered harm, 47% of the patients with limited English proficiency had moderate temporary harm or worse, compared with only 25% of the patients who could speak English well. The rate at which patients with limited English proficiency suffered permanent or severe harm or death was 3.7%, compared with 1.4% of the patients who spoke English well.[7]

Statistics from the United Nations Educational, Scientific, and Cultural Organization (UNESCO) Institute of Statistics show that about 750 million adults (about 16% of the world's adult population) lack basic literacy skills.[8] Even a higher percentage may have health literacy deficiencies. For example, more than 89 million people in the United States (about one in four) have limited health literacy. A Canadian study showed that 60% of Canadian adults have limited health literacy skills, and studies from Europe, Australia, and Latin America have reported similar findings.[9]

4. Cultural barriers. Providing efficient and effective care requires having conversations in which the provider and patient both understand the meaning of words, concepts, and metaphors.[10] Establishing this kind of effective communication often requires a provider to share cultural knowledge with a patient. Bridging the cultural gap often requires extra effort or resources. Cultural differences

also affect the working relationships between providers, as physicians and nurses, for example, sometimes have different value systems relating to how patients are cared for and treated.[11,12]

5. Age-related challenges. Children mature at different rates and have different capacities to understand and participate in decisions about their health care. While living with a chronic or terminal illness can greatly accelerate a child's level of maturity, children who seem capable of making rational decisions still need support from their families. There are particularly unique challenges associated with communicating with adolescents. For example, adolescents may not readily disclose information for fear of being judged. Adolescents are the least likely of all age groups to receive medical care, yet are the age group most likely to engage in high-risk behaviors that may result in a need for medical care.[13]

At the opposite end of the age spectrum, elderly patients have their own set of unique considerations. Some elderly patients may have cognitive deficits or hearing disabilities, which make communication more challenging. Multiple comorbidities also contribute to miscommunication between caregivers and elderly patients. Effective communication with patients and families is particularly important at the end of life, especially when communicating with families about withdrawing of life-sustaining treatment.

6. Errors in medical orders and test results. Verbal orders or test results, given both in person and over the telephone to patients and fellow providers, are another type of error-prone communication. Different accents, dialects, and pronunciations can make it difficult for the receiver to understand the order or result. Sometimes, drug names and numbers sound alike, such as erythromycin and azithromycin or 15 and 50, affecting the accuracy of the order or result. Background noise, interruptions, and unfamiliar drug names and terminology often compound the problem.

Solutions to improve communications

Health care providers can improve communications with patients during key moments in their relationships— from admission to discharge to follow-up care—by understanding common communication challenges and implementing solutions shown by evidence to improve communication outcomes. Improving the quality and consistency of communication along the continuum of care is a challenge facing health care providers, particularly at points of transition, or handovers, between them.

1. Improve handover communications. Communicating critical information about the patient every time he or she is transferred is essential, whether the transfer is from one care provider to another, from one level of care to another, or from one facility to another, including discharge to home. When the patient and family are included in the hand-off process, they can clarify information and ask and answer questions. Handoffs are optimally done face to face between providers; at a minimum, verbal communication should supplement written records so there is the opportunity to clarify information and ask questions.

Conducting transitions of care at the bedside has become common practice in many organizations. Transitions of care at the bedside allow for patient and family participation in the patient's care. Research conducted on six wards in two hospitals in Queensland and Western Australia demonstrated that bedside handovers (transitions of care at the bedside) were a successful means of communication in a variety of clinical settings; many organizations such as the Griffith University, Australia, developed a standard operating protocol for bedside handover.[14]

Keeping the patient's medical record current is an important aspect of handover communications because all health care practitioners must have information about the patient's current and past medical experiences to help make the best decisions. JCI standards require the medical record to be available during inpatient care, for outpatient visits, and at other times as needed. Making medical, nursing, and other patient care notes available to all the patient's health care practitioners is vital for the optimal care of the patient.[5]

JCI requires the use of standardized methods, forms, or tools to facilitate consistent and complete handovers of patient care, including 1) I PASS THE BATON, 2) SBAR, and 3) The Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™.

1. I PASS THE BATON

The U.S. Agency for Healthcare Research and Quality provides an effective example of a hand-off checklist of critical information, using the "I PASS THE BATON" acronym:

I = Introduction—Introduce yourself and your role/job (include patient).
P = Patient—Name, identifiers, age, gender, and location
A = Assessment—Presenting chief complaint, vital signs, symptoms, and diagnosis
S = Situation—Current status/circumstances, including code status, level of uncertainty, recent changes, and response to treatment
S = Safety Concerns—Critical lab values/reports, socio-economic factors, allergies and alerts (falls, isolation, and so on)

[THE]

B = Background—Comorbidities, previous episodes, current medications and family history
A = Actions—What actions were taken or are required? Provide brief rationale.
T = Timing—Level of urgency and explicit timing and prioritization of actions
O = Ownership—Who is responsible (nurse/doctor/team)? Include patient/family responsibilities.
N = Next—What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

2. SBAR (Situation—Background—Assessment—Recommendation)

Many health care organizations have adopted the SBAR technique to standardize their processes for transitions of care. The SBAR technique was originally used by the U.S. military for nuclear submarines. A patient safety team from Kaiser Permanente in Oakland, California, developed a health care version of this technique to facilitate communication between providers during transitions of care.

S = Situation: What is the situation about which you are calling?
- Identify yourself, the unit, and the patient (by using two patient identifiers—name and birthdate).
- Briefly state the problem: what it is, when it started, and the severity

B = Background: Provide background information relevant to the situation, which may include the following:
- The patient's chart or electronic health record
- The admitting diagnosis and date and time of admission
- A list of current medications
- Allergies, intravenous fluids, and labs
- The most recent vital signs
- Lab results, with the date and time each test was performed and results of previous tests for comparison
- Other clinical information

A = Assessment: What is your assessment of the situation?
R = Recommendation: What is your recommendation, or what do you want? For example, do you want the patient to be admitted, the patient to be seen now, or an order to be changed?

3 The Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

This protocol uses multiple strategies to achieve the goal of always identifying the correct patient, correct procedure, and correct site. The essential elements of the Universal Protocol are the following:

- Verifying the correct patient, procedure, and site
- Ensuring that all relevant documents, images, and studies are available, properly labeled, and displayed
- Verifying that any required blood products, special medical equipment, and/or implants are present
- Actively involving the patient in the site marking whenever possible and having the mark be visible after the patient is prepped and draped

2. Discharge patients effectively. A crucial factor in transitions of care at discharge is understanding the environment to which the patient will be returning or transferred. Can the environment sustain the treatment that has been initiated, or is a different environment required? It is imperative to understand the ability and willingness of the patient's caregiver to provide needed care. It is helpful to understand the services the patient had prior to admission, for example, home care. Care providers from such services may continue to provide ongoing care and treatment so they must be included in communications.

Effectively discharging patients requires the communication of follow-up instructions about referrals, transfers, or ongoing self-care in a standardized fashion. Following the "5 Ds of discharge" is one way of making sure the patient understands what he or she must do to ensure successful continuity of care and care outcomes.

1. **Diagnosis**—Does the patient understand his or her diagnosis and why he or she was in the hospital or receiving care from the physician?
2. **Drugs**—Does the patient know each medication he or she must take, the reason for the medication, when to take the medication, and how to administer it (swallow, sub-lingual, chew, subcutaneous, intramuscular, inhale, and so on)? Also, does the patient have the resources to obtain the medications?
3. **Diet**—Does the patient know and understand any dietary restrictions? Does the patient need a nutrition consult?
4. **Doctor follow-up**—When should the patient see the doctor next? Can the patient make the necessary appointment and get appropriate transportation? Include the name and location of sites for continuing care.
5. **Directions**—Are there any other directions necessary to increase the patient's ability to achieve optimal health? Does the patient understand, for example, when urgent care should be obtained?

Include family members in the discharge process when a patient's condition or abilities prevent him or her from understanding the follow-up instructions or when family members play a role in the continuing care process. Provide all instructions in a simple, understandable manner in language the patient understands. If complex care instructions are given, allow enough time for patient and family comprehension. Conduct discharge conversations when the patient is not influenced by illness, lack of sleep, or medication side effects. Written instructions reinforced by verbal communication and "teach-back" are most effective, without leaving anything to memory. This process includes having the patient and participating family members repeat back the information they received to demonstrate understanding and having them perform a treatment or procedure they must do on their own at home.

When the care team changes as a result of a discharge, continuity of patient care requires that essential information related to the patient be transferred with him or her. To ensure that the new care team receives this information, the discharge summary covers the reason for admission, significant findings, diagnosis, procedures performed, medications and other treatments, and the patient's condition at transfer.[5]

3. Accommodate language and literacy needs. Accommodating patients' language and literacy needs is an important task for every health care organization. This work begins by knowing the language needs and literacy levels of the population and community served. Training staff to identify and respond appropriately to patients with literacy and language needs—including the use of medical interpreters—contributes to a patient-centered environment that values clear communication in all interactions with patients, from the reception desk to discharge planning.

Training staff members to recognize the behaviors of patients with low health literacy skills is necessary because many patients have become adept at hiding these deficiencies. Many clinicians mistakenly assume that patients can read and understand complex materials. Regardless of a patient's educational or demographic background, assume that he or she needs help understanding health conditions and treatment options and what is being done for them and why. When patients do not understand their treatments, they may become frustrated and uncooperative, which can lead to longer hospital stays, higher health care costs, opportunities for medical errors, and compromised patient safety.

Use multiple teaching methods to meet the needs of patients with different learning styles. For example, when educating patients, use pictures, models, audio recordings, or video recordings instead of only providing verbal instructions or giving them written materials.

4. Overcome cultural barriers. JCI standards require hospitals to reduce cultural barriers when communicating with patients.[5] Respect patients' cultural preferences, and eliminate barriers to health care access and delivery of services. Keep in mind the needs of your diverse patient population. Patients may be aged, have disabilities, or speak multiple languages or dialects.

5. Meet age-related needs. Primary school children may be able to participate in their health care decisions, but parents make final decisions about their care. Clinicians can give children age-appropriate information about their care, but should understand that children of this age may agree or disagree with their plan of care without fully understanding its implications.

Uphold confidentiality with all patients. It is particularly important to reassure adolescents that everything discussed is confidential. Explain all medical procedures fully before commencing. Some adolescents are able to make the same types of decisions as adults. To ensure that an adolescent can make appropriate health care decisions, assess the adolescent's ability to understand and communicate relevant information, think and make choices with a degree of independence, and assess the potential benefits, risks, and consequences of multiple options.

The following tips from the U.S. National Institute on Aging can help clinicians communicate better with elderly patients.[15]

- Introduce themselves clearly by name and role.
- Assess and compensate for vision and hearing problems that can affect communication.
- Establish respect from the outset by using formal terms of address, such as Mr., Mrs., or Ms.
- Decrease anxiety by asking questions about family or outside interests.
- Avoid rushing elderly patients, and give them enough time to talk about their concerns.
- Speak slowly to give patients time to process what is being said.
- Try not to interrupt patients early in the interview because when interrupted, patients are less likely to reveal all their concerns.
- Use simple, common language, and ask patients if they understand what is being said.
- Tell the patients when changing the subject.
- Give clues such as pausing briefly, speaking a little bit more loudly, gesturing toward what will be discussed, gently touching the patient, or asking a question.

When educating elderly patients, consider asking if they have brought or are wearing the right eyeglasses. Use alternatives to printed materials, such as tape-recorded instructions, large pictures or diagrams, or other aids if elderly patients have trouble reading because of either sensory impairment or low literacy skills.

6. Communicate accurate medical orders and test results. JCI standards recommend limiting verbal communication of prescription or medication orders to urgent situations only, when immediate written or electronic communication is not feasible and when the prescriber is present and the patient's chart is available. Other exceptions include during a sterile procedure or life-threatening emergency.[5]

JCI standards also require the development of guidelines for requesting and receiving test results on an emergency or STAT basis, the identification and definition of critical tests and critical values, and the identification of to whom and by whom critical test results are reported. Monitoring compliance with reporting critical test results is vital. Furthermore, it is important to *write down*, or enter into a computer, the complete order or test result by the receiver of the information. The receiver should *read back* the order or test result, and the sender must confirm that what has been written down and read back is accurate.[5]

JCI standards can help improve your organization's communications with patients

In addition to what has been covered above, JCI standards provide these recommendations:[5]

- Communicate the expected cost of care clearly to patients and/or their families.
- Orient patients to the inpatient environment and equipment related to the care and services provided.
- Inform patients about all aspects of their medical care and treatment, and encourage them to participate in care and treatment decisions, including having the right to refuse or discontinue treatment, withhold resuscitative services, and forgo or withdraw life-

sustaining treatments (based on the laws, regulations, and culture of the country).

- Obtain patient informed consent for surgery, anesthesia, procedural sedation, use of blood and blood products, and other high-risk treatments and procedures through a process defined by the hospital and carried out by trained staff in a manner and language the patient can understand.
- Prepare a written statement of patient and family rights and responsibilities that is given to patients or visible to the outpatient population. Develop a statement that is appropriate to the patient's age, understanding, and language. When written communication is not effective or appropriate, the patient and family need to be informed of their rights and responsibilities in a language and manner they can understand.

By following evidence-based practices developed to improve communications, health care providers can develop better relationships with patients, leading to better health outcomes. JCI stands ready to assist through its standards and other tools designed with the needs of patients and providers in mind.

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Exhibit 3

Corrigendum

ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

Clinical Psychological Science
1–2

DOI: 10.1177/2167702619843297
www.psychologicalscience.org/CPS
SAGE

Corrigendum: In an Absolute State: Elevated Use of Absolutist Words Is a Marker Specific to Anxiety, Depression, and Suicidal Ideation

Al-Mosaiwi, M., & Johnstone, T. (2018). In an absolute state: Elevated use of absolutist words is a marker specific to anxiety, depression, and suicidal ideation. *Clinical Psychological Science, 6*, 529–542. doi:10.1177/2167702617747074

There were errors in some of the statistics reported in this article. In all three studies, a mixed-effects model was used in which forum, the random factor, was nested within condition, the fixed factor. The model was estimated correctly, and all statistical tests and inferences are correct. However, in hand calculating standard deviations, the authors mistakenly used the degrees of freedom (*df*) for forums rather than the *df* for each condition. Thus, the reported standard deviations are too high, and in cases in which these standard deviations were used to calculate standardized effect sizes (Cohen's *d*), the reported effect sizes are too low. None of the model statistics or inferences are affected, nor are any of the raw effect sizes. The corrections detailed below do not alter the article's results or conclusions.

On page 533, in the first paragraph of the Results section, before the sentence beginning "Mixed-effects models . . . " on line 9, the following new sentence needs to be inserted:

> Because low-frequency words cannot be measured reliably at the members level, we used the forums as the subject's category. This is important in comparing the performance of different dictionary dimensions. Effect sizes (Cohen's *d*) were calculated from the *t* values produced by the mixed-effects model ($d = 2t\sqrt{df}$).

Also on page 533, in the third paragraph of the Results section, all of the standard deviations and confidence intervals are incorrect. The entire corrected paragraph appears below:

Multilevel mixed-effects model for the absolutist index. There was a large, significant difference in the absolutist index between the Study 1 groups, as determined by a multilevel mixed-effects model, $F(3, 29) = 71.549$, $p < .001$. Using paired comparisons in the mixed-effects model, we compared the control group with each of the Study 1 test groups to assess our first hypothesis. We also compared the suicidal ideation forum group with the remaining two test groups (anxiety and depression forums) to assess our second hypothesis. The mean absolutist index for the control forum group ($M = 0.97\%$, $SD = 0.11$) was significantly lower than anxiety ($M = 1.45\%$, $SD = 0.10$, $p < .001$, $d = 3.24$, 95% CI = [0.36, 0.52]), depression ($M = 1.45\%$, $SD = 0.10$, $p < .001$, $d = 3.14$, 95% CI = [0.35, 0.52]), and suicidal ideation ($M = 1.80\%$, $SD = 0.14$, $p < .001$, $d = 4.56$, 95% CI = [0.72, 0.98]) test forum groups. Moreover, the suicidal ideation group was significantly greater than both the anxiety ($p < .001$, $d = 1.74$, 95% CI = [–0.54, –0.29]) and depression ($p < .001$, $d = 1.71$, 95% CI = [–0.54, –0.29]) groups (Fig. 1a). These results are consistent with both of our Study 1 hypotheses. Post hoc comparisons with a Bonferroni correction revealed that there was no significant difference between anxiety and depression forum group means ($p = 1.00$).

On page 536, in the first paragraph of the Study 2 section, all of the standard deviations, confidence intervals, and effect sizes are incorrect. The entire corrected paragraph appears below:

Multilevel mixed-effects model for the absolutist index. Our third hypothesis predicted that mental health forum groups strongly associated with absolutist thinking (BPD and ED) would use more absolutist words than mental health forum groups less associated with absolutist thinking (PTSD and schizophrenia). A multilevel mixed-effects analysis found that there was a significant difference in the absolutist index between Study 2 groups, $F(3, 16) = 5.515$, $p = .009$. Paired comparisons revealed that the mean absolutist index for the BPD forum group ($M = 1.47$, $SD = 0.12$) was significantly greater than the PTSD ($M = 1.13$, $SD = 0.07$, $p < .001$, $d = 1.93$, 95% CI = [–0.38, –0.14]) and the schizophrenia forum groups ($M = 1.14$, $SD = 0.10$, $p < .001$, $d = 1.94$, 95% CI = [–0.42, –0.20]). They also revealed that the absolutist index of the ED forum group ($M = 1.25$, $SD = 0.12$) was significantly greater than the schizophrenia ($p = .009$, $d = 0.81$, 95% CI = [–0.25, –0.05]) but not PTSD ($p = .081$, $d = 0.84$, 95% CI = [–0.22, 0.01]) forum groups (Fig. 1b). A critical assumption in this contrast is that the control and test groups have similar levels of psychological distress. We sought to verify this assumption using the LIWC negative emotions dictionary. A paired comparison found no significant difference in the mean negative emotions index between the Study 2 control ($M = 3.51$, $SD = 0.73$) and test ($M = 3.71$, $SD = 0.31$, $p = .335$) forum groups (Fig. 1c). Therefore, it seems that absolutism is associated with certain types of psychopathology forums and not psychological distress forums per se.

Finally, also on page 536, in the first paragraph of the Study 3 section, all of the standard deviations, confidence intervals, and effect sizes are incorrect. The entire corrected paragraph appears below:

Multilevel mixed-effects model for the absolutist index. Our final hypothesis predicted that the recovery forum group would use significantly more absolutist words than the Study 1 control forum group. Paired comparisons in a multilevel mixed-effects model found that the mean absolutist index of the recovery forum group ($M = 1.31\%$, $SD = 0.14$) was significantly greater than the Study 1 control forum group ($p < .001$, 95% CI = [–0.41, –0.24], $d = 2.02$). Paired comparisons also found a significant difference in the absolutist index between the recovery forum group and the anxiety group ($p = .018$, 95% CI = [–0.01, 0.23], $d = 0.56$) and depression group ($p = .018$, 95% CI = [–0.01, 0.22], $d = 0.52$). Like the anxiety and depression groups, the recovery group also had a significantly lower absolutist index than the suicidal ideation group ($p < .001$, 95% CI = [0.37, 0.67], $d = 2.31$). Although the absolutist index of the recovery group was significantly different from anxiety and depression groups, the more accurate bias-corrected CIs reveal that the differences are marginal; relative effect sizes reveal that the recovery group absolutist index is closer to anxiety and depression ($d < 0.56$) than to the control group ($d = 2.02$; Fig. 2a). We noted earlier that the contents of the recovery forums were very positive. To illustrate this fact, we ran the LIWC positive emotions dictionary on the above groups (Fig. 2b). There was indeed a very large difference in the prevalence of positive emotions. Paired comparisons found that the recovery forum group contained more positive emotion words than all the remaining groups (ps $< .001$).

All of these errors have been corrected.

Empirical Article

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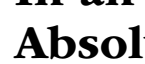
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In an Absolute State: Elevated Use of Absolutist Words Is a Marker Specific to Anxiety, Depression, and Suicidal Ideation

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Abstract

Absolutist thinking is considered a cognitive distortion by most cognitive therapies for anxiety and depression. Yet, there is little empirical evidence of its prevalence or specificity. Across three studies, we conducted a text analysis of 63 Internet forums (over 6,400 members) using the Linguistic Inquiry and Word Count software to examine absolutism at the linguistic level. We predicted and found that anxiety, depression, and suicidal ideation forums contained more absolutist words than control forums (*d*s > 3.14). Suicidal ideation forums also contained more absolutist words than anxiety and depression forums (*d*s > 1.71). We show that these differences are more reflective of absolutist thinking than psychological distress. It is interesting that absolutist words tracked the severity of affective disorder forums more faithfully than negative emotion words. Finally, we found elevated levels of absolutist words in depression recovery forums. This suggests that absolutist thinking may be a vulnerability factor.

Keywords

affective disorders, depression, text analysis, cognitive style, anxiety, open data, open materials

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Absolutist thinking underlies many of the cognitive distortions (Beck, 1979; Burns, 1989) and irrational beliefs (A. Ellis & Harper, 1975) that are purported to mediate the core affective disorders. Words, phrases, and ideas that denote totality, either of magnitude or probability, are often referred to as "absolute." Absolutist thoughts are independent of context and unqualified by nuance. In this observational study, we aimed to measure absolutist thinking in a specific and ecologically valid manner. We then compared its relative association between a variety of affective and nonaffective groups.

Absolutist thinking has strong empirical links to three distinct mental health groups: suicidal ideation, borderline personality disorder (BPD), and eating disorder (ED). Regarding suicidal ideation, structured response formats have shown more extreme value judgments by suicidal patients than controls (e.g., Neuringer, 1961, 1964). Thematic analysis by independent raters also deemed the stories and poetry of suicidal individuals as highly "polarized" (Litinsky & Haslam, 1998; Wedding, 2000). In addition, dichotomous thinking, cognitive rigidity, and problem-solving deficits have been repeatedly found to co-occur in suicidal individuals (for review, see T. E. Ellis & Rutherford, 2008). This is supported by a series of empirical studies from Pollock and Williams (1998, 2001, 2004; J. M. G. Williams & Pollock, 2008).

BPD patients also make more extreme responses on structured response formats than controls (e.g., Moritz et al., 2011; Napolitano & McKay, 2007; Sieswerda, Barnow, Verheul, & Arntz, 2013; Veen & Arntz, 2000). Some scholars have used "spontaneous reactions" or short interviews to identify extreme or dichotomous thinking styles (e.g., Arntz & ten Haaf, 2012; Arntz & Veen, 2001).

With respect to ED, the Dichotomous Thinking in Eating Disorders Scale (Byrne, Allen, Dove, Watt, & Nathan, 2008) is widely used in ED studies (e.g., Antoniou, Bongers, & Jansen, 2017; Palascha, van Kleef, & van Trijp,

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2015). Although obesity and anorexia are often studied separately, they both link to absolutist thinking. For obesity, several reviews have found that avoiding absolutist dichotomous thinking improves weight loss maintenance (e.g., Ohsiek & Williams, 2011). Absolutism often takes the form of perfectionism in anorexia, as identified through clinical observations (e.g., Fairburn, Cooper, & Shafran, 2003; Garner, Garfinkel, & Bemis, 1982), structured response formats (e.g., Feixas i Viaplana, Montebruno, Dada, Castillo, & Compañ, 2010; Zotter & Crowther, 1991), and interviews (e.g., Johnson & Holloway, 1988).

Despite the inclusion of absolutist thinking into many cognitive therapy models for anxiety and depression (Beck, 1979; Burns, 1989; C. Williams & Garland, 2002), this association remains mostly neglected in the empirical literature (A. Ellis, 1987). In a notable exception, Teasdale et al. (2001) found that an "absolutist, dichotomous thinking style" predicted future depressive relapse, over and above the content of responses. This was evidenced by both positive and negative "extreme responses" on Likert-type scales.

Attempts to investigate absolutist thinking have mostly employed some type of structured response format. Ertel (1985) was the first to use quantitative text analysis to measure dogmatism with the manual Dogmatism Text Analysis Tool. More recently, with the advent of automated text analysis, Cohen (2012) measured "cognitive rigidity" in the "spontaneous autobiographical narratives" of undergraduate students and found correlations with negative emotionality. Unlike structured response formats, these natural language text analysis studies have more ecological validity.

With the growth of social media, Internet forums are increasingly being used as a source of naturalistic writing for research in depression and other affective disorders (e.g., Fekete, 2002; Griffiths, Calear, & Banfield, 2009; Houston, Cooper, & Ford, 2014). It is believed that insights into the cognitive processes associated with particular affective disorders can be gleaned from how people with those disorders write about their experiences. In three connected studies, we investigated the frequency of absolutist words contained in different affective and nonaffective Internet forum groups (Table 1; for more details, see Table S1 in the Supplemental Material available online). In the first study we compared anxiety, depression, and suicidal ideation (test) groups with general, asthma, diabetes, and cancer (control) groups. We had two specific hypotheses:

Hypothesis 1 (H_1): The percentage of absolutist words in anxiety, depression, and suicidal ideation test forum groups will be significantly greater than in Study 1 control forum groups.

Table 1. Characteristics of Test and Control Internet Forums

Study	Condition	Group	Forums[b]	Members[c]
Study 1	Control	General[a]	7	917
		Asthma	4	418
		Diabetes	4	587
		Cancer	4	451
	Test	Anxiety	6	597
		Depression	6	529
		Suicidal Ideation	4	368
Study 2	Control	PTSD	6	534
		Schizophrenia	6	591
	Test	BPD	4	326
		ED	5	547
Study 3		Recovery	7	558

Note: PTSD = posttraumatic stress disorder; BPD = borderline personality disorder; ED = eating disorder.
[a]General forums = Mumsnet (Women), Ladies Lounge (Women), Gentlemen's Club (Men), Ask Men (Men), Pensioners Forum (Elderly), Student Room (Young), Work Problems. [b]Number of Internet forums in each group. [c]Number of members who contributed to that group's corpus.

Hypothesis 2 (H_2): The percentage of absolutist words in the suicidal ideation forum group will be significantly greater than in both anxiety and depression forum groups.

Our second hypothesis is partly based on the strong association between suicidal ideation and absolutist thinking (for review, see Arffa, 1983). But also, as suicidal ideation is the more severe mental health concern, it could be hypothesized that absolutist thinking will be correspondingly more extreme.

In Study 2, our aim was to show that absolutist words reflect absolutist thinking, rather than psychological distress. We attempted to control for psychological distress by comparing groups believed to have similar levels of negative emotions but different levels of absolutist thinking (Table 1 and Table S1). We compared mental health groups strongly associated with absolutist thinking (BPD and ED, cited above) with mental health groups less associated with absolutist thinking (posttraumatic stress disorder [PTSD] and schizophrenia). Although we recognize that PTSD and schizophrenia may also have some links to absolutist thinking, the literature suggests these links are likely to be much weaker than those of BPD and ED. Relatively few researchers have examined absolutist thinking in PTSD and schizophrenia, and these have often been limited or produced mixed results (e.g., Colbert, Peters, & Garety, 2010; Joseph & Gray, 2011). Conversely, there is a widespread consensus, based on a multitude of studies, that BPD and ED are firmly linked to absolutist

thinking (e.g., Alberts, Thewissen, & Raes, 2012; Napolitano & McKay, 2007; Veen & Arntz, 2000). We also measured the frequency of negative emotion terms to further support the assumption that the four mental health groups had comparable levels of negative emotions.

Hypothesis 3 (H_3): The percentage of absolutist words in BPD and ED test forum groups will be significantly greater than in PTSD and schizophrenia control forum groups.

In Study 3, we aimed to determine the extent to which absolutist thinking could be a cognitive vulnerability factor for depression and suicidal ideation. In a subset of depression and suicidal ideation forums, there are "recovery" subforums (Table 1 and Table S1). These subforums are visited by members who feel they are currently out of depression. They often write very positive posts about their progress and words of encouragement to other members. Theoretically, a cognitive vulnerability factor should not only be present during an episode of depression but also persist during recovery. Therefore,

Hypothesis 4 (H_4): The percentage of absolutist words in the recovery forum group will be significantly greater than in Study 1 control forum groups.

Previous text analysis research has examined many different dictionary "dimensions." When analyzing written samples from anxious, depressed, or suicidal individuals, an increased use of personal pronouns and negative emotion words has commonly been found (Bucci & Freedman, 1981; Fekete, 2002; Lorenz & Cobb, 1952; Rude, Gortner, & Pennebaker, 2004; Stirman & Pennebaker, 2001; Weintraub, 1981). In particular, pronouns have been identified as having a stronger relationship with affective disorder than negative emotions (Pennebaker & Chung, 2013). Like pronouns, absolutist words are functional; they help determine our style of writing, not its contents. Moreover, functional words are ordinarily outside of conscious control (Pennebaker & Chung, 2013); therefore, they can serve as implicit markers. We believe a shift in focus to how we think rather than what we think can provide greater insight into possible cognitive mechanisms underlying affective disorders.

From the outset, we identified and validated a single dictionary of interest, as this study was motivated by specific a priori hypotheses. This is in contrast to previous text analysis studies that have used a subset of already constructed dictionaries or identified features of interest based on the data itself (e.g., using an iterative process with cross-validation and feature reduction; Mladenić, 2005). The large data set in this study, from 12 different groups, representing 63 different Internet forums and more than 6,400 members, afforded a degree of ecological validity not achievable in experimental studies. However, as with many observational studies, these benefits come with inherent costs. We had limited information about the members posting in the forums, and for the most part, their true identities and motivations were unknowable. Recognizing this limitation, we hope that follow-up studies, using alternative experimental designs, will extend the findings presented here.

Method

Forum selection

We used English-language Internet forums as a source of naturalistic writing for our test and control categories. For all three studies, representative websites were located through a Google search (search words: e.g., "suicide forums," "asthma forums"). Forums were selected for inclusion into the study on the basis of Google rank (Table 1 and Table S1), were popular (thus yielding sufficient data for analysis), and were actively moderated with clearly written moderation policies. Each group in the test and control categories was composed of between four to seven separate forums, as determined by forum availability. For Study 1, control groups were carefully selected to provide the broadest level of control. The "general" group provides a gender control with two forums for female members (Mumsnet and Ladies Lounge) and two for male members (Askmen and Gentlemen's Club). The general group also controls for age, with a designated forum for young members (Student Room) and older members (Pensioners Forum). The asthma and diabetes groups control for chronic physical illness, and the cancer group controls for severe physical and psychological distress. Study 3 recovery forums were located within Study 1 depression and suicidal ideation test forums.

Data collection

Forum members can either introduce a new topic ("first posts") or contribute to an ongoing discussion ("replies"). In the interest of simplicity and interpretability, only first posts were collected. Posts were copied and pasted into a text document ready for subsequent text analysis. Where an individual member contributes multiple posts, these were combined into a single text document. All text files used in this study

are hosted on Figshare (doi:10.6084/m9.figshare.4743715). If a forum was further divided into subforums, only the single most appropriate subforum was used (Table S1). For each test and control forum, we aimed to collect 30,000 words. Seven out of the 63 forums were not large enough to provide a 30,000-word corpus but were nevertheless retained in the study as they surpassed 10,000 words. Posts were only collected if they met our selection criteria: (a) contain a minimum of 100 words, (b) be authored by a representative member of that online community (i.e., not written on behalf of someone else/news article etc.), and (c) be written in continuous prose (i.e., not lists, poems). Posts from all test and control forums which met the selection criteria were collected sequentially as presented by the respective forum website (usually by date order). Posts were collected between April and May 2015 and December and January 2016. All data in this study was collected from the public domain; therefore, although ethical consideration is still important, informed consent is not required. This complies with the University of Reading research ethics guidelines and the ethical guidance for Internet-mediated research set out by The British Psychological Society (British Psychological Association, 2013). The aggregate data used in this study are hosted on Figshare (doi:10.6084/m9.figshare.4743547.v1).

Word count text analysis

Word counting text analysis was conducted using validated dictionaries that characterize a particular linguistic dimension (i.e., negative words, auxiliary verbs, family related words). For this study, we validated an absolutist and a nonabsolutist words dictionary using independent expert judges.

Absolutist and nonabsolutist words indicate magnitudes or probabilities; absolute words do so without nuance (i.e., always, totally, entire), whereas nonabsolute words indicate some degree of nuance (i.e., rather, somewhat, likely). Both dictionaries are composed of functional words devoid of valence, mostly adverbial intensifiers or modal verbs. A subclass of nonabsolutist words, which we have termed "extreme words," indicate extreme (but not absolute) magnitudes or probabilities (i.e., "very"). Although the terms *extreme* and *absolute* have previously been used interchangeably (e.g., Teasdale et al., 2001), we treat them here as qualitatively distinct.

To construct these dictionaries, we initially brainstormed more than 300 absolutist words and 200 nonabsolutist words (including extreme words). Testing on pilot data (control and test groups) revealed that many of the words on these original lists were too obscure to register with sufficient frequency for analysis. Consequently, the original dictionaries were reduced to the most prevalent 22 absolutist words and 43 nonabsolutist words (including 21 extreme words). Although this was based on a mostly arbitrary cutoff, it was intended that the lists be large enough to produce representative dictionary percentages, but small enough to facilitate independent validation by experts. The 22 absolutist words and 43 nonabsolutist words were combined into a single list of 65 words. Five independent expert judges were asked to categorize them as absolute, nonabsolute, and/or extreme. Two of the judges are clinical psychologists from the University of Reading Charlie Waller Institute and three are linguists from the University of Reading School of Clinical Language Sciences. Judges were permitted to place words into more than one category (i.e., extreme and absolute). The agreement between our original categorization of the words (absolutist/nonabsolutist) and that of the judges ranged between 83% and 94%, whereas the interjudge agreement was 96%. Words were considered absolute, extreme, or nonabsolute on the basis of a majority decision by the judges. Three words, *anything, need*, and *needed*, were moved from the absolutist dictionary to the nonabsolutist dictionary as they were not categorized as absolute by the majority of judges. All the words on our nonabsolutist dictionary were judged nonabsolute. Judges showed almost no agreement on extreme words, this category was consequently removed from the analysis (collapsed into the nonabsolutist category).

The resulting 19-word absolutist dictionary is shown in Table S2 in the Supplemental Material. Both dictionaries were used in the text analysis of test and control groups. We also ran dictionaries contained within the Linguistic Inquiry and Word Count program (LIWC; Pennebaker, Booth, Boyd, & Francis, 2015). This program provides 73 validated dictionaries covering a wide range of "dimensions" (i.e., questioning words, affective processes, auxiliary verbs). All dictionaries, other than the absolutist dictionary, were run purely for the benefit of comparison.

The LIWC text analysis software was used to test our absolutist and nonabsolutist dictionaries as well as the LIWC dictionaries. It calculates the prevalence of a given dictionary as a percentage of the total number of words analyzed. Throughout, we have referred to this percentage measure of a dictionary's prevalence as its "index." In each forum, we calculated an index for 75 dictionaries (1 absolute, 1 nonabsolute, and 73 LIWC).

For the absolutist index we have endeavored to account for false positives. There are three principal types of false positives: a negation before the absolutist word (i.e., "not completely"), a qualifier before the absolutist word (i.e., "almost completely"), and a salutation (i.e., "hello everyone"). These would ordinarily register on our absolutist index and distort our measure

of absolutism. Fortunately, the LIWC (2015 version) can also count phrases, so we ran a second version of our absolutist dictionary composed of the most common false positives (as described). The absolutist false positive index was subtracted from the absolutist index to provide a better estimate of absolutism. We nevertheless rely on the assumption that any remaining false positives are equally distributed between groups.

Results

Study 1

Data analysis. The control and test category forums were subdivided into groups as shown in Table 1. To analyze the data, a multilevel mixed-effects modeling approach was adopted (the SPSS syntax script can be found in the Supplemental Material). This is the recommended analysis method for this type of data structure (Baayen, Davidson, & Bates, 2008). Members were nested within forums, and forums were nested within groups (i.e., depression). Because low-frequency words cannot be measured reliably at the members level, we used the forums as the subject's category. This is important in comparing the performance of different dictionary dimensions. Effect sizes (Cohen's d) were calculated from the t values produced by the mixed-effects model ($d = 2t/\sqrt{df}$). Mixed-effects models consider both fixed and random effects and can be used to assess the influence of the fixed effects on the dependent variables after accounting for some outside random effects. Residuals were weighted by the word count of each text file and all the analysis was conducted using IBM SPSS software (version 21). To correct for positive skew in the data, we used a log10 (x + 1) transformation, adding 1 to deal with 0 values (cf. Yamamura, 1999). We report raw values for descriptive statistics to facilitate a more intuitive understanding. The bootstrap procedure was also used to produce better estimates of p values and confidence intervals (CIs). This method is often recommended because it does not assume normally distributed data (Cumming, 2014). Bootstrapped CIs (95%; bias-corrected and accelerated) were computed through 1,000 random resamples (with replacement) using the stratified sampling method, with forums as the strata variable.

Control group. There was no significant omnibus effect among the control groups as determined by a multilevel mixed effects model, $F(7, 11) = 0.754$, $p = .635$ (Table 1 and Table S1). Consequently, they were combined into a single "control group." It is important that this suggests that the absolutist index is largely independent of content, as it demonstrates remarkably little variance across a wide range of very different discussion topics.

Multilevel mixed-effects model for the absolutist index. There was a large, significant difference in the absolutist index between the Study 1 groups, as determined by a multilevel mixed-effects model, $F(3, 29) = 71.549$, $p < .001$. Using paired comparisons in the mixed-effects model, we compared the control group with each of the Study 1 test groups to assess our first hypothesis. We also compared the suicidal ideation forum group with the remaining two test groups (anxiety and depression forums) to assess our second hypothesis. The mean absolutist index for the control forum group ($M = 0.97\%$, $SD = 0.11$) was significantly lower than anxiety ($M = 1.45\%$, $SD = 0.10$, $p < .001$, $d = 3.24$, 95% CI = [0.36, 0.52]), depression ($M = 1.45\%$, $SD = 0.10$, $p < .001$, $d = 3.14$, 95% CI = [0.35, 0.52]), and suicidal ideation ($M = 1.80\%$, $SD = 0.14$, $p < .001$, $d = 4.56$, 95% CI = [0.72, 0.98]) test forum groups. Moreover, the suicidal ideation group was significantly greater than both the anxiety ($p < .001$, $d = 1.74$, 95% CI = [–0.54, –0.29]) and depression ($p < .001$, $d = 1.71$, 95% CI = [–0.54, –0.29]) groups (Fig. 1a). These results are consistent with both of our Study 1 hypotheses. Post hoc comparisons with a Bonferroni correction revealed that there was no significant difference between anxiety and depression forum group means ($p = 1.00$).

Multilevel mixed-effects model for the comparison dictionaries. Using the LIWC software, we produced indices for our nonabsolutist dictionary and all 73 LIWC dictionaries. We were interested in determining which comparison dictionary index would produce comparable significance levels and effect sizes to that of our absolutist index. We again conducted a multilevel mixed-effects model and pairwise comparisons for each of the 74 comparison dictionary indices. Table 2 displays the test statistics and effect sizes for the 16 dictionaries with the largest effects. Notably, our absolutist index has satisfied the study hypotheses better than any of the linguistic dimensions previously linked to affective disorder (negative emotions, personal pronouns etc.). Although "negative emotion" words were predictably more prevalent in test group forums than control forums, they paradoxically were less prevalent in suicidal ideation forums than anxiety or depression forums. This was also the case for other content dictionaries like "sad," affect," and "feel."

Analysis of covariance. We ran an analysis of covariance (ANCOVA) to measure the unique predictive validity of absolutist words after partialling out the effects of the negative emotion words, pronouns, and certainty words. Negative emotions and pronouns have previously been identified as strong linguistic markers of affective disorder, and the certainty words index is the most conceptually related to our absolutist index. We found that there was still a significant main effect for the absolutist

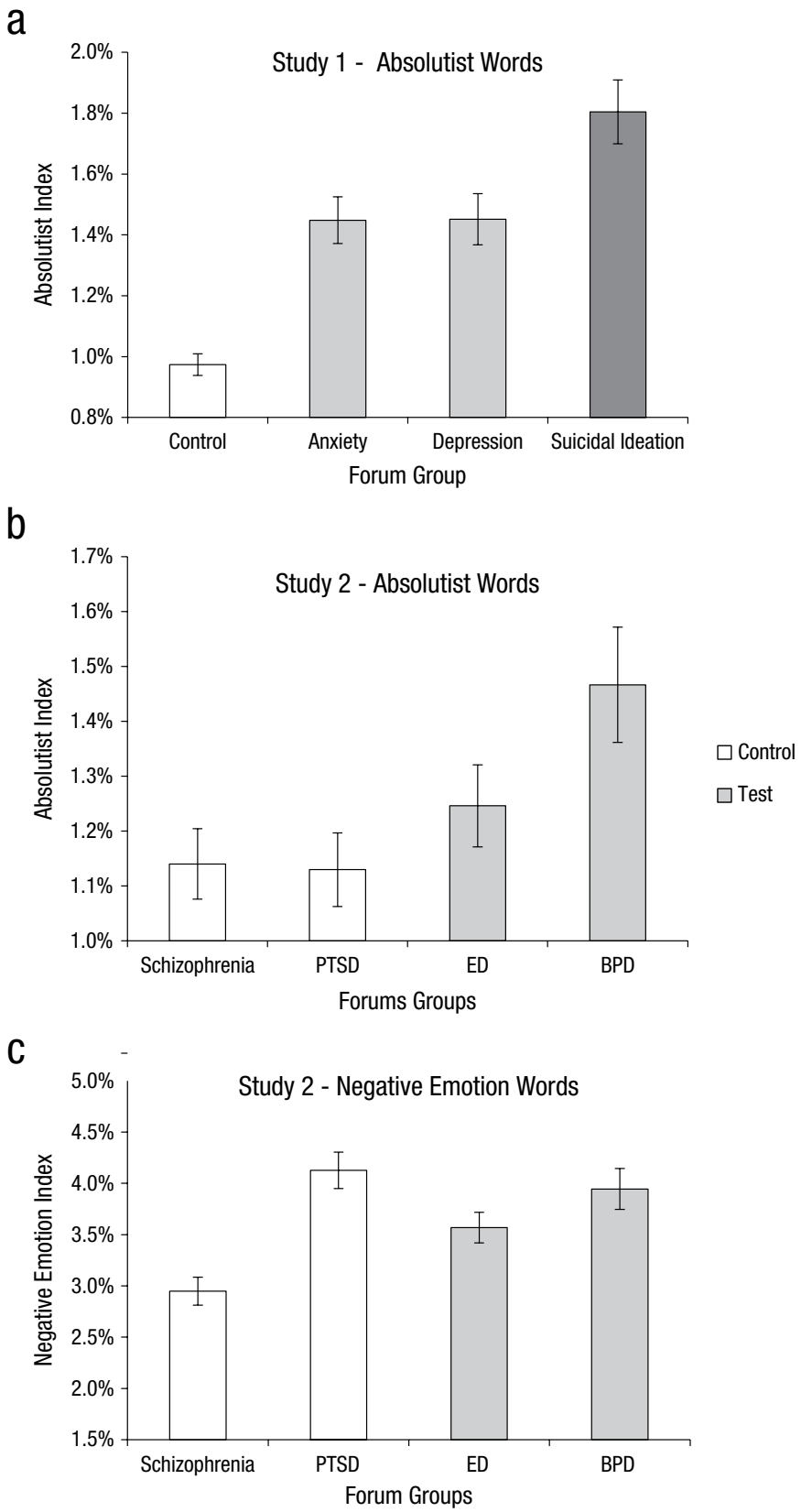

Fig. 1. Mean percentage of (a) absolutist words in Study 1 groups, (b) absolutist words in Study 2 groups, and (c) negative emotion words for Study 2 groups. Error bars indicate 95% bootstrapped confidence intervals. PTSD = posttraumatic stress disorder; ED = eating disorder; BPD = borderline personality disorder.

Table 2. Results for Study 1 Paired Comparisons

	H_1						H_2			
	Control < anxiety		Control < depression		Control < suicidal ideation		Anxiety < suicidal ideation		Depression < suicidal ideation	
Dictionary	*d*	*t*	*d*	*t*	*d*	*t*	*d*	*t*	*d*	*t*
Absolutist	3.24	8.57**	3.14	8.48**	4.56	12.43**	1.74	4.62**	1.71	4.60**
Death	1.95	5.02**	2.42	6.29**	8.08	21.37**	5.70	14.82**	5.28	13.82**
Anxiety	10.04	27.21**	2.68	7.37**	0.52	1.44	6.67	−18.27**	1.47	−4.06**
Neg. emo	5.81	15.85**	4.36	11.98**	3.56	9.92**	1.05	−2.90*	0.05	−0.14
Sad	2.02	5.56**	5.18	14.38**	3.70	10.44**	1.78	4.96**	0.51	−1.43
Affect	4.47	12.18**	3.69	10.15**	3.23	9.03**	0.37	−1.02	0.15	0.41
Anger	2.43	6.65**	2.38	6.59**	3.54	9.94**	1.36	3.76*	1.35	3.77*
Certain	1.84	4.89**	2.02	5.43**	3.21	8.78**	1.51	4.07**	1.34	3.63*
Pronouns	2.53	6.96**	2.56	7.10**	2.90	8.12**	0.69	1.92	0.65	1.81
Insight	3.04	8.08**	2.69	7.24**	1.22	3.35*	1.08	−2.92*	0.87	−2.35*
Article	2.41	−6.57**	2.34	−6.43**	2.64	−7.35**	0.57	−1.57	0.60	−1.65
Swear	1.02	2.75*	0.98	2.67*	2.55	7.06**	1.49	4.08**	1.50	4.12**
Feel	2.32	6.36**	2.08	5.72**	1.17	3.27*	0.64	−1.78	0.48	−1.33
Function	1.75	4.83**	2.15	5.97**	2.01	5.63**	0.48	1.33	0.18	0.50
I	1.87	5.15**	1.95	5.37**	1.88	5.22**	0.27	0.74	0.21	0.57
Negate	0.77	2.13*	1.89	5.26**	1.95	5.49**	1.13	3.16*	0.32	0.9

Note: Displayed are 16 dictionaries with the largest effects. For each dictionary, three *t* tests compared the transformed data for the control group index (dictionary % prevalence) to each of the test groups (anxiety, depression, and suicidal ideation forums) to address Hypothesis 1 (H_1). Two *t* tests also compared the suicidal ideation forum group with the remaining two test groups (anxiety and depression) to address Hypothesis 2 (H_2). LIWC dictionaries are ordered according to average Cohen's *d* effect size. Neg. emo = negative emotions; I = first-person singular pronouns (e.g., *I, me, my*).
*$p < .05$. **$p < .001$.

index between groups, after controlling for the certainty index, negative emotions index, and the pronoun's index, $F(3, 3860) = 20.575$, $p < .001$. Paired comparisons reveal that all contrasts remained significant to $p < .01$.

Confirmatory factor analysis. For Study 1 forums, we calculated indices for each individual *word* in the absolutist and nonabsolutist dictionaries using an in-house python script (full python code is available in the Supplemental Material) and the Natural Language Tool Kit (Bird, Klein, & Loper, 2009). This means that we had the percentage prevalence of each *word* rather than each dictionary. Using these data, we conducted a confirmatory factor analysis on the combined list of 65 absolutist and nonabsolutist words with a direct oblimin rotation and a loadings cutoff > 0.55. We found that the highest loading words on the first factor were all absolutist except for *really* (which is an adverbial intensifier) and *anything*, which we had originally categorized as absolutist but, because of a lack of independent expert validation, was moved to the nonabsolutist dictionary. The highest loading words on Factor 2 were all nonabsolutist except for the absolutist word *definitely*. Other than *definitely*, no absolutist word loaded outside of Factor 1. The factor analysis was not able to separate "extreme words" from nonabsolutist words (see Table S3 in the Supplemental Material). To examine the absolutism factor further, we used structural equation modeling to test the model fit of the seven highest loading words on Factor 1 from the factor analysis. Model fit was assessed using AMOS version 24 (SPSS). A seven-item, one-factor model adequately fit the data ($\chi^2 = 14.461$, $df = 14$, goodness of fit index = .912, comparative fit index = .996, normed fit index = .903). Including more words in the model reduced the model fit below generally accepted levels.

Sensitivity analysis. The smallest group in this study is the suicidal ideation group. Inferences about this group are based on data from 368 members in four separate suicidal ideation forums. Moreover, these forums may be perceived as less conventional than others used in this research. For this reason, we conducted a sensitivity analysis to ensure the results obtained from this group are robust. The multilevel mixed-effects model for the absolutist index was recalculated after sequentially excluding all data from each of the suicidal ideation forums in turn. This produced four sets of test statistics, each with one suicidal ideation forum excluded. Paired comparisons showed that the absolutist index for the suicidal ideation group remained significantly greater than the control group (ps < .001, ds = 3.85–4.41), the anxiety group (ps < .001, ds = 1.39–1.71), and the depression group (ps <

.001, *d*s = 1.37–1.69). The narrow range of effect sizes for each comparison confirms that these findings are robust, and not driven by a forum outlier in the suicidal ideation group.

Study 2

Multilevel mixed-effects model for the absolutist index. Our third hypothesis predicted that mental health forum groups strongly associated with absolutist thinking (BPD and ED) would use more absolutist words than mental health forum groups less associated with absolutist thinking (PTSD and schizophrenia). A multilevel mixed-effects analysis found that there was a significant difference in the absolutist index between Study 2 groups, $F(3, 16) = 5.515$, $p = .009$. Paired comparisons revealed that the mean absolutist index for the BPD forum group ($M = 1.47$, $SD = 0.12$) was significantly greater than the PTSD ($M = 1.13$, $SD = 0.07$, $p < .001$, $d = 1.93$, 95% CI = [–0.38, –0.14]) and the schizophrenia forum groups ($M = 1.14$, $SD = 0.10$, $p < .001$, $d = 1.94$, 95% CI = [–0.42, –0.20]). They also revealed that the absolutist index of the ED forum group ($M = 1.25$, $SD = 0.12$) was significantly greater than the schizophrenia ($p = .009$, $d = 0.81$, 95% CI = [–0.25, –0.05]) but not PTSD ($p = .081$, $d = 0.84$, 95% CI = [–0.22, 0.01]) forum groups (Fig. 1b). A critical assumption in this contrast is that the control and test groups have similar levels of psychological distress. We sought to verify this assumption using the LIWC negative emotions dictionary. A paired comparison found no significant difference in the mean negative emotions index between the Study 2 control ($M = 3.51$, $SD = 0.73$) and test ($M = 3.71$, $SD = 0.31$, $p = .335$) forum groups (Fig. 1c). Therefore, it seems that absolutism is associated with certain types of psychopathology forums and not psychological distress forums per se.

Comparison of Study 1 with Study 2. In comparing the absolutist index of Study 1 and 2 groups, post hoc comparisons with a Bonferroni correction revealed that the suicidal ideation forum group had an index significantly greater than ED and BPD forum groups ($p < .001$). ED but not BPD had an index significantly lower than anxiety and depression forum groups (*p*s = .001). Study 2 control forum groups PTSD and schizophrenia had an index significantly lower than all Study 1 test forum groups (*p*s < .001).

Sensitivity analysis. The smallest group in this study is the BPD group. Inferences about this group are based on data from 326 members in four separate BPD forums. This group also produced the most extreme absolutist index scores. Once again, we conducted a sensitivity analysis to ensure the results obtained from this group are robust. The multilevel mixed-effects model for the absolutist index was recalculated after sequentially excluding all data from each of the BPD forums in turn. This produced four sets of test statistics, each with one BPD forum excluded. Paired comparisons show that the absolutist index for the BPD group remained significantly greater than the PTSD group (*p*s < .026, *d*s = 1.25–1.91) and the schizophrenia group (*p*s < .008, *d*s = 1.56–2.24). Once again, the positive findings from the smallest group in the study appear to be robust and not dependent on any single forum outlier.

Study 3

Multilevel mixed-effects model for the absolutist index. Our final hypothesis predicted that the recovery forum group would use significantly more absolutist words than the Study 1 control forum group. Paired comparisons in a multilevel mixed-effects model found that the mean absolutist index of the recovery forum group ($M = 1.31\%$, $SD = 0.14$) was significantly greater than the Study 1 control forum group ($p < .001$, 95% CI = [–0.41, –0.24], $d = 2.02$). Paired comparisons also found a significant difference in the absolutist index between the recovery forum group and the anxiety group ($p = .018$, 95% CI = [–0.01, 0.23], $d = 0.56$) and depression group ($p = .018$, 95% CI = [–0.01, 0.22], $d = 0.52$). Like the anxiety and depression groups, the recovery group also had a significantly lower absolutist index than the suicidal ideation group ($p < .001$, 95% CI = [0.37, 0.67], $d = 2.31$). Although the absolutist index of the recovery group was significantly different from anxiety and depression groups, the more accurate bias-corrected CIs reveal that the differences are marginal; relative effect sizes reveal that the recovery group absolutist index is closer to anxiety and depression (*d*s < 0.56) than to the control group ($d = 2.02$; Fig. 2a). We noted earlier that the contents of the recovery forums were very positive. To illustrate this fact, we ran the LIWC positive emotions dictionary on the above groups (Fig. 2b). There was indeed a very large difference in the prevalence of positive emotions. Paired comparisons found that the recovery forum group contained more positive emotion words than all the remaining groups (*p*s < .001).

Sensitivity analysis. Although the recovery group is relatively large, with 558 members in 7 different forums, this group is somewhat unconventional and the number of members in each forum were somewhat unequal (see Table S1). We therefore deemed it appropriate to conduct another sensitivity analysis to ensure the results obtained from this group are robust. The multilevel mixed-effects model for the absolutist index was recalculated after sequentially excluding all data from each of the recovery forums in turn. This produced seven sets of test statistics,

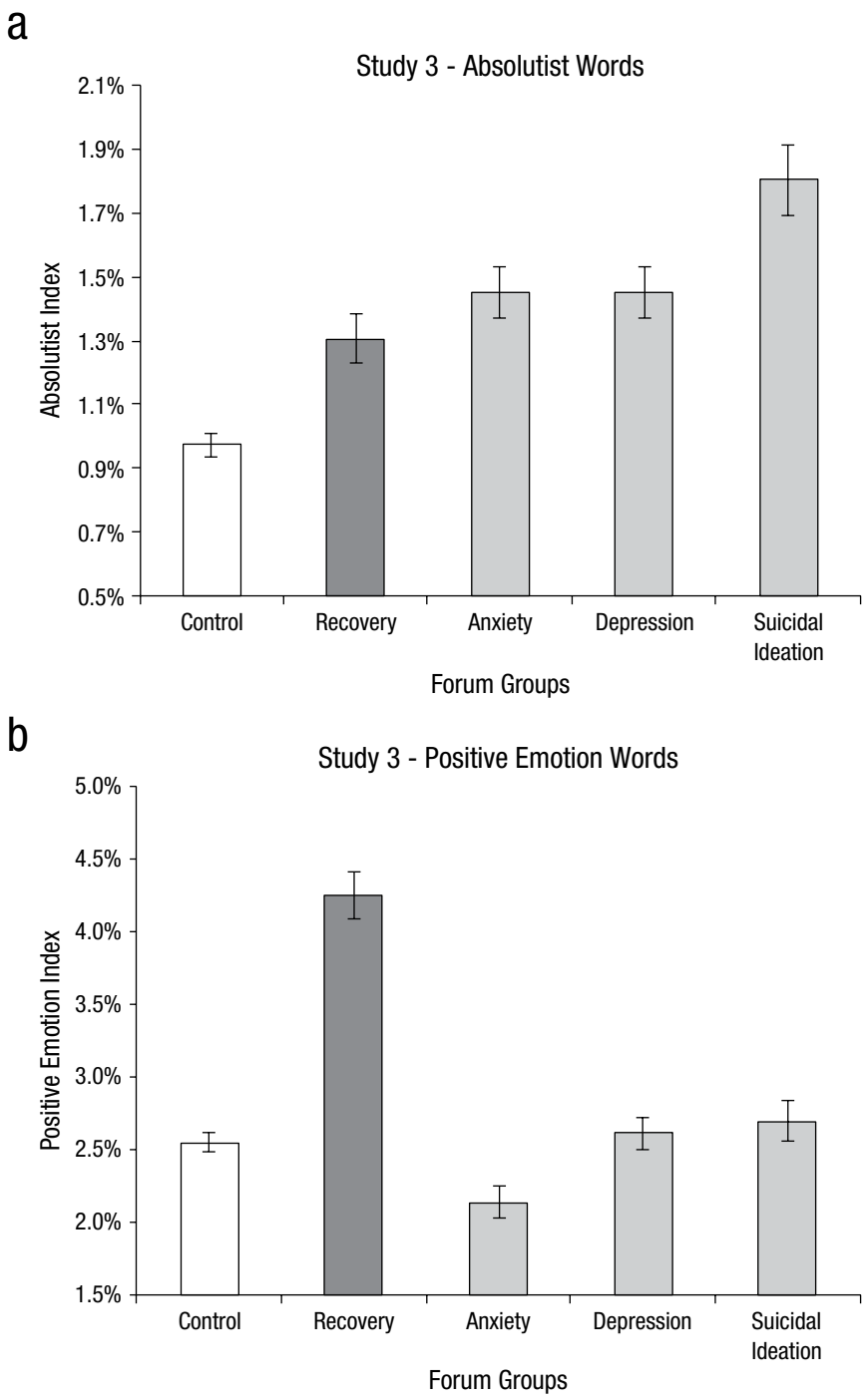

Fig. 2. Mean percentage of (a) absolutist words and (b) positive emotion words for the recovery group and all Study 1 groups (control, anxiety, depression, suicidal ideation). Error bars indicate 95% bootstrapped confidence intervals.

each with one recovery forum excluded. Paired comparisons show that the absolutist index for the recovery group remained significantly greater than the control group ($ps < .001$, $ds = 1.88–2.30$). This again confirms that the positive findings from this group are robust and not dependent on any single forum outlier.

Discussion

Main findings

The data we have presented confirm that the use of absolutist words is elevated in the natural language of various affective disorder forum groups. As expected, in Study 1 we found that the percentage of absolutist words in anxiety, depression, and suicidal ideation test groups was significantly greater than in control groups (H_1), and that the percentage of absolutist words in the suicidal ideation forum group was significantly greater than in both the anxiety and depression forum groups (H_2). These findings have support from a previous study, Fekete (2002) used an adapted Weintraub text analysis method on four Internet forums (suicide, depression, anxiety, and a journalism control). They found significant results for 13 language variables including negations and dichotomous expressions. Our first study has built on this preliminary finding, using a wider range of more rigorous controls, a larger corpus of data, and a hypothesis-driven study design.

In Study 2, consistent with our expectations, we found the absolutist index was greater for BPD and ED forums than PTSD and schizophrenia forums, although this did not reach significance between ED and PTSD. All four mental health groups contained similar amounts of negative emotion terms, but only BPD and ED are strongly associated with absolutist thinking. This suggests that our index is more sensitive to absolutism than psychological distress.

In Study 3, we proposed that if the absolutist index for the recovery forums was similar to depression forums, this would suggest that absolutist thinking has some trait-like qualities that persist outside of depressive episodes. This is indeed what we observed. Even though the recovery forums were largely very positive, the percentage of absolutist words in the recovery group had overlapping CIs with both the anxiety and depression forum groups, and was significantly greater than the control forum group. It is widely acknowledged that an episode of depression increases the risk of future depressive episodes (Teasdale et al., 2000). In many ways, preventing this recurrence is the focus of most treatments. Consequently, there is keen interest in identifying potential cognitive vulnerability factors which are observed during episodes of depression and persist even after the episode has ended. Our findings indicate that absolutism may be such a vulnerability factor. The "scar hypothesis" (Lewinsohn, Steinmetz, Larson, & Franklin, 1981) provides a different explanation. Here the depressive episode itself alters the linguistic style/vocabulary of the individual, this then persists as a "scar" after the depressive episode has abated.

Comparison with other dictionaries

Text analysis research on written data from depressed and suicidal individuals has repeatedly shown elevated use of negative emotion words and pronouns (for review, see Tausczik & Pennebaker, 2010). We also found these to be strong markers of affective disorder in the present study. However, we have paradoxically found that "negative emotions," "sad," "affect," and "feel" dictionaries were more prevalent in anxiety and depression than the suicidal ideation group. This is inconsistent with the belief that suicidal individuals have a greater amount of negative emotions (de Klerk et al., 2011; Orbach, Mikulincer, Gilboa-Schechtman, & Sirota, 2003; Stein, Apter, Ratzoni, Har-Even, & Avidan, 1998), and some research has previously shown that "negative emotion [words] use tends to increase approaching suicide" (Pennebaker & Chung, 2013). These mixed findings only reaffirm that "function" words are a better gauge of thinking processes than "content" words (Chung & Pennebaker, 2007). Our absolutist dictionary also produced larger effects than pronouns (and its first-person singular subcategory), which had previously been identified as better markers of affective disorder than negative emotion words (Pennebaker & Chung, 2013).

The LIWC "certainty" index (Table 2) is the most closely related to our absolutist index, comprising words that denote high or total certainty. Although indeed similar, the certainty index does not include some words that are absolutist (i.e., "nothing") and contains others that are not (i.e., "frankly"). Moreover, unlike our absolutist dictionary, many of its component words are not neutrally valenced (i.e., perfect).

Finally, we found that "swear" words produced a similar significance pattern to absolutist words (Table 2). Swear words are commonly used as adverbial intensifiers (Peters, 1994; Romero, 2013). For example, instead of writing "I'm *completely* sick of this," depressed/suicidal individuals may write something akin to "I'm *fucking* sick of this," replacing the absolutist word "completely" with something even more forceful, both functionally serving as adverbial intensifiers of the strongest kind.

Absolute versus extreme

Previous studies have often used the terms absolute and extreme interchangeably (e.g., Teasdale et al., 2001). A central assumption in the present research is that absolutist words are uncorrelated with extreme words; this assumption was tested. We found that only 25% of absolutist words were also deemed extreme by some of the independent expert judges. Moreover, none

of the words we had categorized as extreme were deemed absolutist, with the single exception of *really*, which was categorized as absolutist by one out of the five judges. This was reaffirmed by the confirmatory factor analysis (Table S3), in which only words we had categorized as absolutist loaded onto Factor 1, with the single exception, once again, of the adverbial intensifier *really*. We believe that a clear distinction should be made between these two concepts in future research; and that the terms should not be used interchangeably.

Anxiety and depression within control groups

Individuals with cancer, PTSD, and schizophrenia have high levels of comorbid anxiety and depression. This might lead us to expect a higher absolutist index for these forum groups. However, the cancer group produced an absolutist index identical to the other Study 1 control groups; and the PTSD and schizophrenia groups had a significantly lower absolutist index than all Study 1 test groups. This may be because symptoms of anxiety and depression in cancer, PTSD, and schizophrenia have a known specific cause, namely, having cancer, PTSD, or schizophrenia. One does not have to be absolutist, or even disposed to affective disorder, to experience feelings of anxiety or depression about a brain tumor, a traumatic event, or hallucinations. In contrast, anxiety and depression disorders often have multiple vague or even unknown causes. Predisposed individuals are pushed into anxiety and depression by circumstances that by necessity would not have the same effect in the general population.

Implications

The maladaptive status of absolutist thinking is a recognized part of cognitive therapy (CT; C. Williams & Garland, 2002). To date, theoretical and anecdotal support has mostly served as the basis for its inclusion; we hope the findings from our studies will add empirical justification. The extent to which absolutist thinking is currently addressed by CT depends on the form of CT used and the preferred methods of each practitioner. For example, combatting absolutist thinking is at the very core of rational-emotive behavioral therapy (David, Lynn, & Ellis, 2009), whereas reducing negative thoughts takes primacy in other forms of CT. Recently, research into treating cognitive vulnerabilities and preventing relapse has migrated toward the new "third-wave" therapies (Teasdale et al., 2000). These therapies, such as mindfulness-based cognitive therapy and acceptance and commitment therapy, are largely geared toward increasing cognitive flexibility (e.g., Kahl, Winter, & Schweiger, 2012). Our findings are therefore in step with the recent trend toward cultivating adaptive cognitive *processes* (i.e., flexibility) as distinct from changing the *content* of thoughts (i.e., negativity).

Limitations and future directions

Because this study had large samples from multiple sources, and a naturalistic observational design, it consequently had low experimental control. For example, we could only infer general demographic characteristics from different forums (e.g., women post on Mumsnet and young people post on Student Room). Usernames served to distinguish members, however it is possible that some members might post using more than one profile or use different usernames for different forums. Fundamentally, the identities and motivation of users are largely unknowable, and this is an inevitable limitation in this study. As outlined in the methods, we did check that the authors of posts were at least purporting to be a representative of the relevant online community, but we had no power to go beyond this basic check. Follow-up studies could use an experimental study design, and perhaps alternative methodologies, to replicate and extend the findings initially presented here. Despite likely being limited to a smaller sample size and perhaps lacking ecological validity, such studies would be able to control participant characteristics, writing topics and the setting.

Our findings in this study relate to differences between groups, such an analysis provides important insights into the markers associated with affective disorder. However, in this research, we have not addressed within-person variation in absolutist thinking and how that relates to changes in affective symptoms at an individual level (cf. Molenaar & Campbell, 2009). For example, are individual changes in suicidal ideation over time reflected in changes in use of absolutist words? Future research could seek to track absolutist thinking (and affective disorder) in individuals over time. This could have even greater utility for clinical practice.

In measuring aggregate differences in absolutist words between groups we have not examined the specific nature of the relationship. Although we present data that may point to absolutism as a possible cognitive vulnerability factor, the extent and mechanism of any causal role are not addressed here. Future intervention studies could examine the causal status of absolutist thinking; one possibility would be to use a cognitive bias modification paradigm (Hallion & Ruscio, 2011). The aim would be to introduce some manipulation of absolutist thinking in participants and then examine the subsequent effects. Alternatively, a narrow form of

cognitive behavioral therapy that focuses on targeting absolutist thinking could be clinically trialed.

Author Contributions

M. Al-Mosaiwi created the research design from an initial idea contributed by T. Johnstone. M. Al-Mosaiwi collected, analyzed, and interpreted the data under the supervision of T. Johnstone. M. Al-Mosaiwi drafted the manuscript, and T. Johnstone provided critical revisions. Both authors approved the final version of the manuscript for submission.

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Declaration of Conflicting Interests

The author(s) declared that there were no conflicts of interest with respect to the authorship or the publication of this article.

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Open Practices

All data and materials have been made publicly available via Figshare and can be accessed at https://doi.org/10.6084/m9.figshare.4743547.v1. The complete Open Practices Disclosure for this article can be found at http://journals.sagepub.com/doi/suppl/10.1177/2167702617747074. This article has received badges for Open Data and Open Materials. More information about the Open Practices badges can be found at https://www.psychologicalscience.org/publications/badges.

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Index of Exhibits to the
Declaration of Amber Norris

Exhibit	Description	
1	Declaration of W.D. (Apr. 12, 2019)	REDACTED & UNDER SEAL
2	Declaration of Gail Masek (interpreter for W.D.) (Apr. 12, 2019)	REDACTED & UNDER SEAL
3	W.D. Medical Record: Special Needs Orders (SNOs)	
4	W.D. Medical Record: Initial Mental Health Assessment (June 21, 2016)	
5	W.D. Medical Record: Nurse – Intake – Screening (June 21, 2016)	
6	W.D. Medical Record: Intake and Receiving Screening (June 21, 2016)	REDACTED & UNDER SEAL
7	W.D. Medical Record: Initial Mental Health Assessment (June 21, 2016)	
8	W.D. Medical Record: Provider – Physical – Intake (June 22, 2016)	
9	W.D. Medical Record: Health Assessment – History (June 22, 2016)	REDACTED & UNDER SEAL
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12	W.D. Medical Record: Optometry Encounter Notes (June 18, 2018)	REDACTED & UNDER SEAL
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Exhibit	Description	
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20	Declaration of F.L.H (Apr. 12, 2019)	REDACTED & UNDER SEAL
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Exhibit	Description	
68	J.H. Medical Record: Initial Mental Health Assessment (May 22, 2017)	
69	J.H. Medical Record: MH Treatment Plan and MH – Individual Counseling (May 26, 2017)	REDACTED & UNDER SEAL
70	J.H. Medical Record: Nurse – ICS Response (two entries) (July 17, 2017)	
71	J.H. Medical Record: Dental – Urgent Care (July 17, 2017)	
72	J.H. Medical Record: MH – Sick Call – Unscheduled and Related Handwritten Notes (July 17, 2017)	REDACTED & UNDER SEAL
73	J.H. Medical Record: Provider – Follow Up Care (Feb. 13, 2018)	
74	J.H. Medical Record: HNR (Mar. 6, 2018) and Provider – Sick Call – Scheduled (Mar. 9, 2018)	REDACTED & UNDER SEAL
75	J.H. Medical Record: Nurse – Sick Call – Unscheduled (June 15, 2018)	
76	J.H. Medical Record: HNR (June 16, 2018) and Provider – Follow Up Care (June 19, 2018)	REDACTED & UNDER SEAL
77	J.H. Medical Record: MH – Individual Counseling (July 3, 2018)	
78	J.H. Medical Record: MH – Individual Counseling (July 26, 2018)	
79	J.H. Medical Record: HNR (Dec. 1, 2018) and Nurse – Sick Call – Scheduled (Dec. 2, 2018)	REDACTED & UNDER SEAL
80	J.H. Medical Record: HNR (Dec. 5, 2018), Nurse – Sick Call – Scheduled (Dec. 7, 2018); Provider – Sick Call – Scheduled (Dec. 20, 2018)	REDACTED & UNDER SEAL
81	J.H. Medical Record: HNR (Dec. 23, 2018) and Nurse – Sick Call – Unscheduled (Dec. 27, 2018)	REDACTED & UNDER SEAL
82	J.H. Medical Record: MH – Individual Counseling (Jan. 24, 2019)	
83	Declaration of K.P. (Apr. 22, 2019)	REDACTED & UNDER SEAL
84	Declaration of Gail Masek (interpreter for K.P.) (Apr. 22, 2019)	REDACTED & UNDER SEAL

Exhibit	Description	
85	K.P. Medical Record: Provider – Physical – Intake, Health Assessment – History, Health Assessment – Physical, "Deaf Mutism" Diagnostic Code, SNO ("Deaf and Mute"), and List of SNOs (Aug. 25, 2016)	REDACTED & UNDER SEAL
86	K.P. Medical Record: MH – Intake (Aug. 25, 2016)	
87	K.P. Medical Record: HNR (Aug. 19, 2018) and Nurse – Sick Call – Scheduled (Aug. 20, 2018)	REDACTED & UNDER SEAL
88	K.P. Medical Record: Dental – Urgent Care (Aug. 21, 2018)	
89	K.P. Medical Record: Dental – Routine Treatment (Aug. 28, 2018)	
90	K.P. Medical Record: Nurse – Chart Note (Dec. 22, 2018)	
91	K.P. Medical Record: HNR (Dec. 24, 2018) and Nurse – Sick Call – Scheduled (Dec. 25, 2018)	REDACTED & UNDER SEAL
92	K.P. Medical Record: HNR (Dec. 29, 2018) and Nurse – Sick Call – Scheduled (Dec. 30, 2018)	REDACTED & UNDER SEAL
93	K.P. Medical Record: HNR (Jan. 29, 2019) and Nurse – Sick Call – Scheduled (Jan. 31, 2019)	REDACTED & UNDER SEAL
94	K.P. Medical Record: Nurse – Sick Call – Scheduled (Feb. 8, 2020)	
95	K.P. Medical Record: Nurse – Sick Call – Scheduled (Feb. 27, 2020)	
96	K.P. Medical Record: Nurse – Treatment Call – Scheduled (Mar. 5, 2020)	
97	K.P. Medical Record: MH – Non-Clinical Contact Note (Mar. 5, 2020)	
98	K.P. Medical Record: Nurse – Treatment Call (Mar. 7, 2020)	
99	K.P. Medical Record: MH – Individual Counseling (Mar. 11, 2020)	
100	K.P. Medical Record: Provider – Sick Call – Scheduled (Apr. 17, 2020)	
101	Declaration of F.L. (Nov. 18, 2019)	REDACTED & UNDER SEAL

Exhibit	Description	
102	Declaration of Gail Masek (interpreter for F.L.) (Nov. 18, 2019)	REDACTED & UNDER SEAL
103	F.L. Medical Record: Nurse – Intake – Screening, Diagnostic Code Entry ("Deaf mutism (finding)"), Family History Review, Symptoms Review, and Intake and Receiving Screening (Oct. 2, 2018)	REDACTED & UNDER SEAL
104	F.L. Medical Record: Dental – Intake (Oct. 2, 2018)	
105	F.L. Medical Record: MH Intake (Oct. 2, 2018)	
106	F.L. Medical Record: Provider – Physical – Intake, Diagnostic Code Entry ("Acquired deaf mutism"), Health Assessment – History, and Health Assessment – Physical (Oct. 3, 2018)	REDACTED & UNDER SEAL
107	F.L. Medical Record: HNR (Dec. 12, 2018)	REDACTED & UNDER SEAL
108	F.L. Medical Record: Provider – Follow Up Care (Dec. 12, 2018)	
109	F.L. Medical Record: SNO (Jan. 17, 2019)	
110	F.L. Medical Record: Nurse – Sick Call – Unscheduled (Feb. 11, 2019)	
111	F.L. Medical Record: Provider – Follow Up Care (Feb. 14, 2019)	
112	F.L. Medical Record: Provider – Follow Up Care (Mar. 8, 2019)	
113	F.L. Medical Record: HNR (Nov. 22, 2019) and Nurse – Sick Call - Scheduled (Nov. 23, 2019)	REDACTED & UNDER SEAL
114	F.L. Medical Record: HNR (Mar. 12, 2020) and Provider – Follow Up Care (Mar. 20, 2020)	REDACTED & UNDER SEAL
115	F.L. Medical Record: Provider – Sick Call – Scheduled (May 26, 2020)	
116	S.C. Medical Record: HNRs (Mar. 3, 2016; Mar. 4, 2016; and Apr. 15, 2016)	REDACTED & UNDER SEAL
117	S.C. Medical Record: MH – Individual Counseling (July 29, 2016)	

Exhibit	Description	
118	S.C. Medical Record: Nurse – Sick Call – Scheduled (Aug. 1, 2018)	
119	S.C. Medical Record: Provider – Sick Call – Scheduled and Health Problem/Condition (May 21, 2019)	REDACTED & UNDER SEAL
120	S.C. Medical Record: Audiology (Aug. 20, 2019)	REDACTED & UNDER SEAL
121	S.C. Medical Record: Provider – Follow Up Care (Feb. 10, 2020)	
122	S.C. Medical Record: Nurse – ICS Response (Apr. 2, 2020)	
123	S.C. Medical Record: Nurse – Infirmary Admission (Apr. 3, 2020)	
124	S.C. Medical Record: Nurse – Infirmary Rounds (Apr. 4, 2020)	
125	Declaration of F.A.H. (Nov. 26, 2019)	REDACTED & UNDER SEAL
126	Declaration of Alejandra S. Torres (interpreter for F.A.H.) (Nov. 26, 2019)	REDACTED & UNDER SEAL
127	F.A.H. Medical Record: Provider – Chronic Care and Refusal to Submit to Treatment Form (May 8, 2019)	REDACTED & UNDER SEAL
128	F.A.H. Medical Record: MH – Individual Counseling (May 15, 2019)	
129	F.A.H. Medical Record: MH – Individual Counseling (June 6, 2019)	
130	F.A.H. Medical Record: Nurse – Sick Call – Scheduled (July 19, 2019)	
131	F.A.H. Medical Record: Nurse – Return From Offsite (July 19, 2019)	
132	F.A.H. Medical Record: Provider – Follow Up Care (July 23, 2019)	
133	F.A.H. Medical Record: MH – Psychiatrist – Scheduled and MH – AIMS Review (July 29, 2019)	
134	F.A.H. Medical Record: MH – Individual Counseling (Sept. 4, 2019)	

Exhibit	Description	
135	F.A.H. Medical Record: Provider – Chronic Care (Mar. 25, 2020)	
136	F.A.H. Medical Record: MH – Mid-Level – Scheduled (Apr. 23, 2020)	
137	F.A.H. Medical Record: MH – Health and Welfare Rounds (May 8, 15, 21, and 29, 2020)	
138	Declaration of C.L. (Nov. 26, 2019)	REDACTED & UNDER SEAL
139	Declaration of Alejandra S. Torres (interpreter for C.L.) (Nov. 26, 2019)	REDACTED & UNDER SEAL
140	C.L. Medical Record: Nurse – Return From Offsite (June 10, 2019)	
141	C.L. Medical Record: Provider – Follow Up Care (June 14, 2019)	REDACTED & UNDER SEAL
142	C.L. Medical Record: Provider – Chronic Care (Sept. 14, 2019)	
143	C.L. Medical Record: Provider – Chronic Care (May 27, 2020)	
144	Declaration of D.M. (Dec. 6, 2019)	REDACTED & UNDER SEAL
145	Declaration of Alejandra S. Torres (interpreter for D.M.) (Dec. 6, 2019)	REDACTED & UNDER SEAL
146	D.M. Medical Record: MH – Psychiatrist – Scheduled (Aug. 5, 2019)	
147	D.M. Medical Record: Nurse – Sick Call – Scheduled (Aug. 19, 2019)	
148	D.M. Medical Record: MH – Individual Counseling (Sept. 6, 2019)	
149	D.M. Medical Record: Provider – Chronic Care (Sept. 18, 2019)	
150	D.M. Medical Record: MH – Mid-Level – Scheduled (May 5, 2020)	
151	D.M. Medical Record: MH – Individual Counseling (May 7, 2020)	

Exhibit	Description	
152	D.M. Medical Record: MH – Mid-Level – Scheduled (May 19, 2020)	
153	R.S. Medical Record: MH – Individual Counseling (June 3, 2019)	
154	R.S. Medical Record: MH – Individual Counseling (Feb. 18, 2020)	
155	R.S. Medical Record: MH – Psychiatrist – Scheduled (Mar. 11, 2020)	
156	R.S. Medical Record: MH – AIMS Review (Mar. 11, 2020)	
157	R.S. Medical Record: Nurse – Sick Call – Scheduled (May 28, 2020)	
158	Declaration of J.F.B (June 1, 2020)	REDACTED & UNDER SEAL
159	J.F.B. Medical Record: Nurse – Sick Call – Unscheduled (Mar. 27, 2019)	
160	J.F.B. Medical Record: Nurse – Sick Call- Unscheduled (Apr. 17, 2019)	
161	J.F.B. Medical Record: Provider – Sick Call – Scheduled (Apr. 23, 2019)	
162	J.F.B. Medical Record: Provider – Follow Up Care (May 7, 2019)	
163	J.F.B. Medical Record: Provider – Follow Up Care (May 21, 2019)	
164	J.F.B. Medical Record: Provider – Follow Up Care (June 19, 2019)	
165	Declaration of C.M. (June 2, 2020)	REDACTED & UNDER SEAL
166	C.M. Medical Record: MH – Individual Counseling (Dec. 5, 2019)	
167	C.M. Medical Record: MH – Individual Counseling (Jan 2, 2020)	
168	C.M. Medical Record: Provider – Chronic Care (Jan. 7, 2020)	

Exhibit	Description	
169	C.M. Medical Record: MH – Group Counseling (Jan. 13, 2020)	
170	C.M. Medical Record: MH – Individual Counseling (May 20, 2020)	REDACTED & UNDER SEAL

Exhibit 1

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. 2:12-cv-00601-ROS

DECLARATION OF [redacted]

I [redacted] declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted]. I have been in ADC custody since June 2016. I am currently housed at ASPC-Eyman Complex, in Meadows Unit. I am over the age of 18 and if called as a witness, I could and would testify competently to the facts stated below, all of which are in within my personal knowledge.

2. I am completely deaf in both ears without hearing aids. I have a little residual hearing, so when I have hearing aids, I can hear environmental sounds and voices, but I cannot distinguish words or understand speech. I received new hearing aids approximately seven months ago.

3. I was born deaf and have been using American Sign Language (ASL) since I was four years old. I learned and practiced ASL at church several times a week with other deaf children, and at a church summer camp for deaf children that I attended for twelve summers.

4. ASL is my primary and preferred method of communication. I was in school from 1956 to 1971, when I graduated high school. During that era, ASL was not available in mainstream schools so I was not taught in ASL.

5. I have never had my proficiency level in reading and writing English assessed. I am not fluent in written English and am not able to understand complex information in written English. I am able to understand simple sentences in written English, such as "I want water," but not beyond that level.

6. Since entering ADC custody, I have not had any kind of language assessment and no one has tested my English language abilities. No one has asked about my preferred method of communication.

7. Written notes during medical appointments are not effective for me because I mostly do not understand the writing. When I can't understand what the nurses or providers are trying to write, I get frustrated and end the appointment.

8. I have repeatedly requested ASL interpreters for medical appointments and have been repeatedly told "no." The only ASL interpreters I have had in medical appointments at ADC has been other prisoners who knew some ASL (fingerspelling in). Other than that, I have never been provided an in-person ASL interpreter, or an ASL interpreter through Video Remote Interpreting or Video Phone, for any medical appointment while in ADC custody.

9. On January 9, 2019, I submitted a Health Needs Request (HNR) asking for my dentures to be adjusted. Another prisoner helped me write out the HNR; he wrote out the problem on another piece of paper, and I copied the sentence onto the HNR form. I did not request an ASL interpreter on the HNR, but when I went to medical for the appointment, I gave them a piece of paper asking for an interpreter and was told "no." I understand that my medical record for that appointment states "communicated through a interpreter with sign." To the best of my recollection, I did not have an ASL interpreter for this appointment. I tried to communicate in ASL the problems I was having with my dentures, but the dentist did not understand me. The dentist wrote information down on a piece of paper, but I did not understand the writing. They did not adjust my dentures and I still cannot wear them without them causing me to gag. I do not understand what they are going to do about my dentures.

10. On October 21, 2018, I had an appointment with a provider about my chronic care conditions. To the best of my recollection, I have never had an ASL interpreter for a chronic care appointment and did not have one for this appointment. The provider showed me a list of medicines on the computer screen and wrote down information on a piece of paper and showed it to me, but I did not understand what the provider wrote. What I understand is that I take medication for blood pressure, Ibuprofen for back and knee pain, and another medication for my kidney. I am not sure that I have high cholesterol. I am not taking medication or shots for diabetes.

11. On September 28, 2018, I had an appointment with a nurse after I came back from my off-site audiology appointment. I understand that my medical record for that

appointment states "Pt is deaf, but able to make needs known." I did not have an ASL interpreter for that appointment. The nurse tried to communicate with me by typing on the computer and showing me what she had typed, but I did not understand what the nurse was trying to communicate. I do not remember the nurse trying to explain how to submit an HNR if I had problems, or if she did I did not understand what she was trying to communicate.

12. On September 20, 2018, I had an appointment with a nurse about my back and leg pain. I understand that my medical record for this appointment states "Cannot speak, uses a sign language inmate to communicate." To the best of my recollection, during this appointment I went to medical with a friend of mine, another prisoner who knew some ASL. The nurse would only allow me in the room at first, but after the nurse and I tried to communicate and could not understand each other, the nurse eventually let my friend come in to help us communicate.

13. On August 12, 2018, an Incident Command System (ICS) emergency was called after I felt like I was going to black out and I was brought to medical. During that incident I was shaking and felt funny, and everything was spinning. I understand that my medical record for that ICS states "Healthcare Staff Used for Interpreter Services," and "IM has a translator who knows sign language who assisted with the translation." No one on the healthcare staff tried to communicate with me in ASL during the ICS, and no other person interpreted either. During the ICS I was worried about what happened to me and wanted to be able to ask what was going on but could not because I had no interpreter. No one explained to me what happened or what I should do to follow up. All I knew was that I stayed in medical for a while and was then sent back to my housing unit.

14. On June 18, 2018, I had an appointment with an optometrist. At the appointment I wrote a note and asked for an ASL interpreter, but no interpreter was provided. The optometrist was speaking to me fast and I did not understand him, and he did not try to write anything down. I was not able to explain to the optometrist what was happening with

my eyes during the eye test. The updated prescription glasses that I received after this appointment are not the correct prescription; I see better out of my old glasses that have an outdated prescription. I did not understand that I was diagnosed with cataracts, or if the optometrist tried to explain this I did not understand it.

15. On July 24, 2017, when I was living in Cook Unit, I had an appointment with a provider. I understand my medical record for this appointment states: "Healthcare Staff Used for Interpreter Services." To the best of my recollection, I never had healthcare staff or another prisoner interpret for me during medical appointments at Cook. While there was a Video Phone that we could use for phone calls and legal calls at Cook, it was never used during medical appointments. In general, at Cook providers would insist on writing notes during appointments to try to communicate, the same as at Meadows.

16. During my intake appointments in 2016 I did not have an ASL interpreter. The providers would only try to communicate by written notes and I was not able to understand very well what they were trying to tell me. I understand that my medical record from my mental health intake appointment on June 21, 2016, states: "Im deaf but able to read lips, read basic sentences and write basic responses." I am sometimes able to understand a bit by lip reading, but someone would have to talk very slowly and the providers talk too fast for me to understand. I cannot have a conversation with someone by lip reading.

17. This declaration was written for me and read to me with the assistance of a sign language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED this 12th day of April, 2019 in Florence, Arizona.

[redacted]

Exhibit 20

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. 2:12-cv-00601-ROS

DECLARATION OF [redacted]

I, [redacted] declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted]. I have been in ADC custody since November 2018. I am currently housed at ASPC-Eyman Complex, in Meadows Unit. I am over the age of 18 and if called as a witness, I could and would testify competently to the facts stated below, all of which are in within my personal knowledge.

2. I am profoundly deaf in both ears without hearing aids. Without hearing aids I can only hear very loud sounds, and cannot hear any words. I do not currently have hearing aids. When I have a hearing aid in my right ear, I can hear sounds, voices, and some words, but cannot fully understand speech. My left ear is completely deaf and damaged too severely to benefit from a hearing aid.

3. Although I was not born deaf, I lost my hearing due to illness at age seven. My first languages were English and Spanish, but after I became deaf I learned and used American Sign Language (ASL) as my primary language.

4. I am fluent in ASL and it is my primary and preferred method of communication. I was educated in ASL primarily in schools for the deaf, including the Phoenix Day School for the Deaf and Sequoia School for the Deaf. When I attended mainstream school, I had an ASL interpreter in class. I attended Mesa Community College for a few semesters following graduation from high school, and had ASL interpreters for all my classes, with the exception of one class I took on becoming a Certified Deaf Interpreter, which was taught in ASL.

5. I received some speech therapy when I was a teenager and am able to vocalize some English words, but generally when I try to speak English hearing individuals are not able to understand me.

6. When I graduated high school, my proficiency in reading and writing English was determined to be at about a third grade level. I am not fluent in written English and am not

able to understand complex information in written English. I do not know medical vocabulary in English.

7. Since entering ADC custody, I have not had any kind of language assessment and no one has tested my English language abilities. I have also never been asked about my preferred method of communication.

8. Written notes during medical appointments are not effective for me because I mostly do not understand the writing. For example, out of several pages of notes the doctors write, I can usually understand just a few words.

9. I have never been provided an in-person ASL interpreter, or an ASL interpreter through Video Remote Interpreting or Video Phone, for any medical appointment while in ADC custody.

10. At my intake appointments at Alhambra, I informed staff that I was deaf and asked for an ASL interpreter, but no interpreter was provided during that process. I was only given a bracelet that says "Hearing Impaired" on it, which I have attached to my identification badge. Following my experience at my intake appointments, I have not requested ASL interpreters in medical appointments because it did not seem like it was something I could request.

11. I have asthma and use an inhaler, and I submitted a Health Needs Request (HNR) on February 21, 2019, asking for a refill for my inhaler. I was able to write my identifying information and the first sentence of the description on the HNR, but another prisoner helped me by writing the rest of the description on the HNR because I was not able to write it. I am not able to read the response written in the "Plan of Action" section and I do not understand what it means. All I know is that medical would not give me a second inhaler, and I need one so that I have an inhaler available in the several days between when my prescription runs out and when it is refilled.

12. I sometimes try to fill out HNRs by copying old forms, but I cannot write well so mostly other prisoners write out my HNRs for me. The HNRs I submitted on the following

dates were written by another prisoner on my behalf: November 9 and 14, 2018; January 4 and 11, 2019.

13. At my optometrist appointment on February 10, 2019, the optometrist just spoke at me and I did not understand him, and he did not try to write anything down. I tried to communicate by fingerspelling in ASL and vocalizing the letters on the eyechart. All I was able to understand from the interaction is that I need prescription glasses, which I guessed because the optometrist showed me a prescription.

14. On February 1, 2019, when I was seen by medical after returning from an off-site appointment, the nurse I saw tried to communicate with me by writing notes, and I only understood it a little. There was a lot of vocabulary that the nurse used that I did not understand.

15. On January 24, 2019, I had an appointment with a provider about foot pain and my request for new shoes. I have foot problems and require a special kind of shoe or insole. During the appointment, the provider tried to communicate with me by talking, writing on the computer, and filling out a form on the computer and showing it to me, which I mostly did not understand. I did not understand when I left the appointment why medical was not going to provide me shoes.

16. On January 14, 2019, I had an appointment with a nurse about my foot pain and my request for an eye exam. I understand that my medical record for that appointment states "health care staff used for interpreter services." I do not remember healthcare staff ever interpreting for me during any medical appointments, including this one.

17. On December 12, 2018, I had an appointment with a provider about my request for hearing aids. The provider tried to communicate with me through written notes, but I didn't understand very much of it. I do not remember being shown a written treatment plan, or I did not understand it if it was shown to me. I did not know when I left that appointment what was going to be done so I could get hearing aids.

18. On December 11, 2018, I had an appointment with a nurse regarding my request for hearing aids. The nurse tried to communicate to me through written notes, and understood just a little bit of the written notes.

19. On November 17, 2018, I had an appointment with a provider about my asthma and foot pain. I understand that my medical record for that appointment states "health care staff used for interpreter services." I do not remember healthcare staff ever interpreting for me during any medical appointments, including this one.

20. On November 18, 2018, I had my medical and mental health intake appointments at Alhambra. During these appointments the providers interviewed me, gave me papers to fill out, and wrote on the computer, but I did not understand what was going on very well. I did not have an ASL interpreter during any of my intake interviews.

21. On November 29, 2018, I filled out and signed a Durable Health Care Power of Attorney form and a Living Will form. No one explained to me what these forms mean, and I am not sure what these forms are or what they mean. I didn't understand most of the writing on the forms, I just saw where the boxes were to sign and signed them. These forms were not interpreted for me in ASL before I signed them. On the Living Will form I just picked the last choice without understanding the choice or what it meant. After the choices were interpreted for me by an ASL interpreter in my interview for this declaration, I do want the choice that is selected on the Living Will form.

22. On November 9, 2018, I submitted an HNR to request an inhaler and on November 11, 2018, I signed a refusal form for the inhaler. No one explained to me what the refusal form was or what it meant, and I did not understand that it was a refusal and do not understand the words on the form. I did not intend to refuse asthma treatment of any kind. I would have never refused asthma treatment, I wanted two inhalers.

23. On November 8, 2018, I was given a Mental Health Consent form to sign. No one explained to me what this form was, but I was expected to sign it so I did. I can understand some of the words, but do not understand what the form means.

24. This declaration was written for me, and then read to me with the assistance of a qualified sign language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED this 12th day of April, 2019 in Florence, Arizona.

Exhibit 48

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. 2:12-cv-0060l-ROS

DECLARATION OF [redacted]

I, [redacted] declare:

1. I was a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number was [redacted]. I was in ADC's custody from about July 9, 2007 until September 5, 2018.

2. I am over the age of 18 and if called as a witness, I would and I could testify competently on the facts listed below, all of which are within my personal knowledge.

3. I was a *Parsons* class member for portions of 2015 and 2018 when I was in ADC's custody at the Arizona State Prison Complex (ASPC)-Eyman Prison. In 2015, and early 2016, I was housed at ASPC-Eyman. Later, I was transferred to ASPC-Kingman, a private prison under contract with ADC which is operated by The Geo Group, Inc. I returned to ASPC-Eyman Prison in June 2018 and remained there until my release from prison in September 2018.

4. I am deaf. I was born with very little functional hearing. Growing up, I lost more of my functional hearing. As an adult, I cannot hear conversational speech. With hearing aids, I can hear and feel the vibration of loud sounds, such as the slamming of a door or the clapping of an audience.

5. My primary and preferred method of communication is sign language and I need a sign language interpreter to communicate effectively with hearing persons about important, complex or lengthy communication.

6. I use a combination of American Sign Language (ASL) and Signed Exact English (SEE). I am fluent in ASL.

7. ASL is a visual language with its own vocabulary, word order, and sentence structure that is different from English. There is no written form of ASL. There is not a sign for every English word or an English word for every sign.

8. SEE is a type of sign language that attempts to communicate in a form closer to the English language.

9. For complex, technical, important or new information, I rely on ASL. For basic, straightforward communication, I use SEE. ASL is necessary for complex, technical, important or new information because it is more of a visual language that helps me see what is being said. ASL helps me clarify in real time when I do not understand what is being said.

10. I do vocalize some words while I sign. I do not know if my speech is clear or understood by others.

11. When I have a qualified sign language interpreter, the interpreter matches my language needs and moves between ASL and SEE for effective communication.

12. When I attended elementary and middle school during the 1970s, I attended schools that used the oral method of instruction. The oral method of instruction focuses on use of lip reading and speech when communicating with others. The schools provided instruction in lip reading; a Phonic Ear, which is an assistive listening device that amplified sound; and speech therapy. The school did not provide any instruction in sign language.

13. Lip reading proved to be an ineffective way for me to learn and receive information from spoken English. I missed a lot of information presented in school because only about one-third of the English language can be understood from reading lips. Other factors can diminish the ability to read lips, such as poor lighting, a speaker's facial hair that covers the lips, the distance between the speaker and me, and whether the speaker is looking directly at me. Lip reading over an extended period of time is exhausting and can lead to decreased comprehension and mistakes. I also find that many hearing persons become inpatient when asked to repeat information missed while lip reading.

14. Because my hearing continued to deteriorate, in high school, I began attending schools for the deaf where I learned sign language and attended classes taught in sign language.

15. I learned ASL during high school. For the first three years of high school, I attended Model Secondary School for the Deaf (MSSD), a residential high school program for deaf and hard-of-hearing students located on the Gallaudet University campus in Washington, D.C. Later, I attended California School for the Deaf (CSD) in Fremont, California. At these high schools, I received ASL instruction. At the schools, all class information, communications during class, and other school-related communications with my peers and teachers were in ASL. I also used ASL to communicate with my peers after school and on weekends in the residential program.

16. During my last year of high school, I transferred to a public high school with hearing students. The school district provided an ASL interpreter for all of my classes. The ASL interpreter translated all class information, communications during class, and other school-related communications with my peers and teachers. I was able to learn and participate in all my classes because I received the instruction in ASL.

17. I completed high school.

18. I am able to understand important, lengthy and complex medical or healthcare information presented in ASL, such as information related to medical examinations, diagnosis, treatment, risks and benefits of medications.

19. During the time that I was in ADC custody, ADC did not provide a sign language interpreter for any health care visit. Instead, healthcare staff exchanged notes with me during visits.

20. Exchanging notes about my health care does not provide effective communication for many reasons. I receive less information when it needs to be written because it takes longer to write than to speak/translate information in sign language, and the healthcare providers are in a hurry. If I do not understand a concept or a medical term in the note, the healthcare provider often does not provide a sufficient explanation for the same reasons. I can understand basic health information, but when it comes to the side effects of medications, for example, I have difficulty understanding. Complex information, such

as lab results and the normal values for the lab results, often requires translation into ASL for me to understand fully the communication. I am also unable to provide the full details of my symptoms, concerns or reason for the visit because it takes time to write down the information and the healthcare provider is often too inpatient to wait.

21. While I was in ADC custody, no one asked me for my primary or preferred language or assessed my communication needs or my ability to write or speak English.

22. In December 2014, when I was housed at ASPC-Eyman, I filled out a Health Needs Request because there was a lump on my right testicle and I was concerned that it might be prostate cancer, herpes or a tick. ADC did not provide a sign language interpreter for this health care visit. Health care staff did an exam and some lab work. However, health care staff did not write notes or use an interpreter to explain what they thought the lump might be, what conditions they were trying to rule out, what lab tests they were running, or what the lab work might reveal. Health care staff did not communicate the results of the lab tests to me in notes or with an ASL interpreter. I tried to ask again but health care staff did not communicate with me.

23. On March 26, 2015, when I was housed at ASPC-Eyman, I filled out a Health Needs Request because a medication that I was taking was producing alarming side effects. After I took the medication, my throat closed off. It did not close off completely, but it made it hard to breathe and felt like it was coated with peanut butter and I could only communicate what was going on by writing it down on paper. There was no interpreter for me to explain the side effects to the healthcare professional. Healthcare staff wrote a note that I could stop taking the medication. I thought I understood that they were going to prescribe a different medication to replace the one that caused the side effects.

24. On June 10, 2015, when I was housed at ASPC-Eyman, I filled out a Health Needs Request because the healthcare provider gave me the same medication that I had explained, using notes, caused side effects. When I got the refill it was the same pill that

caused the side effects. I wanted a different medication. I just got a note back saying that they would discontinue giving me the medication instead.

25. On June 18, 2015, when I was housed at ASPC-Eyman, I filled out a Health Needs Request because I could not understand the doctor's handwriting about my previous questions about the medication causing a side effect.

26. On February 13, 2016, when I was housed at ASPC-Eyman, ADC tested me for (what I believe) was for Tuberculosis (TB). They did not use written notes or sign language services to explain to me whether it was routine test, if there was any TB in the facility, or the results of the testing.

27. On June 21, 2018, a healthcare professional processed me into ASPC-Eyman upon my transfer from ASPC-Kingman. At the visit, ADC did not offer or provide a sign language interpreter. I did not receive any patient education or information about how to access healthcare at the facility. We communicated by writing and answering questions on paper.

28. This declaration was taken, written and read to me with the assistance of a qualified legal sign language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty that the foregoing is true and correct.

EXECUTED this 2nd day of April, 2019 in Phoenix, Arizona.

[redacted]

Exhibit 52

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. 2:12-cv-00601-ROS

DECLARATION OF [redacted]

I, [redacted] declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted] I have been in ADC custody since January 2016. Until recently, I was housed at ASPC-Tucson Complex, in the Catalina Unit. Currently, I am housed at ASPC-Lewis.

2. I am over 18 years old and if called as a witness, I would and I could testify competently to the facts listed below, all of which are within my personal knowledge.

3. I became hard of hearing when I was 5 years old. I continued to lose my residual hearing until I was 13 years old. At that time, I became completely deaf. I do not have any residual hearing.

4. As an adult, I do not use hearing aids. I cannot hear spoken words or environmental noises, such as sirens. I do feel vibrations from loud noises.

5. I communicate using a form of Pidgin Sign English (PSE). PSE combines elements of American Sign Language (ASL) and English. PSE is not the same as Signed Exact English (SEE), which is a language that uses signs signed in the same order and following the grammar rules of English.

6. There are many varieties of PSE, some more closely related to ASL and others more closely related to English. There is not one set of grammatical rules for PSE because there are so many varieties of PSE. The variety of PSE that I use includes conceptual ASL in an order that approximately follows English word order.

7. PSE is my primary and preferred language. I have a passing fluency in ASL, which means I can understand and use ASL. However, I feel more comfortable using PSE because it was not until I was 14 years old that I received formal education in ASL. So prior to age 14 years old, I was familiar with English vocabulary and word order.

8. When provided a qualified sign language interpreter, the sign language interpreter will observe my use of language and adjust the interpreting to meet my specific language needs.

9. When new, complex or important healthcare information is presented to me, I need the sign language interpreter to use ASL conceptual signing so that I can fully understand the communication. For example, with unfamiliar healthcare information or words, I need the interpreter to translate concepts into ASL because ASL provides more detailed information about the concept than an English word. When I understand the concept in ~~new or more complicated concept~~ in ASL, I can then ask questions to make sure I understand the new or complex concept. ASL uses hand shape, position, and movement; body movements; gestures; facial expressions; and other visual cues to convey new or complex concepts.

10. I was exposed to written and spoken English before I became deaf. As I lost my hearing, my family introduced me to home signs to communicate because I could not hear conversational speech.

11. When I attending elementary and middle school from about 1987 to 1995 and still had some residual hearing, I attended a school that used the oral method of educating deaf students. Under the oral method, the teachers emphasized lip reading, speech, and imitating speech on the lips. I was not able to fully participate and learn with the oral method because I missed information. It was difficult to follow along in class as my hearing loss became more profound. The school did not teach sign language, but the students used ASL and PSE to communicate with each other.

12. After becoming completely deaf, I attended the Phoenix Day School for the Deaf (PDSD). There, I began to receive formal training in sign language and was taught American Sign Language (ASL). The school conducted classes in sign language. I communicated with teachers and other students in sign language. I was able to learn and fully participate in school once I learned sign language and the information was presented in ASL.

13. I attended high school at South Mountain High School. In high school, I attended regular classes. The school district provided sign language interpreter(s) for the full

school day. The assigned sign language interpreter(s) translated all classes in ASL. The interpreter translated all class information, communications during class, and other school-related communications.

14. I completed high school and earned a diploma.

15. I am fluent in PSE and can understand complex communication in PSE, which as I stated above combines conceptual ASL and English, including information about medical conditions, treatment, diagnoses, testing, and risks and benefits of treatment.

16. I sign to communicate. I do make vocalizations as I sign, but there is no situation in which I am comfortable using spoken English to communicate. I do not vocalize in complete words and I do not feel confident that others would understand my vocalizations.

17. My primary and preferred method of communication is PSE.

18. I cannot effectively communicate with healthcare providers using written notes.

19. I do not know if the school district ever did a specific assessment of my ability to read or write in English, but as a high school graduate of a regular high school, I feel comfortable in reading and writing in English about basic, everyday communications. I cannot communicate effectively about new, important or complex healthcare information in written notes.

20. I need a qualified sign language interpreter because reading and writing notes in English about important healthcare information or about rules and policies affecting my healthcare is an ineffective method of communication. Important, often complex, communication takes a long time to explain, or may introduce information to me that I am unfamiliar with. I find that often when using notes to communicate in healthcare visits, the healthcare professionals provide less information than they would provide if they could say it. The notes are short. It takes a lot less time to tell me information than to write it down. The healthcare professionals are, at times, impatient, if I need to follow up on information in the note or if I write that I do not understand. Because I am not

fluent in written English, mistakes and misunderstandings are likely to occur. Mistakes about healthcare information can have serious consequences.

21. Although my elementary school provided instruction in lip reading when I attended an oral school ~~in elementary school,~~ lip reading is not an effective way for me to receive important information. I cannot understand most English words through lip reading alone. Other factors can make lip reading even less effective or useless. For example, if the person turns away from me, looks down at a file or paperwork when talking to me, or the lighting in the room is too low, I will not be able to read their lips.

22. While in the community, I requested and used sign language interpreters, either in-person or remotely through Video Remote Interpreting (VRI), during medical appointments. I preferred on-site sign language interpreters because the communication was generally clearer and the interpreter could understand and match my language needs better. Depending upon the reason for the healthcare visit, VRI may not be flexible enough to communicate the information.

23. When I reentered ADC's custody and processed through Intake in the Alhambra Unit in 2016, neither ADC nor their healthcare provider asked me to identify my primary language or preferred language. No one performed any assessment of my ability to communicate in English or my language needs. At Alhambra Unit, ADC personnel showed me written questions in English and asked me to indicate yes or no. I was not familiar with some of the medical terminology in the questions that were asked during intake. I did the best I could without a sign language interpreter.

24. Since ADC's intake processing, neither ADC nor their healthcare provider have asked about my primary or preferred language for communication in healthcare encounters.

25. Neither ADC nor its healthcare provider has ever offered me a sign language interpreter for any healthcare visit while I have been in ADC's custody. I have never refused interpreter services at ADC.

26. On February 18, 2018, I transferred from ASPC-Kingman to ASPC-Tucson facility and was sent to the Medical Unit for processing. There was no sign language interpreter for the visit. Healthcare staff did not provide any patient education or any explanation about how the health services worked at ASPC-Tucson during the appointment. Healthcare staff exchanged a few basic notes with me during the visit.

27. On February 22, 2018, I had another visit in the Medical Unit in which they asked about a history of my past diagnoses of asthma and Hepatitis C. There was no interpreter provided and the only communication occurred through some basic notes. I wanted information about the status and prognosis of Hepatitis C. I have not received any information about the results of lab tests, whether the results are favorable or poor, the treatment guidelines for incarcerated persons living with Hepatitis C, and what physical symptoms to look for as a sign that treatment may be necessary. Although I received some basic information in written English about dietary recommendations, I did not receive any detailed patient education about lifestyle and dietary information. Based on a limited exchange of notes with other non-deaf incarcerated persons, they appear to be better informed by healthcare staff at ADC about their diagnosis of Hepatitis C than I am.

28. On May 17, 2018, I had an appointment to see a doctor for a visit about my diagnosis of Hepatitis C. When I arrived for the appointment, I learned that the appointment would be conducted as a telemedicine appointment. There was no sign language interpreter present at the doctor's office or at my location in the ASPC-Tucson. There were no captions. A nurse was present in the room with me but she did not sign and did not write notes to tell me what the doctor was saying. She would listen to the doctor and type notes into a laptop. The laptop was not turned in my direction so I could not read the screen. There was no written transcript of the information that the doctor provided. The appointment lasted about 5 minutes and ended abruptly.

29. Even to this day, ADC and their healthcare provider have not provided me with a consultation about the status and prognosis of my chronic condition of Hepatitis C.

30. This declaration was taken, written, and read to me with the assistance of a qualified sign language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

DATED May 6, 2019 in Buckeye, Arizona.

[redacted]

Exhibit 62

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Richard Pratt, Division Director, Health Services Contract Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF [redacted]

I, [redacted], declare:

1. I was formerly a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number was [redacted]. I was in ADC's custody from about December 17, 2016 through January 25, 2019, when I was released.

2. I am over the age of 18 and if called as a witness, I would and I could testify competently on the facts listed below, all of which are within my personal knowledge.

3. I was a *Parsons* class member during my time at ADC. I was housed in ASPC-Tucson, in Catalina, Manzanita, and Winchester Units.

4. I was born deaf. When I was five years old, I had surgery to get cochlear implants, but I stopped using them a few years later, because they would give me headaches. Presently, I do not use hearing aids or implants. I cannot hear sounds, but when sounds are loud, I can hear and feel the vibrations.

5. My primary and preferred method of communication is American Sign Language (ASL). I started learning ASL with my family when I was four years old, and I am fluent in ASL. My family and I learned ASL together, and most members of my family are fluent in ASL.

6. ASL is a visual language with its own vocabulary, word order, and sentence structure that is different from English. There is no written form of ASL. There is not a sign for every English word or an English word for every sign.

7. I completed high school and studied automotive mechanics at Mesa Community College (MCC). At MCC, I had an ASL interpreter for my classes.

8. I am able to read and write basic information in English, but when it comes to more complex, difficult information, I can only communicate using ASL. I often find it difficult to communicate just by writing in English, so I rely on ASL instead. I am unable to vocalize in English.

9. I am able to understand important, lengthy and complex medical or healthcare information if it is presented in ASL, such as information related to medical examinations, diagnosis, treatment, risks and benefits of medications.

10. While at ADC, I was not provided a certified ASL interpreter during important medical and mental health encounters, including medical appointments, psychiatric consults, psychologist/therapy meetings, dental procedures, and intake.

11. There were several times I was asked by ADC prison officials and medical staff if I could read lips. I responded "No" each time I was asked this question. I have never learned to read lips because I use ASL to communicate. Instead of providing an ASL interpreter for me during my appointments, medical staff would exchange written notes in English.

12. There were times when Corrections Officers–III (CO-IIIs), would try to speak to me. They would use other inmates as "interpreters." These "interpreters" were not fully fluent in ASL and could only sign basic information or use finger-spelling to spell out English words.

13. Around December 7, 2016, I went through the intake process at ASPC-Phoenix. The intake process includes dental, mental health, and health evaluations. I asked for an ASL interpreter, but I was told that officials could not find an interpreter. I was shown a list of questions and was told to nod "yes" or "no" to each question. There were medical terms in English I did not understand and since the intake process is designed to be quick, I could not ask for clarification.

14. On May 22, 2017, ADC had another inmate translate for me when I met with a nurse. The appointment was about medication, but the other inmate was not a qualified ASL interpreter. He also did not translate very well because he only knew basic signs.

15. I did not want to use inmates to "interpret" during my other health encounters because my medical information is private and because I was afraid that the inmate

"interpreter" would tell other inmates about my health problems, and they would use the information as a tool to threaten me.

16. On May 26, 2017, I met with a psych associate. I asked the psych associate for an ASL interpreter for the appointment, but I was denied. Instead, we communicated by exchanging written notes in English. I wanted to discuss my anxiety but I had a hard time discussing it with just pen and paper. This meeting was short and most of the time was spent on reading and writing down questions and responses. It was very difficult to fully discuss my mental health problems this way.

17. Around July 17, 2017, I was punched in the jaw by another inmate. The punch was so severe that it dislocated my jaw, my jaw had to be wired shut, and I had to have surgery. After I was attacked, I was placed in a holding cell for less than a day. During this time, I was losing a lot of blood and I felt dizzy. I tried to communicate how I was feeling, but I was only given a towel for the blood.

18. During treatment, I asked for an ASL interpreter, but I was denied. I was forced to communicate by writing in English. I tried to explain to medical staff how I was feeling, and the pain I was experiencing, but it was difficult to go into detail in writing. I could not express some of the issues I had or the pain I was feeling in writing.

19. On February 13, 2018, I had lab work performed. This was to get clearance to work in the kitchen. On March 6, 2018, I filled out a health needs request (HNR) to get the results to the lab work. I was not asked whether I needed an interpreter, nor was I given one to explain what the lab results meant. The provider and I communicated by exchanging written notes in English. The provider did not explain the test results, but just told me that I was cleared to work in the kitchen.

20. On June 14, 2018, when I was housed in the Catalina unit, I filled out an HNR for extreme earaches. While cleaning my right ear, I accidentally pushed too hard, causing bleeding. I was in pain for several days. On June 15, 2018 I saw a nurse and was told, through handwritten notes, that there was no bleeding and given ibuprofen. On June 19,

2018, I was still in a lot of pain, and during this healthcare encounter, the provider identified some bleeding and noted that my ear was tender. When I was seen by the nurse, I was not asked whether I needed an ASL interpreter, nor was I provided with one.

21. On July 3, 2018, I met with a psych associate. We communicated by exchanging notes in English. I expressed how frustrated I was because I lost phone privileges for trying to call my family more than three times, using TTY. I also expressed how frustrated I was and how lonely I felt because the other inmates would not take the time to try to communicate with me. This meeting was short and I felt like it did not help me at all.

22. On July 26, 2018, I had individual counseling appointment with a psychologist. We communicated by writing notes in English. I told the psychologist about how frustrated I was with not having an ASL interpreter and not being able to communicate, and how isolated I felt.

23. On December 5, 2018, I filled out a HNR for excessive itch problems and dry skin. Parts of my body were irritated and I was given anti-itch cream earlier, but it did not help. The itching went on for weeks and it kept spreading. I requested to be seen by a provider with an ASL interpreter, but I was not given an interpreter.

24. On December 23, 2018, I filled out a HNR to be seen by a provider. I was experiencing flu symptoms: headaches, upset stomach, and runny nose. I asked to have an ASL interpreter, but when I was seen by the nurse, I was not provided with an interpreter.

25. There were programs and group counseling ADC offered. I went to a few of these programs and asked for an interpreter, but was denied. I wanted to participate because I thought it could be useful, but when I went, I could not understand what was being said. I stopped attending after a couple of sessions.

26. This declaration was taken, written for me, and read to me with the assistance of a qualified legal sign language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty that the foregoing is true and correct.

EXECUTED this 25 day of November, 2019 in Phoenix, Arizona.

[redacted]

Exhibit 83

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. 2:12-cv-00601-ROS

DECLARATION OF [redacted]

I, [redacted] declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted] I have been in ADC custody since October 2014. I am now housed at ASPC-Tucson Complex, in the Catalina Unit.

2. I am over the age of 18 and if called as a witness, I would and I could testify competently to the facts listed below, all of which are within my personal knowledge.

3. I am completely deaf. I cannot hear spoken words or environmental noises, such as alarms or sirens. I do not have any residual hearing. I do not use hearing aids.

4. I was born deaf. I am "deaf of deaf," which means I was born deaf in a deaf family. I am eighth generation deaf.

5. American Sign Language (ASL) is my first, primary, and preferred language.

6. I grew up communicating with my family in ASL. My mom was the first person to teach me signs. In the beginning, she taught me home signs, which are signs that we made up or modified to use at home. She then began to teach me ASL. My immediate family members are deaf, except for my dad. He is hard of hearing, but he is fluent in ASL and communicates with me in ASL.

7. I completed high school through Grade 11.

8. I was educated in ASL. For about one year, I attended the California School for the Deaf (CSD) in Fremont, California. That school taught all classes in ASL. I received all formal education in ASL at the California School for the Deaf. For the rest of my education, I went to public schools and attended regular classes, in which the school district provided me an ASL interpreter for the full school day. The ASL interpreter interpreted all class information, communications during class, and any other school-related communications. My ASL interpreter in school also educated me about ASL.

9. I am fluent in ASL and can understand complex communication in ASL, including information about medical conditions, treatment, diagnoses, testing, and risks and benefits of treatment.

10. I sign to communicate. I do not vocalize English words when communicating with non-deaf individuals.

11. While in the community, I requested and used ASL interpreters, either in-person or remotely through Video Remote Interpreting (VRI), during medical appointments.

12. When I was in the custody of the California Department of Corrections and Rehabilitation (CDCR) and in California prison, I used professional ASL interpreters for medical appointments. CDCR always provided a professional ASL interpreter for all my medical appointments.

13. When I entered ADC's custody in the Alhambra Unit, ADC did not ask me for my primary language or preferred language. ADC did not perform any assessment of my ability to communicate in English.

14. During intake, I wrote a note to ADC healthcare staff that I was deaf and asked for an ASL interpreter, but staff did not provide an interpreter for intake. All intake information collected by healthcare staff was obtained by having me read information on a paper and indicating "yes" or "no" by nodding or shaking my head. I did not understand a lot of the vocabulary in the medical questionnaire when I read it and had to guess.

15. Since intake, ADC healthcare staff have not asked about my primary language or my preferred language. I have never been provided an ASL interpreter for any of my healthcare encounters at ADC.

16. During healthcare encounters at ADC, ADC has either attempted to use an unqualified fellow incarcerated person to interpret, used written English notes, or simply ignored that I could not hear and talked to me. None of these methods provide me with effective communication during healthcare encounters because my first and primary language is ASL, and I am not fluent in English.

17. In my dental visit described below, ADC used [redacted] an incarcerated person, to interpret communications. After this visit, I told healthcare personnel that I did not want to use an incarcerated person for any future medical visits. [redacted]

knows some basic signs and can fingerspell English words. But he is not fluent in ASL. He can sign simple sentences, such as, "How are you?" but he does not know how to translate English into ASL. ASL is an entirely different language from English, with different vocabulary, sentence order, grammar and other rules. There is not an English word for every sign or a sign for every English word. [redacted] is not fluent or proficient in ASL to convey complex information or medical information.

18. I do not believe I can be provided effective communications by having any incarcerated person to translate during healthcare encounters because they are not impartial. Incarcerated persons may not accurately interpret information for me, like ASL interpreters are required to do, because of their personal relationship with me and their unwillingness to convey news that makes them uncomfortable, or that they find too personal or revealing.

19. When an incarcerated person is also under ADC custody, I do not feel comfortable that they can interpret the information impartially for many reasons. They have their own interests, such as whether they fear voicing my complaints to ADC or want to appear as if they are more skilled in signing than they might actually be.

20. I do not believe I can be provided effective communications by having any incarcerated person translate during healthcare encounters because they are not subject to the same ethical requirements of ASL interpreters. A licensed ASL interpreter is required to keep communications confidential. In medical discussions with an ASL interpreter, I would be able to have complete confidentiality like other incarcerated persons because both the medical staff and ASL interpreter are required to keep my information confidential, but an incarcerated person is not required to do the same and can tell my private medical information to anyone he chooses. Other non-deaf incarcerated persons are not required to sacrifice confidentiality to achieve effective communication during a healthcare encounter. It puts me at risk when other incarcerated persons know my healthcare information. If an incarcerated person who interprets for

me tells other incarcerated persons about my healthcare concerns, another incarcerated person could use that information against me.

21. I would be uncomfortable sharing sensitive, personal information with medical staff if another incarcerated person was there and could have access to all the information I was sharing.

22. In some encounters, healthcare staff wrote notes to attempt to communicate with me. Handwritten notes are not an effective way for me to communicate with medical staff because I am not fluent in reading and writing in English. I am only comfortable communicating about very basic information in writing in English. I understand only basic written English and can only write responses in basic English. I am not able to understand complex information in English, including medical information about health conditions, treatment, testing, diagnosis, and risks and benefits of treatment and medication. For me, communication in English leads to misunderstandings and miscommunication. Because of the language differences, I may not even know that a misunderstanding has occurred.

23. I do not recall whether the public school assessed my proficiency in reading and writing in English because I always had an ASL interpreter to translate information from English to ASL.

24. ADC did require that I take a test called the "TABE" because I had not graduated high school. I believe an ADC staff person told me that I scored at about 3.5 grade level on the TABE. During the TABE, I read written material in English and answered questions. ADC did not provide an ASL interpreter during the test. I recall a lot of the English vocabulary in the TABE was not familiar.

25. In August 2018, I had a terrible toothache that was a 10 on a scale of 0-10 with 10 being the most painful. On August 20, 2018, I filled out a Health Needs Request (HNR) form. I wrote in the HNR that I am deaf and cannot hear or talk and need sign language. I was seen on August 21, 2018, and no interpreter was present. I was upset that there was

no interpreter. The healthcare staff that they would try to write notes to me or get an incarcerated person to translate.

26. Healthcare staff used [redacted] an incarcerated person, to interpret for that appointment, but he did not know enough signs to be able to effectively translate my questions or concerns or convey responses to my questions. The healthcare staff made up a sign to show a pulling motion, which is how I knew they planned to pull my tooth. I wanted to know why they could not do anything other than pull it. I did not want my tooth pulled. I could not make myself understood and I could not understand why there were no other choices. In the end, all I knew was they were going to pull the tooth. The pain was so bad that I allowed them to pull the tooth without understanding any options and the risks and benefits of having a tooth pulled rather than fixed.

27. The healthcare personnel pulled my tooth on August 28, 2018. [redacted] was present but he did not translate any information about the procedure.

28. I was given a medication for the tooth extraction. The only information that I had about the medication was the information on the medication itself. The staff did not provide any patient education or instructions about taking the medication. I did not ask any questions because I knew that [redacted] was not able to effectively translate my questions or their answers. I just took the pill bottle and tried to read and understand the directions on my own. And while I understood the directions, I did not get to ask questions about what side effects to expect and whether I would likely need to refill it.

29. After the August 2018 visit, I do not recall that ADC used [redacted] at any of my appointments because I believed he had left the facility.

30. On December 24, 2018, I filled out an HNR because I was not feeling well. I had the following symptoms: upset stomach, headache, a suspicious bump in my mouth, and dry skin on both feet. In the HNR, I wrote, "Please make sure you provide (American Sign Language interpreter) on appointment due to Policy D.O. 704.15." I was very

concerned about the sore in my mouth and wanted an oral cancer screening. I had been a smoker for many years and was worried it could be cancer of the mouth.

31. When I was seen on December 25, 2018, I wrote down, "Where is the interpreter?" The nurse, RN Thayer, wrote a note to me that there was no ASL interpreter. I asked him to provide a copy of that note but he refused to do so. The health care staff offered to allow me to use a TTY to communicate during the visit.

32. The healthcare staff wanted to use the TTY for a purpose it is not intended for—to have a face-to-face communication. Instead of calling another individual, the healthcare staff wanted us to sit side-by-side and take turns typing on the TTY keyboard and reading the screen or printout.

33. Even if the TTY was intended for face-to-face communications, which it is not, the TTY is an obsolete phone for people who are deaf to make telephone calls to hearing people. The deaf person types a message (in English) on a keyboard to the hearing person and the hearing person types a message back (in English). If the hearing person is using a regular phone, the hearing person will speak the message as if they were talking to another hearing person, and a relay operator will type that into English. When the person is done, they type "GA" (or say "Go Ahead") for the next person to begin. The deaf person then reads the written English message. The communication is entirely in English. In the community, videophones have replaced TTYs. Most deaf people do not use a TTY anymore. Using the TTY produces a scroll of paper with the written English communication exchanges. I tried to explain that the TTY is not effective for our healthcare communications because it is essentially the same as writing notes, except that the information is typed. I tried to explain that I am not able to communicate effectively using written English. Videophones allow people to communicate using ASL.

34. I refused to use the TTY to communicate for the health care appointment. It is really difficult to explain your communication needs without an ASL interpreter. It

means I have to read and write notes in English to explain why English is not an effective way for me to communicate or receive communications about my healthcare.

35. I was examined on December 25, 2018, but no one explained to me the results of the examination of my mouth. They looked in my mouth, but no one told me if it looked like oral cancer, if testing should be done, if there was testing to check if it was cancer, and what to look for and report in the future. A female nurse did try and fingerspell some information to me and I appreciate that she was trying to communicate, but fingerspelling some words is not the same as communicating in ASL. She used the hand signs for the the letters of the alphabet to spell out English words. Fingerspelling provides limited information. It would be the same as if a hearing person went to the doctor's office and they spelled out isolated words letter-by-letter rather than have a conversation with you about your symptoms, history, and reasons for requesting the appointment.

36. ~~To date, I have not received any follow up about the oral cancer screening.~~ I still have the same spot in my mouth. It has not disappeared or healed. However, it is difficult for me to examine the inside of my own mouth. Healthcare staff told me in a note that I would have a consultation about my mouth in early March and that the visit would be through video. I told them I would need a sign language interpreter, ~~but no one has gotten back to me about my request and the appointment has not occurred.~~ *

37. On December 29, 2018, I filled out an HNR because I was experiencing left arm pain. I have a history of a gunshot injury in my left arm and there was pain. I wanted to get it checked out. I wrote on the HNR that I am deaf to give ADC notice that I would need an ASL interpreter.

38. On December 30, 2018, I arrived to see the nurse. There was no interpreter. They gave me a form and asked me to sign it. I did not fully understand the form, but I did not intend to refuse healthcare services. Plaintiffs' counsel, through an ASL interpreter, showed the form to me and explained what it meant. It is attached as Exhibit A. I did not know that was what the form was and thought I was instead refusing ~~for an~~ to

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* Recently, I saw a doctor at Banner Hospital-South Campus who, using VRI, examined my mouth, explained my condition, and treatment options. With VRI, I understood the communication.

KP

go forward until there was an unqualified incarcerated person to interpret for me but could still have a medical examination with an interpreter. The healthcare staff did not examine me about the pain in my left arm. I continue to experience left arm pain.

39. On January 29, 2019, I filled out an HNR to ask that a television be provided as a way to address the loneliness and isolation that I experience as a deaf individual in prison.

40. On January 31, 2019, a nurse saw me about the HNR. There was no interpreter present. Only basic communication was exchanged using notes. Without an ASL interpreter, I could not really explain my feelings of loneliness and isolation and what it is like to be deprived constantly of language. I wanted to be able to explain how it is different for me as a deaf individual to deal with the boredom in prison because, unlike non-deaf incarcerated persons, I cannot relieve the boredom by purchasing inexpensive CD players or radios. I need a TV with captions, but TVs are more expensive and must be purchased from our inmate accounts. I wanted to explain that I get so lonely and bored that it feels like it is driving me crazy. Although there are some TVs in common area, often times the other individuals housed in my unit want the captions turned off because they feel it affects their enjoyment. The nurse did not approve the television. They wrote a note that they referred me for a visit with the psychologist, but I have not seen the psychologist yet. I never did see a psychologist, but even if I had been provided a visit with a psychologist, it will not have been useful without an ASL interpreter.

41. Although I do not recall the exact date, ADC did provide a television for my cell in March 2019.

42. Recently, in March 2019, Correction Officer III Caylor asked [redacted] a fellow incarcerated person who is also deaf, and me to help set up a new TTY for use in medical. Using notes, I told COIII Caylor and the nurse that was present that I still need an ASL interpreter. I wrote a note to explain that a TTY is the same as writing on a piece of paper and it is not effective for me. The nurse wrote that the TTY was temporary. She indicated thumbs up about the TTY and I indicated thumbs down.

43. ~~Plaintiffs' counsel showed me documents, attached as Exhibit B and C, which the sign language interpreter translated for me. I was not provided any patient education and if I had been provided patient education it would have required a sign language interpreter for me to understand.~~

44. This declaration was taken, written, and read to me with the assistance of a qualified sign language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on April 22, 2019 in Tucson, Arizona.

[redacted]

Exhibit 101

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Richard Pratt, Director, Health Services Contract Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF [redacted]

I, [redacted], declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted]. I have been in ADC custody since October 2, 2018.

2. I am over the age of 18 and if called as a witness, I would and I could testify competently on the facts listed below, all of which are within my personal knowledge.

3. From October 2, 2018 to October 9, 2018 I was housed at ASPC – Phoenix. From October 9, 2018 to May 21, 2019 I was housed ASPC – Lewis. I am currently housed at ASPC-Tucson in Catalina Unit.

4. I became deaf when I was approximately five years old, after developing meningitis. Growing up, I was able to communicate with my mother using American Sign Language (ASL). She was fairly fluent in ASL, but not completely fluent. I communicated with my other family members using body motions and gestures.

5. I cannot hear anything at all without hearing aids. When sounds are extremely loud, I can feel the vibrations from the sound, like when a train or plane is passing by. Hearing aids help me hear some sounds and understand my physical surroundings, but I still cannot distinguish words.

6. I attended Kendall Demonstration Elementary School for the Deaf in Washington D.C. I then attend high school in Long Island, New York and graduated in 1991. In high school, I was taught in a mainstream classroom with an emphasis on reading and writing English words. I am also fairly fluent in Pidgin Signed English (PSE).

7. ASL is a distinct language and its vocabulary and structure is different from English. There is no written form of ASL. While ASL is not the same in all parts of the country, with time, I am able to adapt and understand ASL wherever I am living.

8. I am able to read and write basic sentences in English. It takes me a long time to decode and decipher what is being written in English. When it comes to more complex information, like medical terms or legal terms, I need an ASL interpreter to effectively

communicate. There are certain medical terms that after reading them in English, I have no idea what they mean.

9. I went through intake at ASPC-Phoenix – Alhambra Unit when I entered ADC custody on October 2, 2018. The medical, dental, and mental health intakes were done through writing and passing notes with providers in English. I requested an ASL interpreter during my intake appointments because I did not know what was being asked, but I was told that was not possible. The providers shook their heads and looked frustrated when I did not know how to respond to certain questions, but no ASL interpreter was provided.

10. The health care provider during intake used complex words that I did not understand. I was given a TB test, but at the time, I did not know it was a TB test because no one had explained to me what the test was for, so I initially refused the test. The provider told me that if I did not go through with the test, I would get a disciplinary ticket. I did not want to get a ticket, so I went through with the TB test.

11. During my mental health intake appointment, I again asked for an ASL interpreter, but one was not provided. In that appointment I felt like I was not understanding the questions the provider was asking me because they were using words I did not understand. The provider asked if I wanted to be placed in "PC." At the time, I did not know what "PC" meant, and I felt like I could not ask for clarification.

12. During my dental intake appointment, I wanted to ask about getting a filling for a tooth but I did not know how to explain it in English. I felt like I could not find the right words to explain the pain I was in or what type of procedure I needed.

13. When I first entered ADC custody, nobody informed me of how to write a health needs request (HNR). I went for months without knowing how to request medical assistance. I was also not given information on how to file a grievance.

14. I did not have hearing aids when I came into custody, and when I first entered ADC in early October 2018, I requested that I be provided new ones. Although I cannot

understand words, I can make out sounds when I wear hearing aids, which is important during emergency situations. For example, if a riot took place and loud sirens and alarms were going off, if I had hearing aids I would be alerted to it, and I could then look to the corrections officers for further instructions. Without hearing aids, I would not know that there was a problem and that I needed to follow officers' orders. I did not receive hearing aids until May 17, 2019.

15. On December 20, 2018, I requested a cotton blanket because I was allergic to the wool blankets ADC provided. I saw a provider two weeks later, and did not have an ASL interpreter at the appointment. The provider communicated with me using written notes. At this appointment on January 2, 2019, the provider also was using notes to tell me something about my problems with kidney stones and an update on getting hearing aids. I did not understand what was in these written statements, and I tried to explain what the wool blanket did to my skin with gestures. The provider finally sent me for an allergy test and it was confirmed that I have an allergy to wool. I was then given a non-wool blanket.

16. On February 11, 2019, I met with a health care provider about persistent pain in my lower back and we did not have an ASL interpreter at the appointment. At that time my back had been sore for weeks. I tried to describe the pain I was experiencing and the provider prescribed me a new prescription medication. I tried to ask what the medication was and what was it for, but the provider did not answer. I refused the medication and I think they made a note of it in my medical record. I later found out that the provider had thought I was complaining about a sore on my buttocks, but it was soreness in my lower back. If I had an ASL interpreter during the appointment, I could have clearly described what my medical issues were and the provider and I could have had a conversation about the medication they were trying to prescribe for me.

17. On March 8, 2019, I saw a health care provider about my back. We did not have an ASL interpreter and the provider wrote notes to me. I was experiencing problems with

my lower back relating to kidney stones. I tried to gesture indicate the area that was bothering me, but I later found out that the provider misunderstood me and thought that I was experiencing pain in the middle of my back.

18. This declaration was taken, written for me, and then read to me with the assistance of a qualified legal sign language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty that the foregoing is true and correct. ^ of perjury F.M.L.

EXECUTED this 18 day of November, 2019 in Tucson, Arizona.

[redacted]

Exhibit 125

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Richard Pratt, Director, Health Services Contract Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF [redacted]

I [redacted] declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted] I have been in ADC custody since August 2007. I am currently housed at ASPC-Eyman in Rynning Unit.

2. I am over the age of 18 and if called as a witness, I would and I could testify competently on the facts listed below, all of which are within my personal knowledge.

3. I was born in Sinaloa, Mexico, in a town called La Cruz de Elota. I am a Mexican citizen.

4. Spanish is my first and only language, and I grew up speaking Spanish at home and in my community. I attended school in Mexico until the second grade, when I left school. All classes I attended in school in Mexico were taught in Spanish.

5. I came to the United States when I was seventeen years old, and was arrested almost immediately. I have been incarcerated and in ADC custody ever since.

6. Because I am a Mexican citizen, I am not eligible to participate in mandatory educational programming offered by ADC. As a result, I have never attended classes in English or been taught English.

7. I have never been asked about my language preferences or abilities during the thirteen years I have been in ADC custody, and I have never had a language assessment of any kind during that time.

8. I do not speak English at all, and I am not fluent in English. I am not able to understand basic information in English, let alone any medical words or concepts in English.

9. I have never had an in-person neutral Spanish interpreter during one of my medical appointments in ADC. Once a Correctional Officer who spoke Spanish acted as an interpreter for me during a doctor's appointment, but then he gossiped to the entire yard about my medical condition (Hepatitis C), so that was the last time I agreed to have a Correctional Officer interpret during one of my appointments. I have never had an

appointment with a nurse or provider that spoke Spanish fluently. I have occasionally had the provider use a telephonic Spanish interpreter from Language Line to communicate with me during an appointment.

10. When I need to submit a Health Needs Request (HNR) I usually write them out myself in Spanish, but sometimes I ask other prisoners to write out the HNR for me in English.

11. As far as I am aware, my medical conditions include Hepatitis C, anxiety, insomnia, and priapism.

12. On September 4, 2019, I had a mental health counseling appointment with a psychologist. I understand that my medical record for this appointment notes that no interpreter services were needed for this appointment. At the beginning of this appointment I asked the psychologist if we could use the telephonic Spanish interpreter because my English skills are not good. The psychologist told me she could understand me in Spanish, and while it did seem like she understood what I was saying during the appointment, she only spoke English back to me and I didn't understand what she was saying. I didn't understand what was going on during the appointment, and I was frustrated that I was unable to ask questions I had about my medication for depression and insomnia. I wanted to ask her whether these medications might be bad for my liver, because I already have Hepatitis C. Because I was not able to understand the psychologist or communicate well in the appointment due to the lack of a Spanish interpreter, I was not able to resolve these questions concerning my healthcare.

13. On July 29, 2019, I had a mental health appointment with a psychiatrist to discuss my medication. I understand that my medical record for this appointment notes that no interpreter services were needed for this appointment. I asked the psychiatrist for a Spanish interpreter, but one was not provided. Communicating with the psychiatrist in this appointment was difficult. He seemed to understand when I said "medicina" that I was talking about my medication but then I ended up having to "act out" what I was

experiencing with my medication – that it wasn't helping, and that I still couldn't sleep well. I never understood what the psychologist told me in that appointment, and I wonder whether he understood what I was trying to communicate through gestures and acting out what was happening to me. I also wanted to be able to ask about whether the medication I am taking might cause any potential long-term harm to my liver. However, because without a Spanish interpreter I was communicating mostly by gestures in this appointment, I did not know how to ask the question. I still do not know about any of the long-term risks of the medication I am taking, if there are any.

14. On July 23, 2019, I had a doctor's appointment, to follow up on an outside hospital visit for my priapism. At the beginning of that appointment, the doctor didn't understand me and I didn't understand the doctor. The doctor wanted to use a Correctional Officer to interpret during the appointment, but I refused. After that, the doctor got a Spanish interpreter on the phone from Language Line and a telephonic interpreter was used for this appointment. Because there was a telephonic Spanish interpreter available, during this appointment I was able to communicate well and understood what the doctor was asking me, and was able to tell him what was happening with my condition and was understood. To the best of my recollection, this was the first time a doctor used Language Line for an interpreter in my appointment since I came to ASPC-Eyman in November 2018.

15. On July 19, 2019, I had an appointment with a nurse as I returned to ASPC-Eyman after an off-site visit to the emergency room concerning my priapism. I understand that my medical record for this appointment notes that no interpreter services were needed for this appointment. I cannot recall if I requested a Spanish interpreter for this appointment, however I was not able to communicate with the nurse verbally because she didn't understand me when I spoke Spanish. Instead, I had to gesture and show her the part of my body that hurt, and she asked me a lot of questions in English that I did not understand.

I left that appointment not knowing what was going to happen next, and priapism still continues to be an issue for me.

16. On June 6, 2019, I had a mental health counseling appointment with a psych associate. I understand that my medical record for this appointment notes that no interpreter services were needed for this appointment. I do not recall whether I requested a Spanish interpreter for this appointment; over the years it has been very frustrating to be constantly denied interpreters, so sometimes I just do not ask. However I do remember that I was not able to communicate well with the psych associate during this appointment, and that I had to gesture and act out that I was having problems with my medication not working. I do not know whether the psych associate understood me, and I did not understand what was being told to me in English during the appointment. It was not helpful for me to meet with the psych associate because I was unable to communicate with him.

17. On May 13, 2019, I had a mental health counseling appointment with a psych associate. I understand that my medical record for this appointment notes that no interpreter services were needed for this appointment. I recall that this psych associate didn't speak Spanish well, but that he did speak some basic Spanish, and seemed to understand what I was telling him in Spanish, and was able to respond to the questions I asked him in Spanish.

18. On May 8, 2019, I was told to come to medical and thought it was just for a nurse's line visit to have a routine temperature and blood pressure check done. Because of this, I did not want to go to the appointment, and told the nurse I wanted to refuse. Because the nurse did not speak Spanish and I did not have an interpreter, I was either not told or if I was told, I did not understand if she was telling me that I was refusing a chronic care appointment with the provider concerning my Hepatitis C. The nurse instead just gave me the refusal paperwork and indicated that I had to sign it without explaining what I was refusing in a way that I could understand. As a result, I signed the refusal form and did

not have the appointment. If I had known it was a chronic care appointment to see the doctor about my Hepatitis C I would have never refused it. and would have gladly gone to the appointment.

19. This declaration was taken, written for me. and then read to me with the assistance of a Spanish language interpreter.

Pursuant to 28 U.S.C. § 1746. I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED this 26 day of November. 2019 in Florence, Arizona.

[redacted]

Exhibit 144

(Redacted)

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Richard Pratt, Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF [redacted]

I, [redacted], declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted]. I have been in ADC custody since 2008. I am currently housed at ASPC-Florence Complex, in East Unit. I am over the age of 18 and if called as a witness, I could and would testify competently to the facts stated below, all of which are within my personal knowledge.

2. I am a native Spanish speaker. I cannot speak, write, or read English fluently. I have no formal education in English. I have a limited English vocabulary that I have learned by reading Spanish to English books.

3. I cannot independently submit any paperwork (Health Needs Request forms, inmate letters, grievances, etc.) in English. I ask other prisoners in my unit to help me write paperwork in English. If no one is available to help, I will write my own paperwork in Spanish. However, in my experience, I typically do not get a response if I turn in my paperwork in Spanish. If I do receive a response, it is always in English, so I have to ask someone to translate it for me. I do not always feel comfortable asking other prisoners to translate my confidential paperwork, such as medical and mental health responses, but I have no other option.

4. If I have an upcoming medical appointment, I will write down what I need to say in Spanish, ask another prisoner to translate it for me in English, then memorize the words in English before my appointment.

5. On September 18, 2019, I had a chronic care appointment with Nurse Practitioner (NP) Dorothy Igwe. Ms. Igwe does not speak to me in Spanish, only English. During this encounter, I could not understand what was being said because it was conducted in English and no interpretation services were provided. I informed NP Igwe as best I could in English that I could not understand, but she said we would try our best to understand each other. The nurses and correctional officers present that day also did not understand Spanish. NP Igwe only went off what the medical chart in the computer said and did not listen to my concerns regarding my chronic care issues, which include

diabetes and hypertension, among others. I was told by NP Igwe that she did not have time to listen to all my concerns because she had other patients. In all, this encounter only last about two or three minutes.

6. On September 6, 2019, I had an individual counseling session with my psychologist, Sherry Holly-Reps. No Spanish interpretation was provided, and Ms. Holly-Reps spoke in English only. I could only understand when Ms. Holly-Reps asked me if I was feeling suicidal or homicidal because I have learned these words while incarcerated. I do not feel like I can communicate my feelings well enough to the psychologist. I have learned a few words like "happy," "sad," "angry," and "depressed" from other prisoners, but I cannot elaborate further in English. I cannot explain to the psychologist in English why I feel those emotions, and I cannot understand anything the psychologist says that might be able to help me feel better.

7. On August 19, 2019, I had a sick call encounter with Registered Nurse (RN) Donna Cripe regarding an insect bite. I had to try and explain what was wrong in poor English because no Spanish interpreter was provided, and Ms. Cripe does not speak Spanish. I could not communicate very well, so I showed RN Cripe the insect bite and let her examine me without any further conversation.

8. On August 5, 2019, I saw Psychiatrist Adiza Sulley regarding my psychiatric medications. A Spanish interpreter was not present for this appointment, and Ms. Sulley spoke only in English. I requested a medicine similar to Zyprexa that would not affect my diabetes. In order to communicate this, I had another prisoner write down what I needed to say in English and practiced it before going to my appointment.

9. In my time incarcerated in ADC, I have only had Spanish interpretation services once—during a medical appointment in 2012 while housed at ASPC-Tucson. Since then, I have not had any interpretation services during my medical or mental health appointments. To my knowledge, none of the medical or custody staff working in the ASPC-Florence, East Unit clinic can speak Spanish.

10. This declaration was written for me and read to me with the assistance of a

Spanish language interpreter.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED this 6 day of December 2019, in Florence, Arizona.

[redacted]

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Exhibit 158

(Redacted)

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[ADDITIONAL COUNSEL LISTED ON SIGNATURE PAGE]

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Richard Pratt, Division Director, Division of Health Services Contract Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF [redacted]

I, [redacted] declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted]. I have been in ADC custody since August 2016. I am currently housed at ASPC-Yuma in Cibola Unit.

2. I am over the age of 18 and if called as a witness, I would and I could testify competently on the facts listed below, all of which are within my personal knowledge.

3. I was born in Mexico, and I am a Mexican citizen.

4. Spanish is my first and only language. I attended school in Mexico until the tenth grade, when I left school. All classes I attended in school in Mexico were taught in Spanish.

5. I came to the United States in early 2014, and was arrested that same year on August 22. I was then transferred to ADC custody in 2016.

6. Because I am a Mexican citizen, I am not eligible to participate in mandatory educational programming offered by ADC. As a result, I have never attended classes in English or been taught English.

7. I have never been asked about my language preferences or abilities during the thirteen years I have been in ADC custody, and I have never had a language assessment of any kind during that time.

8. I do not speak English at all, and I am not fluent in English. I only know very rudimentary words and phrases in English like “hello” and “how are you?” I cannot carry a basic conversation in English. I am not able to understand any medical words or concepts in English.

9. I have seen nurses and a provider at ASPC-Yuma, Cibola Unit, regarding gastrointestinal concerns since March 2019. I do not know what condition I have but have continuous stomach bloating and find small amounts of blood in my stool.

10. On March 27, 2019, I saw Registered Nurse (RN) Tammie Young regarding my gastrointestinal concerns. Another nurse, who I believe is a Licensed

Practical Nurse (LPN), was present to provide Spanish interpretation services. I was seen again on April 17, 2019, by RN Young and Spanish interpretation was provided by another nurse.

11. On April 23, 2019, I saw Nurse Practitioner (NP) Clarisse Ngueha-nana, who claimed to be able to conduct my appointment in Spanish. Yet, NP Ngueha-nana spoke to me in mostly English and limited Spanish during this encounter. Because I do not know English, I was only able to speak with NP Ngueha-nana in Spanish. It became apparent that NP Ngueha-nana did not speak Spanish well and was not understanding the questions I was asking. For example, I asked NP Ngueha-nana why she was prescribing me medication for hemorrhoids when it was my stomach that was the problem. She was not able to respond to my question.

12. On May 7, 2019, I was again seen by NP Ngueha-nana regarding my ongoing gastrointestinal concerns. Again, no interpreter was called and NP Ngueha-nana spoke to me in English and limited Spanish.

13. On May 21, 2019, I saw NP Ngueha-nana again and this time a nurse was called in to help interpret. Unfortunately, the nurse was not fluent in Spanish and was not able to clearly communicate medical concepts or words.

14. On June 19, 2019, I saw NP Ngueha-nana for a fourth time to discuss a recent Alternative Treatment Plan for a gastrointestinal specialist consult request. This time, a correctional officer was asked to interpret. The correctional officer told me in Spanish that NP Ngueha-nana would like to perform a rectal exam. I did not feel comfortable with having a correctional officer who supervises my unit be present in my medical encounters. Further, I did not want to have a rectal exam in front of the correctional officer. I found this request to be an invasion of my medical rights to privacy and refused the exam.

15. This declaration was taken, written for me, and then read to me with the assistance of someone fluent in Spanish.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing

is true and correct.

EXECUTED this 1st day of June, 2020, in Yuma, Arizona.

/s/ [redacted]

[redacted]

On June 1, 2020, due to the closure of Arizona State Prisons in light of the COVID-19 pandemic, I translated from English to Spanish and read the contents of this declaration, verbatim, to [redacted] by telephone. I am fluent in Spanish. [redacted] orally confirmed that the contents of the declaration were true and correct. [redacted] also orally granted me permission to affix his signature to the declaration and to file the declaration in this matter.

TANIA AMARILLAS DIAZ

Exhibit 165

(Redacted)

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[ADDITIONAL COUNSEL LISTED ON SIGNATURE PAGE]

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Attorneys for Plaintiff Arizona Center for Disability Law

[ADDITIONAL COUNSEL LISTED ON SIGNATURE PAGE]

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

David Shinn, Director, Arizona Department of Corrections; and Richard Pratt, Division Director, Division of Health Services Contract Monitoring Bureau, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-ROS

DECLARATION OF [redacted]

I, [redacted], declare:

1. I am a prisoner in the custody of the Arizona Department of Corrections (ADC). My ADC number is [redacted] I am incarcerated under the name [redacted] My chosen name is [redacted] I have been in ADC custody since 2008. I am currently housed at ASPC-Tucson Complex, in Rincon Mental Health Unit.

2. I am over the age of 18 and if called as a witness, I could and would testify competently to the facts stated below, all of which are within my personal knowledge.

3. I was born in Mexico, and I am a Mexican citizen.

4. I am a native Spanish speaker. I cannot speak, write, or read English fluently. I have no formal education in English. I have a very limited English vocabulary that I have learned during my incarceration.

5. Because I am a Mexican citizen, I am not eligible to participate in mandatory educational programming offered by ADC. As a result, I have never attended classes in English or been taught English.

6. Due to my limited English vocabulary, I submit my Health Needs Request (HNR) forms and grievance documents primarily in Spanish. I may be able to submit HNR forms and grievance documents in English if someone else writes for me. I receive written responses to my HNR forms and grievance documents in English. I require assistance from other incarcerated people to understand what the response says.

7. On December 5, 2019, I saw Psych Associate Samantha Contreras for an individual counseling session to discuss my mental health treatment plan. Ms. Contreras speaks some Spanish but is very limited in her vocabulary. I did not have an interpreter for this appointment. Ms. Contreras is aware that I speak very little English and require an interpreter. I tried to express to Ms. Contreras in Spanish how I was feeling and let her know that I had a lot of anxiety following an assault that occurred in April 2018 while I was housed in ASPC-Lewis. Following that incident, I attempted to take my own life. I did not feel that I was able to fully communicate my feelings to Ms. Contreras because of our language barrier. Ms. Contreras tried her best to listen and counsel me, but I did not

think that she understood everything going through my head at the time because I do not believe she was able to understand everything I was saying in Spanish. I appreciated her effort and willingness to listen even though I could not communicate everything I wanted to say. Ms. Contreras said I could reach her anytime via an Inmate Letter or HNR.

8. On January 2, 2020, I saw Ms. Contreras again for an individual counseling session. Again, no interpreter was present for this appointment. I tried to talk to Ms. Contreras in Spanish about my anxiety, depression, and coping skills, but I did not know how to convey my emotions. The inability to communicate with my clinician negatively affects my mental health. I feel like I cannot truly express myself to Ms. Contreras in order to receive helpful advice because Ms. Contreras cannot understand everything I say to her in Spanish, and I am not able to talk about my mental health in English.

9. On January 7, 2020, I saw Nurse Practitioner Natalie Bell for a chronic care appointment. At this appointment, Nurse Martinez was present and acted as the interpreter. This is the first time I have been provided an interpreter during a medical appointment even though I have requested interpretation services in the past. I felt I was able to finally understand what was being discussed and ask questions of my provider because I was able to speak Spanish and have everything NP Bell said translated for me. Prior to this, I was not able to fully communicate with my provider.

10. On January 13, 2020, I attended a group counseling session led by unlicensed Psych Associate Kathleen Bailey. This was the first time in many weeks that I have attend group counseling. I typically do not attend counseling groups because no interpreter is provided, and I cannot follow along with what is being discussed because conversations are in English. During this group, no interpreter was provided. I relied on other incarcerated people to translate for me while the group discussed their emotions and coping skills in English. I could not actively participate in the group and join the discussion. When there are no other incarcerated people in the counseling group who speak Spanish, I sit and try to understand what little I can but do not say or share anything.

11. In February 2020, Mental Health Aide Nubia Salas Garcia started a

counseling group for people like me whose primary language is Spanish. The group sessions stopped in April 2020 due to COVID-19. While groups were happening, I was able to attend regularly with seven or eight other Spanish-speaking incarcerated people. I really enjoyed being part of a group that allowed me to fully participate and express what I was feeling. During the group, we played games and had discussions with each other in Spanish. It is important for my mental health to be able to communicate in Spanish to Ms. Salas Garcia and the other group members because we can all understand each other. I enjoyed attending this group.

12. On May 20, 2020, I saw Ms. Bailey for an individual counseling session. Before we began, Ms. Bailey escorted me to the Correctional Officer III (COIII)'s office located in my unit to use the phone to call the language line interpreter. To my knowledge, this is the only phone available to call the language line. The office was being used at the time, and I was told it would be a while before it would be available. Because it was almost time for me to go eat, and I did not want to wait long for fear of missing my meal, I agreed to conduct the individual counseling session in English. I was able to understand Ms. Bailey's questions because they were very simple and are the same questions I answer every time I check in with mental health staff. For example, I was asked if I was feeling suicidal or homicidal, if my medication was helping, and if I was having any trouble sleeping. The questions were easy to answer because they were almost all "yes" or "no" questions, and I am familiar with these English phrases from previous mental health encounters.

13. This declaration was taken, written for me, and then read to me with the assistance of someone fluent in Spanish.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED this 2nd day of June, 2020, in Tucson, Arizona.

/s/ [redacted]

[redacted]

On June 2, 2020, due to the closure of Arizona State Prisons in light of the COVID-19 pandemic, I translated from English to Spanish and read the contents of this declaration, verbatim, to [redacted] by telephone. I am fluent in Spanish. [redacted] orally confirmed that the contents of the declaration were true and correct. [redacted] also orally granted me permission to affix her signature to the declaration and to file the declaration in this matter.

TANIA AMARILLAS DIAZ