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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 2:90-CV-00520-KJM-DB

PLAINTIFFS' BRIEF RE: EVIDENCE SUPPORTING SERIOUS MENTAL ILLNESS AS RISK FACTOR FOR COVID-19 AND NEED FOR ADDITIONAL MENTAL HEALTH INTERVENTIONS

Judge: Hon. Kimberly J. Mueller
Crtrm.: 3, 15th Floor, Sacramento

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INTRODUCTION

At the June 12, 2020 COVID-19 status conference, the Court asked whether Defendants were aware of guidance specific to treating and managing the risk of COVID-19 in the mentally ill incarcerated population. *See* Tr., ECF No. 6722 at 19 (June 16, 2020). In response, Dr. Joseph Bick, Director of Health Care Services for CDCR, stated that there was no such guidance, and also that there has not been "evidence for adverse outcomes specifically related to the mental health of clients." *Id.* at 20.; *see id.* at 20-21. Dr. Bick went on to state that he did not "believe there are specific strategies that need to be developed regarding our mentally ill patients" with respect to managing their COVID-19 risk. *Id.* at 21. Notwithstanding the foregoing, Dr. Bick acknowledged "that for many of our patients, including the mentally ill, … there are particular challenges to them maintaining hygiene and following the guidance that we're providing but nothing that I've seen [] is specific to the mental health patients." *Id.*

On June 19, 2020, in response to the Court's question and Dr. Bick's assertions at the June 12 status conference, Plaintiffs shared with Defendants and the Special Master team a letter collecting dozens of readily available scientific sources that identify serious mental illness ("SMI") as a risk factor for COVID-19. *See* Decl. of Michael W. Bien in Supp. of Pls' Br. Re: Evidence Supporting SMI as Risk Factor for COVID-19 & Need for Add'l Mental Health Interventions, filed herewith ("Bien Decl."), at ¶ 10. Those sources describe an increased risk in the SMI population of both COVID-19 infection and adverse outcomes, along with the need for additional mental health interventions for the SMI population during the COVID-19 pandemic. *See generally* Sections I, II, & III, *infra*. Plaintiffs also explained the need to rely on analogous medical or behavioral conditions, along with common sense, to inform CDCR's COVID-19 response, in light of the novelty of the pandemic and lack of time to conduct carefully controlled scientific studies. Bien Decl., at ¶ 10; *see also* Decl. of Robert M. Sapolsky, Ph.D., *Arevalo v. Decker*, No. 1:20-cv-02982, Dkt. 3-3 (S.D.N.Y. Apr. 13, 2020), attached to Bien Decl. as **Exhibit 29** (explaining that in the absence of COVID-19-specific research, mental health impacts on

COVID-19 infections can be extrapolated with "considerable confidence" from existing science). Because of the lack of scientific guidance specific to COVID-19, a novel coronavirus, these same approaches have been used proactively in the larger community since the very beginning of the pandemic to manage the public health crisis. The parties, under the supervision of the Special Master, briefly discussed these issues at the June 23, 2020 COVID-19 taskforce meeting. *Id.* at ¶ 10.

Plaintiffs informed the Court at the June 26, 2020 COVID-19 status conference of the materials provided to Defendants and the Special Master. *Id.* at ¶ 10. Defendants confirmed that additional discussions and work were necessary in light of the materials Plaintiffs had provided. *Id.* at ¶ 10. The Court thereafter invited the parties to file pleadings and the supporting evidence of publications showing that SMI is a risk factor for COVID-19.

Accordingly, Plaintiffs have described below and provided as exhibits guidance specific to managing COVID-19 risk in SMI and/or closely related populations, along with findings demonstrating the need for additional mental health interventions to deal with the impacts of social distancing and other major lifestyle changes resulting from the pandemic. Plaintiffs also include herein some recently discovered additional studies and guidance that have not previously been provided to Defendants and the Special Master given the rapidly evolving understanding of the novel virus.

I. SMI Is Well-Established as a COVID-19 Risk Factor.

SMI's status as a COVID-19 risk factor is well-established, both directly and by analogy to similar conditions. *See generally* Section II, *infra*. Recently, this correlation has been shown to play out dangerously in both national data and in the CDCR population.

On June 15, 2020, the Centers for Disease Control and Prevention ("CDC") published a statistical analysis of all COVID-19 cases that had been reported to the agency between January 22 and May 30, 2020. *See* CDC, *Morbidity and Mortality Weekly Report: Coronavirus Disease 2019 Case Surveillance – United States, January 22-May 30, 2020*, Vol. 69 (June 15, 2020), attached to Bien Decl. as **Exhibit 2**. The CDC identified a

number of underlying health conditions that lead to increased COVID-19 risk of adverse outcomes, including psychological and psychiatric conditions. *See id.* at 4, Tbl. 2 & n.*. Critically, individuals in the CDC study who had at least one underlying health condition were six times more likely to be hospitalized (45% versus 7.6%), and 12 times more likely to die (19.5% versus 1.6%) from a COVID-19 infection. CDC, *Morbidity and Mortality Weekly Report: Coronavirus Disease 2019 Case Surveillance – United States, January 22-May 30, 2020*, Vol. 69 at 1, 4, 6 (June 15, 2020), attached to Bien Decl. as **Exhibit 2**.

The SMI population also tends to experience other high-risk underlying health conditions at a disproportionately high rate, caused, at least in part, by common side effects of psychotropic medications. *Compare id.*, *with* Ann K. Shinn, et al., *Perspectives on the COVID-19 Pandemic and Individuals with Serious Mental Illness*, Journal of Clinical Psychiatry (Apr. 28, 2020), attached to Bien Decl. as **Exhibit 31** (identifying cardiovascular disease, obesity, metabolic syndrome, diabetes, and respiratory conditions as comorbidities correlated with SMI and/or the use of psychotropic medications to treat SMI); Jeffrey L. Geller, et al., *Patients with SMI in the Age of COVID-19: What Psychiatrists Need to Know*, Psychiatric News (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 30** (same).

According to the CDC study, older adults are far more likely to contract COVID-19 than average and are also far more likely to be hospitalized and die. *See id.*; Bien Decl., at ¶¶ 5-8. While the overall incidence of infection was 403 cases per 100,000, the per-100,000 incidence for people ages 70-79 was 464, and the incidence for people age 80 and older was 902. *See* Bien Decl., at ¶ 8 & **Exhibit 2**. Overall, 14% of all infected patients were hospitalized, 2% admitted to ICU, and 5% died, while 28% of patients who were age 80 and over died. *See id.* And 50% of those 80 years or older with at least one underlying health condition died as a result of their infection (as compared to 30% of those without an underlying condition). *See id.*

Plaintiffs' recent data analysis confirms the trends in the CDCR population are paralleling the national trends. *See* Bien Decl., at ¶¶ 2-4 & **Exhibit 1**. Specifically, data

from CDCR's COVID-19 Registry as of July 1, 2020 at approximately 8:36 am showed 4,808 active or resolved cases (excluding patients deceased or released) among incarcerated patients. *Id.* at ¶ 3. *Coleman* class members made up 40% of those hospitalized, and the mean age of hospitalized patients was 61.3 years-old (median 61.5 years-old). *Id.* at ¶ 4. Of those who have died from COVID-19 in CDCR, 50% were *Coleman* class members at the time of their death or were recent former participants in the Mental Health Services Delivery System. *Id.* The mean age of patients who have died from COVID-19 in CDCR custody is 62.6 years-old. *Id.* All of the patients who died were either 55 or older, a *Coleman*, *Armstrong* or *Clark* class member, or designated high-risk medical. *Id.* A recent twenty-third decedent, whose cause of death CDCR has not yet been confirmed but who tested positive for COVID-19, was a 71-year-old *Coleman* and *Armstrong* class member. COVID-19 is an equal opportunity killer, but those with underlying health conditions, including SMI and other disabilities, experience starkly different outcomes than those without such conditions.

II. Two Common Characteristics of the SMI Population Lead to Their Increased Risk of Both Contracting COVID-19 and Experiencing a Poor Outcome, Including Death, from a COVID-19 Infection, and Available Data Shows These Characteristics Are Prevalent in the *Coleman* Class.

Two aspects of SMI are likely to contribute significantly to the greater risk class members experience both in rates of COVID-19 infection and poor outcomes from infection. First, individuals with SMI often have functional limitations or engage in behaviors that increase the likelihood of transmission and/or the severity of the disease once infected. Second, individuals with SMI have a high rate of medical comorbidities that lead to more and more severe complications, and poor ultimate outcomes, from COVID-19 infection. At least some of these comorbidities are caused by the use of psychotropic medications to treat various mental illnesses.

A. Those with SMI typically engage in behaviors or have functional limitations that make it harder to engage in infection control practices like social distancing, and are therefore more likely to contract COVID-19.

Those with SMI, like other groups with behavioral differences and functional limitations, are less likely to be able to understand and/or benefit from basic infection control practices critical to stemming the spread of COVID-19. Specifically, individuals with certain forms or expressions of mental illness will typically find social distancing, handwashing, mask-wearing, and other COVID-19 infection avoidance strategies very challenging. They may not understand social distancing and similar requirements, or simply may not be able to comply with those requirements, at least on a consistent basis. These tendencies are well-documented and various governmental and scientific sources have advised that these differences must be taken into account in caring for people with SMI and similarly situated populations.

For example, the Department of Health and Human Services has issued guidance to healthcare facilities, including psychiatric facilities, for infection control considerations specific to the SMI and those with similar functional limitations. *See* Department of Health & Human Services, Centers for Medicare and Medicaid Services, March 30, 2020: *Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers*, attached to Bien Decl. as **Exhibit 3**, at 8 ("Special consideration should be given to patients with psychiatric or cognitive disabilities to ensure they are able to adhere to the COVID-19 discharge recommendations and fully comprehend the significance of the precautions, or they have a family member or significant other involved to assist with these restrictions."); *cf.* Department of Health & Human Services, Centers for Medicare and Medicaid Services, March 30, 2020: *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities*

(PRTFs), attached to Bien Decl. as **Exhibit 4** ("Facilities should adhere to the infection prevention and control practices issued by the CDC. It may be appropriate to consult with your state health agency for guidance based on the unique challenges of instituting infection prevention and control with individuals with intellectual disabilities in an ICF/IID.").

The CDC has acknowledged this issue as well, *see* CDC, *Coronavirus Disease 2019 (COVID-19): People with Disabilities*, attached to Bien Decl. as **Exhibit 5** (explaining that individuals in certain disability categories may "be at increased risk of becoming infected or having unrecognized illness"; the categories include "[p]eople who have trouble understanding information or practicing preventative measures, such as hand washing and social distancing"), as have numerous scientific publications, *see* Ann K. Shinn, et al., *Perspectives on the COVID-19 Pandemic and Individuals with Serious Mental Illness*, Journal of Clinical Psychiatry (Apr. 28, 2020), attached to Bien Decl. as **Exhibit 31** (explaining that features of SMI "may make it harder for people with SMI to find accurate information about COVID-19 and to organize, appraise, and translate health information into behavior that reduces risk of exposure and infection," and noting factors that contribute to poor health outcomes for individuals with SMI include typical delays in accessing medical treatment, difficulty recognizing and reporting medical symptoms, and lower rates of adherence to treatment for medical conditions); *COVID-19 Can Have Serious Effects on People with Mental Health Disorders*, Healthline (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 6** (linking SMI and COVID-19 risk due to a number of behavioral and functional factors: typical congregate living situations, substance abuse, limits on ability or understanding of the need for self-care and social distancing; and a tendency to delay in seeking out medical treatment); Nicole M. Benson, et al., *COVID-19 Testing and Patients in Mental Health Facilities* (May 11, 2020), attached to Bien Decl. as **Exhibit 8** (explaining that management of COVID-19 may be challenging for individuals with psychiatric disorders due to their inability to adhere to recommendations like physical distancing and frequent handwashing); Jeffrey L. Geller, et al., *Patients with SMI in the*

Age of COVID-19: What Psychiatrists Need to Know, Psychiatric News (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 30** (cognitive deficits, mental disorganization, and similar features of mental illness will play a role in SMI individuals' understanding of the disease and necessary steps for hygiene and prevention; physiological and other expressions of anxiety disorders, like panic attacks, may make it difficult for mentally ill individuals to identify COVID-19 symptoms and may lead to over- or under-reporting of symptoms; and for various other reasons, people with SMI may delay in seeking out medical care); *cf.* Andrea Fiorillo et al., *Psychosocial interventions to reduce premature mortality in patients with serious mental illness* (May 15, 2020), attached to Bien Decl. as **Exhibit 9** (recommending a psychosocial approach to treating behavioral differences in SMI individuals that lead to higher mortality rates); Joseph Shapiro, *COVID-19 Infections and Deaths Are Higher Among Those with Intellectual Disabilities* (June 9, 2020), attached to Bien Decl. as **Exhibit 10** (finding that people with intellectual or developmental disabilities have risks two or more times greater both of contracting COVID-19 and having poor outcomes from an infection); Marla Milling, *People with Intellectual and Developmental Disabilities More Likely to Die from COVID-19* (May 28, 2020), attached to Bien Decl. as **Exhibit 11** (describing same); CDC, *People with Developmental and Behavioral Disabilities* (May 27, 2020), attached to Bien Decl. as **Exhibit 36** ("Some people with developmental or behavioral disorders may have difficulties accessing information, understanding or practicing preventative measures, and communicating symptoms of illness."); Alzheimer's Association, *Coronavirus (COVID-19): Tips for Dementia Caregivers*, attached to Bien Decl. as **Exhibit 12** ("Most likely, dementia does not increase risk for COVID-19 … just like dementia does not increase risk for flu. However, dementia-related behaviors, increased age and common health conditions that often accompany dementia may increase risk. For example, people with Alzheimer's disease and all other dementia may forget to wash their hands or take other recommended precautions to prevent illness.").

Given the abundant, consistent guidance on this point, Plaintiffs have requested that

Defendants develop additional policies, training, and procedures for managing COVID-19 prevention for the *Coleman* class.

B. People with serious mentally illness have significantly higher rates of comorbid medical conditions that place them at greater risk for COVID-19 infection and poor outcomes than do those without mental illness.

Unfortunately, it is well established that people with SMI tend also to be at higher risk for medical comorbidities or otherwise are particularly vulnerable to COVID-19 infection and/or serious complications arising therefrom. *See, e.g.*, World Health Organization, *Management of Physical Health Conditions in Adults with Severe Mental Disorders*, at 60 (2018), attached to Bien Decl. as **Exhibit 13** ("People with [SMI] are at greater risk than the general population for exposure to infectious diseases"); *id.* at 10, 61 (noting "the association between [SMI] and infectious diseases" and that infectious diseases "contribute to the high rates of premature death amongst people with [SMI]"); Jeffrey L. Geller, et al., *Patients with SMI in the Age of COVID-19: What Psychiatrists Need to Know*, Psychiatric News (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 30** ("Patients with SMI are particularly vulnerable to COVID-19 due to generally being in worse physical health than the general population. They typically … have more medical comorbidities such as hypertension and diabetes. In addition to the widely recognized risk factors for COVID-19—diabetes, chronic obstructive pulmonary disease (COPD), and cardiovascular disease (CVD)—the American College of Cardiology also identified obesity and hypertension as risk factors for viral respiratory illnesses, including COVID-19. CVD and its risk factors—psychotic illness being an independent risk factor for CVD—are twice as high in patients with schizophrenia than in the general population. Likewise, obesity is twice as prevalent and diabetes is at least three times as prevalent in people with SMI compared with the nonpsychiatric population in all age groups."); *COVID-19 Can Have Serious Effects on People with Mental Health Disorders*, Healthline (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 6** (noting the increased risk of comorbidities that impact respiratory function or otherwise make seriously mentally ill

individuals more susceptible to COVID-19 and adverse outcomes therefrom); Matthew J. Akiyama, M.D., et al., *Flattening the Curve for Incarcerated Populations – COVID-19 in Jails and Prisons*, New England Journal of Medicine (May 28, 2020), attached to Bien Decl. as **Exhibit 14** (identifying mental illness as one social determinant that impacts physical health at a greater proportion in incarcerated populations and therefore leads to an increased COVID-19 risk in these settings); Nicole M. Benson, et al., *COVID-19 Testing and Patients in Mental Health Facilities* (May 11, 2020), attached to Bien Decl. as **Exhibit 8** ("[Patients in mental health facilities] are at higher risk for complications of COVID-19 because they frequently have underlying medical conditions that worsen their prognosis (*e.g.*, cardiac disease, history of smoking)."); Andrea Fiorillo et al., *Psychosocial interventions to reduce premature mortality in patients with serious mental illness* (May 15, 2020), attached to Bien Decl. as **Exhibit 9** ("Compared with the general population, patients with serious mental illness (SMI), *i.e.*, schizophrenia, major depression, and bipolar disorders, have higher levels of morbidity, poorer health outcomes, and higher mortality rates.[] In particular, life expectancy is reduced up to 25 years.[] The causes of this premature mortality have been extensively analyzed, and the vast majority is due to the higher incidence of physical health problems, such as cancer as well as cardiovascular, respiratory, metabolic, and infectious diseases."); Ann K. Shinn, et al., *Perspectives on the COVID-19 Pandemic and Individuals with Serious Mental Illness*, Journal of Clinical Psychiatry (Apr. 28, 2020), attached to Bien Decl. as **Exhibit 31** (explaining that even without COVID-19, individuals with SMI have 3.7 times the mortality rate than the general population, largely due to cardiovascular and respiratory diseases); *Open Letter to ICE from Medical Professionals Regarding COVID-19*, at 2 (Mar. 13, 2020), attached to Bien Decl. as **Exhibit 15** (identifying SMI individuals as particularly vulnerable to COVID-19 infection); Decl. of Robert M. Sapolsky, Ph.D., *Arevalo v. Decker*, No. 1:20-cv-02982, Dkt. 3-3 (S.D.N.Y. Apr. 13, 2020), attached to Bien Decl. as **Exhibit 29** (chronic stress and related mental health conditions have medical impacts including depression of the immune system, leading to vulnerability to infectious viruses like

COVID-19 and ensuing disease; Type II diabetes; obesity; hypertension; inflammation of the lungs or other body systems; and cardiovascular disease); *cf.* Laura M. Maruschak et al., *Pandemic Influenza and Jail Facilities and Populations*, 99 Am. J. Public Health (2009) at S339-44 attached to Bien Decl. as **Exhibit 16** (partially as a result of higher rates of mental illness, incarcerated individuals are "particularly vulnerable" to influenza pandemics); Department of Health & Human Services, Centers for Medicare and Medicaid Services, March 30, 2020: *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs)*, attached to Bien Decl. as **Exhibit 4** at 3 (noting "the high infection rate of COVID-19 and the increased vulnerability of people with disabilities to have serious response[s] due to complications"); CDC, *Coronavirus Disease 2019 (COVID-19): People with Disabilities*, attached to Bien Decl. as **Exhibit 5** ("Adults with disabilities are three times more likely than adults without disabilities to have heart disease, stroke, diabetes, or cancer than adults without disabilities.").

The increased risk of medical comorbidities may be due at least in part to the side effects of psychotropic medications used to treat SMI. Jeffrey L. Geller, et al., *Patients with SMI in the Age of COVID-19: What Psychiatrists Need to Know*, Psychiatric News (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 30** (antipsychotic medications tend to increase obesity, metabolic syndrome, diabetes, and cardiovascular symptoms, and certain other psychotropic medications tend to depress respiratory function); Ann K. Shinn, et al., *Perspectives on the COVID-19 Pandemic and Individuals with Serious Mental Illness*, Journal of Clinical Psychiatry (Apr. 28, 2020), attached to Bien Decl. as **Exhibit 31** (psychotropic medications can lead to increased risk of diabetes and cardiovascular disease).

Below are references to scientific articles that describe the relationship between common mental health conditions and the types of comorbid medical conditions that place people with SMI at higher risk for COVID-19 infection and adverse outcomes:

- **Anxiety:** Catherine Kariuki-Nyuthea et al., *Anxiety and Related Disorders and Physical Illness*, 179 Comorbidity of Mental and Physical Disorders 81 (2015), at 82, 85, attached to Bien Decl. as **Exhibit 17** (describing "a growing body of evidence for a strong bidirectional association between anxiety and related disorders and co-occurring general medical conditions," including respiratory illnesses; association resulting in part from fact that "anxiety and related disorders may lead to vulnerability for various medical conditions").

- **Bipolar Disorder:** Joshua D. Rosenblat & Roger S. McIntyre, *Bipolar Disorder and Immune Dysfunction: Epidemiological Findings, Proposed Pathophysiology and Clinical Implications*, 7 Brain Sci. 144 (2017), at 1, 11, attached to Bien Decl. as **Exhibit 18** ("Bipolar disorder (BD) is strongly associated with immune dysfunction. Replicated epidemiological studies have demonstrated that BD has high rates of inflammatory medical comorbidities, including autoimmune disorders, chronic infections, cardiovascular disease and metabolic disorders.").

- **Depression:** Janice K. Kiecolt-Glasera et al., *Depression and immune function: Central pathways to morbidity and mortality*, 53 Journal of Psychosomatic Research (2002), at 873, 875, attached to Bien Decl. as **Exhibit 19** (depression "directly prompts immune dysregulation," "may lead to subsequent maladaptive immune and endocrine changes," and "may also contribute to prolonged infection"); American Psychological Association, *Stress Weakens the Immune System*, attached to Bien Decl. as **Exhibit 20** ("[D]epression hurts immunity; it's also linked to other physical problems such as heart disease.").

- **Posttraumatic Stress Disorder:** Gretchen N. Neigh et al., *Co-Morbidity of PTSD and Immune System Dysfunction: Opportunities for Treatment*, 29 Curr. Opin. Pharmacol. 104 at 2 (2016), attached to Bien Decl. as **Exhibit 21** ("PTSD is associated with poor self-reported physical health as well as high rates of comorbidities, such as cardiovascular, respiratory, gastrointestinal, inflammatory and autoimmune diseases.")

- **Schizophrenia:** Sukanta Saha et al., *A Systematic Review of Mortality in Schizophrenia. Is the Differential Mortality Gap Worsening Over Time?*, 64 Arch. Gen. Psych. 1123, 1125 & Fig. 1, Tbl. 1 (2007), attached to Bien Decl. as **Exhibit 22** (explaining that "people with schizophrenia had 2.5 times the risk of dying compared with the general population," including 3.1 times the risk of dying from respiratory diseases).

- **Stress:** American Psychological Association, *Stress Weakens the Immune System*, attached to Bien Decl. as **Exhibit 20** (citing S.C. Segerstrom & G.E. Miller, *Psychological Stress and the Human Immune System: A Meta-Analytic Study of 30 Years of Inquiry*, Psychological Bulletin, Vol. 130, No. 4 (2004)) ("For stress of any significant duration—from a few days to a few months or years, as happens in real life—all aspects of immunity went downhill. Thus long-term or chronic stress, through too much wear and tear, can ravage the immune system."); Decl. of Robert M. Sapolsky, Ph.D., *Arevalo v. Decker*, No. 1:20-cv-02982, Dkt. 3-3 (S.D.N.Y. Apr. 13, 2020), attached to Bien Decl. as **Exhibit 29** (chronic stress has medical impacts including depression of the immune system, leading to vulnerability to infectious viruses like COVID-19 and ensuing disease; Type II diabetes; obesity; hypertension; inflammation of the lungs or other body systems; and cardiovascular disease).

C. CDCR's data shows that the *Coleman* Class, as is typical of SMI populations, has high rates of medical comorbidities that place them at heightened risk of COVID-19 infection and poor outcomes.

The *Plata* Receiver has confirmed that the trends described above do, indeed, play out in the *Coleman* population. Data provided to Plaintiffs in April shows that *Coleman* class members are roughly 50% more likely to have at least one COVID-19 risk factor than their non-*Coleman* counterparts. *See* Decl. of Donald Specter in Supp. of Pls' Reply Br., ECF No. 6559, Exhibit B, Page 17 (Apr. 1, 2020). Roughly a third of the *Coleman* class is 50 years or older, *see* Decl. of Michael W. Bien in Supp. of Pls' Emergency Motion to Modify Population Reduction Order, ECF No. 6529, at ¶ 55 (Mar. 25, 2020), and age is a significant risk factor for COVID-19, *see* CDC, *Morbidity and Mortality Weekly Report: Coronavirus Disease 2019 Case Surveillance – United States, January 22-May 30, 2020*, Vol. 69 at 1, 4, 6 (June 15, 2020), attached to Bien Decl. as **Exhibit 2**. *Coleman* class members are typical of the larger population of people with SMI, with high rates of medical comorbidities that both render them particularly susceptible to COVID-19 and make COVID-19 particularly dangerous to them.

Coleman class members are at significantly increased risk for COVID-19 infection and resulting severe complications. CDCR's experience with hospitalizations and deaths among class members is consistent with the available scientific information regarding these types of poor outcomes, but CDCR's current policies and practices do not appear to take this information into account. Plaintiffs have urged Defendants to reallocate resources and attention to save more lives by focusing on those—like *Coleman* class members—who have dramatically increased risk of contracting COVID-19 and of experiencing adverse outcomes, including hospitalization and death due to COVID-19, but have not seen significant efforts in this respect to date.

III. Defendants Must Develop a Plan to Address and Treat the Increased Stress and Anxiety Associated with the Pandemic on Underlying Emotional and Psychological Conditions at the Same Time that They Plan to Restore Mental Health Care to Meet Program Guide Standards.

Defendants are obligated to restore mental health care to Program Guide levels as

soon as possible and must prepare additional strategies to address current class members' and non-class members' heightened mental health needs during the pandemic.

A. *Coleman* class members are likely to experience new or increased symptoms as a result of the pandemic and interventions to address the same, and non-class members are likely to experience mental health symptoms for the same reasons.

Due to their pre-existing mental health conditions, class members are more vulnerable than most populations to the mental health impacts caused by the isolation, changes in daily structure and routine, and other social changes arising from the pandemic. *See* Benjamin G. Druss, *Addressing the COVID-19 Pandemic in Populations with Serious Mental Illness* (Apr. 3, 2020), attached to Bien Decl. as **Exhibit 7** ("It will also be important to address the psychological and social dimensions of this epidemic for patients. Worry could both exacerbate and be exacerbated by existing anxiety and depressive symptoms. Physical distancing strategies critical for mitigating the spread of disease may also increase the risk of loneliness and isolation in this population. Those who become ill may face dual stigma associated with their infections and their mental health conditions."); Jeffrey L. Geller, et al., *Patients with SMI in the Age of COVID-19: What Psychiatrists Need to Know*, Psychiatric News (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 30** (noting severe impacts of increased isolation on those with pre-existing mental health conditions); Ann K. Shinn, et al., *Perspectives on the COVID-19 Pandemic and Individuals with Serious Mental Illness*, Journal of Clinical Psychiatry (Apr. 28, 2020), attached to Bien Decl. as **Exhibit 31** ("For people with psychotic disorders, the current circumstances may exacerbate feelings of perplexity, anxiety, and paranoia and may also become integrated into the content of delusions. … The pervasive uncertainty about what to expect and how long the shutdown will last is a major source of distress for many."; "[For some with SMI], isolation measures further reduce and collapse social networks, which are often already tenuous. … Simple but meaningful daytime routines …. are now impossible.").

Due to the stress and isolation resulting from the pandemic and associated

interventions, it is quite likely that incarcerated persons who were not previously class members may require mental health services and support, and may present with SMI. *See generally id.* Individuals with or without pre-existing mental health conditions may also experience medical complications or physiological changes from COVID-19 that create or exacerbate mental health conditions. *See* Aravinthan Varatharaj et al., *Neurological and Neuropsychiatric Complications of COVID-19 in 153 Patients: A UK-Wide Surveillance Study*, The Lancet (June 25, 2020), attached to Bien Decl. as **Exhibit 34** (noting altered mental status as an outcome of COVID-19 complications, including psychosis, dementia-like conditions, and affective, or mood, disorders).

Putting aside their particular vulnerability to COVID-19, many class members now find themselves in near-total lockdown, resembling solitary confinement, further exacerbating their pre-existing conditions. *See, e.g.*, Keramet Reiter, et al., *Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States*, 2017-2018, 110 Am J. Public Health (Jan. 1, 2020), attached to Bien Decl. as **Exhibit 23** (describing negative mental health impacts of the solitary confinement and segregation settings); Jeffrey L. Metzner et al., *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. of the Am. Academy of Psychiatry and the Law 104, 104 (2010), attached to Bien Decl. as **Exhibit 24** (same); Brief of Amici Curiae Professors and Practitioners of Psychiatry and Psychology in Support of Petitioner, *Prieto v. Clarke*, No. 15-31, 2015 WL 4720278 (U.S. Aug. 5, 2015), attached to Bien Decl. as **Exhibit 25** (same); Craig Haney, *The Psychological Effects of Solitary Confinement: A Systematic Critique*, 47 Crime and Justice 365, 368, 374 (2018), attached to Bien Decl. as **Exhibit 26** (same); Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J. L. & Policy 325, 330-32 (2006), attached to Bien Decl. as **Exhibit 27** (same); Jeffrey L. Geller, et al., *Patients with SMI in the Age of COVID-19: What Psychiatrists Need to Know*, Psychiatric News (Apr. 7, 2020), attached to Bien Decl. as **Exhibit 30** ("During this pandemic, it is reasonable to expect that new cases of SMI will arise and need to be addressed by the psychiatric workforce."; "[B]eyond fear of, exposure to, or

actual infection by coronavirus producing psychiatric symptoms, the act of quarantine and isolation itself induces psychiatric symptoms."; "Increased restrictions and overcrowding lead to behavioral outbursts …."); AMEND: Changing Correctional Culture, *The Ethical Use of Medical Isolation – Not Solitary Confinement – to Reduce COVID-19 Transmission in Correctional Settings*, attached to Bien Decl. as **Exhibit 33** ("Research shows that keeping people socially isolated in a closed cell without a meaningful opportunity to communicate with family, friends, and loved ones or to participate in exercise, educational, and rehabilitative programming (solitary confinement) causes immense, and often irreparable, psychological harm.").

Given the pandemic-induced isolation, increased stress, and far-reaching impacts to daily life experienced by incarcerated people in CDCR, it is likely that the need for mental health services—for current class members and non-class members alike—will only increase as the months and possibly years of the pandemic wear on.

B. Defendants must take affirmative steps to provide additional mental health and supportive services during the pandemic.

Since Defendants, like the larger nation, are no longer in the initial crisis management phase of the pandemic, the next step must be to look to, and plan for, the long road ahead. Tangible impacts of the pandemic on daily prison life and the provision of mental health care are now an indefinite reality. Plaintiffs have urged Defendants not only to devise solutions for the delivery of basic mental health care that has been discontinued or curtailed due to their temporary COVID-19 policies, but also to take into account the additional demand for mental health services from both existing class members and the remainder of the population.

Clinicians can do more to educate class members on COVID-19 prevention strategies through in-cell activities, counselling by non-clinical staff, and discussions in clinical groups, individual sessions, and IDTTs, and educational materials should be tailored to the *Coleman* class and others with limited health literacy or particular challenges in implementing prevention strategies like social distancing. *See* Department of

Health & Human Services, Centers for Medicare and Medicaid Services, March 30, 2020: *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs)*, attached to Bien Decl. as **Exhibit 4** at 1-2 (advising health care providers treating those in residential psychiatric facilities to take specific, tailored steps to communicate and educate patients regarding infection control practices, including hygiene); Benjamin G. Druss, *Addressing the COVID-19 Pandemic in Populations with Serious Mental Illness* (Apr. 3, 2020), attached to Bien Decl. as **Exhibit 7** ("People with serious mental illnesses should be provided with up-to-date, accurate information about strategies for mitigating risk and knowing when to seek medical treatment for COVID-19. Patient-facing materials developed for general populations will need to be tailored to address limited health literacy and challenges in implementing physical distancing recommendations …. Patients will need support in maintaining healthy habits, including diet and physical activity, as well as self-management of chronic mental and physical health conditions."); Ann K. Shinn, et al., *Perspectives on the COVID-19 Pandemic and Individuals with Serious Mental Illness*, Journal of Clinical Psychiatry (Apr. 28, 2020), attached to Bien Decl. as **Exhibit 31** (explaining that people with SMI need additional discussion with medical and mental health providers to help understand the risks and benefits of mental health and medical treatment, and that providers must increase communication and relationship-building efforts overall); *cf.* CDC, *Preparing for Coronavirus in Nursing Homes* (June 25, 2020), attached to Bien Decl. as **Exhibit 35** (staff should educate patients on infection control, hygiene, and related issues, along with strategies to address increased anxiety and stress resulting from the pandemic); CDC, *People with Developmental and Behavioral Disabilities* (May 27, 2020), attached to Bien Decl. as **Exhibit 36** (noting that individuals with developmental and behavioral disorders should take extra care of their mental health and it is critical that they take affirmative steps to identify and manage stress during the pandemic). The recent experience at San Quentin of numbers of incarcerated persons

refusing testing or refusing monitoring and treatment is evidence of the need for enhanced resources and attention necessary for patient education. In an atmosphere of fear, anxiety and distrust, communications tailored to the specific needs of the *Coleman* class and other incarcerated persons with cognitive differences are critical.

COVID-19 mitigation and prevention techniques, and strategies to address the additional stress imposed by the pandemic, should be incorporated into treatment plans. *See* Benjamin G. Druss, *Addressing the COVID-19 Pandemic in Populations with Serious Mental Illness* (Apr. 3, 2020), attached to Bien Decl. as **Exhibit 7** ("For any given patient, psychological symptoms will emerge in a unique personal and social context that should be considered in developing a treatment plan."); Ann K. Shinn, et al., *Perspectives on the COVID-19 Pandemic and Individuals with Serious Mental Illness*, Journal of Clinical Psychiatry (Apr. 28, 2020), attached to Bien Decl. as **Exhibit 31** (mental health providers must undertake individualized approaches tailored to individuals' weaknesses and strengths to help patients cope during the pandemic). Helping patients understand how they can be proactive in preventing infection will not only reduce stress and anxiety, but will also help reduce actual infection rates (both because of the preventive measures as such and because the reduction in stress and anxiety will likely have a positive impact on class members' overall health and immunity).

Access to clinicians via tele-mental health should be increased. For example, with COVID-19 at play, patients and/or clinicians may prefer a tele-mental health session to an in-person session. Both should be able to request this type of contact (as is true outside prisons). This can reduce COVID-19 risk not only to the patient and the clinician but also to custody staff, while also ensuring the patient receives meaningful, substantive treatment.

As this Court is aware, significant numbers of class members and other incarcerated persons in CDCR today are in cells or other housing without access to television, radio, tablets or any other entertainment devices. Some of these locations are the tent or gym housing set up for the pandemic. Other such housing includes reception centers and segregation units, as well as certain CTC and MHCB units. Access to reading, writing,

and drawing materials, activity packets, envelopes, and stamps is also limited. Immediate and thorough efforts must be taken to address these dangerous deprivations of basic and simple tools necessary to address the increased social anxiety, isolation, and seclusion caused by the pandemic and the near total lockdown and deprivation of programming and activities and treatment that has resulted.

Defendants should also use all available resources (including the Governor's emergency powers) to find ways to increase treatment, programming, and activities for the *Coleman* class and all incarcerated persons to combat the stress and isolation caused by COVID-19. Emergency powers could be used to procure entertainment devices, activity books, and other materials more quickly than through the usual processes. *See* AMEND: Changing Correctional Culture, *Urgent Memo, COVID-19 Outbreak: San Quentin Prison* (June 15, 2020), at 7, attached to Bien Decl. as **Exhibit 32** (individuals in medical isolation must be provided, at a minimum, free access to personal tablets with movies, increased access to free canteen items, personal effects and free phone calls, perhaps on state-owned cell phones, and daily opportunities for yard time."). Emergency powers can be used as necessary to resolve or remove technological and security barriers to procuring computers, tablets, radios, books, magazines and other supplies.

This urgent effort should start with the segregation units but must also include Reception Centers and other areas of the prisons that currently restrict access to entertainment devices due to lack of access to functioning electrical outlets or cable. The first section of Appendix A incorporated into Title 15, the Authorized Personal Property Schedule, is called Granted Exemption Requests. *See* Inmate Property: Matrix – Authorized Personal Property Schedule (Apr. 1, 2014), excerpt attached to Bien Decl. as **Exhibit 28**. The exemptions seem to identify all of the units in all of the prisons that do not allow entertainment devices for various reasons. *See id.* These portions of the regulations must be amended on an emergency basis to allow full access to entertainment devices. The alternative is serious mental health decompensation among class members and non-class members alike.

Defendants must take immediate steps to mitigate the harm caused to class members and all incarcerated persons by the total restrictions on visiting, volunteer-based programming, and activities (religious, educational, substance abuse, veteran, restorative justice, etc.). Free telephone calls must be expanded and made available to all prisoners, including those in quarantine. Visiting must be restored by setting up appropriate protocols for video visits, visits through glass, or other measures. Programming such as religious services, education, veterans' groups, AA groups, and others must be safely restored with appropriate limitations to assure social distancing and/or with increased use of technology.

Severe restrictions on yard time must be lifted—fresh air and exercise are crucial to stress reduction, and physical and mental health. Efforts to maximize fresh air and exercise, consistent with social distancing and other infection control measures, must be implemented.

Plaintiffs continue to urge Defendants to consider the distribution of cell phones (with appropriate security measures) to allow for communication with both family and mental health clinicians while maintaining social distancing. *See* AMEND: Changing Correctional Culture, *Urgent Memo, COVID-19 Outbreak: San Quentin Prison* (June 15, 2020), at 7, attached to Bien Decl. as **Exhibit 32**. Cell phones are already widely available (but contraband) in the prisons. Cell phones with appropriate security restrictions can be obtained and used without undue security risks.

Defendants must also, of course, continue to consider safe population reduction and density-decreasing measures. *See* AMEND: Changing Correctional Culture, *The Ethical Use of Medical Isolation – Not Solitary Confinement – to Reduce COVID-19 Transmission in Correctional Settings*, attached to Bien Decl. as **Exhibit 33** ("Prisons, jails, and other places of detention that are not able to comply with ethical standards of quarantine and medical isolation in the COVID-19 pandemic should urgently implement strategies to release or transfer people to locations that have the capacity to meet community standards of medical care."). Population reduction focusing on high-risk, vulnerable populations,

including the *Coleman* population, for targeted releases—rather than general releases based on political risk—must begin as soon as possible.

CONCLUSION

Plaintiffs appreciate the opportunity to provide the foregoing materials to the Court. Plaintiffs anticipate further focused discussions in the task force regarding what, if any, targeted efforts Defendants will commit to taking to address the serious risk of COVID-19 to the *Coleman* class, and to implement interventions to address the many significant mental health impacts of the pandemic. Plaintiffs expect to apprise the Court of the parties' progress on these issues in the forthcoming status conference statement on COVID-19 issues, and to continue to urge Defendants to take necessary steps to protect and treat the *Coleman* class.

CERTIFICATION

In preparing this brief, Plaintiffs' counsel reviewed the following Court orders: Minute Order, ECF No. 6741 (June 26, 2020); Order, ECF No. 6600 (Apr. 10, 2020).

DATED: July 2, 2020

Respectfully submitted,

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