

**THE NATION'S CORRECTIONAL STAFFING CRISIS:
ASSESSING THE TOLL ON CORRECTIONAL
OFFICERS AND INCARCERATED PERSONS**

HEARING

BEFORE THE

**SUBCOMMITTEE ON CRIMINAL JUSTICE
AND COUNTERTERRORISM**

OF THE

**COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE**

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

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FEBRUARY 28, 2024
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Serial No. J-118-55

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**THE NATION'S CORRECTIONAL
STAFFING CRISIS: ASSESSING THE
TOLL ON CORRECTIONAL OFFICERS
AND INCARCERATED PERSONS**

WEDNESDAY, FEBRUARY 28, 2024

UNITED STATES SENATE,
SUBCOMMITTEE ON CRIMINAL JUSTICE
AND COUNTERTERRORISM,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice at 2:30 p.m., in Room 226, Dirksen Senate Office Building, Hon. Cory A. Booker, Chair of the Subcommittee, presiding.

Present: Senators Booker [presiding], Whitehouse, Padilla, Ossoff, Butler, Cotton.

Also present: Senator Welch.

**OPENING STATEMENT OF HON. CORY A. BOOKER,
A. U.S. SENATOR FROM THE STATE OF NEW JERSEY**

Chair BOOKER. We are officially gaveled in. And I just want to say good afternoon, everybody. It means a lot that everyone is here for an important hearing in this discussion. And I just want to give a lot of gratitude to folks making time out of their schedule to be a part of this. I want to welcome our witnesses, many in whom journeyed really far to be a part of this Subcommittee hearing.

And I'm also particularly grateful to have Tom Cotton as my Ranking Member in this work, that his staff and he has done to make this hearing successful. We face a stark reality today. Our national correctional system, I think it's fair to say, is in crisis.

The Bureau of Prisons is undergoing a well-documented staffing shortage with 21 percent of correctional positions vacant, BOP has imposed more and more mandatory overtime forcing officers to work 10, 12, 15 and we heard earlier today, 18-hour shifts.

This disrupts their lives, makes it harder for them to find childcare or simply just to be with their families. The BOP has also relied on staff augmentation, pulling case managers, teachers, psychologists, away from their work to perform duties they aren't often fully trained for.

Our State's prisons are also functioning with dangerously low levels of staff in a way that I think we'll elucidate today. Over the last few years, we've seen an increase in the prison—in the population of incarcerated individuals, which has now led to overcrowding.

Correctional officers and their staffs are really struggling with this. These are some extraordinarily dedicated law enforcement Americans, yet they are overworked and underpaid and struggling with the resultant mental health challenges.

I was stunned to find out how undercompensated they were when I sat down with Mrs. Brandy Moore White. It just did not compute to me how little we are paying them. And this, I want to say leads to chronic stress. It doesn't just dissipate once officers leave the facility, it really follows them home.

Devastatingly it is estimated that 156 active-duty correctional officers take their own lives each year. That's three individuals a week. The Nation's correctional infrastructure is also in despair and more susceptible to extreme heat and cold, flooding, and other weather events.

In Texas, more than two-thirds of the Texas prisons have no air conditioning, even after 10 incarcerated individuals have died from heat related illness in the month-long heat wave back in 2011. This crisis has a profound human toll.

In Georgia, it took 5 days for correctional staff to discover an incarcerated person's decomposing body after their death. In Missouri, despite multiple complaints and requests to see a dentist, an incarcerated individual pulled out his own teeth because he never received adequate dental care.

Earlier today, the Judiciary Committee held a hearing about the Inspector General's disturbing findings that staff shortages were a contributor to deaths of incarcerated people in the Bureau of Prisons, not to mention the challenges and hardships placed upon our correctional officers.

Our prisons have a weighty mandate to promote public safety by maintaining a humane and secure correctional environment and preparing incarcerated individuals to reenter society. Plainly, it is not possible to accomplish this mandate with an overworked workforce laboring in unsafe and even undignified conditions.

Look, the Ranking Member, and I have areas of agreement and areas of not, but one thing he and I feel fiercely about—I've heard him speak about it—is this importance of public safety, safe neighborhoods, safe communities, a safe country.

If you look at our Founding Documents, so much of them, the establishment of our government was about keeping people safe, about public safety. Well, there's a direct connection between what happens in our prisons and the safety of our community because 95 percent, roughly of the people who go into prison come back out.

An estimated 65 percent of the people incarcerated in the United States have a substance abuse disorder. But instead of providing services, we see that they're not getting basic medical care, which again, has a direct correlation to how they behave outside of prison as well.

The proven way to lower recidivism rates is to ensure access to medical care, including mental health and substance use treatment, which empower individuals through programming to ensure that incarcerated individuals are able to be successful when they're released.

We even know there's a connection between incarcerated individuals being connected to their children and their families and their

recidivism rates. What we need is common sense, evidence-based policies that promote proven methods to lower recidivism rates, and empower people to succeed.

Our correctional officers are public safety officials. They are critical to the safety of our Nation. They are law enforcement individuals, yet to deny them the resources or support we give to other members of law enforcement or to have them disproportionately underpaid, relative to the work of other law enforcement individuals, it's not just disrespect, it actually undermines their mission of public safety.

This crisis is a public safety issue, and it is a moral issue. If you want to see the character of a country, don't look in our places of business, our fields of science and education alone, look within our prisons. The condition of our prisons says so much about the character of who we are as a country.

The people that work there, the people incarcerated there, do their conditions, do their work environment, do the conditions of their incarceration reflect the highest standards of a Nation of our greatness. We should be setting the global example of incarceration and remediation, repair, and restoration.

I look forward to this productive conversation with this extraordinary panel. I'm grateful again for everybody being that. And with that, I turn it over to the Ranking Member of this Subcommittee, my colleague from Arkansas, Senator Tom Cotton.

**OPENING STATEMENT OF HON. TOM COTTON,
A. U.S. SENATOR FROM THE STATE OF ARKANSAS**

Senator COTTON. Thank you, Senator Booker. This hearing touches on an important topic. I think we can all agree that our prisons are understaffed. In the Federal system alone, we have about 40 percent of our prison correctional officer positions unfilled, even though Congress has already appropriated money to fill those positions, and crime is increasing in the country, in part because we've been too eager to empty out our prisons and let violent, dangerous criminals back into our communities far too early.

The revolving door of poorly resourced prisons and increasingly weak sentences is worsening crime nationwide. We need to reverse that trend. In 1992, as the Nation faced an epidemic of homicides and violent crime with people scared to leave their homes in some cities, then Attorney General Bill Barr released a report called *The Case for More Incarceration*.

In that report, he argued that the failure to incarcerate leads to more crime and costs much more than spending on prisons. He was right then, and he's right now. And as Congress spent more on getting tougher on crime and setting up sufficient prison space, crime rates dropped dramatically.

Unfortunately, too many would soon forget that success. You might even say that we were a victim of our success. A decade ago, when our prison population peaked, many argued that the high crime days of the 1990's were in the past, and we spent too much money on our prisons. If we had just let criminals out, they argued we could save money on prisons.

After all, why would we need prisons anymore if crime has decreased by so much. It's astounding that anyone ever believed that.

But the idea that increased prison populations were somehow unconnected to a declining crime was repeated over and over.

The New York Times was especially fond of this line of argument. In August, 1998, they ran an article entitled Prison Population Growing, Although Crime Rate Drops. Almost exactly 2 years later, the same reporter at the New York Times published an article entitled Number in Prison Grows Despite Crime Reduction. And in 2004, that very same reporter published yet another article in the New York Times. The headline was, Despite Drop in Crime, an Increase in Inmates.

Now, maybe the New York Times was not getting its money's worth from that particular reporter, but eventually people started believing that prison populations were too high if crime rates weren't so bad. And over the past decade, the total State and Federal prison population in the United States has dropped by more than 20 percent.

In the Federal system alone, it's decreased by 30 percent, and as prison started to empty in 2014, not surprisingly, violent crime rates shot up nationwide by more than 10 percent, in just 2 years. In big cities, the change has been even more dramatic as reduced prison populations combined with de policing, and so-called criminal justice reform measures, to weaken penalties for committing crimes were adopted.

A study from Iowa State University researchers in the early 2000's ran the numbers to find out how much crime cost our society. Each armed robbery, every single one cost society more than \$335,000. The University of Chicago study similarly found that an armed robbery cost hundreds of thousands of dollars to society.

These aren't just the immediate costs to the victim, like replacing stolen property and getting medical treatment after an assault or paying for the funeral if someone dies. It also includes other costs of crimes such as higher insurance costs, shuttered businesses and laid off employees, behavioral changes, from avoiding places and activities where you might become a crime victim. As well as the cost of increased police patrols in the high crime areas.

The University of Chicago study put the total cost of crime in the United States at around \$5.76 trillion per year, which means that the State and Federal prison costs only about 1 percent of the total cost of crime.

So, we should be spending more, not less because we have a under incarceration problem in this country. We need to cut government spending in many areas. But criminal justice and national security are two of the main areas where government needs to spend, has to spend whatever it takes to keep our people safe.

The title of today's hearing is not exactly what I would've chosen. It mentions assessing the toll of understaffed prisons on correctional officers and incarcerated persons. The right word there would be criminals or inmates.

But one group we can't forget is the victims of those crimes. Fully funding and staffing our criminal justice system and our prison leads to less crime, and it creates an environment where criminals have their best shot at rehabilitation.

So maybe today's hearing should have instead borrowed from that old report from Attorney General Barr and been entitled, The

Case for More Incarceration. We have a great panel of witnesses here, and I thank you all for your appearance. I look forward to hearing from you about how we can make our prisons safe, secure, and functional again.

Chair BOOKER. All right. We have a distinguished panel of witnesses today. We will now introduce each of them and then after the introductions, we're going to have you guys stand, raise your right hand and we'll administer the oath.

Our first witness is John E. Wetzel. Mr. Wetzel is the founder and board chair of Keystone Restituere Justice Center, KRJC. A nonprofit organization dedicated to providing assessable and translatable data-driven solutions in the fields of corrections and criminal justice. A strategic management policy and research organization.

KRJC seeks to elevate institutions and agencies to new heights, to better serve communities. Mr. Wetzel served as a former Pennsylvania Secretary of Corrections from 2011 to 2021 under both Republican and Democratic Governors, and began his career as a correctional officer. Mr. Wetzel is a graduate of Bloomsburg University.

Our next witness is Santia Nance, co-founder of Sistas in Prison Reform. Ms. Nance has been a criminal justice reform advocate in Virginia since 2019. After reconnecting with a loved one, her fiancé Quadaire Patterson, focused on decarceration and second chances. She centers her work around oversight of the Virginia Department of Corrections and ending mandatory minimums in Virginia. Ms. Nance is also the editor of brilliancebehindbars.com, A website that aims to humanize and uplift currently incarcerated individuals. Ms. Nance graduated from Virginia Commonwealth University with a BS in mass communication and is a senior advertising professional at a major agency.

Next, we have Stephen B. Walker, National Wellness director of One Voice United. Mr. Walker is a California resident—we'll forgive him for that—and lifelong activist in the area of child protection and crime prevention. Along with his role at One Voice United, he's also the director of Governmental Affairs for the California Correctional Peace Officers Association. Mr. Walker previously worked within the California Youth Authority for 26 years as a youth correctional officer. And Senator Butler will have a moment for a rebuttal later on to that California comment.

[Laughter.]

Chair BOOKER. We also have two other witnesses that Ranking Member Senator Tom Cotton will introduce. I am pleased though to see that Brandy Moore White is here sending—sitting in the Center Square. The president of the Council of Prison Locals 33 on this panel.

Ms. White, I want to thank you and my staff actually wants to thank you for meeting with us a few weeks ago. It was enlightening to me and even more so in the longer conversation you had with my team, and we're looking forward to your testimony.

But for the other introductions, I'm going to turn it over to Ranking Member Tom Cotton to introduce the final witnesses.

Senator COTTON. Thank you. I'm pleased to introduce Brandy Moore White. Mrs. White is a highly qualified person to speak on

prison staffing issues. She has been a career official at the Federal Bureau of Prisons for the past 2 decades. She's seen all of this first-hand and is still on the front lines today. She was elected last year as National President of the Council of Prison Locals, the union representing our Federal corrections officers.

She has previously served in leadership roles in the Council of Prison Locals for virtually her entire career. Maybe most importantly, she is from the great State of Arkansas where she was born and raised, and where she has spent the entirety of her corrections career. Brandy, thank you for joining us today and welcome.

I'm also pleased to introduce Ralph Mangual, Mr. Mangual is the Nick Ohnell Fellow and Head of Research for Policing and Public Safety Initiative at the Manhattan Institute for Policy Research—

Chair BOOKER. That's right next to New Jersey.

Senator COTTON [continuing]. He's also an accomplished author and a contributing editor of City Journal. And his work has been featured in a wide array of major publications. He's well known to us. He's also testified several times for this Subcommittee and other Committees.

He currently serves on the New York State Advisory Committee to the U.S. Commission on Civil Rights. He holds a BA from City University of New York, and a JD from DePaul University College of Law in Chicago. Ralph, welcome back and thank you for joining us today.

Chair BOOKER. Will the witnesses please rise and raise your right hand.

[Witnesses are sworn in.]

Chair BOOKER. Let the record show that all of them said I do, as if they were getting married. Get down please.

[Laughter.]

Chair BOOKER. And appreciate your affirmative responses. You're each going to have 5 minutes for an opening statement. Mr. Wetzel, we'll start with you, please.

STATEMENT OF JOHN E. WETZEL, FOUNDER AND BOARD CHAIR, KEYSTONE RESTITUTERE JUSTICE CENTER, FORMER PENNSYLVANIA SECRETARY OF CORRECTIONS, HARRISBURG, PENNSYLVANIA

Mr. WETZEL. Thank you, and, thanks for the opportunity to once again talk about corrections, a field I spent my entire life doing. Part-time correctional officer at age 20, while at Bloomsburg University. Nine years as a correctional officer, counselor, head of the counseling department at a large county jail in Pennsylvania. Head of the training academy, county warden, longest serving corrections secretary in the history of Pennsylvania.

This field means everything to me. And you know, I can't imagine any of the centers in here have been in a hearing in the last 2 years that hasn't been about a crisis. I mean, it may be the most over used word in our vocabulary right now as it comes to the public sector because everything's in crisis. But I think we need to use accurate language. We have a system on a brink of failure, and it's a system we all need.

It doesn't matter what side of the aisle you're on, what you want out of your correction system, whether you think it's underused or overused. What we need—what our mandate is, what our covenant is, and as it relates to corrections, is that we do something to impact the trajectory of people who couldn't follow the rules.

So, in—I mean, you don't, you know, to many people's point, you don't get sent to a State prison or Federal prison for jaywalking. All right. So implicit in that is that someone who comes to us, has not been—has not complied with what we expect out of our citizenry, right?

So, if we want to make a good investment in our correction system, we should do something to take them off that trajectory, right? That no—that's not happening anywhere. There may be a handful of systems, there may be a handful of jails who are actually delivering this covenant of making people—having people at least not get worse, if not come out better and less likely to commit a crime.

You know, we talk about public safety. I would argue it's actually broader. It's community safety, and our communities are less safe because of this crisis, if you want to use that term, this on the brink of failure correction system. I'm from Pennsylvania, born, raised, will never live in another State. And I will tell you that it's not just public safety in Pennsylvania.

We spent a very nervous week in Pennsylvania because of a jail escape. It closed down major events right outside of Philadelphia. People who were not adjacent to the correction system in Pennsylvania are adjacent to the correction system. It's critical that we understand in America, we're all adjacent to the correction system.

Nobody should feel good about the fact that we have National Guard members, people who—and listen, I spent 11 years—all but 11 years, 3 months short of 11 years running the sixth biggest prison system in America. All right. I've worked a lot with the National Guard.

We had floods, we have major events, that's what they're there for. They're covering the position of correctional officers at a time where people who aren't in this city are concerned about what's going on over the country, all over the world. And we're using soldiers to man our jails and or prisons because we don't—we have inadequate staff.

And the notion that some—we're going to push some idea to this field that's going to now work, where we've been pushing ideas forever, we have to think differently about this. And, you know, we can look to history and I love looking to history, especially when you're in this building.

You know, 50 years ago as a result of Attica, the National Institute of Corrections was created. Some of you may not have heard about that, and that's part of the indictment of the divestment in the intellectual development of this field.

Listen, we're not going to fix problems if we don't have our correctional staff, who are remarkable people who dedicate their lives. You don't even hear about them, you don't know about them. Heck, it—now you don't even wear your uniform home because you don't know what someone's going to say to you at the grocery store, all right.

But they're dedicating their life, and they don't have a mechanism to develop professionally. Like, I would not be sitting here if the National Institute of Corrections did not offer what was called a clip course for some of your old people, they used to have to send you a course and you'd actually fill it out and send it back. It wasn't online. That's how I learned how to staff, all right. That's not available today.

So, the National Institute of Corrections, just to give you a little history, was invented out of—came about after Attica, right. And Attica was not at a Federal prison, right. But Warren Berger, who was the Supreme Court Justice at the time, as or Chief of the Supreme Court, as well as other—the Attorney General, others were so bothered by what happened and what led to it that they felt like we needed a different approach.

So, they developed this National Institute of Corrections that was not actually part of the Bureau of Prisons, which it is now. It was adjacent, what it was designed to do was tap the best and brightest from corrections, right. To solve these problems, to sync through the—to advise you guys. So, you actually made decisions on data that used to happen. Believe it or not, it used to happen that you'd make decisions based on actual data.

You can't even get data on one of your biggest expenditures. You can't get accurate data and, you know, thank God I'm not the director of Bureau of Prisons. I have a world of respect for her stepping up in the system. But let me give you context as somebody sits in, she's been a job maybe 2 years, a year and a half, I'm sure for her it probably feels like 20 years.

And she's asked questions about data. You have mainframe computers, haven't updated it, like you have old data systems. So, you look at any other sector and you look at how you would resolve problems. You would use technology, you would use innovation. Look at the work of Clayton Christiansen Institute of Disruptive Innovation. Look at the medical field, look at poverty, attacking it by bringing technology to a field, right. By identifying individuals in the field, like incarcerated people, like correctional officers that are ignored by the market, right.

There's no research and development. You don't see patents flying out at how we address this issue.

[The prepared statement of Mr. Wetzel appears as a submission for the record.]

Chair BOOKER. I'm going to hold you to 5 minutes.

Mr. WETZEL. Sorry.

Chair BOOKER. No, I'm sorry. It's a real 5 minutes, not a senatorial 5 minutes.

[Laughter.]

Mr. WETZEL. Sorry.

Chair BOOKER. No, no worries. No, we really appreciate it. We're looking forward to hearing more of your testimony, and it's an insightful presentation. I'm going to move on to Ms. Nance and for her actual 5 minutes.

**STATEMENT OF SANTIA NANCE, CO-FOUNDER, SISTAS IN
PRISON REFORM, RICHMOND, VIRGINIA**

Ms. NANCE. Don't worry, I'll give you 5 minutes. Chair Booker, Ranking Member, Senator Cotton, and Members of the Subcommittee, thank you all for having me today. My name is Santia Nance. I'm the mother of a middle schooler, a Virginia voter, vice president of an advertising company and fiancé to Quadaire Patterson, who has served 15 years on a 20-year sentence.

Quadaire made some poor decisions when he was a young adult, only 20 years old, and he was homeless. He takes full responsibility for the decisions that led to his current incarceration. But spending all of his 20's and half of his 30's in prison, he's made the most of his time in prison and seized every opportunity to prepare for his successful reentry.

He received his GED in 2012 and has taken college courses through Ohio University and studying to be a paralegal. He has a trade in brick masonry and assist with reentry efforts and mentorship through Brilliance Behind Bars.

Quadaire is housed at Lawrenceville Correctional Center, which has been facing a lot of staffing shortages since at least 2018, and the Virginia Department of Corrections has estimated that they need a number—almost 100 incarcerated officer, or sorry, correctional officers.

While a partnership during incarceration is already hard enough for me and my family, short staffing there has impacted us tremendously. Quadaire was diagnosed with glaucoma in 2012, and he needs his eye drop medication called latanoprost. Without this medication, it's not only difficult for him to do everyday tasks, but to keep up with his coursework and his studies.

Quadaire has filed multiple grievances in the past couple years and requests to see the eye doctor, and this eye doctor only comes to the facility once a month. But he's only been met with, you're on the waiting list. So, it's just been ridiculously hard to get him in front of the eye doctor to get his prescription renewed.

Because of short staffing, he's seen how—at firsthand—how this has affected services and programming necessary for rehabilitation. For example, religious gatherings like church on Sunday, they get canceled at the last minute.

Now only one correctional officer runs the gym instead of four. So, music, anger management, substance abuse programming, those have all been interrupted, causing difficulty to encourage rehabilitation for the people at Lawrenceville.

While prison does require physical separation, we stay in contact through visitation a couple times a month, phone all day when we can and email when we can. But short staffing has interfered with our ability to maintain our family bond. My visits on January 28 and February 4 of this year were canceled due to staffing concerns.

And my recent 2-hour visit on February 18 was cut short by 45–50 minutes due to the wait time of the long line of visitors and it was staffed by only one correctional officer where there should have been four or five in the office processing us.

But she was the only one who knew how to do all five jobs and was willing to step up. Whether there are lockdowns in the prison or an extended count time due to lack of employees to cover shifts,

I suffer not knowing the reason why Quadaire is not calling. I haven't heard from him since Sunday of this week, and I often fear the worst when I'm unable to reach anybody At Lawrenceville.

There's a trend of these events that happen during holidays, bad weather, and evenings as people might be calling out of work. Quadaire knows that he has to be held accountable for the mistakes he made, but the issues caused by understaffing go well beyond affecting those behind the prison walls. It punishes me and my son as well.

After reconnecting with Quadaire 6 years ago, I co-founded an organization called Sistas in Prison Reform. Our mission and purpose is to bring humanization to those behind the walls and collaborate with Virginia's lawmakers.

Through this work and my personal experience. I believe that the answer to this crisis—if we're going to use that word—to identify those who have received harsh sentences and have rehabilitated themselves, and to release those who have proven they're ready to come home and do not pose a public safety risk.

Like many others in Virginia, Quadaire sentence includes 13 years of mandatory time, but this harsh mandatory sentence was not necessary to protect the public or to prepare Quadaire to reenter society. Quadaire is rehabilitated and ready to join our communities. There are many mechanisms to identify what rehabilitation looks like, good behavioral records while in prison, educational milestones, safe environments to go home to, secure jobs, and the list goes on.

There are people like Quadaire, my fiancé, that our State and Federal tax dollars are wasting money on when these incarcerated people could be home and paying taxes and giving back to their communities.

Reducing the population would lessen the burden of the officers and allow them to maintain a manageable environment that focuses on those who still need rehabilitation. Thank you for your time and for the opportunity to share my story today.

[The prepared statement of Ms. Nance appears as a submission for the record.]

Chair BOOKER. Thank you, Ms. Nance. Mrs. Moore White.

**STATEMENT OF BRANDY MOORE WHITE, PRESIDENT AFGE,
COUNCIL OF PRISON LOCALS 33, FOREST CITY, ARIZONA**

Mrs. WHITE. Thank you. Good afternoon, Chairman Booker, Ranking Member Cotton, Members of the Subcommittee and distinguished guests. I want to sincerely thank the Subcommittee for the opportunity to present the perspective of our Federal prison system and from the professional hardworking men and women of the Federal Bureau of Prisons.

For far too long, this conversation has been missing a key element. That's the professional law enforcement officers who have dedicated their lives to protecting their coworkers and communities and safely housing inmates. The Council of Prison Locals represents nearly 30,000 correctional professionals across the country and 121 Federal prisons.

These professional law enforcement officers who work tirelessly in some of the most violent, self-contained cities in the country

keep us all safe from some of the world's most dangerous human beings.

Today I would like to discuss our primary concerns, which are the current critical staffing levels and pay structure within the Bureau of Prisons, both of which must be addressed urgently.

Staffing levels in the Bureau of Prisons have reached alarming levels. Over the past 7 years, the authorized positions within the Bureau have decreased from 43,369 to the current count of 34,470 staff members. This reduction of nearly 8,900 staff members not only compromises the safety and security of both staff and inmates, but it also raises major concern and hinders our ability to effectively carry out the Bureau's mission and rehabilitate and reintegrate.

The impact of these staffing cuts is particularly evident among our correctional officers. Despite the President's request and subsequent legislation, the number of correctional officer positions has drastically fallen short of what has been appropriated by Congress.

At the close of 2023, we had approximately 12,300 correctional officers, which is more than 8,000 less or 40 percent below of the appropriated number of 20,446 officers. This number follows a year of hiring initiatives enacted by our agency. Within the current staffing levels, the Bureau of Prison, the First Step Act cannot be successfully enacted. Staff used for programming are often pulled from their positions and used to backfill shortages of correctional officers.

Augmentation, reduces inmate access to recidivism, reducing activities like programming, recreation, and educational initiatives. Additionally, because of the lack of staffing, correctional officers are forced to do mandatory overtime. Overtime officers are frequently mandated—at the last minute—to stay in additional eight plus hours, often several times a week.

This diminishes skills and awareness, it reduces acuity and causes general fatigue, which greatly hinders supervision. Augmentation, and mandatory overtime have become the norm. This detracts from our programming. It compromises the safety and security of the institutions, but it also greatly affects the mental health and well-being of our employees.

The union believes that the staffing crisis can only be resolved by addressing our insufficient pay band issues. The current pay structure within the Bureau is significantly lower than that of other Federal law enforcement agencies, including the U.S. Marshals, Immigration and Customs, and Border Patrol.

The Bureau's pay scale is non-competitive with State and local law enforcement and even the private sector market. Without addressing these pay disparities, the Bureau will continue to struggle and attract and retain employees. The Bureau must be required to increase the pay bands to correct the staffing crisis.

Because the Bureau is unable to solve its biggest problem, it now requires the direct intervention of the administration, OPM and the Legislative Authority of Congress to immediately correct. The Council of Prison Locals has worked diligently with Members of Congress to properly fund the Federal Bureau of Prisons.

However, even with additional funding, there continues to be a decline in correctional officers. Congress must now demand over-

sight and accountability. The Bureau of Prison staffing has graduated from a crisis to a catastrophe with real human consequence. The Bureau must use the funding that has been appropriated to fully hire the correctional officers needed to safely house incarcerated inmates.

In order to achieve this, efforts must be made to raise the pay bands and make our Federal law enforcement officers competitive with other law enforcement agencies. Chairman Booker, Ranking Member Cotton, and Members of the Subcommittee, this concludes my formal statement, and I truly look forward to answering any of your questions and providing additional insight.

[The prepared statement of Mrs. White appears as a submission for the record.]

Chair BOOKER. I'm grateful for your testimony. Mr. Walker.

STATEMENT OF STEPHEN B. WALKER, NATIONAL WELLNESS DIRECTOR, ONE VOICE UNITED, SACRAMENTO, CALIFORNIA

Mr. WALKER. Thank you, sir, Chairman Booker, Ranking Member Cotton and—that would help, wouldn't it? Chairman Booker, Ranking Member Cotton, and esteemed Members of the Committee, I would like to thank you for the opportunity to speak with you today.

My name is Stephan Walker. I am a representative of One Voice United, a national organization advocating for the welfare of correctional officers and other frontline staff and ensuring that our expertise and perspectives are included in the national debate around criminal justice reform.

Before One Voice, I served as a youth correctional officer for 35 years in the California Department of Corrections and Rehabilitations. And currently serve as the director of Correctional Health for the California Correctional Peace Officers Association.

Today, I sit before you to address the existential staffing crisis in America's prisons and jails, in hopes of advancing a national nationally sanctioned dialog. This crisis has no borders, is not one State's issue and cannot be solved by a single department or entity.

It is a systemic, and a systemic issue and impacts every aspect of corrections, by asking staff to do more with less and often resulting in excessive work hours and multiple mandated shifts leading to increased burnout, less job satisfaction, and an inability to perform everyday security and rehabilitative functions.

We are in full support of the position Mrs. Moore White offered on augmentation. From experience, I can tell you that it is not enough to just find a warm body to fill a vacant position. To be a competent and professional correctional officer takes time, supervision, and training.

Not to mention the fact that augmentation takes key personnel and nurses, teachers, and administrators out of their primary functions without replacement of the services loss. For staff, personnel shortages lead to diminished observational skills, less intelligence gathering, overtime surges, slow response and strained family relationships and collective wellness.

In fact, multiple studies indicate that correctional officers suffer from PTSD, depression, suicide, heart disease, and shortened life-

span and other physical and psychological ailments at a rate well above the general public.

For those in our care personnel shortages mean programs are slashed, visits are reduced. Time on lockdown is increased and the patience of everyone behind the walls wears thin. The ratio often surpasses 60 to 1, especially in yards and chow halls. And unpredictable staffing patterns force policy mandated prioritization of institutional safety, which limits programming rehabilitative services, which are essential for promoting positive behavior and reducing recidivism.

Addressing this staffing crisis is crucial for creating a secure environment for both staff and incarcerated individuals. To combat this reality, well-meaning attempts are being initiated by agencies in various States, by lowering entrance requirements for new recruits, shortening academy times, and offering signing bonuses, none of which has successfully addressed this crisis to scale of lasting impact.

Retaining staff is equally important and we must transform employment conditions by moving beyond the traditional top-down paramilitary administrative model. Research and studies done on retention show overwhelmingly that it is not the incarcerated that drive good employees away. It is a lack of communication, recognition, and transparency along with outdated and uninformed policies.

The expectation and demands of today's corrections have outgrown the systemic administrative model, leading to a profession where staff feel devalued and expendable. This has resulted in a growing reluctance among officers to silently endure this challenge, highlighting a clear misalignment between the needs and values of new officers and the prevailing culture and operations of corrections. Fortunately, there are remedies and actions that can be taken to address these issues, but they require thoughtful planning and input from all stakeholders.

Addressing this crisis requires appealing to potential employees by valuing their goals, integrating them into a respected team from day one, providing empirical training, better pay, lower healthcare costs, holistic wellness programs and attractive incentives such as educational benefits, pensions, and reducing vesting periods.

In concluding without achieving these—including the—without achieving these objectives and including the voices and experiences of those who will be impacted by their success or failure, true rehabilitation is unrealistic and prisons will continue to fall short of their primary mission of creating a safe and humane atmosphere for successful reentry back into society.

I appreciate the opportunity to appear before you today and look forward to answering any questions you may have.

[The prepared statement of Mr. Walker appears as a submission for the record.]

Chair BOOKER. Thank you very much. Mr. Mangual, and you've been so generous because you testify often and I pronouncing that well, right, Mangual?

Mr. MANGUAL. Mangual. Yes.

Chair BOOKER. Mangual?

Mr. MANGUAL. Close enough.

Chair BOOKER. Thanks. I had a phonetic that's wrong. It says M-A-I-N. Mangu. Mangu.

Mr. MANGUAL. Mangu. Mangu.

Chair BOOKER. Mangual. Thank you, sir.

**STATEMENT OF RAFAEL A. MANGUAL, NICK OHNELL FELLOW,
MANHATTAN INSTITUTE, NEW YORK, NEW YORK**

Mr. MANGUAL. All right. Well, Chairman Booker, Ranking Member Cotton, and other Members of the distinguished body, I'd like to begin by thanking you for the opportunity to offer remarks on this important topic. As was said earlier today, the first duty of any government, whether local, State, or Federal, is to keep its people and their property secure.

And one of the primary ways in which governments provide that security is through criminal justice systems. The police are the most visible elements of these systems, but they're certainly not the only ones. Indeed, their effectiveness depends in large part on other criminal justice actors.

Prosecutors still need to prosecute, judges still need to adjudicate and sentence, and crucially, correctional institutions need to secure and hopefully better the prisoners that they take in. Effectively managing a correctional population however, requires investment.

Unfortunately, we have seen throughout this country an unwillingness to adequately invest in corrections, as decarceration, the pursuit of correctional population declines, has become both a policy priority in its own right and also the preferred means of alleviating the pressures on correction systems created by staffing shortages, facility maintenance costs gross and overcrowding.

I'd like to use the remainder of my time to make three points. First, decarceration where the pursuit is a public policy good unto itself or as a means of cost saving is not a cost-free endeavor.

Second, the potential cost saving effects of decarceration, at least in the short and intermediate terms, are more limited than they might appear to be based on average cost per inmate figures.

And third, making the necessary investments in our criminal justice system to address issues like understaffing overcrowding and security concerns will not only help improve correctional outcomes, but it will keep the government out of a position in which budget constraints require it to make choices that ultimately harm public safety.

On the first point, most of the public safety risk associated with any significant scale decarceration effort derives from the loss of incapacitation benefits. Those are the beneficial effects of an active offender's removal from society, which come in the form of crimes not committed as a result of that offender being behind bars.

One study recently found that for the period of 1991 to 2004, proved each additional prison year served prevented approximately eight index crimes. And that's an estimate that's based on both Federal and State prisoner populations.

Now, the Federal prison population consists of inmates who on average pose a somewhat lower risk of recidivism, but the risk of recidivism posed by Federal offenders is far from zero. An analysis of more than 25,000 offenders released in 2005 found that just

under 50 percent were rearrested over an 8-year observation period.

Now, some might be tempted to argue that the recidivism data of those released pursuant to the First Step Act, or FSA, strengthens the case for decarceration. But those data do just the opposite. While it's true that only about 12 percent of FSA beneficiaries have recidivated, according to the April, 2023 annual report, the recidivism data for FSA beneficiaries nevertheless illustrates just how little low hanging fruit there is in the Federal population.

According to that report, nearly 9 in 10, or 88.3 percent of the more than 24,000 releasees who had a risk assessment done were rated minimum risk or low risk. Moreover, the bulk of those offenders, more than 20,000 of them in fact, had only been released for a year prior to that report's publication, meaning that their lack of rearrest may simply be a function of the short observation period.

The much larger State prison population, more than two thirds of which is in primarily for a violent or weapons offense, poses an even more pronounced risk of recidivism with 9-and 10-year recidivism rates for releasees breaking 80 percent.

So, while it's certainly the case that some small subset of the country's prison population consists of inmates whose incarceration no longer serves a legitimate phenological end, the vast majority of prisoners in the U.S. both State and Federal pose a significant risk of re-offending.

As for the second point, the cost savings potential of decarceration efforts may not be what they seem. It's often noted that it costs an average of \$42,000 a year to incarcerate a single Federal prison inmate. However, the problem with using this figure is that it might give you the impression that you save \$42,000 if you incarcerate one fewer inmate.

But the lion's share of the average cost per inmate is a function of fixed costs. The marginal cost per inmate tends to be a much lower figure, albeit more difficult to calculate. Moreover, the potential savings associated with decarceration are also going to be eaten into by the costs associated with the additional crimes that might occur as a result.

Indeed, the estimated annual cost of crime in the U.S. is in the trillions and a single homicide has been estimated to cost nearly \$9 million. While an assault can carry a societal price tag of more than \$107,000.

Third, and finally, despite the numbers that can be thrown around with regard to the cost of doing criminal justice in the United States, it remains the case that our criminal justice system is underfunded and in need of an upgrade, that includes staffing. It is almost certainly the case, that there are measures on which the Federal and State correctional authorities can perform better.

But it is also likely the case that boosting performance and improving outcomes will depend on the degree to which Congress and State legislatures are willing to direct resources to these institutions in order to facilitate such improvement.

And that is a political choice, one with dire consequences for those inside and ultimately, outside of our nation's, prisons populations. We can and should choose wisely.

Thank you very much. I look forward to your questions.

[The prepared statement of Mr. Mangual appears as a submission for the record.]

Chair BOOKER. Mr. Mangual, thank you very much for that testimony. I appreciate that. And if there's no objection, I'm going to save my questions for the end and go straight to Senator Butler for her California rebuttal.

[Laughter.]

Senator BUTLER. It's nothing like coming to a hearing with Senator Booker in the Chair. Thank you, sir for your continued generosity, Senator Cotton, bless you for serving with Senator Booker.

[Laughter.]

Senator BUTLER. Yes. And thank you to the witnesses and all of you, I am assuming that a number of you are correctional officers yourself and I appreciate you being here and being present in the work that you do.

A couple of questions and I'm going to take the privilege of starting with my California resident, Mr. Walker. Good to see you. Again, it was—I was excited to hear that you were coming to today's panel because I know you as an advocate for officers, and it is in our working together that I have really seen your heart and indeed your legacy—your family's legacy for doing this work.

Not just you, but as I understand, your father and your son. Three generations in your family have contributed your time and talent to public service in this way. And we're grateful. Can you talk about the evolution of the profession and the catastrophe or crisis or and fill in the blank of what it is that officers are experiencing today, just from the lens of that generational engagement?

Mr. WALKER. Thank you, Senator. It is a pleasure to see you again. Yes, my family has—we've literally given our lives to this occupation. And unfortunately, it's taken more from us than is advertised, your commitment is supposed to be.

And, it's not just my family. It's every one of these people sitting behind me. It's taking from them silently. And as far as the evolution of it, that it's hard to say because I started in the 80's, where we were legitimately tasked with rehabilitation, and we had the capacity to do that.

We had the staffing for it, we had the resources for it, and the population was managed. And we went through that tough on crime era where, we literally went from having single bunked individuals to triple bunked, to unconventional sleeping arrangements.

And that ability of rehabilitation, that ability of engagement, of socializing, to understand what the needs were of the individuals we were tasked with supervising and caring for, went out the window. Unfortunately, my father didn't do a good job of telling me what the job was and I came into the agency. I didn't, likewise—didn't communicate with my family what I was enduring. And my son came into the agency, and it cost him his life.

We cannot keep operating the way we are. It is literally killing people slowly. We are poisoning ourselves every time we walk back into, and every time we introduce someone to this environment, in the absence of having the services, resource, and personnel to adequately manage the new mission. Because society is asking for something different, and we're still operating off of an antiquated model of incarceration. It's the default. It's what we know best.

Helping people, serving people is the challenge that I think that we're—society and this body actually wants to see. They want to see people return to their communities better.

Senator BUTLER. Yes.

Mr. WALKER. And if not, then we keep them.

Senator BUTLER. Yes. Mr. Chair, that response was worth my entire 5 minutes.

Mr. WALKER. I'm sorry.

Senator BUTLER. No, don't. Your family has given more than 5 minutes' worth. And so, I appreciate you sharing that. I would love to, Mr. Chairman, submit questions to the panel after the hearing.

Chair BOOKER. Of course. And before I defer to the Ranking Member, Mr. Walker, I think I could speak for the whole entire Subcommittee about our grief and our sorrow about your son's loss. The story of dedication of your family through generations in and of itself is extraordinary.

But the circumstances of your son's death, should not have happened. And we're grateful for you sharing that, what has got to be unimaginable grief with this Committee, so thank you. And I'll now defer to the Ranking Member Tom Cotton.

Senator COTTON. Mr. Walker, I also express my condolences. And your family's story is an important reminder for many people that, like military service, law enforcement is often a family affair in this country. And some families bear the brunt of that service to keep our country and our people safe.

Ms. White, this morning, the director of the Bureau of Prisons testified in front of the full Committee. She said that the Bureau has only 14,899 correctional officer slots. Those slots are 82 percent filled. In other words, the Bureau has approximately 12,300 correctional officers, officers today. Is she correct in your understanding that the Bureau is nearly fully staffed?

Mrs. WHITE. No, sir.

Senator COTTON. Could you explain a little bit more why?

Mrs. WHITE. Sure. So, I have one of her staffing reports in front of me. The agency is very protective of their numbers. As you guys have seen in many hearings. As of pay period 26, which was December 30 we are showing 12,306 officers. Typically, I have to reach out to 121 institutions and get their staffing reports to compile those, to get those numbers.

But that's the number I show, and that's why I testified to those numbers. I did hear, she testified this morning to 14,000 and some change, and I have a hard time believing that since December 30, she has brought on over 2000 officers.

Senator COTTON. Yes. As it happens, I just went on their website and since the hearing, and I looked up any potential openings, and they list openings and it says location, prisons nationwide. And the number of openings is many vacancies.

Mrs. WHITE. Correct.

Senator COTTON. Many is capitalized. Many vacancies to what? I think I'll submit that screenshot for the record, Mr. Chairman. While, I'm at that, I'm,—

Chair BOOKER. That might be the first time in Senate history, a screenshot has been submitted, but no objection.

[The information appears as a submission for the record.]

Senator COTTON. Okay. And I think what happened this morning, is that the director was speaking—only if you might say—about frontline correctional officers, excluding things like lieutenants or supervisory correctional officers. Is that your understanding?

Mrs. WHITE. Yes, sir.

Senator COTTON. So, it would be as if the Secretary of the Army gave you only the number of privates he had, not the number of NCOs and officers he had; is that right?

Mrs. WHITE. Right. So many times we disagree on numbers, and again, they're not very public with their numbers—

Senator COTTON. Okay.

Mrs. WHITE [continuing]. But oftentimes when I've discussed with them, there is a series, it's a 007, and there's other individuals that are included in that series, counselors, lieutenants, other individuals that are not primary correctional officers.

So, I don't know if that's the confusion or the difference in the numbers, but according to my records, we have—

Senator COTTON. Okay.

Mrs. WHITE. Right around 12,000 officers.

Senator COTTON. And you believe that the number of Bureau of Prison correctional officers over the last year has decreased, not increased. Correct?

Mrs. WHITE. Absolutely.

Senator COTTON. Okay. Thank you. Mr. Mangual, the total Federal and State prison population has declined by more than 20 percent since it peaked in 2013. Has violent crime increased or decreased as the prison population declined?

Mr. MANGUAL. It's gone up significantly.

Senator COTTON. That's right. All right. Would you say that there's been at least some inmates in Federal and State prisons who don't necessarily need to be there? At least maybe not as long as they are, at least some?

Mr. MANGUAL. Sure.

Senator COTTON. Okay.

Mr. MANGUAL. But I think it's also important to recognize that there is a significant number of individuals on the street today who need to be inmates.

Senator COTTON. All right. My next question. At least some criminals out on the streets who maybe should be in prisons today?

Mr. MANGUAL. Quite a few more.

Senator COTTON. And which one is higher? The number of people in prison who maybe don't need to be there, and the number of people on the streets who maybe do need to be in prison?

Mr. MANGUAL. I would say certainly it's the number of people on the street who do need to be in prison. And one indicator of that, it's just the clearance rate numbers in this country.

If you look at the eight index felonies that are consistently tracked by the Federal Government, the clearance rate only hovers at about 50 percent for the violent ones and about 20 percent for the nonviolent ones. Which indicates that a vast majority of the crime—the serious felony crime goes unanswered for. So that in and of itself should tell you.

Senator COTTON. Isn't it the case that the vast majority of crimes are committed by a very small percentage of the population?

Mr. MANGUAL. That's exactly right. I mean, the bulk of our crime problem is and has long been driven by very, very active—overactive offenders. And so, you can actually get a lot of bang for your buck by, you know, targeting correctional resources appropriately.

Senator COTTON. And I think you testified earlier that something like eight crimes are avoided for every person in prison.

Mr. MANGUAL. Per year. Yes. And that's a pretty conservative estimate because it's an estimate derived from official crime reports. And one of the other things that we know is that most crime that occurs in this country does not get reported, and that's evidenced—

Senator COTTON. Okay.

Mr. MANGUAL [continuing]. By the consistent disparity between the National Crime Victimization Survey, and UCR.

Senator COTTON. Okay. My time's almost up, Mr. Chairman. One more administrative matter. I have a letter dated yesterday from the Major County Sheriffs of America urging Congress to prioritize legislation that supports the recruitment and retention of law enforcement in all areas to include corrections.

Of course, the county sheriffs also have an important correctional role of play as they run our county jails as well. I ask for consent that this letter be added to the hearing record.

[The information appears as a submission for the record.]

Chair BOOKER. I will add it with considerable alacrity. Is that it?

Senator COTTON. That is all.

Chair BOOKER. I'm going to now defer to Senator Whitehouse.

Senator WHITEHOUSE. Thanks very much. I'm sorry I had to step out for a minute. I had a Federal agency in my office with a project in Rhode Island that needs a little attention, and that's what we do.

I'm delighted that you-all are here. Thank you very much. My Rhode Island experience has been that we've been pretty successful at being able to reduce prison populations. I think the numbers are 23 percent reduction from 2008 to 2016, and another 34 percent from 2017 to 2021.

A lot of that has been diverting people away at early stages. I helped launch the drug court when I was attorney general. We also now have a very well-run Veterans Court that helps, again, divert people away from the criminal justice system in a way that is very effective.

And if you've ever been to what they call a Veterans Court graduation and compared that to the day of a district court conviction, in one case, the guy's going out the back door in Manacles and the family is crying, and in the other case, he's coming back to a cheering family and their balloons.

And they've had very, very, very good results with reduced re-offending and reincarceration. And we're launching a Mental Health Court as well to try to manage better the interaction between the mental health system and the criminal justice system.

So, we have a relatively small population, so it helps because there's quite a lot of direct hands-on care and all of this. But I do want to express my appreciation to the Rhode Island Brotherhood

of Correction Officers who say that they walk the toughest beat in the State. Mr. Wetzel, I'm sure you appreciate that.

But we've worked on—earned time credits. We've reduced mandatory sentencing. We've had the diversion programs that I mentioned apart from just the attorney general's own regular diversion. And it's had that result and it's been really essential to do that.

Mrs. White, I'm sorry about these results with the First Step Act. I was the author of the Reentry part of the First Step Act, along with my colleague Senator Cornyn on this Committee.

And it's frustrating that an act that bodes so well and has produced quite good results and has reduced re-offending and re-incarceration and has prepared people better for reentry, particularly set them up to deal better with addiction issues can't get the attention it needs to succeed because of all these multiple demands on the staff to try to get there.

So, if there are specific recommendations that you have from your closeup perch as to things we should be poking at the Bureau over or things that we should be particularly focused on funding, I guess my point here is that I have seen a lot of stuff work in Rhode Island to dramatically reduce prison populations and make it—the difficult job of the Brotherhood of Correction Officers safer and easier.

And to me, the First Step Act was an effort to take some of those lessons and move them into the Federal system. So, as I said, it's irritating and frustrating that we are where we are on that.

So, any comments that you have, and if you want to think about it and get back to me with a more precise list.

Mrs. WHITE. Sure.

Senator WHITEHOUSE. Please take it also as a question for the record.

Mrs. WHITE. Absolutely. I can definitely speak on, we did testify, one of my board members on the committee for First Step Act. And, as we testified, we do think it's a, a phenomenal program. And I think if we can get the staffing that we need, it would be a much more successful program in the Federal Bureau of Prisons. There is more detailed stuff that I will submit to your office.

Senator WHITEHOUSE. Okay. I'm assuming that there are sort of mandatory staffing requirements at various posts in the prison that require people to be pulled off to go and hit those mandatory posting requirements that generally the problem?

Mrs. WHITE. So, we do what we call augmentation. And so, anyone who works, say education, health services, anywhere, if there is a vacancy and we start our day every day in almost every prison with vacancies.—

Senator WHITEHOUSE. Yes.

Mrs. White—for the correctional roster, you get pulled or augmented to a correctional officer post. And so that's part of the issue. And that's why I said staffing. If we can get our staffing to where it needs to be, those individuals would not have to be pulled off with their post and they could provide the class or the training, or the programming or whatever that they should be doing instead of being a correctional officer for the day.

Senator WHITEHOUSE. Yes. Okay. Well, my time's up, Chairman, thank you for the hearing. Thank you to this distinguished panel, and Mr. Wetzel, thank you for your service.

Chair BOOKER. Senator Whitehouse, I'm grateful. I'm told by my staff the order of appearance and this is the order we'll go in. And Senator Ossoff, Senator Padilla, and no disrespect to the two aforementioned gentlemen, the best for last Senator Welch.

Senator OSSOFF. Thank you, Mr. Chairman. Thank you for bringing us together grateful also to Senator Cotton for supporting this hearing. And thank you to our panelists for your expertise and experience. Mrs. White, as you know, Senator Braun, Chair Durbin, and I have introduced bipartisan legislation to overhaul Federal prison oversight and strengthened security at Federal prisons.

And the purpose of this bill is to help identify and address threats to the safety and welfare of both incarcerated people and the thousands of correctional officers and others who work in our Federal prisons every day. And that's the Federal Prison Oversight Act.

Mrs. White, the Council of Prison Locals, which represents more than 30,000 correctional officers, worked with us to develop this legislation, and has endorsed the legislation. Can you speak to the Committee about why correctional officers support our bill and what it would mean for your members who are working in Federal prisons every day?

Mrs. WHITE. Sure. So, as you said, we have been in support and we have worked really hard to help get this. We have—for years the Council Prison Locals, the union has gone to bar and ask for additional funding. For years we thought funding was our only issue, if we could get more money, we could fix the problems.

And the union was very successful in doing so. But over the years, we have come to know that funding is not the issue. Sometimes it might be an oversight issue of where the funding is going.

So, we have been strategic in where we ask for funding the last couple of years. This year we probably will be a little even more strategic. But as I said in my opening and in the written statement, we welcome any oversight. We need accountability. We need help. The Bureau, I think, is the second largest in DOJ budget. And we're not sure where all of that money is going. And so, any oversight from anyone I think would be super helpful.

Senator OSSOFF. Well, I'm grateful to you and your organization for helping us to develop this legislation—

Mrs. WHITE. Thank you.

Senator OSSOFF [continuing]. And for the advocacy of the correctional officers across the country who are urging Congress to pass it. It's a bipartisan bill aimed at improving oversight within BOP, strengthening the security of Federal prisons.

It's got strong support from the Council of Prison Locals, strong support from Reform Advocates, and look forward to working with it to continue to urge it across the finish line here in the Senate and in the House.

Mr. Wetzel you, I believe, are also familiar with the legislation. And based upon your extensive experience working in corrections, what impact do you believe it would have on conditions and safety in Federal prisons, both for incarcerated people and staff?

Mr. WETZEL. It's essential. I don't see how you make progress in the Federal system without knowing—you can't even lay out a data-driven, or problem Statement because you don't have enough information. The very essence of fixing a problem is being able to define it, and come up with a problem statement, independent oversight. And that kind of forced transparency, real time on a regular basis is essential to moving the Bureau of Prisons and any agency forward.

Senator OSSOFF. Well, I appreciate your input and your support for the legislation as well. And I want to talk a little bit about the impact of understaffing on some of these specific safety issues. I led a PSI investigation a couple years ago, found that female inmates in more than two thirds of Federal prisons that housed female inmates, had faced sexual abuse from BOP employees.

How do chronic understaffing issues lead to a higher incidence of abuse? And again, just to clarify, make sure I present the statistic correctly. In two thirds of Federal prisons that housed female inmates, female inmates faced sexual abuse from BOP employees, how is this linked to understaffing?

Mr. WETZEL. Yes. I think assault by a staff member, assault by another incarcerated person, name any bad event, and the very essence of stopping bad events is supervision. And you design facilities and you design them with a staffing plan.

And so, when you have half the people to do that staffing plan, and you have a hundred—let's say you have a hundred housing units and you have 50 people to cover them, there's no one on those housing units.

And at some point, the human beings on those housing units who are locked in cells, have to come out of those cells. They have to be fed, they have to get medication. There's a series of things that happen, without people, it doesn't happen.

And so, when you get people out and there's nobody there, there may be some folks who are among them who want to do harm to them. So, it undermines supervision and that this—the staffing shortages filter the whole way up.

One of the things that I think is a really good illustration for you of what, how staffing impacts other things is we heard about BOP issuing a memo about something, I forget what it—what it was, but the memo was issued from the director, and this is pre Collette, and you observed it, several—the IG observed at several prisons that it wasn't happening, right.

That communication has to happen through people. You're talking about a 40 percent vacancy rate. These, I mean, these guys need roller skates. I mean, if you've done a round, just a round in a Federal prison, right, you think you can just walk through and not get stopped by someone, or if something's going on the, I mean, it—just, it's wide open for what can happen when you have half the people you need. There's no kiosks in corrections. It doesn't work like that.

Senator OSSOFF. Well, thank you Mr. Wetzel, and thank you. And one thing that's become very clear to me through the oversight that I've worked on, on these issues is a shocking statistic like that. It's not an indictment of the overall BOP workforce. The over-

whelming majority of correctional officers are hardworking public servants who try to do the right thing every day.

Failures by management, failures at headquarters, failures at high levels of the Federal Government have put these teams in impossible circumstances. And the Federal Prison Oversight Act—a bipartisan bill with strong support across the board—is vital to addressing these issues. Thank you all for your testimony. Thank you, Mr. Chairman.

Chair BOOKER. Thank you, Senator Ossoff, for your, not just questions in this hearing, but for your work on these issues as a senator and even before. And someone else who's worked with—on these issues for a lot of his career. Senator Padilla you're up for questioning.

Senator PADILLA. Thank you, Mr. Chair. Thank you to all the panelists especially my friend Stephen Walker for being here today. Come back to you in a minute. But we've—a lot of the discussion I've tracked has dealt with the consequences of the staffing shortages that has brought us to this point.

My first question is, in the spirit of a little bit of the problem solving, you know, for years we know that BOP has been experienced a staffing crisis with the consequences both for correction staff as well as incarcerated individuals and know that there's officers from California facilities who regularly contact my office sharing what's going on in facilities throughout the State and sharing the frustrations that they face.

So, my question is actually for Mrs. White, what are the greatest barriers in your opinion, not just to recruitment, and not just to retention, but also to morale of correctional staff and what recommendations you have for how they can be addressed? You already started touching on it's more than just funding, so.

Mrs. WHITE. Correct. So, funding in my opinion, is the biggest, compared to border patrol or ICE. Our officers make an average of \$37,000 a year less. That in itself would be a morale booster to up their pay. But when we can address the pay issue and bring more staff on board—I started 20 years ago and it was a great place to work.

We had enough staff, we had enough staff to do the vast majority of the duties that we needed to do. And that in itself, having people, we had it—was more like a family than a coworker. We had each other's back, we supported each other. If I was running behind, my coworker would help.

We don't have that now because people are so frustrated. If I call in sick, it leaves someone to get mandated and then they're angry with me, it doesn't matter if I have a sick child or anything like that. So, I think the staffing, the effect it's had on the morale is huge. So, getting the staffing back to where it could be is—would be my top priority.

Outside of that, we do absolutely have to focus on wellness because as Mr. Walker was testifying to the PTSD rate of correctional officers, our correctional staff is far above—even studies show—even higher than military. Because we are exposed to inmates or criminals who have been convicted day in and day out.

None of them are happy to be in the location that they are. They—not all of them—but a vast majority of them are not pleas-

ant to deal with. And we deal with that 5 to 7 days a week, 8 to 16 hours a day, depending on—so if we can up our wellness programs and get it back to more of a family, where we support each other outside of the pay and increasing the staffing. I think those are the biggest things on our plate right now.

Senator PADILLA. Thank you, both your comments and your reference to Mr. Walker's. Good transition to my next question. It's a—first is a comment for Mr. Walker and he can respond or not respond is your choice. Because it's good to see you again. The comment is this, I love you, brother. Thank you for being here.

But let me tee up my question, you know, because I made reference earlier that my office does hear from my officers facilities throughout the State. Just most recently within the last couple of weeks, FCI Victorville, FCI Mendota visited my office to highlight how staffing shortages have compromised their safety with specific examples, impeded their ability to fulfill their responsibilities, and of course, negatively impacts their lives outside of work, not just inside of work, but outside of work, right.

They describe the emotional toll and strains on family that it causes especially when it comes to you know, mandatory overtime. Imagine those who are trying to make sure their young children are taken care of, who we could give example after example.

So, to address the staffing shortages, in addition to pay, to your point Mrs. White, the Bureau must support its corrections officers by ensuring they have that sufficient time off and provide them with the necessary mental health and wellness resources that they need.

So, Mr. Walker, you described some personal experience with the Committee earlier in your testimony, whether it's specific to the back-to-back mandatory shifts or anything else. Can you give other examples of how the staffing shortages impacts officers' lives and wellness and what are the suggestions you have for the Senate?

Mr. WALKER. Wow, that's a lot. First off, thank you Senator and I love you too, sincerely, thank you for your friendship. The problem of wellness within corrections is that they treat it like it's a one off. This is not—it has to be something preventative and it has to be comprehensive, ongoing, continuous, because the environment that you're steeped in every single day is relentless in its assault.

As Ms. White testified to, prisons are not happy places. No one wants to be there. So, the ability to mitigate, to address the impact that you are walking into a place where your hypervigilance is continuously activated, and the amount of dopamine and cortisol, and epinephrine and everything else is continuously flooding you. And you have no idea that that's happening. There has to be an education process to help you understand and to help your family understand those—the ramifications of that, so that you can create the preventative measures internally, externally, and personally.

Because it—there's no way you get away from it. And, and I know we're running over time, but there's a tremendous amount of work that has to be done, and we can't simply believe it's the blue pill and that we're just going to keep on in the excitement of existence in the system.

Senator PADILLA. Right. Mr. Chairman, I know my time is up. I'll just end with this comment because based on Mr. Walker's re-

sponse and for consideration of the panelists and this Committee, what is PTSD when there is no P? That's what you just described.

Senator PADILLA. Thank you, Mr. Chair.

Chair BOOKER. Wow. Before I go to Mr. Welch, I just want to warn Mr. Walker, given the power and potency of Senator Padilla love, you've exceeded your amount of love you're allowed to receive in a Senate hearing.

And for the sense of proportionality and balance, I just want to let all the other witnesses know, that I love you, as well.

[Laughter.]

Chair BOOKER. Senator Welch.

Senator WELCH. I love you too.

[Laughter.]

Senator WELCH. And it's nice to meet you.

[Laughter.]

Senator WELCH. It is just a chill place when we got Senator Booker in charge, right?

[Laughter.]

Senator WELCH. But you know what, I really do—we do appreciate you. I mean, it's incredible work you do. It's hard work and dangerous work at times. And so, thank you. I just want to express that gratitude to you. You know, I want to ask you—a couple of you—on the basis of your experience, something is relevant to us in Vermont. We don't have a residential reentry facility. We're one of only two States, in fact, I think we're really the only one. Hawaii had one, and there were some issues there. They want to get another one.

But and I'm a former public defender, so I've dealt with a lot of people that you deal with after the court process. But I know Mr. Wetzel, you've had a lot of experience with this in Pennsylvania, and I would like you to just explain why residential reentry programs are really beneficial for the criminal justice system, for public safety and of course for the well-being of the person who's moving from the end of their sentence in that last 12 months to the community. Could you do that for us?

Mr. WETZEL. I could, and thank you. And I got to tell you, let me pander a little bit in prepping and the work we're doing, really—

Senator WELCH. You know, you—my experience here, you don't get resistance on pandering from U.S. Senators.

Mr. WETZEL. Well, I figured I felt all the love in the room from the Chairman, so I figured I'd share it myself. But I got to spend some time with your director Nick Demel—

Senator WELCH. Right.

Mr. WETZEL [continuing]. And in several of your prisons actually looking at national staffing with the Correctional Leaders Association. And I think if you'd ask him or ask anyone, imagine somebody being locked up for 1, 3, 5, 7 years, 10 years, imagine just the amount of technology that's been developed—

Senator WELCH. Right.

Mr. WETZEL [continuing]. To go from incarceration—and incarceration right now—and I keep looking back to these guys because it's never felt like this inside facilities before. I mean, 30 years, 35 years, you know, even systems that didn't put an emphasis on re-

habilitation necessarily. There was a relationship, like it was relational between correctional staff and incarcerated people.

And some of that modeling modified behavior, that—so the—and on top of just the need to give people tools to adjust to society after being locked up, just decisionmaking.

Mr. WETZEL. Right. You don't make decisions when you're incarcerated. You don't pick what to eat. So, just kind of getting used to that in a world that's flying was always important. There are no services inside prisons. You don't have a 40 percent vacancy rate and think you're delivering high quality programming and preparing people to get out.

So, I mean, right now I think it's even more important that you have these—you guys call them residential reentry centers at the Federal level or halfway houses where people can come up first, take a breath, right?

Senator WELCH. Right.

Mr. WETZEL. Get out, get used to it, and then start plugging them into services, like in Pennsylvania, we have a great career link network, right. That we can leverage off other systems from the State to get people and help people get back on their feet and become contributing members. So, it's a really critical, really critical.

Senator WELCH. Thank you. And I'll ask you, Mrs. Moore White, as well to get your thoughts on that.

Mrs. WHITE. I mean, I have to second what he said. Typically, in prison, you don't have a cell phone. We do—we now have tablets and stuff like that, but it—I can only imagine it is life altering walking out of a prison into society today.

And I flash back to Shawshank Redemption, and when they released the guy from prison or whatever, he truly, like, he asked his boss, can I go to the restroom boss? It's a different world. And so, any transition time that they could have from prison until fully outside without supervision, I think is extremely helpful.

Senator WELCH. Okay. I thank you very much. And I yield back, Mr. Chairman.

Chair BOOKER. I'm very grateful. Ms. Nance, you have an interesting perspective that I think is really valuable that I'd like to pull out a little bit more. And I'd like to ask you the question of understanding your—what the inmates are going through and the lack of support from the understaffing.

How does that affect, in your opinion, the preparedness of inmates to reenter society? Why is this conversation we're having so vital, not just for the inmates being released, but also the communities into which they're being released?

Ms. NANCE. Thank you, Chair. I definitely want to echo everything that has been said amongst the other witnesses. I do think that there's a very high relationship that could happen when it comes to the people who are working in facilities and the incarcerated people.

So, I've seen personally, in my experience, the best outcome when those relationships are strong. So, I talk a little bit about my loved one, but one of the things that's been very beneficial to him is when there is someone like a unit manager who is in his build-

ing that is trying to have their back and really trying to make sure that they do have access to the resources that they need.

So, for instance, even paperwork. Like, I've been trying to get this paperwork, get this request in so that I can go to the law library and people aren't listening, they're not getting my paperwork. I'm trying to request medicine.

There's a unit manager in my loved one's building that will say, I got you. And it might take a week, it might take a couple weeks, it might take a few days, but she always gets back to them. And that really makes a difference.

And I do know that he's told me that she suffers from burnout and depression because she might be one of the only people who's willing to go there and give her all like a 100 percent, to her job just because she cares about the human beings that are behind the walls.

So, it really does impact those individuals because at the end of the day, like you said, 95, 90 percent, whatever that figure is, people are going to come home. So, the better we can make the environment for them, the better they're going to be when they do reenter society.

Chair BOOKER. So, no, I really appreciate you testifying to—really the fact that there are so many people that are working in corrections that are trying to do the right thing by their inmates, but are unable because they're stressed out, they're overtaxed, they're unable to do the jobs that they were designed to do.

But just to push a little bit more on the impact, not specifically your loved one, individually, but on an issue, I think Mr. Mangual explored really well in his testimony about this idea of recidivism rates and how high they are.

Is it your experience that should inmates get the kind of resources they were intended to get, not just for the First Step Act, but even go back 10, 15 years ago, that these recidivism rates could come down?

Ms. NANCE. Absolutely, Senator. I think what's really, really interesting about programming in prisons is it gets talked about in a way that feels very, very frequent, right. But what happens is there are people who have case plans, there are people who also have interests.

So, the more that we can connect them to things that are not necessarily them sitting inside a cell, the more likely they're going to be to have hope, to have morale, to be able to do something that's bigger than themselves and take their journey on rehabilitation.

Like I heard Mr. Walker say that there was a time where people were really trying to do their job of rehabilitation and say, Okay, this is what I'm doing when I go to work. And I do think that that mentality could really have an impact on our system and have an impact on recidivism.

Chair BOOKER. And what I've found, I think every human has found that when you apply yourself to some task that demands discipline and hard work, and you begin to see the rewards of that, whether it's advancing in your own education or in programs to deal with alcohol and drug abuse, that that sort of training you get from grit prepares you for other areas.

And when you're denied choices or the opportunity to experience that, it has an impact on what your behavioral patterns will be when you're released from incarceration, correct?

Ms. NANCE. Absolutely. So, I would say that even as a human being, like all of us, we've all experienced accomplishments, we've all experienced what that looks like to be able to say, I did it. Like that pushes you forward, that makes you a better person, that makes you a more productive member of society, that makes you better in yourself.

And that is no different for incarcerated people. And they need to have that opportunity to be able to do that and feel accomplished and be better for when they come home.

Chair BOOKER. Right. And I live in a community that I would consider being over incarceration, but I talk to young men that come home, and if they haven't had exposure to opportunities to develop these skills and often felt like they were treated like an animal inside, that when they come back out, you often see them not able to rehabilitate and going back to the same kind of patterns and often coming with mental health conditions and others that were worsened while they were there. That really has an impact on the safety of communities. Would you agree?

Ms. NANCE. Absolutely, Senator. There's so big of a hole in mental health resources behind the walls. And I—my personal therapist, she'll say, does he have access to mental health services? And I'm like, no, he does not.

But I do think that really trying to shift that mindset, from behind the walls and really being able to communicate with people in a way that is not an institutionalized mindset would definitely prepare them for reentering society.

Chair BOOKER. And so, when I was mayor of the city of Newark and I started seeing the recidivism rates, I knew that I could lower my crime rates in my community if I could do something to lower those recidivism rates.

And we did a lot of things in partnership with the Manhattan Institute, was which actually one of my best allies when I was mayor and setting up programs to attack what I thought was a source—one of the sources of crimes is these populations coming out of prison that were not prepared to reintegrate.

Mr. Walker and Mrs. White, my heart is really heavy about knowing what correctional officers face every single day. I thought the wise comment—he shouldn't just come in here and drop wisdom and then just walk out like that.

But Senator Padilla, who talked about PTSD, not—the P is really not there. One of my best experiences as mayor was working with law enforcement and seeing the trials and tribulations of my police officers, but yet they're also in environments where they get to be a hero, they get the approbation of communities, they get the support.

But I look at my correctional officers, and they're not in those kind of environments. And they don't have the same, unimaginable stressors. It's just a disproportionate amount of that. And Mr. Walker, before I get to Mrs. White, I think you can speak to that in a personal way about us as a society creating these institutions

that put so much stress and strain on the correctional officers themselves.

And not only don't support our correctional officers, but put them in environments where there has been increased deterioration of their well-being and what the consequences of that are. And I'm wondering if you can speak to that for me

Mr. WALKER. Mr. Chair, yes. Look, these systems were designed to punish people. And the byproduct of it, of the not fully continuing to consider it, is that the people that you put into that environment are also being traumatized.

They are experiencing traumatic incidents every day, and there's nothing in the hiring description or the job description that forewarns you of what you're going to experience, and how to not vicariously pass that on to your loved ones, to your children. Because the thing that I'll—I'm willing to bet you, any one of these officers sitting behind me or Mrs. White will tell you that their significant other has told them at some point, "don't talk to me like I'm an inmate".

Because we flip this switch when we walk into this environment. And it's not that anybody ever tells you that you have to do it. It's so ingrained in the culture and the institution that you pick it up as a survival mechanism. It's a human that—it's one of the traits of,——

Chair BOOKER. So, under normal circumstances, Mr. Walker, we should be doing more for the mental health and well-being of our correctional officers. But that the added stressor of under staffing to me, and again I——

Mr. WALKER. Yes.

Chair BOOKER [continuing]. Talked to a lot of the Capitol police officers, when we had our worst period post January 6, where officers were being held over again and again and I would talk to parents and things—I didn't even think through, not as a parent myself, about what kind of chaos it throws your family into——

Mr. WALKER. Yes.

Chair BOOKER [continuing]. So now you have the stressors of the job plus the stressors of understaffing and what that means. It just seems to me almost like you're throwing your correctional officers into a kind of punishment prison environment in and of itself——

Mr. WALKER. Yes.

Chair BOOKER [continuing]. Not to mention then being underpaid and feeling the financial strains——

Mr. WALKER. And the lack of public not—appreciation's not the appropriate word, because nobody's doing it for the pat on the back, but there's this stigma attached to being a correctional officer and people just don't look at the job as something of value to the—to society.

Chair BOOKER. And so, you said something Mrs. White in your testimony, and I put it in quotes here because I just wanted to come back to you on it. You talked about upping our wellness programs.

Mrs. WHITE. Correct.

Chair BOOKER. I really—and I've talked to FOP, I've talked to a lot of law enforcement organizations, because they're all concerned about suicide rates in law enforcement in general. And I don't

think Americans fully understand what—from our border patrol agents all the way to our correctional officer what it means to do this work.

But I just want that “up our wellness programs.” I just want you to flash that out. Like, what would you want from Congress if we were—if you had a chance to help mandate when it comes to that kind of wellness, what would you tell us to do?

Because I know in the last panel, I could see it in a bipartisan way, it affecting people when they started hearing these issues of mental health for our correctional officers.

Mrs. WHITE. Sure. I think the list is extremely lengthy. Something that I didn't get to hit on with Mr. Padilla, that I think also would increase wellness and staff morale is support from the top of our agency. We hear a lot of policy changes and you going to get this and you going to get that. And, you know, we're so busy dotting our i's and crossing our t's with paperwork that we don't truly see the human aspect anymore.

And that's what I was trying to hit on 20 years ago. It felt more like a family. We had bonfires together. We would go get a drink together or, or hang out. For birthdays we would, you know, I started in health services, we would take an after-hours trip and go to a restaurant and celebrate. And people were so burned out that they don't even do that.

My husband is a former combat veteran and correctional officer. So, we, you know, just activities outside of our house, we don't typically do because of the PTSD and the stress and the, things that we take home. I think there's a ton of things, exercise programs.

I think that exploring additional activities because we get so locked into our careers and what we do that we don't, if you ask me right now what I enjoy doing outside of here, I do union stuff 24/7.

I don't have an activity that I could tell you I enjoy. I think those things are essential to helping the wellness of our staff. And as Mr. Walker had said, actually identifying that we are under stress is a huge thing. A lot of our officers are assaulted and they want to go straight back to post because that's who we are.

We don't want to accept that we have been harmed in any way that we may need to decompress and take a moment. It's—that's huge in corrections. We're, you know, we have to prove that we are big and bad and somebody, and so we walk back into a place where we just got assaulted from.

I think things of that nature are detrimental to us. I think that we have to be able to identify, first that we're under stress and we're not good at that. But then at offer programs, our—the Bureau offers something called EAP, Employee Assistance Program. You can call, you get like six free sessions a year. But the stigma behind actually utilizing that service is horrendous. And so, our employees will not do that.

Chair BOOKER. So, I hope you'll work with my staff—

Mrs. WHITE. Absolutely.

Chair BOOKER. Will kind of move across the law enforcement about how can we start emphasizing mental health.

Mrs. WHITE. Absolutely.

Chair BOOKER. I just want to pull this out because my staff really thought it was an important point. Seven years ago, I guess we did a hiring freeze—

Mrs. WHITE. Yes.

Senator BOOKER [continuing]. And it was one of the—it was almost like the straw that broke the camel's back? Mrs. White. Absolutely.

Chair BOOKER. Could you explain that to—for the record?

Mrs. WHITE. Sure. So, 2016, we had a lot of vacant positions. I think that was kind of the start of what I call the perfect storm. Twenty years ago, people were knocking down the door to come to the Bureau of Prisons. It was a great salary. I doubled my salary. I was a pharmacy technician prior to coming into the prison. I applied three different times.

People were knocking down the door to get into our agency. The pay and the benefits were phenomenal. You didn't really think about the—like Mr. Walker said, you don't really read, and know the mental toll that it will take on you. It was the pay and the benefits that was the pull to coming in—and I totally lost my train of thought. Tell me your question again—

Chair BOOKER. No, no.

Mrs. WHITE. I'm so sorry.

Chair BOOKER. No. What happened 7 years ago?—

Mrs. WHITE. Sure.

Chair BOOKER [continuing]. That was with straw that broke the camel's back.

Mrs. WALKER. So, it was a unspoken, we had 6 or 7,000 vacant positions, and the agency was unofficially told to freeze them—

Chair BOOKER. Right.

Mrs. WHITE [continuing]. And from that point the agency has shuffled and juggled numbers and percentages to the point that it wasn't a true, we are not hiring. It wasn't a true cutoff, but they weren't hiring. And so even—because they weren't hiring and then through attrition, we lost even more individuals.

And honestly, I can't tell you that it's the agency, or, DOJ or who we for many years have tried to pull out where these freezes are coming from. But it is detrimental, and that was the start. 2016 was the start of the downfall.

I came in, in 2004, 2003, we had a legal decision we called *mission critical*. And prior to me coming, my home institution for a city, Arkansas, we had four people on the compound to basically just monitor and run the compound and the traffic. We now on a good day, have two individuals to do that. They called it mission critical, and they cut a lot of positions.

And then the 2016, they froze all the positions. And so, it has just been a constant decline from that point. And so that's what I was telling, I think Senator Ossoff as far as when we—when the council goes out and meets with congressional officials, we have asked for staffing. We have asked for pay, we have asked for a lot of things, but we have tried to hone in because while every year we've been successful in getting additional pay and stuff like that, we have not truly been successful in getting additional officers added, even though the number is 20,446 and we set around 12,000 officers.

Chair BOOKER. Could you just inform the floor if I'm not necessary for this vote, you can close the vote out. Okay. I'm just being pushed because there's a floor vote going on right now, but if I'm not essential for it. I want to stay on point just because we have this extraordinary opportunity to flesh some of this out.

And so that seemed in the previous panel this afternoon to Mr. Wetzel, the problem that I saw, is there's just no way to catch up, when the competition for people who are willing to do this kind of work is so fierce.

And I want you to flesh that out for me because she's saying I'm trying to hire people when I'm offering them less pay, more difficult working conditions and hours. I mean, who would choose this job if I could work in State corrections, county corrections, in the free market where we're in a high labor demand market, there's just no way out of this hole unless Congress does something to create financial incentives. Am I wrong or am I right?

Mr. WETZEL. No. You're a hundred percent right. And, plus you don't even have the agility to be competitive in a market where you're competing with everyone. So, what's left is folks who—I mean 5 to 15 year. So, you're in so long you can't get out. I mean, one of the things that is a cautionary tale that should scare us to death is the retention rate of new people coming into corrections.

I saw reported in Pennsylvania Department of Corrections budget hearing, 37 percent within 18 months. There's systems that are—have about a 20 percent retention rate, year one. So, what that signals is that look, when you're in it at some period of time, it's all you know, you talk about rallying.

Sadly, for us, it's the get it done kind of mentality means we're going to get it done and the folks who are in are going to stay in. It's running new people out, because when you have no point of reference and you go through training and you hear this aspirational stuff, and you look at this generation who wants to be mission driven, and you come in and there's supposed to be two people working with you, and you're by yourself and it doesn't recognize anything, and you can make the same amount of money across the street, it's not going to happen.

Chair BOOKER. And so, you're one of the people I look to, and I have a ton of respect for, because I think you have a view of the whole—the sort of correctional complex in the country. There's no way out of this trap—you can just give me yes or no. There's no way out of this trap we're in right now, unless we find ways to make a more financially attractive career, not job, a career path for people who are thinking about going into corrections. Is that correct, yes?

Mr. WETZEL. No. Actually, you can't throw money at it, it's not—that's not going to fix it.

Chair BOOKER. Okay.

Mr. WETZEL. You have to fundamentally change the work conditions. Yes. I mean, if this was a warehouse, you won't work in a warehouse where you have a chance of getting stabbed every day.

Senator BOOKER. Right.

Mr. WETZEL. And if you could work at a warehouse and make less, and you're not invested in the pension and the kind of stuff, why wouldn't you?

Chair BOOKER. Right.

Mr. WETZEL. We have to fund, I mean, there's no—when you look at—just look at the State employers and State prison systems are two or three employer, add county jails. You're talking about huge numbers of correctional officers around the country, right. So, you would think there'd be career concentrations in corrections. You would think academia, we need other sectors to pay attention. We need strategies for other sectors that have worked in this crisis.

We can't keep—this is like Henry Ford said, "If I asked what people what they wanted, they would've said build faster horses." We're well beyond—you can't throw money at a situation.

Chair BOOKER. Right.

Mr. WETZEL. How much can I pay you to go risk your life?

Chair BOOKER. Right. Now, that's wise. And I see Mr. Walker, Mrs. White just shaking their heads up and down and smiling like—

Mr. WETZEL. Well, in any other world, it wouldn't even be a question—

Chair BOOKER. Right.

Mr. WETZEL [continuing]. Just in corrections, all of a sudden, we think—we apply different rules that defy logic anywhere else in the world, and then we expect good outcomes from that, it may—it defies logic even more than most things in this building do. I'm sorry.

Chair BOOKER. I want to get into two more things real quick. There was a lot of—the Inspector General was talking about contraband being snuck into prisons. The danger of telephones in prisons and more. And I figure I—it would be nice to ask people who actually have been correctional officers about how do you stop contraband coming into prisons. Because I think that was something else that I think people left thinking about. Well, if we just make it a felony and not a misdemeanor and some quick answers and solutions.

But I think you-all probably have some wisdom on this. How do you stop this contraband that endangers officers as well. How do you stop the contraband from coming into prisons? I'm going to allow it a jump ball.

[Laughter.]

Mrs. WHITE. I can start.

Chair BOOKER. Yes.

Mrs. WHITE. More equipment, more staff are definitely helpful. But—

Chair BOOKER. More equipment, meaning screeners and—

Mrs. WHITE. Not necessarily, so they're—Senator Cotton is on like a cell phone jamming bill—

Chair BOOKER. Yes.

Mrs. WHITE [continuing]. That's super helpful, if we could jam the signal to the cell phones and the drones that are dropping drugs into our prison—

Chair BOOKER. Yes.

Mrs. WHITE [continuing]. That's incredibly helpful. There is technology out there. It is costly.

Chair BOOKER. Yes. Okay. Excellent. Mr. Walker, did you have something to add?

Mr. WALKER. Creating penalties for it is not the answer. Look, I'm sitting in a cell and I know that it's illegal and I'm going to do it anyway because I have a need. So, I think that's part of the thought process or the thought exercise that has to take place is—not the illegal part obviously, but the part where the guy just needs a cell phone so he can stay in contact with his family, his—who—so the need part undercuts some of that contraband introduction into the system.

Specifically, in the area of cell phones, I think the tablets—like California, we're doing the tablets now. So, it—so that communication of being able to talk with your children, talk to your loved one, that's cutting down some of that, the blockers—it's not a blocker, but it's an authorization process, so it's tracking everything. And someone mentioned it in the hearing this morning—

Chair BOOKER. Yes.

Mr. WALKER [continuing]. Is that they can track every call that's made in—

Chair BOOKER. And so those three things—

Mr. WALKER [continuing]. And around the State prisons.

Chair BOOKER [continuing]. One is this—the rates at which, the cost at which to make these calls, the difficulties is to communicate your family. If you create ease of communication, the pressure for people getting phones for that—and those who want those phones to continue to do illegal activity outside, though, that's where the equipment that you're talking about.

Mr. WALKER. Yes.

Chair BOOKER [continuing]. Is more helpful.

Mr. WALKER. Yes.

Chair BOOKER. That's really helpful. I don't know if—

Mr. WETZEL. Let me just add this. Any other sector, you'd say technology, for the military, they—you R and D, and you'd have this stuff that didn't require staff. Our answers in corrections, against this, we want to throw staff at it or we want to lock more people up that we don't have the resources to manage anyhow.

Chair BOOKER. Right.

Mr. WETZEL. So, all our discussion is around the two things we cannot do, this—we have to pull from other sectors. It's technology, it's creativity, it's academia. It's bright young minds coming in the field and thinking differently.

Chair BOOKER. That's—I'm grateful you said that. Just Mr. Wetzel, I want to stay on you. There are thousands of released folks on home confinement. Their recidivism rates are dramatically low. If they're compliant right now, is there any reason to bring them back in?

Mr. WETZEL. Absolutely not. At a hearing about staffing at a 40 percent vacancy rate. That should be criminal, if you're going to bring somebody back who's not committing a crime.

Chair BOOKER. Okay. Before I close out Mr. Mangual, because I just love and respect the academic work you do and the studies you do, and you said something that I maybe want to have a hearing on. And it's a bipartisan bill that I have called the VICTIM Act, because in communities like mine, the closeout rates for serious violent crime is so low.

And there's a great researcher that I read back in my mayoral days who said, inner city communities often have too much law enforcement that they don't need, which is low level drug crimes and not enough law enforcement that they do need.

And so our bill, the VICTIM Act, is to try to get a lot more resources to close out those serious violent crimes, which the closeout rates are so low, really affirming, which my experience really was in line with what you said, that the number of people committing minor crimes when I was mayor were just a small group of individuals who, when I first became mayor, our closeout rate on murders was like 20 percent. I used to joke that this is the best place in America to kill somebody because it's so unlikely that you'll get caught.

Would you affirm the part of what I just said that said that, like, something has to be done in getting law enforcement the resources they need to focus on the criminals that are at the center of a lot of the larger, more serious crimes?

Mr. MANGUAL. Absolutely. But I do think it's important to recognize that there is a lot of overlap between offenders who commit the most serious crimes and offenders who commit some of them lower-level crimes.

And one of the most interesting statistics out of the early 1990's in New York when then Chief Bratton of the Transit Police Department in 1990 started a big fare evasion program, right. And, you know, I think people rightly think of fare evasion is a relatively low-level offense.

Two statistics that came out of that enforcement program I think really shocked a lot of people and created a lot of support for the kind of broken window strategy that you know, caught hold after that. One was that somewhere around 1 in 20 of the individuals who were arrested for evading the fare had an illegal weapon on them.

And something like one in seven were found to have an outstanding felony warrant, which is, you know, a two pretty significant figures. And what that tells us is that most criminals don't specialize. I think the research makes this pretty clear, which means that tomorrow's shooter can be yesterday's retail thief. Yesterday's thief can be, you know, next week's car thief, et cetera.

So, I wouldn't necessarily sort of push the paradigm that, you know, the only way to sort of solve the more serious crimes is to abandon enforcement on the lower level stuff. I think it's important to put ourselves in a situation in which we can do both.

And one of the things that, you know, is very clear, and there's great research by Anthony Braga, who's a professor now at the University of Pennsylvania, which is developing into one of the best criminology departments in the country, frankly, looking at clearance rates for non-fatal shootings. Because we see so many resources get diverted into homicide investigations, which understandably so you know, non-fatal shootings, which are the only difference between a fatal shooting and a non-fatal shooting is usually aim and chance. They don't get as many resources.

And when you increase those resources, when you put the same amount of time in, what they found is that you can increase the clearance rate, but all of that really comes down to a question of

resources. And like I said, during my testimony, writ large across the board, the criminal justice systems throughout this country are underfunded on so many counts. A lot of the bad results that we see and that we want to improve are simply a function of our inability to correctly staff, to have morale, to have high quality individuals taking these positions and dedicating themselves and doing them well.

And part of that is, you know, creating pay parity. You know, part of that is, you know, having incentives, you know, promotional ceilings being raised and giving people a sense of ownership and pride in the work that they do.

But really, it's just a function of building out that infrastructure. So many departments, police departments, correctional departments are working off technology that's 30, 40 years old, you know, there are no data scientists within these institutions doing the kinds of analysis to inform the deployment of resources in any kind of strategic way that—

Chair BOOKER. So, there's enough head nodding on this Committee when as you're talking, you're getting a lot of affirmation. I want to just sort of end on this because when you fairly talked about the First Step Act and the analysis we have—so far is only a shorter period of time. It's not that 8-year window you were discussing.

But I guess what frustrates me, not with anything you said, but just frustrates me in general, is what I started seeing when I was mayor, which was when we were punishing—thought we were this—better punishing inmates by taking away Pell Grants and all of these things, when all the data showed a dollar invested in allowing somebody a pathway, people with—coming out with BAs, where MAs have dramatically lower rates.

And I don't remember the exact data point, but it was something like every dollar spent in education programs paid for itself, returned to the taxpayer in terms of just the reduced recidivism rates.

And so, to have a First Step Act that, as Senator Whitehouse said, so passionately, that is not being done because we don't have the staff to do it. This is something good to pursue because the data you're talking about recidivism would go down even further if there was actually access to the programs that were articulated by the 86 members of the Senate that voted for that Act. Would you agree with that?

Mr. MANGUAL. Yes. Look, I think that's certainly the hope, but it's again, it's hard to know if we don't have the resources to properly implement these things I mean, one of the most staggering statistics that came out of the last year annual report on the First Step Act was that about 29,000 individuals had been released as a result of the First Step Act.

And if you look at the breakdown of individuals who had received any of the evidence-based recidivism reduction programs, about 14,000, almost half hadn't received any programs. Now, part—a big part of that was because a good chunk of that number never actually entered a BOP facility.

But, you know, also part—and partly because they just receive lower sentences, but, you know, being able to faithfully implement

these things, they take time, they take resources. If you don't have those, you simply can't actually flesh out the plan for—to any level where we can, you know, say with any kind of, you know, scientific certainty whether it works.

Chair BOOKER. Mr. Mangual, you and I are going to agree there, and I'm going to professionalize saying your name correctly. I just want to say a few points before we close because I have seen how—and this goes to the point we're talking about—how when a kid gets caught up in the system early it actually can create cycles of criminality, because of the experiences they have in the criminal justice system.

And, you know, there's the very famous cases like Kalief Browder and others where he was accused of stealing a backpack, waited for 2 years before being even adjudicated. My first time I went to Rikers with Jared Kushner's father, Charlie Kushner, I asked the kids how long they'd been incarcerated, and they were like, you know, 6 months, 8 months, a year. And I said, well, what have you been convicted of? And they hadn't been convicted.

And, many of them had spent time in solitary confinement. And the difference between that experience and the experience where I grew up in an affluent neighborhood where kids would often do the same kind of things, would have station house adjustments and never enter a system that traumatized them in the first place.

And so, this idea that we create low-level penalties, and I struggled with this when I was mayor, that yes, when we stopped—we started saying, we're not going to ignore. And this idea of ignoring crimes, if there's no accountability, then you're inviting the thing to continue. It's just like common sense, right?

So, we said this, open air drinking, which was the biggest complaints I got from citizens in my community. You know, we were going to start to talk, we weren't going to take people to prison, we weren't going to give them the kind of ticket that would create a poverty trap.

And we did find people that had illegal possession of firearms and the likes. I'm not disagreeing with that. But what I'm disagreeing with in terms of policy is creating a system that takes our children into the system, traumatizes them, they come back out, they start falling further and further behind in school, or what have you.

We have to find a way to create a system that reflects the best of our values. And it starts with supporting the professionals that are a part of doing a job. Ms. White, when you talked about the mission of corrections, it is not just punishment. It is not, no correctional officer will say that. It's so much of about this understanding that we are a society that believes in rehabilitation, that believes in redemption, and creating systems that promote and support that which ultimately doing that to public safety.

I am really grateful for this panel and for you all, allowing this engagement. I'm grateful for my Ranking Member who I have a lot of respect for because I know he's seeking the same ends that I am in our society, safe, strong communities. I'm really happy that my friends, like Senator Padilla talked about love because we're ultimately trying to create a more beloved community here in our country.

And today in the United States Senate, the five of you have really brought, I think the best of not just testimony, the best of heart and intention to help us to solve very, very difficult problems. I have learned a lot from you, and I know that the record will reflect. I hope the makings of some bipartisan ideas to really advance it, including the bill that we're looking at now as a result of this morning's hearing, which is Ranking Member Cotton's bill, directly to your idea of creating better equipment.

Thank you everybody for your time, for your testimony. I know there's some official closing remarks I'm supposed to make, and I know the word love is not in them. Let me see. Closing, here it goes.

Thank you to our Ranking Member, Senator Cotton. I think I've done that already. Yes, sufficiently. Thank you to each of our Subcommittee Members who are not here to hear this, special thank you to our witnesses. I think I've given you a special thank you. Federal and State prisons are suffering from overstaffing. There's language that reflects what I've already said.

This is the stuff I have to say. I want to remind the Members of the Subcommittee that questions for the record are due a week from today, Wednesday, a week from today at 5 p.m. And I ask that the witnesses, and I know as busy as you are, as understaffed and undersupported as you are, might be in your job, please respond to those questions in a timely manner. They will be more helpful than you know from a Committee that really wants to do some substantive work in this area.

And with that, this hearing is adjourned. I'm grateful.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

[Additional material submitted for the record follows.]

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Statement to the U.S. Senate's Subcommittee on Criminal Justice and Counterterrorism

Joint Hearing On: "The Nation's Correctional Staffing Crisis: Assessing the Toll on Correctional Officers and Incarcerated Persons."

Wednesday, February 28th, 2024

Washington, DC

Considerations for federal efforts to assist state and local law enforcement agency efforts to address the crime spike

Submitted by:

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**The Manhattan Institute for Policy Research does not take institutional positions on federal, state, or local legislation, rules, or regulations. Although my comments draw upon my research and writing about criminal justice issues as an Institute fellow, my statement to the Subcommittee is solely my own, and should not be construed as my employer's.

Statement of Rafael A. Mangual

Statement

Chairman Booker, Ranking Member Cotton, and all other members of this distinguished body, I'd like to begin by thanking you for the opportunity to offer remarks on this important topic.

The first duty of any government—whether local, state, or federal—is to keep its people and their property secure. One of the primary ways in which governments provide that security is through criminal justice systems. The police are the most visible elements of these systems, but they're certainly not the only ones. Indeed, their effectiveness depends in large part on other criminal justice actors. Prosecutors still need to prosecute, judges still need to adjudicate and sentence, and, crucially, correctional institutions need to secure and hopefully better the prisoners they take in.

Effectively managing a correctional population, however, requires investment. Unfortunately, we have seen throughout this country an unwillingness to adequately invest in corrections as decarceration—the pursuit of correctional population declines—has become both a policy priority in its own right, but also the preferred means of alleviating the pressures on the corrections system created by staffing shortages, facility maintenance costs, and overcrowding.

I'd like to use the remainder of my time to make three points:

First, decarceration—whether pursued as a public policy good unto itself or as a means of cost-saving—is not a cost-free endeavor. The downside risks associated with that project become more pronounced as you begin to move beyond the margins of the prison population.

Second, the potential cost-saving effects of decarceration—at least in the short and intermediate terms—are more limited than they might appear to be based on cost-per-inmate figures based on a division of total corrections spending by the imprisoned population.

Third, making the necessary investments in our criminal justice system to address issues like understaffing, overcrowding, and security concerns will not only help improve correctional outcomes, but will keep the government out of a position in which budget constraints require it to make choices that will ultimately harm public safety.

On the first point, most of the public safety risk associated with any significant-scale decarceration effort derives from the loss of incapacitation benefits—i.e., the beneficial effects of an active offender's removal from society which come in the form of crimes not committed as a result of the offender being behind bars. One study recently found that for the period 1991–2004, “each additional prison-year served prevented approximately” eight index crimes.¹ That estimate, which is somewhat conservative given that it is based in part on official crime counts (most crimes are not actually reported), is based on both state and federal prisoners. This is important to point out because the more-limited jurisdiction of the federal government (which lacks a general police power) means that the federal prison population consists of inmates who, on average, pose somewhat lower risks of recidivism. But even if lower than it is for state prisoners,

¹ <https://gspp.berkeley.edu/assets/uploads/research/pdf/p69.pdf>

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the recidivism risk posed by federal offenders is far from zero. An analysis of more than 25,000 federal offenders released in 2005 found that just under 50% were rearrested over an eight-year observation period.² It's also worth noting that rearrest was closely associated with the age and criminal history of the releasees, as well as with the type of offense they were incarcerated for. For example, the study found that 68.3% of firearms offenders and 67.3% of robbery offenders were rearrested during the study period, compared to 34.2% of fraud offenders and 44.4% of larceny offenders.³

Some might be tempted to argue that the recidivism data for those released pursuant to the First Step Act (FSA) strengthens the case for decarceration; but those data do just the opposite. While it's true that only about 12% of FSA beneficiaries had recidivated according to the April 2023 FSA annual report, the recidivism data for FSA beneficiaries nevertheless illustrates the *limits* of relatively safe decarceration efforts with regard to just how many prisoners we can release without harming public safety. According to that report, a little over 29,900 federal offenders were released pursuant to provisions of the FSA.⁴ However, a closer look at the recidivism tables shows that nearly 9 in 10 (88.3%) of the more than 24,000 releasees who had a risk assessment were rated minimum (37.4%) or low (50.9%) risk.⁵ Nearly half of the releasees (which comes to less than 10% of the 2022 BOP population, and less than 1% of the national 2022 prison population⁶) didn't complete any recidivism reduction programming, which is notable because, in many cases, this was because they "were never designated to a BOP institution but rather served their sentence at a jail or pre-trial facility or were released due to time-served sentences."⁷ Moreover, the bulk of these offenders (more than 20,000 of them) had only been released for a year prior to that report's publication, meaning that their lack of rearrest may simply be a function of the short observation period.⁸

The much larger state prison population (more than two-thirds of which is in primarily for a violent or weapons offense⁹) poses an even more pronounced risk of recidivism, with 9- and 10-year recidivism rates for releasees breaking 80%.¹⁰

So while it is certainly the case that some small subset of the country's prison population consists of inmates whose incarceration no longer serves a legitimate penological end, we must also understand that the vast majority of prisoners in the U.S.—both state and federal—pose a significant risk of reoffending.

² https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2016/recidivism_overview.pdf

³ https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2016/recidivism_overview.pdf

⁴ <https://www.ojp.gov/first-step-act-annual-report-april-2023>

⁵ *Id.*

⁶ <https://bjs.ojp.gov/document/p22st.pdf>

⁷ *Id.*

⁸ https://assets.foleon.com/eu-central-1/de-uploads-7e3kk3/41697/first_step_act_methodology_vf.1f6848fb2e22.pdf?first-step-act

⁹ <https://bjs.ojp.gov/document/p22st.pdf>

¹⁰ [https://bjs.ojp.gov/BJS_PUB/rpr24s0810yfup0818/Web%20content/508%20compliant%20PDFs and https://bjs.ojp.gov/content/pub/pdf/rsorsp9yfu0514.pdf](https://bjs.ojp.gov/BJS_PUB/rpr24s0810yfup0818/Web%20content/508%20compliant%20PDFs_and_https://bjs.ojp.gov/content/pub/pdf/rsorsp9yfu0514.pdf)

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As for my second point, it must be said that the costs savings potential of decarceration efforts may not be what they seem. It's often noted that it costs an average of over \$42,000 to incarcerate a single federal prison inmate for a year—a figure arrived at “by dividing the number representing the Bureau of Prisons (Bureau) facilities' monetary obligation (excluding activation costs) by the number of inmate-days incurred for the fiscal year, and then by multiplying the quotient by the number of days in the fiscal year.”¹¹ The problem with using this figure is that it might give the impression that you would save approximately \$42,000 a year by incarcerating one less inmate. That would be a massive overstatement because the lion's share of the average cost per inmate per year is a function of fixed costs—i.e., costs that aren't a function of how many inmates are incarcerated (think operation/administration costs associated with staffing, food, electricity, and debt service).¹² The marginal cost per inmate tends to be a much lower figure, albeit much more difficult to calculate.¹³

Not only are the potential savings associated with decarceration more limited, they are also going to be eaten into by the costs associated with the additional crimes that might occur as a result. Depending on the offense, these costs can be staggering. Indeed, the estimated annual cost of crime in the United States is in the trillions.¹⁴ A single homicide has been estimated to cost society nearly \$9,000,000, while an assault can carry a society price tag of more than \$107,000.¹⁵ Crime can also have other deleterious and costly effects that can be harder to see.¹⁶

Third and finally, the first two points weigh against dealing with the constraints posed by staffing shortages and other issues within the federal prison system by decarcerating and in favor of dealing with those constraints by investing in what is ultimately a core function of government. Despite the numbers that can be thrown around with regard to the cost of doing criminal justice in the United States, it remains the case that our criminal justice system is underfunded and in need of an upgrade—something my Manhattan Institute colleague Charles Fain Lehman thoroughly documented in a recent Manhattan Institute report, which

¹¹ [https://www.federalregister.gov/documents/2023/09/22/2023-20585/annual-determination-of-average-cost-of-incarceration-fee-coiff#:~:text=Based%20on%20FY%202021%20data,%2437%2C012%20\(%24101.40%20per%20day\).](https://www.federalregister.gov/documents/2023/09/22/2023-20585/annual-determination-of-average-cost-of-incarceration-fee-coiff#:~:text=Based%20on%20FY%202021%20data,%2437%2C012%20(%24101.40%20per%20day).)

¹² <https://www.vera.org/downloads/publications/price-of-prisons-updated-version-021914.pdf> (see endnote 10).

¹³ <https://journals.sagepub.com/doi/10.1177/08874034211060336>.

¹⁴ <https://www.journals.uchicago.edu/doi/abs/10.1086/715713?journalCode=jle#:~:text=The%20estimated%20annual%20cost%20of,%243.92%20trillion%20net%20of%20transfers.>

¹⁵ <https://www.journals.uchicago.edu/doi/abs/10.1086/715713?journalCode=jle#:~:text=The%20estimated%20annual%20cost%20of,%243.92%20trillion%20net%20of%20transfers.>

¹⁶ Other studies have shown impacts on mental health, student performance, economic mobility, and economic investment. See, e.g., https://tspace.library.utoronto.ca/bitstream/1807/99389/1/The%20impact%20of%20secondary%20exposure_Shape.pdf (showing that African Americans are disproportionately impacted by gun violence exposure in terms of their mental health); <https://www.pnas.org/doi/10.1073/pnas.1000690107> (finding that “Among African-Americans, the strongest results show that exposure to a homicide in the block group that occurs less than a week before the assessment reduces performance on vocabulary and reading assessments by between ~0.5 and ~0.66 SD, respectively.”); and <https://www.sciencedirect.com/science/article/abs/pii/S009411901730058X> (finding, among other things, that “a one standard deviation decline in violent crime as experienced during late adolescence increases the expected income rank in adulthood by at least 2 points.”).

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recommended, among other things, “[r]ehabilitat[ing] failing prisons and jails.”¹⁷ The more conspiratorial-minded might wonder whether the failures that stem from inadequately resourcing the criminal justice system, which has drawn the ire of many reform activists and abolitionists, are the point. A stronger case for upending a system can be made when the institutions within it perform suboptimally; and institutions become more likely to perform suboptimally if they are inadequately resourced.

It is almost certainly the case that there are measures on which federal and state correctional authorities can perform better; but it is also likely the case that boosting performance and improving outcomes of interest will depend on the degree to which Congress and state legislatures are willing to direct resources to these institutions to facilitate such improvement. For example, in his report, Lehman noted that “as of the end of 2021... 24 states and the federal government still have prison populations over 90% of the lower bound for overcrowding; 12 have populations over 100%.”¹⁸ Yet, very little has been done to increase carceral capacity to address this very real problem, which can exacerbate others within prison walls. This is a political choice—one with dire consequences for those inside and, ultimately, outside of our nation’s prisons. We can and should choose more wisely.

Thank you.

¹⁷ <https://manhattan.institute/article/modernize-the-criminal-justice-system-an-agenda-for-the-new-congress>

¹⁸ <https://media4.manhattan-institute.org/wp-content/uploads/modernize-the-criminal-justice-system-an-agenda-for-the-new-congress.pdf>

Statement of Santia Nance

Hearing on “The Nation’s Correctional Staffing Crisis: Assessing the Toll on Correctional Officers and Incarcerated Persons”
Senate Judiciary Subcommittee on Criminal Justice and Counterterrorism
Wednesday, February 28, 2024

Chair Booker, Ranking Member Senator Cotton, and members of the Subcommittee, my name is Santia Nance. I’m the mother of a middle-schooler, Virginia voter, vice president of an advertising company, and fiancé to Quadaire Patterson, who I reconnected with 6 years ago and who has served 15 years of a 20-year sentence.

Quadaire and I met in high school when we were both in the Navy Junior ROTC program and spent time together when I was in college. This changed instantly the summer of 2007, when he and his family members were forced out of their home, and they had to split up. This wasn’t the first time this has happened, as Quadaire had a difficult childhood moving state-to-state, that led to some poor decisions when he was a young adult and was homeless. He takes full responsibility for those that led to his current incarceration.

But spending his entire 20’s in prison and beyond, Quadaire has made the most of his time and seized every opportunity to prepare for his successful reentry. He received his GED in 2012 and is taking print-based college courses at Ohio University and studying to be a paralegal. He has a trade in brick masonry, and even assists with re-entry efforts and mentorship through his project, Brilliance Behind Bars.

Quadaire is housed at Lawrenceville Correctional Center - the last private prison in the Virginia Department of Corrections that the state will assume control of by August 2024.¹ Lawrenceville has been facing staffing shortages since at least 2018, and the Virginia Department of Corrections estimated that when it assumes control of Lawrenceville, it will need to increase staffing by 93 correctional officers to provide enough relief to other officers and to ensure security.² While a partnership during incarceration is already hard enough, short staffing in Lawrenceville has impacted my family tremendously. Short staffing has affected his ability to access essential medical services and programming and has created difficulties for my family staying in touch and visiting with Quadaire.

As a glaucoma patient diagnosed in 2012, Quadaire needs his eye drop medication – Latanoprost – which relieves the pressure on his eyes and reduces discharge. He’s been instructed to take these nightly, before he sleeps, so that when he wakes up, his vision is clearer. Without this medication, it is not only difficult for him to do everyday tasks, but also to keep up with his coursework and studies. Quadaire has filed multiple grievances and requests to see the eye doctor that only comes to Lawrenceville once a month, but he has only been met with ‘you are on the waiting list.’ Knowing that he’s only 35 years old and suffering blurry vision, there are

¹ Sarah Vogelston, *Virginia to close four prisons, reassume controls of sole private prison*, VIRGINIA MERCURY (Dec. 15, 2023), <https://virginiamercury.com/2023/12/15/virginia-to-close-four-prisons-reassume-control-of-sole-private-prison/>.

² *Id.*; see Virginia Dep’t of Corrections, “Lawrenceville Correctional Center Management Study” (Sept. 18, 2020), <https://rga.lis.virginia.gov/Published/2020/RD516/PDF>.

serious concerns of developing cataracts and blindness, which is a possible side effect of his condition.

Quadaire has his dream job working in the religious library in the gym as a Chaplin's Clerk. He has also been the organizer of the Zen Buddhist group, leading other men through meditation to help them stay grounded. Because of short staffing in Lawrenceville, he has seen first-hand how this has affected the way people have been able to get services restored to pre-Covid levels. For example, he has seen religious gatherings, like church on Sunday, getting canceled at the last minute. Various programming is offered in the gym, so this goes beyond just religious services. Now, with only one correctional officer running the gym instead of 4 - music programs, anger management programs, substance abuse programming and sports, have all been interrupted - causing difficulty to encourage rehabilitation for Quadaire and the people at Lawrenceville.

While prison does require physical separation, we stay in contact through visitation, phone and email. For people with loved ones in prison, close contact creates the best outcome for all parties. 95% of people in prison will come home; and strengthening family bonds has been scientifically proven to increase public safety and reduce recidivism. But short staffing has interfered with our ability to maintain our family bond.

On February 18, 2024, I went to visit Quadaire. I was surprised to see the longest line of visitors I've seen in months, and only one correctional officer working in the visitation office. When I stood there to hand in my I.D, I noticed that she was sitting behind the body scanner, operating it; before she took my ID, opened the door for someone else, and then patted down a different person. In the 5 years since I've visited, there have been at least 4 people in the office getting us through security. It took over 45 minutes for me to get into the room to see my fiancé, which cut deeply into my 2-hour visit. This was after my visits on January 28th and February 4th were canceled due to staffing concerns.

Whenever there are lockdowns in the prison or extended 'count' times due to lack of employees to cover the shifts, the phones may be down, and the population doesn't have access to the JPay kiosk. I suffer not knowing the reason why he is not calling, and often fear the worst, as I'm unable to reach anyone at Lawrenceville. When I call the facility, asking for an explanation, I get met with no answer, minimal information, or simply a disconnection. There's a trend of these events on holidays, weather events, and evenings, as people are calling out of work.

We understand that Quadaire needs to be held accountable for mistakes made, and he is the first to say so. But the issues caused by understaffing go beyond affecting those behind the prison's walls - it punishes me and my son as well.

After reconnecting with Quadaire 6 years ago, I've been educating myself on policy, laws, and advocacy to create meaningful change involving prison conditions and extreme sentencing. I co-founded an organization called Sistas in Prison Reform, where our mission and purpose are to bring humanization to those behind the walls and collaborate with Virginia's lawmakers. Through this work and through my personal experience with Quadaire, I believe that the answer to the nationwide staffing shortage and increasing public safety for prison staff, incarcerated people, and their families - is to identify those who received harsh sentences and have

rehabilitated themselves, and release those who have proven they are ready to come home and do not pose a public safety risk. Like many others in Virginia, Quadaire's sentence includes 13 years of mandatory minimum time. But this long and harsh mandatory sentence was not necessary to protect the public or to prepare Quadaire for reentry. Like so many others, Quadaire is rehabilitated and ready to rejoin our communities. There are many mechanisms to identify what rehabilitation looks like - good behavioral records while in prison, educational milestones, safe environments to go home to, secured jobs, extensive time spent in prison, and the list goes on. There are SO many people - like my fiancé - that our state and federal tax dollars are wasting money on when these incarcerated people could be home PAYING taxes and giving back to their communities. Reducing the population would lessen the burden of the officers and allow them to maintain a manageable environment that focuses on those who still need rehabilitation.

Thank you for your time and for the opportunity to share our story.



**Statement of Stephen Walker
Wellness Director
One Voice United**

**Before the Subcommittee on Criminal Justice and Counterterrorism of the U.S. Senate
Judiciary Committee**

**Hearing on “The Nation’s Correctional Staffing Crisis: Assessing the Toll on Correctional
Officers and Incarcerated Persons”**

February 28, 2024

Chairman Booker, Ranking Member Cotton, and esteemed Members of the Committee, I would like to thank you for giving me the opportunity to speak with you today.

My name is Stephen Walker, and I am here representing One Voice United, a national organization dedicated to advocating for the welfare of correctional officers and other front-line staff and ensuring their expertise and perspectives are included in the national debate around criminal justice reform.

Before joining One Voice, I served as a youth correctional officer for 35 years with the California Department of Corrections and Rehabilitation and am currently the Director of Correctional Health for the California Correctional Peace Officers Association.

Today, I sit before you to address the existential staffing crisis in America’s prisons and jails, in hopes of advancing a nationally sanctioned dialogue.

This crisis has no borders, is not one state's issue and cannot be solved by a single department or entity. It is a national problem that impacts every aspect of the mission of corrections by asking staff to do more with less, often resulting in excessive work hours and multiple mandated shifts per week, leading to increased burnout, less job satisfaction, and an inability to perform everyday security and rehabilitative functions.

As a result, non-custody and inexperienced custodial staff are being ordered to fill custody and security positions, with little training or experience, processes called augmentation and diversion.

From experience, I can tell you that it's not enough to just find a warm body to fill these vacancies. To be a competent and professional Correctional officer takes time, supervision, and training. Not to mention the fact that augmentation takes key personnel (nurses, teachers, administrators) out of their primary function without replacement of the services lost.

For staff, personnel shortages lead to diminished observation skills, less intelligence gathering, surges in overtime, slower response times, and strained family relationships and collective wellness. In fact, multiple studies indicate that correctional officers suffer from PTSD, depression, suicide, heart disease, a shortened lifespan, and other physical and psychological ailments at a rate well above the general public.

For those in our care, personnel shortages mean programs are slashed, visits are reduced, time on lock down is increased, and the patience of everyone behind the walls wears thin. In many prisons, ratios often surpass 60:1, escalating in yards and chow halls, where unpredictable staffing complements further skew this imbalance, compelling a policy-mandated prioritization of institutional safety above all else.

To combat this reality, well-meaning attempts are being initiated by agencies in various states to lower entrance requirements for new recruits, shorten academy times, and offer signing bonuses, none of which have successfully addressed this crisis to a scale of lasting impact.

Additionally, inadequate staffing levels limit the availability of programming and rehabilitative services, further hindering efforts to promote positive behavior and reduce recidivism among those in custody. Addressing the staffing crisis is essential to mitigating these safety risks and creating a secure environment for both staff and incarcerated individuals.

Retaining staff is equally important; we must transform employment conditions by moving beyond the traditional top-down paramilitary administrative model.

Research and studies done on retention show overwhelmingly that it is not the incarcerated population that drives good employees away, it is a lack of communication, recognition, and transparency, along with outdated and uninformed policies. In short, the level of expectations and demands of today's corrections system have outgrown the current administrative model of training and have diminished the profession to a point where staff feel devalued and expendable.

Because of the willingness of staff to no longer silently endure the challenges, it has become clear that the short and long-term needs, and values of new officers no longer align with the current culture and demands of corrections departments.

Fortunately, there are remedies and actions that can be taken to address these issues, but they require thoughtful planning and input from all stakeholder groups.

Addressing the staffing crisis in corrections requires appealing to potential employees by valuing their goals and integrating them into a respected team from day one, providing empirical training, better pay, lower healthcare costs, holistic wellness programs, and attractive incentives such as educational benefits, pensions, and reduced vesting periods.

Without achieving these objectives and including the voices and experiences of those who will be impacted by their success or failure, true rehabilitation is unrealistic, and prisons will continue to fall short of their primary mission of creating a safe and humane atmosphere for successful re-entry back into society.

I appreciate the opportunity to appear before you today and look forward to answering any questions you may have.

Supporting Attachments

- I. Written Testimony Submission from James Paul McCravey III (pp. 4-5)
- II. OVUCorrectional Officer Wellness Project Summary Guide (pp. 6-12)
- III. OVU Blue Ribbon Commission Report on Correctional Staff Wellness
available at <https://onevoiceunited.org/wp-content/uploads/2022/10/BRC-Report-2022.pdf>
- IV. I Am Not Okay, Correctional Staff Wellness White Paper
available at https://onevoiceunited.org/wp-content/uploads/2021/10/Wellness_White_Paper_Edited_OCT17_2021.pdf
- V. Navigating the Future of Corrections Economic Impact Study Report
available at <https://onevoiceunited.org/wp-content/uploads/2020/09/Economic-Impact-Study.pdf>

**Subcommittee on Criminal Justice and Counterterrorism of the U.S. Senate Judiciary
Committee**

**Hearing on "The Nation's Correctional Staffing Crisis: Assessing the Toll on Correctional
Officers and Incarcerated Persons"**

**Written Testimony of James Paul McCravey III
Former Correctional Officer**

February 28, 2024

Chairman Booker, Ranking Member Cotton, and esteemed Members of the Committee, thank you for holding this hearing on the nation's correctional staffing crisis and for allowing me the opportunity to submit this written testimony.

My name is James Paul McCravey III, and I served as a corrections officer at the Michigan Department of Corrections from 2013-2019.

As a former corrections officer, I can attest to the profound challenges posed by the ongoing national staffing crisis and know firsthand the toll it takes on staff and those within our care.

My journey into the corrections field wasn't a typical one; inspired by a passion for criminal justice, I initially intended to pursue a career in law enforcement, however, a conversation with the Dean of my college, who also happened to be an inspector at the Charles Egeler Reception and Guidance Center, convinced me to give corrections a try. Little did I know the profound impact this decision would have on my life.

From the outset of my career in March of 2013, staffing shortages were glaringly apparent. While classroom study and physical training had made us feel ready, no amount of training could fully prepare me for the actual experience of working behind the walls.

Stepping into the facility for the first time, I felt the weight of the responsibility upon me and the dire situation I had walked into. On any given shift, it was not uncommon for us to be short by 20 or more officers, leading to daily mandates for colleagues, straining both morale and safety.

For many of my coworkers the reaction to new officers was mixed. While some veteran officers welcomed the relief we brought to the understaffed system, there was an underlying concern about turnover and skepticism surrounding how many of the new officers would stay beyond their first year. Some saw us as transient, using the job as a steppingstone to other pursuits or looking for on-the-job experience to apply to other state departments. Despite this, we were welcomed as individuals capable of offering some reinforcement amidst the staffing crisis.

Rising through the ranks and becoming a Sergeant, I began to take on additional responsibilities and witnessed firsthand the ways that understaffing undermined our ability to maintain order and safety within the facility. Daily decisions about canceling programs or denying incarcerated people their rightful privileges became sources of tension and unrest, adding to an already delicate environment.

At the academy, and during my first year, I was taught to be fair and consistent with all incarcerated individuals and I prided myself on treating everyone with dignity and respect. But consistency became increasingly difficult amidst staffing shortages and our concept of fairness was tested because we had no other choice than to cancel visitations, shorten yard time and act in a manner conducive to safety, which deprived those incarcerated of privileges, programs and contact with the outside world, and led to growing resentment and frustration.

If that wasn't enough, my dedication to the work was tested beyond the confines of the prison walls when I learned that my newly born infant son was diagnosed with noonan syndrome and juvenile leukemia and was in the hospital for the first seven months of his life, with six of those seven months on life support. Balancing the demands of the job with the needs of my family became an untenable challenge.

The inability to access a phone during shifts meant agonizing waits for updates on my son's condition coupled with uncertainty about if I would be able to attend doctors' appointments, leave on a minute's notice if the hospital called or spend time with my family as we tackled such a huge situation.

To make matters worse, I always felt like I was letting my brothers and sisters inside the prison down because they were mandated to work overtime and missing time with their own families while I dealt with my own personal struggles.

At first, I tried to make the situation work, stepping down from Sergeant and going back to a corrections officer, thinking that I would have more flexibility, but after a few short months, I felt as though I was still letting everybody inside and outside of the prison down and I didn't want to be that person.

The reality of being torn between my duty to the job and the needs of my family became too overwhelming to bear, despite the support of my colleagues. Ultimately, I had to prioritize my family's well-being over my career in corrections and made the hard decision to leave.

Reflecting on my experience, I can't help but feel that the staffing crisis I encountered within the MDOC is just a small part of a larger crisis that affects everyone involved in the American correctional system. Understaffing compromises safety, undermines the mission of rehabilitation, and strains relationships for staff, families and those incarcerated.

Don't get me wrong, despite the challenges, I loved my job and to this day, I miss the comradery and familial relationships with my fellow officers and the sense of purpose I felt when I walked inside those gates.

My hope and desire for sharing my story is that others will recognize the urgent need for systemic change and some relief can come to those officers continuing to work 16-hour days, in difficult conditions with no end in sight.

Thank you for the opportunity to share my story and I look forward to continuing the dialogue on this critical matter.



Mental Health

The U.S. correctional system is at a breaking point. Every American touched by the system – officers, administrators, the currently incarcerated and their family members – experiences challenges that can, and do, negatively impact their mental health. Among America’s nearly 450,000 correctional officers (COs), PTSD and depression are at near-epidemic proportions, driving extreme rates of psychological and even physical harm.

The mental health of correctional officers is inextricably linked to the health and safety of the entire prison population. That means lasting systemic reform can only occur through approaches that address the mental health crisis facing COs today.



A national survey of correctional officers found 91% of respondents feel that “PTSD is a serious and pervasive issue within corrections.”



These mental health conditions aren’t just psychological; they have real, dangerous physical effects as well. Stress manifests itself in the human body in a variety of ways, including (but not limited to):

PSYCHOLOGICAL EFFECTS

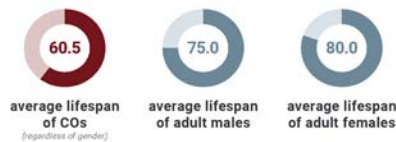
- ▶ Addiction
- ▶ Anxiety
- ▶ Flashbacks
- ▶ Guilt
- ▶ Lack of Concentration
- ▶ Paranoia
- ▶ Social Withdrawal

PHYSICAL EFFECTS

- ▶ Chest Pains
- ▶ Dizziness
- ▶ Heart Disease
- ▶ Insomnia
- ▶ Obesity
- ▶ Opioid Abuse
- ▶ Self-Harm
- ▶ Ulcers

Stress levels (and the accompanying psychological and physical impacts) are so high and so prevalent that the average correctional officer can expect to live to just 59-62 – a full 14-21 years less than the general public.

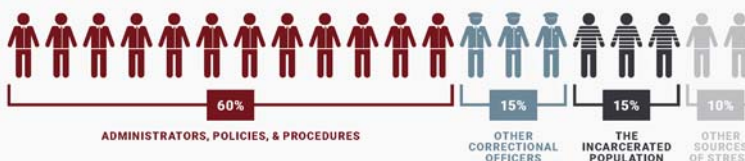
It is estimated that 156 active duty correctional officers take their own lives each year. That’s three deaths every week, and 34.8 suicides per 100,000 correctional officers each year. The suicide rate among the general population is less than half of the rate among COs: 14.2 deaths per 100,000 Americans.





Causes of Stress

Before beginning the long-overdue work of reforming the U.S. correctional system and addressing the mental health challenges facing correctional officers (COs) today, it's imperative to understand the sources of those mental health challenges – namely, the stress COs live with every day.



60% ADMINISTRATORS, POLICIES, & PROCEDURES



The source of a majority of CO stress comes directly from the top: administrators and the policies and procedures they implement. That's not to say it's done on purpose: unfortunately, sometimes administrators don't realize how dangerous the job really is, making them more likely to unknowingly implement harmful decisions and less likely to address challenges they just don't see.

Order and control are key to maintaining a safe prison, so when new policies and procedures are imposed on officers without their input it can create not only resentment but serious disruption to their job of maintaining that order and security. And often, administrators don't ask for COs' input before making decisions, which can have the secondary effect of sowing distrust among employees.

One key decision that adds to COs' stress is staffing – or, more accurately in most cases, understaffing. Not only is lack of staff a major contributor to CO burn-out, understaffing strains every aspect of a correctional system.

- ✦ In private prisons, managers are under pressure to maximize revenue by minimizing the number of staff needed to run the facility, and their bonuses, salaries, and pensions are based on how well they maximize profit – meaning more inmates and fewer staff.
- ✦ In public prisons, staff are often being asked to take on more programming and education without additional resources or manpower, which can result in safety risks when staff are spread too thin.

As prison populations fall, policymakers and leaders should take the opportunity to enact guidelines that ensure a return to safe staffing levels, instead of allowing administrators to cut COs as well in a race to the bottom.

15% OTHER CORRECTIONAL OFFICERS



It's the job of COs to maintain order within their prison, which means projecting strength and invulnerability at all times. That can be hard to shake after hours – and makes COs fearful of sharing their mental health challenges, lest they experience repercussions (like ostracization, limited assignments, and diminished opportunities) for seeking help. In the worst cases, COs may even be bullied by their peers for showing perceived weakness. **A culture shift within prisons is necessary in order to alleviate CO stress and begin the process of destigmatizing seeking help.**

15% THE INCARCERATED POPULATION



Perhaps the most well-known source of CO stress is the incarcerated population. COs must be hyperaware of their surroundings at all times, as they are at any moment at risk of harm. That can range from being verbally threatened, to spit on, to stabbed with any number of items – including, sometimes, contaminated needles.

Even when COs want to help or mentor an incarcerated person, they are actually prohibited from doing so in many cases because of overfamiliarity rules. These rules make it difficult to establish any kind of civil relationship and trust between COs and the incarcerated population.

10% OTHER SOURCES OF STRESS



In addition to the more quantifiable sources, there are other more general factors that may contribute to correctional officers' stress. COs and prisons often do not appear in the media unless it is for a negative reason, creating a wholly negative public perception of the correctional system. This also leads to a negative "Hollywood portrayal" that perpetuates the stereotype and doesn't tell the stories of the overwhelmingly good number of COs in the field today.

Challenges with Facility Administrations



Surprisingly, the biggest source of stress for correctional officers (COs) today isn't the incarcerated individuals they work with – it's the administrations they work for. National studies have shown that approximately 60% of staff stress comes from policies, procedures and the administrators themselves. Here are some of the reasons why.

LACK OF ACKNOWLEDGMENT OF CHALLENGES



Too often, administrations don't see the real, everyday dangers and mental health strain that come along with being a CO. Before policies and procedures can be put in place to help relieve that strain, administrators need to acknowledge that it exists. Changing that mindset is crucial to any meaningful reform.

DISTRUST OF ADMINISTRATION



Even after administrators acknowledge a problem exists, they rarely ask for COs' input on new or improved policies and procedures. Sometimes, staff don't find out about a change until the day it's implemented! Often, COs are asked to implement policies that have direct impacts on staff or the incarcerated population – but without having been part of the conversation, they don't have an understanding of why the change is being made. Administrators can't do what's best for the facility without on-the-ground information and insights from COs. That means sometimes they accidentally put staff in danger, leading to a distrust of the administration among COs.

INADEQUATE EQUIPMENT



Officers rely on their equipment to keep them safe and help them do their jobs to the best of their ability. But they have no control over the equipment they're provided or the condition it's in. All too commonly, that means COs are left to work with radios that don't work, dangerous vehicles, outdated fire extinguishers, and not enough protective equipment like handcuffs, OC spray, gloves, face guards and protective vests. In addition to being a source of stress for officers, it leaves them feeling as though administrators have a disregard for their safety.

LACK OF JOB RECOGNITION



Law enforcement officers and first responders are often covered in the news for the good work they do on the job – unfortunately, COs rarely make the front page when they save someone's life or avert another crisis. That's why recognition from facility administrators is so important. Too often, administrators are slow to recognize and appreciate COs, making it difficult for COs to have a sense of pride in a job well done. Simple recognition from administrations would go a long way in improving COs' job satisfaction, self-esteem and overall mental health.



CHALLENGE SPOTLIGHT: UNDERSTAFFING

Staffing impacts virtually every aspect of how a correctional facility operates. Understaffing is one of the biggest threats to a CO's safety and security – and therefore one of the biggest sources of stress.

When a facility first opens, government officials determine how many COs are needed to safely staff it, based on a variety of factors including security classification, incarcerated population and physical layout. While there are minimum staffing levels in addition to the recommended operational staffing levels, too often administrators feel pressure to get by with as few staff as possible.

- ✦ In private prisons, managers are under pressure to maximize revenue by minimizing the number of staff needed to run the facility, and their bonuses, salaries, and pensions are based on how well they maximize profit – meaning more incarcerated individuals and fewer staff.
- ✦ In public prisons, staff are often being asked to take on more programming and education without additional resources or manpower, which can result in safety risks when staff are spread too thin.

Additionally, reported staffing ratios can be misleading. They're calculated based on the number of staff against the number of incarcerated individuals – but individual COs only work 40 hours per week, and incarcerated individuals are there all 168 hours of the week. These staffing ratios are only accurate if every CO worked 24/7 and never went home. Better ratios can be determined by "post audits," where every post is evaluated on every shift to determine the true staffing requirements.

This understaffing means often a CO can be in charge of overseeing as many as 70 or even 100 incarcerated individuals at a time, especially in yards and cafeterias of larger jails and prisons. This stressful situation contributes to employee burn-out and negatively impacts the incarcerated population, too; COs don't have the opportunity to focus on rehabilitation when they are so focused on having to maintain order.

Facility administrators should commit to bringing staffing back to safe levels, and not decrease the number of staff as prison populations fall.

Solutions



The crisis of correctional officer (CO) mental health is reaching a breaking point, but there are approaches that can help address these challenges. Administrators need to do more than just make these solutions available – they need to work to create a culture where mental health care is encouraged and valued. Long-term, lasting reform can not be achieved through tactical shifts alone, but requires psychological, cultural, and strategic change as well.



+ INDIVIDUAL THERAPY

One-on-one counseling for staff members with a licensed practitioner. If confidentiality issues and exposure are a concern staff can opt for individual counseling by third party providers that removes those possibilities. It allows the staff member to be unencumbered in their discussions and to avoid any feelings of discomfort that they feel exposing their emotions in a group setting of their peers may cause.

+ GROUP THERAPY

An advantage of group therapy is that it allows staff to share their experiences, fears and emotions and to realize they are not alone. Similarly, peer-to-peer counseling can be very effective in addressing mental health challenges shared among many COs.

+ COGNITIVE BEHAVIOR THERAPY (CBT)

Cognitive behavioral therapy (CBT) has been found to help significantly with depression treatment. In CBT, an individual and their therapist work together to agree on patterns of behavior that need to be changed. The goal is to recalibrate the part of the brain that's keeping such a tight hold on happy thoughts.

+ MENTAL HEALTH FIRST AID

Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues. Although MHFA has been taught around the world for nearly two decades, recent implementations in correctional facilities have been promising and well-received by staff.

+ EMOTIONAL INTELLIGENCE

Emotional intelligence refers to the ability to identify and manage one's own emotions, as well as the emotions of others. Improving EI can decrease anxiety and stress and help train staff to better handle day-to-day situations.

+ COGNITIVE PROCESSING THERAPY (CPT)

CPT teaches people to identify how traumatic experiences have affected their thinking. It also teaches them to evaluate and change their thoughts. CPT usually takes 12 sessions and can be delivered in an individual or group format. The goal is for patients to learn ways to have more healthy and balanced beliefs about themselves, others, and the world.

+ EXPOSURE THERAPY

This technique involves re-living the traumatic incident and is a more controversial treatment option. However, it does have its supporters and COs can work with their therapist to determine if it's the right approach for them.

+ PSYCHODYNAMIC THERAPY

Psychodynamic therapy is a form of talk therapy. It's designed to help patients find relief from mental or emotional stress. Proponents of psychodynamic therapy believe present-day problems are linked to unconscious conflicts arising from events in the past.

+ EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

In EMDR, patients pay attention to a back-and-forth movement or sound while calling to mind the upsetting memory until shifts occur in the way they experience that memory and more information from the past is processed. By processing these experiences, people can get relief from PTSD symptoms and change how they react to memories of their trauma.

+ STELLATE GANGLION BLOCK (SGB) INJECTIONS

A newer technique for treating PTSD, SGB injections – primarily used to reduce physical pain – are now being used in our veterans to deal with severe PTSD. The results have been promising from a clinical trial recently reported by JAMA Psychiatry of the American Medical Association (2016 – 2018).

+ MEDICATION

Some individuals suffering from anxiety, depression, PTSD, and other mental health disorders may be prescribed medication to help manage their conditions. Side effects can be substantial and certain medications may impact awareness and function, and all COs should work with their doctors to ensure they receive the prescription that's right for them.

These solutions have been tested and proven among the general population, but unfortunately there is very little research as it relates to specific applications to corrections. Given the reluctance of correctional officers to seek mental health care, these approaches as applied to corrections are relatively new and underscore the importance of greater implementation, research, and data collection. One Voice does not recommend any course of action, makes no medical advice and just seeks to share approaches that have worked in some cases. Any mental or physical health care treatments should be undertaken in consultation with individuals' doctors.



The Nation's Correctional Staffing Crisis: Assessing the Toll on Correctional Officers and Incarcerated Persons

Testimony By:
John Wetzel

Founder and Board Chair, Keystone Restituere Justice Center (www.keystonejustice.org)
Former Secretary of the Pennsylvania Department of Corrections, 2011-2021

February 28, 2024
Senate Subcommittee on Criminal Justice and Counterterrorism

INTRODUCTION AND OVERVIEW

Good afternoon Chairman Booker, Ranking Member Cotton, and members of the Subcommittee on Criminal Justice and Counterterrorism. My name is John Wetzel, the founder and Board Chair of the Keystone Restitutive Justice Center (KRJC),¹ a new non-profit dedicated to working tirelessly to improve our communities from the ground up as we take on challenges facing our correctional and criminal justice systems. I am privileged to be Pennsylvania's longest serving Secretary of Corrections. I served in this position for 11 years from 2011-2021 under two different governors. Prior to becoming Secretary, I worked in county corrections for more than 20 years: I started as a county corrections officer, headed a training academy and treatment department, and eventually became warden of a county correctional system. In addition, I was a member of the congressionally established Chuck Colson Task Force for the Obama Administration and Independent Review Committee under the Trump Administration, which concluded during the Biden Administration. I have a broad perspective and specific knowledge about the issues we are discussing today.

The critical infrastructure resource of corrections is alarmingly close to failure. It has long failed staff and incarcerated people. You can see that failure in outcomes around their health and safety and what happens when both staff and the incarcerated leave the corrections system.

Dr. Nneka Jones-Tapia's holistic safety practice captures an important theme: the connectedness of corrections staff, the incarcerated, and the people both groups care about in the communities in which they live. Yet, we've seen fewer adequate resources made available to the corrections field in order to support Maslow's hierarchy of needs and the wellness of both staff and incarcerated.

The impact of these problems and challenges negatively affects our community at large and, ultimately, creates community safety issues.

In Pennsylvania, my home state, we had a period of more than a week in one area where people were locked in their homes in fear of a county jail escapee. The escape occurred because of inadequate staffing.

We also have facilities using the National Guard in place of correctional officers at a time when we are all concerned about national security. Indeed, we want these soldiers to be available for national safety, yet we are using them as correctional officers.

I believe these problems require urgent leadership from the federal government: attention and ideas certainly; investment in the potential of the human beings who both work and live in correctional facilities absolutely.

To be sure, we have made progress. We have seen some systems using the potential of the incarcerated to make their systems better and more humane, resulting in better results and outputs. But we need to invest in the potential of corrections staff, including coming up with research-based ideas, to invest in their potential. These kinds of focused investments have transformed and actually disrupted other fields.

¹ www.keystonejustice.org

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You have invested in corrections before. Fifty years ago, the National Institute of Corrections (NIC) was founded, and its first budget was three years later for \$5 million.² This was an investment in the intellectual capacity of the field. It was leadership — executive, legislative and judicial — that led to that critical moment in corrections history. We now need a rededication to that kind of critical investment. The NIC does not enjoy that scope of funding 50 years later, and unfortunately, some of the ideals and goals that helped establish the NIC have dissipated.

CREATING CORRECTIONAL SUCCESS

Creating correctional success requires us to be deliberate about addressing and improving correctional culture. The physical and mental health and overall well-being of correctional officers and incarcerated people are often affected by the same factors. Safe and healthy correctional officers mean better jails and prisons, better conditions for incarcerated people, and ultimately better safety for the larger community in which the jail or prison is located.

I am happy to report that the Keystone Restituere Justice Center is fortunate to have been given the opportunity to address these issues through a multi-year grant from the Bureau of Justice Assistance. Under this grant, we are partnering with the Correctional Leaders Association to invest in the health and safety of our correctional officers. We will be convening with, among others, the formerly incarcerated and labor to help us build, for example, that Venn diagram that shows our common interests and overlapping goals. The work we will be doing is predicated on building a safe and healthy culture within our correctional systems.

At the backdrop of all this is that while the specific mission statements of various correctional agencies sometimes differ, they typically include three common themes: protecting the community, taking care of its employees, and helping to ensure that the incarcerated make a safe and successful transition back to their communities. Elevating all of these individuals for success will result in enhanced community safety. But unless we can address the extraordinary staffing challenges, our correctional employees and their families, the incarcerated and their families, and our communities as a whole will suffer.

Let me describe for you the scope and depth of the problems related to staffing and some potential solutions.

THE SCOPE OF STAFFING SHORTAGES

The most significant challenge our correctional systems face is insufficient staffing. Inadequate staffing presently affects our local, state and federal prisons and jails. And it is a problem that is not going to go away anytime soon. According to a recent article in USA Today:

Prisons across the country have long struggled to recruit and retain staff, but the most recent data from the U.S. Census Bureau shows the situation is particularly dire. In 2022, the number of people working for state prisons hit its lowest mark in over two decades.³

² <http://tinyurl.com/4td9arru>; <http://tinyurl.com/27b7ahu4>

³ <http://tinyurl.com/yr78xktz>

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Georgia had half of its correctional officer jobs empty last year.⁴ It has been reported that West Virginia, Florida and New Hampshire have called in National Guard troops to provide correctional support.⁵ Almost half the jobs for guards at New York's maximum-security prisons were unfilled in mid-2023.⁶ And the problem is only getting worse: the Bureau of Labor Statistics and other scholars forecast a 7% decline in the correctional officer workforce by 2032.⁷

On top of high rates of staff vacancies, we are also seeing increasingly higher rates of turnover during the last decade. The result is increased use of overtime to fill critical posts. Overtime is either voluntary or mandatory, but either way, staff are sometimes working an unhealthy number of hours, which can lead to less security and worse outcomes.⁸

While there may be different reasons for the waning staffing levels — e.g. people leaving the job during the COVID-19 pandemic, shifting perceptions of the work, enticing opportunities in other industries, new generations entering the workforce with different ideals, and low rates of compensation for the job — the impact is the same: correctional facilities are not functioning optimally. Indeed, some are not even functioning properly.

Let's be clear: this problem is not going away. It will not dissipate with time or marginal solutions. We are at a tipping point. There are signs of failure that we must not ignore, signs which the Bureau of Prisons Inspector General has written about and which we cite to in this testimony.

THE NEXUS OF CORRECTIONAL SUCCESS AND COMMUNITY SAFETY

Correctional success and community safety are inextricably intertwined. Take for instance the frequent requirement for incarcerated people to complete programs, either because they are court-mandated or because participating will improve one's chances of earning release. And consider that programming helps to rehabilitate the incarcerated, such as through drug, alcohol, and behavioral health treatment, vocational training, and educational classes. In other words, we rely on programming to help rehabilitate people who are incarcerated to improve upon the version of themselves that brought them to the correctional facility initially, thus improving community safety when they are released. Yet programming is so often the first area of operations to collapse when staffing is too short to safely accommodate programs alongside other key daily activities. Indeed, the recent report from the Bureau of Prisons Inspector General on inmate deaths states that "BOP Staffing Shortages, Particularly in Health and Psychology Positions, Hinder the Provision of Treatment and Programs for Mental Health Needs and Substance Abuse Disorders."⁹

Successful programming and reentry programs also promote hard work, personal accountability, and can help keep families together when incarcerated reintegrate back with their families. What is more,

⁴ *Id.*

⁵ *Id.*

⁶ <http://tinyurl.com/txcapa8d>

⁷ E.g., <http://tinyurl.com/3uawncd6>; <http://tinyurl.com/49w4vh8e>

⁸ The recent report by the Bureau of Prisons Inspector General regarding inmate deaths notes that the BOP's reliance on mandated overtime can negatively affect staff morale and performance, posing risks to institutional safety and security. See <http://tinyurl.com/mrdjzhyy>.

⁹ <http://tinyurl.com/mrdjzhyy>. The report goes on to say that "understaffing in Health Services and Psychology Services positions can limit an institution's ability to provide treatment and programs that may help mitigate the risk of inmate death, including mental health and substance abuse programming." *Id.*

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the majority of our states allow incarcerated individuals to earn some version of "earned time" — that is, they are eligible to receive time credited toward their sentence for completing certain rehabilitative programs.¹⁰ In short, inadequate staffing levels have been shown to lead to reduced programing, which means reduced rehabilitation, increased recidivism, larger prison populations, less security within the prisons, and consequently less community safety.

As I just noted, staffing shortages also diminish security within our correctional institutions. According to criminologist Bryce Peterson, "[i]t is likely that the staffing shortage that's happening right now across the country is going to have some impact on safety and security, including escapes."¹¹ An inadequate number of correctional officers necessarily means fewer security checks and a diminished ability to find contraband like drugs, weapons, and cell phones, or to address any brewing or festering security issues between the incarcerated. This puts the well-being and ultimately the lives of correctional officers and incarcerated people at risk. To that end, the BOP Inspector General noted that the staffing shortage at two institutions the Inspector General staff visited resulted in an inadequate number of cell searches, leading to inmates possessing dangerous contraband which ultimately contributed to inmate homicides and suicides.¹²

Inadequate staffing also leads to escapes. One needs to look no further than my own state of Pennsylvania, which has seen at least six escapes in 2023. There is a direct connection between inadequate staffing levels and escapes.

DECISIONS BY THIRD PARTIES, INCLUDING LEGISLATORS, LAW ENFORCEMENT AND SERVICE PROVIDERS, AFFECT THE OPERATIONS OF JAILS AND PRISONS.

Our correctional systems are affected by events that occur outside of the prison walls (such as new laws, police and prosecution strategies, current societal events, governmental fiscal appropriations, supply chain issues, and of course staffing issues). At the same time, the quality of operations at our correctional institutions affects the safety and well-being of the communities to which incarcerated people return.

Consider that community safety is enhanced by, among other things, a healthy criminal justice system, effective use of social services and treatment programs, strong and innovative educational institutions, effective policing and prosecution, strong neighborhoods, families, and mentors. Community safety, on the other hand, is diminished when the work of these systems, entities and individuals does not yield the results we would like.

So what happens when community safety has been diminished? There is often a reaction, which may include changes to laws, policies and budgets. Such decisions directly affect corrections. These decisions may affect the numbers of individuals entering the facility, the facility's ability to offer important programs and to implement or sustain best-practices, and how many individuals may be paroled from the facility. In turn, decisions by and practices of correctional officials affect incarcerated people in their jails and prisons, which ultimately affects community safety because the vast majority of them are eventually released to their communities.

¹⁰ <http://tinyurl.com/y4f6x8dk>

¹¹ <http://tinyurl.com/5n7azk4s>

¹² <http://tinyurl.com/mrdjzhy>

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What does all of this mean? The work of legislators, prosecutors, public defenders, police, treatment providers, neighborhood and community groups, budget secretaries, principals and college presidents, and leaders of our faith-based institutions must be done in tandem with corrections officials. Our successes, our innovations, and our ability to inspire and change lives are enhanced when we accept that what each of the systems and groups do affects corrections, and that what corrections does affects each of these entities as well.

For example, were there more access to behavioral health treatments and were the stigma around behavioral health reduced, we would see lower prison admissions because more individuals would receive the treatment they need to reduce the likelihood of committing a crime and those with serious mental illness who were incarcerated could be the focus of behavioral health treatment within the jail or prison. Similarly, were at-risk youth better able to be linked to mentors who could help them navigate their challenging environments, fewer would ever see the inside of a jail or prison.

In my own state of Pennsylvania when I was Secretary of the Department of Corrections, we recognized a similar reality when we were able to significantly improve our criminal justice system through Justice Reinvestment Initiatives (JRI). The result of the work was a lower prison population, fewer technical parole violators returning to state prison, less crime, fewer disparities, and procedural justice for crime victims. In short, a more just system. Central to JRI was the convening of stakeholders. They engaged in honest conversations, analyzed data, asked for more data, looked carefully about proposed policy changes, and had the opportunity to make suggestions about new ideas. We recognized that all the stakeholders affected by the criminal justice system had to be present, that the proposals and solutions could not be pre-ordained, and that stakeholders needed to be able to discuss how proposals would specifically affect the operations of their agencies or entities.

ADDRESSING CORRECTIONS STAFFING MEANS BETTER OUTCOMES FOR CORRECTIONAL OFFICERS, INCARCERATED PEOPLE, AND COMMUNITIES AS A WHOLE.

Successfully addressing challenges related to correctional staffing will not only improve the on-duty morale of the workforce, but ultimately, we will see it reflected in improved outcomes for the incarcerated population, for families of our staff, and for our communities.

Addressing the staffing problems must prioritize the health and safety of its correctional officers. Correctional officers whose physical or mental health is not good can burn out and leave their jobs, thus worsening the staffing challenges. And for those who do not change careers, their work suffers. This affects their ability to keep prisons safe and secure, to interact positively with those individuals who are incarcerated, and to manage effectively important institutional programming.

Ensuring the health and safety of correctional officers is also important to helping incarcerated people. One of the strongest motivational forces that can encourage a person to change is receiving genuine respect and support from another person. Anyone who has worked as a corrections officer knows that rapport and relationship building both keeps you safe and gets the job done. Safe institutions, good programming, reducing recidivism, and maximizing the potential for a law-abiding successful life to those individuals after release depends, therefore, on the health and safety of our correctional officers.

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Sadly, correctional officers may bring home their emotional challenges from work, which means that addressing staffing challenges will necessarily also help their spouses, significant others, and children, among others.

A HOLISTIC FOCUS ON THE HEALTH OF CORRECTIONAL STAFF.

Focusing on the physical and mental health of our correctional staff is vitally important. We have no other choice. Consider that whereas roughly 1 in 7 combat veterans reports experiencing symptoms of PTSD, approximately 1 in 3 correctional officers experiences these symptoms, making correctional officers more than twice as likely to suffer from PTSD than someone who literally went to war. Multiple studies have found they have higher rates of PTSD and suicide than both police and military veterans, including those who saw combat in Iraq and Afghanistan.¹³

Investing in improving the behavioral health of correctional officers requires us to first understand that many of them suffer trauma from their job. We have to find new ways of addressing their trauma and look to when government has made investments in similar circumstances even when resources were scarce. A holistic approach, indeed, involves addressing mindfulness and emotional intelligence.

After all, high vacancy rates mean correctional officers are challenged every day about how to optimize their physical and mental health and their ability to manage and cope in and out of work. Correctional officers are mothers and fathers, mentors, coaches, and caretakers. They are connected to their communities. Their communities suffer when they suffer, and ultimately benefit when we can identify ways of helping them heal and recover.

As a society, we have begun to better understand trauma—its causes and its effects and how it can be managed. We can utilize the research that has gone into addressing trauma in other circumstances and apply it to the corrections population.

I am reminded of a former Navy SEAL, Jason Henderson, whose hands-on training in combat-proven techniques through his non-profit, Four Pillars Collective, have been effective in the mental and physical management of a crisis.¹⁴ This is the type of holistic healing we need in our corrections field.

THE CORRECTIONS FIELD NEEDS TO BE INNOVATIVE AND IMPROVE ITS TECHNOLOGICAL AND INTELLECTUAL CAPACITIES.

Addressing the problems associated with staffing challenges also requires innovation.

As in any other area of community safety, investing in this field is critical. Governmental appropriations on the federal, state, and local level can help address wage disparities, outdated facilities, and antiquated equipment. But improvements require so much more.

The present technological and intellectual capacities of the field are not sufficient. For example, a data repository that captures and reports critical metrics on the workforce and operational characteristics

¹³ <https://www.rand.org/pubs/monographs/MG720.html>; James, Lois, and Natalie Todak "Prison employment and post-traumatic stress disorder: Risk and protective factors." *American journal of industrial medicine* 61, no. 9 (2018): 725-732; Spinaris, Caterina G., Michael D. Denhof, and Julie A. Kellaway. "Posttraumatic stress disorder in United States corrections professionals: Prevalence and impact on health and functioning." *Desert Waters Correctional Outreach* (2012): 1-32.

¹⁴ <https://www.fourpillarscollective.com/about>

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of corrections would be helpful. While data about law enforcement agencies and activities are well-captured and published, corrections data is much harder to find. Publicly available data on prisons and jails improves transparency with the public but also increases the visibility of a sector of agencies allowing people to better recognize them as part of their communities. The field also needs more research and evaluation, and improving the collection of and maintenance of data could help foster this needed work.

Technology can also convert complex processes and decisions that require use of valuable time by corrections officers into simple and teachable rules-based work that can eventually become automated. Corrections is in need of innovation on a scale that we call "disruptive." Disruptive innovation can help us reframe our approach, including replacing existing practices with those that are more efficient, effective, and productive.

Practices borne from disruptive innovation can particularly benefit local jails, which frequently experience budget shortfalls, struggle with understaffing (especially in rural areas), and manage a needy population.

The ability of state and local corrections directors to be innovative is challenging. The political environment does not necessarily allow them to take reasonable and informed risks, to think outside of the box. Having a space to identify and discuss new ideas, some of which may be novel but borne of a thoughtful and innovative approach, is central to improving the intellectual capacity of the profession.

THE WORK OF KRJC

I would be remiss if I did not tell you how I am now trying to contribute to elevating community safety and the health and wellness of corrections professionals. I recently founded the Keystone Restitutive Justice Center, which is a non-profit organization in Pennsylvania, to try to achieve many of the goals I have outlined. Our Executive Director is Greg Rowe, who is the former Director of the Pennsylvania District Attorneys Association and before that served as the criminal justice policy advisor in the Rendell Administration. We provide accessible and translatable, data-driven solutions to the field of corrections and community safety. By focusing on proactive, preventative work that provides support to institutions, agencies, and communities, our work will help them meaningfully improve outcomes.

In addition to the federal work I described earlier, we will also be working on correctional staffing challenges in Pennsylvania. And we will be networking "learning communities" of Pennsylvania's counties, where we will work with stakeholders and others whose voices must be heard, including individuals directly affected by the systems and policies we are examining and the decisions we may make. We will employ a "pull strategy" to work out sustainable solutions, not overly simplistic solutions to wrongly defined problems, but rather responsive solutions we will shape from a clear understanding of the challenges our institutions and affected individuals face. To do this, we will be focusing on Pennsylvania's counties whose leaders are most ready for and excited by innovation. Some of our work will involve quantifying information and analyzing data to determine the kinds of technology needed to make fundamental performance improvements. A component of the learning communities that we are very excited about is the potential to partner with the Pennsylvania State System of Higher Education to utilize the 10 universities across Pennsylvania as intellectual thought partners in our work with county community safety systems. Our work with the universities can help to keep bright young minds in Pennsylvania in order to work in these systems and to provide research and data support for the counties as well.

Another significant challenge is our behavioral health system. Utilizing a similar approach, we will subsequently partner with some of the same counties to help foster and enhance prosecutor led behavioral

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diversion. Indeed, our prisons have become the largest behavioral health treatment facilities. And we need to work to change this unfortunate fact.

This is the opportunity to use technology and innovation to make positive and real change. Indeed, in exploring ways other sectors have a role, I spoke with Ann Christenson of the Christensen Institute, who observed that there are opportunities for using technology and innovation to make meaningful and quantifiable changes to the experiences correctional staff and incarcerated people actually feel, without overhauling infrastructure or significantly interrupting operations.

CONCLUSION

I greatly appreciate your time and attention this afternoon. The need to work to address the incredible staffing challenges is great, and all systems and all players need to be involved. Our staffing challenges are not going away anytime soon, and we must be thoughtful, imaginative, inclusive, dynamic and thorough as we ensure that our correctional officers, prisons, jails, incarcerated people and communities as a whole are safe and healthy.



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**WRITTEN STATEMENT OF
BRANDY MOORE WHITE
NATIONAL PRESIDENT
COUNCIL OF PRISON LOCALS**

FOR THE

**SENATE JUDICIARY: SUBCOMMITTEE ON CRIMINAL JUSTICE AND
COUNTERTERRORISM**

***“The Nation’s Correctional Staffing Crisis: Assessing the Toll on
Correctional Officers and Incarcerated Persons”***

**PRESENTED:
February 28, 2024**

I would like to sincerely thank the Sub-committee for this opportunity to present the perspective of our federal prison system from the professional, hard-working, men and women, of the Federal Bureau of Prisons. For far too long this conversation has been missing a key element; the professional law enforcement officers that have dedicated their lives in service to ensuring safety, rehabilitation, and the fair treatment of inmates in our care, as well as, protecting their coworkers and communities.

The Council of Prison Locals represents nearly 30,000 correctional professionals, across the country, in 121 federal prisons. These professional law enforcement officers, who work tirelessly in some of the most violent self-contained 'cities' in the country, keep us all safe from some of the world's most dangerous human beings.

Today I would like to discuss our primary concerns, which are the current critical staffing level and pay structure within the Bureau of Prisons, that pose significant challenges and must be addressed urgently. Staffing levels in the Bureau of Prisons have reached alarming levels. Over the past seven years, the authorized positions within the Bureau have decreased from 43,369 to the current count of 34,470 staff members. This reduction of nearly 8,900 staff members not only compromises the safety and security of both staff and inmates, but it also raises major concerns and hinders our ability to effectively carry out the Bureau's mission of rehabilitation and reintegration.

The impact of these staffing cuts is particularly evident among our Correctional Officers. Despite the President's request and subsequent legislation, the number of correctional officer positions falls short of

what has been allocated by Congress. As of the end of 2023, we have approximately 12,300 correctional officers, which is over 8,000 or 40% below the appropriated number of 20,446. This number follows a year of “hiring initiatives” enacted by the agency.

With the current staffing levels in the Bureau of Prisons, the First Step Act cannot be successfully enacted. Staff used for programming are often pulled from their positions and used to backfill shortages of Correctional Officers, a process known as augmentation. Augmentation reduces inmate access to recidivism by reducing activities like programming, recreation, and education initiatives. Additionally, because of the lack of staffing, correctional officers are forced to do mandatory overtime. Officers are frequently mandated at the last minute to stay an additional 8 plus hours, often several times a week. This diminishes skills and awareness, reduces acuity, and causes general fatigue which greatly hinders supervision.

Augmentation and mandatory overtime have become the “norm”. This detracts from programming, compromises the safety and security of the institutions, but it also greatly affects the mental health and well-being of our employees. Even without staffing shortages, corrections staff are among the highest rated profession to have Post Traumatic Stress Disorder (PTSD), suicide, and divorce rates. We do not yet know the full toll of working in excess of 60-hour work weeks in this environment will take on employees mental health.

The Council believes that the staffing crisis can only be resolved by addressing the insufficient pay band issue. The current pay structure within the Bureau is significantly lower than that of other Federal Law Enforcement Agencies, including the US Marshals, Immigration and

Customs (ICE), and Border Patrol. Additionally, the Bureau's pay scale is non-competitive with state and local law enforcement positions and even the private sector market.

Without addressing this pay disparity, the Bureau will continue to struggle to attract and retain employees. The Bureau must be required to increase pay bands to correct the staffing crisis. Because the Bureau is unable to solve its biggest problem it now requires the direct intervention of the Administration, OPM, and the legislative authority of Congress to immediately correct the pay deficiencies within the Federal Bureau of Prisons. In the past the salary and benefits were what drew individuals to come to work for the Bureau. The Bureau attracted highly qualified and motivated staff. Today, there is nothing attractive about working for the Bureau. It is a high stress job, the pay and benefits are not competitive, we are augmented, forced to work mandator over time, it is shift work including weekends and holidays, subject to government shutdown going weeks without pay, and work day in and day out with individual who have been convicted of crimes that society has deemed unfit to be in the community who do not want to be in prison.

The current starting salary for a correctional officer is \$46,495. At the end of their career, they make \$70,679. This is far below what ICE and Boarder Patrol make. Their starting salary is \$46,696 and their ending salary is \$107,680. That is a \$37,000 difference. Additionally, there are currently county and state police departments offering up to a \$75,000 sign on bonus.

Another pressing issue that will directly affect our ability to retain staff is proposed legislation that would eliminate the use of solitary confinement. Eliminating the Special Housing Unit would make prisons less safe for inmates and the staff inside these institutions, thereby causing more staff to leave the agency. Special Housing is a tool to utilize when inmates cannot follow the rules or when inmates request to be placed there for their own safety. While there have been many disparaging reports in regard to the use of Special Housing over the years, the outright elimination of it will not have a positive effect. The Council remains dedicated to finding reforms and ways to make its utilization more appropriate. We would welcome working with Congress on potential reforms and we have already offered a major reform to the Director of the Bureau of Prisons and her staff.

Additionally, our infrastructure is in disarray. For years the Bureau has either not requested or been funded to a level to even maintain our infrastructure, let alone improve it. Therefore, a lot of prisons need a significant amount of work to be up to standards for our staff and inmates housed in these facilities.

Furthermore, the low morale from all the things mentioned above; high-stress dangerous career, staffing shortages, mandated overtime, augmentation, crumbling infrastructure, and pay disparity within the Bureau has led to difficulty in attracting and retaining qualified personnel. Another government shutdown will only complicate matters even further.

It is imperative that immediate action be taken to address this issue and ensure the Bureau has the necessary resources and support to fulfill its

mandate effectively. This includes increasing staffing levels to safe and manageable ratios, implementing competitive pay structures, and providing adequate training and wellness support for all personnel. By investing in the workforce of the Bureau, we can improve the overall functioning of the federal prison system and enhance the public safety outcomes.

I urge the subcommittee to prioritize these matters and work towards implementing comprehensive solutions that will strengthen the Bureau and promote a more just and effective criminal justice system.

The Council of Prison Locals has worked diligently with members of Congress to properly fund the Federal Bureau of Prisons. However, even with additional funding there continues to be a decline in correctional officers. Congress must now demand oversight and accountability.

The Bureau of Prisons staffing has graduated from a crisis to a catastrophe with real human consequences. The Bureau must use the funding that has been appropriated to fully hire the correctional officers needed to safely house incarcerated inmates. In order to achieve this, efforts must be made to raise the pay bands to make our Federal Law Enforcement Officers competitive with other law enforcement agencies.

Chairman Booker, Ranking Member Cotton, and Members of the Subcommittee, this concludes my formal statement. I look forward to answering your questions and providing additional insight. Thank you for your attention to these important issues, and I look forward to your

continued support and leadership in addressing these critical issues within the Federal Bureau of Prisons.

Senate Judiciary Committee
Hearing on “The Nation's Correctional
Staffing Crisis: Assessing the Toll on
Correctional Officers and Incarcerated Persons”
March 10, 2024
RESPONSE to Questions for the Record

ORIGINAL QUESTION: For Ms. Santia Nance, Impacted Person and Co-Founder, Sistas in Prison Reform

For many years, Senator Cornyn and I have led the One Stop Shop Community Reentry Program Act to help former inmates reintegrate into their communities by creating resource centers that will help them find jobs, housing, mental health services, and substance abuse treatment.

- *Are there other steps Congress can take to help incarcerated individuals prepare for this transition?*

RESPONSE BY SANTIA NANCE:

Hello Senator Amy Klobuchar,

Thank for your work helping current and former incarcerated people, and for your thoughtful question.

In my experience, I have noticed that the re-entry process has potential to be done MUCH earlier in the process during incarceration. In Virginia, the best programs don't become available until you're at 2 years or below prior to release, which means that there are thousands of incarcerated people who are not eligible for re-entry programming. They are also subject to be wait-listed due to a limited number of spots, and waiting to be transferred to lower-level facilities where most of those programs are offered.

My loved one, Quadaire, who received a 20-year sentence, initiated early rehabilitation on his own, as there were no progressive programs available to him earlier in his incarceration due to how much time he had left to serve.

He spent his time reading as many books as he could and studied meditation and tai chi. He has offered advice and leadership on these subjects (although most of it is informal) and he organizes programs and events for those in his facility, and others in Virginia through Brilliance Behind Bars (a website I manage that gives incarcerated folks a chance to write essays). Since we reconnected, I was able to get

him enrolled at Ohio University taking print-based classes, and this was the icing on the cake for him as he felt so much more empowered, capable, and ready for society.

In the past he has said ‘Most people are in here because we didn’t understand society and how it works, and we lacked education.’ A lot of the incarcerated populations are there due to being poor and without a stable environment. Access to higher education could give them a sense of control of their lives moving forward, along with something to hold their attention and give them hope and focus. This could go beyond classes, but even offering more extracurricular and interest-based clubs and organizations, just like universities. It would allow them to see the world better and allow a true adjustment to society as a returning citizen.

While it’s understood that there are SOME higher education opportunities available for few, it should be a true option for all incarcerated people at all points of their confinement. I always like to say – what if we sent people who committed crimes to college instead of prison? How much better would our country truly be?

Thank you again for your question. Please do not hesitate to reach out with further questions.

Santia Nance

Senator Amy Klobuchar
Re: Senate Judiciary Committee
Hearing on "The Nation's Correctional
Staffing Crisis: Assessing the Toll on
Correctional Officers and Incarcerated Persons"

Senator, Thank you for your concern about the impacts of the staffing crisis on people in America's carceral environment. We are appreciative of your inquiry and believe it is prudent to confront the mechanism of accommodation during this crisis—augmentation. We offer the following recommendations, understanding that they are temporary and intermediary steps toward addressing the more significant problem.

Recommendations

- 1) Legislation for the study of utilization and regulation of augmentation, enhanced training, and comprehensive worker support:
 - a) Convene a select subcommittee to evaluate BOP practices, including augmentation use, ensuring transparency, accountability, and adjustments based on effectiveness, and set clear guidelines and limits for augmentation, ensuring it is only temporary under specific conditions.
 - b) Training and Support for Staff:
 - i) Implement comprehensive training programs for non-custodial staff assigned to custodial roles. These programs should cover operational aspects of correctional work, stress management, conflict resolution, and holistic self-care techniques.
 - c) Enact legislation to increase funding for hiring additional correctional staff, directly addressing staffing shortages to reduce reliance on augmentation.
 - d) Enhance and expand incentive programs, ensuring they are competitive and consistent across all facilities, to attract and retain staff, thereby reducing the necessity for augmentation.
- 2) Recommendation that all corrections departments prioritize the establishment of an Office of Corrections Ombudsman.
 - a) Establishing such an office would allow correctional departments to conduct extensive research to monitor the understaffing crisis, analyze recruitment and retention successes and failures, and assess the overall well-being of correctional staff and incarcerated individuals. This would ensure a comprehensive review of the critical issues affecting the system's efficiency and the welfare of all those impacted.

Respectfully,
Stephen B. Walker
Director, National Wellness
OneVoice United



Response from John Wetzel, Founder and Board Chair of the Keystone Restituere Justice Center, to Question from Senator Klobuchar

Senate Hearing on "The Nation's Correctional Staffing Crisis"

Submitted on March 20, 2024

Question from Senator Klobuchar: Are there ways Congress can help improve the way infrastructure projects are administered to ensure that resources are helping those in the field innovate and improve?

Response:

Opportunities such as innovative grants and other forms of funding, demonstration and pilot projects, or traditional budgetary line-items could encourage the use of cross-systems collaboration and innovation. Funding, to be sure, is certainly important because correctional officers need to be paid a competitive wage, and our facilities and the technology within those facilities cannot be antiquated. But better funding without any other assistance is insufficient.

Cross-systems collaboration and innovation can help us achieve an infusion of intellectual capacity that the field so desperately needs. For example, we can incentivize academia intellectual investment. Our public colleges could create tracks for students interested in working in the corrections field. They could also integrate aspects of their research departments into the corrections field to help ensure the collection and analysis of data, which ultimately would help the field utilize best practices and rely on current and timely data. The National Institute of Justice has embedded researchers in practitioner and community-based entities. This is a strong model. Moreover, students at the universities could participate in data collection and analysis as well, thus helping educate them about the correctional field, in addition to quantitative analysis. Additionally, our medical institutions could provide guidance on advancing both physical and mental wellness among correctional staff.

Technology sector intellectual investment can occur as well. Technology institutions could help correctional departments stay abreast of technological advances, thus ensuring modernized technology correctional systems.

And, finally, non-profits that engage in leadership projects could also help correctional leaders learn about management and leadership, skills that can only make the workforce more content and satisfied.

These are only possible examples of collaboration ideas, but Congress could consider providing grant opportunities to states and local government to improve the well-being of correctional systems and employees by incentivizing these kinds of cross-system collaboration.



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**RESPONSE TO QUESTIONS FOR THE RECORD
BRANDY MOORE WHITE
NATIONAL PRESIDENT
COUNCIL OF PRISON LOCALS**

FOR THE

**SENATE JUDICIARY: SUBCOMMITTEE ON CRIMINAL JUSTICE AND
COUNTERTERRORISM**

***“The Nation’s Correctional Staffing Crisis: Assessing the Toll on
Correctional Officers and Incarcerated Persons”***

I would like to sincerely thank the Sub-committee for the opportunity to present the perspective of our federal prison system from the professional, hard-working, men and women, of the Federal Bureau of Prisons.

Thank you for the inquiry regarding immediate steps to improve the morale and wellness of the employees. After careful consideration and analysis, it is evident that implementing a 35% pay increase for our staff members would be the most efficient and effective way to boost morale within our workforce.

A pay raise not only provides tangible benefits to our employees but also serves as a clear demonstration of our commitment to recognizing their hard work and dedication. By offering a competitive salary package we can attract and retain top talent, boost employee morale, and foster a positive work environment conducive to productivity and success for both the staff and the inmates we house.

Research has shown that financial incentives are powerful motivators and can significantly impact employee morale and engagement. In addition to addressing immediate concerns related to our critical staffing numbers, a pay increase can also lead to increased safety, morale, improved performance, and reduced turnover rates, all of which are crucial for the long-term success of our organization.

Additionally, if we are able to attract and retain staff, we would have more opportunities to create wellness programs and have much needed training for the staff. As I am sure you are aware mental health awareness for correctional staff is essential to long term wellness.

We believe that investing in our employees through a pay increase is not only the fastest but also the most effective way to boost morale and enhance overall organizational performance. We are committed to prioritizing the well-being and satisfaction of our staff members and are confident that this strategic decision will yield positive results for both our employees and our organization as a whole to include the inmates in our care.

Thank you for your attention to this matter and please do not hesitate to reach out if you require any further information or clarification.



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February 28, 2024

The Honorable Cory Booker
Chair, Judiciary Subcommittee on
Criminal Justice and Counterterrorism
United States Senate
Washington, D.C. 20510

The Honorable Tom Cotton
Ranking Member, Judiciary Subcommittee
on Criminal Justice and Counterterrorism
United States Senate
Washington, D.C. 20510

Dear Chairman Booker and Ranking Member Cotton:

On behalf of the 1.4 million members of the American Federation of State County and Municipal Employees (AFSCME), including 85,000 correctional officers, I request that you include this letter into the record for the February 28, 2024, Subcommittee hearing entitled, "The Nation's Correctional Staffing Crisis: Assessing the Toll on Correctional Officers and Incarcerated Persons."

No group of individuals understands better the toll of the nation's correctional staffing crisis than AFSCME corrections members. Our members work in both maximum- and minimum-security facilities, state prisons and county jails, juvenile detention centers and forensic hospitals. AFSCME shows our respect for public safety workers by fighting for better pay and benefits, expanded bargaining rights, safer working conditions, and to uphold the standard of professionalism for those in these public safety jobs.

America's correctional institutions are in a dire crisis. Violence, death, sexual abuse, undelivered health services, cancelled rehabilitation programs, escapes and community endangerment have become far too common. All these concerns are connected to and exacerbated by a national staffing shortage in corrections. We applaud you for highlighting this problem through this hearing and urge you to maintain focus on how improvements in correctional staffing can improve our nation's overall criminal justice and rehabilitation systems. Chronic correctional staffing shortages cause operational disruptions that in turn exacerbate existing safety issues, feeds overcrowding, damages rehabilitation efforts and leads to problems retaining needed staff. The high employment vacancy rates threaten a correctional facility's ability to implement appropriate security and safety, putting inmates and staff at risk. Correctional staffing shortages are happening at every level of government, from local jails to state and federal penitentiaries. It is a national problem that requires sustained action.

Some examples of the corrections staffing crisis include:

- In 2023, Maryland AFSCME Council 3 conducted a post-by-post staffing analysis documenting vacancies in correctional facilities across the state and found that an additional 3,417 officers were needed to safely operate Maryland's 19 correctional

facilities.¹ Moreover, **staffing ratios of inmates to officers can exceed 100 inmates to just one corrections officer.** In the same staffing analysis AFSCME Council 3 encountered a shift in which no corrections officer was on duty due to severe staff shortages threatening inmates' safety and health.

- The United States Department of Justice (DOJ) noted **a direct correlation between the shortage of correctional officers in Alabama's prisons for men and the violence, sexual abuse and death of their inmates.** According to a staffing report from 2018, the Alabama Department of Corrections (ADOC) employed just 1,072 out of 3,326 authorized correctional officer positions.² News reports called the prison a "humanitarian crisis."³
- In California's Alameda County Psychiatric Hospital and Santa Rita Jail, DOJ investigators concluded that **"when there are not sufficient security personnel present, mental health staff are hampered in their ability to see prisoners."** And that "in over 85% of the charts our expert reviewed for this issue, there was a notation of a deputy shortage, resulting in limitations on the ability of mental health staff to adequately assess prisoners."⁴
- In Florida's Lowell Correctional Institution, **"[s]evere staffing shortages at Lowell result in inadequate supervision of women prisoners, exposing them to the substantial risk of harm from sexual abuse."**⁵
- In Philadelphia, Pennsylvania, mounting violence, inmate murders,⁶ forced lockdowns, and missed medical and mental health treatment resulted in a **federal court settlement that requires hiring and retention bonuses for Correctional Officers as a way to address chronic staffing shortages in the City's jails.**⁷
- In Massachusetts, the DOJ's designed qualified expert found that the state has **"[i]nadequate staffing levels (both security and mental health) to ensure out-of-cell therapeutic activities for prisoners on mental health watch."**⁸

There are several national and local factors contributing to our nation's correctional staffing shortage, including, but not limited to, a significant lack of investment in front-line staff, the prohibition or elimination of workplace and collective bargaining rights, and policy reforms that ultimately undermine the health and safety of everyone within the facility. The lack of investment and support creates a vicious cycle that affects employees and inmates mental and physical health. For employees, a lack of investment means excessive mandatory overtime, increased workloads, burnout, physical and mental stress that impacts recruitment efforts. For inmates, chronic understaffing causes operational disruptions that in turn exacerbate existing health and safety issues such as time out of their

¹ https://www.afscme.org/2022-23_afscme_staffing_analysis_-_final_0.pdf

² <https://www.justice.gov/crt/case-document/file/1344026/download>

³ <https://www.politico.com/news/2021/12/01/alabama-prisons-humanitarian-crisis-523548>

⁴ <https://www.justice.gov/crt/case-document/file/1388891/download>

⁵ <https://www.justice.gov/crt/case-document/file/1347766/download>

⁶ <https://www.nbcphiladelphia.com/investigators/inmates-murdered-inside-philly-jails-amid-staff-shortages/2812072/>

⁷ <https://www.documentcloud.org/documents/21583993-philadelphia-prison-settlement-agreement>

⁸ <https://www.justice.gov/media/1289391.dl?inline>

cell. High vacancy rates threaten a correctional facility's operation security and safety putting correctional staff and inmates at risk.

In Iowa, the staffing crisis contributed to the murder of two AFSCME members,⁹ Officer Robert McFarland and Nurse Lorena Schulte. For years, AFSCME Council 61 sounded the alarm about the state's refusal to take the necessary steps to attract, hire and retain more departmental employees. The state instead took steps to make the staffing shortages worse by defunding the public safety department¹⁰ and stripping collective bargaining rights that included the ability to negotiate over safety issues at their facilities.¹¹ Following the murders of Officer McFarland and Nurse Schulte, the state has taken some action to improve safety and ease chronic understaffing, but actions to date have been inadequate and significantly more still needs to be done.¹²

State and local governments cannot address this issue alone. In the absence of congressional action, we will continue to see the deterioration of our correctional system, yet there are steps that can be taken to help support the correctional staff and inmates. AFSCME urges Congress to pass the bipartisan Fighting Post Traumatic Stress Disorder (S. 645, H.R. 472), the Public Safety Officer Concussion and Traumatic Brain Injury Health Act (S. 894, H.R. 2548), and significantly increase funding for the Byrne Justice Award Grant program that funds state and local public safety and rehabilitation initiatives.

Chronic understaffing of corrections officers and staff is a national issue that continues to pervade our justice system putting workers, inmates and the public's safety at risk. The employment conditions and services provided within correctional facilities have a direct impact not only on those who work or are incarcerated, but also the entire local community, state and our nation. The staffing crisis in corrections must be addressed. AFSCME stands with our corrections officers and urges Congress to address this issue expeditiously.

Sincerely,



Edwin S. Jayne
Director of Federal Government Affairs

ESJ:CF:lm

cc: Members of the Judiciary Subcommittee on Criminal Justice and Counterterrorism

⁹ <https://www.desmoinesregister.com/story/news/2021/12/20/anamosa-review-iowa-department-corrections-prison-staffing-security-shortcomings/8914022002/>

¹⁰ <https://www.afscme.org/blog/iowa-prison-worker-deaths-prompt-urgent-call-for-reforms>

¹¹ <https://www.afscme.org/blog/council-61-members-stand-up-for-their-collective-bargaining-rights>

¹² <https://www.afscme.org/blog/iowa-corrections-package-is-good-but-not-good-enough>

CIVIL ACTION NO. 2:14cv601-MHT (WO)
United States District Court, M.D. Alabama, Northern Division.

Braggs v. Dunn

257 F. Supp. 3d 1171 (M.D. Ala. 2017)
Decided Jun 27, 2017

CIVIL ACTION NO. 2:14cv601-MHT (WO).

06-27-2017

Edward BRAGGS, et al., Plaintiffs, v. Jefferson S. DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections, et al., Defendants.

Andrew Philip Walsh, Patricia Clotfelter, William Glassell Somerville, III, Baker Donelson Bearman Caldwell & Berkowitz PC, Birmingham, AL, Brent L. Rosen, Baker Donelson Bearman Caldwell & Berkowitz PC, Brooke Menschel, Ebony Glenn Howard, Jack Richard Cohen, Latasha Lanette McCrary, Maria V. Morris, Rhonda C. Brownstein, Montgomery, AL, Eunice Cho, Atlanta, GA, James Patrick Hackney, William Van Der Pol, Jr., Tuscaloosa, AL, Miriam Fahsl Haskell, Miami, FL, Jaqueline Aranda Osorno, Natalie Lyons, Kristi L. Graunke, Caitlin J. Sandley, Southern Poverty Law Center, Montgomery, AL, for Plaintiffs. Anne Adams Hill, Elizabeth Anne Sees, Joseph Gordon Stewart, Jr., Alabama Department of Corrections, Montgomery, AL, Bryan Arthur Coleman, Evan Patrick Moltz, Luther Maxwell Dorr, Jr., Mitchell David Greggs, Mitesh Bansilal Shah, Maynard, Cooper & Gale, PC, Birmingham, AL, David Randall Boyd, John Garland Smith, John W. Naramore, Balch & Bingham LLP, Montgomery, AL, Jenelle Rae Evans, Michael Leon Edwards, Steven C. Corhern, John Eric Getty, Susan Nettles Han, Balch & Bingham, LLP, Birmingham, AL, Matthew Reeves, William Richard Lunsford, Christopher Stephen Kuffner, Melissa K. Marler, Michael Paul Huff, Stephen Clarence Rogers,

Maynard Cooper & Gale, PC, Huntsville, AL, Christopher Fred Heiness, The Heiness Law Firm, LLC, Birmingham, AL, for Defendants.

Myron H. Thompson, UNITED STATES DISTRICT JUDGE

Andrew Philip Walsh, Patricia Clotfelter, William Glassell Somerville, III, Baker Donelson Bearman Caldwell & Berkowitz PC, Birmingham, AL, Brent L. Rosen, Baker Donelson Bearman Caldwell & Berkowitz PC, Brooke Menschel, Ebony Glenn Howard, Jack Richard Cohen, Latasha Lanette McCrary, Maria V. Morris, Rhonda C. Brownstein, Montgomery, AL, *1179 Eunice Cho, Atlanta, GA, James Patrick Hackney, William Van Der Pol, Jr., Tuscaloosa, AL, Miriam Fahsl Haskell, Miami, FL, Jaqueline Aranda Osorno, Natalie Lyons, Kristi L. Graunke, Caitlin J. Sandley, Southern Poverty Law Center, Montgomery, AL, for Plaintiffs.

Anne Adams Hill, Elizabeth Anne Sees, Joseph Gordon Stewart, Jr., Alabama Department of Corrections, Montgomery, AL, Bryan Arthur Coleman, Evan Patrick Moltz, Luther Maxwell Dorr, Jr., Mitchell David Greggs, Mitesh Bansilal Shah, Maynard, Cooper & Gale, PC, Birmingham, AL, David Randall Boyd, John Garland Smith, John W. Naramore, Balch & Bingham LLP, Montgomery, AL, Jenelle Rae Evans, Michael Leon Edwards, Steven C. Corhern, John Eric Getty, Susan Nettles Han, Balch & Bingham, LLP, Birmingham, AL, Matthew Reeves, William Richard Lunsford, Christopher Stephen Kuffner, Melissa K. Marler, Michael Paul Huff, Stephen

Braggs v. Dunn 257 F. Supp. 3d 1171 (M.D. Ala. 2017)

Clarence Rogers, Maynard Cooper & Gale, PC, Huntsville, AL, Christopher Fred Heiness, The Heiness Law Firm, LLC, Birmingham, AL, for Defendants.

LIABILITY OPINION AND ORDER AS TO PHASE 2A EIGHTH AMENDMENT CLAIM

Myron H. Thompson, UNITED STATES DISTRICT JUDGE

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I. INTRODUCTION

The plaintiffs in this phase of this class-action lawsuit are a group of seriously mentally ill state prisoners and the Alabama Disabilities Advocacy Program (ADAP), which represents mentally ill prisoners in Alabama. The defendants are the Commissioner of the Alabama Department of Corrections (ADOC), Jefferson Dunn, and the Associate Commissioner of Health Services, Ruth Naglich, who are sued only in their official capacities. The plaintiffs assert that the State of Alabama provides constitutionally inadequate mental-health care in prison facilities and seek injunctive and declaratory relief. They rely on the Eighth Amendment, made applicable to the States by the Fourteenth Amendment and as enforced through 42 U.S.C. § 1983. Jurisdiction is proper under 28 U.S.C. § 1331 (federal question) and § 1343(a)(3) (civil rights).

After a lengthy trial, this claim is now before the court for resolution on the merits. Upon consideration of the evidence and arguments, the court finds for the plaintiffs in substantial part. Surprisingly, the evidence from both sides (including testimony from Commissioner Dunn and Associate Commissioner Naglich as well as that of all experts) extensively and materially supported the plaintiffs' claim.

II. PROCEDURAL BACKGROUND

This extremely complex case has been split into three phases: *Phase 1* involved claims under Title II of the Americans with Disabilities Act (ADA), codified at 42 U.S.C. § 12131 et seq., and § 504 of the Rehabilitation Act, codified at 29 U.S.C. § 794, claiming discrimination on the basis of physical disabilities and failure to accommodate those disabilities. The parties settled *Phase 1*. See *Dunn v. Dunn*, 318 F.R.D. 652 (M.D. Ala. 2016) (Thompson, J.). *Phase 2A* involves Eighth Amendment, ADA, Rehabilitation Act, and due-process claims regarding mental-health care. The parties settled the *Phase 2A* ADA and Rehabilitation Act claim. The due-process claims are pending before the court for settlement approval.¹ *Phase 2B* will focus² on medical-care and dental-care claims under the Eighth Amendment.

¹ Earlier in the litigation, the parties also reached a settlement regarding the distribution of razor blades to mentally ill prisoners.

This opinion resolves only the *Phase 2A* Eighth Amendment claim of inadequate mental-health care.² The court has certified a *Phase 2A* plaintiff class consisting of all persons with a serious mental illness who are, or will be, confined within ADOC's facilities, excluding Tutwiler Prison for Women and the work-release centers. See *Braggs v. Dunn*, 317 F.R.D. 634 (M.D. Ala. 2016) (Thompson, J.). While mentally ill prisoners at Tutwiler are not part of the class, ADAP, as

Alabama's designated protection and advocacy organization for the mentally ill, brought claims on their behalf. A seven-week trial followed.

² The defendants did not raise or re-argue exhaustion of administrative remedies during or after the trial, and did not argue exhaustion in their post-trial filings as a reason they should prevail. See Defendants' Post-Trial Brief (doc. no. 1282); see also *Dunn v. Dunn*, 219 F.Supp.3d 1100 (M.D. Ala. 2016).

III. FACTUAL BACKGROUND

Mental-health care in this opinion refers to screening, treatment, and monitoring of mental illnesses, as well as ADOC's policies and practices regarding mentally ill prisoners, including decisions on disciplinary sanctions and housing placements.³ Before diving in to the details of weeks' worth of testimony and thousands of pages of documentary evidence regarding mental-health care within ADOC, the court pauses to provide some background information on ADOC and its mental-health contractor, as well as a summary of the factual findings.

³ The provision of mental-health care to Alabama's prisoners has been litigated at least three times before. See *Laube v. Campbell*, 333 F.Supp.2d 1234 (M.D. Ala. 2004) (Thompson, J.) (approving settlement agreement that provides for inpatient care, suicide prevention and treatment, crisis intervention, and counseling services in a class-action lawsuit brought on behalf of women incarcerated in Alabama); *Bradley v. Harrelson*, 151 F.R.D. 422 (M.D. Ala. 1993) (Albritton, J.) (certifying a class of severely mentally ill male prisoners); *Pugh v. Locke*, 406 F.Supp. 318 (M.D. Ala. 1976) (Johnson, J.) (ordering the State to provide minimally adequate mental-health care, including identification of mentally ill prisoners and provision of care by qualified mental-health professionals), *aff'd and*

remanded sub nom. Newman v. Alabama, 559 F.2d 283 (5th Cir. 1977), *cert. granted in part, judgment rev'd in part on other grounds, and remanded sub nom. Alabama v. Pugh*, 438 U.S. 781, 98 S.Ct. 3057, 57 L.Ed.2d 1114 (1978).

A. ADOC Facilities and Organizational Structure

ADOC runs 15 major facilities (14 for men and the Tutwiler Prison for Women) and houses around 19,500 prisoners in its major facilities.⁴ Approximately 3,400 prisoners are on the mental-health caseload, meaning that they receive some type of mental-health treatment, such as counseling or psychotropic medications.

⁴ ADOC also houses an additional 4,500 prisoners in work centers and work-release centers, bringing the total population in custody to around 24,000.

MAJOR ADOC FACILITIES⁵

⁵ See Pl. Ex. 1260, September 2016 Monthly Statistical Report (doc. no. 1097-19).

1182*1182

Facility	Location	Population
Bibb	Brent	1847
Bullock	Union Springs	1522
Donaldson	Bessemer	1474
Draper	Elmore	1144
Easterling	Clio	1457
Elmore	Elmore	1186
Fountain	Atmore	1242
Hamilton	Hamilton	275
Holman	Atmore	941
Kilby Mt. Meigs	1126	Limestone Harvest
2214	St. Clair	Springville
975	Staton	Elmore
1382	Ventress	Clayton
1254	Tutwiler	Wetumpka
880		

Three of the major facilities, Bullock, Donaldson, and Tutwiler, serve as 'treatment hubs' for mental-health services, containing a residential treatment unit (RTU) and/or a stabilization unit (SU). These two types of units, together referred to as 'mental-health units' or 'inpatient-care units,' house and treat the most severely mentally ill prisoners. The rest of those on the mental-health caseload receive their care through outpatient services: they live in

a unit that is not focused on treatment and ordinarily must go to a different part of the prison to see a mental-health provider.

Under the administrative regulations governing ADOC's mental-health care, RTUs are for mental-health patients who suffer from "moderate impairment in mental health functioning" that puts them at risk in a general-population setting. Joint Ex. 107, Admin. Reg. § 613-2 (doc. no. 1038-130). RTUs are intended to provide a therapeutic environment to mentally ill patients and to help them develop coping skills necessary for placement in general population. RTUs can be 'closed,' meaning that each patient lives in an individual cell with little time spent outside the cell; 'semi-closed,' meaning that the patient still stays in an individual cell but is let out of ¹¹⁸³the cell more often; or 'open,' meaning that the patient lives in an open dormitory with other RTU patients.

SUs are for patients who are suffering from acute mental-health problems—such as acute psychosis or other conditions causing an acute risk of self-harm—and have not been stabilized through other interventions. SUs are intended to stabilize the patient as quickly as possible so that the patient can return to a less restrictive environment. All SU patients are housed in individual cells.

Altogether, the two male treatment hubs have 346 RTU beds and 30 SU beds: Bullock has 250 RTU beds and a 30-bed SU for male prisoners, and Donaldson has an additional 96-bed RTU. Tutwiler has 30 RTU beds and eight SU beds for women. These units provide services to about 2 % of ADOC's overall population.

ADOC is headed by Commissioner Dunn. Associate Commissioner for Health Services Naglich heads the Office of Health Services (OHS), which is responsible for overseeing the provision of medical and mental-health care to prisoners. ADOC uses private contractors to deliver medical and mental-health care services to prisoners. Under the mental-health contract with a

third-party vendor, OHS has access to the contractor's internal documents and records, and the contractor is required to send certain reports, such as monthly operating reports and annual contract-compliance reports, to OHS. The only OHS staff member with mental-health expertise is Dr. David Tytell, the chief clinical psychologist. Dr. Tytell serves as the main liaison between the mental-health contractor and ADOC, and communicates with the contractor's program director at least weekly. ADOC also directly employs 'psychological associates,' who are counselors responsible for conducting certain psychological tests at intake and for providing group sessions and classes for non-mentally ill prisoners. They report to their respective facilities' wardens, rather than OHS or the mental-health contractor.

B. MHM Organizational Structure

MHM Correctional Services, Inc. is ADOC's contractor for mental-health care. MHM is a for-profit corporation that provides medical and mental-health services to correctional facilities across the country.

MHM's regional office in Alabama is headed by its program director Teresa Houser. She serves as the main liaison between ADOC and MHM. Dr. Robert Hunter, a psychiatrist who serves as the medical director for the Alabama regional office, is charged with supervising psychiatrists and certified registered nurse practitioners (CRNP) stationed at various ADOC facilities. Both Houser and Hunter communicate frequently with ADOC officials, including Associate Commissioner Naglich and Dr. Tytell.

MHM employs a variety of administrative and clinical personnel to fulfill its contract with ADOC. In its regional office, Houser supervises various administrators and managers, such as the continuous quality improvement (CQI) manager, who conducts informal audits of MHM's performance, and the chief psychologist, who supervises psychologists and conducts training for

MHM employees. At the facility level, MHM employs site administrators to provide administrative oversight; these administrators are counselors by training. MHM also employs approximately 45 full-time 'mental-health professionals' (MHPs), who are masters-level mental-health counselors, at prisons across the State. As of December 2016, MHM employed four psychiatrists and eight CRNPs in Alabama; these providers are qualified to diagnose mental illnesses, prescribe psychotropic medication, and provide psychotherapy across multiple facilities. MHM also employs three psychologists and three registered nurses (RNs) for the entire State. The RNs are stationed at the three treatment hubs, Bullock, Donaldson, and Tutwiler; they administer medication, provide crisis intervention, and supervise the licensed practical nurses (LPNs) at their facilities. MHM employs approximately 40 LPNs, individuals with 12 to 15 months of health-care training. The LPNs are responsible for conducting mental-health intake at Kilby and Tutwiler, monitoring medication compliance, maintaining medication records, and conducting side-effects monitoring tests for psychotropic medications. While the LPNs stationed in the mental-health treatment units are supervised by the on-site RN, at all other places, including at intake screening, LPNs have no on-site supervision. Lastly, MHM employs six to eight activity technicians, who organize or assist in therapeutic, social, and recreational activities for patients in mental-health units.

C. Summary of Factual Findings

1. Fact Witnesses

Over the course of seven weeks, the court heard testimony as to whether ADOC's mental-health care violates mentally ill prisoners' constitutional rights. The trial opened with the testimony of prisoner Jamie Wallace, who suffered from severe mental illnesses, intellectual disability, and substantial physical disabilities. Wallace stated that he had tried to kill himself many times,

showed the court the scars on arms where he made repeated attempts, and complained that he had not received sufficient treatment for his illness. Because of his mental illness, he became so agitated during his testimony that the court had to recess and reconvene to hear his testimony in the quiet of the chambers library and then coax him into completing his testimony as if he were a fearful child. The court was extremely concerned, by what it had seen and heard from this plaintiff, about the fragility of his mental health. At the end of Wallace's testimony and out of his presence, the court informed the attorneys for both sides that it wanted a full report on his mental condition and the steps that were being taken to address that condition. Unfortunately, and most tragically, ten days after Wallace testified, he killed himself by hanging. Because it appeared that adequate measures may not have been put in place to prevent Wallace's suicide, the court put the parties into mediation to attempt to come up with immediate, interim procedures to prevent future prisoner suicides. The parties eventually came up with such procedures. Without question, Wallace's testimony and the tragic event that followed darkly draped all the subsequent testimony like a pall.

The plaintiffs' case then proceeded with testimony from Commissioner Dunn, who aptly described the prison system as wrestling with a "two-headed monster": overcrowding and understaffing. Dunn Testimony at 26. The court also heard from Associate Commissioner Naglich and MHM's program director Houser, for whom overcrowding and understaffing (both as to correctional staff, as noted by Dunn, and mental-health staff) were a mantra. They, with admirable candor, as with many other fact witnesses and the experts from both sides, essentially agreed that the staffing shortages, combined with persistent and significant overcrowding, contribute to serious systemic deficiencies in the delivery of mental-health care.

The inadequacies in the mental-health care system start at the door, with intake screening for prisoners who need mental-health care. ADOC boasts one of the lowest mental-illness prevalence rates among correctional systems in the country. But this is not because Alabama has fewer mentally ill prisoners than the rest of the country ¹¹⁸⁵or the best mental-health care system ^{*1185} for its prisoners; rather, according to experts from both sides, this is because a substantial number—likely thousands—of prisoners with mental illness are missed at intake and referrals for evaluation and treatment are neglected. As a result, many ADOC prisoners who need mental-health care go untreated.

Even when identified, mentally ill prisoners receive significantly inadequate care. Mental-health and correctional staffing shortages drive inadequate treatment. Individual and group counseling sessions are delayed or canceled due to shortages of counselors and correctional officers to escort prisoners to the sessions and to provide security. As a result, mental-health staff often have to resort to cell-side contacts, which cannot be considered substitutes for meaningful, confidential, out-of-cell appointments. Treatment planning is often pro forma and not individualized and fails to provide a meaningful and consistent course of treatment. Mental-health units intended as a therapeutic environment for the most severely ill prisoners operate like segregation units, with little counseling, therapeutic programming, or out-of-cell time. ADOC does not provide hospital-level care for those who need it.

ADOC also fails to provide adequate care to prisoners expressing suicidality and undergoing mental-health crises. Mental-health staff fail to use appropriate risk-assessment tools to determine suicide risk. ADOC has an insufficient number of crisis, or 'suicide-watch,' cells—special cells for the protection of suicidal prisoners. Because they have a limited number of cells to work with, they gamble on which prisoners to put in them and frequently discount prisoners' threats of self-harm

and suicide. The insufficient number of crisis cells also results in the use of unsafe rooms such as shift offices to house suicidal prisoners. The suicide-watch cells that do exist are dangerous: visibility into many of the cells is poor, making it difficult to monitor; many cells have tie-off points for ligatures that can be used for suicide attempts; dangerous items used for inflicting self-injury are often found. Prisoners in these cells receive less contact with and less monitoring by providers than the acuity of their condition demands. When they are released to general population or segregation, prisoners receive inadequate follow-up.

ADOC's segregation practices inflict further harm on prisoners suffering from inadequate mental-health care. Due to the effects of isolation, placement in segregation endangers mentally ill prisoners, and the risk of harm increases with the length of isolation and the severity of their mental illness. This danger is compounded by the limited access to mental-health care and monitoring available within ADOC's segregation units and dangerous conditions inside the cells. Despite these dangers, ADOC does not have a meaningful mechanism that prevents mentally ill prisoners from being placed in segregation for lengthy periods of time. Moreover, many mentally ill prisoners land in segregation due to symptoms of mental illness. This combination of conditions is often deadly: most suicides in ADOC occur in segregation.

For years, ADOC has failed to respond reasonably to these problems. Despite knowledge of serious and widespread deficiencies, it has failed to remedy known problems and exercised very little oversight of its mental-health care contractor. Associate Commissioner Naglich, who is in charge of contract monitoring, admitted that she has been aware of the contractor's deficient performance and inadequate quality-control process; however, she does not monitor the contractor to ensure that it provides minimally adequate care. Moreover, ADOC officials ¹¹⁸⁶admitted on the stand ^{*1186} that they have done

little to nothing to fix problems on the ground, despite their knowledge that those problems may be putting lives at risk.

The psychological and sometimes physical harm arising from these systemic deficiencies is palpable. Unidentified and under-treated mental illness causes needless pain and suffering in the form of persistent or worsening symptoms, decompensation,⁶ self-injurious behavior, and suicide. The skyrocketing suicide rate within ADOC in the last two years is a testament to the concrete harm that inadequate mental-health care has already inflicted on mentally ill prisoners.

⁶ Decompensation refers to exacerbation of symptoms of mental illness and impaired mental functioning; it calls for a "more structured or sheltered setting for more intensive treatment interventions." Burns Testimony at vol. 1, 173.

In fact, as explained earlier, the court had a close encounter with one of the tragic consequences of inadequate mental-health care during the trial. Over the course of the trial, two prisoners committed suicide, one of whom was named plaintiff Jamie Wallace. Prior to his suicide, defendants' expert, Dr. Patterson, concluded based on a review of Wallace's medical records that the care he had received was inadequate. Dr. Haney, a correctional mental-health care expert, met Wallace months before his death, while he was housed in a residential treatment unit, and in his report expressed serious concerns about the care he was receiving.⁷ Wallace's case was emblematic of multiple systemic deficiencies. Wallace testified, and his records reflected, that mental-health staff did not provide much in the way of consistent psychotherapeutic treatment, which is distinct from medications administered by nurses and cursory 'check-ins' with staff. MHM clinicians recommended that he be transferred to a mental-health hospital, but ADOC failed to do so. His psychiatrist at the time of his death testified that the medically appropriate combination of

supervised out-of-cell time and close monitoring when he was in his cell was unavailable due to a shortage of correctional officers. As a result, Wallace was left alone for days in an isolated cell in a treatment unit, where he had enough time to tie a sheet unnoticed; because his cell was not suicide-proof, he was able to find a tie-off point from which to hang himself.

⁷ During their meeting, Wallace began to cry, leaned over the interview table, and told Dr. Haney, with tragic prescience, "[T]his place is killing me." Joint Ex. 459, Haney Expert Report (doc. no. 1038-1043) at 40.

The case of Jamie Wallace is powerful evidence of the real, concrete, and terribly permanent harms that woefully inadequate mental-health care inflicts on mentally ill prisoners in Alabama. Without systemic changes that address these pervasive and grave deficiencies, mentally ill prisoners in ADOC, whose symptoms are no less real than Wallace's, will continue to suffer.

2. Expert Witnesses

Plaintiffs and defendants presented five experts in the correctional mental health and correctional administration fields.⁸ By and large, experts from both sides agreed that ADOC facilities are suffering from severe systemic deficiencies that are affecting the delivery of mental-health care. For example, experts from both sides agreed that ADOC suffers from severe overcrowding; correctional understaffing; mental-health staff shortages; deficient treatment planning; inadequate psychotherapy; inadequate use of mental-health units; inappropriate placement of segregation¹¹⁸⁷ inmates; and inappropriate use of segregation for mentally ill prisoners.

⁸ In a separate order with an opinion to follow, the court finds that four of the experts' methodologies survive *Daubert* challenges. No objection was raised against plaintiffs' expert Dr. Craig Haney.

Defendants' correctional mental-health care expert, Dr. Raymond Patterson, is a forensic psychiatrist who has worked for various state and federal correctional institutions as a provider and as a consultant. In preparation for his testimony, he reviewed the individual plaintiffs' medical records and deposition transcripts, visited and conducted audits of six facilities, and reviewed ADOC regulations, MHM policies and procedures, MHM monthly reports, and other expert reports. His conclusions regarding systemic deficiencies in ADOC's mental-health care system largely tracked those of Dr. Kathryn Burns, one of the plaintiffs' experts: he credibly concluded that ADOC needs more mental-health staff; ADOC's identification and classification of mental illness are inadequate; MHM's unlicensed practitioners should be supervised; treatment planning is deficient; too few patients are getting inpatient care; ADOC should provide hospitalization as an option for the most severely ill patients; and suicide prevention measures are inadequate.⁹

⁹ Based on his review of medical records and deposition testimony, Dr. Patterson also offered his opinions about whether individual plaintiffs' care was adequate. However, because this is a case alleging systemic inadequacies in the delivery of mental-health care, the court need not determine the adequacy of care for any particular individual. Furthermore, because Dr. Patterson did not meet with any of the plaintiffs, and deposition transcripts, by Dr. Patterson's own admission, are not a reliable source for determining credibility or making clinical diagnoses of an individual, the court gives little weight to his opinions as to whether the care provided to the individual plaintiffs was adequate.

Defense expert Robert Ayers is a correctional administration expert who has been involved in the California prison system for over 40 years. In preparation for giving his opinion, Ayers reviewed plaintiffs' expert reports, visited six facilities, and

talked with ADOC and MHM staff during those visits. He agreed with plaintiffs' experts that ADOC facilities are understaffed and overcrowded. He opined that ADOC's written policies related to mental-health care seemed to be adequate. However, he credibly explained that, mainly due to the severe understaffing and the lack of documentation, he had reasons to doubt that correctional officers and mental-health staff were actually complying with ADOC policies and procedures. He also concluded that ADOC was not providing an adequate level of care to all prisoners with mental-health needs.

Dr. Kathryn Burns, the chief psychiatrist for the Ohio Department of Rehabilitation and Correction, is a correctional mental-health expert for the plaintiffs. To prepare for her testimony, Dr. Burns visited nine major ADOC facilities, touring housing units, mental-health treatment areas, and crisis cells; she held formal interviews with 77 prisoners and spoke to an additional 25 prisoners at cell-front; she also reviewed documents such as medical records, ADOC regulations, MHM's quality-improvement (or 'continuous quality improvement' or 'CQI') and multidisciplinary-team meeting minutes, suicide tracking sheets, and audit results. Based on her review of this evidence, she identified a wide range of problems in the delivery of mental-health care, including: insufficient mental-health staffing and correctional staffing; inadequate identification and classification of mental illness; inadequate treatment, including cursory counseling appointments, inadequate treatment plans, dearth of group counseling, and inadequate use of mental-health units; and inadequate response to self-injurious behavior and mental-health crises. Dr. Burns credibly opined that these inadequacies, separately and taken together, subject mentally ill prisoners to a substantial risk of harm from untreated symptoms, continued pain and suffering, decompensation, self-injurious behavior, and suicide.

Dr. Craig Haney, a professor of psychology at the University of California Santa Cruz, is an expert for the plaintiffs in the psychological effects on prisoners of incarceration and particularly of segregation. His testimony focused on the state of segregation units and their impact on prisoners' mental health, based on his visits to seven facilities, interviews with numerous prisoners, and review of documents such as deposition transcripts of ADOC and MHM personnel, medical records, monthly statistical reports, and quality-assurance documents, among others. He testified that segregation units he saw were "degraded, dilapidated, deplorable," and that these units and conditions have a significant negative psychological impact on prisoners. Haney Testimony at vol. 1, 79. Furthermore, he explained how ADOC's segregation practices harm mental health of all prisoners, and especially that of prisoners who are already mentally ill.

Lastly, plaintiffs' expert Eldon Vail is a correctional administration expert who has worked in corrections for over 30 years. Vail toured seven prisons, spending a day at each, and conducted confidential interviews with 42 prisoners. He also reviewed ADOC policies and procedures, meeting minutes, reports and logs generated by ADOC, deposition testimony of ADOC and MHM personnel, and other documentary evidence. His testimony focused on matters of prison administration, including security, staffing, and behavior management, and the impact of these factors on the provision of mental-health care and on prisoners' mental health. He credibly testified that the level of correctional understaffing at ADOC was so low as to be "shocking," and that it has cascading effects on mental-health care: inadequate staff to transport prisoners to appointments and supervise treatment activities; inadequate staff to monitor segregation inmates, who have higher suicide risks; and overcrowded crisis cells filled with prisoners who feel unsafe due to violence in general-population dorms. Vail Testimony at vol. 1, 34.

IV. EIGHTH AMENDMENT LEGAL STANDARD

The Eighth Amendment's prohibition on "cruel and unusual punishments" extends to a State's failure to provide minimally adequate medical care that "may result in pain and suffering which no one suggests would serve any penological purpose." *Estelle v. Gamble*, 429 U.S. 97, 103, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976); *Harris v. Thigpen*, 941 F.2d 1495, 1504 (11th Cir. 1991) ("Federal and state governments ... have a constitutional obligation to provide minimally adequate medical care to those whom they are punishing by incarceration."). The State's obligation to provide medical care to prisoners includes psychiatric and mental-health care. *Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986) ("Failure to provide basic psychiatric and mental-health care states a claim of deliberate indifference to the serious medical needs of prisoners."). The 'basic' mental-health care that States must provide if needed by a prisoner includes not only medication but also psychotherapeutic treatment. *See Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) ("Even if this case involved failure to provide psychotherapy or psychological counselling alone, the court would still conclude that the psychiatric care was sufficiently similar to medical treatment to bring it within the embrace of *Estelle*."). The State's obligation remains even if it has contracted with private parties to provide medical care. *West v. Atkins*, 487 U.S. 42, 56, 108 S.Ct. 2250, 101 L.Ed.2d 40 (1988). That is, the State is ¹¹⁸⁹liable for the contractor's unconstitutional policies and practices if the contractor is allowed to determine policy either "expressly or by default." *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 706 n.11 (11th Cir. 1985).

To prevail on an Eighth Amendment challenge, plaintiffs must prove that prison officials acted with deliberate indifference to serious medical needs. *Estelle*, 429 U.S. at 105–06, 97 S.Ct. 285. This inquiry consists of both objective and

subjective tests. The objective test requires showing that the prisoner has "serious medical needs," *Estelle*, 429 U.S. at 104, 97 S.Ct. 285, and either has already been harmed or been "incarcerated under conditions posing a substantial risk of serious harm." *Farmer v. Brennan*, 511 U.S. 825, 834, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994). Subjectively, a prisoner must show that a prison official acted with deliberate indifference to that harm or risk of harm; that is, the official must have "known[] of and disregarded[] an excessive risk to inmate health or safety." *Id.* at 837, 114 S.Ct. 1970; see also *Farrow v. West*, 320 F.3d 1235, 1245 (11th Cir. 2003).

V. FINDINGS OF FACT AND CONCLUSIONS OF LAW

In this section, the court first discusses the basis for its finding that the plaintiffs have serious mental-health needs that require mental-health treatment. The court then lays out the common factors contributing to the substantial risks of harm in ADOC: shortages of mental-health staff, understaffing of correctional officers, and overcrowding. After that, the court proceeds through seven different ways in which ADOC's mental-health care system has caused actual harm and a substantial risk of serious harm; the treatment of mentally ill prisoners at Tutwiler; issues on which the court does not, at this time, find for the plaintiffs; and the defendants' knowledge of such harm and risks, and their failure to act in a reasonable manner to mitigate those risks. The section concludes with a discussion of the defendants' legal defenses based on *Ex parte Young*, 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908).

A. Serious Mental-Health Needs

To prove an Eighth Amendment claim based on inadequate mental-health care, plaintiffs must show that they have serious mental-health care needs. A serious need is "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person

would easily recognize the necessity for a doctor's attention." *Farrow v. West*, 320 F.3d 1235, 1243 (11th Cir. 2003). Thus, courts may find the existence of serious needs even when prison staff have failed to recognize an inmate's need for treatment. *Danley v. Allen*, 540 F.3d 1298, 1310–11 (11th Cir. 2008) (finding that plaintiff, whose requests to see a nurse had been rebuffed, demonstrated a serious medical need in that he had difficulty breathing and swollen, burning eyes, and a fellow inmate brought his condition to the attention of correctional officers), *overruled on other grounds*, *Randall v. Scott*, 610 F.3d 701, 709 (11th Cir. 2010). A serious mental-health care need was found where a doctor, nurse, and correctional officials recognized that a prisoner "engaged in self harm" and "showed outward signs of mania and depression." *Jacoby v. Baldwin Cty.*, 596 Fed.Appx. 757, 763 (11th Cir. 2014).

One of the factors that courts consider in finding a serious medical need is "whether a delay in treating the need worsens it." *Danley*, 540 F.3d at 1310. "The tolerable length of delay in providing medical attention depends on the nature of the medical need and the reason for the delay." *Hill v. Dekalb Reg'l Youth Det. Ctr.*, 40 F.3d 1176, 1188 (11th Cir. 1994) (citation omitted). Factors relevant to determining "the tolerable length of delay include the "seriousness of the medical need," "whether the delay worsened the medical condition," and "the reason for delay." *Id.* at 1189.

Because this is a Rule 23(b)(2) class action lawsuit challenging defendants' actions "on [a] ground[] that appl[ies] generally to the class"—that is, defendants' provision of inadequate mental-health care—the plaintiffs must show that serious mental-health needs exist on a system-wide basis, rather than on an individual basis.¹⁰ *Fed. R. Civ. P.* 23(b)(2). As explained in the class-certification opinion, the plaintiffs' claim and the remedies they seek are systemic. *Braggs v. Dunn*, 318 F.R.D. 652, 667 (M.D. Ala. 2016). In other words, "plaintiffs are not seeking adjudication of demands for particular individualized treatment,"

and any relief the court grants "would be appropriate for everyone subjected to the substantial risk of serious harm plaintiffs claim [ADOC's inadequate mental-health care system] creates—that is, prisoners with serious mental illness." *Id.* at 668.

¹⁰ Earlier in the litigation, this court certified a class consisting of "persons with a serious mental-health disorder or illness who are now, or will in the future be, subject to defendants' mental-health care policies and practices in ADOC facilities, excluding work-release centers and Tutwiler Prison for Women." *Braggs v. Dunn*, 317 F.R.D. 634, 640 (M.D. Ala. 2016) (Thompson, J.).

It is clear that a number of prisoners in ADOC's custody have serious mental-health needs, and the issue is undisputed. As a preliminary matter, MHM places prisoners on the caseload only if they have been diagnosed with a condition that requires treatment. Therefore, all prisoners on the caseload meet the legal requirement for having a serious mental-health need. Prisoners on the mental-health caseload have wide-ranging illnesses, such as bipolar disorder, schizophrenia, schizoaffective disorder, major depressive disorder, mood disorders, borderline personality disorder, anxiety, and PTSD.¹¹

¹¹ The concept of 'serious mental-health need' in the Eighth Amendment context should not be confused with 'serious mental illness,' a term of art in the mental-health care field. As plaintiffs' psychiatric expert Dr. Burns testified, 'serious mental illness' can be defined by three components: the diagnosis, the degree of disability, and the duration of the diagnosis or disability. Certain diagnoses are by definition serious mental illnesses, because they last a lifetime and are accompanied by debilitating symptoms; these diagnoses include bipolar disorder, schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, and any

other diagnoses with psychosis. Dr. Hunter, MHM's medical director, agreed with this assessment, testifying that a person with well-controlled schizophrenia still has a serious mental illness, because it requires continued treatment, even if he or she is only mildly impaired at the moment. Other diagnoses, like anxiety and PTSD, may reflect a serious mental illness depending on the degree and duration of the impairment. Dr. Burns testified that ADOC's administrative definition of serious mental illness tracks this understanding of serious mental illness. See Joint Ex. 88, Admin. Reg. § 602 (doc. no. 1038-1039) at 11 (defining "serious mental illness" as "[a] substantial disorder of thought, mood, perception, orientation, or memory such as those that meet the DSM IV criteria for Axis I disorders ... [and] persistent and disabling Axis II personality disorders."). According to experts on both sides, treatment of serious mental illnesses requires, at a minimum, multidisciplinary efforts to coordinate and implement interventions, including psychotherapy or counseling, psychotropic medications, and monitoring for signs of decompensation or progress. It also requires careful treatment planning and maintaining medical records in order to ensure continuity of care.

Furthermore, the court heard testimony from multiple prisoners, both named plaintiffs and class members, who clearly exhibited serious mental-health needs. For example, plaintiff R.M. has been diagnosed with paranoid schizophrenia and admitted ¹¹⁹¹ that he is out of touch with reality; he testified to what were obviously his delusions regarding his blood relationships to three different well-known terrorist figures and his owing billions of dollars to the United States treasury. Similarly, medical records made clear that plaintiff Q.B. has suffered from years of delusion and hallucination; he was on involuntary psychiatric medication orders for years while in ADOC custody. Lastly,

as explained earlier, plaintiff Jamie Wallace¹² had been diagnosed with bipolar disorder and schizophrenia, among other mental-health conditions, and he testified that he heard voices of his deceased mother telling him to cut himself. In sum, plaintiffs presented more than sufficient evidence establishing their serious mental-health needs.

¹² When the trial began, the court used full names of prisoner-witnesses, but the parties agreed to use initials after Jamie Wallace's testimony.

Because only prisoners with serious mental-health needs have a cognizable Eighth Amendment claim, when the court refers to 'mentally ill prisoners' in this opinion, it is referring to only those with serious mental-health needs.

B. Serious Harm and Substantial Risks of Serious Harm Posed by Inadequate Care

In addition to showing a serious medical need, plaintiffs must establish that they have been subjected to serious harm, or a substantial risk of serious harm—the second part of the 'objective' test under the Eighth Amendment jurisprudence—as a result of inadequate mental-health care. Put another way, plaintiffs must show that their serious medical need, "if left unattended, 'poses a substantial risk of serious harm.'" *Farrow v. West*, 320 F.3d 1235, 1243 n.13 (11th Cir. 2003) (quoting *Farmer v. Brennan*, 511 U.S. 825, 834, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994)). Defendants may be held liable for "incarcerating prisoners under conditions posing a substantial risk of serious harm." *Farmer*, 511 U.S. at 834, 114 S.Ct. 1970.¹³

¹³ While courts have sometimes used the "serious need" and "substantial risk of serious harm" tests interchangeably, they appear to be somewhat distinct: the "serious need" requirement examines whether a prisoner has a medical problem requiring attention; the "substantial risk of serious harm" test examines whether the

defendant's inattention to or mistreatment of the medical need threatens serious harm to the prisoner. Of course, a plaintiff may face a serious medical need because defendant's inattention has caused or exacerbated a medical condition, see, e.g., *Helling v. McKinney*, 509 U.S. 25, 113 S.Ct. 2475, 125 L.Ed.2d 22 (1993) (concluding that prisoner's claim based on potential future effects of exposure to tobacco smoke could be a viable Eighth Amendment claim), but this does not change the fact that the focus of the "serious need" inquiry is the prisoner's condition, while the "substantial risk of serious harm" inquiry focuses on the effects of inadequate health care.

The "serious harm" requirement "is concerned with both the 'severity' and the 'duration' of the prisoner's exposure" to the harm, such that an exposure to harm "which might not ordinarily violate the Eighth Amendment may nonetheless do so if it persists over an extended period of time." *Chandler v. Crosby*, 379 F.3d 1278, 1295 (11th Cir. 2004) (citation omitted). While mere discomfort is insufficient to support liability, *id.*, "unnecessary pain or suffering" qualifies as serious harm, *LaMarca v. Turner*, 995 F.2d 1526, 1535 (11th Cir. 1993).

Plaintiffs may bring an Eighth Amendment challenge to a condition that is already inflicting serious harm on them at the time of the complaint or to prevent serious harm which is substantially likely to occur in the future—a substantial risk of serious harm. As the Supreme Court explained in ^{1192*}*Helling v. McKinney*, 509 U.S. 25, 113 S.Ct. 2475, 125 L.Ed.2d 22 (1993), a case in which a prisoner challenged his prolonged exposure to second-hand smoke, "a remedy for unsafe conditions need not await a tragic event," because "the Eighth Amendment protects against future harms to inmates," even when the harm "might not affect all of those exposed" to the risk and even when the harm would not manifest itself immediately. *Id.* at 33–34, 113 S.Ct. 2475. In other

words, plaintiffs must show "that they have been subjected to the harmful policies and practices at issue, not (necessarily) that they have already been harmed by these policies and practices." *Dunn v. Dunn*, 219 F.Supp.3d 1100, 1123 (M.D. Ala. 2016) (Thompson, J.). In the class-action context, the plaintiff class must show that it, as a whole, has been subjected to policies and practices that create a substantial risk of serious harm. *Braggs v. Dunn*, 317 F.R.D. 634, 654 (M.D. Ala. 2016) (Thompson, J.).

Moreover, multiple policies or practices that combine to deprive a prisoner of a "single, identifiable human need," such as mental-health care, can support a finding of Eighth Amendment liability. *Gates v. Cook*, 376 F.3d 323, 333 (5th Cir. 2004) ("Conditions of confinement may establish an Eighth Amendment violation 'in combination' when each would not do so alone, but only when they have a mutually enforcing effect that produces the deprivation of a single, identifiable human need such as food, warmth, or exercise—for example, a low cell temperature at night combined with a failure to issue blankets.") (citing *Wilson v. Seiter*, 501 U.S. 294, 304, 111 S.Ct. 2321, 115 L.Ed.2d 271 (1991)). The Eleventh Circuit Court of Appeals has recognized this 'totality of conditions' approach in prison-conditions cases. See, e.g., *Hamm v. DeKalb Cty.*, 774 F.2d 1567, 1575–76 (11th Cir. 1985).

Mentally ill ADOC prisoners, defined here as prisoners with serious mental-health needs, have suffered harm and are subject to a substantial risk of serious harm due to ADOC's inadequate mental-health care. Based on the trial testimony, the court finds seven interrelated areas of inadequacy: (1) identification and classification of prisoners with mental illness; (2) treatment planning; (3) psychotherapy; (4) inpatient mental-health care units; (5) crisis care and suicide prevention; (6) use of disciplinary actions for symptoms of mental illness; and (7) use of segregation for mentally ill prisoners. In all seven areas, experts from both sides by and large agreed

about significant flaws affecting mentally ill prisoners.¹⁴ MHM and ADOC staff also recognized and corroborated the existence and severity of these issues. Even Associate Commissioner Naglich essentially agreed that some of these were problems so significant that ¹¹⁹³they must be fixed as soon as possible, ^{*1193}because lives are at risk.¹⁵ These inadequacies, alone and in combination, subject mentally ill prisoners to actual harm and a substantial risk of serious harm—including worsening of symptoms, increased isolation, continued pain and suffering, self-harm and suicide.

¹⁴ The 'stacked Swiss cheese' analogy, well known in the healthcare and risk-management contexts, may be useful here. In this analogy, a layer of Swiss cheese represents a mechanism to prevent harm, and an error is a hole in that layer. Ideally, each layer is sufficiently redundant to catch or ameliorate errors and to prevent holes from lining up. However, if each hole is too big, errors from each layer compound and result in an inadequate system. See James Reason, *Human Error: Models and Management*, 320 *Brit. Med. J.* 768 (2000). Applied to this context, each layer of mental-health care within ADOC—identification of symptoms at intake and referral; treatment planning; provision of psychotherapy; inpatient care; crisis care; and consideration of mental health in prisoner placement decisions—is riddled with too many holes to prevent mentally ill prisoners from falling through the cracks. Moreover, each layer's error is compounded by latent errors in inter-related layers of care: for example, delinquent counseling appointments fail to address a sudden deterioration in a prisoner's condition, which is worsened by the lack of a properly functioning referral system and a suicide-watch protocol.

¹⁵ As discussed later, some of the policies and practices affecting mentally ill prisoners are determined by ADOC, others by

MHM: for example, ADOC is responsible for staffing decisions and placement of prisoners in mental-health units and segregation; MHM is responsible for policies and practices in intake screening, the referral system, treatment planning, and psychotherapy. However, ADOC is still liable for policies and practices determined by MHM, for three reasons. First, ADOC's decisions regarding mental-health staffing, correctional staffing, and overcrowding have directly impacted MHM's policies and practices, such as frequently delayed and cancelled counseling sessions and the use of LPNs to conduct intake screening. Second, for some of the practices, ADOC has expressly authorized MHM to determine them on its behalf by contracting out its constitutional obligation to provide mental-health care. Third, even when ADOC has not expressly authorized MHM to make these policies—that is, when MHM's policies and practices contravene ADOC's administrative regulations or contractual requirements—ADOC through its lack of oversight has de facto delegated its decision-making authority to MHM. See *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 706 n.11 (11th Cir. 1985) (holding that "whe[n] a governmental entity delegates the final authority to make decisions," either expressly or by default, then "those decisions necessarily represent official policy" in the context of contracting out medical care for prisoners). Therefore, the court finds that ADOC is liable for the policies and practices described here, despite the fact that MHM is the entity providing mental-health care and determining some of the policies and practices related to mental-health care.

I. Contributing Conditions

Three conditions contribute to all of the deficiencies in ADOC's treatment of mentally ill prisoners: understaffing of mental-health care providers, understaffing of correctional officers,

and overcrowding.¹⁶ Associate Commissioner Naglich and defendants' expert witnesses largely agreed with plaintiffs that these conditions present significant challenges to the system today. Correctional and mental-health understaffing, both alone and in combination, impose substantial risks of serious harm to mentally ill prisoners, and overcrowding compounds these risks.

¹⁶ Defendants advanced a few versions of the argument that variability across different facilities negates ADOC's liability: defendants argued that experts visiting seven, eight, or nine facilities instead of visiting all 15 facilities renders their opinions irrelevant or not reliable; that certain facilities are not as overcrowded as others; and that plaintiffs did not prove that every single facility suffers from a shortage of crisis cells. As explained in the class certification opinion, *Briggs v. Dunn*, 317 F.R.D. 634, 655-66 (M.D. Ala. 2016), evidence of systemic practices that may have differing levels of impact at different facilities may establish liability against ADOC: mentally ill prisoners are subject to a substantial risk of serious harm from practices that are common in ADOC facilities no matter where they are housed currently, because they may be housed in any of these facilities in the future due to ADOC's frequent and unpredictable transfers of prisoners across facilities.

a. Overcrowding

ADOC facilities are significantly and chronically overcrowded. Publicly available information on ADOC's inmate population and capacity plainly lays out the magnitude of overcrowding: ADOC's September 2016 monthly statistical report states that ADOC held 23,328 prisoners in facilities that are designed to hold only 13,318; this brings the occupancy rate to over 175 %. Pl. Ex. 1260, September 2016 Monthly Statistical Report (doc. no. 1097-19) at 2, 4.¹⁷ Plaintiffs' expert Vail ¹¹⁹⁴ testified ^{*1194} that the magnitude of overcrowding

in ADOC is the worst he has seen in his career in corrections and consulting for other correctional systems across the country. According to Vail, California, whose overcrowded correctional system was found to be unconstitutional, approached an occupancy rate of 170 %; a three-judge court subsequently ordered the State to lower the occupancy rate to 137.5 %, a target rate that was affirmed by the Supreme Court. *Brown v. Plata*, 563 U.S. 493, 539–42, 131 S.Ct. 1910, 179 L.Ed.2d 969 (2011). The sheer magnitude of overcrowding within ADOC has meant that some ADOC facilities, including Kilby, Bibb, Staton, and Easterling, house more than double the number of prisoners they are designed to hold. Pl. Ex. 1260, September 2016 Monthly Statistical Report (doc. no. 1097–19) at 4. Even maximum-security facilities use open-bay dormitories filled with wall-to-wall rows of double bunk beds, holding up to 240 prisoners in a single room, where officers do not have a line of sight on most of the prisoners they are assigned to supervise.

¹⁷ Parties have put forth evidence regarding the Alabama Prison Transformation Initiative, a proposal by the now-former Governor to build new prisons. At this point, the court does not see any need to determine the effects of the proposal, because the case at hand asks the court to evaluate whether the current state of mental-health care in existing ADOC facilities is constitutionally inadequate, rather than whether a hypothetical system of mental-health care in new prisons would be adequate.

b. Mental-Health Understaffing

ADOC has maintained mental-health staffing levels that are chronically insufficient across disciplines and facilities. Witness after witness identified significant mental-health staffing shortages as one of the major reasons for ADOC's inability to meet the rising mental-health care needs of prisoners. Most significantly, Associate Commissioner for Health Services Naglich

admitted that MHM has been understaffed since 2013 and remains understaffed today. MHM's program director Houser stated bluntly that MHM staffing shortages make it difficult to "do the work required under the contract," and that the current caseload for MHM staff does not meet an "acceptable standard." Houser Testimony at vol. 2, 24–25.

Over the course of the trial, evidence showed that the mental-health caseload per MHM provider has been increasing since 2008, largely due to three reasons: (1) an increasing number of prisoners with mental-health needs across ADOC; (2) multiple budget cuts over the years; and (3) ADOC's long-time refusal to increase the authorized number of mental-health staff positions despite repeated requests from MHM, even when an initiative to transfer some of the caseload to ADOC staff—so-called "blending of services"—was not implemented as planned.¹⁸

¹⁸ After years of refusing to increase staffing, ADOC approved a small staffing increase in September 2016, shortly before the trial in this case, when it extended the contract with MHM for another year. However, both Associate Commissioner Naglich and MHM's program director Houser testified that understaffing has persisted despite the recent increase.

ADOC's prisoner population has had increasing needs for mental-health services over the last decade. As multiple MHM providers and expert witnesses from both sides testified, ADOC's prisoner population has become more mentally ill over the last decade, both in terms of the number of individuals who need mental-health care and in terms of the acuity of mental-health care needs. MHM's medical director, Dr. Hunter, testified that the number of prisoners receiving regular mental-health services within ADOC (also known as being 'on the caseload') has been increasing since 2003, which has been "concerning" and "tax [ing his] ability to adequately do" what "he is required to do under the contract. Hunter

Testimony at ____ (For transcripts that are not yet finalized, the court leaves the page numbers blank.) He also explained that, since 2003, the number of prisoners coming into the system with severe mental illness has been increasing. MHM's own documents showed that between 2008 and 2016, the mental-health caseload increased by 25 % across all facilities. Pl. Dem. Ex. 25, Pricing, Caseload and Staffing Comparison Over Time (doc. no. 1071-5).

As the need for mental-health services has been increasing substantially, MHM and ADOC have been hiring fewer and fewer providers over the years, exacerbating the staffing shortage. In 2009, ADOC reduced MHM's compensation under the contract and the number of authorized positions to be hired by MHM. In 2013, the state legislature further reduced ADOC's mental-health care budget by 10 %. ADOC and MHM then renegotiated their 2013 contract to reduce the previously agreed-upon "minimum required staffing," cutting close to 20 full-time equivalent positions. Naglich Testimony 2-211; Pl. Dem. Ex. 140, MHM Staffing Increase Chart (doc. no. 1148-59); *see also* Pl. Dem. Ex. 25, Pricing, Caseload, and Staffing Comparison Over Time (doc. no. 1071-5). During that same contract renewal period, ADOC and MHM also reduced the number of positions that are covered by the contractual 'staffing rebate' provision, under which MHM must pay back ADOC if it does not fill all authorized positions. In other words, the revision allowed MHM to leave clinical staff positions unfilled without being penalized, even though the overall number of authorized positions had already been reduced. Houser described this latter modification as a way to make the reduction in payment and staffing under the contract "more palatable for MHM." Houser Testimony at vol. 1, 49.

Another driving force behind MHM's mental-health understaffing is ADOC's failure to implement the 'blending of services' initiative successfully. Houser explained that this initiative

was established in 2009 in response to ADOC's reduction in both the amount it would pay to MHM under the contract and in the staffing provided for in the contract: MHM's caseload would be reduced by transferring treatment of prisoners with lower-acuity mental-health issues to ADOC's psychological associates; the initiative was an "attempt to make sure that the inmates received mental health services" despite the staffing reduction and increasing caseloads. Houser Testimony at vol. 1, 14. However, ADOC failed to implement the initiative across its facilities: MHM's staffing was reduced, but at many facilities, psychological associates did not take over any caseload from MHM. Naglich explained that, because some wardens were resistant to letting psychological associates carry significant caseloads, MHM staff remained responsible for most of the patients, even though there were now fewer MHM providers than before. Houser testified that blending of services is not currently happening anywhere in ADOC in the way it was designed to happen, despite MHM's reduced staffing levels. ADOC's chief clinical psychologist Dr. David Tytell admitted that the initiative has failed to work. However, ADOC has not restored MHM's staffing to the pre-2009 level.¹⁹

¹⁹ Chronic mental-health understaffing is also compounded by vacancies that are left unfilled for many months.

The result of ADOC's refusal to increase MHM's staffing level or even to restore staffing to the pre-2009 level has been chronic shortages of mental-health care *1196 providers. Dr. Hunter testified that the staffing shortage has had a significant impact on scheduling of psychiatric visits and medication management. Several mental-health counselors testified that their caseloads have soared; Houser testified that MHP caseloads at some facilities have been twice what they should be, which is "never an acceptable standard." Houser Testimony at vol. 2, 25. Increasing caseloads due to understaffing have also led to a

high turnover rate among staff: according to Houser, staff resign because of their frustration with increasing caseloads, leaving the rest of the staff with even higher caseloads; recruiting also suffers because of the overwhelming caseloads that mental-health staff are expected to manage. MHM's monthly operating report submitted to ADOC for May 2016 described the problem in stark terms: "Mental health caseloads are running high at many of the facilities. Staff has attempted to accommodate the increased numbers, however quality cannot be maintained at current staffing levels." Joint Ex. 343 (doc. no. 1038-702) at 19. As explained in more detail in the following sections, this understaffing also has prevented MHM from providing care that complies with ADOC's administrative regulations, the contract, and professional standards for minimally adequate care in a prison system.²⁰

²⁰ Examples of inadequate care caused by mental-health shortages include: lack of timely provision of counseling services; inadequate treatment planning; and inadequate monitoring of suicidal patients as well as those housed in mental-health units and segregation units.

Not surprisingly, experts from both sides opined that ADOC does not have a sufficient number of mental-health staff for a system of its size. Dr. Patterson, the defense expert, concluded based on his review of medical records and site visits that ADOC's mental-health care system is significantly understaffed. Plaintiffs' expert Dr. Burns agreed with this assessment based on her review of medical records and MHM internal records, which revealed that caseloads for psychiatric providers and counselors were too large to allow for sufficient counselling or therapeutic group activities. Dr. Burns concluded that ADOC needs more psychiatric staff, psychologists, registered nurses, and activity technicians.²¹

²¹ Dr. Burns also testified that the mental-health staffing requirements in a 2001 settlement agreement between ADOC and

a class of male prisoners provide a helpful benchmark for adequate staffing levels. See Order Approving Settlement Agreement, *Bradley v. Harrelson*, No. 2:92-cv-70 (M.D. Ala. June 27, 2001) (Albritton, J.), ECF No. 412. Dr. Burns explained that while the number of ADOC prisoners in need of mental-health services has increased since the *Bradley* settlement, ADOC has entered into mental-health contracts that provide significantly fewer high-level practitioners, as well as more practitioners with lower levels of qualification, compared to the *Bradley* requirements. For example, under *Bradley*, ADOC was required to provide eight psychiatrists for approximately 20,600 prisoners; today, it employs five psychiatrists for close to 24,000 prisoners. While the staffing requirements derived from an out-of-court settlement do not set a constitutional floor for adequate mental-health care, the comparison with the *Bradley* settlement is relevant, though not dispositive, for determining whether the current staffing levels are adequate.

MHM's corporate office—which exercises contract-compliance oversight but does not directly provide care in Alabama—has repeatedly raised mental-health understaffing in the annual clinical contract-compliance review reports (hereafter 'contract-compliance reports') sent to Associate Commissioner Naglich's Office of Health Services. Starting in 2011, each annual contract-compliance report included information on multiple facilities that were suffering from staffing shortages, "compromising [MHM's] ability to provide monthly follow-up for all caseload inmates." Pl. Ex. 1190, 2011 Contract-Compliance Report (doc. no. 1070-8) at 15. The 2013 report also noted the impact of the staffing reduction that year, stating that "[d]espite the increase in the size of the caseload across ADOC, MHM's contract has been compressed to include significant staffing cuts at all sites." Pl. Ex. 114, 2013 Contract-Compliance Report (doc. no.

1070–4) at 1. The report also warned that, at Donaldson, where one of the two male residential treatment units is located, "[c]urrent staffing pattern does not support the delivery of adequate services to inmates and that they have been reduced to providing minimal and 'triage-based' services rather than effective and thoughtfully planned treatment." *Id.* at 5. In 2016, MHM reported significant backlogs in treatment and staffing shortages at Donaldson and Bullock, the two male facilities that house ADOC's most seriously ill mental-health patients. Pl. Ex. 115, 2016 Contract-Compliance Report (doc. no. 1070–5). Even after the partial staffing increase in September 2016, Houser stated that MHM remains understaffed and pointed to mental-health understaffing as a cause for a plethora of issues, including insufficient identification of mental illness at intake and referrals; missed counseling appointments and group sessions; and inadequate monitoring of prisoners in mental-health crises.

Based on Associate Commissioner Naglich's testimony and other evidence, the court finds that MHM has been consistently and significantly understaffed at least since 2013, and that it is still understaffed even after ADOC approved a small staffing increase in September 2016 as part of its one-year contract extension.

c. Correctional Understaffing

In addition to mental-health understaffing and overcrowding, a significant shortage of correctional officers also hinders the delivery of mental-health care and poses a substantial risk of harm to prisoners who need mental-health care. As with mental-health staffing shortages, witness after witness, including both defendants, testified that a significant shortage of correctional officers has been one of the biggest obstacles to providing mental-health care in ADOC. In Associate Commissioner Naglich's words, the problem of insufficient mental-health staffing is "compounded by" the lack of sufficient correctional staffing at ADOC. Naglich Testimony at vol. 2, 208.

ADOC has reported an ever-increasing shortage of correctional officers in its annual reports and monthly operating reports since 2006. In 2010, ADOC summarized that "[c]orrectional staffing continues to fall short of required levels—impacting the inmate to officer ratio and overtime necessary to cover essential posts," and reported that the shortage rate was 12.2 % at close-custody (highest security) facilities and 21.2 % at medium-security facilities. Joint Ex. 463, Vail Expert Report (doc. no. 1038–1048) at 39 (quoting ADOC Annual Report FY 2010). Essentially the same statement regarding the officer shortage appeared in every annual report until 2013, when the shortage rate across facilities shot up to 43.3 %. The report in 2015 showed officer shortage rates of over 25 % at 13 of the 15 major prisons and over 50 % at six of those; the highest was 68 % at Bibb. Donaldson was barely under 25 %; only one prison, Hamilton, the facility for the elderly and the infirmed, was below 25 %. *Id.* at 39–40 (citing ADOC Annual Report FY 2013, 2015). As of September 2016, ADOC reported having filled only about half of the authorized positions for correctional officers. Pl. Ex. 1260, September 2016 Monthly Statistical Report (doc. no. 1097–19) at 16 (showing 51.1 % overall *1198 staffing level).²² The staffing level continued to drop throughout 2016, according to Associate Commissioner of Operations Grantt Culliver.

²² Throughout the trial, there was confusion as to how ADOC defined 'authorized positions' for the purpose of deriving shortage rates published in their annual reports. During the defendants' case, ADOC's chief of staff Steve Brown finally clarified that the number of authorized positions was determined based on a staffing ratio of 1:6 or 1:7, which were ratios that ADOC considered close enough to the "ideal" ratio of one correctional officer for every five inmates. However, as plaintiffs' expert Eldon Vail and ADOC officials explained, adequate staffing numbers cannot be calculated by simply

dividing the inmate population by the staffing ratio that is deemed to be ideal; rather, it requires a facility-by-facility determination that considers numerous variables, such as the layout and design of the facilities, level of security, level of programs and activities, and state and local standards and statutes. Vail also explained that 1:5 is not an "ideal" ratio but likely the average of staffing ratios from state correctional systems that responded to a survey conducted by the Association of State Correctional Administrators. The ratios also do not take multiple shifts and leave time into account. Therefore, while ADOC relied on the authorized position numbers derived from such calculations in its annual reports, the shortage rates in those reports are not reliable indicators of understaffing, except as a metric to measure change in staffing over time. However, as shown later, there is ample evidence, both from expert testimony and ADOC staff's testimony, that ADOC suffers from a serious correctional staffing shortage.

It is alarming that ADOC has not conducted any staffing analysis in the last decade to determine exactly how many officers are needed to keep officers and prisoners safe within its facilities. It is also alarming that ADOC's own reports have been relying on authorized-position numbers based on rudimentary ratios that do not take into consideration the actual layouts of facilities. This failure to conduct any staffing analysis is all the more troubling because at least one ADOC official, Associate Commissioner Grantt Culliver, has the expertise to conduct staffing analyses and has been training other state correctional officials on how to conduct staffing analyses. Vail also testified that it is not resource-intensive to obtain a staffing analysis from the National Institute of Corrections, since the Institute provides grants and other resources to state

prison systems that host training for correctional officials in their own facilities, as ADOC has done.

Understaffing has been a persistent, systemic problem that leaves many ADOC facilities incredibly dangerous and out of control. Defendants' correctional administration expert Robert Ayers observed multiple high-security units not being monitored at all and an entire unit at Bibb overseen by a single control booth officer and a single officer on the floor; he opined that such understaffing was "not acceptable." Ayers Testimony at _____. Plaintiffs' correctional administration expert Vail agreed with this conclusion and elaborated that many facilities are struggling to have sufficient numbers of correctional officers to station at least one officer per dorm—including the highest-security facilities, such as Holman and Kilby. Not surprisingly, a severe shortage of officers leads to dangerous and violent conditions, especially in high-security facilities with overcrowded dormitories.²³ In these conditions, prisoners and correctional officers alike are justifiably afraid for their safety—a jarring image that many prisoner-witnesses and experts painted in their testimony. For example, class member M.P., who is now housed in Ventress, stated repeatedly how dangerous it was to be in a general-population dorm at St. Clair; he was enormously relieved to be transferred to another prison.²⁴ Multiple experts also¹¹⁹⁹ testified that during their site visits, prison officials did not allow them to enter certain parts of the prison, such as the second and third tiers of the Holman segregation unit and a whole half of Bibb, because the officials could not guarantee their safety.²⁵

²³ Vail explained that ADOC's use of open dormitories in maximum-security facilities is almost unheard of in corrections.

²⁴ The witness's fear is well-warranted: St. Clair is the most violent facility in ADOC, accounting for a quarter of assaults with serious injuries within the system, while

housing only 4 % of ADOC prisoners. Pl. Ex. 1260, September 2016 Monthly Statistical Report (doc. no.1108-37) at 4, 12.

²⁵ In fact, although the court has visited a number of prisons over the years, the United States Marshals Service, in consultation with defense counsel, advised against the court's visit to Holman Correctional Facility in this case due to safety concerns.

As a result of the officer shortage, ADOC has an exceedingly high overtime rate. Overtime rate refers to the proportion of the number of hours worked by correctional officers as overtime compared to the total number of hours worked. A high overtime rate undermines security and officer morale, which in turn has negative implications for mental-health care. ADOC's chief of staff Steve Brown admitted that the current overtime rate of over 20 % is not sustainable in the long run, because it decreases retention of officers and increases the number of disciplinary actions against officers. Multiple vulnerability analyses—ADOC's internal critical assessments of each facility's security risks—also found that mandatory overtime and overuse of overtime have affected staff morale and contributed to high turnover rates. Pl. Ex. 146, Bullock Vulnerability Analysis (doc. no. 1087-3); Pl. Ex. 185, Donaldson Vulnerability Analysis (doc. no. 1087-6); Pl. Ex. 204 Elmore Vulnerability Analysis (doc. no. 1087-8).²⁶

²⁶ A related issue is the new set of staffing ratios that ADOC Chief of Staff Brown presented during the trial, which counted overtime hours performed by existing correctional officers as additional officers. These ratios are also misleading. First, according to plaintiffs' expert Vail, counting overtime hours as additional full-time correctional officers is not the standard practice to determine whether correctional staffing is adequate. Second, these ratios do not take into consideration

that officers working overtime are less effective than officers working standalone shifts, or that the overtime rate in ADOC is extremely high compared to other correctional systems, especially in facilities such as Donaldson, Kilby, St. Clair, Tutwiler, Draper, Holman, Bullock, and Easterling. Def. Dem. Ex. 19 (doc. no. 1148-60) (showing the eight facilities with 15 % or higher overtime rate). Furthermore, as with the authorized-position calculations discussed above, these ratios do not account for the fact that many ADOC facilities are designed with little direct line of sight from officer stations into prisoner living areas, and have dorms with rows and rows of bunk beds obstructing officers' views; both factors require higher officer-to-inmate ratios than facilities with better line of sight or fewer bunked dorms.

Lastly, even if the court were to accept the current staffing ratios calculated by Brown's staff as accurate, only two of the 14 facilities meet the 7:1 (for medium custody) or 6:1 (for close custody) thresholds. In other words, even using this overly inclusive metric to measure staffing sufficiency, ADOC is significantly understaffed.

This chronic and severe correctional understaffing has compromised mental-health care in many ways. Most significantly, as discussed in more detail in Part V.B.4, correctional officers are needed to provide security for mental-health programming and escort prisoners from their cells to appointments if they are not in general population. Due to insufficient correctional staffing, appointments and group activities are frequently canceled and delayed, significantly impairing MHM staff's ability to provide treatment. *See, e.g.*, Pl. Ex. 115, 2016 Contract-Compliance Report (doc. no. 1070-5) at 3 (MHM staff not being able to access patients at Bullock, Donaldson, Holman, St. Clair, and Staton due to correctional staffing shortages, and expressing

concern about their own safety at five facilities); Pl. Ex. 105, 2014 MHM Implementation Review Report (doc. no. 1070-3) at 3 (20 to 70 % of mental-health appointments were canceled due to correctional officer shortages at the Donaldson residential treatment unit in 2014). Based ¹²⁰⁰ on the testimony of Ayers, one of the defense experts, and almost all MHM providers and managers who testified, the court is convinced that the correctional staffing level falls intolerably short of providing adequate care to prisoners who need to be escorted to their mental-health appointments.

Second, understaffing impacts correctional officers' ability to supervise mentally ill prisoners effectively. According to plaintiffs' expert Vail, understaffing compromises overworked correctional officers' alertness and ability to respond to incidents, crises, and emergencies, and to exercise the patience and restraint necessary to supervise mentally ill prisoners. This effect is even more pronounced in segregation and crisis cells. Without sufficient correctional staff, officers are unable to check on prisoners isolated from the rest of the population as frequently as they must in order to guarantee their safety. As a result, decompensating prisoners go unnoticed, leading to extended suffering without access to treatment, and more frequent crisis situations.

Correctional understaffing, combined with overcrowding, also has a more direct impact on prisoners' mental health. The combination of overcrowding and understaffing leads to an increased level of violence, both because of the difficulty of diffusing tension and violence in an overcrowded open-dormitory setting, and because of the lack of supervision by correctional officers. See Pl. Ex. 1260, ADOC September 2016 Monthly Statistical Report (doc. no. 1108-37) at 12 (reporting nearly 200 assaults with serious injuries and seven homicides in the fiscal year ending in September 2016). According to Dr. Haney, plaintiffs' expert on correctional mental health and solitary confinement, prisoners' legitimate fear of violence is a common source of

anxiety and mental instability: for prisoners who already suffer from mental illnesses, this environment increases their likelihood of decompensation. The level of danger and lack of control arising from overcrowding and insufficient staffing also contributes to a punitive culture, in which officers prioritize security concerns over mental-health treatment and are quick to treat mental-health symptoms as behavioral problems; dealing with violence and emergencies also diverts correctional resources away from regular mental-health programming and treatment. Untreated or undertreated mental illness in turn creates a greater need for mental-health services, provision of which is limited by the very shortage of officers that created the increased need in the first instance. Furthermore, mental-health problems are much more likely to go unnoticed in overcrowded and understaffed prisons, because correctional officers who are spread too thin are less likely to notice any unusual behavior by a particular prisoner. These observations made by Dr. Haney all rang true in the evidence before the court. Lastly, as Dr. John Wilson, a psychologist who serves as one of the directors of MHM's national Clinical Operations Department, explained to MHM's program director Houser, "experience and research" confirm that suicides tend to increase with overcrowding, and "basic unrest at a systems level" can cause a spike in suicides. Pl. Ex. 1224, October 1, 2015 Email from Wilson to Houser (doc. no. 1117-24) at 2. In fact, the suicide rate within ADOC has more than doubled in the last two years, as 'unrest at a systems level' continues to plague ADOC facilities. Taken together, ADOC's low correctional-staffing level, in the context of its severely overcrowded prisons, creates a substantial risk of serious harm to mentally ill prisoners, including continued pain and suffering, decompensation, self-injury, and ¹²⁰¹suicide.¹²⁰¹ 2. Identification and Classification of Prisoners' Mental-Health Needs

As one expert put it, ADOC's mental-health care system "falls apart at the door": the system fails to identify and classify appropriately those with mental illnesses, and the effect of this under-identification cascades through the system. Haney Testimony at vol. 1, 30. Because of inadequate identification and classification, seriously mentally ill prisoners languish and decompensate in ADOC without treatment, ending up in crisis care and engaging in destructive—sometimes fatal—self-harm.

Timely identification and appropriate classification of prisoners with mental illness are essential to a functioning mental-health care system. As experts explained, and as common sense would dictate, mental-health treatment cannot begin unless providers are aware of who needs treatment and for what. Failure to identify those who need mental-health services denies them access to necessary treatment, creating a substantial risk of harm to those who remain unidentified. See *LaMarca v. Turner*, 995 F.2d 1526, 1544 (11th Cir. 1993) (affirming conclusion that systematic denial of access to treatment constitutes deliberate indifference to a serious medical need).

a. Inadequate Intake Process

ADOC's system for identifying prisoners with mental illness is significantly inadequate. According to three experts—defense expert Patterson and plaintiffs' experts Burns and Haney—the percentage of prisoners within ADOC with mental illness (referred to as the 'prevalence rate') is substantially lower than the national average: the average rate of mental illness for men in correctional systems ranges between 20 % and 30 %; ADOC's prevalence rate is between 14 % and 15 %. See Joint Ex. 346, June 2016 MHM Monthly Statistical Report (doc. no. 1038–708) at 1.

As experts from both sides testified, ADOC's prevalence rate is abnormally low and reflects that the system is under-identifying prisoners with

mental illness. Defense expert Dr. Patterson explained that experts do not expect to see much variation in actual prevalence rates across correctional systems, and that he has not seen anything that suggests that ADOC would have a lower prevalence rate than other correctional systems for any reason other than under-identification. Dr. Burns agreed and explained that it is highly likely that the abnormally low prevalence rate is due to under-identification, rather than because Alabama prisoners have fewer mental-health issues compared to those in other States. She added that she does not know of any States that have lower prevalence rates than Alabama. Assuming that ADOC's actual prevalence rate for mental illness actually tracks the national figure of between 20 % and 30 %, somewhere between 1,200 and 3,600 prisoners should be receiving mental-health care but are not, because between 5 % and 15 % of ADOC's 24,000 prisoners have not been identified as having a mental illness.

A closer examination of the two main processes of identifying prisoners with mental-health care needs—intake and referral—sheds light on why ADOC's prevalence rate is so low. First, ADOC's mental-health screening process at intake fails to identify a substantial number of prisoners with mental-health issues. Licensed practical nurses, who have very limited training, are responsible for conducting mental-health screening for prisoners at intake at Kilby (for all male prisoners) and Tutwiler (for all female prisoners). No higher-level provider supervises the LPNs during the intake process. The intake LPN fills out forms and ¹²⁰²questionnaires and decides ^{*1202}whether to refer a prisoner for further examination by a psychiatrist or a nurse practitioner. If the LPN determines that a prisoner does not need to be referred to a psychiatrist or nurse practitioner, a mental-health code of MH-0, denoting no need for mental-health care, is entered into the system. Prisoners who are designated as MH-0 by an LPN do not receive any further evaluation or any mental-health

treatment unless referred to mental-health services later by a staff member or the prisoners themselves. On the other hand, if the LPN refers the prisoner for evaluation, a psychiatric provider completes an evaluation, gives a diagnosis if appropriate, and assigns a mental-health code, which determines the level of care the prisoner subsequently receives and ranges from MH-0 (no mental-health need) to MH-6 (in need of hospitalization).²⁷

²⁷ Associate Commissioner Naglich testified that psychological associates, who have master's degrees in counseling and are employed by ADOC, also have the ability to refer prisoners to psychiatric providers at intake. However, other evidence suggested that this rarely, if ever, happens. Dr. Hunter explained that ADOC's intake process, which involves psychological tests, is a parallel track to MHM's screening process, and that they do not overlap; the court interpreted this to mean that ADOC's psychological associates do not interact with psychiatric providers on the MHM side for further evaluation of prisoners. In addition to Dr. Hunter's testimony, no documentary evidence could be found to support Naglich's assertion that psychological associates do refer prisoners for further examinations during the intake process. See also Joint Ex. 100, Admin. Reg. § 610 (doc. no. 1038-122) (detailing the mental-health screening process to be conducted by the contractor staff). Given Dr. Hunter's familiarity with the intake process and the lack of any documentation of psychological associates' referrals, the court finds that the initial intake process is primarily or entirely done by an LPN.

Experts from both sides agreed, and the court finds, that the intake screening process conducted by an LPN without any on-site supervision by a higher-level provider contributes to under-identification of prisoners with mental illness. This is because LPNs, who only have 12 to 15 months of general medical training—very little of

which may be related to mental health—are not qualified to assess the presence or acuity of mental illness symptoms based on information obtained during the intake process. Intake forms that LPNs fill out include questions that require clinical assessments, rather than simple yes-or-no questions based on physical observations. See Joint Ex. 85, Admin. Reg. § 601 Mental Health Forms and Disposition (doc. no. 1038-106); Burns Testimony at vol. 1, 44-45. According to the experts, LPNs are not qualified to make such clinical assessments. Moreover, although LPNs may make referrals based on self-reported symptoms of mental illness, a proper intake system cannot solely rely on self-reporting to identify mental-health needs. As Dr. Burns testified, the use of unsupervised LPNs for intake mental-health screening presents an "obvious" risk of under-identification. Burns Testimony at vol.1, 120361-62.²⁸ *1203 The use of inadequately supervised LPNs for intake is compounded by insufficient mental-health staffing. Houser testified that MHM does not have sufficient staffing or space to conduct mental-health screenings at Kilby (where all male prisoners are screened), and her staff have had to send prisoners to other facilities without conducting the initial intake screening. This in turn has increased the workload for mental-health staff at the receiving facilities and has created delays in the provision of mental-health care to those who need treatment. Dr. Patterson, the defense expert, agreed that insufficient staff at intake has led to insufficient identification of prisoners with mental illness, and that this failure to identify increases the risk of continued pain and suffering and potential suicides among those who are not receiving the mental-health care they need.

²⁸ Experts from both sides also observed that the intake process does not include an assessment for suicide risk, a serious systemic issue that may have contributed to the recent dramatic increase in the suicide rate. See Joint Ex. 461, Patterson Expert Report (doc. no. 1038-1046) at 69 (concluding that ADOC's lack of suicide

risk evaluation and management is an area of substantial concern); Burns Testimony at vol. 1, 63; Pl. Ex. 1267, 2015-2016 Chart of ADOC Suicides (doc. no. 1108-38) (showing 12 suicides between September 2015 and December 2016). ADOC has now implemented suicide risk assessments as part of their regular intake procedure based upon Dr. Patterson's recommendation. However, as discussed in more detail later, ADOC has not incorporated suicide risk-assessment tools into other parts of the mental-health care system, despite Dr. Patterson's recommendation to do so.

b. Inadequate Referral Process

The other mechanism for identifying and classifying prisoners with mental illness, the referral process, is riddled with delays and inadequacies. The purpose of the referral process is to identify prisoners whose mental illnesses develop during their incarceration and prisoners whose mental-health needs were not identified during the intake process. Furthermore, the referral process enables the system to respond to the changing mental-health needs of prisoners as they arise, regardless of their initial mental-health assessment results. In a functioning system, referrals from prisoners or staff would be triaged based on the urgency of the articulated needs: some may warrant immediate action, such as placement in a suicide-watch cell or an immediate evaluation by a psychiatrist, while others may be addressed over a longer period of time. According to Dr. Patterson, the defense expert, triaging is important because the assessment process enables clinicians to determine appropriate next steps, and delays in doing so pose a risk of untreated symptoms, including a risk of death from critical yet unmet treatment needs.

As with the intake screening procedure, experts from both sides concluded that ADOC's referral process suffers from serious deficiencies. First, ADOC does not have a system to triage and

identify the urgency of each request, and to make referrals according to the level of urgency. MHM's contract-compliance reports have identified this issue year after year, starting in 2011: the reports stated that processed referral slips did not reflect acuity levels, and the logs of referrals did not record the relevant date and time information, making it impossible to ensure timely processing and referrals. Despite perennial indications that referral requests were being processed in a haphazard manner, ADOC still does not have any system of tracking and processing referrals to ensure that urgent requests are actually referred to providers, or that providers are able to handle requests in a timely fashion: an audit performed by defense experts in May 2016 revealed that referral forms still do not note urgency levels that would enable triaging.²⁹

²⁹ Plaintiffs have objected to the use of the audit results on *Daubert* grounds, contending that the methodology used to conduct the audit was not reliable and has not been accepted in the field of correctional mental-health care as a way of evaluating adequacy of care. Based on Dr. Patterson's testimony on the methodology, the audit results are admitted. However, as will be explained more extensively in a separate *Daubert* opinion, limitations in the methodology and implementation of the audit have been taken into consideration in evaluating their weight.

Second, the referral process is inadequate because correctional officers are ill-positioned to notice behavioral changes. As plaintiffs' expert Vail testified, severe overcrowding and understaffing make it difficult for correctional officers to notice behavioral changes. It is simply unrealistic to rely on ADOC's overburdened correctional officers to identify and refer prisoners who may need mental-health treatment, except perhaps for those prisoners with the most obvious symptoms of mental illness.

In addition to delaying treatment or leaving mental-health symptoms untreated, ADOC's broken referral process has contributed to the phenomenon of prisoners engaging in self-harm or other destructive behavior in order to get attention of mental-health staff. Experts described examples of "increasingly desperate acts" to get the attention of MHM and necessary services, such as self-injury, fire setting, and suicide attempts. Joint Ex. 460, Burns Expert Report (doc. no. 1038-1044) at 29; Hanev Testimony at vol. 1, 72 (describing frequent fires in segregation units as desperate attempts to get attention for their needs, including mental-health needs). The court also heard from class member J.A., who has repeatedly engaged in self-harm and expressed suicidal ideation. After summarizing his various attempts to obtain mental-health services while in segregation, including starting fires, J.A. observed, "[G]etting help in prison is harder than getting out of prison." J.A. Testimony at ___. These are snapshots of unnecessary pain and suffering that could be avoided or at least minimized if prisoner requests for mental-health services were being addressed on a timely basis.

c. Inadequate Classification of Mental-Health Needs

ADOC also fails to classify the severity of mental illnesses accurately. The mental-health coding system is intended to reflect the level of functioning a mental-health patient has and correspond to his or her treatment needs and housing requirements. Through multiple revisions, the coding system now includes 13 different codes, ranging from MH-0 to MH-9, with sub-codes for some levels, such as MH-2d. In broad strokes, a higher numbered MH code reflects more intensive care needs: MH-0 refers to no mental-health care need; MH-1 and MH-2 refer to mild impairment or stable enough to receive only outpatient care; MH-3 through MH-5 refer to those who need inpatient care, in either the residential treatment unit (RTU) or intensive

stabilization unit (SU); MH-6 refers to those who need to be hospitalized. See Joint Ex. 105, Admin. Reg. § 613 (doc. no. 1038-127).³⁰

³⁰ ADOC's mental health coding system was amended twice in 2016. According to the latest version, a new level (MH-9) refers to those who cannot be transferred to any facility and must be held at the current housing facility. However, the description of the code does not give any specifics about the patient's symptoms and only specifies who may revise such a code. Joint Ex. 107, Admin. Reg. § 613-2 (doc. no. 1038-130). There is no MH-7 or MH-8 in the system.

Testimony from multiple witnesses and experts made clear that ADOC's mental-health coding system often fails to accurately reflect prisoners' mental-health needs.³¹ For example, plaintiff R.M. has been coded MH-2 and housed in general population for most of his incarceration since 1994, despite his severe paranoid schizophrenia and resulting delusions. He was eventually given a higher code and transferred to the Bullock RTU,¹²⁰⁵ but Dr. *1205 Burns testified that he may need an even higher level of care, and that he suffered from inadequate care while housed for years in an outpatient facility. Likewise, a prisoner identified as # 12 in Dr. Burns's report was clearly delusional and believed that televisions and radios were speaking to him; he was in an outpatient facility at the time of his interview with Dr. Burns, but needed to be in a long-term, inpatient facility due to the severity of his schizophrenic symptoms. An email from Associate Commissioner Naglich to Dr. Hunter in December 2015 discussed a schizophrenic prisoner who was clearly delusional and eventually killed another prisoner and threatened to kill a correctional officer; he had been coded as MH-1, which is intended to denote someone who is stabilized with a 'mild' impairment. Lastly, Dr. Hanev gave examples of patients who have been repeatedly placed on suicide watch for engaging in self-harm and

suicide attempts but were designated as MH-0—that is, not having any mental-health treatment needs—including plaintiffs L.P and R.M.W., and former plaintiff J.D. Haney Testimony at vol. 2, 113–20; *see* Pl. Dem. Ex. 131, Movement History of Exemplar Plaintiffs (doc. no. 1126–10).

³¹ Dr. Burns explained that inappropriate classification of mentally ill patients partially stems from a lack of proper documentation in treatment plans and progress notes. Combined with a high turnover rate of staff and frequent transfers between facilities, inadequate documentation means that information about a patient's symptoms and treatment is not well preserved. As a result, symptoms are evaluated without the context and history of each patient, leading to a higher risk of under-classifying and underestimating the acuity of mental illnesses.

d. Inadequate Utilization of Mental-Health Units

As experts from both sides concluded, ADOC does not adequately utilize residential treatment unit beds and fails to provide residential-level care to those who need it, leading to persistent or worsening symptoms. Defendants' expert Dr. Patterson opined that roughly 15 % of prisoners on the mental-health caseload should be housed in RTU or intensive stabilization unit settings; in other words, approximately 515 ADOC prisoners should be housed in the RTU or the SU.³² However, only 310 of the 376 RTU and SU beds were being used to house prisoners with mental-health needs as of September 2016. Joint Ex. 344, September 2016 Monthly Operating Report (doc. no. 1038–703). This practice of not filling even existing mental-health unit beds has persisted for years, as reflected in MHM's monthly operating reports. *See, e.g.*, Joint Ex. 321, December 2015 Monthly Operating Report (doc. no. 1038–666) at ADOC0319118–19; Joint Ex. 320, December 2014 Monthly Operating Report (doc. no. 1038–665) at ADOC0319016–17 (showing 299 beds

occupied in December 2015 and 177 beds occupied in December 2014).³³ Dr. Patterson credibly opined that this significant shortfall suggests ADOC has been under-identifying those who need residential treatment—a problem that starts with the inadequate intake screening process. He also observed another flaw in RTU admission management: he explained that those who are repeatedly sent to the SU should be admitted to the RTU to receive more long-term, intensive treatment, rather than being released back to general population after a stay in the SU. He also noted that prisoners who are admitted to RTUs often stay only for a short period, despite their pronounced needs for long-term treatment. Because there is little programming available in the RTU, the utility of an RTU placement is quickly exhausted, according to Patterson.¹²⁰⁶ Dr. Burns agreed with Dr. Patterson's assessment that ADOC needs to house more patients in the RTU, especially when RTUs have available beds. She also observed during her facility visits multiple prisoners who needed residential treatment but were in general population.

³² These numbers are based on the number of patients currently on the mental-health caseload. Because ADOC misses a significant portion—at least 5 % of the inmate population, or a third of those who are already on the caseload—of those who need mental-health care during its intake screening and referral processes, it is likely that even more prisoners need residential mental-health care than calculated here.

³³ As explained in more detail later, many of the cells in the mental-health unit are being used to house segregation prisoners without any mental-health needs.

In sum, ADOC's significantly inadequate identification and classification practices create a substantial risk of serious harm to prisoners with mental illness. These practices result in a failure to treat or under-treatment of prisoners' serious mental-health needs. As will be discussed later,

these practices also have a downward-spiral effect on the rest of the system: those who do not get needed treatment often end up in crisis cells, frequently receive disciplinary sanctions, and may be placed in segregation, where they have even less access to treatment and monitoring.

3. Inadequate Treatment Planning

Correctional systems have a duty to provide minimally adequate mental-health care to prisoners with serious mental-health needs. *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976) (deliberate indifference to serious medical needs of prisoners constitutes "unnecessary and wanton infliction of pain proscribed by the Eighth Amendment") (internal quotation and citation omitted); *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) (holding that prisoners have a constitutional right to psychiatric care under *Estelle v. Gamble*). Expert testimony from both sides established that such minimally adequate care requires treatment planning. Treatment planning is the foundation of all forms of health care; through the process, providers involved in the treatment identify the patient's target symptoms, treatment goals, and next steps, and coordinate long-term care as necessary. When staff from multiple disciplines—for example, psychiatric, psychological, nursing, and even correctional—are involved in a patient's treatment, treatment planning should involve key people from each discipline in order to ensure consistent and informed treatment. Treatment planning is particularly important in the prison context, where prisoners have almost no ability to ensure the consistency of their own treatment; it is even more crucial in the context of ADOC, where prisoners are frequently transferred across correctional facilities and the staff turnover rate is high. As experts described, without coordinated long-term planning, treatment is often ineffective and runs a substantial risk of prolonging pain and suffering of those who have treatable mental illnesses. Failure to provide meaningful treatment planning constitutes a substantial deviation from acceptable

standards of prison health care; such deviations can pose a substantial risk of serious harm to those who have serious psychiatric needs. *Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996) (noting that providing care where the quality is "so substantial a deviation from accepted standards" can constitute an Eighth Amendment violation).³⁴

^{1207*}1207 ADOC fails to provide adequate treatment planning. First, experts for both sides found that ADOC's treatment plans are not individualized to each prisoner's symptoms and needs, resulting in 'cookie-cutter' plans that remain the same even though there may have been changes in that prisoner's mental-health state. As defense expert Dr. Patterson explained, a patient's lack of progress in treatment does not justify the use of a cookie-cutter treatment plan: providers should try different interventions that could be effective, rather than sticking to the same intervention when the patient is not responding to it. Likewise, treatment plans should reflect the changes in the treatment environment, such as an admission to the SU or placement on suicide watch. However, ADOC treatment plans often have general patient goal statements such as "identify triggers" or "identify coping mechanism" repeated in subsequent plans, without showing any progress or change in the mental state of the patient; they also often fail to reflect the fact that the patient has been placed in a different environment that would impact his or her mental health and treatment mode. Whether the rote repetition results from a lack of follow-through on the plans or mere sloppiness in filling out the plans, both present hazards to prisoners with mental illness.

³⁴ As an aside, the court notes that treatment planning can be viewed as serving similar purposes as medical recordkeeping, which also ensures continuity of care and coordination between different providers. Courts have held that maintaining accurate and complete records of mental-health treatment is an essential component of a minimally adequate mental-health care system. See, e.g., *Ruiz v. Estelle*, 503

F.Supp. 1265, 1339 (S.D. Tex. 1980) (Justice, J.), *aff'd in part, rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982), *opinion amended in part and vacated in part*, 688 F.2d 266 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042, 103 S.Ct. 1438, 75 L.Ed.2d 795 (1983); *Balla v. Idaho State Bd. of Corrections*, 595 F.Supp. 1558, 1577 (D. Idaho 1984) (Ryan, J.) (adopting the *Ruiz* standard of six essential components of a minimally adequate mental health treatment program, including complete and accurate records); *Coleman v. Wilson*, 912 F.Supp. 1282, 1298 (E.D. Cal. 1995) (Karlton, J.) (same).

ADOC's treatment-team meetings are also inadequate. Treatment-team meetings are an essential part of the treatment planning process, where providers from various disciplines involved in the patient's treatment discuss developments and next steps to ensure coordinated care. However, the meetings at ADOC happen haphazardly, with members of the treatment team missing from the meetings and signing new treatment plans on different days. This haphazard attendance creates a risk of different providers having an inconsistent approach or course of treatment for the same patient because some of the treatment team are unaware that a new treatment plan has been put into effect. Furthermore, the meetings frequently occur without any participant with prescription privileges, especially at some outpatient facilities where the only provider with prescription privileges is a nurse practitioner who visits the facility as infrequently as once per month. As a result, treatment plans are often developed without the input of a provider with expertise in psychotropic medication. Experts from both sides agreed that ADOC's treatment planning without all necessary participants is problematic and falls below the standard of care because it deprives patients of a coherent treatment plan and continuity of care.

Inadequate treatment planning subjects mentally ill prisoners to the risk of exacerbating symptoms, prolonged pain and suffering, serious injury from self-harm, and even death. As Dr. Burns explained, treatment plans serve an essential function of making sure that all providers' treatment is consistent. Dr. Burns credibly opined that not having a consistent approach to a prisoner's treatment poses a risk of exacerbating or neglecting problems that may arise from mental illness, such as self-injury. Specifically, according to Dr. Burns, failing to address the issue of repeated self-injury due to a lack of coordinated treatment and inconsistent approaches by different providers creates a substantial risk that patients will continue to engage in self-harm; these patients can eventually end up disabled or dead as a result of continued self-harm. Defense expert Patterson agreed with Burns's emphasis on the critical importance of coordinated treatment and identified inadequate treatment planning as one of the most significant deficiencies in ADOC's mental-health care system.

In the context of ADOC, where transfers of prisoners and changes in providers are frequent, the impact of inadequate treatment planning is exacerbated. Because written treatment plans are generic, counselors and patients often have to start from scratch when patients are moved from counselor to counselor. A former mental-health professional testified that prisoners who are transferred to a new counselor are often adversely affected, not only because the counselor has to start anew the process of building rapport with the prisoner, but also because treatment plans and progress notes often contain insufficient information to enable a different provider to learn about the patient or continue a consistent course of treatment. Plaintiff C.J. also testified to the difficulties in having to start over with a new counselor after each transfer. In sum, without the continuity of care and consistent treatment approaches provided through proper treatment planning, providers are substantially hindered

from addressing symptoms of mental illness, exposing patients to continued pain and suffering, worsening self-injurious behavior, serious bodily injury, or even death.

4. Inadequate Psychotherapy

Constitutionally adequate mental-health care in prisons requires more than simply providing psychotropic medications to mentally ill prisoners. Prison systems must provide not only psychotropic medication but also psychotherapy or counseling to prisoners who need it to treat their serious mental-health needs. See *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) (adopting district court's conclusion that "[e]ven if this case involved failure to provide psychotherapy or psychological counselling alone, the court would still conclude that the psychiatric care was sufficiently similar to medical treatment to bring it within the embrace of *Estelle*."). As Dr. Burns explained, from a clinical perspective, having both modalities of treatment—medication and counseling—is important because one particular modality does not work for everyone. According to Dr. Burns, research indicates that seriously mentally ill patients need counseling and medication, along with non-structured or recreational activities, and that psychotherapy is an effective and essential mode of treatment for mental illness. She credibly opined, and the court finds, that not providing individual or group therapy poses a substantial risk of serious harm, including continued symptoms, pain, and suffering, as well as self-harm and suicide attempts.

Insufficient mental-health and correctional staffing at ADOC undermines the availability and quality of individual and group counseling sessions. First, as explained earlier, inadequate mental-health staffing combined with the increasing number of prisoners on the mental-health caseload has driven up the number of prisoners on each counselor's caseload. As a result, both the frequency and quality of counseling sessions have suffered over

time, according to both experts and MHM providers. MHM's medical director Dr. Hunter testified that the caseload has increased in recent years to the point of taxing his staff's ability to carry out MHM's contractual obligation: MHM counselors' caseloads have increased from 60 patients to between 80 and 90; some facilities have only one counselor, who treats more than 100 patients; nurse practitioners' caseloads have increased from 10–15 patients per day to 20–25 patients per day.

MHM's program director Houser also testified that caseloads for counselors were sometimes twice as much as they should be; as a result, she said, counselors are "continually getting behind."

¹²⁰⁹Houser Testimony *1209 at vol. 2, 25. In addition to seeing patients, counselors also have to attend meetings, document their treatment actions, design treatment plans, go on rounds in segregation units, and respond to crises as they arise.³⁵ Due to counselors' increasing caseloads and mounting job responsibilities, individual counseling appointments are frequently canceled or delayed. For example, during a spot audit of the caseload at Bibb, 212 out of 213 cases had overdue counseling appointments. Pl. Ex. 576, December 2, 2015 Email from Davis-Walker to Houser (doc. no. 1112–26). Defense expert Patterson also observed that counseling appointments are frequently delayed due to staffing shortages and opined that "these delays contribute to a failure to provide necessary mental health services"; the potential harm in such delayed appointments includes "continued pain and suffering of mental health symptoms including suicide and disciplinary actions due to inadequate treatment." See Joint Ex. 461, Patterson Expert Report (doc. no. 1038–1046) at 64.

³⁵ Much testimony centered around how long a typical counseling session lasts. The court heard conflicting testimony: some counselors testified that most sessions do not last longer than 30 minutes; some refused to give a more concrete estimate

altogether, other than saying their sessions might range from ten minutes to two hours. Moreover, there is no documentary or otherwise reliable evidence establishing such numbers. Given the lack of documentation, the number of patients on each clinician's caseload at any given moment is a more reliable proxy for the quality and frequency of therapy: even if some patients receive sufficiently long counseling sessions, the context of overwhelming caseloads means that the clinicians are not able to give such counseling sessions to most patients, by virtue of not having enough time in the day and having other duties. Therefore, the court finds that the overwhelming caseloads of psychiatric providers and counselors as relayed by Dr. Hunter and Houser are more indicative of the quality and frequency of counseling sessions for the vast majority of prisoners on the mental-health caseload.

Caseloads that are—as MHM's Houser put it—much higher than an "acceptable standard" may explain why so many prisoners testified that 'counseling sessions' do not amount to much. Dr. Patterson's review of the medical records within ADOC revealed that most progress notes from counseling sessions only contained short descriptions of symptoms, instead of reflecting clinical judgments and overall assessments of the patient's progress. Similarly, Dr. Burns noted that the overwhelming majority of progress notes she reviewed indicated that the patient was 'fine,' had 'no complaints,' or had nothing to talk about. She explained that a short, vague statement like "I'm alright" is not a sufficient indicator of a stable mental-health state: instead of moving on to the next patient simply because the patient's initial self-reporting does not expressly indicate distress, the clinician should probe deeper; notes on asking follow-up questions about medications, mood, job assignments, or disciplinary sanctions would reflect a proper counseling session. Based on the

prisoners' descriptions and the experts' observations, the court finds that counseling sessions are often inadequate.

The chronic lack of sufficient correctional staffing has also contributed to frequent disruptions in the provision of psychotherapy. Dr. Burns credibly opined that insufficient correctional staff has interfered with access to treatment, as evinced by frequently canceled or delayed individual counseling sessions and group sessions. In particular, as she noted, the frequency of counseling sessions for those in segregation is especially low due to officer shortages: since segregation inmates must be escorted from their cells by correctional officers, mental-health appointments are frequently canceled or delayed when there are not enough officers to cover both the essential security posts and mental-health ^{1210*}1210 appointments. Ayers, defendants' correctional expert, also credibly opined that ADOC was failing to respond to the needs of mentally ill prisoners due to the correctional staffing shortage. Likewise, a nurse practitioner at Donaldson credibly testified that she has experienced a persistent problem of not being able to see patients due to a lack of correctional staffing, and that the problem has been getting worse over the years. She and other providers testified that when insufficient correctional staffing does not allow prisoners to be escorted to the mental-health offices, the mental-health providers may go to the cells themselves and attempt to talk to their patients at the cell-front. However, as agreed by MHM's medical director Hunter and experts Burns and Hancy, these cell-front check-ins are insufficient as counseling and do not constitute actual mental-health treatment; Hancy explained that these contacts serve solely a monitoring purpose—that is, to ensure that the patient is responsive and not decompensating, rather than to treat the underlying mental illness. Indeed, while visiting five different facilities and their segregation units, the court observed the difficulty of standing outside a closed cell door to speak to a

prisoner about mental-health needs: most cell doors are solid with small, perhaps 12-by-6-inch windows, some of which were completely fogged over and others shielded by wire mesh or obfuscated by paper pasted on the window, either by the prisoner or from outside; and most of these segregation or high-security cells are in large, auditorium-like spaces, where sounds echo throughout the units, resulting in a panoply of unintelligible yet very loud noises. Conducting a counseling session across the door in these loud spaces seemed nearly impossible: the court had a hard time imagining having a meaningful conversation in such an environment, let alone a conversation for the purposes of mental-health treatment.

As with these cell-front sessions, ADOC's provision of psychotherapy often lacks confidentiality. Experts and other clinician witnesses explained that confidentiality between providers and patients is a hallmark of and a necessary condition for mental-health treatment, yet some ADOC facilities lack a confidential setting for counseling sessions. Obviously, cell-front interactions between mental-health staff and prisoners are not confidential, as many staff witnesses testified, and as the court observed firsthand. Moreover, many facilities lack mental-health offices with windows and doors that would ensure the visibility of the counseling session to the correctional officer who is providing security without sacrificing sound confidentiality. For example, as the court saw on its tour of St. Clair Correctional Facility, the walls in the mental-health offices do not extend from floor to ceiling, and they lack doors; in other words, the offices resemble tall cubicles. Anyone nearby, including other prisoners and the correctional officer who escorted the prisoner there, could hear the content of a counseling session. Moreover, correctional officers often stand by the door of counseling offices with the door ajar for safety purposes, and counseling sessions are sometimes held in lieutenant's offices where other correctional

officers are present and holding disciplinary hearings. As Dr. Haney explained, prisoners often do not feel safe sharing their mental-health issues in the presence of correctional officers or other prisoners because what they share with the mental-health staff may make it easier for others to exploit them; as a result, the lack of confidentiality undermines the effectiveness and quality of counseling sessions.³⁶ The quality of psychotherapy also suffers due to use of unsupervised, unlicensed counselors, referred to as 'mental health professionals' in ADOC. The court finds, based on expert testimony from both sides, that the lack of supervision for unlicensed MHPs is a significant, system-wide problem affecting the delivery of mental-health care within ADOC. ADOC's own contract for mental-health care specifies that all MHPs must be licensed. However, only four out of 47 MHPs employed at ADOC were licensed as of February 2016, and this problem has persisted for years.³⁷ The standard of care and state regulations mandate that an unlicensed counselor be supervised by a licensed psychologist, who is required to co-sign the counselor's notes and review the treatment provided. Because MHM employs only three psychologists, most MHPs work at prisons without a psychologist, and the chief psychologist of MHM, Dr. Woodley, provides no actual supervision to unlicensed MHPs. In fact, most MHPs' clinical work is supervised by their respective site administrators, who are also mostly unlicensed counselors with their own caseloads—in other words, the supervisors generally have the same level of credentialing and education as the MHPs they are supervising. If the site administrators have any problems, they consult with Dr. Woodley. Dr. Patterson, a defense expert, credibly opined that it is unacceptable for an unlicensed counselor, rather than a licensed psychologist, to supervise another unlicensed counselor. He identified the lack of supervision of unlicensed providers as a systemic deficiency.

³⁶ By the same token, Dr. Haney found it problematic that at some facilities 'inmate newsletters' identify exactly who is on the mental-health caseload, thereby increasing the stigma of mental-health care and discouraging prisoners from seeking mental-health treatment due to fear of exploitation by others.

³⁷ Associate Commissioner Naglich testified that unlicensed counselors can work in ADOC facilities only if they obtain a license within six months of starting employment. However, this testimony was contradicted by the employment data, as well as Houser's testimony that MHM cannot hire licensed counselors within the contract budget. Indeed, of the four current and former MHM counselors who testified at trial, none had become licensed despite having worked in ADOC for multiple years.

ADOC's provision of group therapy is also inadequate. Dr. Burns testified that infrequent and inadequate individual counseling can pose a substantial risk of serious harm to prisoners with mental illness, if the same patients do not have access to group therapy. Burns further explained that group therapy is especially important in a correctional system, which often does not have enough resources to provide individual counseling to all of the prisoners who need psychotherapy. Group sessions, like individual therapy, help prisoners with mental illness manage their symptoms, so that they do not deteriorate to the point of needing residential treatment; outpatient group therapy also enables mental-health staff to identify those who need more intensive treatment. Burns opined that therapy groups on depression, post-traumatic stress disorder, and medication management issues should always be offered to those on the mental-health caseload, and that not offering such group treatment in the context of an under-resourced correctional mental-health system creates a substantial risk of harm to prisoners suffering from those illnesses. Despite the

importance of group therapy for those who receive inadequate individual therapy, many seriously mentally ill ADOC prisoners with little access to individual therapy also have little access to group therapy. MHM's program director Houser admitted that groups have been not happening at many facilities, including RTUs and SUs, due to ¹²¹²the correctional staffing shortage.*¹²¹²In sum, mental-health understaffing, correctional understaffing, the use of unsupervised, unlicensed counselors, and lack of confidentiality all undermine the efficacy and frequency of psychotherapy for mentally ill prisoners within ADOC. These conditions have created a substantial risk of serious harm for those who need counseling services, leaving them at a greater risk for continued pain and suffering, self-injurious behavior, suicidal ideation, and, as discussed later, disciplinary actions in response to symptoms of mental illness.

5. Inadequate Inpatient Care

Problems of inadequate psychotherapy and treatment planning become even more pronounced for prisoners in mental-health units, where ADOC houses the most severely mentally ill prisoners in its custody. Mental-health units (also referred to as inpatient units) include residential treatment units and intensive stabilization units. These units, which are located at Donaldson, Bullock, and Tutwiler, house about 2 % of prisoners within ADOC's custody.³⁸ Given that prisoners housed in mental-health units have already been identified as having the most severe mental-health needs within ADOC, these patients are at higher risk of decompensation than other mentally ill prisoners if treatment is insufficient or if their housing environment is not therapeutic. And yet, despite ADOC and MHM's awareness of these prisoners' acute needs, the most severely mentally ill have been receiving grossly inadequate care; in fact, one of the experts described ADOC's mental-health units as operating "almost exactly the same way" as segregation, as illustrated by the placement of segregation inmates without mental-

health needs in the same unit and the inadequate out-of-cell time and treatment. Hancy Testimony at vol. 2, 104.

³⁸ Practices within Tutwiler's mental-health units are discussed separately in Section V.B.9.

a. Improper Use of Mental-Health Units

ADOC has had a persistent and long-standing practice of placing segregation inmates without mental-health needs in mental-health units. This practice allows prisoners without mental-health needs to occupy beds that should be reserved for prisoners who have heightened mental-health care needs and seriously undermines the therapeutic purpose of the mental-health units. Starting in 2012 and continuing through 2016, in its yearly contract-compliance reports, quarterly continuous quality improvement (CQI) meetings, and monthly operating reports, MHM repeatedly discussed ADOC's problematic placement of segregation inmates in the RTU and SU. ADOC's own audit of the Donaldson RTU in 2013 also identified the presence of segregation inmates without mental-health needs as a problem. While Associate Commissioner Naglich testified that segregation inmates were moved out of the Bullock SU by the end of 2013, evidence showed that the problem continued through 2016. For example, Brenda Fields, a clinical operations associate from MHM's corporate office, testified that the presence of segregation inmates in the RTUs and SUs was noted as a problem in early 2016. Most recently, in December 2016, the list of prisoners in the Donaldson RTU included 13 segregation prisoners who did not have a mental-health code appropriate for mental-health units. Pl. Ex. 1264, December 2016 Donaldson Segregation List (doc. no. 1099-8) at 14; Culliver Testimony at

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 Dr. Tytell, ADOC's chief clinical psychologist, ¹²¹³explained that wardens place ^{*1213}segregation inmates in the RTU or the SU when they do not have space for them elsewhere. He explained that

MHM currently is expected to contact him or Naglich whenever this happens, but did not confirm whether this was always the case. Nevertheless, according to Tytell, the problem has been recurring. He conceded that it is ultimately the wardens, rather than the mental-health staff, who decide how cells in the mental-health units are used.

As all experts, MHM providers, and Dr. Tytell agreed, placing segregation inmates in a mental-health treatment unit is highly problematic. The reasons are multifold. First, having segregation inmates in the same unit as mental-health patients creates a security risk for mental-health patients: the segregation inmates' presence prevents programming from taking place and diverts correctional officers' attention away from mental-health patients and their needs. MHM's medical director Dr. Hunter testified that housing segregation prisoners in mental-health units compromises mental-health treatment, and that he has made this clear to ADOC. Dr. Woodley, MHM's chief psychologist, informed ADOC that the presence of segregation inmates in the Bullock SU "undermine[s] the utility of this unit making it nearly impossible to operate it for its intended purposes." Joint Ex. 323, February 2016 MHM Monthly Operating Report (doc. no. 1038-668) at 23.

Second, as Dr. Tytell and other experts explained, because mental-health inmates are particularly vulnerable, and those placed in segregation generally have behavioral problems, the presence of segregation inmates increases mental-health patients' risk of being victimized through manipulation or violence. MHM and Dr. Tytell were aware of this risk, as one of the MHM staff members explained during a CQI meeting that using the Bullock RTU as a "disciplinary dorm" is "putting our vulnerable [inmates] at risk." Pl. Ex. 717, July 2015 Quarterly CQI Meeting Minutes (doc. no. 1044-11) at MHM029600. Associate Commissioner Naglich also agreed that

segregation inmates in mental-health units can cause tension within the unit and anxiety to mental-health patients.

The housing of segregation inmates in mental-health units also contributes to the shortage of SU cells for those who actually need urgent mental-health treatment. Associate Commissioner Naglich acknowledged that patients awaiting SU admission could be in an "emergency" situation, as these patients require the highest level of care available within ADOC. Naglich Testimony at vol. 1, 208. However, since 2011, the Bullock SU has had a backlog of patients awaiting admission. While Naglich maintained that after the 2013 audit, ADOC actually moved all segregation inmates out of the Bullock SU in order to alleviate the backlog, she was unable to produce any documentation supporting her testimony. (During her testimony Naglich reassured the court that she could produce documents showing that she did move segregation inmates out of the Bullock SU in 2013. However, when she did bring in documents purportedly showing such transfers, none of them actually showed that any segregation inmates were moved out of the SU.) Moreover, in 2016, MHM continued to report that segregation inmates were still present in the SU, and that SU cell shortages were causing delays for patients who need SU-level care. Clearly, the placement of segregation inmates in SU beds continues to affect the most severely ill.

b. Inadequate Out-of-Cell Time and Programming

ADOC's mental-health units often fail to serve 1214 their therapeutic purpose due to insufficient 1214 out-of-cell time and scarce programming for their patients. One of the plaintiffs' experts, Dr. Haney, who for multiple decades has studied isolation and segregation in correctional facilities, noted that ADOC's 'celled' mental-health units³⁹ resemble and operate like segregation units.⁴⁰ Experts on both sides pointed to specific traits of ADOC's mental-health units that contribute to this segregation-like atmosphere and the lack of a

therapeutic milieu: the presence of segregation inmates within the mental-health units, as explained above; a severe lack of out-of-cell time; and a lack of meaningful treatment activities.

³⁹ A part of each RTU is an 'open RTU,' consisting of dormitories with rows of beds, rather than individual cells.

⁴⁰ Dr. Haney was not the only one who thought ADOC's celled mental-health units were indistinguishable from segregation units. In the corrective-action plan provided to ADOC in 2013, MHM stated that "conceptualiz[ing] the [Bullock] SU as a treatment unit, not as segregation" was necessary to further the goal of stabilizing patients. Ironically, or perhaps not surprisingly, Associate Commissioner Naglich also had a hard time distinguishing between segregation units and stabilization units during her testimony, frequently referring to stabilization units as segregation units.

Out-of-cell time is crucial for patients housed in mental-health units. Without bringing patients out of their cells for counselling sessions, treatment team meetings, group sessions, and activities, placement in a 'mental-health unit' does no good for patients who need the highest level of care; careful observation and treatment cannot happen when confined in a small cell all day. In fact, without out-of-cell time and effective treatment, housing severely mentally ill prisoners in a mental-health unit is tantamount to "warehousing" the mentally ill. See *Wyatt v. Aderholt*, 503 F.2d 1305, 1309 n.4 (5th Cir. 1974) (affirming the district court's finding that a state mental hospital was functioning as a "warehousing institution ... wholly incapable of furnishing treatment to the mentally [ill] and ... conducive only to the deterioration and debilitation of the residents' ") (quoting *Wyatt v. Stickney*, 344 F.Supp. 387, 391 (M.D. Ala. 1972) (Johnson, C.J.)). Furthermore, as Dr. Haney explained, out-of-cell time is especially important for mentally ill prisoners for

two reasons. First, mentally ill prisoners experience more pressure and stress from a confined environment, and they have a more acute need to relieve that type of stress due to their vulnerable mental state; in other words, isolation makes it more likely that their conditions will deteriorate. In that sense, out-of-cell time is in and of itself therapeutic. Second, out-of-cell time ensures that mental-health patients' socialization skills do not atrophy to the point that they become uncomfortable with human interaction altogether.

Patients housed in ADOC's mental-health units receive very little out-of-cell time. This puts them at a substantial risk of continued pain and suffering, decompensation, and self-harm. As Dr. Haney observed, at the Donaldson RTU, patients with serious mental illnesses are left inside their cells virtually all day, with no daily activities; this is similar to ADOC's treatment of segregation inmates, whose out-of-cell time at ADOC does not exceed five hours per week. Dr. Burns concluded, and the court agrees, that the RTUs and SUs offer "little treatment except for psychotropic medication due to staffing level shortages of both treatment and custody staff." Burns Testimony at vol. 1, 26. Dr. Haney also noted that an unduly harsh and punitive practice limiting property makes mental-health units far from therapeutic and exacerbates prisoners' idleness. He observed ¹²¹⁵that mental-health unit inmates ¹²¹⁵are allowed very little property, which means that they do not have books to read or other things to keep them engaged while spending the vast majority of their time in their cells. The court also observed firsthand the idleness of seriously mentally ill prisoners during its visits to Bullock and Donaldson's mental-health units: the majority of prisoners in those units were lying in their cells, often in a fetal position and facing the wall; there appeared to be no way to engage in any remotely meaningful activity in the cell.

Dr. Patterson, the defense mental-health expert, testified that, in prisons around the country, the standard out-of-cell time for those in mental-

health units is ten hours of structured therapeutic activity and ten hours of unstructured activity per week. While a standard practice within the industry does not necessarily set the constitutional floor, a substantial deviation from the acceptable professional standard could support a finding of an Eighth Amendment violation. *Steele*, 87 F.3d at 1269.

Patients in ADOC's RTUs and SUs get a vanishingly small amount of time outside their cells compared to the standard practice. In 2013, MHM acknowledged that the lack of programming was problematic for the Bullock SU, telling ADOC that "[i]ncreased programming will assist in staff's ability to stabilize inmates sooner and address the waiting list problem thus easing the bottleneck." Pl. Ex. 689, MHM Corrective Action—Donaldson May 2013 (doc. no. 1069-5) at 13-14. As of June 2016, three years after the 2013 audit, patients in the SU at Bullock were still getting about 30 minutes of individual therapeutic contact per week and about 2.5 hours of non-therapeutic group contacts per week. Joint Ex. 346, June 2016 Monthly Operating Report (doc. no. 1038-708) at 4.⁴¹

⁴¹ The presence of segregation inmates in the mental-health units contributes to the dearth of out-of-cell time afforded to mentally ill prisoners in those units. Dr. Haney testified that it is very difficult to operate a unit that has mixed populations, and that it is not surprising that a unit that contains both segregation inmates and mental-health patients would be treated like a segregation unit. This is partially because correctional officers get confused as to how to operate a unit with two conflicting purposes—discipline and treatment. Relatedly, having segregation inmates in the unit means that mental-health patients cannot be let out of their cells as easily, especially when correctional staffing is minimal or inadequate.

Prisoners in RTUs do not fare much better than in the SUs: Dr. Patterson found that RTU programming—which provides prisoners' main opportunity to leave their cells—is inadequate.⁴² MHM and ADOC's internal documents also recognized this lack of out-of-cell time for RTU inmates in the 2013 Donaldson audit: the audit results revealed that no groups were being held for Donaldson RTU patients, and that providers were having difficulties keeping appointments due to correctional staffing shortages. MHM's corrective-action plan following the audit stated that "ADOC not enforcing the out of cell time and not supporting MHM with the process" is a challenge in ensuring that RTU patients are let out of their cells daily. Pl. Ex. 689, MHM Corrective Action—Donaldson May 2013 (doc. no. 1069–5) at 12. The problem of inadequate out-of-cell time at the Donaldson RTU has continued in spite of the corrective-action plan: in early 2016, MHM's corporate office recommended "continued advocacy for RTU patients to receive outdoor recreation." Pl. Ex. 115, 2016 Contract–Compliance Report (doc. no. 1070–5) at 15. As of ¹²¹⁶September *1216 2016, Donaldson RTU patients were getting fewer than two group contacts per week on average. Joint Ex. 344, September 2016 Monthly Operating Report (doc. no. 1038–703) at 3.

⁴² Tellingly, Dr. Patterson stated that while Tutwiler's RTU programming is much better than RTUs at male facilities—Bullock and Donaldson—it is still only "close to adequate," but not adequate. Patterson Testimony at vol. 1, 92.

In addition to the lack of general out-of-cell time, mental-health units also fail to provide an adequate amount of treatment to these severely mentally ill prisoners because of shortages of mental-health staff. MHM's program director Houser testified that groups have not been taking place at many facilities, including RTUs and SUs; indeed, an alarmed site administrator at Donaldson informed Houser in August 2015 that staffing

losses at the facility have made it all but impossible to meet the needs of patients at the RTU. In December 2015, Houser asked Dr. Hunter to have one of the psychiatric providers at Bullock, Dr. Edward Kern, provide more services in the RTU in addition to his work in the SU. Dr. Hunter responded that, because the SU was so short-staffed and needed to be prioritized, shifting resources to the RTU would be difficult; he also noted that Dr. Kern had returned after a week of vacation to "what was essentially a zoo on [the SU]." Pl. Ex. 382, Email from Houser to Hunter (doc. no. 1112–6). The 2013 Donaldson audit also found that the psychiatric coverage was insufficient and the logs for RTU rounds by providers were not being kept, making it impossible to tell whether RTU patients were getting any check-ins or treatment or whether their progress was being monitored. Pl. Ex. 689, MHM Corrective Action—Donaldson May 2013 (doc. no. 1069–5) at 1–2.

The correctional staffing shortage also affects the amount of therapeutic care that patients at Donaldson and Bullock receive. Houser admitted that a lack of officers for the RTUs and SUs often cause the cancellation of group activities. The impact of the officer shortage was also consistently documented by ADOC and in reports that were sent to Associate Commissioner Naglich and OHS for their review. For example, during OHS's 2013 audit of Donaldson, the auditors noted numerous deficiencies caused by the correctional staffing shortage. First, mental-health staff were manning laundry and showers instead of providing mental-health care, because there were not enough correctional officers to perform those basic duties. Scheduled activities and out-of-cell time were not being provided due to the correctional officer shortage, and MHM's corrective-action plan stated that the "[RTU] has to be conceptualized as an RTU and not as segregation." Pl. Ex. 689, MHM Corrective Action—Donaldson May 2013 (doc. no. 1069–5) at 9. The same was true at the Bullock SU: the

problem of 'access to patients'—meaning that mental-health staff were unable to provide treatment to patients due to correctional officer shortage—was first identified in 2013, and then again in 2014 and 2016 contract-compliance reports. See Pl. Ex. 114, 2013 Contract-Compliance Report (doc. no. 1070-4); Pl. Ex. 105, 2014 Contract-Compliance Report (doc. no. 1070-3); Pl. Ex. 115, 2016 Contract-Compliance Report (doc. no. 1070-5). As Naglich testified, because there are simply not enough correctional officers, the problem of accessing patients in RTUs and SUs recurs on a regular basis, even when it has been temporarily alleviated through reassigning officers to particularly problematic areas. As a result, patients in the SU often receive their individual psychiatric contact via cell-front check-ins. As explained earlier, this utter lack of confidentiality negates the therapeutic utility of these contacts. Such cursory contacts with the most severely ill patients are gravely inadequate.

The severe effects of warehousing, rather than treating, seriously mentally ill prisoners was crystalized in two incidents at the Donaldson ¹²¹⁷RTU, where two different ^{*1217}patients set their cells on fire out of frustration about not getting let out of their cells. The internal email reporting one of the incidents explained that the problem of not letting patients out of their cells was due to correctional staffing shortages. Pl. Ex. 518, January 22, 2016 Email from Wynn-Scott to Houser (doc. no. 1112-18).

Jamie Wallace's last 10 days in the Bullock stabilization unit further exemplify the inadequate treatment provided to the most severely ill patients: his medical records for his final 10 days reflected no group activities, one cell-side treatment plan note, and two psychiatric progress notes.

The lack of out-of-cell treatment in mental-health units adds the risk of harm posed by the harsh effects of isolation to that posed by inadequate treatment in general. As Associate Commissioner

Naglich admitted, inadequate treatment of patients in inpatient units can lead to "additional exacerbation of their mental health symptoms," including further hallucinations and delusions, and suicide. Naglich Testimony at vol. 3, 144-45. In addition, as experts testified, mentally ill prisoners are at a substantial risk of decompensating and being subject to prolonged pain and suffering when placed in an isolated environment. In other words, ADOC's failure to provide adequate treatment and out-of-cell time in mental-health units forces the most severely mentally ill patients to face yet another risk factor for decompensation, even though their placement was for the specific purpose of alleviating the symptoms of their mental illness. Inadequate out-of-cell time and treatment in this context therefore compounds the risk of harm that is already inherent in a nonfunctioning mental-health care system.

c. Lack of Hospital-Level Care

ADOC also creates a substantial risk of serious harm to prisoners at the most severe end of the mental-health spectrum, because it does not provide hospital-level care or a hospitalization option for prisoners housed there. According to experts from both sides, hospital-level care or hospitalization should be available when patients pose a danger to self or others and interventions in the SU do not improve their condition: due to the harmful effect of isolation in an SU cell, staying in the SUs cannot be a long-term solution for patients who experience repeated episodes of deterioration.

Although many ADOC prisoners require hospital-level care, very few actually receive it. Virtually all psychiatric providers who testified agreed that they knew or noticed ADOC prisoners who needed to be transferred to a hospital. ADOC's administrative regulations dictate that those who are kept in the SU for over 30 days without stabilizing should be considered for hospitalization; the same provision also mandates that the treating psychiatrist recommend a transfer

to a state psychiatric hospital if the treatment team determines that all mental-health interventions possible within ADOC have been exhausted, and that the inmate has not responded to those interventions. Joint Ex. 138, Admin. Reg. § 634, Transfer to State Psychiatric Hospital (doc no. 1038–168). However, ADOC virtually never transfers patients to hospitals, except in the case of prisoners nearing the end of their sentence. Dr. Hunter and Associate Commissioner Naglich corroborated this point, and Dr. Kern could recall only four prisoners in the last six years who were transferred to a hospital before the end of their sentences. Dr. Kern explained that MHM tries to deal with acutely ill patients' symptoms within ADOC even though ADOC cannot provide hospital-level care, instead of pursuing hospitalization as required by the administrative regulation, because the waiting list for a bed in a ¹²¹⁸hospital can be six months long or longer.^{*1218} Several factors differentiate hospital-level care from what is provided in ADOC, as defense expert Dr. Patterson explained. Hospitals are able to offer a high level of monitoring for suicidal and decompensating patients while not isolating them in a cell: hospitals or hospital-like environments are better at treating severely mentally ill patients because patients can leave their rooms to request help from staff, instead of having to wait until correctional officers or mental-health staff check on them; most of the patients' interactions in a hospital are based on doctor-patient or nurse-patient relationships, rather than guard-prisoner relationships; and the goal of the staff is to treat the patients, rather than to incarcerate them. Dr. Kern also admitted that dealing with patients who need hospital-level care within an SU or RTU is challenging because in those units, providers have a very limited ability to give patients out-of-cell time. He also added that, if he could, he would like to have SU patients "four to six, possibly eight hours out of their cell every day," but that this is impossible because "there are not enough security staff." Kern Testimony at 21. In other words, without a hospitalization option or another

method of providing hospital-level care, the providers are forced to choose between the benefits of close monitoring and restriction of activity and the harmful effects of isolation and losing socialization opportunities.

Both Dr. Patterson and Dr. Burns expressed strong disapproval of ADOC's failure to provide hospital-level care. As Dr. Burns put it, waiting for an unstable patient's end of sentence to transfer him or her to a hospital is akin to "someone with chest pain who has to wait until they're released from prison to get taken to a hospital to have the chest pain treated. We wouldn't do that in the case of chest pain. I'm not sure why we do it in the case of inmates with serious mental illness." Burns Testimony at vol. 1, 168–69. Dr. Patterson opined that there should be a hospital-like setting or actual hospitalization of patients with the most severe cases of mental illness; he did not see any hospital-like environment within the ten facilities he toured. He also explained that placement in the stabilization unit, the highest level of care available within ADOC, should be a time-limited treatment intervention, because the SU is a highly isolated setting and likely to exacerbate conditions of those prisoners experiencing acute symptoms; and that if a patient is not stabilized in the SU, the patient should be moved to a hospital. Patterson emphatically stated, without any qualification, that refusing to transfer patients to mental health hospitals until the end of their sentences is simply "wrong," and that it puts the most severely ill patients at a substantial risk of harm. Patterson Testimony at vol. 1, 174. In other words, for the most severe cases of acute mental illness, there is no alternative to a hospital setting, due to these stark differences in treatment options and milieu.

The grave risk of serious harm in failing to provide hospital-level care to severely ill prisoners was quite obvious in the case of Jamie Wallace. Less than two months before he testified in court, clinicians recommended that Wallace be transferred to a hospital. Despite the clinical recommendation, ADOC chose not to pursue

hospital admission. In court, Wallace testified that voices in his head told him to kill himself; and indeed, he had attempted suicide multiple times. After testifying in court, highly agitated and destabilized, Wallace languished in a crisis cell and an SU cell before ending his life. Less than two weeks had passed since his testimony regarding inadequate mental-health care in ADOC.

6. Inadequate Suicide Prevention and Crisis Care

Like its inpatient care, ADOC's suicide-prevention procedures and crisis care suffer¹²¹⁹ from serious deficiencies. Identification, treatment, and monitoring of those who have heightened suicide risks are important because they provide the last safety net before the worst possible outcome in mental-health care: suicide. Reflecting its importance, courts have held that a minimally adequate mental-health care system must have a functioning suicide-prevention program. *See, e.g.*, *Ruiz v. Estelle*, 503 F.Supp. 1265, 1339 (S.D. Tex. 1980) (Justice, J.) ("[I]dentification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program."), *aff'd in part, rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982), *opinion amended in part and vacated in part*, 688 F.2d 266 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042, 103 S.Ct. 1438, 75 L.Ed.2d 795 (1983); *Madrid v. Gomez*, 889 F.Supp. 1146, 1258 (N.D. Cal. 1995) (Henderson, C.J.) (adopting the suicide-prevention program standard from *Ruiz* as part of "constitutional minima"); *see also Greason v. Kemp*, 891 F.2d 829, 835–36 (11th Cir. 1990) ("Where prison personnel directly responsible for inmate care have knowledge that an inmate has attempted, or even threatened, suicide, their failure to take steps to prevent that inmate from committing suicide can amount to deliberate indifference."); *Waldrop v. Evans*, 871 F.2d 1030, 1036 (11th Cir. 1989) (finding that failure of a prison staff member to notify competent

authorities regarding the inmate's dangerous psychiatric state and self-harm may constitute deliberate indifference).

Prisoners are at an elevated risk of suicide due to the conditions prevalent in ADOC facilities. As Dr. John Wilson, the psychologist from MHM's national Clinical Operations Department, explained to MHM's program director Houser, "[e]xperience and research confirm" the following: "Suicides increase with crowding, drugs, assaults, low staffing rates, lack of meaningful programming, and significant changes in facility mission/population such that inmates are moving between facilities more frequently or are uncertain about whether they will be housed or ... when there is basic unrest at a systems level, it can cause a spike." Pl. Ex. 1224, October 1, 2015 Email from Wilson to Houser (doc. no. 1117–24) at 2. Given the widespread presence of these factors in ADOC, the need for effective suicide prevention and crisis care cannot be overstated.

Suicide prevention consists of assessing and managing suicide risk: assessing the risk entails using a suicide risk-assessment tool to identify those who are at heightened risk and the level of that risk; managing the risk involves both short- and long-term care that provides meaningful therapeutic contact to alleviate suicide risk. Suicide prevention also involves physically restricting suicidal prisoners' ability to harm themselves. The short-term care provided to prisoners who are undergoing acute mental-health crises is called 'crisis care.'

The standard of care in correctional mental-health care and ADOC regulations require that a suicidal prisoner be placed in a special cell that minimizes risks of self-harm and suicide. These 'crisis cells' or 'suicide-watch cells' must be free of structural designs that would facilitate self-harm or suicide attempts, such as tie-off points where prisoners can tie a ligature to hang themselves; they also must be free of items that prisoners can use to harm themselves, such as sharp items and ropes.

Patients on suicide watch are stripped of personal belongings and regular clothes and given a suicide-proof blanket and a suicide smock.

Both correctional officers and mental-health staff have the ability to place any prisoner on suicide watch, after which a mid- or high-level provider is required to *1220 conduct a thorough mental-health assessment that includes the use of a suicide risk-assessment tool.⁴³ While on suicide watch, patients are to receive a high level of care in order to resolve the crisis and return to a less isolated and restrictive setting as soon as possible; such care includes close monitoring, daily re-evaluation of treatment plans, and frequent contacts with mid- or high-level providers such as psychiatrists and psychologists. If a patient on suicide watch is not stabilized within 72 hours, mental-health staff is required to evaluate the patient for admission to the stabilization unit. Discontinuing suicide-watch procedures requires an order from a psychiatrist, psychologist, or a nurse practitioner after an in-person evaluation.

⁴³ Suicide risk-assessment tools include a checklist of risk factors and protective factors, such as age, gender, length of sentence, contact with family, and engagement in treatment, just to name a few. These tools also require the clinician to make a holistic assessment based on the answers and the appropriate weight of each factor to estimate the overall risk of suicide.

ADOC prisoners in crisis may alternatively be placed in a crisis cell on mental health observation (MHO). MHO refers to a similar, short-term monitoring status for patients whose conditions are not as acute as those on suicide watch but still merit an observational status, or who have been recently released from suicide watch. Patients on MHO may be released only by a psychiatrist, psychologist, or nurse practitioner, but—unlike in suicide watch—the patients are allowed regular clothes and limited property.

ADOC's suicide-prevention efforts and crisis care suffer from multiple inadequacies. First, ADOC and MHM's use of a suicide risk-assessment tool is too limited to adequately identify those at high risk. Moreover, many prisoners at heightened risk of suicide or self-harm do not receive crisis care because of a severe shortage of crisis cells and staffing, and due to a culture of skepticism towards threats of suicide. Second, suicidal prisoners are often placed in unsafe environments both because of the shortage of crisis cells and because many crisis cells contain unsafe physical structures, such as tie-off points, and dangerous items that can be used for self-harm. Third, prisoners who are identified as suicidal receive inadequate monitoring and treatment. Lastly, inappropriate releases from suicide watch and a lack of follow-up care often push suicidal prisoners back into crises again and again, driving up the demand for crisis cells and diverting resources away from day-to-day, long-term treatment.

ADOC's inadequate crisis care and long-term suicide-prevention measures have created a substantial risk of serious harm, including self-harm, suicide, and continued pain and suffering. ADOC has experienced a dramatic increase in suicide rates in the last two years. Alabama's reported suicide rate was five per 100,000 between 2000 and 2013; by fiscal year 2015–2016, the rate had shot up to over 37 per 100,000. This is more than double the national average of 16 suicides per 100,000 prisoners in state and federal correctional systems. Patterson Testimony at vol. 2, 27; *see also* U.S. Department of Justice, Bureau of Justice Statistics, Mortality in Local Jails and State Prisons, 2000–2013—Statistical Tables (2015) at Table 28. In the fiscal year starting in October 2016, the rate is projected to be over 60 per 100,000, based on the first three months of the year. *See* Pl. Ex. 1267, 2015–2016 Chart of ADOC Suicides (doc. no. 1108–38). Defense expert Dr. Patterson testified that he does not know of any prison system that has a suicide rate

over 25 or 30 per 100,000. It is in the context of ¹²²¹the magnitude of the ^{*1221}suicide rate at ADOC that the court now considers ADOC's failure to provide a functioning suicide-prevention system.

a. Failure to Provide Crisis Care to Those Who Need It

ADOC fails to provide suicide-prevention services and crisis care to many prisoners who need it. This failure stems from inadequate identification of those who are at heightened risk of suicide, combined with a culture of cynicism toward prisoners' threats of suicide and self-harm and a severe shortage of crisis cells. The majority of suicides in ADOC are committed by prisoners who are not on the mental-health caseload, which means that many of the prisoners' needs were never identified through the intake or referral process, and no intervention happened before their deaths. *See* Pl. Ex. 1267, 2015–2016 chart of ADOC suicides (doc. no. 1108–38) (showing eight out of 11 suicides between September 2015 and December 2016 committed by those who were not on the mental-health caseload).

According to correctional mental-health experts on both sides, the administration of a suicide risk-assessment and management tool by a qualified provider is widely recognized to be an essential part of mental-health care: it should be used as a part of the intake screening process and whenever a prisoner threatens or attempts to harm himself or actually does so. The purpose of a suicide risk-assessment tool is to assess whether a prisoner presents an increased risk of suicidal behavior in order to manage that risk through early intervention. As defense expert Dr. Patterson explained, the suicide risk-assessment tool must be completed in a face-to-face encounter by a high-level provider or a mid-level provider with high-level supervision, because the tool comes with clinical guidelines and requires clinical judgment.

ADOC and MHM did not use a suicide risk-assessment tool for many years and only recently began using one only at intake. While examining ADOC's mental-health care in connection with this case, defense expert Patterson noticed that no suicide risk-assessment tool was being used, even though MHM had such a tool. Dr. Patterson recommended that a risk-assessment tool be used throughout the system, including at intake, upon placement in a crisis cell, and any other time a prisoner is deemed to have a heightened suicide risk. He also specifically indicated that a casual assessment without using a form is not acceptable—a form with appropriate clinical guidelines should be used in each instance.

As a result of this exchange, which took place in the summer of 2016—more than two years after this lawsuit was filed—MHM began using a suicide risk-assessment tool at intake for new prisoners entering ADOC.⁴⁴ However, contrary to Patterson's recommendations, MHM is not using the assessment tool when prisoners threaten or engage in self-harm or are placed in crisis cells. For example, Dr. Patterson found no suicide risk assessment had been completed for plaintiff Jamie Wallace in December 2016 despite his repeated threats of self-harm and suicide and his stay in a crisis cell shortly before he killed himself. Prisoners who threaten suicide frequently do not receive any kind of face-to-face assessment by high-level providers, let alone one involving a risk-assessment tool. The failure to perform proper suicide risk assessments to identify prisoners with a heightened risk of suicidal behavior places seriously mentally ill prisoners at an "obvious," substantial risk of serious harm. Burns Testimony ¹²²²at vol. 1, 63.^{*1222} A chronic shortage of crisis cells also contributes to ADOC's failure to provide crisis care to those who need it. While the exact number of crisis cells sufficient for any given prison system depends on the needs of the population and the treatment options available, it is clear that the number of crisis cells in ADOC is grossly inadequate. Witness after witness—

including Associate Commissioner Naglich and MHM managers—agreed that having two crisis cells for 3,800 prisoners at the Staton–Draper–Elmore complex, two crisis cells for 1,900 prisoners at Bibb, and two crisis cells for 2,700 prisoners at Fountain, is insufficient.⁴⁵ MHM's medical director Hunter testified that the number of crisis cells in each of the 15 major facilities within ADOC is insufficient. In addition to the low number of crisis cells across the system, the backlog of placements at the Bullock stabilization unit has contributed to the shortage: when the SU does not have a bed for the most acutely ill prisoners, often due to the presence of segregation inmates, mentally ill prisoners end up staying in crisis cells for much longer than 72 hours, though the explicit purpose of crisis cells is to serve as a short-term placement while the prisoner stabilizes.⁴⁶

⁴⁴ No efforts have been made to administer the risk-assessment tool to the vast majority of prisoners in the system, who went through intake before that date.

⁴⁵ Plaintiffs' expert Vail testified that inadequate outpatient and routine care would increase the need for crisis care, and inadequate crisis care would also increase the number of those who are placed on suicide watch over and over again, reinforcing the need for more crisis cells. Documentary evidence of prisoners being repeatedly placed on suicide watch supports this conclusion.

⁴⁶ The O dorm at Kilby, a small cell block with 13 cells, has been used as overflow crisis cells for the rest of the system. Transferring suicidal prisoners from their home institution to crisis cells at a different institution, while preferable to housing them in a place that is not suicide-proof, poses a host of problems. First, it takes multiple correctional officers to transport a prisoner, which exacerbates the problem of correctional-officer shortages and may not even be possible depending on the staffing

level at the time the crisis is happening. Second, it jeopardizes the prisoner's mental state even further, since changing the environment of someone who is already in crisis can add to the distress the prisoner is experiencing. Dr. Tytell referred to the transfer experience as potentially "traumatic." Tytell Testimony at _____. Third, it interferes with continuity of care, where the team that was familiar with the patient's symptoms and treatment is no longer in charge of treatment, and a new team of providers must get up to speed to treat a new patient, all in the context of time-sensitive care.

A related issue that arose during the trial is how to characterize the O dorm at Kilby. Trial testimony showed that the O dorm is sometimes also used as a segregation overflow for Kilby. Pl. Ex. 1257, Duty Post Log for O Dorm (doc. no. 1097-20) (showing "seg walk" and "seg shower" as part of tasks completed by correctional officers in O dorm). This practice makes it more likely that Kilby will run out of crisis cells. It also raises the same concerns that experts and MHM providers expressed regarding housing suicidal prisoners in a segregation unit or housing mental-health patients with heightened treatment needs and increased vulnerability near segregation inmates in general, as explained in more detail in the section on segregation practices.

Because ADOC has a limited number of cells to work with, ADOC and MHM staff gamble on which prisoners to put in them and frequently discount prisoners' threats of self-harm and suicide, instead of properly evaluating suicide threats by having a qualified provider administer a suicide risk-assessment tool. For example, in CQI meetings and multidisciplinary staff meetings, MHM staff discussed "call[ing] their bluff" and "tak[ing] the gamble" on prisoners who threatened to commit suicide or severely injure themselves. Pl. Ex. 720, February 2014 Quarterly CQI

Meeting Minutes (doc. no. 1044-14) at MHM029579; *see also* Pl. Ex. 718, April 2015 Quarterly CQI meeting minutes (doc. no. 1044-12) at MHM029570 (discussing concerns about ^{1223*}¹²²³ feigning suicidality to avoid being sent to segregation and that it is ADOC's responsibility to find a safe place for "genuinely suicidal inmates" (emphasis in original)). Discussions during these meetings included statements such as "99 % often do not act on their threats." Pl. Ex. 721, January 2015 Quarterly CQI meeting minutes (doc. no. 1044-15) at MHM029614. Staff meeting minutes and medical records of patients also included conclusory statements suggesting that prisoners who are claiming suicidality and self-harm tendencies are in fact malingering or seeking 'secondary gains'—such as getting out of a segregation cell, or getting away from an enemy, or debt problems. In response to MHM staff's use of this type of language in medical records, MHM's Chief Psychologist, Dr. Woodley, instructed staff to not use "malingering" and "secondary gain" in written documentation because one "cannot know [a prisoner's] motivations for certain." Pl. Ex. 721, January 2015 Quarterly CQI meeting minutes (doc. no. 1044-15) at MHM029614. Contrary to this instruction, MHM staff continued to write off prisoners' threats of self-harm as motivated by inmate-to-inmate debt or secondary gains, rather than conducting a proper assessment. In the March 2015 monthly operations report, MHM reported to ADOC that there have been "occasions where the inmate would not be placed on watch despite claiming to be suicidal, especially if the inmate is well known to the treatment staff as having a history of bluffing and/or no actual attempts." Joint Ex. 328, March 2015 Monthly Operations Report (doc. no. 1038-673) at 14. A progress note from Jamie Wallace's medical records dated five days before he committed suicide was representative of this culture: it noted that Wallace was "using crisis cell/threats to get what he wants." Joint Ex. 496, Jamie Wallace Medical Records (doc. no. 1037-1062) at ADOC0399861.

In sum, MHM staff frequently treat threats of self-harm as behavioral rather than mental-health issues, writing off threats instead of delving deeper to address underlying mental-health needs through a mental-health evaluation and suicide risk assessment.⁴⁷

⁴⁷ Some correctional officers also fail to take threats of self-harm seriously, and even worse, respond in dangerous ways. As Dr. Hunter testified, ADOC officers have responded to prisoners' threats of self-harm with sarcasm or cracked jokes about suicidality, and even challenged inmates to follow through with suicide threats; on several occasions, ADOC officers essentially called a prisoner's bluff and then that person attempted suicide.

This skeptical approach towards threats of self-harm poses substantial and obvious risks. First, those who should be on suicide watch may not receive the crisis care that they need and may kill or harm themselves. Gambling with threats of self-harm is dangerous: obviously, as experts and MHM staff agreed, not all prisoners who express suicidality are feigning it, and a number of prisoners do in fact become suicidal and engage in self-harm. Furthermore, the risk of misinterpreting a prisoner's motivation is heightened by MHM's failure to use a suicide risk-assessment tool after an instance or threat of self-harm. Second, hostile attitudes towards prisoners in mental health crises can "cause inmates to become more aggravated and agitated," making it more difficult to treat the inmate. Houser Testimony at vol. 2, 160. Third, prisoners who make threats or engage in self-harm but are not actively suicidal may nevertheless suffer from underlying mental-health issues that need to be addressed.

As experts from both sides agreed, no bright line distinguishes 'behavioral problems' from 'mental-health problems': even if someone is engaging in self-harm for 'secondary gains,' a high-level clinician should evaluate the underlying mental-^{1224*}¹²²⁴ health issues, for four reasons. First, the

presence of suicidality is not a yes-or-no question; according to the experts, it is well established that suicide risk is on a continuum, and a meaningful suicide-prevention program requires monitoring for an increased risk of suicide. Second, even in the absence of genuine suicidal ideation, engaging in self-harm is a mental-health issue because it indicates suffering from psychological distress and a lack of proper coping mechanisms to resolve problems. Therefore, instead of ignoring those who resort to self-harm to seek attention, staff should provide assistance.⁴⁸ Third, as Dr. Burns cautioned, chalking up instances of self-harm to behavioral problems not deserving of treatment may actually encourage such behavior: research in behavioral management shows that negative reinforcement of self-harm is more likely to prompt the prisoner to engage in more dramatic and even lethal self-harm. Finally, people who engage in self-harm can also accidentally kill or severely injure themselves without having a specific intent to do so; therefore, monitoring and assessment are necessary even if a prisoner's suicidality is deemed not genuine.

⁴⁸ Interestingly, on the topic of 'secondary gains,' plaintiffs' expert Vail posited that with a functioning protective-custody system, in which prisoners who feel unsafe can be moved away from their enemies, the problem of trying to determine who is genuinely suicidal would be alleviated. While all prison systems have conflicts among prisoners and a risk of inmate-on-inmate violence, he explained, prisoners in other correctional systems who feel unsafe generally pursue other avenues to protect themselves, such as requesting protective custody or transfer, rather than requesting to be placed on suicide watch. According to Vail, prisoners generally do not request suicide watch solely for protection because suicide cells are not, generally speaking, a desirable environment. This testimony suggests that to the extent non-suicidal ADOC prisoners actually are electing such an undesirable cell environment for

protection, either the protective custody system is inadequate, or general population dorms are ridden with so much violence that it is rational for prisoners to choose suicide-watch cells over the dangerous environment of general population. Vail's observations also indicate that improving the protective-custody system and addressing the underlying problem of prisoner safety could be a safe and effective way of ensuring that only those who need crisis cells are placed there; it would also be a solution that does not involve placing suicidal prisoners at a substantial risk of serious harm by taking a gamble on whether prisoners are actually suicidal.

To emphasize, the court does not mean to suggest that a prisoner must always be kept on suicide watch upon a threat of suicide; as experts noted, some threats of suicide or self-harm are not genuine. However, as the experts explained, these threats should not be written off without the use of an appropriate suicide risk-assessment tool by a qualified provider in a face-to-face evaluation. Based on the overall assessment of the evidence, the court finds that ADOC's current practice was devoid of any system to ensure that suicidal prisoners are appropriately evaluated.

b. Placement of Prisoners in Crisis in Dangerous and Harmful Settings

Due to the chronic shortage of crisis cells, ADOC frequently places those on suicide watch in inappropriate environments, such as offices for correctional staff (also called 'shift offices'), libraries, and segregation cells. These inappropriate placements put suicidal prisoners at a grave risk of self-harm and suicide.

ADOC and MHM have repeatedly placed suicidal prisoners in dangerous environments due to a lack of available crisis cells. MHM's Dr. Hunter complained to ADOC in his March 2015 monthly operating report that ADOC officers at some facilities were placing prisoners on suicide watch

in cells that are not crisis cells to avoid having to travel. He was also aware of at least a dozen times when prisoners in crisis at Bibb Correctional Facility were placed in shift offices over the weekend while waiting for transportation to another facility. ADOC's Dr. Tytell recalled multiple instances in 2015 in which prisoners in crisis were being housed in shift offices for multiple days; he admitted that this practice was inappropriate but commented, "[Y]ou have to work with what you got." Tytell Testimony at _____. During a 2016 ADOC tour, Dr. Haney found a prisoner who was housed in a mental-health office;⁴⁹ the prisoner had been there for over a day without receiving any treatment, even though he was deemed to be suicidal. Lastly, at least one documented case of suicide in the last three years occurred while a prisoner awaiting crisis-cell placement was housed in a room behind a shift office.⁵⁰ Houser Testimony at vol. 3, 55.

⁴⁹ Dr. Haney also noted that this prisoner was locked in the office with no access to a bathroom.

⁵⁰ A related problem is the inadequate mental-health staffing at prisons that provide only outpatient mental-health care: those who are confined in crisis cells, or even more inappropriate settings, such as shift offices or libraries, do not have access to mental-health care over the weekend, because most outpatient-only prisons do not have mental-health staff on weekends. In other words, despite their 'crisis' condition, suicidal prisoners in these facilities are often left in a crisis cell or a non-suicide-proof environment for multiple days waiting to see a mental-health staff member.

This practice of placing suicidal prisoners in unsafe environments increases the risk that prisoners will engage in self-harm, including suicide attempts. The consensus among the experts from both sides, as well as MHM and ADOC staff, was that housing a suicidal inmate in

a space like a shift office is quite dangerous: not only are these places full of items that can be used for self-harm, but, depending on where the prisoner is placed, such placements can also cut off suicidal prisoners from the treatment that they desperately need.

Placing suicidal prisoners in cells that are either in or adjacent to death row or segregation also poses a number of problems. Holman Correctional Facility's suicide-watch cells are located on death row. As plaintiffs' expert Dr. Haney explained, the "juxtaposition of prisoners who are potentially suicidal with prisoners who are under a sentence of death" is "extremely problematic" for those in the throes of a mental health crisis. Haney Testimony at vol. 1, 101–02; Joint Ex. 459, Haney Expert Report (doc. no. 1038–1043) at 35. Defense expert Dr. Patterson agreed: bringing prisoners in crisis from general population into a death-row unit would make them more likely to decompensate, because death-row units are not designed to be therapeutic; moreover, death-row units are largely self-contained and are subject to their own regulations that are likely harsher and more punitive than the regulations in an ordinary unit. Dr. Patterson also expressed concern that death-row inmates would retaliate against inmates in crisis cells, creating even more stress for these vulnerable prisoners.⁵¹

⁵¹ ADOC also sometimes places crisis-care inmates in stabilization units. This is problematic not so much for the suicidal inmates but for the others: according to Dr. Hunter of MHM, housing suicidal prisoners in crisis cells within an SU negatively impacts MHM's ability to care for the severely mentally ill already in the unit.

c. Inadequate Treatment in Crisis Care

The care provided to prisoners on suicide watch is also grossly inadequate. ADOC and MHM fail to provide adequate treatment to patients in crisis cells and, to make matters worse, frequently keep

them in crisis cells for much longer than appropriate or necessary.¹²²⁶ As Dr. Burns credibly opined, out-of-cell counseling sessions for prisoners on suicide watch are important both because they can help eliminate suicidal thoughts and because they assist providers in meaningfully modifying treatment plans to address the causes of a crisis. However, prisoners on suicide watch and mental-health observation are not consistently receiving out-of-cell appointments with counselors.

Prisoners are frequently kept for extended periods of time in crisis cells, instead of being transferred to an RTU or SU for intensive, longer-term treatment. According to ADOC's administrative regulations, anyone who is on suicide watch for more than 72 hours should be considered for placement in a mental-health unit. As experts on both sides agreed, crisis-cell placement is meant to be temporary and should not last longer than 72 hours, because the harsh effects of prolonged isolation in a crisis cell can harm patients' mental health. However, since as far back as 2011, MHM has, by its own report, considered transferring prisoners in crisis to treatment units only in a small fraction of the crisis placements that last longer than 72 hours. See Pl. Ex. 1190, 2011 Contract-Compliance Report (doc. no. 1070-8) at 22 (in 2011, only 20 % of those housed in crisis cells for over 72 hours were considered for transfer); Pl. Ex. 105, 2014 Contract-Compliance Report (doc. no. 1070-105) at 11 (in 2014, 29 %); Pl. Ex. 115, 2016 Contract-Compliance Report (doc. no. 1070-3) at 11 (in 2016, 13 %). MHM's CQI manager testified that extended stays in crisis cells are "sometimes" necessary because there is a "full house" in the appropriate treatment unit. Davis-Walker Testimony at vol. 2, 102. See also Pl. Ex. 1219, September 2014 Emails between MHM and ADOC (doc. no. 1047-10) (discussing a prisoner who was on suicide watch for 25 days at Bibb, waiting for a transfer to Bullock SU).

Contrary to the CQI manager's characterization, documentary evidence showed that prisoners are in fact frequently kept in crisis cells for much longer than 72 hours. See Pl. Ex. 721, January 2015 Quarterly CQI Meeting Minutes (doc. no. 1044-15) at 4 (showing examples of long crisis-cell stays, such as 240 hours at Limestone, 429 hours at Staton, and 620 hours at Ventress, and suggesting that weekend hours were not being counted); Pl. Dem. Ex. 141, 2016 Crisis Cell Placements (doc. no. 1156-2) (showing that a majority of facilities have multiple prisoners being housed in crisis cells for longer than 144 hours, some of them exceeding 200 hours, in 2016). At St. Clair, Dr. Haney confirmed that one of the prisoners he interviewed had been housed in a barren suicide-watch cell in the infirmary for five months—well beyond the intended duration of crisis-cell stays. These extremely lengthy stays in crisis cells contribute, in turn, to a shortage of crisis cells throughout the system. They also illustrate that prisoners are not getting the treatment they need to stabilize and be moved out of crisis cells, or that ADOC and MHM are leaving these mentally ill prisoners in extremely isolated environments for longer than appropriate.

d. Unsafe Crisis Cells

Despite their purpose of preventing self-harm and suicide, crisis cells in ADOC facilities are unsafe. First, crisis cells are riddled with physical structures that provide easy opportunities to commit suicide. Experts from both sides agreed that having crisis cells free of tie-off points is a critically important feature of suicide prevention in prisons. The National Commission on Correctional Health Care (NCCHC), a professional organization that promulgates standards for correctional health care and provides accreditation to facilities that follow those standards, requires that crisis cells be free from tie-off points that can be used for self-injurious behavior.⁵² ADOC's history makes clear the critical importance of this issue: all but one suicide within ADOC in the last two years

happened by hanging. However, many of ADOC's crisis cells have easily accessible tie-off points, such as sprinkler heads, hinges, fixtures, and vents, making them incredibly dangerous for suicidal prisoners. In fact, defense expert Dr. Patterson stated that making crisis cells suicide-proof is the "number-one issue" to be addressed. Patterson Testimony at vol. I, 296.

⁵² While professional standards like those promulgated by NCCHC do not necessarily set the constitutional floor for minimally adequate mental-health care under the Eighth Amendment, substantial deviations from accepted standards can indicate an Eighth Amendment violation. *See Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996) (holding that providing care where the quality is "so substantial a deviation from accepted standards" can constitute deliberate indifference). Moreover, ADOC's contract with MHM requires MHM to comply with those standards.

Examples of unsafe crisis cells abound. As Dr. Haney noted and the court saw firsthand during prison visits in February 2017, in the Bullock SU, where some prisoners on suicide watch are kept, sprinkler heads are located directly above the sink and the toilet, making it easy for suicidal prisoners to climb up to tie a ligature on the sprinkler head. In fact, that is how Jamie Wallace committed suicide while housed in an SU cell at Bullock. As plaintiffs' experts observed, crisis cells in St. Clair, Kilby, and Holman all have tie-off points; MHM's Houser also admitted that many crisis cells across ADOC facilities are out of compliance with NCCHC standards for suicide cells because they have tie-off points.

Unsurprisingly, MHM staff have repeatedly expressed concerns about the safety of crisis cells in multiple facilities, as reflected in contract-compliance reports and CQI meeting minutes: in 2011, staff expressed concern about the unsafe features of crisis cells at Fountain; in 2012, staff reported concerns about the safety of Ventress

crisis cells; in 2016, MHM's contract-compliance report stated that crisis cells in Holman are unsafe because of the open bars on the doors.

Another dangerous aspect of many ADOC crisis cells is the difficulty of monitoring the prisoner inside. The design of the cell doors and windows and the layout of the facilities often prevent a direct line of sight into the cell. For example, Dr. Haney testified that suicide-watch cells at Donaldson, located in the infirmary and known as Z-Cells, had grates over the windows that made it very difficult to see into a cell even when standing directly in front of a door and peering in. At St. Clair, Dr. Haney noted that suicide-watch cells were located in a hallway in the infirmary; they, too, were hard to see into and easy to ignore. Pl. Dem. Ex. 107, St. Clair Suicide Watch Cell (doc. no. 1125-62). Associate Commissioner of Operations Culliver noted that even though Holman crisis cells have barred fronts, it is nonetheless impossible to see into these cells from the officers' cube located closest to them. Culliver also acknowledged that the solid crisis-cells doors at many facilities, including Bullock, Donaldson, Fountain, Kilby, and St. Clair, make it impossible for an officer or mental-health provider on the unit to see into the cells and check on the prisoners housed within them without walking up to the door and looking through the small glass window.

ADOC's practice of allowing prisoners in cells to cover the windows with paper or other material exacerbates the visibility problem. Dr. Haney noticed this practice in Donaldson, Holman, St. Clair, and Bibb, describing it as incredibly problematic because ¹²²⁸it blocks any type of monitoring entirely. Dr. Haney witnessed a particularly disturbing incident while touring Bibb. He entered the infirmary and went to speak with the prisoners housed in the crisis cells. As he was speaking to one, a lawyer touring the facility with him discovered that a prisoner in another crisis cell was, at that very moment, attempting to hang himself—the prisoner had somehow procured a cord to wrap around his neck and had

attempted to cover the window with a blanket. Allowing prisoners to cover the windows of their cells is dangerous in any context, but it is particularly unacceptable for prisoners known to be suicidal. Due to the visibility problems with many ADOC suicide-watch cells, defense expert Patterson opined that suicidal prisoners should be under direct, constant observation while in those cells. He also explained that camera observation by an officer at the control station may not be sufficient, because by the time that officer notices a suicide attempt, it might be too late; moreover, the officer likely has other responsibilities that would preclude careful monitoring of any single cell.

The dangerousness of crisis cells and the significant risk of harm caused by such conditions are compounded by ADOC's rampant failure to prevent introduction of dangerous items into crisis cells. Admittedly, the parties in 2014 reached a settlement that prohibits ADOC officers from providing disposable razor blades to prisoners on suicide watch and in segregation. *See* January 16, 2015 Order Denying Motion for Preliminary Injunction (doc. no. 84).⁵³ However, the problem of dangerous items in crisis cells has continued, according to a number of ADOC officials and MHM staff. Suicidal prisoners have access to inappropriate items—such as sharp implements—either because they bring the items with them when placed on suicide watch and correctional officers do not search them, or because correctional officers or inmate 'runners' who perform various housekeeping tasks around the unit bring the items to the crisis cells. MHM's Houser stated that prisoners have access to improper items in safe cells at a number of facilities, including specifically Donaldson, St. Clair, Staton, and Holman; she was not sure whether this problem had been addressed at any of these facilities. Dr. Hunter of MHM and Associate Commissioner Culliver both testified that finding sharp objects in a suicide-watch cell has been a problem at Bibb, despite the installation of flaps

on cell doors that were intended to stem the flow of contraband. Lastly, Holman's crisis cells are particularly problematic, as Associate Commissioners Naglich and Culliver admitted: although passing prisoners are able to slip items to those housed in crisis cells at a number of facilities, this sort of exchange is particularly easy at Holman, where the crisis cell doors have open bars. Yet, when asked what MHM had done to address this issue, Houser responded that after each incident, MHM staff would "ask [ADOC] to please do a better job." Houser Testimony at vol. 3, 16. She could not identify any other efforts either by MHM or ADOC to address this issue.⁵⁴

1229*1229 e. Inadequate Monitoring of Suicidal Prisoners

⁵³ Defendants argued that inappropriate items found in crisis cells can no longer be part of the case because of this settlement. However, the problem is broader in scope: the settlement agreement to discontinue providing razor blades by no means discharges ADOC's responsibility to ensure that objects with which suicidal prisoners can engage in self-harm are not found in crisis cells.

⁵⁴ The risk of allowing suicidal prisoners access to sharp implements is obvious. However, as Dr. Burns explained, sharp items pose a serious risk even to prisoners who do not have any intention of killing themselves but engage in cutting; it is easy to cut too deep by accident and cause potentially fatal bleeding.

The unsafe features of crisis cells heighten the importance of monitoring prisoners for signs of decompensation or suicide attempts. However, ADOC's monitoring practices are woefully inadequate.

According to ADOC's administrative regulations and the standard of care for mental-health care in prisons, suicide-watch checks should take place at staggered, or random, intervals of approximately every 15 minutes, rather than exactly every 15

minutes. For prisoners on mental-health observation, these staggered checks should occur approximately every 30 minutes. Staggered intervals prevent prisoners from timing their suicide attempts, because otherwise they can predict exactly when checks will occur. Such monitoring procedures are all the more crucial when suicidal inmates are housed in cells that have little visibility; as plaintiffs' expert Vail bluntly stated, without regular checks, "[Y]ou have no idea if they're alive or dead." Vail Testimony at vol. 1, 96.

Dr. Burns and Dr. Hancy both testified that many of the monitoring logs they had seen during their site visits and document review had pre-printed times or had handwritten pre-filled times at exact intervals. This practice reflects prison staff's lack of understanding that checks should be performed at staggered intervals, and makes it impossible to ensure that staggered checks are actually happening. Associate Commissioner Naglich admitted that staff are not permitted to use monitoring logs with pre-printed times, but that some continue to use them. She also testified that officers and staff are not permitted to handwrite times and signatures in advance of, or in lieu of, their actual checks. However, during the post-trial prison tours, the court came across multiple logs where times at 15- or 30-minute intervals had been pre-filled, even though the parties had agreed during the trial to correct this practice, and the court had ordered compliance with the agreement several weeks before the tours. This evidence of non-compliance greatly troubled the court, as it showed that policy changes are not being implemented on the ground even when a court order is involved.

For the most acutely suicidal, constant—rather than staggered-interval—watch is necessary. As Dr. Burns opined, correctional systems must have a constant-watch procedure for individuals whose risk of suicide is the highest, due to their engagement in self-injurious behavior or threat of suicide with specific plans: if a prisoner is waiting

for an opportunity to kill himself, it is too dangerous to walk away, and he must be constantly observed. For this reason, the NCCHC standards classify constant-watch procedures as an "essential" standard, and MHM is contractually obligated to follow all NCCHC standards.⁵⁵

⁵⁵ NCCHC promulgates two types of standards: essential and important. As the terms would indicate, the distinction between the two denotes the relative importance of each standard. The essential standards are mandatory conditions for accreditation by NCCHC; only 85 % compliance with important standards is required.

ADOC and MHM had not provided constant watch for acutely suicidal inmates prior to Jamie Wallace's death. During the trial, in the wake of Jamie Wallace's suicide, the court urged the parties to propose interim measures to prevent more suicides. Plaintiffs then filed a motion for temporary restraining order seeking to institute constant watch and other suicide-prevention measures. Plaintiffs' Emergency Motion for Temporary Restraining Order (doc. no. 1075). The parties reached an interim agreement in early January. Phase 2A Interim Relief Order Regarding Suicide *1230 Prevention Measures (doc. no. 1102). The agreement mandated a constant-watch procedure for those deemed acutely suicidal and forbade using pre-printed or pre-filled forms for other types of suicide watch. While defense counsel represented to the court that it was Commissioner Dunn's intent to keep the constant-watch procedure until told otherwise by the court or experts, the court also heard testimony that the current implementation of suicide-prevention measures and constant watch is not sustainable.⁵⁶ The parties defined 'constant watch' as a "procedure that ensures one-on-one visual contact at all times, except to the extent that the physical design allows an observer to maintain an unobstructed line of sight with no more than two people on suicide watch at once." Interim

Agreement Regarding Suicide Prevention Measures (doc. no. 1102-1). MHM's Houser testified that the implementation has been difficult because some facilities do not have a layout conducive to constant watch, due to the location of the windows on cell doors and structures that obstruct a direct line of sight into crisis cells. As a result, MHM has had to transfer some prisoners to other facilities. Another obstacle in the implementation stems from a lack of sufficient correctional staffing: for example, the Holman crisis cells, located on death row, are unsafe for mental-health staff, because without sufficient correctional staffing on duty, prisoners often throw objects from second and third tiers at the mental-health staff conducting constant watch on the first tier. Finally, according to Houser, the annual budget for a permanent constant-watch procedure is projected to be over \$4 million, but MHM was initially provided only \$200,000 to meet the immediate needs of the interim agreement mandating constant watch.⁵⁷

⁵⁶ In addition, there were allegations of non-compliance with the constant watch procedures at Kilby. See Plaintiffs' Motion to Renew the Temporary Restraining Order Regarding Suicide Prevention Procedures (doc. no. 1171). This allegation of non-compliance will be discussed in *infra* Part V.D.

A separate issue is whether Commissioner Dunn's representation that he will enforce the interim agreement indefinitely is binding on ADOC or his successors. This issue is taken up in Part V.D.

⁵⁷ Houser explained that prior to the interim agreement, MHM could not staff constant watch under the current contract amount and was not expected to do so, even though NCCHC standards mandate constant watch.

f. Inappropriate Release from Suicide Watch and Inadequate Follow-up

Prisoners are routinely released from suicide watch improperly and receive inadequate follow-up care after their release from suicide watch. These practices create a substantial risk of recurring self-injurious behavior and suicide.

As experts from both sides explained, suicidal prisoners should be released only with the approval of a psychiatric provider (psychiatrist or nurse practitioner) who has made a face-to-face assessment that their condition was sufficiently stabilized to warrant it. In 2016, MHM reported to ADOC that it was discharging patients from suicide watch without a face-to-face assessment; the decisions were based instead on whatever information lower-level mental-health staff communicated over the phone to on-call doctors and nurse practitioners. A nurse practitioner at Donaldson and St. Clair testified that generally she will not authorize the release of a prisoner from suicide watch at St. Clair without seeing him in person; however, when she is not at St. Clair (a significant majority of the hours in the week), staff call Dr. Hunter to authorize the release remotely. Associate Commissioner Naglich admitted that this practice of authorizing suicide-watch release without a face-to-face evaluation was not specific¹²³¹ to any particular facilities,¹²³¹ but that it reflected a general shortage of psychiatrists; she further agreed that it put the prisoners at risk of premature release. Evidence also showed that prisoners have, on occasion, been released from suicide watch by correctional staff without any mental health assessment at all; this is even more unacceptable. See, e.g., Pl. Ex. 436, September 19, 2014 Email between Houser and ADOC (doc. no. 1074-26) (notifying Naglich about a death-row inmate who was released from a crisis cell by ADOC officer, without notice or approval by mental-health staff).

According to experts on both sides, follow-up care is necessary upon release from suicide watch both for prisoners on the mental-health caseload and for those who are not. For those who are already on the mental-health caseload, follow-up care entails

incorporating what providers learned from the most recent crisis into the prisoner's treatment plans and modifying interventions in order to address the factors that contributed to the self-injurious behavior or suicidal ideation. For those who were not on the caseload, follow-up care allows providers to assess whether the prisoner's risk of self-injury remains low, and to determine whether the prisoner should be added to the mental-health caseload to address underlying mental-health issues. As Dr. Burns credibly opined, the failure to provide follow-up care that addresses the root of self-injurious behavior creates a substantial risk that the self-injurious behavior will continue and result in serious injury or death.

The follow-up care provided to many prisoners upon their release from suicide watch at ADOC is woefully inadequate. Both Dr. Haney and Dr. Burns observed multiple instances of prisoners who were released directly from crisis cells back into segregation, with little or no follow-up treatment in subsequent weeks. For example, experts observed that plaintiffs L.P., R.M.W., and C.J. and prisoner J.D. all had a pattern of cycling between crisis cells and segregation with little follow-up treatment after crisis-cell release. As explained further later, prisoners in segregation—even those on the mental-health caseload—have little access to meaningful treatment, due to severe staffing shortages that prevent prisoners from being brought out of their cells and a lack of group activities.

Once again, Jamie Wallace provides a concrete example of the lack of follow-up care and the resulting harm. During his testimony, he repeatedly insisted that he rarely received therapeutic care when not on suicide watch. Dr. Burns corroborated his testimony, noting that despite his very acute mental illness, Wallace had only one individual counseling session in the two-month period following a suicide watch placement in 2015, and that his treatment plan did not change or reflect the fact that he came off of suicide watch

in late August 2016. The same lack of follow-up care was repeated in 2016: he was discharged from suicide watch two days before he committed suicide; in those two days, he received no follow-up care.

In sum, the combination of inadequate identification of needs for crisis care, unsafe cells, inadequate monitoring, and inadequate treatment has created a substantial and grave risk of serious harm for ADOC's prisoners who have a high risk of engaging in self-injurious behavior and suicide attempts.

7. Inappropriate Use of Disciplinary Actions

ADOC has an unacceptable practice of disciplining mentally ill prisoners for behavior that stems from their mental illnesses and doing so without adequate regard for the disciplinary sanctions' impact on mental health. Mentally ill prisoners are routinely disciplined for harming ¹²³²*¹²³³ themselves or attempting to do so. These punitive practices in turn subject mentally ill prisoners to a substantial risk of decompensation and increased suffering. *Cf. Coleman v. Wilson*, 912 F.Supp. 1282, 1320 (E.D. Cal. 1995) (Karlton, J.) ("[B]eing treated with punitive measures by the custody staff to control the inmates' behavior without regard to the cause of the behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illnesses" violated seriously mentally ill prisoners' Eighth Amendment rights); *Casey v. Lewis*, 834 F.Supp. 1477, 1548–49 (D. Ariz. 1993) (Muecke, J.) (finding that using lockdowns to punish seriously mentally ill prisoners' behavior stemming from their illness constitutes an Eighth Amendment violation).

Imposing disciplinary sanctions on prisoners for engaging in self-injury creates an additional risk of harm beyond that stemming from inadequate treatment. As plaintiffs' expert Burns explained, because ADOC's practice treats self-injury solely as a behavioral problem rather than a mental-health problem, it fails to address the underlying

mental-health issues through treatment; responding to self-harm in this manner is likely to escalate the self-injurious behavior, potentially resulting in serious physical injury or even death. Furthermore, if a disciplinary action results in segregation, mentally ill prisoners are at an even higher risk of harm—as will be discussed in detail later—because of the detrimental effects of isolation and of the limited access to treatment, both of which can in turn worsen underlying mental illness.

The practice of punishing prisoners for engaging in self-harm is common and system-wide at ADOC, despite a written policy purporting to prohibit it. ADOC's administrative regulation states that, although they are not exempt from compliance with rules and regulations, inmates "will not be punished for symptoms of a mental illness."⁵⁸ Joint Ex. 128, Admin. Reg. § 626 (doc. no. 1038–151). ADOC has engaged in a practice of automatically disciplining prisoners who engage in self-injurious behaviors. In fact, Naglich's Office of Health Services deemed this practice problematic as early as 2013, when it conducted an audit of services provided in Donaldson. As a result, MHM's post-audit corrective-action plan stated that ADOC is to stop "automatically apply[ing] disciplinary sanctions to male inmates who engage in self-injurious behavior." Pl. Ex. 689, MHM Corrective Action—Donaldson May 2013 (doc. no. 1069–5) at ADOC045459.⁵⁹ The person responsible for implementing this change was Dr. Ron Cavanaugh of OHS, who was to review files of prisoners who may have been sanctioned for symptoms of mental illness and send instructions on how to deal with self-injurious behavior *1233 to ADOC officials in charge of supervising the disciplinary process.

⁵⁸ Defendants elicited testimony from various practitioners and prisoners that it is sometimes appropriate to discipline a prisoner for a violation of administrative rules despite the fact that he suffers from a mental illness. But plaintiffs have not

disputed this point. Instead, they have offered evidence to show that many mentally ill prisoners are punished as a direct result of their mental illness, which the experts credibly testified is harmful. For example, defense counsel asked multiple prisoners, including plaintiff Jamie Wallace and class member M.P., whether it was 'appropriate' to be disciplined for having a contraband—a razor blade, for example—in the cell; however, these prisoners actually had received disciplinary sanctions for engaging in self-injurious behavior, not for having contraband.

⁵⁹ While the corrective-action plan for Donaldson specifies "male inmates," Associate Commissioner Naglich testified that she understood the policy change—to cease automatic disciplinary sanctions for engaging in self-harm—applied to both male and female prisoners. Naglich Testimony at vol. 2, 135.

Although the 2013 corrective-action plan required follow-up action to address this issue, ADOC did not take meaningful action to change this practice, and prisoners continue to face sanctions for self-injurious behavior. Associate Commissioner Naglich's staff could find no documentation of any file reviews conducted by Dr. Cavanaugh or instructions sent to Associate Commissioner Culliver or the regional coordinators, who according to Naglich were the officials responsible for enforcing this policy change. Associate Commissioner Culliver was likewise not aware of any policy change or new instructions regarding self-harm and disciplinary sanctions. Dr. Tytell, who replaced Dr. Cavanaugh after his death and was aware of this issue at Donaldson, testified that he and Associate Commissioner Naglich have discussed that imposing disciplinary sanctions for self-injury continued to be a problem, including in the RTU and SU. However, Dr. Tytell has done nothing to monitor, let alone address, this issue. When asked what, if anything, she personally has

done to implement this policy change, Associate Commissioner Naglich admitted that she had reviewed only one single prisoner's disciplinary record; in that case, she intervened to recommend that convictions be removed based on the indications in his medical records that he was decompensating at the time of the infraction.

Not surprisingly, in 2016, plaintiffs' expert Dr. Burns credibly concluded that "desperate acts to get the attention of MHM staff and necessary services," including self-injury and suicide attempts, "often result in disciplinary action and placement in segregation where mental health treatment is even more difficult to access." Joint Ex. 460, Burns Expert Report (doc. no. 1038-1044) at 29. She also saw evidence of prisoners with untreated serious mental illness being "essentially punished for symptoms of their psychiatric illness," such as prisoners with bipolar disorder being placed in disciplinary segregation for untreated manic behaviors. Burns Testimony at vol. 1, 27-28.

A related problem is ADOC's inadequate mental-health evaluation process for prisoners facing disciplinary charges. Not taking mental health into consideration when determining appropriate sanctions is dangerous because certain sanctions, such as placement in segregation, expose mentally ill prisoners to a substantial risk of worsening symptoms and significantly reduced access to monitoring and treatment.

Under ADOC's administrative regulations, disciplinary actions against prisoners whose mental-health code is MH-1 or above require consultation with mental-health staff: once a prisoner on the caseload is charged with a disciplinary infraction, MHM's mental-health counselors are required to conduct a mental-health evaluation and complete a computerized module. Ostensibly, this system allows the counselor to have input into the disciplinary process and to communicate in writing to the disciplinary hearing officer: (1) whether "mental health issues affected

the inmate's behavior at the time of the charge"; (2) whether there are "mental health issues to be considered in disposition if found guilty"; and (3) whether mental-health staff would be present at the hearing. Joint Ex. 467, Mental Health Consultation to the Disciplinary Process, Inmate File of Jamie Wallace (doc. no. 1038-1052) at ADOC031346.

However, the system falls far short in practice: these mental-health evaluations are often brief and perfunctory, and the counselors conducting them understand their role to be limited to an assessment of capacity or knowledge of their infraction, rather than providing input on the ¹²³⁴mental- ^{*1234}health implications of any punishment. For example, Sharon Trimble, an MHM counselor at Kilby, testified that her evaluation process entails informing the prisoner of the charge against him, describing the incident at issue, letting him explain what happened, and making sure that he understands the reasons for a disciplinary hearing. This, in her view, amounts to an assessment of the prisoner's competency; her evaluation concludes when the prisoner "say[s] that [he] did it." Trimble Testimony at ___. She does not otherwise assess whether the prisoner's behavior is related to his mental illness, and she has never made recommendations as to the appropriateness of possible sanctions, including whether placement in segregation was contraindicated by the prisoner's mental illness.

Strikingly, Associate Commissioner Naglich herself did not have a clear understanding of the purpose of the consultation process. While she understood that the consultation process should address whether "the mental health issues contribute[d] to the conduct," she was unsure about whether it involved anything else. Naglich Testimony at vol. 2, 15. She understood the second question in the module—whether mental illness should be considered in determining the punishment—to relate not to the appropriateness of various sanctions in light of the prisoner's mental illness but rather to be largely duplicative

of the first question, regarding culpability. She believed it to be asking "how cognizant or responsible was the inmate at the time of the charge and should that be considered in the disposition if he's found guilty." *Id.*

As explained in the next section, and as agreed by experts on both sides, it is critical that mental illness be considered in determining punishment for infractions because placing mentally ill prisoners in segregation significantly increases the risk of decompensation. ADOC's failure to ensure that mental-health staff can and in fact do express their views as to whether particular prisoners will be harmed by placement in segregation (or some other disciplinary sanction) creates a substantial risk of serious harm.

Moreover, the disciplinary consultation process consistently fails to perform even the limited functions Trimble and Naglich ascribed to it. ADOC's 2013 audit of Donaldson and a quality-improvement study conducted by MHM around the same time recognized that mental-health consultations were often acting as little more than a rubber stamp. The Donaldson audit found that "answers provided by [mental health] appeared to conflict with patients' clinically documented mental health status"—in other words, the consultation documentation from mental-health staff did not reflect the diagnoses in the medical record of the prisoner who was being disciplined. Pl. Ex. 689, MHM Corrective Action—Donaldson May 2013 (doc. no. 1069–5) at ADOC045459. MHM found that "95 % were declared competent to stand hearing with no qualifiers for MH factors," and, relatedly, "that [MHM's] staff did not understand how to fill out form." Pl. Ex. 715, July 2013 Quarterly CQI Meeting Minutes (doc. no. 1044–9) at 4. Not surprisingly, MHM counselor Trimble was aware of only one instance in the course of five years in which a prisoner was not sanctioned because his behavior was considered a result of his mental illness.

The consequences of ADOC's policy of disciplining prisoners for engaging in self-harm combined with the dysfunctional consultation process are frequently egregious: when they attempt to hurt or kill themselves, mentally ill prisoners are routinely found guilty of and punished for "intentionally creating a security, safety, or health hazard," and often are placed in ¹²³⁵segregation. For example, Jamie Wallace ^{*1235} was given disciplinary sanctions and sent to segregation for self-injury and suicide attempts multiple times between 2013 and his suicide in 2016. *See* Joint Ex. 467, Inmate File of Jamie Wallace (doc. no. 1038–1052) at ADOC031352 (Jan. 8, 2013, for cutting his neck with a metal top of a smokeless tobacco can); ADOC031661 (Feb. 3, 2013, attempting to hang himself); ADOC031341 (Nov. 12, 2013, penetrating his ears and bottom lip with a metal object); ADOC031528 (May 25, 2014, intentionally cutting his left wrist); *see also* Pl. Dem. Ex. 2, Summary of J.W. Suicide Attempts (doc. no. 1058–16) (showing six occasions of being sent to segregation for inflicting self-harm, and 12 disciplinary actions for self-harm in total). Records of plaintiff L.P. also reflect that he has received disciplinary segregation for self-harm incidents; plaintiff R.M.W. and class member M.P. testified that they have received multiple disciplinary actions for intentionally creating a security, safety, or health hazard when they had cut themselves. These instances of punitive response can also lead to even graver harm: Dr. Hunter, the medical director of MHM, acknowledged that the combination of a recent disciplinary action and the prospect of a segregation placement was a common factor among prisoners who committed suicide. The trend in suicides since October 2015 corroborated this testimony. In sum, ADOC's disciplinary process has inflicted actual harm and created a substantial risk of serious harm for mentally ill prisoners.

8. Inappropriate Placement and Inadequate Treatment in Segregation

Segregation—also known as restrictive housing or solitary confinement—generally refers to the correctional practice of keeping a prisoner in a cell for 22.5 hours or more a day, usually in a single-person cell, only letting the prisoner out for brief ‘yard’ time and showers.⁶⁰ In ADOC, segregation takes two different forms: disciplinary and administrative. Disciplinary segregation is a type of punishment whereby prisoners are allowed to have extremely limited personal property in their cells and lose privileges such as telephone use and family visits. Administrative segregation is used to separate prisoners from the general population, generally for safety reasons; prisoners in administrative segregation do not formally lose privileges, but are still subject to some property restrictions and receive little out-of-cell time.

⁶⁰ As Dr. Haney explained in his testimony before Congress, exercise time for segregation prisoners hardly involves a ‘yard.’ Pl. Ex. 1272, 2012 Congressional Testimony of Dr. Craig Haney (doc. no. 1126-3) at 5-6. Rather than an open space with greenery, the exercise yards that the court observed at ADOC facilities for segregation prisoners were often small and fenced in with concrete surfaces. Some of the facilities allow only one inmate at a time in a ‘cage,’ a subdivided section of the yard that is fenced in and hardly bigger than the segregation cell itself. Some of the yards, such as the one in Kilby, also had fences totally enclosing the yard, including a fenced ceiling, truly evoking the feeling of a cage.

Trial testimony revealed that segregation has a profound impact on prisoners’ mental health due to the harmful effects of isolation; this impact is worse for those who are already mentally ill. According to the experts, the risk of

decompensation increases with the duration of isolation and the severity of the prisoner’s mental illness.

Plaintiffs ask the court to declare that, due to the risk of harm, mentally ill prisoners as a general matter should never be placed in segregation. However, the court sees no need to reach that broad conclusion, for here, the evidence is ¹²³⁶overwhelming ^{*1236}that the ADOC’s current segregation practices pose an unacceptably high risk of serious harm to prisoners with serious mental-health needs. As the testimony of experts and defense witnesses made abundantly clear, ADOC lacks a functioning process for screening out prisoners who should not be placed in segregation due to mental illness or ensuring that they are not sent there for dangerously long periods, and mentally ill prisoners in segregation receive inadequate treatment and monitoring. It is simply undeniable that these practices pose a grave danger to many mentally ill prisoners placed in segregation.

This section discusses the ways in which ADOC’s segregation practices place these prisoners at a substantial risk of serious harm. After explaining the consensus developed in recent years regarding the harmful psychological effects of segregation in general and on mentally ill prisoners in particular, the discussion turns to the specific risks of harm posed by ADOC’s segregation practices. Finally, the court discusses the heightened level of danger segregation poses to those prisoners with the most serious mental-health needs—that is, those who have conditions classified as serious mental illnesses.

a. Background on Segregation

i. Consensus among Correctional and Mental-Health Professionals on Segregation

Mental-health and correctional professionals have recognized that long-term isolation resulting from segregation, or solitary confinement, has crippling consequences for mental health. Dr. Craig Haney,

who has studied the psychological effects of solitary confinement for more than 30 years, explained that isolation of the type experienced by prisoners in segregation has harmful psychological effects even on those who are not mentally ill, and even mentally healthy prisoners can develop mental illness such as depression, psychosis, and anxiety disorder during a prolonged period of isolation. Summarizing years of research in his field, Dr. Haney explained: "[T]he nature and magnitude of the negative psychological reactions ... underscore the stressfulness and painfulness of this kind of confinement, the lengths to which prisoners must go to adapt and adjust to it, and the risk of harm that it creates. The potentially devastating effects of these conditions are reflected in the characteristically high numbers of suicide deaths, and incidents of self-harm and self-mutilation that occur in many of these units.... These effects are not only painful but can do real harm and inflict real damage that is sometimes severe and can be irreversible. They can persist beyond the time that prisoners are housed in isolation and lead to long-term disability and dysfunction." Joint Ex. 459, Haney Expert Report (doc. no. 1038-1043) at 130-31; *see also Davis v. Ayala*, — U.S. —, 135 S.Ct. 2187, 2210, 192 L.Ed.2d 323 (2015) (Kennedy, J., concurring) (summarizing case law and historical texts that "understood]] and questioned" the "human toll wrought by extended terms of isolation" and observing that "research still confirms what this Court suggested over a century ago: Years on end of near-total isolation exact a terrible price.") The psychological harm from segregation can also lead to symptoms like hallucinations, chest pain, palpitations, anxiety attacks, and self-harm, even among previously healthy people. Burns Testimony at vol. 1, 209; *see also Palakovic v. Wetzel*, 854 F.3d 209, 225-26 (3d Cir. 2017) (summarizing the "robust body of legal and scientific authority recognizing the devastating mental health consequences caused by long-term isolation in solitary confinement," including 1237 "anxiety, panic, paranoia, *1237 depression, post-

traumatic stress disorder, psychosis, and even a disintegration of the basic sense of self-identity," as well as physical harm). The depth of the psychological impact of such isolated confinement conditions on human beings was also reflected in Senator John McCain's observation about his prisoner-of-war experience in Vietnam: "[Solitary confinement] crushes your spirit and weakens your resistance more effectively than any other form of mistreatment. Having no one else to rely on, to share confidences with, to seek counsel from, you begin to doubt your judgment and your courage." Pl. Ex. 1272, 2012 Congressional Testimony of Dr. Craig Haney (doc. no. 1126-3) at 9 (quoting from Richard Kozar, *John McCain: Overcoming Adversity* (2001) at 53).

The serious psychological harm stemming from segregation is even more devastating for those with mental illness. As Dr. Haney explained, mentally ill prisoners are highly likely to decompensate in such an isolated environment, and it is more difficult to deliver treatment to those in segregation units. In other words, mentally ill prisoners in segregation are hit with a double-whammy: they are exposed to a heightened risk of worsening symptoms, while having less access to treatment they need. As a result of the growing body of evidence on the destructive effects of segregation, a general consensus among correctional and psychiatric professionals, while not necessarily establishing a constitutional floor, has developed in the last ten years: placement and duration of segregation should be strictly limited for mentally ill prisoners. For example, as the experts explained, the National Commission on Correctional Health Care has issued a position statement declaring that mentally ill prisoners should not be placed in segregation absent extenuating circumstances, and even in those circumstances, the stay should be shorter than 30 days.⁶¹

⁶¹ See National Commission on Correctional Health Care, Solitary Confinement Position Statement on Solitary Confinement, 2016;

Burns Testimony at vol. 1, 204.

As Dr. Haney explained, prison systems around the country are also moving away from using solitary confinement in general—even for healthy people—unless it is absolutely necessary. See, e.g., Joint Ex. 459, Haney Expert Report (doc. no. 1038–1043) at 133 (referencing Rick Raemisch, *My Night in Solitary*, N.Y. Times (Feb. 20, 2014), available at <http://www.nytimes.com/2014/02/21/opinion/my-night-in-solitary.html> (describing the experience of the head of the Colorado Department of Corrections spending 20 hours in a segregation cell and the efforts to bring down the number of mentally ill prisoners in administrative segregation to single digits among 500 prisoners in segregation); Terry Kupers, et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 Crim. Just. & Behav. 1037 (2009) (describing the reforms in the Mississippi Department of Corrections significantly reducing the population in administrative segregation and its effect on misconduct, violence, and use of force)).

Defense witnesses agreed that mentally ill prisoners should rarely be placed in segregation for prolonged periods of time. Dr. Hunter, MHM's medical director, testified that it is "generally recognized" in the profession, including within ADOC, that prolonged segregation is deleterious to mental health, because of the combination of sensory deprivation and sensory overload: a severe lack of stimulation arises when confined to one space for over 23 hours a day without any meaningful social interactions; sensory overload comes from the chaotic environment of segregation units, filled with loud noises and malodors. Hunter Testimony at _____. ADOC's chief psychologist Dr. Tytell and MHM psychiatrist Dr. Kern also agreed that overwhelming research¹²³⁸ shows that "prolonged isolation has gravely

detrimental effects on mental health, especially for those with pre-existing mental illness. Lastly, Ayers, a defense expert, opined that based on his experience as a correctional administrator, mentally ill prisoners should generally not be placed in segregation; if they are, it should only occur with the explicit approval and hands-on involvement of mental-health staff, and such prisoners should be placed on a fast-track to be moved into more therapeutic settings.

ii. ADOC's Segregation Units

The court heard overwhelming evidence, including from experts on both sides, that the conditions in ADOC's segregation units pose serious risks for mentally ill prisoners—beyond the inherent psychological risks of segregation. ADOC prisoners receive very little out-of-cell time; they are left idle for almost all hours of the day with very little property allowed in the cell; the physical conditions of the segregation cells are often deplorable; and the design of the cells often makes it difficult to monitor the well-being of the prisoners. Associate Commissioner Culliver testified that they "try to give them five hours a week" of out-of-cell time, which means that even when ADOC officers are able to meet their goal, prisoners spend on average over 23 hours per day inside of a cell. Culliver Testimony at _____. As for idleness, not only do segregation prisoners lack access to programming, but they are allowed very few items in their cells to occupy themselves: only a Bible and their current legal paperwork. As Dr. Haney credibly testified based on his extensive experience, it is quite unusual for segregation inmates to be denied access to any other books or a radio. Furthermore, segregation units within ADOC are in significant disrepair, exacerbating the inherent stress of being confined to a small cell and worsening its impact on mental health. As reflected by photographs admitted into the record and as the court witnessed firsthand during facility visits, segregation cells are often poorly lit, with little natural light and only small grated windows, if any. The court observed that they are often filled

with the smell of burning paper and urine; some are extremely dirty with what appears to be dried excrement smeared on the walls and floors; and loud noises travel through the segregation units, some of which house from anywhere between 20 to 50 people on multiple levels.⁶² The court witnessed an overpowering sense of abandonment and despair, with a prolonged stay crushing all hope.⁶³

⁶² Dr. Haney also observed that Bullock's segregation unit has a practice of removing mattresses from cells so that prisoners cannot rest on them during the day, which he described as "extraordinarily draconian." Haney Testimony at vol. 1, 117. Pl. Dem. Ex. 60, Bullock Main Camp, B Dorm (doc. no. 1125-20). The court also observed that Kilby's large segregation unit (also known as 'big seg') has extremely small cells that are only a foot or two longer than the length of a single-sized mattress and only a narrow strip of space that barely fits a toilet, in a stifling unit of fifty cells stacked on top of each other without any ventilation or transparent windows facing outside. Pl. Dem. Ex. 80 & 81, Kilby C Dorm (docs. no. 1125-38, 1125-39).

⁶³ The court notes that the worst thing that could happen in this context is for the correctional officers and ADOC officials to get accustomed to such conditions.

The combination of the lack of any meaningful activity or social contact and the stressors of living in a dilapidated, filthy, and loud housing unit for almost 24 hours per day results in a heightened risk of decompensation for mentally ill prisoners and a heightened risk of developing serious mental-health needs for those who were initially healthy. In addition, as Dr. Haney credibly testified, it is much more difficult for staff to detect decompensation of prisoners while they are housed in segregation:¹²³⁹ when prisoners remain in their cells around the clock, mental-health staff

have a harder time observing the patient and diagnosing illnesses effectively, and correctional officers and fellow prisoners also lack sufficient regular contact with the prisoner to notice the onset of symptoms of mental illness. This difficulty adds to the danger.⁶⁴

⁶⁴ Admittedly, ADOC uses double-celling in some segregation units, which means putting two prisoners into a single segregation cell. At first blush, this practice might seem to mitigate the harmful effects of solitary confinement. However, double-celled segregation has an even more severe impact on the mental health of prisoners. Dr. Haney credibly explained that double-celled prisoners "in some ways ... have the worst of both worlds: they are 'crowded' in and confined with another person inside a small cell but—and this is the crux of their 'isolation'—simultaneously isolated from the rest of the mainstream prisoner population, deprived of even minimal freedom of movement, prohibited from access to meaningful prison programs, and denied opportunities for any semblance of 'normal' social interaction." Joint Ex. 459, Haney Expert Report (doc. no. 1038-1043) at 109.

The design of ADOC's cells and units in which they exist poses additional obstacles for effective monitoring in segregation units. ADOC segregation units often lack visibility into cells, both because of small windows on the doors, which are often grated or difficult to see through, and because of the layout of the cells and the units. Unfortunately, as experts from both sides testified, because of understaffing, officers cannot constantly walk near the cells and are generally unable to monitor what is going on inside. This means that mentally ill prisoners in segregation—including those identified as mentally ill, those with undiagnosed mental illnesses, and those who develop mental illness while in segregation—are at a heightened risk for decompensation without anyone noticing.

These problems exist throughout ADOC facilities. For example, Easterling's unit has tiny windows on doors that do not allow correctional officers to observe inside without being directly in front of the door; as Dr. Haney credibly testified, correctional officers often do not feel safe standing very close to the door because they risk having bodily fluids or food thrown at them through the food-tray slot or the cracks between the door and the wall. (Indeed, the court was repeatedly warned not to walk too close to the doors for that reason during facility tours.) As the court saw firsthand, Donaldson and St. Clair facilities have the same problem of very little visibility into the cells from the officers' station, due to small windows and dim lighting. Lastly, Bibb's segregation units might be the most egregious in terms of visibility: each housing unit has its own segregation unit of a few cells shut off from the rest of the unit, down a long hallway and through a door, with no line of sight from the central officer station and officers entering the space to check on the prisoners only periodically. Dr. Haney was surprised that such units were maintained, because prisoners in these cells have no way of alerting officers if anything was going wrong; they are completely dependent for their safety upon periodic trips that officers make from the central officer station. In fact, Dr. Haney recommended that Bibb's segregation units be closed immediately; he explained that he has never recommended any unit to be closed immediately in his four decades of doing this work, but he thought the risk of harm was too great at Bibb because so little monitoring is available. Defense correctional expert Ayers's testimony also raised concerns: he credibly testified to his suspicion that, because of understaffing and safety concerns, correctional officers were not walking down the hallway away from the central cube at Bibb as frequently as they

¹²⁴⁰claimed.^{*1240} b. ADOC's Segregation of Mentally Ill Prisoners

The evidence clearly establishes that placements of mentally ill prisoners in segregation endangers those prisoners, and that the risk of serious harm to those prisoners increases based on the seriousness of the prisoner's illness, the length of the stay in segregation, and the dangerous conditions discussed above. Against this backdrop, the court explains the ways in which ADOC's placement practices and treatment of mentally ill prisoners in segregation create a substantial risk of serious harm.

i. ADOC's Segregation–Placement Practices

Due to the risks of decompensation created by segregation in general and by ADOC's segregation units in particular, it is critically important that ADOC consider a prisoner's mental health condition when deciding whether to place the prisoner in segregation, and if so, for how long. But here, overwhelming evidence makes clear that ADOC does not ensure that those with a heightened risk of serious harm from mental illness are not placed in segregation or that they are not sent there for dangerously long periods.⁶⁵ In particular, as discussed earlier, ADOC does not have a functioning system for evaluating mental-health risks when deciding whether to place prisoners in segregation; it also fails to evaluate these risks when determining the length of any segregation placement. The result is that prisoners whose mental illness makes them likely to be harmed by segregation are placed there anyway.

⁶⁵ Experts from both sides explained that alternatives to placing mentally ill prisoners in segregation exist. Prison systems across the country, ranging from Maine to Mississippi, have reduced the number of prisoners in segregation generally, and significantly reduced the mentally ill population in segregation. Joint Ex. 459, Haney Expert Report (doc. no. 1038–1043) at 133. For example, California operates a separate housing unit that is devoted to mentally ill prisoners who have committed disciplinary

infractions. These units provide 20 hours of out-of-cell time per week, as well as structured and unstructured therapeutic activities. Arizona has begun similar reforms, providing more programming and out-of-cell time to mentally ill prisoners who committed disciplinary infractions. Haney Testimony at vol. 2, 154–55; Ayers Testimony at ____.

ADOC's current process for placing prisoners in segregation does not adequately consider the impact of segregation on mental health. As explained in the section on disciplinary sanctions, ADOC's administrative regulations mandate that during disciplinary proceedings, mental-health staff provide input to ADOC regarding the impact of mental illness on the prisoner's competency at the time of the offense and at the time of the hearing and give recommendations for the disposition of the offense and the type of sanctions that should be imposed. However, as discussed earlier, MHM staff and ADOC officials expressed confusion as to what role, if any, mental-health staff should play in the disciplinary process, and mental-health staff largely have rubber-stamped ADOC's decisions to send mentally ill prisoners to segregation.

Even when MHM has recommended against placing a particular prisoner or a group of mentally ill prisoners in segregation, there is evidence that ADOC has ignored such input. As MHM's program director Houser testified, ADOC has overridden MHM's recommendations that prisoners whose mental-health code is above MH-3 (which requires residential treatment in a mental-health unit) should not be placed in segregation; she also gave an example of a prisoner who was put in segregation despite MHM's recommendation. She further explained that because MHM is not authorized to move any ¹²⁴¹prisoners, ADOC can override MHM's ^{*1241}clinical judgment and house RTU patients in segregation. Indeed, ADOC correctional staff are not required to follow the recommendations of the

mental-health staff in disciplinary proceedings. Likewise, while regulations require that prisoners in segregation undergo periodic mental-health evaluations, ADOC is not required to move the prisoner if the mental-health evaluation reveals that continued placement in segregation would be detrimental to the prisoner's mental health. Joint Ex. 127, Admin. Reg. § 625 (doc. no. 1038–150) ("The ADOC psychologist or psychological associate will consult with the Warden or designee when their [segregation] mental health assessment indicates that continued placement in [segregation] is contraindicated by changes in the inmate's mental status and functioning. Alternative strategies to facilitate the inmate's mental stabilization will be offered.").⁶⁶

⁶⁶ There is sufficient evidence that these mental-health evaluations in segregation are inadequate, which will be discussed later in section V.B.10.

For their part, MHM staff have been hesitant to oppose ADOC on the placement of mentally ill prisoners in segregation. MHM staff discussed ADOC's use of segregation on mentally ill prisoners during a staff meeting in 2013, expressing frustration that ADOC was over-using segregation on mentally ill prisoners: the meeting summary read, "DOC is over using segregation on MH inmates. They want to punish them. We must be diligent in calling it from a treatment perspective in disciplinary consult. Put MH as factor in the bad behavior. Long term segregation can be detrimental mental well-being. ... Do not recommend a disciplinary action. Say MH is a major factor. We are reluctant to do it because of influence of DOC." Pl. Ex. 715, July 2013 Quarterly CQI Meeting Minutes (doc. no. 1044–9) at 4.

ADOC also fails to ensure that prisoners with serious mental-health needs are not subjected to extremely lengthy periods of segregation. Dr. Haney described examples of several plaintiffs and one former class member who have bounced

between segregation units and suicide-watch cells over lengthy periods of time; three were never put on the mental-health caseload despite repeated instances of self-harm. See Pl. Dem. Ex. 131, Movement History of Exemplar Plaintiffs (doc. no. 1126-10). In particular, plaintiff C.J.'s eight-year-long movement history shows that he has been in segregation or suicide-watch cells for all of those eight years; his mental-health code was eventually elevated to MH-2, but his treatment plan did not change despite his clear deterioration over the years.⁶⁷ See Joint Ex. 459, Haney Expert

1242*1242 Report (doc. no. 1038-1043) at A39.⁶⁸

⁶⁷ Plaintiff C.J. is also an example of prisoners who experience what was referred to during the trial as 'segregation rotation,' whereby a prisoner is sent from one segregation unit at a facility to another segregation unit at another facility every few months. C.J.'s movement history indicated that he has been rotating among three different segregation units in the last eight years, averaging eight months at each facility at a time. Pl. Dem. Ex. 131, Movement History of Exemplar Plaintiffs (doc. no. 1126-10). This practice, according to Associate Commissioner Culliver, is used to "give staff a break" and "give the inmate an opportunity to restart." Culliver testimony at _____. Culliver did not know how many people were on segregation rotation currently, or how many mentally ill prisoners are on segregation rotation.

This practice adds an additional set of risk factors to the already debilitating and harmful practice of housing mentally ill patients in segregation for prolonged periods of time. Dr. Haney testified that moving mentally ill prisoners from one environment to another disrupts treatment, because of lack of continuity of care and providers: a new set of staff must get to know the patient, and the usefulness of the information that staff have already gathered on the person gets lost when the

prisoner is transferred. C.J. testified that he often has to start anew with new counselors at each facility, and when he goes back to the old facility after a year or two of absence, the former counselor is often no longer working there because of the high turnover rate. Furthermore, as Dr. Haney testified, frequent transfers of mentally ill prisoners have an adverse impact on their mental health because they have a more difficult time adjusting to new environments than those who are not mentally ill.

⁶⁸ Dr. Haney also stated that cycling between segregation and general population may also indicate that those prisoners are likely suffering from the after-effects of prolonged stays in segregation, which are leading to more disciplinary infractions.

Not surprisingly given ADOC's disregard for segregation's impact on mental health, mentally ill prisoners are overrepresented in ADOC segregation. While only 14 % of the ADOC population is on the mental-health caseload, mentally ill prisoners make up 21 % of those in segregation. Looking at individual facilities year by year, most facilities' segregation units have a far higher rate of mentally ill prisoners compared to the general population: throughout 2014, 2015, and 2016, Bibb, Easterling, Kilby, St. Clair, Staton, and Ventress each had a disproportionately high number of mental-health patients in segregation; Holman and Limestone's segregation population also had a disproportionately high number of mental-health patients more than half of the time period. Only four of the 12 major male facilities—Bullock, Donaldson, Fountain, and Hamilton—did not have disproportionate numbers of mental-health patients in segregation for most of the three years.⁶⁹ See Pl. Dem. Ex. 127, Overrepresentation of the Mentally Ill in Segregation, 2014-2016 (doc. no. 1126-8).

⁶⁹ The plaintiffs' summary chart and MHM's monthly operations reports count Draper and Elmore as part of Staton, because the

three facilities are in the same complex.

Experts on both sides were alarmed by ADOC's systematic overuse of segregation for mentally ill prisoners, who are most vulnerable to the risk of deterioration in such an isolated environment. Ayers, a defense expert for correctional administration who reviewed ADOC records, was troubled by forms he saw for administrative segregation in which the reason for segregation placement was 'psychiatric.' Dr. Hancy and Dr. Burns were also troubled by the number of prisoners with unaddressed mental illnesses they encountered in segregation units. In sum, ADOC lacks a functioning process for screening out prisoners who should not be placed in segregation due to mental illness or ensuring that they are not sent there for dangerously long periods.

ii. Treatment and Monitoring in Segregation Units

ADOC prisoners with serious mental-health needs must contend not only with dangerous and unhealthy conditions in segregation units but also with significantly less access to mental-health treatment. Mental-health patients' needs are considerably greater in segregation due to the harsh effects of isolation, yet instead of receiving more treatment to mitigate these effects, prisoners in segregation have less access to care than in general population and are not adequately monitored for signs of decompensation. The court heard extensive evidence that, due to staffing shortages, mental-health treatment and monitoring in segregation are gravely more limited than in general population, and nonexistent at some facilities. This denial of minimal medical care contributes to the substantial risk that prisoners in segregation with serious mental-health needs will decompensate, experience increased pain and ¹²⁴³suffering, or worse, harm or kill themselves.*¹²⁴³

As Houser, MHM's program director, credibly testified, even though mental-health patients' needs are considerably greater in segregation due to the harsh effects of isolation, prisoners in segregation are not allowed to leave their cells for

mental-health groups or therapeutic activities. As a result, mental-health patients in segregation receive less treatment than they otherwise would outside segregation, despite their heightened need.⁷⁰

⁷⁰ According to Houser, MHM and ADOC discussed a pilot project for long-term treatment programming in the segregation unit at St. Clair, but the project never got off the ground because of the lack of support from ADOC.

On top of the lack of access to group therapy or other programming, ADOC's segregation prisoners have very little access to individual treatment. For example, in the month of June 2016, the number of 'seg interventions'—that is, out-of-cell treatment encounters with mental-health staff—at seven facilities with mentally ill prisoners in segregation was zero, despite having many, sometimes dozens of, mental-health patients in those units; three facilities had more than zero but fewer than five seg interventions. See Joint Ex. 346, June 2016 MHM Monthly Operations Report (doc. no. 1038–708) at 2.

The dearth of individual treatment in segregation is mainly due to correctional understaffing. Houser observed that mental-health patients in segregation were not getting the services they required, "not by [MHM's] choice," but because of ADOC's failure to bring inmates out of their segregation cells for treatment. Houser Testimony at vol. 2, 100. MHM staff have consistently complained of the difficulties of reaching patients in segregation due to the chronic correctional staffing shortage. See, e.g., Pl. Ex. 950, July 2014 Holman Multidisciplinary Meeting Minutes (doc. no. 1097–4) (reporting issues with psychiatric providers seeing patients in segregation due to "walks, feeding, and DOC shortage, etc."); Pl. Ex. 1191, 2012 Contract–Compliance Report (doc. no. 1070–9) (noting the lack of documentation or notes for treatment of mentally ill prisoners in segregation).

In the absence of correctional officers to provide security and escort for segregation prisoners who need mental-health treatment, mental-health staff have to conduct cell-front check-ins, instead of actual treatment sessions. But because segregation units are not hospitable environments for a personal conversation—let alone confidential conversations—these interactions are brief and cannot replace individual counseling sessions.⁷¹

⁷¹ As discussed in the section regarding sound confidentiality and psychotherapy, most ADOC segregation units are not conducive to having a cell-front conversation, due to heavy solid doors and very loud units with dozens of cells in a single unit. As the court saw during its tours of five prisons, none of the units—even the ones at Bibb, where only three cells are in a unit—were conducive to confidential conversations, because of the proximity to other cells and prisoners.

'Segregation rounds,' whereby mental-health counselors go around the segregation unit to check on the well-being of prisoners, also are of limited utility due to understaffing and visibility issues. ADOC regulations require that these rounds happen at least twice per week. As with other cell-front encounters, segregation rounds are not meant to replace individual psychotherapy.⁷² However, ¹²⁴⁴within ADOC, segregation ^{*1244}rounds do not adequately serve even the limited purpose they are intended to serve. Dr. Hunter described them as 'drive-bys,' sometimes even without verbal exchanges. The cursory nature of the monitoring was further crystalized by the testimony of staff who conduct these rounds. Dr. Tytell, who served as an ADOC psychologist at Donaldson before taking his current position, testified that segregation rounds for over 120 prisoners at Donaldson took between 1.5 hours and 2 hours, including the time to walk between cell blocks—meaning no more than one minute per prisoner on average. A former counselor at Bibb testified that it would take her 35 minutes to an hour to

complete the rounds at all six housing units with 18 double-celled cells, meaning one to two minutes per prisoner, including the time to walk between six housing units. A lack of visibility into many of these cells—due to small, sometimes covered windows, blocked views, and safety concerns associated with standing too close to the door—makes it even more difficult to provide effective monitoring.

⁷² Furthermore, as Dr. Haney testified, while segregation rounds by mental-health staff are crucial for checking for signs of decompensation or crisis, they cannot replace periodic out-of-cell clinical assessments of prisoners' mental-health status, because it is difficult to observe someone's behavior and accurately assess the prisoner's mental health through cell-front encounters.

One vivid example of ADOC's failure to monitor segregation prisoners' mental-health status concerned plaintiff R.M.W. After a month of segregation placement during which she was twice sent to a crisis cell and had multiple episodes of self-injury, the segregation mental-health evaluation form indicated that the inmate was "appropriate for placement" and the recommendation was "segregation placement not impacting inmate's mental health." Joint Ex. 404, March 28, 2014 Review of Segregation Inmates—R.M.W. (doc. no. 1038-859) at MR017081. Nothing in her medical records suggests that a suicide-risk assessment was done after any of the episodes or before this review to ascertain the impact of segregation and likelihood of recurring self-harm.

Even these cursory rounds by MHM staff do not actually happen as often as they should, or at all at some facilities. The lack of documentation of segregation rounds combined with the acute staffing shortages led defense expert Ayers to doubt that ADOC was able to conduct segregation rounds as often as required. The site administrator

for Holman confirmed Ayers's belief, by credibly testifying that insufficient segregation rounds have been a problem at Holman since 2008 due to staffing shortages, and that the problem has only worsened since then. According to her, at Holman, instead of a separate mental-health segregation round, a counselor accompanies the warden and other security officers during a weekly segregation review board, where the warden and other officials walk from cell to cell to review each segregation prisoner's status and potentially change the prisoner's segregation sentence based on their conduct. Sometimes, she is able to visit only one prisoner in segregation per week due to the correctional staffing shortage.

Monitoring by ADOC staff in segregation is also ineffective. Correctional expert Vail credibly opined that ADOC lacked enough correctional staff to conduct monitoring rounds in segregation every 30 minutes—the level of monitoring in segregation units necessary to keep prisoners safe from self-harm and suicide. Indeed, he saw logs at ADOC that suggested that no segregation checks were done for multiple hours. Even defense expert Ayers, while not explicitly concluding that monitoring was inadequate, implied so by saying that better monitoring of segregation inmates would address the high suicide rates within ADOC.

This lack of monitoring is even more troubling given that ADOC segregation cells are not suicide-proof. Many segregation cells have grates, sprinkler heads, and other structures that could be used as tie-off points. Furthermore, during the facility tour, the court saw many segregation prisoners with ropes hanging across their cells as clothes lines, which can be easily used to commit ¹²⁴⁵suicide. Allowing prisoners to ^{*1245}cover their cell door windows with papers further heightens the risk of suicide.

The dearth of individual encounters outside the cell, haphazard cell-front encounters, and inadequate monitoring in ADOC all show that

ADOC fails to provide adequate treatment and monitoring.

In sum, the evidence is clear that ADOC's segregation practices—inadequate screening for the impact of segregation on mental health, and inadequate treatment and monitoring—pose a substantial risk of serious harm to prisoners with serious mental-health needs. This serious inadequacy also has effects on other areas of mental-health care. According to Dr. Haney, this is because "[i]t's very difficult to deliver adequate mental-health care in isolation units, and mentally ill prisoners deteriorate in isolated units. So the inadequacies of the mental health system actually are exacerbated by the use of isolation for mentally ill prisoners." Haney Testimony at vol. 1, 29. In other words, ADOC's segregation practices perpetuate a vicious cycle of isolation, inadequate treatment, and decompensation.

The skyrocketing number of suicides within ADOC, the majority of which occurred in segregation, reflects the combined effect of the lack of screening, monitoring, and treatment in segregation units and the dangerous conditions in segregation cells. Because prisoners often remain in segregation for weeks, months, or even years at a time, their decompensation may not become evident until it is too late—after an actual or attempted suicide.⁷³ Since September 2015, seven of eleven suicides within ADOC facilities happened in segregation units; of the four that have occurred since October 2016 (the current fiscal year), all but one involved a prisoner in segregation.⁷⁴ As explained above, these suicide numbers are astounding compared to the national average across state prison systems. By subjecting mentally ill prisoners to its segregation practices, ADOC has placed prisoners with serious mental-health needs at a substantial risk of continued pain and suffering, decompensation, self-injurious behavior, and even death, and the court cannot close its eyes to this overwhelming evidence.

⁷³ While no aggregate data on the average or typical lengths of segregation stays were presented, the court, during its visits to six facilities, was able to view forms on the front of segregation cells showing how long the prisoner had been there: most were there for at least several weeks, some for months or even over a year. As discussed earlier, some inmates, like plaintiff C.J., are placed on 'segregation rotation,' which can keep prisoners in segregation units for years on end. Experts on both sides unequivocally denounced ADOC's practice of prolonged segregation stays.

⁷⁴ The only one that did not take place in segregation was plaintiff Wallace, who was in the Bullock stabilization unit. See Pl. Ex. 1267, 2015–2016 Chart of ADOC Suicides (doc. no. 1108–38).

c. Segregation of Prisoners with Serious Mental Illness

The court heard significant evidence that extended segregation—even absent consideration of the conditions at ADOC—poses a substantial risk of harm to all mentally ill prisoners, and plaintiffs asked the court to so conclude. However, as mentioned before, because ADOC's segregation practices fall so far short of protecting prisoners with serious mental-health needs from a grave risk of decompensation and other harms, the court need not, at this time, decide whether segregation poses an unacceptably high risk of harm to all mentally ill prisoners as a general matter. That said, the testimony of the experts, clinicians who work for ADOC, and even Associate Commissioner Naglich herself overwhelmingly established that one particular subset of prisoners with serious mental-health needs should never be placed in ¹²⁴⁶segregation in the absence of extenuating circumstances: those who suffer from a 'serious mental illness.'

As discussed earlier, 'serious mental illness' is a term of art in the field of psychiatry that refers to a certain subset of particularly disabling conditions. Serious mental illness is defined by the diagnosis, duration, and severity of the symptoms. Certain diagnoses, such as schizophrenia and disorders accompanied by psychosis, are by definition serious mental illnesses, because they last a lifetime and are accompanied by debilitating symptoms; others, such as major depression and anxiety disorder, may be considered serious mental illnesses depending on the severity of the individual's symptoms.

As Dr. Burns credibly opined based on the literature in the field, those who suffer from serious mental illness should not be put in segregation as a general matter because prisoners with serious mental illness experience worsening symptoms in such an isolated environment, and because they are likely to have reduced access to treatment in segregation units. Burns added that, even when extenuating circumstances exist, segregation placements for such prisoners should still be short term, and access to necessary treatment must be provided. Indeed, as Dr. Burns pointed out, the American Correctional Association and the American Psychiatric Association take the position that seriously mentally ill people should not be placed in segregation unless absolutely necessary, and if so, they should only remain for the shortest duration possible—no longer than three to four weeks. American Correctional Association, Restrictive Housing Performance Based Standards, August 2016; American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2012).

Associate Commissioner Naglich candidly agreed with Dr. Burns that placing seriously mentally ill prisoners in segregation is "categorically inappropriate," and that such placement is tantamount to "denial of minimal medical care." Naglich Testimony at vol. 5, 73. She described a new mental-health coding system in development

at ADOC that would prevent all prisoners with serious mental illness from being placed in segregation. While she could not tell the court when the "rollout" of the new system would be complete, she assured the court that once completed, "no seriously mentally ill inmate would be housed in a segregation setting." Naglich Testimony at vol. 5, 67. MHM's program director Houser agreed with the bright-line rule against placing prisoners with serious mental illness in segregation: she explained that prisoners classified as MH-3 or above, which are designated for RTU or SU placements and considered to have a serious mental illness, should never be in segregation because "their mental health capacity would not allow them to be able to be maintained in such an environment." Houser Testimony at vol. 2, 109.

While there was no dispute between the parties that placing seriously mentally ill prisoners in segregation amounts to denial of minimal care, a question was raised as to whether the new system that Associate Commissioner Naglich described has been implemented. Associate Commissioner Culliver, who has the primary responsibility for inmate placements, transfers, and correctional staffing levels, testified after Naglich that there had not been any recent official policy change on the placement of mentally ill prisoners in segregation, and that he did not know about any changes that would prohibit officers from placing certain prisoners in segregation or would limit the duration of segregation placements. Naglich's subordinate, Dr. Tytell, later testified that an effort to change the coding system began only after ¹²⁴⁷Naglich testified that the policy change was ¹²⁴⁷already being rolled out, and that no new official coding system existed. He further explained that she instructed him to email the wardens at Donaldson to move ten individuals whose mental-health code was MH-2 or higher out of segregation and into the RTU, only after her testimony in court. She did not instruct him to do so with any other facility, and Tytell was not aware of any other facilities moving mentally ill

prisoners out of segregation units at the time of his testimony in January 2017. Based on the evidence presented—especially given Associate Commissioner Culliver's lack of knowledge or involvement in a major change to segregation policy—the court cannot conclude that ADOC has implemented this policy change of not placing prisoners with serious mental illness in segregation.⁷⁵ Given the consensus on the substantial risk of harm of decompensation for these mostly severely mentally ill prisoners, the court concludes that it is categorically inappropriate to place prisoners with serious mental illness in segregation absent extenuating circumstances; even in extenuating circumstances, decisions regarding the placement should be with the involvement and approval of appropriate mental-health staff, and the prisoners should be moved out of segregation as soon as possible and have access to treatment and monitoring in the meantime.

⁷⁵ The court further notes that the system that Associate Commissioner Naglich described would prevent the placement of seriously mentally ill prisoners in segregation only if the mental-health coding system were accurately classifying prisoners' mental-health needs.

9. Tutwiler

As ADOC's only major facility for women, Tutwiler Prison for Women serves as the treatment hub for all female prisoners in Alabama. While the same factors contributing to inadequate mental-health care—mental-health understaffing, correctional understaffing, and overcrowding—apply to Tutwiler, the provision of mental-health care at Tutwiler differs in some ways. This is because Tutwiler administrators, as a result of other litigation, have revised policies to make them more 'gender-responsive' and 'trauma-informed'—that is, responsive to female prisoners'

experience of past traumatic events.⁷⁶ Some of these revisions involve regulations governing mental-health care.⁷⁷

⁷⁶ Defense counsel suggested that the approval of certain policies at Tutwiler by monitors hired by the U.S. Department of Justice signifies that those policies are constitutionally adequate. However, there are two flaws with this argument. First, the DOJ monitor was not necessarily evaluating policies to ensure that mental-health care was adequate under the Eighth Amendment: the lawsuit that resulted in the monitoring was not about mental-health care, nor was the monitor's job to set the constitutional floor of mental-health care. Second, the monitors' approval of certain policies, such as segregation placement, does not mean that ADOC's actual practices are constitutionally adequate.

⁷⁷ For example, newly implemented practices include limiting pre-disciplinary hearing segregation to 72 hours, submitting monitoring logs for segregation cells to an independent reviewer, and having a compliance visit to the stabilization unit every six months to ensure 15-minute interval checks.

Yet, despite these policy changes, the care provided to mentally ill prisoners at Tutwiler suffers from some of the same inadequacies that affect mental-health care for men. Tutwiler lacks adequate mental-health and correctional staffing. As in the facilities for men, a significant portion of mentally ill patients are not being identified or appropriately classified; no suicide risk-assessment tool is used outside of intake; and the provision of counseling sessions is seriously inadequate. The court has sufficient evidence before it to conclude that these problems pose a ¹²⁴⁸substantial¹²⁴⁸ risk of serious harm to Tutwiler prisoners with serious mental-health needs.

Tutwiler suffers from the same serious deficiencies in identification and classification of prisoners' serious mental-health needs. The mental-health identification and classification processes at Tutwiler function the same way as at male correctional facilities: an LPN conducts the initial intake screening, without any on-site supervision by an RN or any other higher-level provider. Tutwiler also lacks a triage system for referral requests, and therefore requests to see a mental-health provider do not get classified or tracked to ensure that they are processed. The resulting under-identification is apparent in the number of prisoners on the mental-health caseload. Experts from both sides testified that women in prison have a significantly higher incidence rate of mental illness compared to their male counterparts: the estimated rate ranges between 75 to 80 %, according to Dr. Burns. At Tutwiler, only 54 % of prisoners are on the mental-health caseload. Joint Ex. 346, June 2016 Monthly Operating Report (doc. no. 1038-708). As with the rest of the system, experts from both sides testified that the low rate stems from ADOC's inadequate intake and referral processes. Experts from both sides also testified that an insufficient number of prisoners are getting care in mental-health units at Tutwiler despite the severity of their illnesses. As explained above, such inadequate identification and classification of serious mental-health needs create a substantial risk of serious harm by failing to treat mental illness.

Expert testimony also showed that no suicide risk-assessment tool is being used at Tutwiler, except at intake, as is the case in male facilities. As explained earlier, failing to assess suicide risks of prisoners who threaten or attempt self-harm or suicide places those prisoners at a substantial risk of harm.

As at the male prisons, individual counseling sessions at Tutwiler are frequently delayed and canceled due to shortages of mental-health staff and correctional officers. An ADOC psychologist

at Tutwiler testified that the correctional staffing shortage that causes such delays and cancellations of counseling sessions is a topic of discussion at almost every multidisciplinary meeting. Furthermore, MHM contract-compliance reports and the minutes from CQI meetings consistently reported that Tutwiler's caseload is "bursting at [the] seams," and that MHM had difficulty meeting outpatient needs for counseling. Ex. 670, April 2015 Quarterly CQI Meeting Minutes (doc. no. 1056-7) at MHM031224; *see also* Pl. Ex. 532, 2015 Contract-Compliance Report (doc. no. 1070-7) at 4, 13 ("At Tutwiler, staff are attempting to manage extremely large caseloads, which at times can be very challenging"; "significant staffing shortages in psychiatry" reported at Tutwiler); Pl. Ex. 114, 2013 Contract-Compliance Report (doc. no. 1070-4) at 1-2 (discussing decrease in treatment availability at Tutwiler due to staffing cuts and increasing size of caseload across all facilities).

In sum, inadequate identification and classification of mental-health needs, inadequate screening for suicide risk, and inadequate psychotherapy create a substantial risk of serious harm to mentally ill prisoners at Tutwiler. On the other hand, while also concerned about the number of crisis cells, suicide-watch placements, segregation placements, and treatment and monitoring available in segregation and in crisis care at Tutwiler, the court does not have sufficient evidence to find that those areas pose a substantial risk of serious harm to Tutwiler's prisoners.⁷⁸

1249*1249 10. Other Issues

⁷⁸ The court also notes that the experts from both sides presented affirmative evidence that the care being provided in the Tutwiler RTU is adequate, or close to adequate.

This section discusses several issues on which the court does not at this time find for the plaintiffs. First, there is substantial evidence that periodic mental-health evaluations for all prisoners in segregation are inadequate, but the court, out of an

abundance of caution and exercising its discretion, leaves this issue to be further addressed by the parties. Second, evidence was insufficient to establish a substantial risk of serious harm arising from ADOC's medication management practices or the supervision of certified registered nurse practitioners.

On the first issue, substantial evidence suggested that ADOC is not conducting adequate periodic mental-health assessments of prisoners in segregation to identify those who *become* mentally ill while in segregation. Dr. Haney credibly opined that periodic out-of-cell assessments are necessary not only to monitor for decompensation among those identified as mentally ill, but also to identify prisoners not on the mental-health caseload who may develop mental illness while in segregation. Just as identification and classification of mental-health needs at intake are essential in a functioning mental-health care system, it is also essential to identify those who need mental-health treatment in segregation. ADOC's own administrative regulation requires periodic mental-health assessments of prisoners in segregation, even for those who are not on the caseload, though it does not appear to require out-of-cell assessments. Joint Ex. 127, Admin. Reg. § 625 (doc. no. 1038-150). However, evidence suggested that such assessments at ADOC are cursory at best. For example, as discussed above, plaintiff R.M.W.'s segregation mental-health evaluation form completed in the same month when she was sent to suicide watch twice and had multiple incidents of self-injury simply had some check marks and stated "inmate appropriate for placement" and "segregation placement not impacting inmate's mental health." Joint Ex. 404, March 28, 2014 Review of Segregation Inmates R.M.W. (doc. no. 1038-859) at MR017081. No mention of her suicide-watch placements or self-injury episodes was included, and no suicide risk-assessment tool was completed. Ample evidence of correctional and mental-health understaffing—and the fact that staff are often unable to conduct segregation

rounds consisting of much shorter, cursory cell-front interactions—also suggests that ADOC is unable to provide meaningful mental-health assessments of prisoners in segregation. However, the court believes that it should solicit more input from the parties before determining whether ADOC is conducting adequate periodic mental-health assessments of prisoners in segregation. Therefore, the Eighth Amendment finding remains open as to this discrete issue, and the court will take it up with the parties after this opinion is issued.

Second, the court is able to conclude on the record before it that plaintiffs did not present sufficient evidence to establish that prisoners in ADOC custody face a substantial risk of serious harm in two areas: medication management and supervision of certified registered nurse practitioners. Plaintiffs did not present sufficient evidence to establish that ADOC's medication management practices are inadequate based on ADOC allegedly letting cost concerns override clinical needs and not being responsive to patients' concerns about side effects. While plaintiffs presented anecdotal evidence of providers' refusal to continue previously prescribed medications or to switch medications despite continuing side effects, the court did not see any independent clinical assessments of these patients' medication needs. Absent any contrary clinical assessments, ^{1250*}1250 credibility findings, or more direct evidence of ADOC's failure to prioritize patients' clinical needs over medication costs, a constitutional determination about the adequacy of these kinds of medication decisions would invade the province of psychiatric providers' medical judgment. *Estelle v. Gamble*, 429 U.S. 97, 107, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976) (holding that matters for "medical judgment" do not raise an Eighth Amendment concern). The testimony established only that clinicians talk about the cost of medications during meetings, and that managers commend providers for keeping prices down as a team; further, some prisoners were discontinued

on medications they were originally prescribed, but there is no documentation about the reasons those medications were discontinued. However, these unconnected dots are not sufficient to find that ADOC prioritizes cost concerns over clinical needs when making prescription decisions, because the court is ill-equipped to discern whether the decisions were clinically inappropriate. Furthermore, even plaintiffs' expert Burns found that keeping the cost of medications in mind when making prescribing decisions was not on its own inappropriate or unusual, especially because MHM clinicians' requests for medications that are not pre-approved for use are almost always granted. In other words, absent contrary clinical findings, there is not enough evidence to find that ADOC systematically overrides clinical needs due to cost concerns such that its medication management practices are constitutionally inadequate.

In addition, plaintiffs argued that ADOC's certified registered nurse practitioners were not properly supervised by psychiatrists. Evidence suggested that some of the CRNPs employed by MHM could not meet the state regulatory requirement that they collaborate with an on-site psychiatrist at least 10 % of the hours they work. However, evidence also showed that psychiatrists do supervise and collaborate with CRNPs through other, more informal channels. Therefore, there is insufficient evidence to establish that inadequate supervision has created a substantial risk of serious harm for mentally ill prisoners.

C. Deliberate Indifference

Having found that ADOC's mental-health care system creates substantial risks of serious harm to mentally ill prisoners (defined in this opinion as those with serious mental-health needs), the court now turns to the deliberate-indifference prong of the Eighth Amendment inquiry. In order to prove an Eighth Amendment violation, plaintiffs must show not only that state officials subjected mentally ill prisoners to a substantial risk of

serious harm, but also that defendants acted with deliberate indifference to that risk. As discussed below, despite being repeatedly informed that significant deficiencies existed, ADOC has disregarded and failed to respond reasonably to the actual harm and substantial risks of serious harm posed by its deficient mental-health care system.⁷⁹

⁷⁹ Defendants also asserted that because the named ADOC officials were not involved in the direct provision of mental-health care to prisoners, they could not have been deliberately indifferent to the plaintiffs' serious mental-health needs. This court has already rejected this argument. See *Dunn v. Dunn*, 219 F.Supp.3d 1100, 1157-60 (M.D. Ala. 2016).

To establish deliberate indifference, plaintiffs must show that defendants had subjective knowledge of the harm or risk of harm, and disregarded it or failed to act reasonably to alleviate it. *Thomas v. Bryant*, 614 F.3d 1288, 1312 (11th Cir. 2010). Officials must "be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists," and "draw the inference." ¹²⁵¹ *Farmer v. Brennan*, 511 U.S. 825, 837, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994). The defendant's subjective awareness of a risk of harm can be determined based on circumstantial evidence, including "the very fact that the risk was obvious." *Id.* at 842, 114 S.Ct. 1970. In other words, if a particular risk was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus 'must have known' about it," such evidence permits a trier of fact to conclude that the officials had actual knowledge of the risk. *Id.* at 842-43, 114 S.Ct. 1970 (internal citation omitted).

The disregard prong can be proven in many ways. In the area of medical care, disregard of a risk of harm may consist of "failing to provide care, delaying care, or providing grossly inadequate

care," when doing so causes a prisoner to needlessly suffer the pain resulting from his or her illness. *McElligott v. Foley*, 182 F.3d 1248, 1257 (11th Cir. 1999). Put differently, Eighth Amendment liability may be found if a defendant with subjective awareness of a serious need provides "an objectively insufficient response to that need." *Taylor v. Adams*, 221 F.3d 1254, 1258 (11th Cir. 2000). Although considered part of the subjective component, the requirement that the defendant disregard a risk of harm actually evaluates her response (or lack thereof) by an objective 'reasonableness' standard. *Farmer*, 511 U.S. at 847, 114 S.Ct. 1970.

In some circumstances, a defendant's disregard of a known risk is quite obvious. For example, the defendant might "simply refuse[] to provide" medical care known to be necessary. *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) (allegations that prisoner required a psychiatric evaluation that defendants refused to provide satisfies disregard requirement). If a defendant provides some medical care, the Constitution does not require that the care be "perfect" or the "best obtainable." *Harris v. Thigpen*, 941 F.2d 1495, 1510 (11th Cir. 1991). Nonetheless, a defendant's disregard of the risk can still be found through "delaying the treatment," providing "grossly inadequate care," making "a decision to take an easier but less efficacious course of treatment," or providing "medical care which is so cursory as to amount to no treatment at all." *McElligott*, 182 F.3d at 1255 (collecting cases). In other words, a choice to provide care known to be less effective because it is easier or cheaper can constitute deliberate indifference. In the context of mental-health care, "the quality of psychiatric care can be so substantial a deviation from accepted standards as to evidence deliberate indifference to those serious psychiatric needs." *Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996) (citing *Greason v. Kemp*, 891 F.2d 829, 835 (11th Cir. 1990)). Deliberate indifference can also be found when "[a] prison

official persists in a particular course of treatment in the face of resultant pain and risk of permanent injury" to the prisoner. *Rouse v. Plantier*, 182 F.3d 192, 197 (3d Cir. 1999).

In challenges to a correctional institution's provision of medical care, evidence of systemic deficiencies can also establish the 'disregard' element of deliberate indifference. *Harris*, 941 F.2d at 1505. For example, this element may be met "by proving that there are 'such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care.'" *Id.* (quoting *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980), cert. denied, 450 U.S. 1041, 101 S.Ct. 1759, 68 L.Ed.2d 239 (1981)). As ¹²⁵²an evidentiary matter, these systemic deficiencies may be identified by a "series of incidents closely related in time" or "[r]epeated examples of delayed or denied medical care." *Rogers v. Evans*, 792 F.2d 1052, 1058–59 (11th Cir. 1986). Further, prison officials' efforts to correct systemic deficiencies that "simply do not go far enough" when weighed against the risk of harm also support a finding of deliberate indifference, *Laube v. Haley*, 234 F.Supp.2d 1227, 1251 (M.D. Ala. 2002) (Thompson, J.), because such efforts are not "reasonable measures to abate" the identified substantial risk of serious harm. *Farmer*, 511 U.S. at 847, 114 S.Ct. 1970.

Finally, the defendant institution's response to a known risk must be more blameworthy than "mere negligence." *Farmer*, 511 U.S. at 835, 114 S.Ct. 1970 (citing *Estelle v. Gamble*, 429 U.S. 97, 106, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976)). In other words, the defendant must have disregarded the risk with "more than ordinary lack of due care for the prisoner's interests or safety." *Id.* (quoting *Whitley v. Albers*, 475 U.S. 312, 319, 106 S.Ct. 1078, 89 L.Ed.2d 251 (1986)). However, while an "inadvertent failure" to provide adequate medical care does not satisfy the deliberate-indifference standard, *Estelle*, 429 U.S. at 105–06, 97 S.Ct. 285, in challenges to health-care systems, repeated

examples of negligent conduct support an inference of systemic disregard for the risk of harm facing mentally ill prisoners. See *Ramos*, 639 F.2d at 575 ("In class actions challenging the entire system of health care, deliberate indifference to inmates' health needs may be shown by proving repeated examples of negligent acts which disclose a pattern of conduct by the prison medical staff.").

In an official-capacity suit, the suit is not "against the official personally, for the real party in interest is the [governmental] entity"; therefore, the deliberate-indifference inquiry focuses on the institution's "historical indifference" to the identified risk of harm, rather than the named defendant official's personal indifference. *LaMarca v. Turner*, 995 F.2d 1526, 1542 (11th Cir. 1993) (finding that substitution of a new defendant, "a dedicated public servant who is trying very hard to make [the prison] an efficient and effective correctional institution" does not preclude a deliberate-indifference finding); see also *Laube*, 234 F.Supp.2d at 1249 ("[T]he real parties in interest are the responsible entities: the Department of Corrections and, ultimately, the State of Alabama.").

This case is likely *sui generis* in the extent to which the top ADOC officials had personal knowledge of the substantial risks of serious harm posed by its deficient care and has not responded reasonably to those risks. Much of the evidence came from ADOC officials' own mouths: defendants—particularly Associate Commissioner Naglich—and other officials readily admitted to the existence of serious deficiencies, the risk of harm arising from them, and ADOC's failure to respond. As a result, although plaintiffs do not have to prove personal deliberate indifference by the named defendants in order to establish institutional deliberate indifference, the court's finding of deliberate indifference is well supported by defendants' own admissions of knowledge and

failure to act, in addition to the other circumstantial evidence more typically seen in official-capacity suits.

I. ADOC's Knowledge of Harm and Risk of Harm

The inadequacies plaguing ADOC's mental-health care system were pervasive and well-documented in multiple ways: ADOC received monthly statistical reports and annual contract-compliance reports from MHM; ADOC communicated with ¹²⁵³senior MHM managers through emails and quarterly CQI meetings; ADOC received corrective-action plans from MHM after compliance reviews and audits; ADOC also performed two audits of MHM's performance since 2011. As a result, ADOC has been well aware of the risks presented by the deficiencies in its mental-health care.

ADOC has been well aware of the significant and adverse impact of overcrowding, mental-health understaffing, and correctional understaffing on the provision of mental-health care. Associate Commissioner Naglich admitted that, since 2010, MHM has been struggling to meet contractual requirements due to staffing cuts and increasing caseloads. In addition, MHM's program director Houser repeatedly raised concerns about inadequate mental-health staffing with Naglich, requesting for over a year to amend the contract to increase staffing across facilities; she also told Naglich repeatedly that MHM needed more counselors in order to meet the rising demand, because ADOC's psychological associates were not taking counseling caseloads from MHM providers as anticipated.

Both Dunn and Naglich have been aware that persistent correctional understaffing has interfered with MHM's ability to provide mental-health care. According to Naglich, in the years since 2010, MHM has repeatedly informed ADOC that the lack of sufficient correctional staffing has been seriously impacting its ability to provide care. ADOC's own audit of the Donaldson RTU in 2013 also revealed that check-in rounds, individual

appointments, and regularly scheduled activities had to be delayed or canceled due to the limited number of officers assigned to the mental-health unit. At least since 2013, Naglich has repeatedly complained to ADOC's Commissioner, former Commissioner, and Associate Commissioner of Operations about the chronic shortage of correctional officers interfering with mental-health care. She characterized correctional understaffing as "probably one of the most serious problems facing the department." Naglich Testimony at vol. 2, 174–75.

Ample evidence also demonstrates ADOC's knowledge of the risks of harm arising out of the specific deficiencies in the treatment of mentally ill prisoners discussed earlier. First, MHM managers repeatedly informed ADOC in their reports and emails that the deficiencies arising out of staffing shortages—including difficulties in providing timely counseling sessions and activities—were seriously undermining their ability to provide care. Second, Naglich admitted that the failure to meet the mental-health needs of prisoners with serious mental illness—in other words, the risk of harm arising from failing to identify prisoners in need of mental-health care and providing them with the appropriate level of care—puts them at risk of decompensating.

ADOC was also well aware of the specific deficiencies. To begin, ADOC was aware that its processes for identifying and classifying mentally ill prisoners were inadequate. ADOC has had a persistently low prevalence rate of mental illness, and ADOC officials have known that LPNs with extremely limited training are responsible for identifying prisoners' needs for mental-health services. Moreover, Associate Commissioner Naglich was informed of the persistent pattern of self-injury, attempted suicides, and suicides involving prisoners who had not been identified as mentally ill; MHM's corporate office had repeatedly informed her in contract-compliance reports that requests for mental-health services were not being processed appropriately according

to their urgency level. In sum, the circumstances make clear that she had been exposed to information concerning the problems and thus ¹²⁵⁴*¹²⁵⁴ 'must have known' about them. *Farmer*, 511 U.S. at 842–43, 114 S.Ct. 1970.

Deficiencies in treatment planning have been longstanding, persistent, and well documented, including in reports directly delivered to Associate Commissioner Naglich. MHM notified ADOC of the lack of individualization of treatment plans for years in audits and quarterly CQI meetings. MHM's annual contract-compliance reports to ADOC between 2011 and 2016 also noted that treatment plans were inadequate across all levels of care, from outpatient to crisis care. ADOC's own 2013 audit of Donaldson identified as a problem that treatment team meetings—where treatment planning occurs—frequently were held without all necessary participants.

The problem of insufficient counseling services has also been longstanding and well known. First, Naglich admitted her knowledge of a persistent shortage of counselors and increasing caseloads, as well as a chronic shortage of correctional officers for escorting prisoners to appointments. Second, multiple sources informed her and other ADOC officials of serious problems in the provision of group counseling services; she also admitted that the shortage of correctional officers hindered MHM's ability to provide group therapy sessions. Contract-compliance reports given to Naglich repeatedly informed her that multiple facilities were not getting enough group counseling sessions over the years. MHM's monthly operations reports to ADOC, which contain statistics on the number of individual treatment encounters and group sessions each month, also made clear that little group counseling was occurring at multiple prisons. For example, the monthly operations report for April 2016 showed that no outpatient group therapy was offered at Donaldson, Easterling, Kilby, or St. Clair. Moreover, MHM has repeatedly discussed the problem of increasing caseloads for counselors

and the unavailability of group treatment at many facilities during quarterly CQI meetings, which ADOC Chief Psychologist Tytell attends on behalf of the agency.

ADOC officials have also been aware of the array of well-documented problems plaguing inpatient-level care. MHM has been reporting low utilization rates for RTU and SU beds to Naglich and her office every month; Naglich admitted that she has been aware of the presence of prisoners in segregation without any mental-health needs in mental-health units, and that this disrupts the therapeutic environment; ADOC's audit of Donaldson revealed that patients were not getting sufficient out-of-cell time and counseling; and Naglich has known that ADOC does not provide hospital-level care to patients who need it.

ADOC officials have been well aware of the inadequacies in suicide prevention and crisis care. Commissioner Dunn personally reviews suicide-incident reports and has been aware of the precipitous increase in the suicide rate in the last two years; he has been also aware that most of the suicides were committed by hanging and in segregation. For her part, Naglich has known even of the specific, system-wide conditions that create substantial risks of suicide: she was notified of the chronic crisis-cell shortage⁸⁰ and the backlog at the Bullock SU that has been driving the shortage; MHM complained to her about unsafe crisis cells with tie-off points and low visibility, and her office's own audit included the same findings; and MHM repeatedly reported to Naglich that sharp ¹²⁵⁵items were found in crisis cells. Naglich ¹²⁵⁵*¹²⁵⁵ also admitted that not having a constant-watch procedure for the most acutely suicidal inmates is a serious problem that poses a risk of harm in such a way that "someone could die." Naglich Testimony at vol. 3, 228.

⁸⁰ ADOC Associate Commissioner Culliver and the regional coordinator for medical care, Brendan Kinard, also have been

aware of crisis-cell shortage and the resulting placement of suicidal prisoners in non-crisis cells for years.

Perhaps most dramatically, ADOC has been aware of the actual harm and the substantial risk of serious harm that ADOC's segregation practices pose to mentally ill prisoners. Commissioner Dunn has been aware of the fact that mentally ill prisoners resided in segregation, and that segregation could exacerbate their mental illness. Naglich has been receiving monthly reports that showed overrepresentation of mentally ill prisoners in segregation. MHM staff repeatedly communicated to ADOC officials—both orally and in writing—their concern about ADOC's placement of mentally ill prisoners in segregation. MHM's annual contract-compliance reports between 2012 and 2016 reported that multiple facilities had disproportionate numbers of prisoners on the mental-health caseload in segregation and recommended further review of the mental-health consultation process and monitoring. *See* Pl. Ex. 1191, 2012 Contract-Compliance Report (doc. no. 1070-9); Pl. Ex. 114, 2013 Contract-Compliance Report (doc. no. 1070-4); Pl. Ex. 115, 2016 Contract-Compliance Report (doc. no. 1070-5). Moreover, MHM leadership has communicated the grave and potentially lethal risks of such segregation practices to ADOC officials, including Naglich. For example, over the last four to five years on multiple occasions, Dr. Hunter, MHM's medical director, has had discussions with ADOC leadership regarding mentally ill prisoners' potential to deteriorate while in segregation. MHM's program director Houser has repeatedly informed ADOC officials that placement of mentally ill prisoners in segregation should be avoided because of the potential harm to those prisoners. Naglich herself admitted that housing mentally ill prisoners in segregation is "categorically inappropriate." Naglich Testimony at vol. 5, 73.

While aware of the substantial risk of serious harm posed by segregation, ADOC has also known that certain ADOC disciplinary practices result in frequent placement of mentally ill prisoners in segregation. Associate Commissioner Naglich admitted that ADOC has had a practice of disciplining prisoners for engaging in self-injurious behaviors. Furthermore, both MHM's and ADOC's own audits revealed that the mental-health consultation component of the disciplinary process was not properly functioning to keep mentally ill prisoners out of segregation.

Lastly, ADOC has also been aware of the inadequate monitoring and access to treatment for prisoners in segregation. ADOC's chief psychologist Tytell informed Naglich that segregation rounds by mental-health staff were not being done properly and that mental-health patients in segregation were not receiving treatment. Furthermore, ADOC officials have been well aware that segregation placement has been a common factor among suicides. Indeed, the great danger to mentally ill prisoners in segregation is obvious: prisoners are locked away for weeks at a time in cells with little monitoring and easy access to the means to kill themselves. In other words, ADOC has been aware of the actual harm that has resulted from segregation practices, in addition to the substantial risk of serious harm that ADOC's segregation practices have imposed on mentally ill prisoners.

In sum, evidence established that ADOC has been aware of the gross deficiencies found in its treatment of mentally ill prisoners.

2. ADOC's Disregard of Harm and Risk of Harm

Despite its knowledge of actual harm and substantial risks of serious harm to mentally ill prisoners, ADOC has failed ¹²⁵⁶to respond reasonably to identified issues in the delivery of mental-health care. On a global level, the state of the mental-health care system is itself evidence of ADOC's disregard of harm and risk of harm: in spite of countless reports, emails, and internal

documents putting ADOC on notice of the actual harm and substantial risks of serious harm posed by the identified inadequacies in mental-health care, those inadequacies have persisted for years and years. Suicide risk-assessment tools are still not being used outside of intake; referral requests are still not being triaged according to their urgency levels; records from late 2016 indicated a continued lack of individualized treatment plans and inadequate frequency of individual and group counseling; segregation prisoners without mental-health needs are still found in mental-health units; no hospitalization option or hospital-level care for the most severely ill exists; suicidal prisoners continue to be housed in unsafe cells without adequate monitoring; and mentally ill prisoners still are placed in segregation without a meaningful mental-health consultation process and have even less access to treatment.⁸¹

⁸¹ Likewise, the current levels of mental-health and correctional understaffing and overcrowding also illustrates ADOC's disregard of risk of harm. First, ADOC's response to the shortages of mental-health and correctional staff have been objectively insufficient, because systemic and gross deficiencies arising from understaffing have persisted and effectively denied prisoners access to adequate mental-health care. *Taylor*, 221 F.3d at 1258 (holding that the 'disregard' prong under *Estelle* and *Farmer* can be satisfied through an "objectively insufficient response" by prison officials); *Harris*, 941 F.2d at 1505 (deliberate indifference can be established through "systemic and gross deficiencies in staffing" that effectively deny prisoners access to adequate medical care); see also *Coleman v. Wilson*, 912 F.Supp. 1282, 1319 (E.D. Cal. 1995) (Karlton, J.) ("[G]iven the nature and extent of the crisis and its duration," defendants' purported efforts to remedy the acute shortage of mental-health staff in the prison system were not sufficient to defeat a deliberate-indifference finding). Furthermore,

difficulties in recruiting do not negate the fact that understaffing has caused this serious systemic deficiency. See *Wellman v. Faulkner*, 715 F.2d 269, 273 (7th Cir. 1983) (failure of a prison to fill authorized position weighs "more heavily against the state than for it," partly because the authorized salary was woefully inadequate and the prison's effort was insufficient); *Madrid v. Gomez*, 889 F.Supp. 1146, 1227 (N.D. Cal. 1995) (Henderson, J.) (finding "recruitment difficulties do not excuse compliance with constitutional mandates."). In other words, ADOC's failure to provide mental-health and correctional staffing sufficient to operate a minimally adequate mental-health care system is in itself an unreasonable response under the deliberate-indifference standard.

The same logic applies to overcrowding. While it is true that ADOC does not have the authority to release prisoners or stem the inflow of prisoners from the state's criminal justice system, ADOC's response to overcrowding has been objectively insufficient. This is because the court does not consider the overcrowding problem in a vacuum. ADOC has been well aware of the magnitude and impact of overcrowding on every facet of its operations for years. ADOC's efforts—belatedly pushing for construction of new prisons in 2016, for example—to alleviate the problem have been too little and too late, as reflected in the current 170 % occupancy rate. Considering the institution's historical deliberate indifference to the problem of overcrowding, rather than what ADOC has done under the current leadership only, the court finds that ADOC has disregarded to the harm and risk of harm caused by overcrowding and understaffing.

In addition to its failure to respond reasonably to these deficiencies, ADOC's disregard for the substantial risk of serious harm to mentally ill prisoners manifested itself in two additional ways: its persistent refusal to exercise any meaningful

oversight of MHM's delivery of care; and its unreasonable responses to critical incidents and discrete issues brought to their attention over the 1257 years.⁸² 1257 a. ADOC's Failure to Exercise Oversight of the Provision of Mental-Health Care

ADOC's Office of Health Services, run by Associate Commissioner Naglich, has done vanishingly little to exercise oversight of the provision of care to mentally ill prisoners. This failure exemplifies ADOC's disregard of the substantial risk of serious harm to mentally ill prisoners within ADOC. Two facts provide important context for understanding this failure: first, ADOC has been well aware of the inadequacies in the treatment of mentally ill prisoners discussed above; second, as explained in this section, ADOC has known that MHM's own quality-control process is hopelessly inadequate in implementing corrective actions. Despite clear indications that the same inadequacies persisted year after year, and that its contractor has been failing to implement corrective actions, ADOC chose to exercise close to no oversight, abdicating its constitutional obligation to ensure that the provision of mental-health care is minimally adequate.⁸² Such inaction is clearly unreasonable and therefore amounts to deliberate indifference.

⁸² In fact, instead of penalizing MHM for its known inadequacies, ADOC extended the contract with MHM for one more year in September 2016. Associate Commissioner Naglich credibly testified that, as a result of her negative view of MHM's performance, she recommended awarding the mental-health contract in 2013 to another contractor, rather than renewing the contract with MHM; She likewise stated that before the department extended its contract with MHM in 2016, she told Commissioner Dunn that MHM was not "measuring up." Naglich Testimony at vol. 4, 121, adding that Dunn was also dissatisfied with all the issues that ADOC

has had with MHM. And yet, ADOC renewed the contract with MHM regardless.

As an initial matter, a brief overview of MHM's quality-control processes illustrates the unreasonable nature of ADOC's response. Though designed for 'continuous quality improvement,' MHM's quality-control processes do not ensure that the identified deficiencies are corrected, mainly because many of the necessary corrective actions require cooperation and action by ADOC. MHM's corporate office's annual contract-compliance audit is the only system-wide review of MHM's performance that either MHM or ADOC conducts. Once the review is complete, MHM sends a contract-compliance report, as well as a corrective-action plan, to Naglich's Office of Health Services.⁸³ However, it is unclear whether anyone within MHM monitors the implementation of corrective actions. Moreover, for many of the identified deficiencies, MHM cannot address them effectively without ADOC's help: corrective actions—such as obtaining adequate staff to facilitate therapy appointments and group activities—often require action by ADOC officers 1258 and, crucially, more staffing.⁸⁴ As a *1258 result, without action on ADOC's part, contract-compliance reports often note the same problems recurring year after year: for example, multiple annual reports found that treatment plans were not updated consistently; that crisis cells in various facilities were unsafe for suicidal prisoners; and that prisoners in segregation and mental-health units were not getting regular treatment due to the shortage of correctional officers.⁸⁵

⁸³ One former MHM employee testified that these audit results are not reliable, because MHM staff on site pull medical records to be audited ahead of time and get them up to par before the corporate auditors review them. Plaintiffs' expert Dr. Burns also observed that the facility staff select the files for review, rather than the corporate office randomly selecting the files. While

this testimony raises a concern that the reports may have minimized negative findings, the court relies on them to the extent the reports still found serious deficiencies in the provision of mental-health care.

⁸⁴ MHM's corrective-action plans reflect this conundrum: while MHM is required to send a corrective-action plan in response, much of what is required to fix the deficiencies identified in contract-compliance reports involves ADOC actions. For example, follow-up findings in the corrective-action plan for 2016 included statements such as: "This is a work in progress. Due to the staffing issues currently are not being completed during the required time frame"; "Still working with the MHPs on ensuring that the treatment plan is completed during this time frame of admission." Pl. Ex. 1247, July 2016 Bullock IP Corrective Action Plan (doc. no. 1099-10).

⁸⁵ To be clear, the court notes that many identified problems could be fixed by MHM, but are not.

The regional-level quality-improvement exercises—which includes quarterly audits and 'spot audits' by MHM's CQI manager—also do not seem to result in corrective actions. In fact, the CQI manager admitted that no one is responsible for ensuring that site administrators address the issues identified through her spot checks: she is only responsible for reporting the findings, not addressing the problems; no documentation of site-level follow-up is required. In her own words, "the buck doesn't stop with anyone." Davis-Walker Testimony at vol. 2, 152.⁸⁶

⁸⁶ Asked how she knows that MHM is meeting contract compliance goals if all follow ups are done at the site level and she does not see any of those results, the CQI manager responded, "[O]bviously, you do not understand quality." Davis Walker Testimony at vol. 2, 237. She testified that

the purpose of CQI is "refining [] process[es]," which she defined as determining how to collect data and reflect it in a database. Davis-Walker Testimony at vol. 1, 83. This singular focus on process rather than substance on her part led to one of the more bizarre exchanges of this trial: she insisted that all spot-audit results showing failures to meet contract or regulatory standards were exclusively attributable to data-entry problems, and never to any actual failure to provide appropriate care. For example, she insisted that noncompliance reported in the audit, such as treatment plans that were "outdated or requiring review," reflected database entry problems, even though finding the date of the latest treatment plan did not involve looking in the database. Davis-Walker Testimony at vol. 2, 130-32. Needless to say, the court did not find credible her testimony that all identified problems are attributable to mere data entry errors.

Naglich was well aware of MHM's inability to address identified problems. In fact, Naglich blamed MHM for most of the deficiencies in mental-health care at ADOC and expressed particular dissatisfaction with MHM's CQI process: she complained in court that MHM identifies problems, but does not help ADOC solve those problems. But this was the proverbial pot calling the kettle black: in spite of her concerns about MHM's internal oversight and her knowledge of deficiencies in care, Naglich and OHS—the only ADOC department with responsibility for monitoring mental-health care—have done almost nothing that resembles 'quality-improvement' or even bare-bones contract monitoring in response.

First, Associate Commissioner Naglich admitted that she does not review the contract-compliance reports in full or take actions based on their findings. She asserted that Dr. Tytell, the only staff member at OHS with mental-health expertise, is

responsible for reviewing the reports. However, Tytell denied ever receiving the reports or being responsible for reviewing them.⁸⁷ Not surprisingly, Naglich's testimony also revealed that neither she nor anyone else in her office has taken any corrective measures in response to the numerous ¹²⁵⁹inadequacies identified in the reports.⁸⁸ Second, ADOC has failed to monitor MHM's provision of mental-health care, despite having the tools to do so. ADOC's contract with MHM grants it access to MHM's files and the right to conduct scheduled and unannounced performance reviews. The contract also authorizes ADOC to assess fines for noncompliance found during formal audits. However, ADOC has not made use of these provisions. Since 2011, Naglich's office has conducted only one informal audit—in response to a specific concern raised by a medical provider about a mentally ill inmate—and one 'pilot audit,' both of which were limited to the Donaldson facility.⁸⁸ (Only the first, informal audit produced a written report.) Despite Naglich's own assessment that MHM was "not measuring up," Naglich Testimony at vol. 4, 121, ADOC has not audited, even informally, mental-health care at any prison other than Donaldson, and has not conducted formal audits at any prisons. Because it has not conducted any formal audits, ADOC has not been able to assess MHM any fines for contractual noncompliance.

⁸⁷ Lynn Brown, the only other person within OHS who interacts with MHM regularly, also denied ever seeing the reports or being responsible for reviewing them.

⁸⁸ MHM's program manager Houser explained that Naglich told her the 'pilot audit' would not "count" and that the results would not be used as an "I gotcha." Houser Testimony at vol. 2, 176.

Even when ADOC conducted the informal audits at Donaldson, it did nothing to address the identified problems. The 2013 informal audit of Donaldson revealed that the care provided at the Donaldson RTU was deficient in many ways—so

much so that Associate Commissioner Naglich described it as a "failed audit." Naglich Testimony at vol. 2, 55. As discussed earlier in more detail in Section V.B.5, the audit revealed that providers had difficulties accessing patients because of the correctional staffing shortage; group programming was inadequate; bed space in the treatment units was used to house segregation inmates; mental-health staffing was inadequate; security for mental-health staff was inadequate; and patients were not getting sufficient out-of-cell time. MHM's corrective-action plan identified tasks for both ADOC and MHM. However, Naglich was unable to identify a single follow-up action taken by her office or MHM to address any of these issues. ADOC's lead auditor, Brendan Kinard, admitted that OHS did not do anything to resolve problems identified in the Donaldson audit.

Associate Commissioner Naglich offered no reasonable explanation when pressed about the reason for the lack of follow-up after the dismal results of the 2013 Donaldson audit. She blamed the death of Dr. Cavanaugh, the chief psychologist of OHS and Dr. Tytell's predecessor, who unexpectedly passed away in March 2014. According to Naglich, Cavanaugh had been responsible for contract monitoring, including conducting formal and informal audits of MHM's delivery of care, and for ensuring that the quality of mental-health care is adequate. However, Naglich's excuse did not hold water: when asked to produce any documentation of audits or follow-ups done by Dr. Cavanaugh before he passed away, she was unable to do so; he apparently produced no written reports or emails about his findings or audits. According to MHM's program director Houser, Cavanaugh conducted no system-wide or even facility-wide audits; he simply performed 'reviews' that did not result in corrective-action plans or written reports.

Moreover, the testimony of Dr. Tytell, who took Dr. Cavanaugh's place later in 2014, made clear that ADOC still does little to ensure that MHM is meeting contractual requirements. Tytell admitted

that he does not conduct any system-wide or facility-wide audits, and that he only examines patient records when he is trying to learn something about a specific patient. He attends MHM's quarterly CQI meetings, which last a whole day, but he leaves around lunch time; he has missed one or two of the four quarterly meetings in the last year. He does not look into issues raised at CQI meetings, unless specifically told to do so by Naglich.⁸⁹ Likewise, although he receives programming logs and monthly operations reports from MHM, Tytell does nothing with them because the information is "already old data" that is "a couple months behind." Tytell Testimony at ____.

⁸⁹ Lynn Brown, the other ADOC employee who attends the MHM CQI meetings but does not have any mental-health training, testified that she is not responsible for reporting from the meetings unless specifically told to do so. This office-wide lack of involvement in the CQI process further supports the finding that ADOC has chosen to abdicate its duty of ensuring that MHM's delivery of mental-health care is minimally adequate.

The 2015 Donaldson 'pilot audit' also exemplified ADOC's inadequate response to identified problems in the provision of mental-health care. While conducting the audit, Tytell became concerned that many of the medical records he was examining were not meeting the benchmarks, and called Associate Commissioner Naglich in the middle of the audit to report the "dismal" results. Tytell Testimony at _____. Naglich simply told him to finish the audit. On the last day of the audit, Tytell informally discussed his preliminary findings in an exit interview with the site administrator and two people from MHM's regional office. However, no one at OHS formally communicated with MHM regarding the problems found in the audit or gave written feedback, even though many of the same inadequacies from the 2013 audit were identified again, and Houser

specifically asked for feedback. Because there was no written report, MHM did not develop any corrective-action plans.

After he revised the audit tools based on the 'pilot audit' results, Tytell asked Naglich whether OHS should re-audit Donaldson using the new tools. Naglich told him to not worry about it. Naglich also told him not to conduct any more audits of any other facilities. Tytell disagreed with the decision not to re-audit but did as he was told: as he explained, he "learned to stay in [his] lane," that is, "to do as I am ordered." Tytell Testimony at _____. OHS has not conducted any audit using the revised audit tools since then.

In sum, in failing to exercise adequate oversight of MHM's performance and to address deficiencies identified in the "failed" results of the 2013 Donaldson audit and the "dismal results" of the 2015 Donaldson audit, ADOC's response to its knowledge of harm and risk of harm in the mental-health care system has been objectively unreasonable.

b. ADOC's Unreasonable Responses to Identified Deficiencies

ADOC has also failed to respond reasonably to discrete issues that come to its attention, even when lives may be at stake. In response to many of the deficiencies identified above, ADOC officials admitted to doing nothing in response to being informed. ADOC officials also repeatedly testified that they simply told someone else about the risk of harm being created by deficient treatment of mentally ill prisoners, and took no other action, even though informing someone else within ADOC previously had failed to result in any change. Insisting upon a course of action that has already proven futile is not an objectively reasonable response under the deliberate-indifference standard.

Examples of such unreasonable responses abound. First, as multiple ADOC and MHM staff admitted, sharp items in crisis cells have been a recurring

problem in multiple facilities. When Dr. Tytell ¹²⁶¹was ^{*1261}asked about this problem, he simply stated: "I'm always told that things will be taken care of and things will be done. How to check up on it and follow up on it, I don't know how unless I'm told that it happens again." Tytell Testimony at ____ Tytell's statement epitomized ADOC's inadequate response to problems that pose serious risks to prisoners: the sole ADOC official with mental-health expertise insists on passing the buck even when the issue involves self-harm by suicidal prisoners, and even when his past experience has clearly shown him that simply bringing problems to the attention of others does not fix those problems.

Associate Commissioner Naglich likewise shirked responsibility when asked about the issue of sharp items found in crisis cells: even though she knew that correctional officers were not following protocol by failing to search crisis cells for sharp items that could be used for self-harm, she maintained that she does not have the authority to tell correctional officers to follow the protocols "because it's a security concern, so all that we can do is relay that concern to security." Naglich Testimony at vol. 4, 115. However, Associate Commissioner Culliver credibly testified that as an associate commissioner herself, Naglich has the authority to tell correctional officers to comply with administrative regulations and protocols.

Associate Commissioner Naglich's testimony was also full of admissions that, despite knowledge of risks of harm, ADOC took no action at all. She admitted that she had known about problems regarding visibility into crisis cells at least since ADOC's 2013 audit of Donaldson, but she did not know what, if anything, had been done to correct these problems in the years since. When asked why she has not done anything personally to address this issue that she acknowledged as "critical," she stated that she does not have enough staff to do so. Naglich Testimony at vol. 1, 173-74. Naglich also admitted that ADOC officials did nothing in response to their own audit finding that

ADOC had a practice of automatically applying disciplinary sanctions for self-injury. Likewise, she took no action in response to MHM's repeatedly-expressed concern—which she shared—that mentally ill prisoners are overrepresented in segregation, until after she told the court that mentally ill prisoners should not be in segregation. She unconvincingly testified that if she had been notified that the mentally ill were disproportionately being housed in segregation, she "would have looked at each one of those facilities." Naglich Testimony at vol. 5, 138. Naglich, in fact, had been informed for years that mentally ill prisoners have been overrepresented in segregation.⁹⁰ Yet, she admitted that she never inquired into the facilities reported to have disproportionate numbers of mentally ill prisoners in segregation.

⁹⁰ As explained in the knowledge section, MHM managers, including Dr. Hunter and Houser, have both discussed this issue with her on multiple occasions. In addition, MHM has been sending monthly operations reports and annual contract compliance reports stating the same.

ADOC's response to the skyrocketing suicide rate also demonstrates a frankly shocking level of disregard for a known substantial risk of serious harm. At the highest level, Commissioner Dunn testified that he personally tracks suicide rates and has looked at incident reports; he is, of course, aware of the sharp increase in suicide rates in the last two years within ADOC. However, more than a month after this trial began, he testified that he has not ordered his staff to take any concrete measures other than asking his chief of staff, Steve Brown, to "look into it." Dunn Testimony at vol. 1, 45. He has never attended any meetings ¹²⁶²regarding suicides, ^{*1262}or asked for a written report or follow-up after suicide-related meetings that took place in October 2015 and October 2016.

Associate Commissioner Naglich was not only aware of the increase in the suicide rate, but also the risk factors for suicides. Yet, she and other

ADOC officials made almost no effort to address the problem. In Naglich's view, suicide is a risk for anyone with untreated mental illness—in other words, a lack of treatment, as well as a lack of acute care and suicide-prevention measures, places all mentally ill prisoners at risk of the most serious bodily harm possible. She attended an October 2015 meeting focused on the increase in suicide rates, where she learned that segregation placement was a common factor among suicides. However, neither she nor anyone else at ADOC took any action to change ADOC's housing of mentally ill prisoners in segregation, and no follow-up meeting was scheduled until October 2016. During that 12-month period, six prisoners committed suicide, doubling the annual rate from 2015. After the second meeting, ADOC again took no action. Appallingly, ADOC officials directly responsible for mental health—Naglich and Tytell—and prisoner placement—Culliver—all admitted that they were aware of the sharp rise in suicides, participated in these two meetings on the suicide rate, and took no action.

Associate Commissioner Naglich attempted to explain this lack of response by stating that a new mental-health coding system prohibiting placement of seriously mentally ill prisoners in segregation was in the middle of a roll-out at the time of her testimony in December 2016. However, as explained earlier, her representation was disputed by the testimony of two of her colleagues, who explained that OHS moved ten mentally ill prisoners out of segregation into the Donaldson RTU only after her testimony, and that there was no official policy change.⁹¹ In a way, Naglich's belated transfer of the prisoners is all the more damning: the fact that she and Dr. Tytell could move ten RTU-level prisoners out of segregation and into the RTU over the course of a few weeks suggests that it was well within their ability to prevent seriously mentally ill prisoners from being housed in segregation. They could have taken this action in 2015, after the first meeting on suicides, or in 2016, after the second

meeting, rather than waiting until January 2017. By that time, twelve more people, including a plaintiff in this lawsuit, had committed suicide.

⁹¹ Tytell also tried to evade responsibility by saying that he was not responsible for the actual transfer or monitoring of the transfer: he first contended that whether mentally ill prisoners are actually being transferred out of segregation was up to the wardens and site administrators, because they have the mental-health codes of prisoners in segregation; he insinuated that he did not have any way of monitoring the movement of mentally ill prisoners in and out of segregation. However, he then admitted that both himself and Associate Commissioner Naglich do have access to the mental-health codes of prisoners in segregation. At the time of his testimony, Dr. Tytell had never run a report to ascertain how many mentally ill prisoners remain to be moved out of segregation, and Naglich had never requested to see such a report.

D. Ongoing Violation

Before granting injunctive relief against a state official for an Eighth Amendment violation, the court must find that the violation is ongoing and continuous in order to fall under the *Ex parte Young* exception of the Eleventh Amendment bar. 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908); see *Idaho v. Coeur d'Alene Tribe of Idaho*, 521 U.S. 261, 281, 117 S.Ct. 2028, 138 L.Ed.2d 438 (1997) ("An allegation of an ongoing violation of federal law where the requested relief is prospective is ordinarily sufficient to invoke the ^{1263*}1263 *Young* fiction."). In interpreting this requirement, the Eleventh Circuit has held that "the ongoing and continuous requirement merely distinguishes between cases where the relief sought is prospective in nature, i.e., designed to prevent injury that will occur in the future, and cases where relief is retrospective." *Summit Med. Assocs., P.C. v. Pryor*, 180 F.3d 1326, 1338 (11th Cir. 1999). In this case, plaintiffs are seeking

prospective injunctive relief to remedy serious inadequacies in the mental-health care system that will continue to put mentally ill prisoners at a substantial risk of serious harm if not corrected. However, during the trial, defendants suggested that in three different areas of mental-health care at issue here, ADOC has started remedying the inadequacies, rendering plaintiffs' claims as to those areas moot and not suitable for resolution by the court. The court disagrees, and addresses each area in turn.⁹²

⁹² The interplay between the mootness inquiry and the ongoing-violation requirement under *Ex parte Young* is somewhat unsettled. However, the Eleventh Circuit, along with the Fifth Circuit and the Sixth Circuit, has suggested that a threat of recurrence sufficient to render a claim not moot should also be sufficient for the ongoing-violation requirement. See *Natl Ass'n of Bds. of Pharm. v. Bd. of Regents of the Univ. Sys. of Ga.*, 633 F.3d 1297, 1308–09 (11th Cir. 2011) (treating a dispute regarding whether the plaintiff alleged an ongoing violation as a mootness inquiry); *K.P. v. LeBlanc*, 729 F.3d 427, 439 (5th Cir. 2013) (rejecting the contention that a non-moot claim did not meet the ongoing-violation requirement, because "[that] theory, if accepted, would work an end-run around the voluntary-cessation exception to mootness where a state actor is involved"); *Russell v. Lundergan-Grimes*, 784 F.3d 1037, 1047 (6th Cir. 2015) ("[A]t the point that a threatened injury becomes sufficiently imminent and particularized to confer Article III standing, that threat of enforcement also becomes sufficient to satisfy ... *Ex parte Young*."). see also *Muhammad v. Crews*, No. 4:14CV379-MWGRJ, 2016 WL 3360501, at *6 n.5 (N.D. Fla. June 15, 2016) (Walker, J.) (summarizing the case law). Here, the court addresses both the mootness argument and the ongoing-violation argument, though the analyses overlap.

First, during the trial, defendants repeatedly argued that the 2014 partial settlement between the parties regarding the distribution of razor blades to prisoners in crisis cells and segregation units has rendered the issue of dangerous items in crisis cells moot. However, the settlement deals solely with the policy of distributing razor blades for shaving to prisoners in those units, rather than the distinct issue of keeping dangerous items—including but not limited to razor blades—from being introduced into crisis cells by other means. Multiple employees of ADOC and MHM testified that the presence of dangerous items in crisis cells has been an ongoing problem. Accordingly, the 2014 settlement of the razor-distribution issue does not moot this inquiry or prevent the court from finding an ongoing violation.

Second, defendants argued that the January 2017 interim agreement 'revamping' suicide prevention protocols moots the issue of suicide prevention and crisis care in general. However, as discussed earlier, suicide prevention encompasses much more than requiring constant watch for the most acutely suicidal prisoners and ensuring staggered-interval checks of others. In fact, various suicide prevention measures discussed in this case are not covered by the interim agreement, and defendants have not implemented them, despite their knowledge of the risk of harm posed by the current conditions. For example, as this court saw firsthand during its facility tours after the trial, segregation cells and some crisis cells continue to have easily accessible tie-off points, despite the fact that most suicides happen in segregation ¹²⁶⁴cells.⁹³ Likewise, despite the ^{*1264} recommendation of defendants' own expert that a suicide risk-assessment tool be used for all prisoners at a heightened risk of suicide, not just prisoners coming through the intake process for the first time, ADOC has failed to assess prisoners for suicide risks outside of the intake process.⁹⁴ When asked by the court why this part of Dr. Patterson's recommendation is not being followed, Associate Commissioner Naglich answered that

she is "not sure where all it's being used" and "it would be a question better asked of MHM."⁹³ Naglich Testimony at vol. 3, 231.

⁹³ MHM's program director Houser explained that ADOC started looking into fixing the doors on the Holman suicide watch cells (which have bars that can provide a tie-off point) during the last week of December 2016. This was close to a month after the trial had begun, and years after MHM started reporting to ADOC that Holman crisis cells are not safe. These belated actions illustrate that without a court order, ADOC will continue to look the other way despite the glaring deficiencies that put mentally ill prisoners at a substantial risk of serious harm, including death.

⁹⁴ As discussed earlier, many prisoners who commit suicide while in ADOC custody are not actually on suicide watch at the time; in fact, many reside in general population units without receiving any mental-health treatment. This suggests that meaningful remedial suicide prevention efforts cannot be confined to those already identified as high risk, but also must include identifying those at high risk among the general population.

⁹⁵ The court attributes this lack of knowledge to the Associate Commissioner being overwhelmed due to understaffing.

Furthermore, evidence suggests that even the limited remedial actions covered by the interim agreement have not been fully implemented. Allegations of noncompliance with the constant-watch procedure resulted in a modification of the interim agreement in order to allow plaintiffs' counsel frequent monitoring visits to crisis cells. The court also witnessed firsthand during the post-trial site visits that essential parts of suicide-watch procedures were still not being followed: many forms for 15-minute and 30-minute staggered-interval checks of prisoners on suicide watch and mental-health observation were pre-filled and at

exact intervals. ADOC's inability to carry out the terms of the interim agreement even in anticipation of this court's announced visit illustrates a severe, ongoing dysfunction in the system, a striking indifference by ADOC to a substantial risk of serious harm, or both. Needless to say, the court finds that the inadequacies in ADOC's suicide-prevention measures are ongoing.

Partly for this reason, the court declines to rely on Commissioner Dunn's testimony that he intends to abide by the interim agreement's constant-watch procedures until an expert or the court tells him otherwise. Dunn's statement regarding his intent to enforce it indefinitely is not reliable given the evidence of noncompliance already shown and Houser's testimony that the budget and the layout of crisis cells make constant watch unsustainable. In addition, Dunn's statement of intention is not enforceable in court, especially given that the order approving the interim agreement specifically states that it does not resolve any of the issues raised in trial. *See Interim Agreement on Suicide Prevention Measures* (doc. no. 1102). In other words, defendants have not satisfied the requirements for making a claim moot by voluntary cessation; the Commissioner's statement cannot be said to have "completely and irrevocably eradicated the effects of the alleged violation," and there is a reasonable expectation that the alleged violation may recur, due to the risk and evidence of non-compliance and the unenforceability of the defendant's statement in court. *See Reich v. Occupational Safety and Health Review Comm'n*, 102 F.3d 1200, 1202 (11th Cir. 1997) (holding that a ¹²⁶⁵ request for injunctive relief may become moot if: (1) "it can be said with assurance that there is no reasonable expectation that the alleged violation will recur and (2) interim relief or events have completely and irrevocably eradicated the effects of the alleged violation.").

Third, defendants have also failed to show that the inquiry into their segregation practices has become moot or that they have stopped placing seriously

mentally ill prisoners in segregation.⁹⁶ As discussed above, evidence suggests that the new coding system as described by Associate Commissioner Naglich has not yet been implemented. ADOC's failure to address such an obvious risk of harm despite their knowledge of the issue for over two years vividly illustrates that the violation is ongoing and will continue if the defendants are left to their own devices.

⁹⁶ Defendants did not make this argument explicitly during the trial, but the court addresses it since Associate Commissioner Naglich's contention regarding the new coding system could be construed as arguing that plaintiffs' claim regarding ADOC's segregation practice is now moot.

E. *Ex parte Young* Defenses

Defendants advance two arguments regarding the *Ex parte Young* doctrine: first, that the defendants, sued in their official capacities, lack the authority to implement the remedy, and therefore cannot be proper defendants; second, that the remedy would require the State to expend money, and therefore is barred by the Eleventh Amendment—an argument that this court already rejected in the summary judgment opinion. Neither argument is viable under the Eleventh Amendment case law and *Ex parte Young*, 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908).

The case law does not support the argument that the Commissioner and the Associate Commissioner were not the proper defendants to sue due to their alleged lack of authority to implement the remedy. The Supreme Court rejected this line of argument in *Papasani v. Allain*, 478 U.S. 265, 106 S.Ct. 2932, 92 L.Ed.2d 209 (1986), where the State of Mississippi contended that plaintiffs had not sued officials who could grant the relief requested, which was to remedy the State's unequal distribution of the benefits from the State's school land. The Court held that one of the named defendants, the Secretary of State, was a proper defendant because he was

responsible under a state statute for "general supervision" of the local school officials' administration of the lands in question; because of those responsibilities, he could be properly enjoined under *Ex parte Young*. *Id.* at 282 & n.14, 106 S.Ct. 2932. The Court's holding ensured that if a state official violates the Constitution while carrying out a responsibility created by virtue of the defendant's office, that defendant may be enjoined under *Ex parte Young*. *See also Ex parte Young*, 209 U.S. at 157, 28 S.Ct. 441 (explaining that "the fact that the state officer, by virtue of his office, has some connection with the enforcement of the act, is the important and material fact"). The defendant's authority to implement the remedy was not relevant to the *Ex Parte Young* analysis.

This circuit has repeatedly held that defendants simply must have "have some connection with' the unconstitutional act or conduct complained of" in order to be proper defendants for an injunctive-relief suit under *Ex parte Young*. *Luckey v. Harris*, 860 F.2d 1012, 1015–16 (11th Cir. 1988) (quoting and citing *Ex parte Young*, 209 U.S. at 157, 28 S.Ct. 441 (internal alterations omitted)). For example, in *Grizzle v. Kemp*, 634 F.3d 1314 (11th Cir. 2011), the Eleventh Circuit held that the Secretary of State is a proper defendant in a suit¹²⁶⁶ challenging the legality of a state^{*1266} election law—even though that official cannot implement the relief of changing the law—since he has "both the power and the duty to ensure that [local boards of elections] comply with Georgia's election code," which " 'sufficiently connect [s] him with the duty of enforcement' " for the potentially unconstitutional law. *Id.* at 1319 (quoting *Ex Parte Young*, 209 U.S. at 161, 28 S.Ct. 441). Conversely, in *Summit Med. Assocs., PC v. Pryor*, 180 F.3d 1326 (11th Cir. 1999), the court found that a state prosecutor is not a proper defendant in a lawsuit challenging a private civil-enforcement statute creating a private cause of action, because a prosecutor has no connection with the enforcement of a civil statute that enables an affected private individual to sue. The application

of *Ex parte Young* in the Eleventh Circuit as well as other circuits is palpably distinct from the defendants' formulation, which elides the distinction between having "some connection" ... with the conduct complained of," *Luckey*, 860 F.2d at 1015–16 (quoting *Ex Parte Young*, 209 U.S. at 157, 28 S.Ct. 441), and the "authority to remedy the alleged wrongs." Defs.' *Ex parte Young* Trial Br. (doc. no. 1098) at 12.

Applying the proper formulation of *Ex parte Young*, the Commissioner and the Associate Commissioner have the constitutional duty to provide minimally adequate mental-health care as the officials responsible for running the Alabama Department of Corrections and its Office of Health Services; therefore, they have "the ability to commit the unconstitutional act" of failing to provide minimally adequate mental-health care, and the *Ex parte Young* doctrine applies. *Okpalobi v. Foster*, 244 F.3d 405, 421 (5th Cir. 2001) (en banc).

Defendants also seem to argue that any time a state official requires someone else's cooperation in order to remedy a constitutional violation, that state official's unconstitutional act is immune from suit. This cannot be. The *Ex parte Young* case law is replete with examples where a court finds the conduct of a state agency unconstitutional, even when the named defendants in their official capacities cannot remedy the violation alone. For example, the Eleventh Circuit found that the *Ex parte Young* doctrine applied to a lawsuit challenging the adequacy of counsel provided to indigent criminal defendants in the State of Georgia in *Luckey v. Harris*, 860 F.2d 1012 (11th Cir. 1988), quoting the "some connection" language from *Ex parte Young*. Remedying some of the allegations in that case, such as inadequate supervision of court-appointed criminal defense counsel, would have required third parties' cooperation, including hiring new personnel to supervise defense attorneys and related budget appropriations—just as potential remedies proposed by the parties in this case might require

an additional budget appropriation and the recruitment of new personnel. In other words, the fact that the named defendants in their official capacities may need third parties' cooperation to carry out some of the potential remedies does not bar *Ex parte Young*'s applicability, because the doctrine only requires "some connection" between the alleged wrongdoing and the officials' responsibility.

Defendants' second argument—that the remedy would require state expenditures in violation of the Eleventh Amendment—is equally unavailing. Defendants argue that because the Commissioner and the Associate Commissioner do not have the authority to appropriate more money to their own budget, they are immune from this lawsuit under the Eleventh Amendment. The Supreme Court has clearly held that the Eleventh Amendment does not bar an order requiring expenditure of state funds if it is ancillary to injunctive relief for an ongoing violation.¹²⁶⁷ In *Edelman v. Jordan*, 415 U.S. 651, 668, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974), the Supreme Court noted that the Eleventh Amendment did not bar suits that had "fiscal consequences to state treasuries" that "were the necessary result of compliance with decrees which by their terms were prospective in nature." The Court in *Edelman* also observed that having to spend more money from the state treasury because the State needs to conform its conduct to the court order is an "ancillary effect" that is "a permissible and often an inevitable consequence of the principle announced in *Ex parte Young*." *Id.* at 668, 94 S.Ct. 1347. The Court reiterated this principle in *Milliken v. Bradley*, 433 U.S. 267, 289, 97 S.Ct. 2749, 53 L.Ed.2d 745 (1977), upholding a district court's order requiring the State defendants to pay one-half of the additional costs attributable to a remedial education scheme to support school desegregation. In both of these cases, the Supreme Court recognized that the State must pay for ancillary costs of prospective, injunctive relief, regardless of whether the named defendants in their official capacities—who were

standing in for the State based on the *Ex parte Young* fiction—had the ability to appropriate more money to their own budget. *See also Lane v. Cent. Ala. Cmty. Coll.*, 772 F.3d 1349, 1351 (11th Cir. 2014) (“The Supreme Court has recognized that compliance with the terms of prospective injunctive relief will often necessitate the expenditure of state funds.”) (citing *Edelman v. Jordan*, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974)). In fact, rather than precluding relief, courts have found inadequate funding to be a basis for finding of deliberate indifference. *See, e.g., Wellman v. Faulkner*, 715 F.2d 269, 273 (7th Cir. 1983).

In sum, defendants are not immunized from liability arising from ongoing constitutional violations simply because they lack financial resources or the authority to mandate certain specific measures that might remedy the violation. On the contrary, the *Ex parte Young* doctrine allows this court to find liability and ensure that the prison system provides minimally adequate mental-health care.

VI. CONCLUSION

For the reasons above, the court holds that the Commissioner of the Alabama Department of Corrections and the Associate Commissioner of Health Services, in their official capacities, are violating the Eighth Amendment rights of the plaintiff class and of plaintiff Alabama Disabilities Advocacy Program’s constituents with serious mental-health needs who are in ADOC custody. Simply put, ADOC’s mental-health care is horrendously inadequate. Based on the abundant evidence presented in support of the Eighth Amendment claim, the court summarizes its factual findings in the following roadmap, identifying the contributing factors to the inadequacies found in ADOC’s mental-health care system:

(1) Failing to identify prisoners with serious mental-health needs and to classify their needs properly; (2) Failing to provide individualized

treatment plans to prisoners with serious mental-health needs; (3) Failing to provide psychotherapy by qualified and properly supervised mental-health staff and with adequate frequency and sound confidentiality; (4) Providing insufficient out-of-cell time and treatment to those who need residential treatment; and failing to provide hospital-level care to those who need it; (5) Failing to identify suicide risks adequately and providing inadequate treatment and monitoring to those who are suicidal, engaging in self

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harm, or otherwise undergoing a mental-health crisis;

(6) Imposing disciplinary sanctions on mentally ill prisoners for symptoms of their mental illness, and imposing disciplinary sanctions without regard for the impact of sanctions on prisoners’ mental health;

(7) Placing seriously mentally ill prisoners in segregation without extenuating circumstances and for prolonged periods of time;⁹⁷ placing prisoners with serious mental-health needs in segregation without adequate consideration of the impact of segregation on mental health; and providing inadequate treatment and monitoring in segregation.

⁹⁷ The court recognizes that ‘extenuating circumstances’ and ‘prolonged periods of time’ are somewhat ambiguous terms but leaves them to be defined during the remedy phase with the parties’ input.

The court further finds that persistent and severe shortages of mental-health staff and correctional staff, combined with chronic and significant overcrowding, are the overarching issues that permeate each of the above-identified contributing factors of inadequate mental-health care.

Braggs v. Dunn 257 F. Supp. 3d 1171 (M.D. Ala. 2017)

Accordingly, it is ORDERED that the court and the parties will meet to discuss a remedy. The court emphasizes that given the severity and urgency of the need for mental-health care

explained in this opinion, the proposed relief must be both immediate and long term. No partial final judgment shall issue at this time as to the claim resolved in this entry.

DONE, this the 27th day of June, 2017.

Part of Thomson Reuters

CIVIL ACTION NO. 2:14cv601-MHT
United States District Court, M.D. Alabama, Northern Division.

Braggs v. Dunn

562 F. Supp. 3d 1178 (M.D. Ala. 2021)
Decided Dec 27, 2021

CIVIL ACTION NO. 2:14cv601-MHT

2021-12-27

Edward BRAGGS, et al., Plaintiffs, v. Jefferson S. DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections, et al., Defendants.

Ashley Nicole Austin, Prison Law Office, Montgomery, AL, Patricia Clotfelter, William Glassell Somerville, III, Baker Donelson Bearman Caldwell & Berkowitz, Birmingham, AL, William Van Der Pol, Jr., Alabama Disabilities Advocacy Program (ADAP), Tuscaloosa, AL, for Plaintiff Edward Braggs. Patricia Clotfelter, William Glassell Somerville, III, Baker Donelson Bearman Caldwell & Berkowitz, Birmingham, AL, William Van Der Pol, Jr., Alabama Disabilities Advocacy Program (ADAP), Tuscaloosa, AL, for Plaintiffs Tedrick Brooks, Gary Lee Broyles, Chandler Clements, Christopher Gilbert, Dwight Hagood, Sylvester Hartley, John Maner, Rick Martin, Willie McClendon, Roger McCoy, Jermaine Mitchell, Tommie Moore, Matthew Mork, Bradley Pearson, Turner Rogers, Timothy Sears, Brian Sellers, Augustus Smith, Hubert Tollar, Daniel Tooley, Joseph Torres, Donald Ray Turner, Jamie Wallace, Robert Myniasha Williams, Roger Moseley, Quang Bui, Charlie Henderson, Sheila Allen, William Sullivan, Serena English, Valerie Wheeler, Justin Hall, Raymond Bosarge, Cordara Dunner, Karen Norris, Cherritha Harris, Brittany Ellis, Tomas Snyder. Edward A. Bedard, Pro Hac Vice, King & Spalding LLP, Atlanta, GA, Evan David Diamond, Pro Hac Vice, King & Spalding LLP, New York, NY, Joshua Christopher Toll, Pro

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Myron H. Thompson, UNITED STATES DISTRICT JUDGE

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PHASE 2A OMNIBUS REMEDIAL OPINION

Myron H. Thompson, UNITED STATES DISTRICT JUDGE

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PART I.

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I. INTRODUCTION

The plaintiffs in the current phase of this longstanding class-action lawsuit are a group of seriously mentally ill state prisoners and the Alabama Disabilities Advocacy Program (ADAP), which represents mentally ill prisoners incarcerated in Alabama. The defendants are the Commissioner of the Alabama Department of Corrections (ADOC) and ADOC's Interim Associate Commissioner of Health Services. They are sued in their official capacities for injunctive and declaratory relief.

Four years ago, the court found that ADOC failed to provide minimally adequate mental-health care to inmates in its custody, in violation of the Eighth and Fourteenth Amendments to the United States Constitution. See *Braggs v. Dunn*, 257 F. Supp. 3d 1171 (M.D. Ala. 2017) (Thompson, J.). Since then, the parties have engaged in a series of court proceedings and negotiations to develop the relief necessary to remedy this constitutional violation. Certain remedies have been entered by agreement of the parties; others have been ordered following adversarial proceedings. And, most recently, the parties presented additional evidence at a series of omnibus remedial hearings between May 24 and July 9, 2021.

This opinion, which the court will issue in three parts, and the accompanying order represent the culmination of these efforts and mark the point at which the claims presented in this phase of the litigation transition into the period of monitoring. They establish an omnibus remedial framework that will govern this phase of the litigation moving forward—a "remedy that addresses the serious constitutional violations" found by the court "and that will be a durable solution for the monitors to help ADOC implement." *Braggs v. Dunn*, No. 2:14cv601-MHT, 2020 WL 7711366, at *8 (M.D. Ala. Dec. 29, 2020) (Thompson, J.).

The court has divided the opinion into three parts primarily for the convenience of the recently created monitoring team. The first part discusses the history of the litigation leading up to this point, and the legal standards governing the court's provision of relief. The second part discusses ways in which conditions in ADOC facilities have changed since the time of the liability opinion. The third part discusses the parties' proposed provisions, the relief that the court orders and its reasons for doing so, and the court's findings under the Prison Litigation Reform Act or PLRA, 18 U.S.C. § 3626(a)(1)(A). While the monitoring team may wish to read the first and second parts, it is the third part that they will find most useful. The court anticipates that

they may use it as a reference guide to better understand the intricacies of the remedial order, which will be their touchstone in determining the defendants' compliance.

While the opinion is long, its length is due in significant part to the fact that in the years leading up to the omnibus remedial proceedings, ADOC addressed some of the problems identified in the liability opinion. The court describes that progress in detail, both to give ADOC due credit and to explain why certain relief that the plaintiff's request, and which may have been necessary at the time of the liability opinion, is no longer needed. In fact, a significant portion of the present opinion is devoted to contextualizing the court's decision to decline to adopt relief. The court's omnibus remedial order does not address certain violations identified in the liability opinion, and it was important to the court that readers, including the parties and the men and women incarcerated in ADOC facilities, understand why.

The opinion is also lengthy because many deeply serious problems remain unresolved, and the court took seriously both its obligation to provide adequate relief and its PLRA obligation to explain why it adopted each of the various remedial provisions it did. When Jamie Wallace took his own life during the course of the liability hearing, the court called it "powerful evidence of the real, concrete, and terribly permanent harms that woefully inadequate mental-health care inflicts on mentally ill prisoners in Alabama." *Braggs*, 257 F. Supp. 3d at 1186. In the four years since, at least 27 more men in ADOC's custody have died by suicide—including one immediately after the conclusion of the omnibus remedial hearings.

The common thread among these tragedies is ADOC's lack of correctional staff. As its own mental-health vendor has noted: "No one disputes that the ADOC has a *severe shortage of Correctional Officers (COs)*, as documented in an April 2019 US Department of Justice report as well as in multiple quotes from ADOC staff to the

media.¹¹⁹³ Wexford Health Response to the February 14, 2020 ADOC Letter on Performance Deficiencies (P-3323) at 2 (emphasis in original). This deficiency in correctional staff is nearly unchanged in its severity and impact since the court's liability opinion four years ago. Indeed, ADOC has *never* reported an increase in the number of correctional supervisors in any quarterly correctional staffing report since it started filing them in 2018. And as at the time of the liability trial and opinion, the lack of correctional staff undermines the department's ability to meet the mental-health needs of its prisoners in numerous, insidious ways. Prisoners do not receive adequate treatment and out-of-cell time because of insufficient security staff to supervise these activities. They are robbed of opportunities for confidential counseling sessions because there are too few staff to escort them to treatment, forcing providers to hold sessions cell-side. They decompensate, unmonitored, in restrictive housing units, and they are left to fend for themselves in the culture of violence, easy access to drugs, and extortion that has taken root in ADOC facilities in the absence of an adequate security presence. The resulting sky-high rates of ¹¹⁹³suicidality ^{*1193} divert scarce mental-health resources from treatment provision to crisis management, exacerbating the deficiencies in care.

Shortly after it released the liability opinion in 2017, the court warned the parties that, because staffing is so key to the provision of mental-health care, it "must be addressed at the outset" and "fully remedied before almost anything else can be fully remedied." Phase 2A Revised Remedy Scheduling Order on Eighth Amendment Claim (Doc. 1357) at 4. The defendants now ask to extend the deadline by which ADOC must attain an appropriate level of correctional staffing even further than previously agreed, from February 2022 to July 2025. It is against this backdrop--four years of severe understaffing and the likelihood of

four more--that the court considers what relief is necessary today to bring Alabama's prison system into constitutional compliance.

II. BACKGROUND

In its June 2017 liability opinion, the court found that ADOC's mental-health care system violated the United States Constitution in seven ways:

"(1) Failing to identify prisoners with serious mental-health needs and to classify their needs properly;

"(2) Failing to provide individualized treatment plans to prisoners with serious mental-health needs;

"(3) Failing to provide psychotherapy by qualified and properly supervised mental-health staff and with adequate frequency and sound confidentiality;

"(4) Providing insufficient out-of-cell time and treatment to those who need residential treatment; and failing to provide hospital-level care to those who need it;

"(5) Failing to identify suicide risks adequately and providing inadequate treatment and monitoring to those who are suicidal, engaging in self-harm, or otherwise undergoing a mental-health crisis;

"(6) Imposing disciplinary sanctions on mentally ill prisoners for symptoms of their mental illness, and imposing disciplinary sanctions without regard for the impact of sanctions on prisoners' mental health; [and]

(7) Placing seriously mentally ill prisoners in segregation without extenuating circumstances and for prolonged periods of time; placing prisoners with serious mental-health needs in segregation without adequate consideration of the impact of segregation on mental health; and providing inadequate treatment and monitoring in segregation."

Braggs, 257 F. Supp. 3d at 1267-68 (footnote omitted).¹

¹ As the court noted in the liability opinion, "only prisoners with serious mental-health needs have a cognizable Eighth Amendment claim." *Braggs*, 257 F. Supp. 3d at 1191. "The concept of 'serious mental-health need' in the Eighth Amendment context should not be confused with 'serious mental illness,' a term of art in the mental-health care field." *Id.* at 1190 n.11. To avoid confusion, where this opinion refers to mentally ill prisoners or prisoners with mental-health needs, the court emphasizes that it refers to those with *serious* mental-health needs.

The court further found that "persistent and severe shortages of mental-health staff and correctional staff, combined with chronic and significant overcrowding, are the overarching issues that permeate each of the above-identified contributing factors of inadequate mental-health care." *Id.* at 1194. Two years later, following additional ¹¹⁹⁴ briefing and argument, the court issued a supplemental liability opinion, finding that "ADOC has not been conducting adequate periodic mental-health evaluations of prisoners in segregation, and that this failure has contributed to the ADOC defendants' violation of the Eighth Amendment." *Braggs v. Dunn*, 367 F. Supp. 3d 1340, 1342 (M.D. Ala. 2019) (Thompson, J.).

In the years following these liability opinions, the parties agreed to a series of stipulations resolving most of the remedial disputes generated by the court's liability findings, with a few significant exceptions that will be discussed below. For each of these agreed-upon stipulations, the court held an on-the-record hearing, reviewing in detail and clarifying the terms of the agreement. At the request of the parties, the court then entered these stipulations as orders.

At the time it entered these orders, the court believed that the agreements met the "need-narrowness-intrusiveness" requirements of the PLRA. See 18 U.S.C. § 3626(a)(1)(A); see also *Cason v. Seckinger*, 231 F.3d 777, 785 n.8 (11th Cir. 2000) ("[W]e do not mean to suggest that the district court must conduct an evidentiary hearing about or enter particularized findings concerning any facts or factors about which there is no dispute. The parties are free to make any concessions or enter into any stipulations they deem appropriate."). However, the orders generally did not contain findings that the provisions of the stipulations met the PLRA's requirements.

In February 2019, the defendants raised as an issue the possibility that these orders did not comply with the PLRA because they did not have PLRA findings. The court then scheduled a set of evidentiary hearings to determine whether the stipulations met the 'need-narrowness-intrusiveness' standard of the PLRA. In the meantime, by agreement of the parties, the court found that each of the orders "temporarily satisf[ie]d the requirements of the PLRA," pending a final determination after the scheduled hearings. Phase 2A Opinion and Interim Injunction (Doc. 2716) at 4.

These hearings were continued several times. They were first continued at the parties' joint request so that the parties could attempt to negotiate a resolution of the remedial disputes addressed by the stipulations in light of the newly

raised PLRA concern. During that process, the parties successfully negotiated certain remedial agreements related to suicide prevention. *See* Joint Notice and Motion to Stay (Doc. 2706) at 2-3. After a lengthy period of mediation, the parties ultimately informed the court on March 20, 2020, that the negotiations on the remaining disputes had not been successful. *See* Joint Notice Regarding Monitoring and PLRA Negotiations (Doc. 2775) at 1. The court scheduled the hearings to begin on April 13, 2020. *See* Phase 2A Revised Remedy Scheduling Order (Doc. 2778) at 5.

The day the parties informed the court that their negotiations had failed, the Alabama State Health Officer suspended all public gatherings of 25 or more people due to the onset of the novel coronavirus (COVID-19) pandemic in Alabama and across the country. *See State Health Officer Issues Amended Health Order Suspending Public Gatherings*, <https://www.alabamapublichealth.gov/blog/2020/03/20.html> (Mar. 20, 2020). Five days later, the first confirmed death of an Alabama resident due to COVID-19 was announced. *See Alabama Announces First Death of a State Resident Who Tested Positive for COVID-19*, <https://www.alabamapublichealth.gov/blog/2020/03/25b.html> (Mar. 25, 2020). On April 3, the State Health Officer issued a stay-at-home order requiring every person in Alabama "to stay at his or her place of residence except as necessary to perform" essential activities. *Order of the State Health Officer*, <https://governor.alabama.gov/assets/2020/04/Final-Statewide-Order-4.3.2020.pdf> (Apr. 3, 2020).

As the threat of COVID-19 became apparent, the parties each moved to continue the April 2020 hearings. *See generally* Defs.' Unopposed Motion to Continue (Doc. 2779); Pls.' Motion to Continue (Doc. 2780). In their motion, the defendants aptly explained that, while "the medical and scientific community continues to analyze the nature of COVID-19, this global pandemic represents an unprecedented threat to public health due to its

contagious nature and rate of mortality for those at significant risk for complications." Defs.' Unopposed Motion to Continue (Doc. 2779) at 2. They requested a continuance to "protect the health of the inmates in the custody of the Alabama Department of Corrections." *Id.* at 3.

The hearings were eventually rescheduled to start on September 14, 2020, with the duration of the temporary PLRA findings on the stipulated remedial orders extended to December 30. *See* Phase 2A Opinion and Order Regarding Long-Term Suicide Prevention Stipulations (Doc. 2977) at 5. Just before the hearings were set to begin, at the close of the defendants' pretrial brief, the defendants indicated an intent to move under the PLRA, 18 U.S.C. § 3626(b)(1), (b)(2), to terminate some or all of the orders scheduled for consideration. *See* Defs.' Pretrial Memorandum (Doc. 2908) at 55-57. The court requested clarification of the defendants' intent, and the defendants filed a formal motion to terminate. *See generally* Defs.' Motion to Terminate (Doc. 2924).

Under the PLRA, the defendants' motion to terminate placed the burden on the plaintiffs to show that the stipulated remedial orders remained necessary to correct a "current and ongoing violation" of federal law. *See* 18 U.S.C. § 3626(b)(3); *see also* *Braggs v. Dunn*, No. 2:14cv601-MHT, 2020 WL 5517262, at *2 (M.D. Ala. Sept. 14, 2020) (Thompson, J.) ("Opinion and Order Regarding the 'Current and Ongoing Violation' Issue"). The statute also required the court to rule on the motion within 30 days, extendable to 90 days for good cause, or else a mandatory stay of prospective relief would go into effect. *See generally* *Braggs v. Dunn*, No. 2:14cv601-MHT, 2020 WL 5735086, at *2 (M.D. Ala. Sept. 24, 2020) (Thompson, J.). The plaintiffs therefore moved that they be allowed to conduct immediate on-site prison inspections to develop the evidence of changed circumstances that would be necessary for the court to be able to consider the remedies

under this standard and in this abbreviated timeframe. See generally Pls.' Motion to Require Onsite Prison Inspections (Doc. 2986).

After the court granted the plaintiffs' motion for prison inspections, the defendants withdrew their motion to terminate. See Defs.' Oral Motion to Withdraw (Doc. 3004); Order (Doc. 3005). While allowing the defendants to withdraw their motion, the court emphasized that it nevertheless took seriously the issues that had prompted the motion. It explained that it would "continue to address, with reasonable speed, which items in the remedial orders at issue may be terminated or modified, either by agreement or court action, as part of the resolution of the PLRA findings or otherwise." Order (Doc. 3005) at 1-2.

The court solicited proposals from the parties about how to proceed in determining whether and to what extent the stipulated remedial orders complied with the PLRA. After receiving these proposals, the court determined that the "shortest path toward concluding this phase of the litigation" was for each party to submit a proposed omnibus remedial order encompassing the entire scope of relief at issue and for the court to hold "a single evidentiary hearing to consider these proposals," after which it would "create a final omnibus remedial order resolving all of the outstanding issues" in this phase of the litigation. *Braggs*, 2020 WL 7711366, at *7-8. This omnibus remedial order would be entered with the need-narrowness-intrusiveness findings required by the PLRA, and the parties would be afforded discovery and the opportunity to present evidence as to whether the disputed remedies met that standard in light of the current conditions in ADOC facilities. See *id.* at *7. The parties agreed to extend the duration of the stipulated remedial orders until that omnibus order was entered. See Joint Request to Extend Phase 2A Remedial Orders (Doc. 3076) at 1-2; Phase 2A Revised Remedy Scheduling Order (Doc. 3077).

Discovery proceeded, and a series of evidentiary hearings were held in May, June, and July 2021. Now, per the process set forth by the court and in the parties' agreements, the omnibus remedial order that accompanies this opinion replaces all of the stipulated remedies entered in this case, and, for the most part, will be the remedial order and injunction that governs this phase of the litigation henceforth.

In the time since the liability opinions, several of the most complicated remedial issues have proceeded on different tracks from the negotiation and stipulation process described above. Chief among these are the issues of correctional staffing, suicide prevention, and monitoring, each of which has been the subject of adversarial proceedings resulting in remedial orders, rather than negotiated agreements. In addition, the remedial issues related to segregation, units not designated as restrictive housing that nonetheless functioned as segregation, and inpatient treatment had each also been the subject of adversarial proceedings, but no remedial order had yet been issued when the shift was made to the present omnibus remedial process. The procedural circumstances differ for each of these issues in significant ways, as follows.

First, perhaps the least procedurally complex of the issues was the matter of the monitoring scheme that will apply to the claims in this phase of the litigation following the close of the remedial process. The court requested a proposed plan from the defendants about how compliance with the court's remedial orders should be monitored, and it gave the plaintiffs the opportunity to respond to the defendants' proposal. The court then held a hearing on the defendants' proposed monitoring plan in which it heard testimony from experts, from the then-ADOC Commissioner and the then-Associate Commissioner of Health Services, and from four individuals whom the defendants proposed as potential members of a monitoring team. See *Braggs v. Dunn*, 483 F. Supp. 3d 1136, 1141-42 (M.D. Ala. 2020) (Thompson, J.).

After staying proceedings on the issue of monitoring for about a year at the parties' request while they endeavored unsuccessfully to mediate the issue, the court issued an opinion and order resolving the parties' disputes and establishing a three-phase monitoring plan. Under this monitoring plan, an external monitoring team will first begin monitoring the defendants' compliance with the remedial orders, then will train an internal monitoring team housed within ADOC itself to take on this monitoring role, and finally will transition the monitoring duties entirely to ADOC to monitor itself. *See id.* at 1141. The object of this approach was to "help ADOC develop internal buy-in, resulting in more active cooperation and timely compliance," and to create "a more effective, less intrusive process and avoid an indeterminate period of external monitoring." *Id.*

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The monitoring opinion and order were entered in September 2020 with PLRA findings. The defendants filed a motion to alter or amend the order, and the court denied that motion. *See Braggs v. Dunn*, No. 2:14cv601-MHT, 2020 WL 6152367 (M.D. Ala. Oct. 20, 2020) (Thompson, J.). The defendants did not appeal. Because there was a recent order resolving the monitoring issue that was entered with PLRA findings, this issue--unique among the remedial disputes in this phase of the litigation--was not among the matters that the omnibus remedial hearings were planned to address. *See Braggs v. Dunn*, No. 2:14cv601-MHT, 2021 WL 83410, at *1 (M.D. Ala. Jan. 7, 2021) (Thompson, J.) (setting forth "the entirety of what will be considered during the omnibus remedial process").

Second, the issues of correctional and mental-health staffing, which the court found to be "overarching issues that permeate each of the" court's liability findings, *Braggs*, 257 F. Supp. 3d at 1268, were also the subject of a remedial opinion and order entered with PLRA findings after adversarial proceedings. *See Braggs v. Dunn*,

No. 2:14cv601-MHT, 2018 WL 985759 (M.D. Ala. Feb. 20, 2018) (Thompson, J.). Unlike the court's monitoring opinion and order, however, the understaffing opinion and order were entered more than three years ago, shortly after the court made its original liability findings. Because of the amount of time that had elapsed, and because the court agreed with the defendants' concerns "about implementing relief without ensuring that it is necessary" in light of changes in conditions, *Braggs*, 2020 WL 7711366, at *6, the parties' disputes regarding what remedies related to staffing should apply to ADOC moving forward were incorporated into this omnibus remedial process.

Both parties acknowledged that correctional staffing levels in particular have not significantly increased since the entry of the court's understaffing remedial opinion and order. The central remaining provision of the correctional understaffing relief was a deadline of February 2022 for ADOC to achieve the staffing levels recommended by the defendants' own staffing experts, Margaret and Merle Savage, a deadline that both parties understood would have to be modified given ADOC's slow pace of progress in filling many of its correctional positions. Accordingly, the parties agreed that the posture of this issue differed somewhat from that of the issues covered by the parties' stipulated remedial orders. While the question as to the latter issues was whether the relief proposed by the plaintiffs satisfied the need-narrowness-intrusiveness standard of the PLRA, the question as to correctional staffing was whether and how the existing remedy should be modified in light of changed circumstances--such as the effects of the COVID-19 pandemic--and in recognition of the existing deadline's implausibility at this juncture. In addition, ADOC has significantly changed the type of correctional officers it uses.

The question as to mental-health staffing was also whether the existing remedial order should be modified or ended. But, in contrast to correctional

staffing, the defendants asserted that mental-health staffing levels have improved considerably since the court's understaffing opinion and order was issued. They brought forth evidence during the omnibus proceedings purporting to show that several facilities are at or near the levels sufficient to allow for adequate care, based on the staffing ratios developed by their consultants. Accordingly, the central issue for the court was whether the evidence in fact reflected the improvements claimed by the defendants, and whether to modify or lift the current relief related to mental-health staffing if so.

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Third, the remedies related to suicide prevention have been the subject of both adversarial proceedings and negotiated agreements. In May 2019, after receiving expert reports and holding a trial on the need for suicide prevention relief, the court issued an opinion and order requiring ADOC to take various immediate steps to mitigate the risk of suicide faced by mentally ill prisoners in ADOC's custody. See *Braggs v. Dunn*, 383 F. Supp. 3d 1218 (M.D. Ala. 2019) (Thompson, J.). This opinion included PLRA findings. See, e.g., *id.* at 1254. Soon thereafter, the parties entered a short-term agreement on the suicide remedies and requested that the court stay its mandates and impose the stipulated short-term remedy instead. See Joint Notice and Motion to Stay (Doc. 2560 & Doc. 2560-1). The court did so, adopting the parties' agreement, as with the other stipulated remedies, that the terms of the agreement met the PLRA's need-narrowness-intrusiveness requirement pending a final determination after a hearing on PLRA compliance. See Order (Doc. 2569); Order (Doc. 2698).

The parties later reached a separate, long-term agreement on suicide prevention remedies. See Joint Filing of Agreements on Suicide Prevention Measures and Mental Health Staffing (Doc. 2606 & Doc. 2606-1). The court approved this agreement but did not issue an associated

injunction, instead putting the enforceability of its order on hold pending a determination of whether the long-term agreement complied with the PLRA. See Phase 2A Order Approving Suicide-Prevention Agreement (Doc. 2699) at 1-2. The short-term stipulations remained in effect pending the results of the omnibus remedial hearings.

The upshot of this posture was that, while the proposed remedial provisions related to suicide were part of the omnibus proceedings and were assessed for their compliance with the PLRA's need-narrowness-intrusiveness requirement, the court's stayed opinion and order regarding suicide provisions would go into effect if the court found that the proposed provisions did not comply with the PLRA. However, because the suicide remedies addressed in the stayed opinion were approved by the court in May 2019--two years prior to the beginning of the omnibus remedial proceedings--the stayed relief would be arguably immediately terminable under the PLRA by motion of the defendants if it went into effect following the omnibus hearings. See 18 U.S.C. § 3626(b)(1)(A)(i).

Finally, there were additional issues that had been litigated by the parties but were under submission with the court at the time of the omnibus remedial proceedings. These included the relief related to ADOC's segregation or restrictive housing units (also known as RHUs), non-RHUs that were nonetheless functioning as segregation units, and inpatient treatment. Because no relief had been entered by the court as to these issues, the proposed remedial provisions related to these matters were situated no differently for purposes of the omnibus proceedings than were the proposed remedies related to the matters covered by the parties' stipulated remedial orders. The court proceeds now to discuss the legal standard under which it assessed these provisions.

III. LEGAL STANDARD

The PLRA requires that, before entering prospective relief to redress constitutional or federal statutory injury in any civil suit regarding prison conditions, a trial court must find that the relief is "narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A). The Eleventh Circuit Court of Appeals has explained that this means the court must make "particularized findings that each requirement" of the relief "satisfies each of the need-narrowness-intrusiveness criteria." *United States v. Sec'y, Fla. Dep't of Corrs.*, 778 F.3d 1223, 1228 (11th Cir. 2015).

The 2021 omnibus remedial hearings from which this opinion results were directed toward determining the appropriate scope of prospective relief to be entered, so this particularized need-narrowness-intrusiveness mandate applied. The defendants in this case have argued that the court must also make a global finding that the relief as a whole meets the need-narrowness-intrusiveness standard; while it is not apparent from the text of the PLRA that this is correct, the court will make such a global finding as well.

The legal standard under which these hearings operated differed in one further way from the need-narrowness-intrusiveness standard that generally governs remedial proceedings in litigation regarding prison conditions. As the court explained in its opinion setting forth the process by which the omnibus remedy would be developed, the length of time that has passed since the liability opinion issued gave the court "grave concerns about implementing relief without ensuring that it is necessary under current conditions." *Braggs*, 2020 WL 7711366, at *6. The specific relief necessary to remedy the constitutional deficiencies found in the court's liability opinion may have changed since the time of that opinion. On some issues, sustained improvements in ADOC's provision of mental-

health care may have rendered some relief inappropriate. In other areas, progress may have been partial, making certain relief that would have been essential at the time of the liability opinion now unnecessary. Also, personnel changes (for example, the introduction of Basic Correctional Officers (BCOs) and Correctional Cubicle Operators (CCOs) to take on some of the duties of correctional officers) might warrant changes in relief. As a matter of equity, the court therefore determined that it would consider changes in circumstances in ADOC facilities--rather than looking only to the circumstances that existed at the time of the liability trial, as the plaintiffs suggested the court should do--to decide whether the relief proposed by the parties was necessary to remedy the violations that the court has found. *See id.*²

² Although this assessment of changed circumstances principally affected the necessity prong of the need-narrowness-intrusiveness inquiry, the court also considered whether conditions had changed such that the proposed relief was either not narrowly tailored to the violations found by the court or not the least intrusive way of correcting those violations.

Although the parties agreed that the PLRA's need-narrowness-intrusiveness mandate applied, their proposed remedial orders each raised issues about how this standard should apply to various aspects of the relief under consideration. The court addresses these arguments below.

A. The "Current and Ongoing Violation" Standard

The defendants argued prior to the hearings and continued to argue during the proceedings that the court needed also to find a "current and ongoing violation" of federal law before entering relief. *See, e.g.,* Defs.' Pretrial Br. (Doc. 3219) at 9-10. As a result, they argued, the plaintiffs were required to "demonstrate that the State acts with deliberate indifference to Plaintiffs' serious

mental-health needs." *Id.* at 10. This "current and ongoing violation" requirement appears in the PLRA in § 3626(b)(3), "which governs the termination of prospective relief by motion of a party." *1200 *Sec'y, Fla. Dep't of Corrs.*, 778 F.3d at 1227. That section of the statute comes into play when a party files a motion to terminate an injunction previously entered in a prison conditions suit, and the statute describes elsewhere in § 3626(b) the circumstances in which a party is empowered to file such a termination motion. See 18 U.S.C. § 3626(b)(1)(A), (b)(2).

2 As the court explained in its opinion setting forth the process by which the remedial hearings would be conducted, "In the absence of a motion to terminate, there is no statutory requirement that the court find a 'current and ongoing violation' of federal law before entering" relief. *Braggs*, 2020 WL 7711366, at *6. This follows from the text of the PLRA, which places the "current and ongoing violation" requirement in the provision applicable to proceedings on a motion to terminate and excludes this requirement from the provision that governs the entry of prospective relief. See 18 U.S.C. § 3626(a)(1)(A), (b)(3). It also is required by Eleventh Circuit precedent. The circuit court in *Thomas v. Bryant*, 614 F.3d 1288 (11th Cir. 2010), considered the argument that although § 3626(b)(3) "governs termination proceedings," nonetheless "the 'current and ongoing' violation requirement should inform [the court's] inquiry" when entering prospective relief outside of the context of a motion to terminate. *Id.* at 1319-20. The court held "that the 'current and ongoing' requirement is distinct from the standard" prescribed by § 3626(a)(1)(A). *Id.* at 1320. The "need-narrowness-intrusiveness limitation governs the initial entry of an injunctive relief in prison litigation cases," while "[w]hether there is a 'current and ongoing' constitutional violation sufficient to avoid termination of the current injunction is a matter to be considered upon motion by either party in a termination proceeding." *Id.*

As discussed above, the defendants filed a motion to terminate in September 2020 but withdrew the motion thereafter. There was no motion to terminate before the court in the remedial hearings preceding this opinion. For this reason, the need-narrowness-intrusiveness standard of § 3626(a)(1)(A) rather than the "current and ongoing violation" standard of § 3626(b)(3) provided the statutory requirements for the hearings, and the plaintiffs were not required to demonstrate current and ongoing deliberate indifference by the defendants.³

³ The evidence in the record demonstrates, and the court so finds, that the plaintiffs crafted their case to conform with this understanding of the legal standard. During the 2021 omnibus relief hearings, the plaintiffs stated explicitly that, if the court had required them to prove a current and ongoing violation, they would have sought further discovery from the defendants and presented more and different evidence. See June 4, 2021, R.D. Trial Tr. at 195-96. Moreover, the court finds that the current record is inadequate to resolve the question of whether ADOC remains deliberately indifferent on a current and ongoing basis. If the court has incorrectly decided this issue, then upon remand the court will allow the parties to engage in the discovery that was disallowed on the issue and the court will resolve the issue based on the evidence presented.

Although they recognized that no termination motion was pending at the time of the remedial hearings, the defendants argued that the requirement of § 3626(a)(1)(A) for the court to find that the relief "extends no further than necessary to correct the violation of the Federal right" and is "the least intrusive means necessary to correct the violation of the Federal right" incorporates the "current and ongoing" requirement. The defendants argued, in other words, that the requirement that the relief be tied to "the violation of the Federal right" raises the

question of precisely what violation the relief must address, and they said the answer ¹²⁰¹ must be a current violation ongoing at the time of the entry of relief. Therefore, plaintiffs requesting prospective relief must show that the violation they seek to address is a "current and ongoing" violation at the time the court enters the relief.

This argument is not without some persuasive force. But ultimately it cannot be squared with the text of the PLRA. The termination provision of § 3626(b)(3) requires a court to find that the relief at issue "remains necessary to correct a current and ongoing violation of the Federal right," and that it is narrowly tailored and the least intrusive means of doing so. 18 U.S.C. § 3626(b)(3). That provision requires *both* a "current and ongoing violation" and that the relief meet the need-narrowness-intrusiveness finding as to that ongoing violation. By contrast, § 3626(a)(1)(A) requires only that the relief "extends no further than necessary to correct the violation of the right" and is narrowly drawn and the least intrusive means to address the violation. The absence of the "current and ongoing" language from § 3626(a)(1)(A), which otherwise duplicates the standard of § 3626(b)(3), is conspicuous and must be given interpretive significance. And interpreting the need-narrowness-intrusiveness requirement to subsume the "current and ongoing violation" standard would make the latter language in § 3626(b)(3) redundant.⁴

⁴ Again in their post-trial brief, the defendants pressed the argument that the court must find current and ongoing deliberate indifference at this stage of the proceedings. This, they said, is due not only to the PLRA--based on the misinterpretation of that statute addressed above--but also because the Eleventh Amendment grants the defendants immunity against the plaintiffs' claims unless the court makes liability findings again. See Defs.' Post-Trial Br. (Doc. 3367) at 37.

In cases both simple and complex, courts routinely make liability findings before making remedial findings. Courts taking that approach do not need to re-do their liability findings at the remedial stage. In that sense, this court is no differently situated than any other. Contrary to the defendants' position, neither the PLRA nor the Eleventh Amendment invalidates that run-of-the-mill procedural tack.

The defendants base their additional argument in significant measure on a single sentence in the court's December opinion describing the omnibus remedial process, in which the court said that "compliance with the PLRA does not displace the court's duty under Eighth Amendment law to find a 'substantial risk of serious injury' before entering injunctive relief." *Braggs*, 2020 WL 7711366, at *6. But nothing whatsoever in that opinion--including the stray sentence the defendants now claim undermines and supersedes everything else the court said before, after, and within its December opinion about the legal standard applicable to the omnibus proceedings--suggests that a new showing of deliberate indifference is required before entering remedies to address constitutional violations for which the court has already found the defendants deliberately indifferent.

B. Burdens of Proof

Plaintiffs seeking prospective relief related to prison conditions generally bear the burden of showing that their proposed remedies satisfy the need-narrowness-intrusiveness standard discussed above. The plaintiffs here, however, argued that by agreeing to the terms of the various stipulated remedial orders that the court had entered, the defendants had either waived or forfeited their argument that any proposed relief that reiterated the provisions of these orders did not comply with the PLRA, or that the defendants were estopped from making such an argument. See Pls.' Pretrial Br. (Doc. 3220) at 24-33.

The court rejected the plaintiffs' waiver, estoppel, and forfeiture arguments under the particular procedural circumstances presented here. It also rejected the plaintiffs' fallback position that the defendants' agreement to the stipulated orders shifted the burden of proof in the proceedings, placing the onus on the defendants to show why the plaintiffs' proposed remedies did not meet the need-narrowness-intrusiveness requirement. *See id.* at 24.

3 When the court determined that omnibus remedial proceedings were "the shortest path toward concluding this phase of the litigation," it instructed the parties to re-assess nearly the totality of the remedies entered in this case, including the stipulated orders, and to compile proposals for what relief is now necessary in light of changed circumstances in ADOC facilities. *Braggs*, 2020 WL 7711366, at *7-8.⁵ Not unexpectedly, some of the provisions included in each party's proposal were drawn from the stipulated remedial orders. But the 2021 omnibus proceedings were not simply a delayed version of the PLRA hearings that had been scheduled for September 2020 before the defendants filed their motion to terminate. They were not directed at assessing the PLRA compliance of the stipulated orders. Rather, the omnibus proceedings were a new process to consider the PLRA compliance of new proposed remedies--remedies which, once entered, would "replace all of the currently operational remedial stipulations." *Id.* While the court considered similarities between the terms of the stipulated orders and the parties' proposed provisions, it was the plaintiffs who were requesting that the court enter their proposed remedies as orders; they therefore bore the burden of demonstrating that their proposals comported with the standards of the PLRA.⁶

⁵ The exceptions to this broad re-assessment, as discussed above, were the provisions of the court's monitoring opinion and order.

⁶ As noted above, the staffing remedy was somewhat differently situated because the dispute there was how the deadline for compliance should be adjusted in light of changed circumstances. Each party therefore bore the burden of demonstrating that its proposed modifications to the understaffing order were tailored to the changed circumstances.

C. The "Facility-by-Facility" Issue

In the defendants' pretrial brief and proposed omnibus remedial order, they raised the argument that a "one-size-fits-all remedy ... remains inappropriate" for the ADOC system because the major prison facilities "present a diversity of circumstances, housing configurations, personnel and capabilities, and each facility possesses its own strengths and its own challenges." Defs.' Pretrial Br. (Doc. 3219) at 12. The defendants made three main arguments in support of this position. First, that relief targeted at particular kinds of units (for instance, remedies pertaining to stabilization units) should not apply in facilities without such units. Second, that certain facilities have improved more than others in particular remedial areas (for instance, in mental-health staffing levels), so relief that is necessary at one facility on a specific issue may not be necessary at another. And third, that any new facilities ADOC may build in the coming years cannot be subject to whatever relief is set in place today because the court cannot make findings as to the necessity, narrowness, or intrusiveness of imposing relief at those facilities until they are constructed.

The first argument seems to be merely a matter of semantics. Any relief that prescribes the conditions or treatment that must be provided on a particular kind of unit plainly does not apply to other kinds of units and therefore has no bearing at a facility without such units. As an example, the plaintiffs' proposed treatment requirements for residential treatment units (RTU) by their terms apply to only residential treatment units; a prison without an RTU would not be subject to them and

need not be monitored for compliance with them. See, e.g., Pls.' Proposed Treatment Guide (Doc. 12033206-1) at 23 ("Preliminary *1203 treatment plans must be created within three (3) working days of a patient's placement in an RTU"). The same holds true when particular conditions of the provision do not apply to a certain location. For example, a requirement that treatment take place in a confidential, out-of-cell location would be implemented differently in a celled facility than it would in a dormitory-style facility. The plaintiffs do not argue to the contrary, and the court finds that no clarifying provision is necessary to set down in words what is facially apparent: A remedial obligation specific to a particular type of unit does not apply to facilities without such a unit. As Dr. Burns explained, these provisions "require the exercise of some common sense about what's applicable and what's not." June 10, 2021, R.D. Trial Tr. at 170-71. The court is confident that ADOC and the EMT will exercise such common sense in implementing the relief ordered today.

45 The defendants' second argument raises an evidentiary question about how pervasive the evidence of problems must be to support findings of systemwide deficiency and the need for systemwide relief. It is clear, as the cases cited by the defendants in support of this argument reflect, that a finding of harm to only one or two inmates is insufficient to support a systemwide remedy without evidence that other prisoners have experienced the same injury. See *Lewis v. Casey*, 518 U.S. 343, 359-60, 116 S.Ct. 2174, 135 L.Ed.2d 606 (1996) (a finding that two inmates were harmed was inadequate, without more, to conclude that a systemwide violation existed); *Thomas v. Bryant*, 614 F.3d 1288, 1324 (11th Cir. 2010) (because "[t]he district court held that the DOC violated the constitutional rights of only two inmates," a non-systemic injunction was appropriate). It is equally clear that systemic relief does not require a finding that every prisoner at

every prison facility has been harmed by the policy or practice that is the subject of the court's order.

The court's liability findings in this case were systemic. See *Braggs*, 257 F. Supp. 3d at 1267-68; see also Defs.' Response to Court's February 2, 2018, Order (Doc. 1595) at 1 (acknowledging that the court's liability findings were systemwide, not limited to certain facilities). To the extent that the court proceeds to discuss harm to individual inmates in individual prisons, it must be remembered that it does so against the backdrop of those findings--findings that were supported by far more than isolated incidents of harm, and that the defendants have not challenged.

For the most part, the relief that remains necessary to correct those systemic violations is also systemic. As the court has held in previously rejecting the defendants' suggestion that relief be limited to certain facilities, "all of ADOC's major prisons--and in particular the prisons for men--form part of an interlocking system." *Braggs*, 2018 WL 985759, at *3 n.2. Focusing relief on only a few facilities "could fatally hinder its ability to remedy the constitutional violation found." *Id.*

Moreover, as Dr. Burns credibly testified based on the information she reviewed before the omnibus hearings, serious violations exist at every major facility. See May 26, 2021, R.D. Trial Tr. at 138. The frequent movement of inmates throughout the prison system also makes facility-by-facility discrepancies in the relief imposed largely inappropriate. See *id.* at 33-34. As the court pointed out in the liability opinion, "mentally ill prisoners are subject to a substantial risk of serious harm from practices that are common in ADOC facilities no matter where they are housed currently, because they may be housed in any of these facilities in the future due to ADOC's frequent and unpredictable transfers of *1204 prisoners across facilities." *Braggs*, 257 F. Supp. 3d at 1193 n.16.⁷

¹²⁰⁵Part of Thompson's The defendants' expert Dr. Metzner suggested that, at least as to some areas of relief, the court should limit its order to certain specific facilities. However, he emphasized that ADOC's policies in these areas should still apply systemwide and noted the "assurances" he had received from ADOC that this would be the case. July 1, 2021, R.D. Trial Tr. at 56; *see also* June 30, 2021, R.D. Trial Tr. at 156-57. For the reasons discussed below regarding ADOC's history of failing to follow the court's orders and its own policies, however, the court does not have confidence in ADOC's assurances and will not currently limit its order on that basis. The court is open to revisiting the scope of its order in the future if there is evidence of systemic improvements. And in the meantime, the court trusts that the monitoring team will make appropriate decisions about whether, how, and how often to monitor the various facilities in light of the team's findings about the scope of deficiencies at each prison.

As to certain issues, however, the evidence may show either that the problems are sufficiently limited to particular prisons that only those facilities should be subject to relief in that area, or that particular prisons have sufficiently distinguished themselves from the remainder of the system that they should be excluded from the relief. This may be true particularly in remedial areas related to the physical environments of the prisons--issues that are by nature facility-specific to a degree. In sum, while system-wide relief is typically necessary for the system-wide violations found in this case, the court will limit relief to specific facilities when the evidence demonstrates that such limitation is appropriate. Similarly, the court will consider whether the relief it has entered should apply to any new major facilities constructed by ADOC if and when such facilities are built, based on whether the evidence shows that the relief should include those facilities.

D. Monitoring of the Proposed Remedies

Although the monitoring process for the proposed remedies was not among the remedial matters at issue in the omnibus proceedings, *see Braggs*, 2021 WL 83410, at *1, the defendants raised two arguments related to monitoring during the proceedings. First, their proposed order included a series of provisions that, if adopted, would establish a monitoring scheme different from the one put in place by the court in its September 2020 monitoring opinion and order. Because the monitoring opinion and order were entered with PLRA findings and were not slated for relitigation in these proceedings, *see id.*, the court declined to adopt the defendants' proposed monitoring provisions.

Second, the defendants argued that various provisions of the plaintiffs' proposed order did not comply with the PLRA because they did not include restrictions on how the external monitoring team (EMT) might decide to monitor the orders. In effect, the defendants took the position that proposed remedial provisions could comply with the PLRA only if the scope of discretion afforded the monitoring team as to how it would monitor those provisions was set forth in the provisions themselves and constrained by them. For instance, the defendants expressed the concern that monitoring could be excessively costly for ADOC if the EMT took particular approaches to monitoring the provisions of the omnibus order, and the defendants argued that the plaintiffs' proposed provisions did not comply with the PLRA because the provisions did not address how they would be monitored or reject the overly expensive monitoring processes envisioned by the defendants.

The scope of the EMT's authority was established by the monitoring opinion and order. The appropriate point at which to raise concerns about ¹²⁰⁵the potential intrusiveness ^{*1205} of monitoring was during the course of litigation that preceded that opinion and order. And indeed, the defendants

did raise these concerns during that litigation--including, according to defense counsel, its concern about the costs of monitoring. *See* June 21, 2021, R.D. Trial Tr. at 132-34, 271-72. The court considered the concerns raised by the defendants at the time, and it found that the monitoring scheme it adopted complied with the need-narrowness-intrusiveness mandate of the PLRA. *See Braggs*, 483 F. Supp. 3d at 1168. The court therefore declined to re-evaluate how the provisions of the proposed omnibus orders might be monitored or to impose a requirement that the provisions themselves expressly prescribe their own monitoring regimes, both of which would amount to re-litigation of an issue recently decided by the court after extensive adversarial proceedings and with particularized PLRA findings.

This concludes the first part of the court's omnibus remedial opinion. Two parts follow.

DONE, this the 27th day of December, 2021.

PHASE 2A OMNIBUS REMEDIAL OPINION

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I. INTRODUCTION

As stated previously, this opinion is divided into three parts. This is the second part, which discusses the ways in which conditions in ADOC facilities have changed since the time of the liability opinion.

II. CHANGED CIRCUMSTANCES IN ADOC FACILITIES

Before addressing the PLRA compliance of the particular remedial provisions that the court will impose, it is necessary to discuss where the conditions of mental-health care in the ADOC system have changed or improved since the liability trial and where they continue to fall short. Certain aspects of the provision of mental-health

care in ADOC facilities are better than they were at the time of the liability trial. Such improvements do not necessarily categorically preclude the need for remedies in those areas, but they do alter the appropriate scope of relief and make certain ¹²⁰⁶ provisions proposed by the plaintiffs unnecessary to ensure sustained constitutional compliance by the department with regard to these issues.

Other parts of ADOC's mental-health care system have not improved since the liability trial. To illustrate these continued shortcomings, the court will first discuss in detail the findings of the liability trial and then will proceed to discuss several recent suicides in the ADOC system in which some of the problems that have been ongoing since the time of the liability findings played a role. To be clear, not every problematic area was a factor in each suicide. But while not every prisoner experienced every problem, the problems are systemic nonetheless. The circumstances of these deaths stand as examples of particularly serious failures in the ADOC's provision of mental-health care and demonstrate the potential consequences of these inadequacies.

Furthermore, while evidence was presented as to each of the 12 suicides that occurred at ADOC between September 2019 and the 2021 hearings, the court now discusses only six of these suicides that show most plainly where mental-health care at ADOC remains below the constitutional floor, although all 12 reflect deficiencies that warrant relief. And finally, the court keeps in mind that failures of mental-health care that result in suicides are not the only serious lapses in treatment. Luck can be the difference between a suicide attempt and a completed suicide. It would be a morbid kind of reactivity to find that inadequacies in the ADOC's mental-health care system require a remedy only when they have resulted in death.

A. The Court's Liability Findings

In its liability opinion, the court identified a host of systemic deficiencies in ADOC's provision of mental-health care to inmates. These issues were interrelated: failures at each step of the process of identifying and treating inmates snowballed to produce a mental-health care system that was "horrendously inadequate" when taken as a whole. *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1267 (M.D. Ala. 2017) (Thompson, J.). And as witnesses and experts from both sides acknowledged, these issues were only exacerbated by the "two-headed monster" of ADOC's struggles with overcrowding and understaffing, which presented a significant challenge to improving any part of the system. *Id.* at 1184.

ADOC's failure to meet the minimum standard of care required by the Constitution "start[ed] at the door," with an inadequate intake process for inmates entering the department's custody. *Id.* The court found that ADOC relied on unsupervised licensed practical nurses (LPNs) to conduct mental-health screening, despite the fact that they lacked the training or qualifications to assess inmates for symptoms of mental illness. See *id.* at 1202. This issue was "compounded by insufficient mental-health staffing," which led to some inmates being transferred to other facilities without having received an intake screening at all. *Id.* at 1203. The department's purported percentage of mentally ill prisoners--one of the lowest in the country--was a clear reflection of the deficiency of this process. As the court concluded, it was the result not of Alabama having fewer mentally ill prisoners than other systems or of providing better mental-health care, but "because a substantial number--likely thousands--of prisoners with mental illness" were being missed at intake. *Id.* at 1185. Because of this failure to identify inmates' mental-health needs, seriously mentally ill prisoners were "languish[ing] and decompensat[ing] in ADOC without treatment, ending up in crisis care and engaging in destructive--sometimes fatal--self-harm." *Id.* at 1201.

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Even when inmates' mental-health needs were identified, referrals for additional follow-up were routinely ignored, leaving inmates without the treatment they needed. The court found that ADOC's referral process was "riddled with delays and inadequacies" at the time of the liability opinion. *Id.* at 1203. Unlike in "a functioning system," ADOC lacked any mechanism for triaging referrals and identifying the urgency of each request, despite the issue being flagged for years in internal audits. *Id.* As a result, there was no way to ensure that even urgent requests would be processed in a timely manner or actually referred to providers. See *id.* Correctional officers, stretched thin by inadequate staffing, were "ill-positioned" to circumvent the broken referral system by noticing inmates' behavioral changes and getting them the help they needed. *Id.* at 1203-04. Indeed, inmates were so desperate to get the attention of mental-health staff that they engaged in self-injury, fire setting, suicide attempts, and other destructive behavior. See *id.* at 1204.

ADOC also failed to properly classify and track those with mental-health needs. At the liability trial, multiple witnesses and experts testified about cases in which ADOC's coding system "fail[ed] to accurately reflect prisoners' mental-health needs." *Id.* For example, inmates who had been placed on suicide watch repeatedly for self-harm and suicide attempts remained coded as an MH-0, or an individual "not having any mental-health treatment needs." *Id.* at 1205. Lack of a functioning classification system made it impossible for the department to flag those in need of help and ensure they received it. As with failures at intake, the result was that seriously mentally ill prisoners were left to "languish and decompensate in ADOC without treatment." *Id.* at 1201.

Even when inmates with mental-health needs did receive care, the court found that their treatment was so deeply flawed as to be constitutionally

inadequate. Experts on both sides described treatment planning as "the foundation of all forms of health care" because it is necessary to ensure that treatment is consistent and informed. *Id.* at 1206. The need for treatment plans is heightened in prisons, where inmates have little ability to manage their own care, and "even more crucial" in the chaotic context of ADOC facilities. *Id.* However, the court found that ADOC provided only " 'cookie-cutter' plans" that were not individualized to each prisoner's symptoms and needs, failed to account for changes in the prisoner's mental-health state, and did not reflect changes in the prisoner's treatment environment. *Id.* at 1207. These plans were developed during "haphazardly" run treatment-team meetings, where lack of attendance by and coordination between members led to conflicting treatment plans being signed into action within days of each other. *Id.* The court determined that this disorganized, pro forma treatment planning process failed "to provide a meaningful and consistent course of treatment" that could actually help address inmates' needs. *Id.* at 1185. As a result, ADOC provided less effective care and ran a "substantial risk of prolonging pain and suffering of those who have treatable mental illnesses." *Id.* at 1206.

The type of treatment that inmates received was no less inadequate. The court concluded that, while "[c]onstitutionally adequate mental-health care in prisons requires more than simply providing psychotropic medications to mentally ill prisoners," ADOC had failed to provide sufficient counseling or psychotherapy to inmates with serious mental-health needs. *Id.* at 1208. Shortages in both mental-health and correctional staffing undermined "the availability and quality of individual and group counseling sessions." *Id.*

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As the court noted, at the time of the liability opinion there were too few mental-health staff to care for the number of prisoners on the mental-

health caseload, a problem that was only growing worse as the caseload grew. *See id.* Staff members' caseloads were sometimes "twice as much as they should be": Counselors were expected to care for 80-90 inmates, while nurse practitioners were expected to see 20-25 inmates per day. *See id.* As a result, providers were "continually getting behind," and counseling sessions would frequently be canceled or delayed. *Id.* (internal quotation marks omitted). And when the sessions did occur, they "[did] not amount to much." *Id.* at 1209. Experts' review of medical records revealed that progress notes from counseling sessions were cursory and vague, and they did not reflect actual clinical judgments or overall assessments of the patients. *Id.*

The lack of adequate correctional staff also interfered with inmates' treatment. Because ADOC did not have enough correctional officers to escort inmates to counseling sessions and to provide security for those sessions, care was frequently disrupted. *Id.* at 1185. Providers testified that not being allowed to see patients due to a lack of correctional staffing was a "persistent problem" that had only gotten worse over the years. *Id.* at 1210. Inmates in segregation were particularly harmed by the staffing shortage, since they had to be escorted from their cells by correctional officers. *See id.* at 1209. As a result, "the frequency of counseling sessions for those in segregation [was] especially low." *Id.*

While experts testified that group therapy could be a helpful tool for the treatment of those receiving inadequate individual therapy, the court concluded that "ADOC's provision of group therapy [was] also inadequate." *Id.* at 1211. Group therapy was equally affected by the staffing shortages within the department, leading sessions to be canceled or simply not to happen. *Id.* As a result, inmates in ADOC custody were left with "little access to group therapy," or indeed to treatment of any kind. *Id.*

Workaround solutions adopted in the face of these staffing shortages only compounded the inadequacy of care. Mental-health providers testified that, when inmates could not be escorted to counseling sessions, they would sometimes "go to the cells themselves and attempt to talk to their patients at the cell-front." *Id.* at 1210. But as experts explained, these non-confidential "cell-front check-ins are insufficient as counseling and do not constitute actual mental-health treatment." *Id.* Indeed, based on personal visits to ADOC facilities, the court found that "[c]onducting a counseling session across the door in these loud spaces seemed nearly impossible." *Id.*

The court further determined that ADOC consistently failed to ensure the confidentiality of psychiatric contacts, which "undermine[d] the effectiveness and quality of counseling sessions." *Id.* at 1210. While expert witnesses testified that "confidentiality between providers and patients is a hallmark of and a necessary condition for mental-health treatment," inmates were frequently receiving check-ins during which they could be heard by correctional officers or other inmates. *See id.* Even when sessions were not held cell-front, they were not necessarily confidential. Many ADOC facilities, the court found, lacked a confidential setting for treatment sessions altogether. *See id.* Other facilities lacked offices with windows and doors that would have allowed security without sacrificing confidentiality, so correctional officers had to be stationed close enough to overhear sessions. *See id.* As a result, prisoners reported that they did not "feel safe 1209 sharing their mental-health issues," which "1209 made it difficult for providers to provide useful counseling." *Id.*

Untrained providers presented another hurdle to adequate treatment of inmates. When there were too few mental-health staff to provide care, ADOC often relied on "unsupervised, unlicensed counselors, referred to as 'mental health professionals,' " to take their place. *Id.* at 1211. The court identified the lack of supervision for

these individuals as "a significant, system-wide problem affecting the delivery of mental-health care," which violated both state regulations and the standard of care for mental-health patients. *Id.*

The result of ADOC's inadequate provision of psychotherapy was care that utterly failed to address the needs of mentally ill inmates. ADOC's failure to provide adequate treatment increased the "substantial risk of serious harm" to inmates, "leaving them at a greater risk for continued pain and suffering, self-injurious behavior, suicidal ideation, and ... disciplinary actions." *Id.* at 1212.

These problems, the court found, became "even more pronounced for prisoners in mental-health units, where ADOC houses the most severely mentally ill prisoners in its custody." *Id.* Inmates in these units, the court found, were "warehouse[ed], rather than treat[ed]." *Id.* at 1216. Despite ADOC's knowledge of these prisoners' acute mental-health needs, it provided them "grossly inadequate care," housing these severely ill individuals in units that operated "almost exactly the same way" as segregation, with minimal out-of-cell time and little treatment. *Id.* at 1212.

Not only was ADOC operating these inpatient treatment units under conditions comparable to segregation, it was also using the units as extra segregation cells to house inmates without mental-health needs. This "persistent and long-standing practice of placing segregation inmates without mental-health needs in mental-health units" compromised the provision of treatment on those units by creating a safety risk to the mentally ill inmates on the unit, by diverting the attention of the scarce correctional officers, and by preventing programming from taking place. *Id.* at 1212-13. Placing segregation inmates in inpatient cells also contributed to a shortage of such cells for prisoners who needed them. *See id.* at 1213.

The "segregation-like atmosphere" of ADOC's inpatient units and the gross inadequacy of the care offered there was also caused by "a severe

lack of out-of-cell time" and the "lack of meaningful treatment activities." *Id.* at 1214. As the court found, the "careful observation and treatment" that prisoners needing inpatient care require "cannot happen when confined in a small cell all day. In fact, without out-of-cell time and effective treatment, housing severely mentally ill prisoners in a mental-health unit is tantamount to 'warehousing' the mentally ill." *Id.* (quoting *Wyatt v. Aderholt*, 503 F.2d 1305, 1309 n.4 (5th Cir. 1974)¹). Inmates housed in ADOC's inpatient units received "a vanishingly small amount of time outside their cells": 30 minutes of individual therapy and 2.5 hours of non-therapeutic group activity per week for those housed in the men's stabilization unit (SU) at Bullock, and little more in the residential treatment units (RTUs). *Id.* at 1215.

¹ In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), the Eleventh Circuit Court of Appeals adopted as binding precedent all of the decisions of the former Fifth Circuit handed down prior to the close of business on September 30, 1981.

¹ This part of the opinion also discusses ADOC's promulgation of policies—an area in which the court declines to order relief.

Along with minimal out-of-cell time, prisoners in the inpatient units received "little treatment except for psychotropic medication due to staffing level shortages of both treatment and custody staff." ¹²¹⁰*Id.* at 1214. Group activities were often cancelled, and mental-health staff were forced to man the laundry and showers instead of providing mental-health care because there "were not enough correctional officers to perform those basic duties." *Id.* at 1216. Individual psychiatric contacts often had to be provided as cell-front check-ins because there was insufficient correctional staff to be able to take inmates out of their cells, "negat[ing] the therapeutic utility of

these contacts" due to a lack of confidentiality and resulting in "cursory" and "gravely inadequate" psychiatric contacts. *Id.*

Finally, ADOC consistently failed to provide hospital-level care to inmates who needed it. When ADOC's available mental-health interventions proved unsuccessful to stabilize or treat a prisoner, the department's regulations required that the inmate be considered for transfer to a psychiatric hospital. Despite those regulations, the court found that "ADOC virtually never transfer[red] patients to hospitals, except in the case of prisoners nearing the end of their sentence." *Id.* at 1217. "As Dr. Burns put it, waiting for an unstable patient's end of sentence to transfer him or her to a hospital is akin to 'someone with chest pain who has to wait until they're released from prison to get taken to a hospital to have the chest pain treated.'" *Id.* at 1218.

ADOC's process for identifying inmates at risk of suicide and providing "meaningful therapeutic contact to alleviate suicide risk" similarly "suffer[ed] from serious deficiencies." *Id.* at 1218-19. The department's approach to risk assessment was "too limited to adequately identify those at high risk," and acutely suicidal prisoners often did "not receive crisis care because of a severe shortage of crisis cells and staffing, and due to a culture of skepticism towards threats of suicide." *Id.* at 1220. ADOC's crisis cells were unsafe, containing tie-off points and dangerous items that could be used for self-injury. *See id.* Suicidal prisoners received inadequate monitoring and treatment, and inappropriate releases from suicide watch and a lack of post-release follow-up care "push[ed] suicidal prisoners back into crises again and again." *Id.*

At the time of the court's liability opinion, ADOC and its mental-health vendor had only recently begun using a suicide risk-assessment tool--a tool that is "widely recognized to be an essential part of mental-health care"--during prisoner intake, and

the department continued not to perform such assessments when prisoners threatened or engaged in self-harm or were placed in crisis cells. *Id.* at 1221. Even acutely suicidal inmates often could not get appropriate intervention due to a lack of crisis cells. "[T]he number of crisis cells in each of the 15 major facilities within ADOC [was] insufficient," and this deficiency was exacerbated by backlogs for admission to the SU, causing suicidal inmates to linger in crisis cells designed for short-term placement. *Id.* at 1222. Without enough cells to provide crisis intervention to everyone who needed it, ADOC would "gamble on which prisoners to put in [the crisis cells] and frequently discount prisoners' threats of self-harm and suicide." *Id.* Staff of ADOC's mental-health vendor frequently suggested that "prisoners who are claiming suicidality and self-harm tendencies are in fact malingering or seeking 'secondary gains'--such as getting out of a segregation cell, or getting away from an enemy, or debt problems." *Id.* at 1223. Despite instructions not to presume that expressions of suicidality were not genuine, mental-health staff "continued to write off prisoners' threats of self-harm as motivated by inmate-to-inmate debt or secondary gains, rather than conducting a proper assessment." *Id.*

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The lack of crisis cells also resulted in acutely suicidal inmates being placed in unsafe environments such as shift offices or non-suicide watch cells. As experts for both parties agreed, "housing a suicidal inmate in a space like a shift office is quite dangerous: not only are these places full of items that can be used for self-harm, but, depending on where the prisoner is placed, such placements can also cut off suicidal prisoners from the treatment that they desperately need." *Id.* at 1225. For instance, one expert found an inmate during a prison tour who had been housed in a mental-health office for more than a day without any treatment or access to a bathroom. *See id.* at 1225 & n.49. Moreover, even the crisis cells themselves were unsafe; the court found that the

cells were "ridden with physical structures that provide easy opportunities to commit suicide." *Id.* at 1226. Despite the fact that the overwhelming majority of recent suicides at ADOC had happened by hanging, "many of ADOC's crisis cells [had] easily accessible tie-off points, such as sprinkler heads, hinges, fixtures, and vents, making them incredibly dangerous for suicidal prisoners." *Id.* at 1227. Certain features of the cells--such as grates over the cell windows--also made it very difficult to see into them, increasing the risk that suicide attempts in the cells would not be interrupted in time to save the inmate's life. *See id.*

Inmates in crisis also received "woefully inadequate" treatment and monitoring, exacerbating the risk of harm. *Id.* at 1229. With respect to treatment, inmates on suicide watch did not consistently receive out-of-cell counseling appointments and were often kept in crisis cells for extended periods of time. "As experts on both sides agreed, crisis-cell placement is meant to be temporary and should not last longer than 72 hours, because the harsh effects of prolonged isolation in a crisis cell can harm patients' mental health." *Id.* at 1226. Nonetheless, mental-health staff "considered transferring prisoners in crisis to treatment units only in a small fraction of the crisis placements that last[ed] longer than 72 hours." *Id.*

As for monitoring, prior to the liability trial, ADOC had not conducted constant watch even for the most acutely suicidal prisoners. Failing to provide this level of watch places those inmates at the highest risk of suicide in grave danger; "if a prisoner is waiting for an opportunity to kill himself, it is too dangerous to walk away, and he must be constantly observed." *Id.* at 1229. Instead, ADOC provided suicide watch checks at 15-minute intervals. But while these checks were supposed to be staggered or random to make them unpredictable to a prisoner who might be looking for a chance to attempt suicide, experts reviewing ADOC's monitoring logs found that they often had

"pre-filled times at exact intervals," making it "impossible to ensure that staggered checks are actually happening." *Id.* This practice continued even after the parties agreed to correct it and the court ordered compliance with that agreement. *See id.*

Finally, the court found that prisoners were routinely released from suicide watch improperly--that is, without a face-to-face assessment by a psychiatric provider--and that they received grievously inadequate follow-up care. Experts "observed multiple instances of prisoners who were released directly from crisis cells back into segregation, with little or no follow-up treatment in subsequent weeks." *Id.* at 1231. This led to "a pattern of cycling between crisis cells and segregation with little follow-up treatment after crisis cell-release." *Id.*

The court also found that "ADOC ha[d] an unacceptable practice of disciplining mentally ill prisoners for behavior that stems from their mental illnesses and doing so without adequate regard for the disciplinary sanctions' impact on mental health." *Id.* Among other problems, the court found that ADOC had a "common and system-wide" practice of "punishing prisoners for engaging in self-harm." *Id.* at 1232. This practice persisted despite an ADOC regulation purporting to forbid it. *See id.* Not only did this "fail[] to address the underlying mental-health issues," it also resulted in segregation placements for mentally ill prisoners, further increasing the risk of harm. *Id.*

This problem was exacerbated by ADOC's failure to consider inmates' mental-health when imposing disciplinary sanctions. As the court found, failing to do so is "dangerous because certain sanctions, such as placement in segregation, expose mentally ill prisoners to a substantial risk of worsening symptoms and significantly reduced access to monitoring and treatment." *Id.* at 1233. At the time, ADOC's regulations required consultation with mental-health staff during disciplinary

actions involving prisoners on the mental-health caseload. But, as the court found, "the system [fell] far short in practice." *Id.* Evaluators conducted superficial assessments, did not understand that they were supposed to assess whether the prisoner's conduct was connected to mental illness, and did not make recommendations about how the inmate's mental health should be considered in the process or what punishments were contraindicated for the inmate for mental-health reasons. *See id.* at 1233-34. As a result, these consultations operated as "little more than a rubber stamp" for the disciplinary process. *Id.* at 1234. This yielded "frequently egregious" consequences: mentally ill prisoners who attempted to hurt or kill themselves routinely received segregation placements as punishment, further heightening their risk of self-harm and suicide. *Id.* Some prisoners "bounced between segregation units and suicide-watch cells over lengthy periods of time" and were "never put on the mental-health caseload despite repeated instances of self-harm." *Id.* at 1241.

While there are "inherent psychological risks of segregation," particularly for people with serious mental illness, the conditions in ADOC's segregation units compounded the risk of harm. *Id.* at 1238. Inmates in segregation experienced a "lack of any meaningful activity or social contact" due to non-existent programming and minimal time out-of-cell; then-Associate Commissioner Culliver testified that ADOC tries to give inmates in restrictive housing five hours per week out-of-cell, "which means that even when ADOC officers are able to meet their goal, prisoners spend on average over 23 hours per day inside of a cell." *Id.* "[W]hen prisoners remain in their cells around the clock, mental-health staff have a harder time observing the patient and diagnosing illnesses effectively, and correctional officers and fellow prisoners also lack sufficient regular contact with the prisoner to notice the onset of symptoms of mental illness." *Id.* at 1239.

Thus, though the extreme isolation made the mental-health needs of inmates in segregation "considerably greater," the court found that "due to staffing shortages, mental-health treatment and monitoring in segregation are gravely more limited than in general population, and nonexistent at some facilities." *Id.* at 1242. Prisoners in segregation lacked access to mental-health groups and therapeutic activities and had minimal access to individual treatment "because of ADOC's failure to bring inmates out of their segregation cells for treatment" due to a lack of correctional staff. *Id.* at 1243. As in the inpatient units, without enough correctional officers to provide the security and escorts necessary to get inmates out of their cells, mental-health staff had to make do with "cell-front check-ins, instead of actual ¹²¹³treatment sessions"--brief, ^{*1213} non-confidential interactions that "cannot replace individual counseling sessions." *Id.* Mental-health rounds in segregation were even more "cursory"; one ADOC doctor described them as "drive-bys," often taking a minute or two per prisoner, and "sometimes even without verbal exchanges." *Id.* at 1244.

The lack of correctional staff also led to inadequate monitoring of inmates in segregation. Most troubling was ADOC's failure to perform monitoring rounds in segregation every 30 minutes, "the level of monitoring in segregation units necessary to keep prisoners safe from self-harm and suicide." *Id.* Plaintiffs' expert Vail "saw logs at ADOC that suggested that no segregation checks were done for multiple hours." *Id.* This lack of adequate monitoring, combined with the lack of suicide resistance of the segregation cells, created extremely dangerous conditions for prisoners in restrictive housing. *See id.* at 1244-45. In that context, both parties' experts "were alarmed by ADOC's systematic overuse of segregation for mentally ill prisoners, who are most vulnerable to the risk of deterioration in such an isolated environment." *Id.* at 1242.

The most acute risk of harm from these segregation practices was felt by prisoners with a serious mental illness: The court found "overwhelming[]" evidence that this "subset of prisoners ... should never be placed in segregation in the absence of extenuating circumstances." *Id.* at 1245-46. As the then-Associate Commissioner of Health Services testified, "placing seriously mentally ill prisoners in segregation is 'categorically inappropriate' ... [and] is tantamount to 'denial of minimal medical care.'" *Id.* at 1246. The program director of ADOC's mental-health vendor at the time "agreed with the bright-line rule against placing prisoners with serious mental illness in segregation." *Id.* The Associate Commissioner further testified that ADOC's then-new mental-health coding system, once fully implemented, would ensure that "no seriously mentally ill inmate would be housed in a segregation setting." *Id.* (quoting Naglich Testimony at vol. 5, 67). But with a lack of evidence at the time that ADOC had implemented this bright-line policy of excluding inmates with serious mental illness from segregation, the court found that "it is categorically inappropriate to place prisoners with serious mental illness in segregation absent extenuating circumstances," and that "even in extenuating circumstances, decisions regarding the placement should be with the involvement and approval of appropriate mental-health staff, and the prisoners should be moved out of segregation as soon as possible and have access to treatment and monitoring in the meantime." *Id.* at 1247.

At the time of the liability trial and opinion, the court also found "substantial evidence ... that ADOC [was] not conducting adequate periodic mental-health assessments of prisoners in segregation to identify those who become mentally ill while in segregation." *Id.* at 1249. After further briefing and argument from the parties, the court issued a supplemental liability opinion finding that ADOC's failure to conduct adequate periodic mental-health evaluations of all

prisoners in segregation contributed to the Eighth Amendment violation found in the original liability opinion. See *Briggs v. Dunn*, 367 F. Supp. 3d 1340, 1342 (M.D. Ala. 2019) (Thompson, J.). The court found that these periodic evaluations of inmates both on and off the mental-health caseload "do not occur with adequate frequency, and that even when they do occur the evaluations are so cursory as not to be worth the paper they are written on." *Id.* at 1350. It concluded that these periodic assessments were "inadequate at identifying signs of psychological harm and 1214decompensation," *1214 placing both mentally ill and non-mentally ill inmates in segregation at substantial risk of harm. *Id.* at 1355.

The court proceeds now to discuss several of the suicides that have taken place in ADOC facilities since the court issued its liability opinion. As became apparent during the course of the omnibus proceedings, many of the liability findings described above appear again in the circumstances of these deaths, evidencing continued problems in these areas. Again, as the court found, "persistent and severe" understaffing permeated many of these deficiencies, *Briggs*, 257 F. Supp. 3d at 1268 ; as will be discussed below, understaffing continues to impede the provision of adequate mental-health care throughout the ADOC system.

B. Recent Suicides

I. Laramie Avery

Laramie Avery was 32 years old when he hanged himself in the restrictive housing unit at Bullock Correctional Facility on April 14, 2020. He had been incarcerated in the ADOC system for 15 months at the time and had never been on ADOC's mental-health caseload nor flagged as a person with a serious mental illness (SMI).

Avery was placed in restrictive housing, or segregation, for the first time in February 2020. During his pre-placement mental-health screening, he appeared intoxicated and confused, and he told the screener that he didn't "have much to live for."

Pls. Ex. 3302 at ADOC518578. An urgent mental-health referral was made, and he was designated as contraindicated for placement in segregation. See Pls. Ex. 3301 at ADOC518513. Avery was placed in the restrictive housing unit despite the contraindication.

In late March, Avery was referred again for mental-health services after asking to see a mental-health provider because of his "documented history of mental illness." *Id.* at ADOC518504. He was never seen for this referral. He was referred again for mental-health services on April 11 and was not seen before his death.

At 9:28 a.m. on April 14, Avery was discovered hanging from the ceiling vent of his cell by a correctional officer during pill call. See Pls. Ex. 3299 at ADOC504208. One minute later, a second officer arrived at the cell, and the cell door was opened. Two minutes later, a doctor and two more officers arrived. At that point, Avery was cut down and placed on a stretcher to be taken to the health care unit. Nine minutes later, Avery arrived at the health care unit, and CPR began. Ten minutes after that, Avery was pronounced dead.

In total, 12 minutes passed between the time when Avery was found hanging in his cell and the initiation of CPR. Two minutes passed between the arrival of a second officer at the cell and the officers' decision to cut Avery down from where he hung. Before cutting Avery down, the officers took a photograph of him hanging from the ceiling of his cell. See Pls. Ex. 3406 at ADOC572292. At the time of Avery's death, the stipulated remedial order related to suicide prevention required that "immediate life-saving measures shall be taken after there are two (2) correctional officers present." Order (Doc. 2569) at 17.

2. Jaquel Alexander

Jaquel Alexander hanged himself in his cell at the Donaldson structured living unit (SLU) on May 17, 2020, when he was 26 years old. The SLU is a

diversionary unit for inmates with serious mental illnesses to avoid placing the inmates in segregation.

Alexander had been in ADOC custody since 2016. It appears from his records that he was first placed in a restrictive housing unit in October 2019. He was placed in restrictive housing again in December 2019, and he acknowledged "considering self-harm or suicide" in a pre-¹²¹⁵placement mental-health assessment. Pls. Ex. 3298 at ADOC539034. He did not receive a suicide risk assessment or further evaluation. See *id.*

During that placement, he submitted a request to see a mental-health provider because he was "having really bad dreams of being killed and suicidal thoughts of hurting myself." *Id.* He was placed on acute suicide watch on December 15 and found to be at high risk of suicide. He was discharged from suicide watch on December 23 but put back on watch on December 25 after he told a mental-health provider during a restrictive housing screening that he was feeling "depressed" and "suicidal." *Id.* at ADOC539035. He was released from suicide watch again the next day.

At this point, Alexander was not on the mental-health caseload and was not flagged as having a serious mental illness. Despite the series of suicide watch placements in December 2019, he did not receive a full mental-health assessment and was not placed on the caseload.

On January 2, 2020, a nursing progress note indicated that Alexander had been "choked out" by his cell mate while in a crisis cell at Fountain Correctional Facility. *Id.* He was transferred to Holman Correctional Facility that day and placed again on suicide watch. The next day, he was removed from suicide watch and sent back to Fountain, where he was placed immediately in restrictive housing. At the time, both an agreed-upon court order and ADOC policy prohibited moving inmates directly from suicide watch to restrictive housing absent documented exceptional

or exigent circumstances. See Order (Doc. 2569) at 16; Pls. Ex. 3180 ("Daniels Directive"). There is no indication in Alexander's records of what circumstances justified this placement.

Alexander was moved from Fountain to Ventress Correctional Facility on January 7; in a meeting with a mental-health provider prior to the transfer, he was "tearful" and said he "just need[ed] MH meds." Pls. Ex. 3298 at ADOC539035. He was put on suicide watch again two days later after expressing suicidal thoughts during a screening before another placement in restrictive housing. On January 15, during another pre-placement screening before another restrictive housing placement, he said he felt "sad, hopeless or depressed," and he acknowledged cutting his wrist. *Id.*

On January 23, Alexander was seen for the first time for a psychiatric evaluation. He was diagnosed with major depressive disorder, placed on the mental-health caseload with a code of MH-C,^{2 2} and flagged as having a serious mental illness. See *id.* His records do not indicate that he ever received a treatment-team meeting or that a treatment plan was ever developed for him. See May 24, 2021, R.D. Trial Tr. at 68-69.

² Since the time of the liability trial, ADOC has created a coding system under which inmates are assigned one of four lettered codes. See Joint Stipulation for the Evidentiary Hearing Regarding the Phase 2A Remedial Order (Doc. 3288) at 8. A code of A indicates that the inmate is not on the mental-health caseload and is not receiving ongoing mental-health services. A code of B indicates that the inmate requires outpatient mental-health services at intervals of 90 to 120 days, has demonstrated stable coping skills for a period of six months or more, and can be housed in facilities that do not provide daily on-site coverage by mental-health staff. A code of C indicates that the inmate requires outpatient mental-health services

at intervals of 30 to 60 days, has a diagnosed mental disorder (excluding a substance use disorder) currently associated with an impairment in psychological, cognitive, or behavioral functioning that substantially interferes with his or her ability to meet the ordinary demands of living, and must be housed in facilities that provide daily on-site coverage by mental-health staff. A code of D indicates that the inmate receives chronic or acute mental-health services and requires placement in a designated mental-health treatment unit.

² As explained in the Savages' staffing analysis and in Meg Savage's testimony, for an essential post to be filled, it need only in fact be occupied 75 % of the time. See Savages' Staffing Analysis (Doc. 1813-1) at 106. In addition, per the parties' stipulations, compliance with this deadline and with the benchmarks below will not be monitored at Hamilton or Tutwiler absent further order of this court. See Joint Stipulation (Doc. 3288) at 3.

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Alexander was placed on suicide watch twice more in February and early March--in February after he expressed suicidality during a screening before placement in segregation, and in March when he cut his wrist with a razor. See Pls. Ex. 3298 at ADOC539035-36. On March 12, he was again placed in restrictive housing after his pre-placement screening mistakenly failed to note that he had a serious mental illness and was therefore contraindicated for segregation placement. See *id.* at ADOC539036. Six days later, he attempted to hang himself with a towel in his segregation cell. See *id.*

These suicidal acts appeared to be connected to fears of being hurt or killed by other inmates. During his pre-placement screening on March 12, he said that he had been "getting away from a hit," and in subsequent interactions with mental-health

providers he said he had "enemies all over this camp" and that he felt unsafe in most of the general population dorms of Ventress. *Id.* On March 29, he was placed again on constant suicide watch after a pre-placement screening for restrictive housing. Throughout these suicide watch placements, he was never referred for a higher level of mental-health care such as placement in a mental-health stabilization unit.

On April 8, 2020, Alexander tried to jump the fence at Ventress. He received a disciplinary infraction for attempting to escape. A mental-health consultation form was provided to his disciplinary hearing officer, but the form had an error code in the box indicating whether Alexander was on the mental-health caseload. *See* Pls. Ex. 3296 at ADOC517817. The consultation form indicated that there were no mental-health issues that needed to be considered if Alexander was found guilty. *See id.* Alexander was found guilty of the violation and sentenced to 45 days in segregation. *See id.* at ADOC517819. He remained in segregation for at least 22 days in spite of his serious mental illness designation.

On May 13, Alexander was moved from Ventress to Donaldson and was placed in the Donaldson structured living unit. His transfer documents incorrectly indicated that he did not have a serious mental illness. *See* Pls. Ex. 3298 at ADOC539037. He received a routine mental-health referral and was scheduled to meet with a mental-health provider on May 15. *See* Pls. Ex. 3297 at ADOC518193.

Early on the morning of May 16, he asked to be placed in a crisis cell and received an urgent mental-health referral. *See id.* at ADOC518191. The on-call mental-health provider was not notified for more than 12 hours.³ *See id.* Alexander met with a nurse instead of the mental-health provider--with a correctional officer present as well--and told the nurse that he was suicidal. *See id.* at ADOC518184. The nurse called the mental-health provider, who, without speaking to

Alexander at that time,⁴ told the nurse to have him returned to his cell and said that she would check on him in the morning. *See id.*

³ Under the stipulated order then in effect, "An emergent or urgent mental-health referral must be communicated verbally, in person or by telephone, to the mental-health staff as soon as possible, but in no case longer than one (1) hour." Phase 2A Order and Injunction on Mental Health Identification and Classification Remedy, Attachment A (Doc. 1821-1) at § 2.2. If the staff member who made the referral did not recognize the referral as urgent and the referral was not recognized as urgent until it was triaged, then it is possible that the 12-hour delay before the referral was triaged and a mental-health provider was subsequently notified would not violate the stipulated order. But, if that was the case, the court is concerned that an inmate "[r]equesting to be placed in a crisis cell" could be understood, even initially, to require only a routine referral. Pls. Ex. 3297 at ADOC518191.

³ The court will require the defendants, within 21 days of the effective date, to submit to the court a proposal for specific dates by which this may be done.

⁴ According to the note for this interaction, the provider "verbalized that she spoke with inmate earlier today." *Id.*; *see also id.* at ADOC518193 (routine referral that resulted in an appointment scheduled for the morning of May 15).

⁴ The defendants' expert Dr. Metzner agreed with Vail that these security checks are "good correctional practice," but did not appear from his testimony to agree with Vail's view about the degree of criticality of these checks. June 30, 2021, R.D. Trial Tr. at 181. However, as Metzner acknowledged, he is an expert in correctional psychiatry, not an expert in correctional administration and security

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 Vail. *See id.* at 180. Accordingly, and based on the evidence that missed security checks played a role in several of the recent suicides, although the court gave due weight to Metzner's opinion on these security checks, it found Vail's testimony on the importance of security checks more persuasive. Moreover, ADOC is falling short of the security-check requirement under either expert's view of the necessary compliance rate. On this issue, the defendants are missing the mark by yards, not inches.

Alexander was sent back to his cell and was not placed on suicide watch. He hanged himself a few hours later. Per the psychological autopsy conducted by ADOC's mental-health vendor Wexford Health Sources, "[a]n opportunity for crisis intervention was missed on the day prior to his death when an MHP [mental-health provider] failed to follow suicide prevention protocol and place the inmate in crisis housing." Pls. Ex. 3298 at ADOC539039. There is no evidence that the mental-health provider was disciplined for this failure or that any other action was taken by the department to prevent such failures from being repeated in the future.

3. Casey Murphree

The day after Jaquel Alexander's death, Casey Murphree, age 49, hanged himself in a restrictive housing cell at Bullock Correctional Facility. He was on the mental-health caseload at the time with a code of MH-B, and he was flagged as having a serious mental illness due to his bipolar disorder.

⁶ Murphree had been incarcerated in ADOC since 1996. For a period of time, he was coded MH-C, but his code was changed to MH-B in April 2019. Under ADOC's mental-health coding system, MH-B and MH-C are the codes reflecting that a prisoner is on the mental-health caseload and is receiving treatment on an outpatient basis; inmates coded MH-C are those who have more significant treatment needs and who therefore meet more frequently with mental-health providers.

Murphree's records indicate that he was reclassified to MH-B at his request, not because of a change in his clinical needs but because he wanted to be able to get a job.⁵ *See* Pls. Ex. 3281 at ADOC518569.

⁵ It is unclear why Murphree believed he could not get a job with a code of MH-C. In general, employment opportunities in State prisons may not be denied based on an inmate's mental-health status if reasonable accommodations would allow the prisoner to perform the work. *See Pa. Dep't of Corrs. v. Yeskey*, 524 U.S. 206, 210, 118 S.Ct. 1952, 141 L.Ed.2d 215 (1998) (holding that Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 *et seq.*, bars States from denying the "benefits" of "vocational 'programs'" to qualified prisoners with a disability).

⁶ Nor are the restrictive housing units unsafe only for inmates on ADOC's mental-health caseload. As illustrated by the deaths of Gary Campbell and Charles Braggs, ADOC does not have sufficient staff to be able to consistently identify people who decompensate and develop mental-health needs in segregation, making the units unsafe for inmates both on and off the caseload.

On February 10, 2020, Murphree met with a mental-health provider for an individual counseling session, which lasted 10 minutes. *See* Pls. Ex. 3280 at ADOC518070. The provider noted that Murphree was rambling, had "irrational thinking," and was "somewhat delusional." *Id.* The plan articulated on Murphree's progress note from the counseling session was for the provider to follow up with him within 30 days. *See id.* There is no indication in Murphree's records that he was ever seen for this follow-up appointment.

At about 6:35 a.m. on May 17, 2020, Murphree received a mental-health referral prior to placement in restrictive housing. *See id.* at ADOC518063. The nurse who filled out the

referral form noted that Murphree had multiple altercations over the previous 24 hours and gave him an emergent referral, which under the then-effective stipulated remedial order required that he be seen within three hours.^{6 6} *See id.* On a pre-placement screening completed at the same time, Murphree was listed as clinically contraindicated for restrictive housing due to his serious mental illness. *See id.* at ADOC518064.

⁶ As Dr. Burns credibly testified, bellicosity and uncooperativeness can be symptoms of bipolar disorder. *See* May 24, 2021, R.D. Trial Tr. at 79.

⁶ The court does not order, as the plaintiffs propose, that "[i]mplementation of the mental-health staffing ratios must be reviewed by appropriately qualified experts agreed upon by the parties or selected by the EMT." Pls.' Post-Trial Br. (Doc. 3370 at 74). The monitoring team's familiarity with ADOC's mental-healthcare system will better position it to evaluate the staffing ratios than any outside expert.

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Murphree was placed in restrictive housing notwithstanding his contraindication for segregation. There is no evidence in his records that any consideration was given to an alternative placement for him. *See* Pls. Ex. 3281 at 1. He was never seen by mental-health staff for the emergent referral made prior to his segregation placement.

At 3:40 a.m. on May 18, 2020, about 20 hours after Murphree entered segregation, he was found dead in his cell with a ligature around his neck. *See id.* By the time he was found, rigor mortis had set in, a process that Dr. Kathryn Burns testified takes several hours. *See* May 24, 2021, R.D. Trial Tr. at 80-81. Under ADOC's administrative regulations, officers must conduct cell-by-cell security checks in restrictive housing every 30 minutes, 24 hours a day. As plaintiffs' expert Eldon Vail credibly testified, these security checks are among the highest priorities of any safety

measures in correctional facilities because the risk of suicide for inmates housed in segregation is so extreme. *See, e.g.*, June 1, 2021, R.D. Trial Tr. at 107.

In addition to these 30-minute security checks by correctional staff, nurses conduct daily rounds in segregation to provide medication and to check whether prisoners need to request medical or mental-health assistance. In Murphree's records, the nurse conducting these rounds in the Bullock restrictive housing unit initialed that she visited him on May 19, 20, and 21, the three days after his death. *See* Pls. Ex. 3280 at ADOC518091.^{7 7}

⁷ At the omnibus remedial hearings, defense counsel represented that, according to his understanding, these round sheets were stored "separate from [an inmate's individual] medical records." May 28, 2021, R.D. Trial Tr. at 12. According to defense counsel, after Murphree committed suicide, his cell was occupied by a new occupant, but "Murphree's sheet remained in the stack of sheets that the medical nurse signs off." *Id.* at 13. There is no evidence in the record to indicate that this is what actually happened, so the court does not know whether to credit it as true. But even if this is what happened, it leaves the court with serious concerns about whether rounds are performed as required and about the reliability and credibility of ADOC's recordkeeping.

⁷ ADOC's consultants explained that they intended the term "qualified mental-health professional," or QMHP, to refer to professionals who are "appropriately licensed to practice (assess for the presence of mental illness, evaluate for the risk of suicide, provide therapy) independently with no supervision required," but not to "associate licensed counselor[s], licensed bachelor[s] of social work, [or] licensed marriage and family therapist[s]." *See* Recommended Staffing Ratios (Doc. 2385-1) at 3. They further explained that "[t]he

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 requirements for QMHPs [would be] generally the same as for psychologists," *id.* at 12, that QMHPs in the restrictive housing units would "provide one 90-minute therapy group" per day, *id.* at 11, and that QMHPs in the SUs would provide "structured therapeutic activity," *id.* at 13.

The parties disagreed as to the term's precise meaning, with the defendants proposing to define the term differently depending on whether it was used in the staffing ratios or in their proposed remedial provisions. Thus, the court was confronted with three different definitions—one from the plaintiffs, and two from the defendants. Much confusion ensued.

For now, suffice it to say that the court assumes that the EMT, in monitoring ADOC's compliance with the staffing ratios, will count as qualified mental-health professionals only those professionals who are qualified to provide therapy.

4. Charles Braggs

Charles Braggs was 28 years old when he hanged himself on July 27, 2020, in his cell in the restrictive housing unit at St. Clair Correctional Facility, where he had been living for more than two years. He was not on the mental-health caseload. At the time of his death, Braggs was 6'4", weighed 131 pounds, and had methamphetamine in his system. *See* Pls. Ex. 3282 at PL9916, PL9921. He had been in restrictive housing for all but one month since his incarceration at ADOC began in 2011.

Inmates like Braggs who are in restrictive housing and are not on the mental-health caseload are supposed to receive mental-health assessments every 90 days to ensure that the stress of segregation has not caused them to need increased mental-health care. In the time Braggs spent in his cell at the St. Clair restrictive housing unit, he received two such assessments: one in December 2018, and one in March 2019. During these assessments, according to Wexford's review of his

death, "he reported auditory hallucinations, sleep disturbances, and reported possible paranoid/delusional thought content and exhibited blunted affect and disheveled appearance." Pls. Ex. 3284 at ADOC539022. In spite of this, "[t]here is no evidence that consideration was given to removing him from the [restrictive housing unit] or that he was referred to or evaluated by the mental health provider." *Id.*

Under the stipulated segregation remedial order then in effect, ADOC was required to conduct 1219 mental-health rounds in *1219 restrictive housing at least weekly, stopping at each inmate's cell to determine whether the inmate might require mental-health care. The last documented round conducted in the St. Clair restrictive housing unit was on May 21, 2020, more than two months before Braggs died. *See* Pls.' Ex. 4119 at 2. Lack of adequate correctional staff was the reason given for this string of missed rounds. *See id.*

On the morning of July 27, 2020, the day Braggs died, he placed a medical request on a sick call form to see a nurse because he had been "having seizures lately." Pls. Ex. 4118 at ADOC590774. He was not seen for this request. According to a prisoner in the cell next to his, who was interviewed by ADOC's chief psychiatrist after Braggs's death, Braggs had been asking for mental-health services for two weeks before he died. *See* Pls. Ex. 4119 at 2.

After speaking with Braggs during medical rounds on the evening of July 27, the nurse asked a correctional officer at 7:15 p.m. to have Braggs brought to the infirmary. *See* Pls. Ex. 4118 at ADOC590777. At 7:25 p.m., the nurse asked the officer again to bring Braggs to the infirmary and was told that Braggs couldn't be brought over "because he didn't have any clothes." *Id.* At 8:00 p.m., the nurse asked the captain on duty to instruct his officers to bring Braggs to the infirmary. *See id.* At 8:15 p.m., the officers found Braggs dead in his cell. *See id.* at ADOC590778.

In the months leading up to his death, Braggs routinely had scheduled out-of-cell time canceled for lack of correctional staff. Inmates in restrictive housing cells are supposed to be allowed out of their cells for five hours each week for exercise; as Dr. Burns testified, the purpose of this requirement is to ensure "a change of scenery, so they're not locked in that same space 24 hours a day, seven days a week." May 24, 2021, R.D. Trial Tr. at 106. In the seven months before his death, Braggs rarely received these required five hours per week out of his cell. In some weeks, records indicate that he received no time at all out of his cell due to understaffing, except for occasional showers or health-care appointments. See, e.g., Pls. Ex. 3921 at ADOC517731.

5. Gary Campbell

Gary Campbell hanged himself in his restrictive housing cell at Limestone Correctional Facility on November 27, 2020, at the age of 43. He was not on the mental-health caseload and was not flagged as having a serious mental illness. He had been living in the cell where he died for more than two years at the time of his death, after being placed in restrictive housing at his own request. During that time, Campbell had received none of the required 90-day mental-health assessments.

In November 2019, Campbell received a mental-health referral after he mailed two letters that were "tangential and disorganized," which the referring officer noted was "[n]ot normal for Campbell." Pls. Ex. 3291 at ADOC546285. In these letters, according to the notes of Nina Tocci, one of ADOC's regional psychologists, Campbell declared that he "is the Wisdom and Power of G-d." Pls. Ex. 3267 at 1. He took "a threatening tone about the ungodly people in the world ('others') and those that 'talk against me,'" and he expressed "that his character was being 'assassinated.'" *Id.*

The following month, he was seen by a mental-health provider in response to this referral. The meeting took place cell-side because Campbell

refused to come out of his cell. See Pls. Ex. 3291 at ADOC546286. According to the progress note of that session, Campbell denied suicidal or homicidal ideation but explained that "he [was] content being in his cell because he has God. [Campbell] reports he knows he will be released from prison eventually and will continue to be a vessel to do God[']s work." ¹²²⁰*Id.* There was no evidence of any follow-up from this session in his records.

In June 2020, Campbell was seen again by a mental-health provider after being referred by the Limestone Warden for another "bizarre letter." *Id.* at ADOC546288. He refused again to come out of his cell for the session, denied suicidal or homicidal ideation, said he was "still content with being in his RH cell," and asked for paper and puzzles. *Id.* There was no evidence of further follow-up or evaluation.

Early in the morning on November 27, 2020, Campbell was found hanging in his cell by correctional officers "after an undetermined amount of time." Pls. Ex. 3292 at ADOC546327. The officers cut Campbell down and called for medical assistance, but they did not remove the sheet from his neck or begin CPR. After nursing staff arrived, Campbell was moved to the medical unit, where CPR was started. At 6:34 a.m., he was pronounced dead. *Id.*

As Wexford staff explained in their review of Campbell's death, "[i]t cannot be ruled out whether ... Campbell was exhibiting symptoms of psychosis as there is not sufficient evidence or a psychiatric evaluation to make that determination." *Id.* at ADOC546328. Campbell "spent two years in an isolated environment, with minimal psychological stimulation." *Id.* Per Tocci's notes, he "lived isolated from others because he was allowed to. He did not come out of [restrictive housing unit] for two years. That was stressful and he was not even aware that talking to someone could have been helpful." Pls. Ex. 3267 at 1.

In sum,¹²²¹ Campbell asked to live by himself for years in a small segregation cell, and ADOC granted his request. It checked on him twice when his rambling and religiously obsessive letters raised alarms, but these cell-side assessments were brief and perfunctory, and they were never followed up with a full mental-health evaluation. At some point, he decompensated further; no one knows when or why because no one was paying attention. Then, one morning, he hanged himself. Sometime later, he was found, cut down, moved to the medical unit, and declared dead.

6. Tommy McConathy

Tommy McConathy, age 32, hanged himself from a ventilation grate in his cell in the stabilization unit at Bullock Correctional Facility on March 2, 2021. When he died, McConathy had a mental-health code of MH-D, indicating inpatient placement, and he was flagged as seriously mentally ill with diagnoses of major depressive disorder and post-traumatic stress disorder.

The Bullock SU has a unique history in this litigation. The stabilization units--the men's unit at Bullock and the women's unit at Tutwiler--are inpatient units "for patients who are suffering from acute mental-health problems--such as acute psychosis or other conditions causing an acute risk of self-harm--and have not been stabilized through other interventions." *Braggs*, 257 F. Supp. 3d at 1183. During the liability trial, a prisoner named Jamie Wallace, who was housed on that unit and who suffered from severe mental illness, testified "that he had tried to kill himself many times, showed the court the scars on arms where he made repeated attempts, and complained that he had not received sufficient treatment for his illness." *Braggs*, 257 F. Supp. 3d at 1184. "Because of his mental illness, he became so agitated during his testimony that the court had to recess and reconvene to hear his testimony in the quiet of the chambers library and then coax him into completing his testimony as if he were a fearful

child." *Id.* Ten days after his testimony, while the trial was ongoing, Wallace hanged himself in his cell in the Bullock SU. *See id.*

Ultimately, the court ordered ADOC to make all ¹²²¹SU cells suicide-resistant. In a ¹²²¹filing in July 2020, the defendants informed the court that it had complied with this requirement and retrofitted all of its SU cells to be suicide-resistant. *See* Response to Phase 2A Order on Inpatient Treatment (Doc. 2880) at 4-5. According to the defendants' filing, suicide resistance requires the "removal of all tie-off points." *Id.* at 4.

McConathy hanged himself in the Bullock SU by tying a bed sheet to a ventilation grate located above the sink in his cell. The grate could be reached by standing on the sink. *See* May 24, 2021, R.D. Trial Tr. at 154. According to defense expert Dr. Jeffrey Metzner, who said he had seen a photograph of McConathy's cell, the ventilation grate was of a type that would generally be suicide-resistant except that a corner of the grate was broken, creating a tie-off point that allowed McConathy to kill himself. *See* July 1, 2021, R.D. Trial Tr. at 2-3. Metzner did not know how long the grate had been broken before McConathy hanged himself from it. *See id.*

Before his death, McConathy's incarceration was characterized by frequent, pervasive sexual and physical violence. As he told a mental-health provider during a therapy session at Kilby Correctional Facility in September 2020, he was being trafficked by a gang and forced to perform sex acts to pay off the gang's debt. *See* Pls. Ex. 3310 at ADOC546530. He told the provider that he would kill himself if he had to go back to Easterling Correctional Facility, where this trafficking had apparently happened. *See id.* Easterling was not the only source of his fear, however; as he said in a crisis counseling meeting a few days later, he had been to five different facilities and "all the inmates are out to harm him." *Id.* at ADOC546541. During a session at the Bullock SU the following month, he told his

counselor that this was his "last try. I want help but I will not let them hurt me again. I will die first." *Id.* at ADOC546648. The provider noted that McConathy was "adamant about his desire to die" if placed in a position where he would be raped again. *Id.*

Six days after that, McConathy was transferred from the Bullock SU to the residential treatment unit, an inpatient unit that at Bullock is a dormitory environment. *See id.* at ADOC546668. The following month, he reported another sexual assault and told his crisis counselor that he "can't function on the RTU!" *Id.* at ADOC546690. At that point, he had been on repeated suicide watches since December 2019. The day after he reported his assault on the RTU, a mental-health provider found McConathy to be "at high risk for continued suicide watch until [his] safety needs are addressed." *Id.* at ADOC546712.

Although the provider indicated that McConathy would be considered for referral to Citizens Hospital, a hospital that has a small number of inpatient beds available for ADOC inmates who have not been successful with any of the levels of care offered in ADOC facilities, McConathy was not transferred to Citizens until 30 days later on January 13, 2021. Safe at the hospital, he stabilized significantly, although he "continued to report fear of returning to a setting in which he would be physically and sexually assaulted." *Pls. Ex. 3312* at ADOC589249. His medications were adjusted, and he was found to be "calm[] and pleasant." *Id.*

On February 18, 2021, McConathy was discharged from Citizens Hospital back to the Bullock SU. On March 1, McConathy was seen by a mental-health provider and said that he "learned a great deal about his mental health at Citizens," but that "he feels people still want to harm him." *Pls. Ex. 3310* at ADOC546887. In the progress note, the plan given was to continue providing ¹²²²therapy and medication, but to release ^{*1222} McConathy from the SU. *See id.* His treatment

team recommended that he be discharged to the Donaldson RTU, a celled environment where they hoped he might be safer than the dormitory setting of the Bullock RTU. *See Pls. Ex. 3312* at ADOC589250.

At around 12:30 p.m. the next day, McConathy was found hanging in his SU cell. He was cut down and CPR was initiated. About 10 minutes later, he was pronounced dead.

C. Changed Circumstances in Areas of Liability

Based on the totality of the evidence presented during the omnibus remedial proceedings, the court proceeds to discuss its findings with regard to the changed circumstances in ADOC facilities related to each of the areas of liability previously found by the court. Serious problems with the provision of mental-health care in ADOC facilities persist in many of the remedial areas discussed below; others show some improvement, and a few show that ADOC has taken significant steps forward since the time of the court's liability opinion. To be clear, the fact that significant deficiencies persist with regard to a particular aspect of the mental-health care offered by ADOC does not mean that every remedial provision proposed by the parties is necessary to correct those deficiencies. Nor does the absence of broad, ongoing deficiencies as to another part of the mental-health care system mean that no relief is necessary: ADOC may be exceeding the constitutional minimum in most but not all elements of a given part of its mental-health care system, and some narrow relief may still be needed to remedy the points at which it continues to fall short. But the general degree of improvement or lack of improvement in the areas of relief that were the subject of the omnibus proceedings will inform the court's determination of precisely what remedies remain necessary in each area and what modes of providing that relief are the most narrowly tailored and least intrusive ways of correcting the violations at issue.

I. Correctional Staffing

As the court found in its liability opinion in 2017, ADOC's severe staffing shortages, "combined with chronic and significant overcrowding, are the overarching issues that permeate each of the" failures of ADOC's mental-health care system that contributed to the court's finding of constitutional deficiency. *Braggs*, 257 F. Supp. 3d at 1268. For that reason, when the court split the remedial phase of this suit into component elements to make developing relief a more manageable task, the court declared that "the understaffing issue must be addressed at the outset." Phase 2A Revised Remedy Scheduling Order on Eighth Amendment Claim (Doc. 1357) at 4. Staffing, the court explained, "must be fully remedied before almost anything else can be fully remedied." *Id.* This approach, the court said, was an act of "triage," *id.*--that is, the act of responding to a disaster "according to a system of priorities designed to maximize the number of survivors," *Triage*, Merriam-Webster Online, <https://www.merriam-webster.com/dictionary/triage> (last visited December 20, 2021). Because having too few staff to provide adequate care to its prison population lay at the heart of all of the court's other findings of constitutional inadequacy, the problem of understaffing had to be addressed first in order to maximize the number of lives saved.

Understaffing was therefore the first of the court's liability findings subjected to remedial proceedings and a long-term remedial order. See Phase 2A Understaffing Order (Doc. 1657).⁸ In that order, the court¹²²³ instructed the defendants, *inter alia*, to obtain a correctional staffing analysis from the firm of Margaret ("Meg") and Merle Savage by May 2018 and, by February 20, 2022, to "have fully implemented the Savages' correctional staffing recommendations," as modified by any subsequent agreements or orders. *Id.* at 2-3.

⁸ The defendants have long disputed the adequacy of the PLRA findings in the opinion accompanying the understaffing

remedial order and raised this issue again during the omnibus remedial proceedings. The defendants' recourse for these complaints was either to appeal the court's order at the time it was issued or to file a motion to modify or terminate that order, under the PLRA or otherwise. Whatever the merits of the defendants' concern may be, the defendants remained obligated to comply with the order absent modification, termination, or reversal.

The Savages timely completed and submitted their staffing analysis and recommendations to ADOC on May 1, 2018. See Savages' Report (Doc. 1813-1) at 2. They recommended that ADOC maintain, in total, 3,826 full-time equivalent correctional officer positions between what are termed "mandatory" and "essential" posts. "Essential" posts are those that are "needed for normal operations but may be temporarily interrupted." *Id.* at 106. As Meg Savage testified during the omnibus proceedings, so-called "normal operations" are "the situation where activities are being conducted routinely as prescribed in all policy and procedures," which includes "such things as programming, recreation activities, vocational and educational systems, all up and running, supervised appropriately." June 16, 2021, R.D. Trial Tr. at 41-42. These positions must be filled 75 % of the time; that degree of interruption does not cause "significant impact" to the operations of the prisons. Savages' Report (Doc. 1813-1) at 106.

"Mandatory" posts, which comprise the vast majority of the 3,826 positions recommended by the Savages, are those that "cannot be left unfilled without jeopardizing safety and security." *Id.* As Meg Savage testified, "in a fully functional agency staffing unit," the number of "mandatory" posts would match the numbers of another designation--"critical minimum" posts--which are those positions that, if they are not staffed at a particular time, should cause a facility to "immediately lock down and make sure that everything is safe,

"because you've reached a critical level." June 15, 2021, R.D. Trial Tr. at 122-24, 129. These "critical minimum" positions are, in Savage's terms, "the practical application of [the] post plan" from the staffing analysis at an individual facility: They may be subject to certain changes on the ground as the responsibilities or units in a particular prison shift, but any changes should be regularly reconciled with the post plan to ensure that they match the "mandatory" posts described there. *Id.* at 126. Because prisons cannot safely operate in a non-lockdown status without these "mandatory" or "critical" posts filled, much less provide the level of programming and recreation prescribed by prison policy, these posts must be manned 100 % of the time. *See id.* at 126-27. Leaving such posts unfilled would yield what Meg Savage called "unacceptable" consequences for safety, such as housing units with no supervision, *id.*; as the Savages explained in their staffing analysis, "[a]ny time staffing falls below Critical Minimum an emergency should be declared, inmates locked down, and steps taken to resolve the problem." Savages' Report (Doc. 1813-1) at 22.

Instead of declaring emergencies and locking down, the evidence demonstrates that ADOC operates daily at staffing levels well below what the Savages considered necessary, and that the system has made only slight progress toward minimally adequate staffing in the three years since the court's understaffing remedial order. The ¹²²⁴ first report on correctional staffing levels that ADOC filed with the court after receiving the Savages' assessment showed that, at the end of March 2018, the system had filled 1,467 of the 3,826 total correctional staff positions. *See* Quarterly Staffing Report (Doc. 1858-1) at 2. The last staffing report before the omnibus remedial hearings, filed exactly three years later, showed that ADOC has now filled 1,830.5 correctional staff positions. *See* Quarterly Staffing Report (Doc. 3246-1) at 4. This number excludes 90 so-called "Correctional Cubicle Operators," who "are not certified officers" and "can have no inmate

contact," and who therefore were not included in the Savages' staffing recommendations. Savages' Report (Doc. 1813-1) at 13, 38. In total, ADOC has gained 459.5 correctional officers and lost 96 supervisors since the Savages submitted their staffing analysis in May 2018. ADOC continues to have filled less than half of the mandatory and essential positions listed in the staffing analysis. At the present pace of improvement--363.5 positions in three years--ADOC is on track to achieve sufficient staffing to safely conduct normal operations sometime in mid-2037.⁹

⁹ The defendants have argued that the posts listed in the Savages' staffing analysis in fact reflected "optimal" staffing levels rather than the levels necessary to safely conduct normal operations. *See, e.g.*, Defs.' Post-Trial Br. (Doc. 3367) at 56-57. Meg Savage made several statements to that effect during her testimony. *See, e.g.*, June 15, 2021, R.D. Trial Tr. R.D. Trial Tr. at 46, 80-81; *see also* Savages' Report (Doc. 1813-1) at 105. Just as often, however, Savage said the opposite in unequivocal terms. *See, e.g.*, June 16, 2021, R.D. Trial Tr. at 50, 54-55. Moreover, the notion that the Savages' analysis described optimal levels is belied by the terms of the analysis itself. "Essential" posts, along with "mandatory posts," are defined as the positions "needed for normal operations." Savages' Report (Doc. 1813-1) at 106. "Normal operations," in turn, are defined as a level between optimal staffing and critical minimum staffing. *See id.* at 22. So too, there exists a third kind of post--"important" posts--and as Meg Savage explained, filling these "important" posts is what allows a prison system to reach optimal levels. *See* June 16, 2021, R.D. Trial Tr. at 50. The Savages' staffing analysis contained no "important" posts in its facility post plans. *See* Savages' Report (Doc. 1813-1) at 121-33. Accordingly, considering all of the evidence, the court finds that the Savages' staffing analysis reflected the posts

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 necessary for ADOC to safely conduct normal operations, not the posts necessary to achieve optimal staffing levels. And regardless, the gist of the Savages' testimony was clear: ADOC's correctional staffing is woefully inadequate.

The evidence presented in the omnibus hearings made clear how this grievous systemwide understaffing is felt daily at ADOC facilities. On a representative week at Donaldson Correctional Facility, the prison managed at most to fill 61 of the 97 mandatory posts at the prison one day on one shift. *See* Pls. Ex. 3860 at ADOC588188-90. In the inpatient RTU and SLU units at Donaldson that week, ADOC filled at most seven of the 13 mandatory posts. *See id.* These were maximum numbers; on other shifts during the week, Donaldson had as few as 21 of the 97 mandatory posts filled prison-wide and only one post filled across the RTU and SLU: a single officer in the control room for those units and no one on the floor. *See id.* at ADOC588208, 217-18.

Donaldson was not an outlier among ADOC facilities in its degree of understaffing. During similarly representative weeks at Bullock, St. Clair, and Easterling, ADOC again did not fill all of the mandatory posts on a single shift at any of the facilities, even counting correctional cubicle officers and trainees. Nor are these facilities the worst of the system; according to the defendants' most recent quarterly staffing report prior to the omnibus remedial hearings, Bibb, Kilby, and Ventress Correctional Facilities all had 1225 correctional *1225 staff vacancy rates of over 50%. *See* Quarterly Staffing Report (Doc. 3246-1) at 3. Only the Hamilton Aged and Infirm Center had adequate correctional staffing as reflected in that report, and otherwise only the Tutwiler Prison for Women had a vacancy rate of less than 40%. *See id.*

ADOC began a pilot program at Easterling, Hamilton, and Tutwiler to begin tracking the fill rate of critical minimum posts at those facilities. *See* June 15, 2021, R.D. Trial Tr. at 112-13. But

instead of an honest assessment of the facilities' critical staffing needs, ADOC elected simply to leave off every mandatory five-day post from the Savages' staffing analysis, including only the mandatory seven-day posts instead. *See* June 17, 2021, R.D. Trial Tr. at 7-8. This across-the-board decision appears both baseless and arbitrary, and it is out of keeping with Meg Savage's testimony that mandatory and critical posts should generally be identical, absent some reason why a particular post might become non-critical based on specific changes at the facility. *See* June 15, 2021, R.D. Trial Tr. at 122-24. Savage testified that she did not know why ADOC had, as she said, "excluded" all mandatory five-day posts in creating these rosters. June 17, 2021, R.D. Trial Tr. at 8.

Of course, necessary staffing levels are always relative to prison population. Incarcerating more prisoners requires more staff; incarcerating fewer requires fewer. What staff are needed may also vary with changes in the responsibilities of a facility, or structural changes such as the opening or closing of particular units. For that reason, among the Savages' recommendations that the court's understaffing order required the department to "fully implement[]," Phase 2A Understaffing Remedial Order (Doc. 1657) at 3, were that "another staffing analysis ... be conducted for every facility starting in January 2019" to reassess the prisons' needs and that an "agency staffing unit" be created to "implement[] and enforce[] ... any changes resulting from this analysis," Savages' Report (Doc. 1813-1) at 20, 100. Among its responsibilities, this agency staffing unit would set critical minimum levels for each facility and ensure that those levels matched the mandatory posts in the staffing analysis. *See id.* at 22; *see also* June 15, 2021, R.D. Trial Tr. at 122-24.

Despite the court's order to implement the Savages' recommendations, ADOC has done nothing in the intervening three years to update the Savages' staffing analysis. Nor has the department established the agency staffing unit; until the

absence of this unit came up in Meg Savage's testimony during the omnibus proceedings, ADOC had taken no steps to set up the staffing unit or hire an agency staffing head. As a result of ADOC's failure to implement these recommendations, Savage testified that she did not know whether the number of correctional staff positions currently needed for the system to operate safely is higher or lower than the number she and her husband found in their 2018 analysis. See June 16, 2021, R.D. Trial Tr. at 9-14.

That said, ADOC's population figures do not suggest that the systemwide number of necessary correctional staff should be radically different going forward than it was at the time of the court's understaffing order. While the system's in-house population has fallen somewhat since that time, nearly all of the decrease is due to the dramatic drop-off of admissions starting in April 2020 as the COVID-19 pandemic took hold. Compare Pls. Ex. 4033 at 3, with Joint Stipulation (Doc. 3288) at 2. Those un-admitted people did not simply disappear; as the parties' joint evidentiary stipulation shows, the decline in admissions has been accompanied by a sustained, coordinate rise in what ADOC terms "County Jail Population: On-The-Way." Joint Stipulation (Doc. 3288) at 2. When those inmates arrive, the correctional staffing needs of ADOC will only increase.

Right now, the lack of correctional staff continues to have profound consequences for the safety of prisoners incarcerated in the ADOC system. Tommy McConathy was raped in the Bullock RTU, where duty post logs show that the entire dormitory was at times staffed by a single correctional cubicle officer in the control room and no one on the dormitory floor. See Pls. Ex. 3403 at ADOC558777; May 28, 2021, R.D. Trial Tr. at 157-58. Charles Braggs's records indicated that he was offered out-of-cell exercise time on only four days in the six months he spent in segregation before his death, and the entries in his file frequently note staff shortages as the reason

why his required out-of-cell exercise time was cancelled. See Pls. Ex. 3921 at ADOC517730-58. Representative duty post logs from St. Clair showed multiple restrictive housing units staffed with a single officer in the control room and no one on the unit floor. See Pls. Ex. 4269 at ADOC588534. Because two officers are required to take an inmate out of his cell, Savage testified that she "honestly d[id] not know" how ADOC could get any of the prisoners on those units out if needed in the case of a mental-health emergency. June 16, 2021, R.D. Trial Tr. at 195. Audits of ADOC's restrictive housing units routinely found compliance levels with the required 30-minute security checks below 20 %; the extraordinary degree to which non-compliance with this requirement puts inmates at risk was illustrated by the case of Casey Murpree, who was not found for hours after his death, after rigor mortis had set in.

Moreover, a candid March 2020 letter from Wexford to ADOC's then-Associate Commissioner of Health Services explained how continued, extreme correctional understaffing undermines the adequacy of mental-health care in ADOC facilities across the board. The absence of correctional staff and the resulting violence and stress among ADOC inmates resulted in decompensation and suicidality, leading to skyrocketing demand for suicide watch--more than 4,000 % above the suicide watch hours anticipated in Wexford's contract. See Pls. Ex. 3323 at 1-2. As a result, Wexford has had to divert its mental-health resources *en masse* to suicide watch, yielding a system of crisis response in lieu of mental-health care. See *id.* In Wexford's words:

"No one disputes that the ADOC has a *severe shortage of Correctional Officers* (COs), as documented in an April 2019 US Department of Justice report as well as in multiple quotes from ADOC staff to the media. Furthermore, no one disputes that this lack of security presence is a major contributing factor to the *ongoing and*

^{Part of the cited language}
 excessively high levels of contraband, inmate drug use, and inmate-on-inmate violence the ADOC has experienced over the past several years.

"With many prison units lacking COs to protect against aggressive and/or predatory troublemakers, many inmates are afraid for their lives, resulting in *unprecedented levels of stress, anxiety, and panic disorders among the ADOC inmate population*. In many cases, the hostile prison conditions lead inmates to suicidal thoughts or acts. This has greatly increased the number of patients Wexford Health must place on suicide watch: fewer security staff enables greater violence; which increases fear and suicidal thinking; which increases the need for suicide watch hours. The dramatic increase in suicide watch volume has left us with no choice but to *replace the performance of routine mental health* ¹²²⁷*tasks*—which comprise a large ^{*1227} part of the audits—with *providing crisis-level services*, to ensure the safety of our patients."

Id. at 2 (emphasis in original).

Taken as a whole, the evidence presented at the omnibus remedial hearings reflected a beleaguered and dysfunctional system where still-egregious correctional staffing deficiencies make providing constitutionally adequate mental-health care impossible. In light of this evidence, the court finds that continued correctional understaffing in all ADOC facilities except the Hamilton Aged and Infirm Center and Tutwiler prison for women places mentally ill inmates in ADOC custody at substantial risk of serious harm, including decompensation, victimization, self-injury, and death.¹⁰

¹⁰ Because of the nearly unchanged severity of ADOC's correctional understaffing and the degree to which it continues to "permeate" the entirety of the department's mental-health care system, *Braggs*, 257 F. Supp. 3d at 1268, this understaffing creates a substantial risk of serious harm regardless of any other continued

deficiencies. However, as will be discussed below, the correctional understaffing is exacerbated by ongoing problems in many of the other areas in which the court has previously found liability.

2. Mental-Health Staffing

In contrast to its minimal efforts to increase correctional staffing, ADOC has made significant, albeit incomplete, progress toward increasing mental-health staffing in ADOC facilities to constitutionally acceptable levels.

In its 2017 liability opinion, the court surveyed levels of mental-health staffing across ADOC disciplines and facilities and found them "chronically insufficient." *Braggs*, 257 F. Supp. 3d at 1194. ADOC's prisoner population had become more mentally ill over the preceding decade, "both in terms of the number of individuals who need[ed] mental-health care and in terms of the acuity of mental-health care needs." *Id.* at 1194. Yet ADOC had hired fewer and fewer mental-health providers—far fewer than it was authorized to hire under its contract with its mental-health vendor. *Id.* at 1194–95. The resulting understaffing caused "a plethora of issues, including insufficient identification of mental illness at intake and referrals; missed counseling appointments and group sessions; and inadequate monitoring of prisoners in mental-health crises." *Id.* at 1197.

To remedy those issues, the defendants proposed a plan with short-run and long-run components. *See* Phase 2A Understaffing Remedial Opinion (Doc. 1656) at 17–18. The short-run component called for ADOC, in the course of slightly more than a year, to double the number of psychiatrists, psychologists, certified nurse practitioners, licensed mental-health professionals and registered nurses employed at ADOC facilities. *Id.* at 18–20. In addition, the defendants proposed that ADOC must fill certain existing positions in its Office of Health Services (OHS)—the ADOC

department responsible for monitoring the provision of mental-health care--and create and fill others. *Id.* at 23–27.

The long-run component of the defendants' plan called for ADOC to employ a team of three mental-health consultants to develop ratios for determining the number of mental-health staff of various types needed per inmate. The defendants proposed to apply those ratios to ADOC caseload numbers, and thereby determine an appropriate number of mental-health staff for each facility and discipline. *Id.* at 20–22. ADOC would then modify its contract with its mental-health vendor to provide the recommended number of staff.

The court found the defendants' proposed plan "minimally adequate" to remedy the constitutional violations identified in its 2017 liability opinion, and ordered its ¹²²⁸ adoption, with slight modifications. Phase 2A Understaffing Remedial Opinion (Doc. 1656) at 1; Phase 2A Understaffing Remedial Order (Doc. 1657) at 1. The court supported this order with PLRA findings. *See* Phase 2A Understaffing Remedial Opinion (Doc. 1656) at 33-37.

To implement the short-run component of the defendants' plan, the court ordered ADOC to hire, by July 1, 2018, the full number of mental-health professionals available to it under its then-existing contract with its mental-health vendor. *See* Phase 2A Understaffing Remedial Order (Doc. 1657) at 4. The court also ordered ADOC to fill the positions of Clinical Director of Psychiatry and Ombudsman in the ADOC Office of Health Services, and to create and fill the positions of Director of Mental Health Services and Southern Regional Psychologist. *See id.* at 6–7.

To implement the long-run component of the defendants' plan, the court ordered ADOC to meet a series of deadlines. First, it ordered the defendants' mental-health consultants--Catherine Knox, Jeffrey L. Metzner, and Mary Perrien--to begin to develop mental-health staffing ratios by September 1, 2018. *See id.* at 4-5. Second, it

ordered that the defendants' consultants submit finalized mental-health staffing ratios to the defendants to be filed with the court by March 4, 2019. *See id.* at 5. Third, it ordered that ADOC modify its contract with its mental-health vendor to provide the positions required by the staffing ratios by August 15, 2019. *See id.* Fourth, it ordered that the defendants' consultants review implementation of the staffing ratios and make recommendations, if necessary, for revising them, by January 15, 2020. *See id.* at 5–6. Finally, it ordered that ADOC's mental-health vendor fill the mental-health staffing positions consistent with the contract by February 15, 2020. *See id.* at 6.

In the months following the entrance of the court's Phase 2A Understaffing Remedial Order, ADOC seemed to the plaintiffs to be dragging its feet, and in July, 2018, the plaintiffs moved to hold the defendants in contempt, alleging that ADOC had failed to meet certain deadlines imposed by the understaffing order, and that it had withheld data concerning its compliance. *See* Pls. First Notice of Non-Compliance and Motion for Order to Show Cause Why Defendants Should Not be Held in Contempt (Doc. 1916). The defendants opposed the motion, *see* Defs. Response in Opposition (Doc. 1936), and after a series of hearings on the nature of ADOC's obligations regarding mental-health staffing, the parties agreed to resolve their dispute by stipulating to various modifications of the court's Phase 2A Understaffing Remedial Order, *see* Amended Stipulations Regarding Mental Health Staffing (Doc. 2283-1). Under the parties' stipulations, which the court entered as an enforceable order, *see* Order (Doc. 2301), ADOC agreed to provide mental-health staffing consistent with certain minimum staffing requirements until such time as its consultants finalized their staffing ratios, and to submit quarterly staffing reports to the court and monthly reports to the plaintiffs.

ADOC proceeded to make significant progress. Its consultants completed their recommended mental-health staffing ratios in February, 2019, *see* Recommended Staffing Ratios for Mental Health

Services (Doc. 2385-1), and in September of the same year the parties jointly filed a mental-health staffing matrix, based on those staffing ratios, specifying the number of full-time-equivalent staff to be hired at each ADOC facility, *see* Mental-Health Staffing Matrix (Doc. 2618-1). The court approved that staffing matrix in December 2019, together with stipulations by the parties regarding the manner in which ADOC was to comply with its consultants' recommendations, ¹¹ and incorporated the staffing matrix and stipulations into an enforceable order. *See* Phase 2A Order and Injunction on Mental-Health Staffing Remedy (Doc. 2688). ADOC then modified its contract with Wexford to hire mental-health staff according to those stipulations and the staffing matrix. *See* P-3321. Those modifications went into effect on October 1, 2020. *See id.* at ADOC528698.

Since then, ADOC has hired a significant number of new mental-health staff. While ADOC has yet to meet the targets set forth in the December 2019 staffing matrix, its consultant, Dr. Metzner, testified that several ADOC facilities have sufficient mental-health staff to provide a constitutionally permissible level of care to their current inmate populations, including Easterling Correctional Facility, Fountain Correctional Facility, Holman Correctional Facility, Kilby Correctional Facility, and Limestone Correctional Facility, *see* June 30, 2021, R.D. Trial Tr. at 123–32, and that certain positions at St. Clair Correctional Facility and Staton Elmore Correctional Facility are adequately staffed, *id.* at 141–42.¹¹

¹¹ Dr. Metzner later testified that he misread a staffing chart prepared by Wexford and overestimated the extent to which the ADOC facilities were staffed by up to 15%. *See* July 1, 2021, R.D. Trial Tr. at 7; July 5, 2021, R.D. Trial Tr. at 65–66. Still, the court does not question that ADOC has made great progress in staffing at the facilities that Dr. Metzner identified.

Nevertheless, while change has come faster in this area than others, its pace has been slower than ordered, and serious deficiencies in mental-health staffing remain. The court's 2018 remedial staffing order set a deadline of August 15, 2019, for ADOC to modify its contract with its mental-health vendor to provide the positions required by the staffing matrix. ADOC failed to meet that deadline, and it has not caught up. Its consultants have not revised their ratios, as they were required to do by January 15, 2020. And although ADOC has made encouraging progress at some facilities, no facility is in complete compliance with the court's 2018 remedial staffing order and the parties' staffing matrix. In fact, according to the most recent staffing report in the record, at only seven of its facilities has ADOC staffed even a single type of position in accordance with the requirements of the staffing matrix. *See* Quarterly Mental-Health Staffing Report (Doc. 3227-1) at 3–4 (reporting that ADOC has fully staffed the positions of mental-health observer, at Bibb Correctional Facility; mental-health observer, at Bullock Correctional Facility; mental-health observer, at Donaldson Correctional Facility; mental-health licensed nurse practitioner, at Fountain Correctional Facility; mental-health observer, at Holman Correctional Facility; mental-health licensed nurse practitioner, at Kilby Correctional Facility; and mental-health observer, at Limestone Correctional Facility at the levels provided in the staffing matrix.). At no facility has it staffed more than one type of position in accordance with the requirements of the staffing matrix. *See id.*

That several ADOC facilities may have enough mental-health staff to serve their current populations is an encouraging development, but not necessarily a permanent one. In response to the COVID-19 pandemic, ADOC largely stopped conducting intake from local jails, and, as a result, its inmate population has fallen below the levels that the staffing matrix was designed to accommodate. *See, e.g.*, June 30, 2021, R.D. Trial

Tr. at 122 (testimony of Dr. Metzner, estimating that ADOC's caseload has decreased by 3,000 inmates due to COVID-19). Both parties agree that, when the pandemic abates, ADOC will likely see a substantial and rapid increase in its inmate population. See Joint Stipulation For Evidentiary Hearing (Doc. 3288) at 2; Pls. Dem. Ex. 236; Pls. Exs. 3224-3232; June 30, 2021, R.D. Trial Tr. at 111 (testimony of Dr. Metzner); July 5, 2021, R.D. Trial Tr. at 76 (testimony of Dr. Metzner). It remains to be seen whether the ADOC facilities that are sufficiently staffed today will stay that way, or whether the requirements of the staffing matrix--which ADOC has not met--are accurate indicators of the quantity of staff needed to provide a constitutionally permissible standard of care once intake from local jails resumes.

More troubling still, ADOC's shortage of correctional staff calls into question the adequacy of mental-health staffing even in those facilities where ADOC has made the most progress. Dr. Metzner based his testimony that certain ADOC facilities have sufficient mental-health staff to serve their current populations on the mental-health staffing ratios; given the number of mental-health staff employed at each facility, he used the ratios to determine the maximum number of inmates those staff could treat. At certain facilities with lower-than-predicted inmate populations, the ratios projected current staffing levels to be adequate. The ratios, however, are based on a set of assumptions, including the assumption that "[t]here will be adequate correctional staffing." See Doc. 2385-1 at 2. Unfortunately, that assumption has proven false and is projected to remain false for years. ADOC has failed to provide adequate correctional staffing, and that failure has had a direct impact on the ability of mental-health staff to treat inmates efficiently. As explained above, extreme correctional understaffing has prevented mental-health staff from treating inmates simply because there are insufficient correctional staff to escort inmates to and from their cells. See *supra* at 73-76; Pls. Ex. 3310 at ADOC546882; May 25,

2021, R.D. Trial Tr. at 140-44; Pls. Ex. 3347 at ADOC553738. It has also resulted in a proliferation of violence, causing a massive increase in suicide watch hours that has required mental-health staff to "replace the performance of routine mental health tasks ... with providing crisis-level services." *Supra* at 76 (quoting Pls. Ex. 3323 at 2). It is therefore almost certain that mental-health staff are unable to treat inmates as efficiently as the staffing ratios assume, and it is likely that more mental-health staff are currently needed even in those facilities where the defendants have made the most progress.

3. Restrictive Housing

The court discussed above and will discuss in more detail below the current risks to inmates in ADOC's restrictive housing units that are the direct result of the system's ongoing dearth of correctional officers. These problems include, for instance, insufficient out-of-cell time and the inadequate provision of the 30-minute security checks necessary to interrupt decompensation and suicide. The court will not further elaborate those problems here. Instead, it notes several additional, serious problems with the mental-health care provided to inmates in ADOC's restrictive housing units that are discussed less elsewhere in this opinion.

First, ADOC continues to lack a functioning process for diverting individuals from segregation who are contraindicated for placement there due to suicide risk, serious mental illness, or other significant mental-health issues. Part of this is due to the deficiencies in the disciplinary process discussed above, which should help prevent inmates who are clinically contraindicated for segregation from receiving segregation sentences. But the pre-placement screening process also is intended to divert inmates from segregation when necessary, and it, too, fails almost categorically to do so. In other words, if ADOC's mental-health care system were functioning adequately, there would at least two layers of protection (the

disciplinary process and the pre-placement screening process) to prevent inmates with serious mental illnesses from being placed in segregation for disciplinary reasons, and one layer of protection (the pre-placement screening process) to prevent inmates with serious mental illnesses from being placed in segregation for non-disciplinary reasons. But neither works in practice, and suicidal inmates and those with serious mental illness are routinely placed in segregation as a result.

ADOC has improved its practice of conducting pre-placement screenings for prisoners entering segregation to assess them for contraindications to restrictive housing, although there is some evidence that these screenings too often miss contraindications. Dr. Burns, for instance, testified about her review of the records of an inmate the parties called D.R., who received pre-placement screenings that "continually said there were no contraindications for [restrictive housing unit] placement, even though he was a person with a serious mental illness." May 25, 2021, R.D. Trial Tr. at 87.

More troubling is that, as of the time of the liability trial, ADOC staff regularly ignore the results of pre-placement screenings. Laramie Avery and Casey Murphree both were flagged in pre-placement screenings as clinically contraindicated for segregation due to mental-health concerns. See Pls.' Ex. 3302 at 518578; Pls.' Ex. 3280 at ADOC518064. Both were placed in restrictive housing anyway, and both died there, Murphree within a day of his arrival. Two mental-health staff members told correctional officers that another inmate referred to as A.J. should not be placed in segregation because of his mental-health; they eventually had to refer him for suicide watch even though he did not need it because the captain with whom they were communicating said he was going to place A.J. in segregation anyway. See May 25, 2021, R.D. Trial Tr. at 27.

Although the court found in the liability opinion that "it is categorically inappropriate to place prisoners with serious mental illness in segregation absent extenuating circumstances," *Braggs*, 257 F. Supp. 3d at 1247, ADOC has never developed a working definition of these "extenuating circumstances"--often now called "exceptional circumstances." See July 1, 2021, R.D. Trial Tr. at 225-26, 233. Under ADOC policy and the orders of this court, inmates coming directly from suicide watch also cannot be placed in restrictive housing in the absence of exceptional circumstances due to the risk that the conditions of isolation may cause them to relapse into suicidality. But with no definition in place, ADOC instead sends these prisoners to segregation, as one provider put it, as "a matter of course." Pls. Ex. 3320 at 1, obtaining pro forma authorizations in minutes with no evidence that alternative placements were considered or that the circumstances were exceptional under any plausible definition of the term.

Within the restrictive housing units, the provision of mental-health rounds has become more consistent. Although Charles Braggs received no weekly mental-health rounds for more than two months before his death, recent audits of almost all of the major facilities show significant compliance with these rounds. See Pls.' Ex. 3255 (Bibb); Pls.' Ex. 3258 (Bullock); Pls.' Ex. 3264 (Easterling); Pls.' Ex. 3269 (Fountain); Pls.' Ex. 3270 (Kilby); Pls.' Ex. 3272 (Limestone); Pls.' Ex. 3276 (St. Clair); Pls.' Ex. 3318 (Tutwiler); Pls. Ex. 3320 (Ventress). This is a recent improvement in many cases, but it is a commendable one.

Periodic mental-health assessments, on the other hand, continue to be conducted¹²³² sporadically if at all, particularly for inmates who are not on the mental-health caseload. Braggs received only two assessments in the two years he had been in his segregation cell at St. Clair before he died. Gary Campbell lived in restrictive housing for nearly three years without a single periodic assessment. When these assessments or other

contacts lead to mental-health referrals, mental-health staff often fail to follow up on them appropriately. Laramie Avery received two referrals in the weeks before his death and was not seen. Jaquel Alexander received an urgent referral the day before he died, and the mental-health provider was not notified of the referral for 12 hours. Casey Murphree received an emergent referral less than 24 hours before his death--the most acute referral level possible, which requires that the inmate be seen within three hours. He was not seen for the referral before he died. As a result of the failure to follow up on referrals appropriately, inmates who are psychologically deteriorating in segregation are missed, do not receive the mental-health treatment they need, and too often decompensate to the point of self-harm and suicidality. Combined with the dearth of correctional staff, these conditions continue to make ADOC's segregation units dangerous for inmates with mental-health needs housed in them.

4. Intake

The court recognizes the hard work ADOC has put into improving the intake process and ensuring that every inmate receives a mental-health screening upon entering ADOC custody. The parties agree that ADOC has completely overhauled its intake process since the time of the liability opinion, and the evidence is clear that every inmate who enters the system is currently receiving this screening. Moreover, the rate of identified mental illness in ADOC facilities has increased, and it now falls within the expected range for both male and female prison populations. This is an encouraging turnaround from the low rates found during the liability trial.

While ADOC has made admirable improvements to intake generally, there are nevertheless issues remaining that require current relief. As Dr. Burns noted, ADOC's own mental-health care provider recommended a variety of changes to the intake process in response to failures identified during reviews of inmate suicides. In particular, ADOC

seems to have struggled to document and follow up on the results of the intake screening. For example, the psychological autopsy Wexford conducted after Laramie Avery committed suicide noted that, while inmates were receiving psychological testing during intake, "there is no interpretation of the results and it's not incorporated into the inmate's treatment during his incarceration." June 2, 2021, R.D. Trial Tr. at 108. After Charles Briggs committed suicide months later, Wexford reiterated that recommendation, writing that, "Psychological Assessments are highly recommended to be interpreted at intake and assessed for any potential risk factors or indicators the inmate may experience an underlying mental health problem that needs further evaluation by a mental health provider." Charles Briggs Psychological Autopsy (P-3284) at ADOC539024. Dr. Burns also noted these issues, expressing her concern that, "although the tests were administered, the results were not being interpreted and used in the treatment of the patients." June 7, 2021, R.D. Trial Tr. at 107.

Nor has the department consistently made an effort to ensure that all of an inmate's previous mental-health records, which may contain important information to facilitate the inmate's treatment, are received and assessed so that providers can accurately determine who is in need of care and what care is needed. This makes it ¹²³³more likely that prisoners who should be ^{*1233} on the caseload will be missed and that providers will make treatment decisions without access to information about an inmate's mental-health history that may be vital to identify the inmate's current mental-health needs. This problem was realized in the treatment of Marquell Underwood. In the course of a routine referral soon after his intake screening, Underwood stated that he had been treated for bipolar disorder prior to his incarceration and reported "an increase in mood swings, including depression and irritability." May 24, 2021, R.D. Trial Tr. at 56. In response, his records were not requested and he was not placed

on the mental-health caseload. *Id.* at 56-57. Roughly 18 months later, he committed suicide, without ever having been placed on the mental-health caseload. In his psychological autopsy, Wexford noted its failure to request documents that may have been relevant for his treatment, recommending that in the future there be "[i]mproved continuity of care ... between county jail and ADOC for any mental health patients or inmates who may have presented with suicidal ideations or self-harming prior to transport." Marquell Underwood Psychological Autopsy (P-3316) at ADOC518596.

Also a concern is ADOC's continued reliance on unsupervised LPNs to help conduct the intake screenings. The court found in the liability opinion that LPNs lacked adequate training and medical knowledge to conduct intake and that utilizing them in that role contributed to ADOC's under-identification of prisoners with mental illness. However, Dr. Burns testified that she had seen LPNs continue to conduct intake screenings even after the liability trial. *See* June 2, 2021, R.D. Trial Tr. at 206. While these LPNs were supposed to be supervised by RNs, Dr. Burns noted that for some of the records she reviewed, it appeared that the RN had signed off on the screening before it was even completed. *Id.*

While it is admirable that ADOC now appears to be conducting intake for all inmates, that alone is not enough. The department's continued failure to adequately track, interpret, and follow up on the results of the intake screening contributes to the same inability to identify inmates noted in the liability opinion, leaving them without the care they need.

5. Coding

It is clear that ADOC has made enormous progress in improving its coding system since the time of the liability opinion. Experts from both sides agreed that ADOC had completely replaced its old number-based system and that all inmates were now receiving the new codes—indeed, the parties

themselves stipulated to this. *See* Joint Stipulation for the Evidentiary Hearing Regarding the Phase 2A Remedial Order (Doc. 3288) at 8; *see also* note 2, *supra*. ADOC also created an SMI designation flag for the first time, and both parties agree that the flag is being used for inmates. It is clear that the department has invested significant resources in creating and implementing this new system, and the court notes with approval the improvements in identifying and tracking inmates that have resulted.

However, the plaintiffs provided extensive evidence that the documentation of codes and SMI flags is inconsistent at best, which creates an opportunity for inmates to fall through the cracks. Dr. Burns credibly testified that she had found inconsistent documentation in her review of inmates' charts, including charts that continued to reflect outdated codes, *see* June 8, 2021, R.D. Trial Tr. at 29, coding that included "not applicable" notations, *see* June 2, 2021, R.D. Trial Tr. at 205-06, and forms that failed to include inmates' SMI designations, *see* May 24, 2021, R.D. Trial Tr. at 70; May 25, 2021, R.D. Trial Tr. 1234 at 33; *id.* at 42. Indeed, on one form ¹²³⁴ she reviewed, "both yes and no [were] circled for SMI," making it impossible to tell what the provider intended to communicate. June 9, 2021, R.D. Trial Tr. at 32. ADOC's internal audit of its mental-health provider indicated an ongoing problem with codes on the Master Problem List not matching codes listed on other documents or in the Office of Health Services database. *See* June 10, 2021, R.D. Trial Tr. at 113. As Dr. Burns testified, without accurate and consistent documentation of inmates' mental-health codes, it is difficult for providers to "know where the mental-health caseload is, who needs what sorts of services," or which inmates might need special attention. June 2, 2021, R.D. Trial Tr. at 229-30.

The court also finds that providers in ADOC are not always coding inmates appropriately to their needs. Dr. Burns presented extensive testimony about the failure of providers to add inmates to the

mental-health caseload or increase their codes even in the face of overwhelming evidence that they were in crisis. For example, Laramie Avery was referred to mental-health several times before his suicide, but he was never added to the mental-health caseload. *See* May 24, 2021, R.D. Trial Tr. at 50. Marquell Underwood bounced back and forth between restrictive housing and suicide watch and reported a history of bipolar disorder, but he too was never placed on the caseload before his suicide. *See id.* at 57. Jaquel Alexander was not added to the caseload until after the "fifth or [sixth] time" he was placed on suicide watch, *id.* at 68, and inmate M.H. was actually downcoded from MH-D to MH-B despite the fact that he had had several recent incidents in which he cut himself and was placed on watch, *see* May 25, 2021, R.D. Trial Tr. at 45. Wexford flagged these failures as an issue in several separate psychological autopsies, but there is no evidence that any action was ever taken to improve the coding process and ensure that inmates were receiving the appropriate codes. *See* May 24, 2021, R.D. Trial Tr. at 61, 70.

Dr. Burns also pointed to several incidents in which providers made decisions about an inmate's mental-health code based on inappropriate factors. For example, Marco Tolbert was downcoded from MH-D to MH-C simply because he asked for it, despite the fact that he appeared disheveled and depressed. *See id.* at 19. Casey Murphree also successfully sought to be downcoded because he thought that it would help him get a job, even though he gave vague responses to questioning about auditory hallucinations and the provider had records showing that he was not fully compliant with his medications. *See id.* at 74. Dr. Burns testified that ability to get a job is not an appropriate clinical factor to consider in determining an inmate's mental-health status and that she saw no evidence that the team had discussed any proper factors before Murphree was downcoded. *See id.* at 74-75. There were similar issues with the SMI flags. Dr. Burns identified a

few inmates with categorial SMIs, a designation that is based on the type of mental illness a person is suffering from and which one "would not expect to be discontinued," but the flags would disappear without explanation. *See id.* at 173-77; May 25, 2021, R.D. Trial Tr. at 35-36; *id.* at 40. These failures seriously call into question ADOC's ability to accurately identify, label, and track inmates' mental-health needs, even despite the department's overhaul of its coding system.

6. Referral

Referrals are the key means by which inmates who are not on the caseload or who need additional care are flagged for further evaluation by mental-health professionals. As experts for both parties reported, inmates depend on referrals to get care--"[i]t's not like they can pick up the phone and make an appointment with somebody" themselves. June 3, 2021, R.D. Trial Tr. at 18. Referrals may be made by prison staff or by the inmates themselves, and ADOC has adopted regulations that lay out the process by which both groups may make a referral. Evidence presented at the omnibus remedial hearings included several referrals made by both groups, indicating that they are aware of and actively using the referral system. While there is some evidence that this process is not always used by inmates--Briggs, for example, had been asking for mental-health services for two weeks before his suicide, according to the inmate in the cell next to his, *see* May 24, 2021, R.D. Trial Tr. at 119-20--it is encouraging that ADOC has created a process that both inmates and staff feel comfortable using as a means to request needed care.

At the time of the liability opinion, ADOC did not have a system to triage and identify the urgency of each referral, which is vital to ensuring that requests are met in a timely fashion and to avoid unnecessary delays in the provision of care. Since that time, however, ADOC has made impressive progress in developing a triage process and implementing it throughout the prison system.

Most of the referrals viewed during the omnibus remedial hearings had been triaged by a mental-health staff member in a timely fashion, which is a major improvement for a system that lacked any sort of triage process only a few years ago. ADOC has made real, important progress, and the court is confident that the department will continue its commitment to ensuring that triage is completed quickly and thoroughly so that inmates can receive the treatment they need. While ADOC has done an admirable job in ensuring that referrals can be made, the system falls apart at the follow-up stage. Over the course of the omnibus remedial hearings, the court received evidence of numerous troubling incidents in which referrals were made but inmates did not receive care within the required timeframes, if at all. In some instances, referrals were not received in a timely fashion. *See* May 25, 2021, R.D. Trial Tr. at 53-54 (noting late receipt of referrals made for inmate T.M.); June 2, 2021, R.D. Trial Tr. at 100 (explaining that there were seven days between when a referral for Marquell Underwood was made and when it was received). In other cases, it was unclear whether there was a documentation error or a failure to provide care. Dr. Burns testified that there were "multiple episodes in which the referral forms ... don't show if there was a mental-health follow-up" at all, leaving her uncertain about whether it had occurred. May 26, 2021, R.D. Trial Tr. at 17. In the vast majority of cases, however, the problem was that mental-health staff did not timely respond to the referrals, leaving the inmates waiting--sometimes for months--on care.

During the triage process, referrals are separated into three categories, each of which requires a different level of urgency of response. The evidence presented at the omnibus remedial hearings indicates that in practice, the categories mean little.

Emergent referrals indicate, as Dr. Burns explained, that "the nurse has determined there's an imminent risk of injury or some otherwise necessary and immediate need for mental-health

services." June 3, 2021, R.D. Trial Tr. at 25. According to the defendants' expert, the common requirement in corrections is that these types of referrals should be responded to within four hours. *See* June 29, 2021, R.D. Trial Tr. at 221. However, inmate R.J. was not seen for three days after he received an emergent referral because mental-health staff were told that there was no security to bring him out for the assessment. In the interim, ¹²³⁶he was not put on ^{*1236} watch, nor is there any indication that mental-health staff attempted to go see him. *See* May 25, 2021, R.D. Trial Tr. at 118-20.

Urgent referrals indicate that "there is an urgent need, like an urgent care center type need." June 3, 2021, R.D. Trial Tr. at 26. Dr. Burns testified that such a need "doesn't have to be responded to instantly, as in the immediate, or as soon as possible, like an emergency need, but it does need to be responded to ... within 24 hours." *Id.* In ADOC, though, inmate T.M. did not receive an assessment for three weeks after he set himself on fire and received an urgent referral. *See* May 25, 2021, R.D. Trial Tr. at 52.

Routine referrals are made "for some nonemergency purpose," and Dr. Burns stated that mental-health staff should have 14 days to respond. June 3, 2021, R.D. Trial Tr. at 26. But frequently the timeframes were much longer. Inmate A.J. was referred on February 28, 2020, but he was not seen until May of that year. *See* May 25, 2021, R.D. Trial Tr. at 27. Inmate W.S. received an assessment by an MHP within two weeks, but that assessment resulted in a referral to the CRNP that was not followed up on for two more months. *Id.* at 178. And at times, ADOC staff failed to respond at all. For example, Laramie Avery received no response to either of the routine referrals that were made in the weeks before his suicide. *See* May 24, 2021, R.D. Trial Tr. at 45-47. Repeated efforts to access care seemed to do nothing to speed up the process. Inmate K.W. had five referrals in less than a month, two of which were urgent, but there were still 22 days between

the first referral and when he was seen, longer than would be acceptable under any time frame. See June 10, 2021, R.D. Trial Tr. at 12, 17.

ADOC itself found low compliance scores with the response timeframes for all three levels during its internal audits. Despite the department's awareness of the problem, however, there is no evidence that ADOC has made progress in avoiding delays and ensuring that referrals are addressed within a reasonable period.

As Dr. Burns testified, these failures to respond are a "red flag" about the state of ADOC's referral system. May 26, 2021, R.D. Trial Tr. at 95. The point of a referral is to get an inmate the care they need in the timeframe in which they need it. Delayed or inadequate follow-up undermines the efficacy of the entire referral process. Indeed, without follow-up, referrals are essentially useless, and referrers are doing nothing more than shouting into the void. And failure to ensure that inmates are seen can have tragic, irreversible consequences. When mental-health staff did not respond to the emergent referral for Casey Murphree on the day it was made, he did not receive any care until "he was found hanging" approximately 20 hours later. May 24, 2021, R.D. Trial Tr. at 76-77.

7. Confidentiality

Confidentiality is, as the court found in its liability opinion and Dr. Burns testified during the omnibus remedial hearing, an "absolutely necessary condition" for the adequate provision of mental-health care. June 3, 2021, R.D. Trial Tr. at 14. Inmates must feel safe enough to speak freely with mental-health staff and disclose personal, sensitive information that is relevant to their treatment. Confidentiality is particularly vital in the prison setting, where inmates may "become vulnerable later to some taunting or blackmail or extortion" if staff or other inmates can overhear their sessions with mental-health staff. *Id.* However, evidence from the omnibus remedial hearings indicated that the department still

struggles to provide confidential spaces for treatment and to ensure that treatment consistently occurs in a confidential setting.

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It would not be fair to ADOC to say that inmates never receive confidential mental-health services. In fact, the court was encouraged to note that many of the sessions discussed during the trial occurred in out-of-cell, confidential settings. However, given the importance of confidentiality to effective mental-health treatment, the court remains concerned about the number of instances of non-confidential sessions raised during the hearing. As Dr. Burns testified, some facilities have extensive confidential treatment space close to where inmates are housed, which is useful for holding sessions with inmates. See, e.g., May 25, 2021, R.D. Trial Tr. at 155 (describing the confidential area at St. Clair); June 7, 2021, R.D. Trial Tr. at 65 (describing the confidential treatment space in Bullock). However, out-of-cell spaces are not always used in ways that maintains confidentiality. Dr. Burns discussed several inmates whose sessions were interrupted, destroying confidentiality. For example, inmate DR was seen in an office, but "people were in and out of the office," making it difficult for him to talk openly with his counselor. May 25, 2021, R.D. Trial Tr. at 88. And inmate A.E. reported that, because he saw his counselor at the same time that he saw the doctor, he had not had a confidential, one-on-one session in years. See *id.* at 90.

Several progress notes described sessions held in what were referred to as "semi-confidential" settings, where the participants were in a setting where they could be overheard but were directed to speak quietly to maintain privacy. Tommy McConathy received crisis counseling "behind a screen" where he and the provider simply talked "with low voices." *Id.* at 6. Progress notes for inmate A.J. indicate that he was seen for treatment in spaces where he and his mental-health provider

had to ^{part of the same hearing} speak] quietly to ensure confidentiality." *Id.* at 26-27. This does not actually ensure confidentiality, and it is not sufficient to meet the court's directive. As Dr. Burns explained, it is not appropriate to think of confidentiality as "partial or semi. It's either all or none." May 24, 2021, R.D. Trial Tr. at 156-57. And it is particularly vital that ADOC make every effort to provide confidentiality for treatment sessions given the tragic consequences that can result when inmates do not receive effective treatment. The court reiterated the importance of confidentiality during the suicide prevention hearing, and Dr. Burns noted that she had seen the issue of confidentiality arise in a number of recent suicides and serious suicide attempts. *See id.*

Nor is it appropriate for ADOC to give up on providing confidential treatment to inmates who are hesitant or unwilling to leave their cells. Several of the instances of non-confidential sessions involved inmates who refused to come out of their cells, which the court acknowledges can be difficult for staff to address. For example, Gary Campbell repeatedly refused to come out of his cell for sessions and had only cell-side interactions with mental-health staff in the months before his suicide. *See* May 24, 2021, R.D. Trial Tr. at 128-29. However, the responsibility to get inmates the care they need, even in the face of their noncompliance, rests with ADOC. Dr. Burns convincingly testified that there was more that the staff could have done to try to ensure confidentiality, including coming back on another day or asking a higher-ranking staff member to make the request. *See id.* at 131-33. As ADOC's own regional psychologist noted in reflecting on Campbell's suicide, he remained in his restrictive housing unit cell for two years "because he was allowed to ... That was stressful and he was not even aware that talking to someone could have been helpful." Email from Nina Tocci Regarding Gary Campbell's Suicide, P-3267 at 1.

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The court is also troubled by the impact understaffing continues to have on the provision of confidentiality. Even in facilities with confidential treatment spaces, out-of-cell interactions require sufficient staff to escort inmates to their sessions and stand watch to address any safety issues. When there are not enough staff to transport and monitor inmates, mental-health staff are forced to go to the inmates and hold sessions cell-side, which are not at all confidential. There were a number of instances discussed during the omnibus remedial hearings in which inmates were not being removed from their cells for counseling sessions. Inmate M.W. received "many cell-side contacts" during his stay in the Bullock SU, May 25, 2021, R.D. Trial Tr. at 40, and inmate A.C. reported that he was not offered any confidential treatment while in the same unit, but that "the counselor came to the door to see him a couple of times a week," June 2, 2021, R.D. Trial Tr. at 69. Inmates that Dr. Burns spoke to at St. Clair reported that they were not always removed from their cells for counseling sessions. *See* June 7, 2021, R.D. Trial Tr. at 86. And inmate Danny Tucker received a follow-up session after he was released from suicide watch that was held cell-side, just hours before he committed suicide in that same cell. *See* June 24, 2021, R.D. Trial Tr. at 16.

ADOC's own audits highlighted the problems with confidentiality at many facilities. Though Dr. Burns described some of the issues with the audits, including small sample sizes, the court is still concerned that the results, taken as a whole, show an overwhelming failure to provide treatment in confidential spaces. Multiple facilities received compliance scores below 50 % on confidentiality, including Bibb, Easterling, Donaldson, and Limestone. *See* Bibb Audit Report (P-3256) at 5 (scoring 30.77 % compliance with confidentiality); Easterling Audit Report (P-3266) at 5-6 (26.09 %); Donaldson Audit Report (P-3263) at 6-7 (22.54 %); Limestone Audit Report (P-3273) at 6 (14.81 %). No facility scored above

70% on the audit. Even accounting for the flaws in the audits, these numbers are troubling, and they indicate a widespread and ongoing issue with ensuring confidential treatment for inmates.

8. Treatment Teams and Plans

Since the court found in the liability opinion that ADOC's treatment planning process was inadequate and resulted in incomplete, generalized, or nonexistent plans, the department has made encouraging progress. Neither the plaintiffs' expert nor the defendants' expert could identify an inmate on the mental-health caseload who lacked a designated treatment team, a reflection of the department's commitment to ensuring that every inmate receives consistent, individualized treatment planning. ADOC has also created new forms for treatment-team meetings to assist mental-health staff in determining who needs to attend the meetings and the timeframes in which they must be completed. Based on the treatment plans discussed during the omnibus remedial hearings, it seems that individuals who should attend meetings are actually in attendance and that those who must miss a meeting are prompted to review the minutes and remain current on the inmate's treatment status. Though the results of ADOC's own audits of treatment teams indicate only mixed levels of compliance with the requirements that each inmate have a specified treatment team and that the team consist of all relevant staff members, it appears that ADOC has made significant progress in ensuring that inmates are assigned treatment teams made up of relevant staff members.

However, there has been less consistent improvement in ensuring that treatment teams are meeting frequently enough to address inmates' changing needs. Treatment teams provide no benefit if they are not actually meeting to check on inmates' progress and adjust their treatment as necessary. The need for treatment-team meetings is linked to inmates' mental states: It is even more

vital that the team meet, and that they do so more frequently, for inmates who are housed in more intensive units, because those inmates tend to be "more unstable" and may need their care to be fine-tuned. June 3, 2021, R.D. Trial Tr. at 161. Testimony from the omnibus remedial hearings revealed a worrying pattern of treatment teams not meeting to discuss inmates for months at a time. One inmate, M.M., did not have any treatment-team meetings for eight months, from July 2020 to March 2021. See June 9, 2021, R.D. Trial Tr. at 211. By the time Dr. Burns spoke with him, in March 2021, she reported that "it was apparent that he needed more frequent contact and monitoring of his condition." May 25, 2021, R.D. Trial Tr. at 97. This held true even for inmates who were housed in intensive inpatient units. For example, when inmate A.E. was housed in the residential treatment unit, he should have had treatment-team meetings once a month. See June 9, 2021, R.D. Trial Tr. at 206. But his treatment records indicate that the team instead met only once every four months. See *id.* at 191. When a treatment team fails to meet at sufficient intervals, inmates may end up failing to get the level of care they need. And the consequences can be tragic--as documented in Wexford's own psychological autopsy, there was no indication that Jaquel Alexander's treatment team met a single time after he was placed on the caseload. See May 24, 2021, R.D. Trial Tr. at 70. He committed suicide just two months later. See *id.* at 68.

When treatment teams do meet, evidence presented at the omnibus remedial hearings suggests that they may not always meet for long enough to have a substantive discussion. Dr. Burns testified to seeing records of treatment-team meetings that lasted "[o]ne minute, three minutes, six minutes maybe." May 25, 2021, R.D. Trial Tr. at 110. And several of these meetings were combined with other treatment sessions, leaving even less time for the team members to review the inmate's progress and determine if adjustments were necessary. For example, one team meeting

that was listed as lasting for six minutes included a simultaneous medication management session. *See id.* A meeting that lasts mere minutes is not sufficient to allow for careful, thorough review of an inmate's file. As Dr. Burns testified, she would expect even a normal, follow-up treatment-team meeting, when "there are no changes and things are going just fine" to last at least 15 to 20 minutes. *Id.* at 135. It is difficult to imagine that the treatment team could discuss an inmate in any real detail in less than half that time.

Treatment teams also frequently lack the information they need to make accurate decisions about inmates' mental-health needs and the care they should be receiving. Dr. Burns detailed dozens of examples of major events that were not included in inmates' files. For example, Casey Murphree had a treatment plan review in October 2019, around the same time as he was involved in "at least five violent altercations resulting in injury." May 24, 2021, R.D. Trial Tr. at 82. However, these altercations were "not reflected in any of the mental-health documentation during this period." *Id.* As a result, Dr. Burns testified, "the people providing his care were unaware that these things were happening, which would have been a trigger to potentially increase their level of contact or nominally look at his medication compliance to see how he was doing." *Id.* Without access to this information about Murphree's clear ¹²⁴⁰deterioration, it was impossible ^{*1240} for the treatment team to provide an accurate assessment of Murphree's progress or develop a treatment plan that would actually address his needs.

This pattern was repeated over and over again. There was poor documentation of inmates' behavioral outbursts, as when inmate Travis Jackson set fire to his cell and received a crisis assessment, but the information was not added to his mental-health record. *See id.* at 145. There was poor documentation of medical issues that could be relevant to an inmate's mental-health treatment, as when inmate J.F. was hospitalized and diagnosed with atrial fibrillation, but there were

"no notes or any indication in discharge planning that medical ... became part of his treatment team to talk about things like medication prescriptions or follow-up." May 25, 2021, R.D. Trial Tr. at 37. These widespread issues with documentation made it difficult for the treatment teams to get a clear picture of the inmates they were caring for, resulting in missed opportunities for additional care or needed interventions.

As a result of these issues, many treatment plans remain inadequate to address the needs of inmates. ADOC's own audit of its treatment planning process found that "master treatment plans and treatment plans following an inmate's discharge from suicide watch are frequently omitted." May 26, 2021, R.D. Trial Tr. at 17-18. When the audit team was able to find and inspect treatment plans, it found that they "were often of poor quality, were left incomplete, or otherwise lacked necessary documentation." *Id.* Compliance percentages at various facilities were low, to the point that the auditor heralded as "progress" the fact that Fountain had "recent treatment plans for about half of the charts reviewed" during a spot audit. *Id.* at 115. Jaquel Alexander serves as a sobering example of the outcome of these inadequate treatment plans. Alexander, whose long history of self-injury and suicide watch placements indicated that he was in desperate need of treatment, was not provided with a treatment plan at all once he was added to the caseload. *See* May 24, 2021, R.D. Trial Tr. at 68. At the time he killed himself, four months later, there was no indication that his treatment team had ever met. *See id.*

Not only are treatment plans frequently inadequate, they are also not being amended to address changes in inmates' needs or circumstances. Treatment planning is particularly crucial at transition points, when the risk is highest that information may be lost and that the consistency of care may be interrupted. However, Dr. Burns testified that in her review of patient records, she found that there were "not always ... treatment plan changes when there's a significant

event, like removal or placement off watch or discharge into outpatient from a residential treatment unit." May 26, 2021, R.D. Trial Tr. at 18. For instance, when inmate Marco Tolbert was released from the residential treatment unit to an outpatient unit, his treatment plan was not updated. See June 2, 2021, R.D. Trial Tr. at 97. He committed suicide three months later, without having been seen by mental-health staff once since his release. See *id.* at 96. ADOC's internal audits of various facilities' compliance with the requirement to update treatment plans after major events also showed low rates of compliance. Several facilities scored in the single digits. See Bullock RTU and SU Audit Results (P-3260) at 9 (showing 11.39 % compliance on major event movements); Bullock Outpatient Audit Results (P-3263) at 10-11 (2.92 % compliance); St. Clair Audit Results (P-3277) at 7 (7.14 % compliance). Dr. Burns expressed particular concern about these results, noting that it was "worrisome" that inmates in need of care would have the opportunity simply to fall through the cracks. May 26, 2021, R.D. Trial Tr. at 103.

1241 *1241

Indeed, ADOC's transfer process is haphazard and poorly documented, exacerbating the inadequacies of the treatment plans. As the court found in the liability opinion, the transfer experience can be particularly difficult for mentally ill inmates, since they often struggle to adjust to their new environment and develop trust with a new set of providers. See *Braggs*, 257 F. Supp. 3d at 1241 n.67. In ADOC, mentally ill inmates are moved between units and facilities frequently, often without any documented consideration of the impact these moves might have on their mental state or care. When inmate T.M. was sent to the residential treatment unit, there was "no transfer note indicating why" or explaining what kind of treatment he needed. May 25, 2021, R.D. Trial Tr. at 53. When he was released from that unit, the same thing happened--he was released without a "discharge note or transfer note" to notify his new

unit that he was coming. *Id.* Inmate J.F. bounced around from Kilby to Bullock to Bibb to Donaldson and then back to Bullock, all without any transfer notes or discharge plans. See *id.* at 36. Inmate M.W. was also transferred, in his case from the stabilization unit to an outpatient level of care, with no "discharge notice or transitional note to the outpatient team." *Id.* at 39-40. In fact, the psychiatrist who directed the discharge was told that it happened by the inmate himself--there was either no notice of it in the inmate's chart or the psychiatrist did not have the chart. See *id.*

The transfer documentation that does exist is not always accurate. For example, when Jaquel Alexander was transferred from Ventress to Donaldson days before his death, the transfer form incorrectly indicated that he had no SMI designation. See Jaquel Alexander Psychological Autopsy (P-3298) at ADOC539037. The lack of clear and consistent communication between units means that relevant information is lost, impacting patient care. The mental-health staff member who completed Alexander's risk assessment after his transfer, who indicated no familiarity with his prior risk factors, identified him as a "low" risk of harm to self. *Id.* And sometimes, inmates themselves simply get lost in the shuffle. For example, when inmate M.H. was released to the residential treatment unit from suicide watch, his records indicate that he was not seen by mental-health staff for a week, despite his obviously fragile state. See *id.* at 44. This lack of adequate communication between providers further disrupts the continuity of inmates' care, leaving staff members without the information they need to provide proper treatment.

9. Psychotherapy

Even when inmates are assessed and identified as in need of care, assigned a treatment team, and provided with a plan to address their particular mental-health concerns, they frequently find themselves without most or all of the treatment they have been prescribed. At the time of the

liability opinion, the court made clear that ADOC's treatment modalities--that is, the types of interventions that are provided to inmates with mental-health needs--were insufficient to meet the constitutionally required standard of care. Unfortunately, the court has not seen much improvement in ADOC's provision of mental-health treatment since that time. Though the court recognizes that ADOC has dealt with enormous challenges in trying to continue treatment during the COVID-19 pandemic, these deficiencies were present even before facilities began to lock down. Inmates in ADOC custody are regularly being denied access to the care they needed, an ongoing violation of their constitutional rights.

In some cases, there are logistical problems that prevent inmates from receiving certain forms of ¹²⁴²care at all. Several inmates ¹²⁴²reported to Dr. Burns that they were not being notified when treatment like group therapy or pill call was available, causing them to miss it. *See* May 25, 2021, R.D. Trial Tr. at 28; *id.* at 142. In other cases, inmates received their prescribed treatment, but far less frequently than they should have. This was true even in the units that should be providing heightened levels of care: Dr. Burns testified that inmates have insufficient access to treatment across ADOC's residential treatment units, stabilization units, structured living units, and outpatient units. *See id.* at 192; May 26, 2021, R.D. Trial Tr. at 16. Inmate A.E. had been without a single counseling session for six months, even though he was in a residential treatment unit and psychotherapy was included in his treatment plan. *See* May 25, 2021, R.D. Trial Tr. at 89. Inmate D.R. said that he was "really only seen very infrequently for counseling sessions," *id.* at 87, while inmate M.M. said that he only "sees his counselor every once in a blue moon," *id.* at 97. Perhaps most concerning, several of the men who recently committed suicide were receiving less care than their treatment plan called for. Marco Tolbert, for example, was not seen by mental-health staff for the three months he was in

general population after being released from the RTU. *See* May 24, 2021, R.D. Trial Tr. at 22. Casey Murphree's provider made a note to follow up with him in 30 days to monitor his depression, anxiety, and attention deficit disorder, but he was not seen. *See id.* at 76. And one of the recommendations included in Jamal Jackson's psychological autopsy was that mental-health staff should actually follow up with all patients "as written on the treatment plans," which they had failed to do for him. June 2, 2021, R.D. Trial Tr. at 112.

When they do occur, counseling sessions are often far too short for any real treatment to occur. Dr. Burns identified a disturbing pattern of counseling sessions that lasted only "[a] matter of minutes." May 25, 2021, R.D. Trial Tr. at 53; *see also id.* at 82 ("[S]ome of those notes were just really a minute or two long in length in terms of an individual session."); *id.* at 110 ("The individual contacts that are documented in the records for people in the SLU by mental-health staff were extraordinarily brief so that, again, these are two or three minute sort of discussions."); *id.* at 129 ("[T]hat's been [a] recurrent theme about people having ... very little time with their counselor"). As she explained, sessions that brief cannot really be considered counseling: "[Y]ou wouldn't be able to cover any information in the space of two minutes about what the counseling is about. If it's about family stress or if it's about grief counseling or if it's about trauma counseling, you barely have any time to discuss not only what the inmate patient's feelings are, but also to provide any guidance or suggestions for how to make things improve. Two minutes just isn't enough time." *See id.* at 135-36. Indeed, Dr. Burns testified that these sessions did not even last as long as she would expect a check-in or "supportive kind of chat" to be, let alone a therapeutic treatment session. *Id.* at 136. The defendants' expert, Dr. Metzner, echoed Dr. Burns, noting that he would have "concerns,

significant concerns" about any counseling session that lasted only three minutes. July 1, 2021, R.D. Trial Tr. at 168.

ADOC has particularly struggled to consistently provide group therapy. Many of the records discussed during the omnibus remedial hearings involved recent cancellations of groups, which are attributable in large part to the COVID-19 pandemic. ADOC largely shut down group treatment for several months at the start of the pandemic, a decision that was in line with CDC recommendations and which Dr. Burns agreed was appropriate under the ¹²⁴³ circumstances. See June 21, 2021, R.D. Trial Tr. at 93, 101-02. And there is evidence that ADOC has begun to reinstitute groups at many facilities as it loosens its lock down. See *id.* at 89-90, 93. However, even before the pandemic hit, inmates reported that groups were sparsely offered and frequently cancelled. Based on her extensive review of patient records, as well as conversations with inmates and Wexford's monthly client reports, Dr. Burns concluded that "people are not getting the number of groups in the residential treatment unit. They're not getting the groups in SLU. They're not getting the groups in SU ... there are ... not enough groups, not enough structured therapeutic activity going on." May 26, 2021, R.D. Trial Tr. at 56-58. ADOC itself came to the same conclusion. In a letter the department sent to Wexford before the pandemic, ADOC concluded that group therapy was not being provided at a sufficient level in RTU, SU, or SLU units. See *id.* at 16.

Beyond the lack of groups, inmates housed in ADOC's inpatient units are not receiving sufficient out-of-cell time in general. Dr. Burns called it a "common theme" among inmates she talked to that they were not receiving an appropriate amount of structured or unstructured out-of-cell time. May 25, 2021, R.D. Trial Tr. at 192. "[R]ecords and interviews" from the Bullock SU revealed that inmates are not receiving sufficient structured or unstructured time. *Id.* at 85-86. There are similar issues in the Tutwiler RTU and SU, see

id. at 70-71, the Bullock RTU, see *id.* at 99-101, the Donaldson RTU, see *id.* at 110, and the Donaldson SU, see *id.* at 140. Indeed, the investigator looking into Tommy Lee Rutledge's death in Donaldson's RTU reported that "inmates never leave their cells." *Id.* at 149. And insufficient out-of-cell time in mental-health units is particularly egregious given that it undermines the purpose of the units, which is to provide inmates with more intensive treatment and support. Without any out-of-cell activities, these units instead end up functioning very much like restrictive housing units instead. See *id.* at 219.

This inadequate out-of-cell time cannot be blamed on COVID-19 restrictions, though the court does note that the pandemic may have exacerbated the problem. Dr. Burns testified to having seen "months and weeks of operation" before the pandemic in which inmates were not receiving the proper amount of out-of-cell time. May 25, 2021, R.D. Trial Tr. at 218. Defendants' expert Dr. Metzner agreed, reporting that while inmates are "not getting 10 and 10, you know, related to COVID issues," it also "wasn't happening" pre-pandemic. June 1, 2021, R.D. Trial Tr. at 202-03.

This finding applies with equal force to the SLU. Although it is not an inpatient unit, the SLU is intended to provide a more supportive, treatment-based alternative to segregation for inmates with mental illness. However, the current lack of programming in ADOC's SLUs means that they are functionally indistinguishable from the restrictive housing units. Indeed, plaintiffs' expert Vail testified that inmates in the Donaldson SLU were getting less out-of-cell time as they should have gotten in the restrictive housing units. See May 28, 2021, R.D. Trial Tr. at 78-80.

Problems with the provision of care are not limited to inmates on the mental-health caseload. Inmates who are not on the caseload but who are in need of mental-health care must be still be provided with adequate treatment, and it is just as urgent that they receive the care they need as it is

for inmates who are on the caseload. Decomensation in prison is common, and emergent mental-health needs must be taken seriously. A review of recent suicides in ADOC custody demonstrates the stakes--several of the men who killed themselves were not on the 1244 mental-health caseload, and despite warning signs, they did not receive appropriate interventions in time. Laramie Avery reported both a history of mental-health treatment and symptoms of mental-health issues, and he received numerous referrals. *See* May 24, 2021, R.D. Trial Tr. at 50. Nevertheless, mental-health staff never responded or performed a more comprehensive assessment. *See id.* Jamal Jackson presented with psychotic symptoms in December, but by the time he committed suicide in May, mental-health staff had not followed up with him once. *See id.* As Dr. Burns reported from interviews she performed at Donaldson, inmates in general population find it difficult to get a response from mental-health staff, let alone a timely response, leaving them without anyone to talk to about their concerns. *See* May 25, 2021, R.D. Trial Tr. at 110.

Finally, documentation of the treatment that does occur is frequently inconsistent or incomplete, making it difficult to ensure that an inmate is receiving appropriate treatment and to effectively maintain continuity of care. For example, progress notes sometimes contained outdated or incorrect information or failed to explain major changes in an inmate's care. Inmate JF's file contained progress notes that "appeared to be pre-written" and contained inaccurate information, such as concluding that he should stay on watch when he had already been taken off watch. May 25, 2021, R.D. Trial Tr. at 34-35. And there was no explanation in Danny Tucker's record for the fact that his SMI flag was removed, *see* May 24, 2021, R.D. Trial Tr. at 178-79, or why he was downcoded to MH-A, *see id.* at 181. Dr. Burns explained that without any information about why

these treatment decisions were made, it would be difficult for other providers to verify whether they were appropriate. *See id.* at 178-79.

In some cases, it appeared that no progress note was written at all. A note on a referral for inmate W.S. indicated that he was seen by a mental-health provider, but there was not "an actual note describing that interaction with him in the chart. Just that he was seen by the MHP on that date." May 25, 2021, R.D. Trial Tr. at 178. This issue was also flagged in Marquell Underwood's psychological autopsy, which recommended that "anytime an inmate is seen by MH for a referral, it is recommended a note, other than writing on the referral form, is generated. This note is recommended to include the plan, referral to other providers, and any further course of action taken with the inmate." Underwood Psychological Autopsy (P-3316) at 15.

ADOC itself acknowledges the deficiencies in the care being provided. In a letter to Wexford, the department chastised the company for the "pattern of failure of mental-health staff to meet with their patients at required intervals and to conduct group therapies on a routine basis." May 26, 2021, R.D. Trial Tr. at 16. This letter was sent before ADOC facilities began to lock down because of the COVID-19 pandemic, further diminishing the amount of care being offered. However, in the years since the liability opinion, ADOC has failed to demonstrate any real, lasting improvement, even in the face of overwhelming evidence that inmates are receiving a level of care that is constitutionally inadequate.

10. Suicide Prevention

At the time of the liability trial, ADOC had just begun using suicide risk assessments to identify prisoners at risk of self-harm. Today, the provision of those assessments has improved substantially; they are broadly used during the intake process and are frequently employed elsewhere in ADOC's mental-health treatment system. The availability of crisis cells has increased as well,

and monitoring of inmates in crisis cells appears generally adequate. ADOC no longer seems to be using pre-filled forms to indicate the times of checks for inmates on close watch. See June 8, 2021, R.D. Trial Tr. at 90. ADOC has also implemented a constant watch procedure for acutely suicidal inmates, a critical component of suicide prevention.

These are significant steps for which the department should be applauded. Where ADOC continues to fall badly short in its provision of mental-health care to suicidal inmates, however, is in the areas of assessment, discharge, and follow-up from suicide watch. Inmates placed on suicide watch too often do not receive suicide risk assessments. Recent audits of Donaldson, Hamilton, Bullock, and Ventress found moderate or poor compliance with requirements to conduct these suicide risk assessments--assessments that defendants' expert Dr. Metzner testified were "dangerous" not to do well. July 1, 2021, R.D. Trial Tr. at 158; see also Pls. Ex. 3559 (Donaldson); Pls. Ex. 3562 (Hamilton); Pls. Ex. 3558 (Bullock); Pls. Ex. 3626 (Ventress). Equally troubling, ADOC often fails to ensure that prisoners requiring suicide watch are considered for placement on the mental-health caseload, even those with repeated suicide watch placements in a short period of time. Marquell Underwood, Jaquel Alexander, and Travis Jackson all had repeated suicide watches before their deaths without being considered for the mental-health caseload, and only Alexander was eventually placed on the caseload after a series of suicide watches.

Moreover, in spite of longstanding ADOC policy and this court's orders, prisoners are routinely discharged from suicide watch directly to restrictive housing with no evident consideration or documentation of exceptional circumstances justifying the placement. One provider at Ventress was chastised for candidly admitting during a spot audit of the facility that prisoners are sent from suicide watch to segregation as "a matter of course"; she was instructed to discuss the facility's

practices in less blunt terms. Pls. Ex. 3320 at 1. Emails authorizing segregation placements for prisoners coming from suicide watch indicated that the transfers are often approved in a matter of minutes after a request is made. Pls. Dem. Ex. 268. This continued practice was implicated in several of the recent suicides. See, e.g., May 24, 2021, R.D. Trial Tr. at 139-40 (discussing Travis Jackson).

Finally, inmates discharged from suicide watch still receive inadequate follow-up assessments and treatment to ensure that they do not decompensate and relapse into suicidality. During the suicide prevention trial, defense expert Dr. Perrien testified that follow-up evaluations in the days immediately after a person is discharged from suicide watch are "absolutely necessary." *Braggs*, 383 F. Supp. 3d at 1264. But ADOC continues to struggle to conduct the follow-up assessments required on each of the first three days after inmates are discharged from suicide watch. For example, inmate J.B. attempted suicide by overdose, was placed on acute suicide watch, and was moved to non-acute suicide watch all in the course of a single day, but he received no follow-ups at all once his suicide watch was discontinued the next day. See May 25, 2021, R.D. Trial Tr. at 49-51. Audits of ADOC facilities show problems with this obligation as well; Bullock, for instance, was found in March 2020 to have only 40-50 % compliance with any of the follow-ups required after a prisoner is discharged from suicide watch. See Pls. Ex. 3558 at 1.

These ongoing inadequacies in ADOC's system of suicide prevention are exacerbated by the broader problem of correctional understaffing in the 1246prisons. As discussed ¹²⁴⁶above, Wexford has identified the "lack of security presence" as "a major contributing factor to the ongoing and excessively high levels of contraband, inmate drug use, and inmate-on-inmate violence," which in turn "increases fear and suicidal thinking" among inmates. Pls. Ex. 3323 at 2 (emphasis removed). This has led to a "dramatic increase in suicide

watch volume" of 4,348 % over the hours anticipated in Wexford's contract, leaving Wexford, in its words, "with no choice but to replace the performance of routine mental-health tasks ... with providing crisis-level services, to ensure the safety of our patients." *Id.*

The court reiterates these findings in part because they shape the court's consideration of an issue hotly disputed between the parties during the omnibus remedial hearings: the rate of suicides in ADOC facilities in recent years relative to rates in other state prison systems. The parties presented contrary data on this question, each with its own set of flaws. The plaintiffs' figures, which purported to show that ADOC's suicide rates are much higher than the national average among prison systems, were based on a cross-year comparison that, according to Dr. Metzner, distorted the numbers. *See* June 30, 2021, R.D. Trial Tr. at 72-73. The defendants' data, which they claimed showed that Alabama prisons have a very low rate of suicides, in fact appeared to demonstrate the opposite: the defendants presented a report showing that the average annual rate of suicide in ADOC prisons from 2001 to 2018 was among the lowest in the country--far lower than the annual rate of suicide in ADOC facilities from 2018 to 2020--suggesting that suicide rates at ADOC have risen dramatically in recent years. *Compare* Pls. Ex. 3223 at 19, *with*, Pls. Dem. Ex. 265.¹²

¹² The defendants did not contest that the plaintiffs' calculation of the annual suicide rate in ADOC facilities from 2018 to 2020 was accurate. They claimed instead that the plaintiffs' comparison of that rate to the national suicide rate across prison systems was skewed. *See* Defs.' Post-Trial Br. (Doc. 3367) at 104. The court does not rely on that comparison here.

Deaths by suicide are the very worst outcomes of deficiencies in a prison system's mental-health care, but they are also rare events, both in Alabama and elsewhere. A few instances of good

or bad luck during serious suicide attempts can make the difference in a given year between a high suicide rate and a low one. *See* June 30, 2021, R.D. Trial Tr. at 7-8. More important to the court's assessment of ADOC's current suicide prevention system was Wexford's compelling explanation that whatever suicides ADOC prevents, it does not by successfully identifying and addressing the mental-health needs of suicidal inmates, but by the brute force tactic of pouring an unsustainable number of man-hours into close and constant watch, to the exclusion of other critical mental-health services. This is not a suicide prevention system; it is a crisis management system. Wexford's decision to pile its resources into the watch procedures as a last-ditch means of averting suicide does not mean that ADOC is performing adequately in the area of suicide prevention. To the contrary, its suicide prevention system remains badly broken, ultimately provides little but constant and close watch to prevent death, and cannot realistically be fixed without sufficient correctional staff to make it possible for Wexford to start moving mental-health resources into other aspects of care.

11. Higher Levels of Care

Within ADOC, two kinds of units are available offering an inpatient level of care: the residential treatment units, or RTUs,¹²⁴⁷ which are short- or long-term placements for inmates with very significant mental-health needs who are at risk of decompensation in less restrictive settings; and the stabilization units, or SUs, which are designed to provide intensive treatment to inmates with acute needs when a crisis cell--which is designed for short-term stays--proves insufficient. In addition, inmates with the most serious mental-health needs for whom even these inpatient units have been unsuccessful may be referred for hospital-level treatment, which is currently provided via 14 beds at Citizens Baptist Medical Center in Talladega.

The provision of hospital-level care appears to have improved since the time of the liability trial. The plaintiffs agree that the 14 beds ADOC currently maintains at Citizens are adequate for the system's mental-health caseload. It is no longer true that ADOC "virtually never transfers patients to hospitals, except in the case of prisoners nearing the end of their sentence," as the court found in the liability opinion. *Braggs*, 257 F. Supp. 3d at 1217. That said, some problems with timely access to hospital-level care remain. After Tommy McConathy was raped on the RTU, a mental-health provider reported that he would be considered for referral to Citizens, but McConathy did not get to Citizens for more than a month after that. *See* Pls. Ex. 3312 at 4. A prisoner whom the parties called M.H., after a series of incidents of serious self-harm and unsuccessful treatment in RTU and SU settings, still waited 10 days after a referral to Citizens before he was sent to the hospital. *See* May 25, 2021, R.D. Trial Tr. at 43-44.

The status of the inpatient units within ADOC is somewhat more problematic. The court found in its May 2020 remedial opinion on inpatient treatment, which included PLRA findings, that there was an "expert consensus" that ADOC needed residential treatment beds sufficient to accommodate 15 % of the mental-health caseload. *Braggs v. Dunn*, No. 2:14cv601-MHT, 2020 WL 2789880, at *4 (M.D. Ala. May 29, 2020) (Thompson, J.). The court further found that the necessary number of beds could not be based on the "current identified need for inpatient treatment," because doing so "encourages ADOC to continue to under-identify the need and underutilize its mental-health units to avoid creating more beds." *Id.* at *8. At the time, ADOC had 446 inpatient beds for men and 58 inpatient beds for women, enough to cover only 12.6 % of the male caseload and 9.5 % of the female caseload. *See id.* But even with that shortfall, many of the inpatient beds remained unfilled,

indicating that ADOC was continuing to fail to identify people who needed inpatient levels of care. *See id.*

Little has changed in this regard since the court's May 2020 inpatient treatment opinion. At the end of March 2021, a Wexford report found that ADOC had a total of 433 inpatient beds between its men's and women's facilities, including totals of 391 RTU beds and 42 SU beds. *See* Defs.' Ex. 4079 at 43-44. Adding the 14 hospital beds at Citizens brings ADOC's residential treatment capacity to 447 beds, a significant decrease from the number of beds available at the time of the court's inpatient treatment opinion. These beds remain underutilized as well; only 30 SU beds and 346 RTU beds were occupied at the end of March 2021, according to the Wexford report. *See id.*

This decline in treatment beds does not reflect an equivalent decline in the mental-health caseload. To the contrary: In March 2021, the mental-health caseload stood at 4,564, meaning that ADOC now has inpatient beds for less than 10 % of its caseload. *See id.* at 42. With the anticipated rise in ¹²⁴⁸admissions in the wake of the COVID-19 ^{*1248}pandemic, this deficit is likely to grow even more severe.¹³

¹³ During the litigation leading up to the court's inpatient treatment opinion, the defendants maintained that structured living unit (SLU) beds should be counted toward the inpatient total. *See Braggs*, 2020 WL 2789880, at *7. Because the SLU is an "outpatient unit" that serves "as an alternative to segregation for inmates with serious mental illness," and because prisoners needing inpatient-level care are prohibited from being housed in the SLU, the court rejected this argument. *Id.* at *9 (emphasis in original). Notwithstanding the court's resolution of this issue, the defendants pressed it again in the omnibus remedial hearings, this time by misrepresenting the testimony of their expert Dr. Metzner to suggest that he

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 agreed that these units should be counted toward the inpatient total. *See, e.g.*, Defs.' Post-Trial Br. at 109-10. But Metzner's testimony was clear: He opined that, while the SLUs are not inpatient units now and should not be counted as such, he believed that converting some or all of those units to inpatient treatment spaces and finding an alternative site for outpatient diversionary unit might be the best way for ADOC to meet the inpatient bed requirements. *See* July 1, 2021, R.D. Trial Tr. at 130-34. Metzner did not testify either that the SLUs currently help fulfill ADOC's need for inpatient beds or that those units could be double-counted as both inpatient units and outpatient diversionary units, as the defendants seek to do. *See id.*

Even for inmates who need inpatient treatment and are lucky enough to be identified as such and placed in one of ADOC's available beds, there remains the problem of temperature regulation. In its May 2020 remedial opinion, the court found that ADOC had failed to adequately regulate the temperatures of its inpatient treatment units. *See Braggs*, 2020 WL 2789880, at *14. High temperatures in inpatient treatment units pose a significant threat to inmates' safety, because nearly 100 % of inmates in mental-health units take psychotropic medications, which thwart the body's ability to regulate its own temperature and prevent inmates from realizing when they are overheating and seeking help. To ensure that ADOC did not needlessly subject inmates to risk of heat stroke, heat prostration, and hyperthermia, the court ordered the defendants to "devise a plan and procedures to address the serious risk posed by high temperatures in the mental-health inmates." *Id.* at *15.

In July 2020, the defendants reported that ADOC had completed installation of HVAC systems in all mental-health treatment units, thereby eliminating the need for any remedial order addressing the issue. *See* Response to Phase 2A Order of Inpatient Treatment (Doc. 2880) at 5-6. On

December 7, 2020, however, Tommy Lee Rutledge died of hyperthermia in the Donaldson RTU. The temperature in his cell was between 101 and 104 degrees. *See* May 25, 2021, R.D. Trial Tr. at 144-45. Rutledge's death makes it abundantly clear that ADOC has not adequately addressed the problem of heat management.

Accordingly, the court finds that while the provision of hospital-level care has improved since the liability trial, problems remain with timely access to hospital-level care, the number of inpatient beds in ADOC facilities remains inadequate to meet the needs of mentally ill prisoners in ADOC custody, and ADOC has failed to mitigate the risk of overheating.

One significant deficiency found by the court in its liability opinion does appear to have been corrected, however: The evidence does not show that segregation inmates without mental illness are currently being housed in ADOC's inpatient units. The department is to be commended for fixing this "persistent and long-standing practice." *Braggs*, 257 F. Supp. 3d at 1212.

12. Discipline

ADOC has taken strides since the liability opinion ¹²⁴⁹ to avoid disciplining prisoners ^{*1249} for engaging in self-harm. In January 2020, ADOC removed from its list of infractions the so-called Rule 505 violation it previously used to discipline inmates for self-injurious behavior. *See* June 14, 2021, R.D. Trial Tr. at 32. The defendants also assert, and the plaintiffs do not dispute, that ADOC also expunged Rule 505 violations from the records of inmates on the mental-health caseload and those with a serious mental illness or intellectual disability. *See* Joint Stipulation (Doc. 3288) at 9-10.

Where ADOC's disciplinary process continues to fall grievously short, however, is in the area of mental-health consultations to the disciplinary process to ensure that an inmate's mental-health needs and contraindications are considered when

assigning punishment for misconduct. After correctional understaffing, this appears to be one of the remedial areas where the least progress has been made since the liability opinion.

As Mr. Vail credibly testified, based on his review of several hundred disciplinary reports, the mental-health consultations provided to hearing officers are wholly useless in almost all cases. Regardless of the prisoner's circumstances or mental-health needs, hearing officers receive superficial, check-box forms almost uniformly indicating that the prisoner is competent to take part in the hearing, that mental illness didn't affect his or her behavior, that there is nothing to consider with regard to mental-health when meting out punishment, and that the mental-health staff member will not be present for the hearing. See May 27, R.D. Trial Tr. at 10. The forms frequently display an error code in the space provided for the consultant to indicate whether the prisoner is on the mental-health caseload. See, e.g., Pls.' Ex. 2953 at ADOC492463. There is no box on the form for the consultant to indicate whether the inmate has a serious mental illness. See *id.* Across the hundreds of disciplinary reports Vail reviewed, he found only eight that included any comment on the inmate's mental-health beyond a notation that there were no mental-health issues to consider. See May 26, 2021, R.D. Trial Tr. at 209-10.

As the court once said of periodic mental-health evaluations in segregation, these consultations are not "worth the paper they are written on." *Braggs*, 367 F. Supp. 3d at 1350. This is true even in cases where the prisoner has serious mental-health needs that cry out for consideration. For example, the consultation to Jaquel Alexander's disciplinary proceeding in April 2020, after he attempted to jump the fence at Ventress, was as useless as most others: It listed an error code where it should have indicated that he was on the mental-health caseload; it said that his behavior was unrelated to any mental-health issues; it declared that nothing related to mental-health need be considered in

determining his sentence; and it informed the hearing officer that mental-health staff would not be present for the hearing. See Pls. Ex. 3296 at ADOC517817. Although by that time Alexander had been diagnosed with a serious mental illness, no indication that he had an SMI appeared on the consultation. See *id.* With no information to suggest that a restrictive housing placement might be harmful to Alexander, the hearing officer sentenced him to 45 days in segregation, where he hanged himself three weeks later.

This will not do. Based on the evidence presented at the omnibus remedial hearings, the court finds that ADOC's system of mental-health consultations is still extraordinarily dysfunctional, with egregious consequences for inmates with mental-health needs. See *Braggs*, 257 F. Supp. 3d at 1234. The consultations remain "little more than a rubber stamp" for the disciplinary process.¹²⁵⁰ *Id.* The dysfunction of this system continues to expose mentally ill inmates facing disciplinary proceedings to serious harm.

13. Training

Finally, it appears that the issue of training could be largely a success story. The evidence presented at the omnibus remedial hearings suggested that ADOC has taken real steps forward in its implementation of the trainings previously developed by experts for both parties. Dr. Burns testified that ADOC has implemented the comprehensive mental-health training, the suicide prevention training, the suicide risk assessment training, and several other training curriculums that it was ordered to conduct, and that current and newly hired staff appear to receive these trainings. See June 22, 2021, R.D. Trial Tr. at 48, 50-51, 53-55; June 23, 2021, R.D. Trial Tr. at 225-26.

There are admittedly still some reasons for concern. In deposition testimony, Cheryl Price, ADOC's Assistant Deputy Commissioner for Operations, said that she herself had not received the comprehensive mental-health training and that she did not know if the training had been provided

to all staff members who were required to receive it. *See* June 1, 2021, R.D. Trial Tr. at 42. Under the stipulated remedial orders currently in effect, all staff who have any direct contact with inmates are required to receive this training. *See* Phase 2A Order and Injunction on Mental-Health Identification and Classification Remedy, Attachment A (Doc. 1821-1) at § 1.1. That order has been in place for more than three years; that Price had not received this training and did not know who still needed to receive it gives cause for concern about the extent to which training is provided.

Similarly, a March 2021 spot audit of Ventress noted that the facility's site program manager "would benefit from training on the Suicide Risk Assessment." Pls. Ex. 3626 at ADOC565532. As Dr. Burns credibly testified, this is "somewhat worrisome because that person will be overseeing the other people and kind of setting the tone." May 26, 2021, R.D. Trial Tr. at 137-38; *see also id.* at 54 (explaining that site program managers are "in charge of mental-health services at a given facility"). The evidence also raised questions about the current sufficiency of ADOC's emergency preparedness drills for suicide prevention; several psychological autopsies following recent suicides recommended that training should be reinforced through emergency preparedness drills, also known as "man-down" drills. *See* Pls. Ex. 3295 at ADOC518575; Pls. Ex. 3302 at ADOC518581; *see also* Pls. Ex. 3263 at 83 (December 2019 audit of Donaldson indicating that the audit team recommended Wexford "begin planning and implementing man-down drills").

More broadly, documentation of trainings has been a significant challenge. Wexford acknowledged as much in a March 2020 letter to the former Associate Commissioner of Health Services. *See* Pls. Ex. 3323 at 5. According to Wexford, "a lack of time and resources" placed it in a position where it was able to train its staff but unable to document this training. *See id.* (emphasis omitted). This lack of documentation

creates serious problems for the tracking and monitoring of training, and it must be corrected; without reliable documentation, ADOC and Wexford run the risk that individuals who have not received necessary training will fly under the radar until after prisoners are harmed.

The trainings at issue are too important to go undocumented; they are foundational to the proper function of ADOC's system of mental-health care and critical to prepare staff to make decisions in what could be life-or-death situations. For some trainings, the connection is immediately apparent:

¹²⁵¹*1251 Emergency preparedness drills are necessary to prepare staff to intervene in suicide attempts and take life-saving action in a moment when every second counts. *See* June 4, 2021, R.D. Trial Tr. at 64-65. Other trainings are necessary to minimize the risk that mentally ill prisoners ever reach this point. Comprehensive mental-health training, suicide prevention training, and suicide risk assessment training all operate to instruct staff to recognize prisoners' mental-health needs in order to facilitate a response that is proportionate to the urgency and severity of those needs. *See id.* at 22-23, 54-55, 57. Recent failures to respond appropriately to indicators of current mental-health needs, particularly signs of possible suicidality, reflect an ongoing need for this training to be received and reinforced. *See, e.g.,* May 24, 2021, R.D. Trial Tr. at 66 (the day before he committed suicide, Jaquel Alexander was not placed on suicide watch after he verbalized suicide ideation); *id.* at 44-45 (Laramie Avery was not placed on suicide watch or diverted from segregation after he twice stated that he did not have much to live for). In light of the need for training to provide a stable foundation for the provision of mental-health care across all other areas of liability, the court will order a few remedial provisions in this area, most notably with regard to documentation. But for the most part, the court finds the evidence presented at the omnibus remedial hearings encouraging.

D. Failure to Comply with Orders and Policies

The defendants argue that ADOC staff should be given broad discretion to determine how best to bring the system into constitutional compliance. The court recognizes the importance, both under the PLRA and in ensuring that relief is practical, of deferring to those who know the system best and building flexibility into the remedy. However, in certain areas, the plaintiffs have presented compelling evidence of years of ongoing constitutional violations and ADOC's failure to make any progress towards compliance. In those areas, the court cannot risk leaving unfettered discretion to the department. Experience has proven that ADOC either cannot or will not take the steps necessary to improve in these areas, a history that demands that the court enter more intrusive relief.

7 The relevant question in considering whether relief ordered under the PLRA is overly intrusive is "whether the same vindication of federal rights could have been achieved with less involvement by the court in directing the details of defendants' operations." *Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1071 (9th Cir. 2010). That a defendant has previously failed to comply with its own policies, or with the court's orders, may indicate that the answer is no.

ADOC has a long history of failing to comply with the remedial orders in this case. In the liability opinion, the court noted that the department had demonstrated deliberate indifference to the state of its mental-health care system for years, "in spite of countless reports, emails, and internal documents putting ADOC on notice of the actual harm and substantial risks of serious harm posed by the identified inadequacies in mental-health care." *Briggs*, 257 F. Supp. 3d at 1256. Indeed, ADOC failed to act to improve its provision of mental-health care until directly prompted by the court, even while claiming credit for actions it had not taken. During the course of the liability trial, the then-Associate Commissioner of Health Services claimed that "a new mental-health coding system prohibiting

placement of seriously mentally ill prisoners in segregation was in the middle of a roll-out at the time of her testimony in December 2016." *Id.* at 1262. However, this turned out to be untrue--"her representation was disputed" ¹²⁵² by the testimony of two of her colleagues, who explained that [the Office of Health Services] moved ten mentally ill prisoners out of segregation into the Donaldson RTU only after her testimony, and that there was no official policy change." *Id.*

Two years later, in the suicide prevention opinion, the court found "ample evidence" that ADOC's noncompliance continued. *Briggs v. Dunn*, 383 F. Supp. 3d 1218, 1246 (M.D. Ala. 2019) (Thompson, J.). It pointed out that ADOC had consistently failed to comply even with the remedial measures "the defendants agreed to implement," *id.* at 1278, and that it had demonstrated "time and again" that it was unable "to ensure that its ground-level staff comply with directives from the top, not to mention with the orders of this court," *id.* "The history of this case," the court concluded, "is replete with evidence of directives given and corrective action plans created that have been doomed to irrelevance because of a lack of follow-through to ensure the directives were obeyed and the plans put into action." *Id.*

These failures have continued through the omnibus remedial hearings. Indeed, the defendants' own witness, Meg Savage, testified to what the court considers one of their more egregious failures: she explained that in the three years that had passed since the court had ordered the defendants to establish an agency staffing unit, they had taken no steps whatsoever toward doing so, despite the fact that without the agency staffing unit, the defendants could not determine the number of correctional staff positions currently needed for ADOC's facilities to operate safely--a necessary precondition for hiring sufficient staff. See June 16, 2021, R.D. Trial Tr. at 9-14.

In other areas, too, ADOC has declined to remedy shortcomings of which it was plainly aware. Dr. Burns identified a number of recommendations made prior to the suicide prevention hearing that were repeated nearly verbatim in the most recent reviews. And even with regard to the earliest psychological autopsies, she testified that there was no indication that ADOC had incorporated their recommendations into its subsequent practice or, indeed, made any effort to do so. See May 24, 2021, R.D. Trial Tr. at 199.¹⁴

¹⁴ While the court does not rely on ADOC's decades-long history of inadequate mental-health care to support the need for relief in this case, that history is nevertheless noteworthy. As the court documented in its previous monitoring opinion, see *Briggs*, 483 F. Supp. 3d 1136, 1171-72 (M.D. Ala. 2020) (Thompson, J.), ADOC's mental-health care was found by a district court to be constitutionally inadequate all the way back in 1972. See *Newman v. Alabama*, 349 F. Supp. 278, 284 (M.D. Ala. 1972) (Johnson, C.J.), vacated in part on other grounds, *Newman v. Alabama*, 522 F.2d 71 (5th Cir. 1975) ("The large majority of mentally disturbed prisoners receive no treatment whatsoever. It is tautological that such care is constitutionally inadequate"). In a separate decision four years later, the court lamented that "nothing ha[d] been done" to address the identified deficiencies and that ADOC continued to violate the Eighth Amendment by failing to provide adequate mental-health care. See *Pugh v. Locke*, 406 F. Supp. 318, 324 (M.D. Ala. 1976) (Johnson, C.J.), *aff'd and remanded sub nom. Newman v. Alabama*, 559 F.2d 283 (5th Cir. 1977), cert. granted in part, judgment rev'd in part on other grounds, and remanded sub nom., *Alabama v. Pugh*, 438 U.S. 781, 98 S.Ct. 3057, 57 L.Ed.2d 1114 (1978). In 1979, the district court again found that, despite monitoring, "nothing ha[d] been done to correct the situation" and placed ADOC into a receivership that lasted until 1988.

Newman v. State of Ala., 466 F. Supp. 628, 631 (M.D. Ala. 1979) (Johnson, C.J.). Just four years after the court's oversight terminated, however, yet another complaint was filed alleging that the conditions for mentally ill inmates in ADOC's custody had deteriorated to the point of unconstitutionality. See Complaint (Doc. 1), *Bradley v. Haley*, No. 2:92cv70-WHA (M.D. Ala. 1992) (Albritton, J.). And though by the end of monitoring in that case, the monitor concluded that ADOC had achieved "remarkable" progress, see Bradley Final Monitoring Report (Doc. 2133-3) at 1, 4, 6, *Briggs v. Dunn*, No. 14cv601-MHT (M.D. Ala. 2018) (Thompson, J.), the court in this case identified deficiencies in nine of the 11 areas in which ADOC had been found by the *Bradley* monitor to have improved. See generally *Briggs*, 257 F. Supp. 3d at 1171.

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The cumulative result of all these failures, as the court made clear during the omnibus remedial hearing, is that the court is unable to rely on ADOC's willingness and ability to self-correct. See June 29, 2021, R.D. Trial Tr. at 133. Instead, for at least those areas that remain the most problematic, the court finds it necessary to order more detailed and specific provisions. As the court said before, paraphrasing Dr. Burns's testimony, such specificity is necessary "when you're dealing with a gross failure to comply or failure to comply over a long period of time." June 2, 2021, R.D. Trial Tr. at 181.

Similarly, the court finds that provisions requiring documentation are particularly important in light of the longstanding nature of ADOC's noncompliance. The defendants have argued that some of the deficiencies that the court identified may well have been "documentation issue[s]" rather than failures to comply. June 29, 2021, R.D. Trial Tr. at 96. As both Dr. Burns and Mr. Vail have explained, however, "in corrections, if you didn't write it down, it didn't occur." May 27,

2021, R.D. Trial Tr. at 121-22; *see also* May 24, 2021, R.D. Trial Tr. at 102. If ADOC really is making progress, adequate documentation is necessary for it to get credit for its improvement.

The history of this case also demonstrates that there is a disconnect between policies that are implemented at a system-wide level and what is actually happening on the ground in ADOC facilities. Indeed, the court at one point described ADOC's failure to comply not only with the court's directives, but with its own policies, as "a severe, ongoing dysfunction in the system." *Briggs*, 257 F. Supp. 3d at 1264. To give just one example: in March 2019, ADOC Deputy Commissioner Charles Daniels announced a directive generally prohibiting the release of inmates from suicide watch directly to segregation, *see Briggs*, 383 F. Supp. 3d 1218, 1273 (M.D. Ala. 2019) (Thompson, J.), yet a mental-health provider later reported to an auditor at Ventress Correctional Facility that inmates were sent to suicide watch to segregation "as a matter of course." Pls.' Ex. 3320 at 1.

Adequate documentation is necessary to correct this disconnect. As Vail testified, "documentation provides for accountability." June 1, 2021, R.D. Trial Tr. at 46. "[I]f you're trying to figure out if ADOC is making progress," it is vital that you have records of the actions that were taken and decisions that were made, when, and by whom. *Id.* Without adequate documentation, the court believes that the department will continue to struggle to ensure that remedies are being successfully implemented.

Finally, ADOC's persistent shortage of correctional staff raises doubts as to whether it is capable of implementing relief in multiple areas simultaneously, thereby heightening the need for thorough documentation. ADOC's shortage of staff has reduced it and its mental-health vendor to a constant state of 'robbing-Peter-to-pay-Paul' borrowing; to implement relief in one area, it must divert staff from another, all with the goal of

triaging--that is, maximizing the number of surviving inmates. As Wexford explained to ADOC, when it "had resources available to conduct training--but not enough to document the training--we went ahead and trained anyway, prioritizing educated, competent *1254 staff above recordkeeping." March 2, 2020, letter from Wexford to ADOC (P-3323) at 5. Similarly, in order to provide adequate crisis monitoring, Wexford diverted staff from other tasks, "disrupt[ing] all routine mental-health caseload activities to address the immediate and more serious needs of inmates in crisis." *Id.* at 3. Given this history, the court is concerned as to whether ADOC can sustain the progress it has made in certain areas while also implementing the court's orders designed to address deficiencies in other areas. In other words, it is simply not enough for ADOC to say that it has achieved compliance in one area; the critical question, as stated, is whether it can achieve and sustain adequate compliance in various areas simultaneously. The history of this case strongly suggests that, because of longstanding and severe understaffing, it cannot. Documentation may therefore be necessary even in areas where ADOC has made the most progress, so as to ensure that that progress does not erode once ADOC turns its attention to other matters.

E. Timeframes

Closely related to the defendants' request for broad discretion is the issue of timeframes. In a number of areas of liability, one or both of the parties propose provisions requiring that certain actions be taken within definite timeframes. The court rejects these proposals in many instances, even when they come from both parties. In a few instances, however, it does adopt specific timeframes. While the provisions containing these timeframes may be more intrusive than ones with more open-ended language, such as "as soon as possible," "within a reasonable timeframe," or indeed no temporal restriction at all, the court

finds them to be necessary, narrowly tailored, and the least intrusive means that will correct the constitutional violation at issue.

Numerous factors support the court's finding that the few provisions it orders containing specific timeframes are necessary, narrowly tailored, and minimally intrusive.

First, most, if not all, of the provisions in question are adopted from interim orders to which the defendants have previously agreed and, in some cases, which the defendants again propose in their proposed remedial order. "[W]here ... the provisions of relief ordered by a court are adopted from an agreement jointly drafted and reached by the parties, it is compelling evidence that the provisions comply with the needs-narrowness-intrusiveness criteria." *Braggs*, 383 F. Supp. 3d at 1253. The fact that the defendants had a hand in drafting and fashioning the language of a provision when it was stipulated, while not dispositive, is certainly an indicator that the provision is necessary, narrowly tailored, and minimally intrusive.

Second, although the defendants maintain that these provisions are no longer necessary, evidence of current conditions reflects that the defendants have not complied with these provisions consistently. Many prisoners continue not to receive care within the timeframes required by court order and ADOC's own policies. ADOC's failures to comply with these provisions while ordered to do so is significant evidence that these failures would continue in the absence of an order. Moreover, as explained above, ADOC's severe shortage of correctional staff has hampered its ability to implement and sustain relief in multiple areas at the same time. Therefore, even assuming that ADOC were to improve the timeliness of its responses in certain areas, the question would remain as to whether it could sustain that progress while making improvements in other areas despite severe staffing shortages. No resort to 'robbing-Peter-to-pay-Paul.'

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Third, credible expert testimony offered by either or both sides underscores the necessity of compliance with these provisions and ties ADOC's observed failures to apply these provisions to substantial harms to prisoners with mental illness and to the constitutional violations that the court has found.

In sum, where the court orders that the defendants must comply with specific timeframes, it does so only after careful consideration of the history of this case, evidence of ADOC's recent practices, and the expert testimony of both sides and a determination that no less intrusive means would be sufficient to redress ADOC's constitutional violations. Moreover, the court anticipates that its specification of these timeframes will allow the defendants to obtain relaxation or termination of the ordered provisions earlier than it would otherwise. This is for two reasons. First, a specific timeframe better enables the monitoring team to determine whether ADOC is in compliance with a given provision, and makes it more difficult for the plaintiffs to dispute compliance. If the compliance team is able to report with reasonable certainty that ADOC is compliant with a provision and can sustain that compliance, the court will, upon request, take up the issue immediately. Second, a specific timeframe provides clear notice to the defendants of what, exactly, is required of them, thereby ensuring that there will be no period during which ADOC struggles to determine what constitutes a reasonable amount of time for taking required action, and no possibility that it will be caught unaware by a determination by the EMT that it is out of compliance with the provision. Moving forward, the clarity of these provisions will best enable the monitoring team to monitor the extent of ADOC's failures and successes and allow the court and the parties to take appropriate action.

F. The Effects of COVID-19

In the December 2020 opinion setting out the process for the omnibus remedial hearings, the court noted that it would consider "the effects of COVID-19" in determining the omnibus remedy. *Braggs v. Dunn*, 2020 WL 7711366, at *8 (M.D. Ala. Dec. 29, 2020). As the court said then, the outbreak of the COVID-19 pandemic "seized and disrupted the progress of this suit as it has the quotidian rituals of all of our lives," and it was necessary to take this disruption into account both in the procedures by which the final remedy for this phase of the litigation was determined and in the substance of that remedy. *Id.* at *3. The court recognized that the pandemic had not only affected the litigation history leading up to these proceedings, but also had the potential to affect the appropriate scope of relief or to require certain temporary alterations of the remedy during the course of the pandemic.

In practice, COVID-19 had two principal effects on the omnibus remedial proceedings themselves, both of which created complicated evidentiary issues related to the court's consideration of whether particular proposed remedial provisions were necessary under current conditions. The first was a problem with the discovery of evidence for the proceedings. Because of ADOC's concerns about the transmission risk involved in conducting site visits and inmate interviews, the plaintiffs' expert Dr. Burns was sharply limited in the extent to which she could conduct these forms of evidence gathering. By agreement of the parties, Burns was the only plaintiffs' expert permitted to conduct site visits, and she was limited to visiting four facilities for short periods of time: up to eight hours each at Donaldson and Bullock, and generally up to four hours each at St. Clair and Tutwiler. *See* Joint Discovery Plan (Doc. 3098) at 12562-3; Facility Inspection and Inmate ¹²⁵⁶ Interview Protocol (Doc. 3098-1) at 1. While on-site, the only inmate interviews permitted were three- or five-minute cell-front interviews through a cell door with appropriate social distancing, although Burns was allowed to identify prisoners

during her visits for follow-up interviews by videoconference. *See* Facility Inspection and Inmate Interview Protocol (Doc. 3098-1) at 2-4.

The defendants argued, and their expert Dr. Metzner testified, that, through no fault of Dr. Burns, these limitations precluded her from developing credible opinions about the provision of mental-health care across the ADOC system, which Metzner said he believed required, among other things, three-day site visits. *See* July 1, 2021, R.D. Trial Tr. at 43. Given the particular history of this litigation, the court disagrees; indeed, it found Burns's testimony generally credible and reliable, including her opinions regarding the provision of mental-health care in ADOC facilities on a systemic level. That is because the evidentiary record of this case was not a *tabula rasa* when the omnibus hearings began. The court found long-standing and systemic deficiencies in its liability opinion, and it reaffirmed in various subsequent remedial opinions that many of these problems continued to exist. On top of those persistent deficiencies, as discussed above, there is the alarming history of ADOC's failure to follow the court's orders and its own policies and regulations. The recurrence of these same system-wide problems in the facilities Burns visited and the records of the prisoners she interviewed amounted to compelling evidence that these issues continue to plague ADOC's provision of mental-health care. The fact that correctional understaffing "permeate[s]" the inadequacies in ADOC's mental-health care system and continues to be a grave problem at every major facility except Tutwiler and Hamilton further supported the credibility of Burns's opinions that the deficiencies she witnessed were emblematic rather than isolated. *Braggs*, 257 F. Supp. 3d at 1268.

The second evidentiary problem that the COVID-19 pandemic caused had to do with the question of what evidence was most helpful for understanding how conditions in ADOC facilities will change as the pandemic wanes. Since March or April 2020, ADOC, like many institutions, has been operating

in some ways rather differently from what it did before. For instance, group therapy sessions and face-to-face counseling became more complicated to conduct safely, and they may have been all but impossible in the early stages of the pandemic when little was known about the virus and the availability of vaccines was a distant hope. But pre-pandemic evidence, at this juncture, is increasingly out of date: several of the ADOC Office of Health Services' facility-wide audits, which the plaintiffs argued need updating because of the amount of time that has passed, were conducted in late 2019. *See, e.g.*, Pls. Ex. 3271 (Kilby OHS Audit from November 2019). In other words, the court faced the question of how to assess current conditions given that nearly the last year-and-a-half were conditions under COVID-19.

That is a question without an easy answer. The court therefore adopted what it believed to be a reasonable approach. As to a given remedial area, when conditions during the pandemic appeared similar to the conditions that existed before the outbreak of COVID-19, the court took recent conditions as indicating how that aspect of ADOC's mental-health care is likely to operate in the future. But when conditions appeared to have worsened during the pandemic, the court considered whether pre-pandemic conditions suggested that the worsening was due to COVID-19, and if so whether the problem would likely be

resolved as the pandemic wanes. As a ¹²⁵⁷hypothetical example, the court would be hesitant to find that the provision of individual counseling remained deficient based solely on evidence that counseling sessions were inconsistently provided in November 2020 without evidence that they were also provided inconsistently in November 2019. This hesitancy gave appropriate flexibility and deference to ADOC in responding to the exceptional threat that the COVID-19 pandemic posed to prison inmates and staff.

⁹ That said, this flexibility has certain limits. COVID-19 does not grant ADOC *carte blanche* to provide inadequate mental-health care for the

duration of the pandemic. The Eighth Amendment does not have a *force majeure* clause. Events since March 2020 have not lessened the mental-health needs of prisoners in ADOC's custody; indeed, the stress and uncertainty caused by the pandemic have likely heightened those needs. Though it may be more difficult to provide certain kinds of mental-health treatment under such conditions, a prison system could not constitutionally pause such treatment for the length of the pandemic, which has now lasted well over a year and which has no end clearly in sight.¹⁵ Thus, while the weight given to evidence of conditions during the pandemic varied depending on how those conditions compared to pre-pandemic mental-health care in the ADOC system, the court in all instances looked to the totality of the evidence—including evidence of recent conditions—to determine whether each particular remedial provision was necessary under current circumstances.

¹⁵ For similar reasons, the court declined to adopt the defendants' request that it grant the monitoring team power to waive remedial provisions during a pandemic or similar unforeseen circumstances. Instead, the difficulties posed by these circumstances should be taken into account when assessing ADOC's compliance with these provisions and whether any non-compliance under such conditions requires further remedial action.

This concludes the second part of the court's omnibus remedial opinion. One part follows.

DONE, this the 27th day of December, 2021.

PHASE 2A OMNIBUS REMEDIAL OPINION

PART III.

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I. INTRODUCTION	
As stated previously, this opinion is divided into three parts. This is the third part, which discusses the parties' proposed provisions, the relief that the court orders and its reasons for doing so, and the court's PLRA findings. The court anticipates that the monitoring team may use this part as a reference guide to better understand the intricacies of the order. Both deal with the following areas of liability, in the following order: correctional staffing; mental-health staffing; restrictive housing; intake; coding; referral; confidentiality; ¹²⁵⁹ treatment teams and plans; psychiatric and therapeutic care; suicide prevention; higher levels of care; discipline; and training. ¹	
II. REMEDIAL PROVISIONS AND PLRA FINDINGS	
A. Correctional Staffing	

The currently operative 2017 understaffing remedial order requires the ADOC to have "fully implemented the Savages' correctional staffing recommendations" by February 20, 2022. Phase 2A Understaffing Remedial Order (Doc. 1657) at 3. As discussed previously, the recommendations that must be "fully implemented" by that date include: (1) hiring for the 3,826 full-time-equivalent correctional staffing positions necessary to fill the "mandatory" and "essential" posts described in the staffing analysis; (2) undertaking "another staffing analysis ... for every facility"; and (3) creating an "agency staffing unit" to "implement[] and enforce[] ... any changes resulting from" the Savages' analysis. Savages' Report (Doc. 1813-1) at 20, 100, 121-33. It is clear at this point that at least the first of these requirements is out of reach. Overall correctional staffing numbers in ADOC's system have barely increased in three years, and the system has filled less than half of the positions necessary to meet the requirement of 3,826 full-time-equivalent officers. This failure must be considered in the context that, despite the court's instruction in 2018 that "the defendants are not to delay implementation until the last minute, but are to begin immediately and swiftly upon receiving" the Savages' recommendations, the defendants had, at the time of the 2021 omnibus hearings, taken no steps whatsoever toward complying with the second and third requirements. *Braggs v. Dunn*, No. 14cv601-MHT, 2018 WL 985759, at *8 (M.D. Ala. Feb. 20, 2018) (Thompson, J.).

a. The Parties' Proposed Provisions

To remedy ADOC's continued, extraordinary correctional understaffing, the plaintiffs propose mainly that the court maintain the existing February 2022 deadline. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 2.1.1. In the alternative, if the court modifies this deadline, the plaintiffs ask that benchmarks be imposed on the ADOC's compliance to ensure that another three-plus years do not pass with minimal progress made and with no intervening points at

which that lack of progress might be reviewed by the court. See Pls.' Post-Trial Br. (Doc. 3370-1) at 342-44. The plaintiffs propose that these benchmarks should prioritize correcting the staffing deficiencies at ADOC's mental-health hubs, intake facilities, and restrictive housing units first, but they do not propose specific benchmarks beyond that general suggestion of structure. See *id.*

The defendants propose that no relief is necessary. See Defs.' Post-Trial Br. (Doc. 3367) at 58-59. In the alternative, they propose two modified deadlines for fixing its correctional staffing deficiencies, as well as new intervening dates for creating the agency staffing unit and completing the updated staffing analysis. See Defs.' Revised Correctional Staffing Proposal (Doc. 3351) at §§ 2.1.1-2.1.7. The first of these deadlines would require the ADOC to reach critical minimum staffing by, at the latest, December 31, 2023. See *id.* at 6. The latter of the deadlines would require the ADOC to fill 85 % of the mandatory posts described in the updated staffing analysis by July 1, 2025. See *id.* In light of Meg Savage's testimony that meeting critical minimum staffing should generally mean filling all mandatory posts, see June 15, 2021, R.D. Trial Tr. at 122-27, it is unclear how these two deadlines would work together: Filling critical minimum posts should require more staff than filling 85 % of mandatory posts. The ADOC's proposal contains no timeline for it to fill any of the essential posts—the positions necessary for "normal operations." June 16, 2021, R.D. Trial Tr. at 41-42. It also does not include any adjustments to the operation of ADOC facilities during the four years before it would under its proposal achieve 85 % of the staffing level at which, according to Savage, the prisons could safely operate in a non-lockdown status.

b. The Court's Ordered Relief

10 The court will adopt a hybrid of the timelines proposed by the defendants and the plaintiffs. In light of ADOC's minimal progress toward

correcting its severe correctional understaffing in the four years since the liability opinion, the court will extend to July 1, 2025, the deadline for filling all mandatory and essential posts prescribed in the most recent staffing analysis in effect at that time.² This extension grants the defendants' request for another four years from the time of the omnibus remedial hearings to achieve the level of staffing necessary to safely conduct normal operations, including programming, recreation, and other activities "as prescribed in all policy and procedures." June 16, 2021, R.D. Trial Tr. at 41-42. Given the exceptionally slow pace of progress the ADOC has made over the past four years, the court finds that this deadline is the earliest date with which it is realistic to expect the department may be able to comply.

However, when the amount of work (much of which should have been done years ago) ADOC must put into achieving adequate correctional staffing is considered, July 2025 is just around the corner. Time is of the essence. Every week and month is dear. The court, therefore, agrees with the plaintiffs that it is necessary to impose certain intermediate benchmarks—that is, "point[s] of reference" against which ADOC's progress may be assessed. *Benchmark*, Merriam-Webster Online, <https://www.merriam-webster.com/dictionary/benchmark> (last visited December 21, 2021). In deference to the ADOC, the court will not attempt to prescribe these benchmarks itself. Instead, it will order the defendants, in consultation with the Savages, to propose realistic benchmarks for the level of correctional staffing ADOC will attain by December 31 of 2022, 2023, and 2024. These benchmarks should be achievable for ADOC, should appropriately prioritize filling mandatory posts and staffing the mental-health hubs and intake facilities, and should put the ADOC on track to comply with the court's order to fill all mandatory and essential posts by July 1, 2025.

Once imposed, ADOC will be required to submit status reports to the court regarding its progress towards meeting them.

The benchmarks need not be enforceable. They are merely meant as a means of measuring ADOC's progress towards filling its mandatory and essential posts by 2025, so that the court and the parties can determine if ADOC is falling behind and take appropriate action immediately. By assessing ADOC's progress against the benchmarks, the court and the parties will decrease the chances that, come four years from the omnibus remedial hearings, they will have to scramble to ensure that ADOC complies with the court's correctional staffing order or, worse, to extend the deadline for doing so by another four years. It is unfortunate that, in all likelihood, eight years will pass from the time of the court's liability opinion before ADOC achieves the staffing it needs to provide inmates the care that the constitution requires. Twelve years would be beyond the pale.

To facilitate meeting these deadlines and benchmarks, ADOC should also create its agency staffing unit and work with the Savages to update the staffing analysis as soon as possible after the issuance of this order.³ The defendants' proposal also contains a provision requiring ADOC to revise the format of its correctional staffing reports; while this may be necessary, the court will not order ADOC to do so now. If the monitoring team determines that alterations to the format of ADOC's reports would aid the oversight of its compliance with these deadlines, the court anticipates that the defendants will work collaboratively with the monitoring team to make those adjustments. Per the Savages' analysis from March 2021, Basic Correctional Officers (BCOs) should not fill and may not be counted for any armed post, and so-called Correctional Cubicle Operators (CCOs) should not fill and may not be counted for any position other than "secure control

room posts with no direct inmate contact." Assessment of Posting Assignments (Doc. 3151-1) at 6, 8.

c. PLRA Findings

The deadlines and benchmarks described above are necessary to correct ADOC's extreme correctional understaffing, which continues to place mentally ill prisoners in ADOC's care at a substantial risk of serious harm for the reasons discussed above. Because these deadlines require only that ADOC fill the positions that its staffing expert Meg Savage credibly testified are necessary for safe, normal prison operations, they are narrowly tailored to correcting the understaffing violation found by the court. And because the benchmarks are not requirements, but merely reference points intended to facilitate the defendants' compliance with the court's order, they are the least intrusive way of ensuring that the violation is corrected. Accordingly, the court finds that the deadlines and benchmarks set forth above are narrowly drawn, extend no further than necessary to correct the correctional understaffing violation found by the court, and are the least intrusive means necessary to correct that violation. See 18 U.S.C. § 3626(a)(1)(A).

However, while these deadlines and benchmarks are necessary to correct the understaffing violation, the court finds that they are not sufficient to do so. As explained above, ADOC has had four years to fix its correctional officer deficiencies since the court found that ADOC's "severe" understaffing, "combined with chronic and significant overcrowding," was an "overarching issue[] that permeate[s] each of the" court's other liability findings. *Braggs*, 257 F. Supp. 3d at 1268. In that time, the system-wide staffing numbers have barely moved. Less than half of the mandatory and essential posts identified by the Savages are currently filled. ADOC remains far from filling even the mandatory positions, which comprise the vast majority of the mandatory and essential posts

described in the Savages' staffing analysis and which, per that analysis and Meg Savage's testimony, are so critical that facilities should lock down if they are not filled 100 % of the time. See June 15, 2021, R.D. Trial Tr. at 127-29.

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The consequences of this extreme understaffing have been catastrophic, just as they were four years ago at the time of the court's liability opinion. Suicide watch hours have shot up more than 4,000 % above the levels anticipated in the mental-health vendor's contract because the absence of security staff causes terrifying conditions to proliferate in the prisons, leading to anxiety, psychological deterioration, and ultimately suicidality. Inmates in celled environments, including treatment environments like the SU and SLU, cannot get out of their cells and are unable to receive necessary mental-health interventions due to a lack of correctional staff. See, e.g., Pls.' Ex. 3310 at ADOC546882; May 25, 2021, R.D. Trial Tr. at 140-44; see also Pls.' Ex. 3347 at ADOC553738. The resulting degree of isolation in these units is akin to or worse than segregation is meant to be under ADOC policy and the court's orders—a disquieting irony as the SLU in particular is intended to provide a diversionary unit for mentally ill inmates to avoid subjecting them to the harm caused by segregation. At the same time, dormitory environments are unsafe even in the most intensive treatment units: Tommy McConathy was raped in the grievously understaffed RTU at Bullock, which sometimes operated with no officers whatsoever on the dormitory floor. See Pls.' Ex. 3403 at ADOC558777; May 28, 2021, R.D. Trial Tr. at 157-58.

Perhaps the most dangerous effects of this severe understaffing are in the restrictive housing units, where most suicides in ADOC facilities occur. Inmates go weeks without any out-of-cell exercise time at all, exacerbating the mental-health effects of isolation. See, e.g., Pls.' Ex. 3921 at

ADOC517730-58. Officers at St. Clair acknowledged that this lack of out-of-cell time was due to insufficient correctional staff. See May 27, 2021, R.D. Trial Tr. at 118; May 28, 2021, R.D. Trial Tr. at 186-87. Units operate without enough officers to get an inmate out of his cell even in the event of a mental-health emergency. See Pls.' Ex. 4269 at ADOC588534; see also June 16, 2021, R.D. Trial Tr. at 195. This problem was reflected in the death of Charles Braggs, who hanged himself in his cell an hour after a nurse asked correctional officers to bring him to the infirmary. See Pls.' Ex. 3284 at 5. Mental-health treatment is nearly non-existent, including for inmates with serious mental illness, in part due to the lack of correctional staff. Clinical encounters are missed for lack of correctional officers to bring inmates to appointments. See, e.g., May 25, 2021, R.D. Trial Tr. at 158-59.

Moreover, experts for both parties testified that the only way to operate segregation units safely given the known risk of decompensation and suicide on those units is to have correctional staff perform cell-by-cell security checks twice an hour, 24 hours per day, for every occupied segregation cell to check on the inhabitant. The court explained in the liability opinion that these checks are "necessary to keep prisoners safe from self-harm and suicide," and it based its finding of constitutional deficiencies in segregation in part on Vail's assessment of ADOC logs "that suggested that no segregation checks were done for multiple hours." *Braggs*, 257 F. Supp. 3d at 1244. Vail credibly testified in the omnibus remedial hearings that this security-check requirement is one of the most important obligations of correctional administration because of how essential it is to keeping inmates safe. See May 27, 2021, R.D. Trial Tr. at 206-07.⁴

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At its current staffing levels, ADOC cannot consistently conduct these checks. As in the liability trial, Vail again found many logs

indicating gaps of multiple hours between security checks. See May 27, 2021, R.D. Trial Tr. at 159-61. Audits of ADOC's restrictive housing units have routinely found compliance levels with the required 30-minute security checks below 20 %. The extraordinary degree to which non-compliance with this requirement puts inmates at risk was illustrated by the case of Casey Murphree, who was not found for hours after his death until rigor mortis had begun. Had security checks been conducted as required by ADOC policy and this court's orders, Murphree's attempt to hang himself might have been noticed and interrupted.

Considering the evidence discussed above and the totality of the evidence presented during the 2021 omnibus remedial hearings, the court now finds that—with the exception of the restrictive housing unit at Tutwiler--ADOC's restrictive housing units are unsafe for prisoners with mental-health needs,⁵ and that while the segregation provisions in the parties' proposed omnibus remedial orders outline a plausible long-term framework for the operation of restrictive housing units once correctional staffing levels rise, neither proposal is adequate to address the serious risk of harm faced *now* by inmates in segregation. No matter what provisions the court might order regarding security checks, mental-health evaluations, out-of-cell time, and other areas in which ADOC has failed to provide adequate care, there is a substantial likelihood that ADOC will be unable to comply fully until it hires significantly more correctional staff—an object that, by ADOC's projection, is years away. Until then, ADOC's pattern of past noncompliance offers little reason to expect that ADOC will implement the provisions that the court orders with the consistency that is necessary to protect inmates in restrictive housing, where ADOC's compliance or noncompliance is a matter of life-and-death.

In light of this finding, the court considered ordering the defendants to close some or all the restrictive housing units at its men's facilities until

correctional staffing levels improve enough to make it possible for ADOC to operate those units safely. However, in deference to ADOC and to ensure that the remedy intrudes no further into the operations of the prison than is necessary to address the risk of harm to inmates in segregation caused by the system's present staffing levels, the court will instead order that ADOC must take additional precautions to protect against the most severe and immediate dangers to inmates in restrictive housing in the event that ADOC fails to comply with the court's orders regarding security checks, mental-health evaluations, out-of-cell time, and other areas in which ADOC has failed to provide adequate care. This is not to excuse noncompliance; it is simply to be realistic about the extreme risks that ADOC's understaffing poses to inmates in restrictive housing.

At this time, the court will not dictate all of the additional steps ADOC must take. Rather, because the parties were not afforded the opportunity to address this issue during the omnibus remedial hearing, it will allow them to submit proposals as to what interim measures are necessary until correctional staffing increases. Possible measures might include hiring temporary observers to monitor inmates in restrictive housing until ADOC hires a sufficient level of correctional staff, or temporarily reducing the number of inmates that ADOC keeps in restrictive housing.

The parties' proposals should also consider how the safety needs of prisoners who require protective custody will be addressed, and they should further discuss how ADOC should manage the dangers posed by prisoners who would present a significant safety or security risk in general population. Part of the court's hesitation to order the closure of any of ADOC's male restrictive housing units stemmed from concern over what would happen with these two groups of prisoners—at the moment, ADOC uses restrictive housing for both groups. The proposals should also suggest means of ensuring that any prisoners moved out of the restrictive housing units do not end up in

functionally identical units: that is, units that offer equivalently deficient levels of monitoring, out-of-cell time, and treatment. In considering the parties' proposals, the court will also adopt a plan for how the relief it orders may be modified if ADOC meets the staffing benchmarks set forth above. The goal is for ADOC to obtain sufficient correctional staff to be able to safely run its prisons, including segregation units if it so chooses. If ADOC's staffing levels begin to improve such that it is able to meet the benchmarks, its capacity to oversee restrictive housing units in a way that does not subject those housed there to a serious risk of harm should accordingly improve as well.

11 The court will order, however, that at least until its correctional staffing improves, ADOC must take certain steps to ensure that its stabilization unit, suicide watch, and restrictive housing cells remain suicide-resistant. Specifically, the court will order that ADOC must check such cells for suicide-resistance before they receive new occupants, and that it must conduct a thorough check of all such cells at least once per quarter to verify that they satisfy every element of Lindsay M. Hayes's Checklist for the "Suicide Resistant" Design of Correctional Facilities (Doc. 3206-5), which the court discusses in more detail below, and which the parties previously agreed to use as a means of gauging suicide-resistance. In addition, the quarterly check must be documented.

The court finds this relief necessary given the unfortunate reality that, until correctional staffing improves, there will likely be lapses in the observation of inmates in the stabilization unit, suicide watch, and restrictive housing cells. These inmates already face a heightened risk of decompensation and suicide, and therefore require an additional layer of protection. The checks are also narrowly tailored and minimally intrusive. In recognition of ADOC's limited resources, the court does not require it to conduct a documented check of every element of the Hayes checklist each time a stabilization unit, suicide watch, or

restrictive housing cell receives a new occupant; rather, a more cursory examination of the cell for tie-off points, visibility, and potentially dangerous items will suffice.

To be clear, precautionary measures in addition to the segregation provisions proposed ¹²⁶⁵ by the parties are necessary in light of the specific claims presented in this case and the scope of the court's remedial responsibilities with respect to those claims. That does not mean that such measures are the only adjustments that should be made immediately at this juncture to align ADOC's operations with the staffing levels it has, rather than the levels it hopes to attain. Other claims could require other adjustments; alleviating the risk of harm to inmates with mental-health needs in ADOC's segregation units is only what this court can do to address this vast and multifaceted problem.

This also is the only adjustment that is necessary *today*. The court takes no position at this point on what further remedies may be necessary in the years to come if ADOC does not improve its correctional staffing. The court emphasizes, however, that, if progress on staffing continues to be elusive, the defendants will have to consider other modifications to ADOC's operations to make the system capable of adequately protecting and treating prisoners with mental illness. When a State incarcerates some of its citizens, it accepts a coordinate obligation to provide them a certain minimum of mental-health care. As experts for both parties testified, there are ultimately two ways to fix the problem of having too few staff to provide this minimal care to an inmate population: staffing can be increased, or the population can be reduced. *See* May 28, 2021, R.D. Trial Tr. at 198-99; June 17, 2021, R.D. Trial Tr. at 98-100. ADOC has options about how to proceed. But one option it does not have is to throw up its hands and declare the staffing challenges too insurmountable for minimally adequate mental-health care to be

possible. The Constitution affords ADOC great latitude in the operation of its prisons, but it does not permit that.

B. Mental-Health Staffing

Although ADOC has made more progress towards remedying mental-health understaffing than it has towards remedying correctional understaffing, its progress is incomplete. According to the staffing ratios developed by ADOC's consultants, which indicate the minimum number of staff needed to treat any given number of inmates, five of ADOC's 15 facilities have enough mental-health staff to treat their current inmate populations. Yet no facility is staffed at the levels called for by the December 2019, mental-health staffing matrix, which the parties developed, using the ratios, to indicate the levels of mental-health staff ADOC could expect to require in the coming years. This discrepancy is the result of the COVID-19 pandemic, in response to which ADOC reduced intake from local jails, thereby reducing its inmate population to abnormally low levels. When intake resumes, ADOC will almost certainly require more staff in each of its facilities to provide a constitutionally permissible standard of care.

Moreover, ADOC's lack of correctional staff has prevented its mental-health staff from treating inmates as efficiently as its consultants assumed when developing the staffing ratios. Therefore, even in those facilities where ADOC has provided the number of mental-health staff called for by the staffing ratios, more mental-health staff are likely needed.

a. The Parties' Proposed Provisions

In light of ADOC's limited progress in hiring mental-health staff, the plaintiffs propose that ADOC must maintain levels of mental-health staffing consistent with or greater than those called for by its consultants' staffing ratios, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 2.2.3.2, subject to the following adjustments and qualifications:

- Staffing levels shall not be less than those set forth in ADOC's October 1, ¹²⁶⁶2020, contract with Wexford. *See id.* at § 2.2.2.

- ADOC must change the staffing ratios for all mental-health positions other than Program Managers and Clerks to ensure that they are filled even when staff are absent on vacations or sick leave. *See id.* at §§ 2.2.3.2.1-2.2.3.2.2.

- ADOC must keep filled the positions of Clinical Director of Psychiatry, Director of Mental-Health Services, Northern Regional Psychologist, Central Regional Psychologist, Southern Regional Psychologist, and Ombudsman, *see id.* at § 2.2.1.

- "Each ADOC major facility must have at least one (1) full-time equivalent ("FTE") licensed Professional ("MHP"). Each treatment hub—Bullock Correctional Facility, Donaldson Correctional Facility, and Tutwiler Prison for Women—must have at least two (2) FTE MHPs. Each treatment hub must have two (2) MHPs on-site for at least eight (8) hours per day every business day, and at least one (1) MHP on the weekends and holidays." *Id.* at § 2.2.3.1.

- "The ratio of CRNPs to psychiatrists must be 1.25:1 on a statewide bases, but not on a facility-by-facility basis." *Id.* at § 2.2.3.2.3.

- All CRNPs working as mental-health staff must be certified to work in psychiatry. *Id.* at § 2.2.3.2.4.

- ADOC's mental-health vendor may consider an [associate licensed counselor] as a [qualified mental-health professional] for 18 months after the start of his or her employment, provided that the [associate licensed counselor] is working towards licensure as an [licensed professional counselor]. During that time, the [associate licensed counselor] can participate, as part of her training, in suicide risk assessments conducted by an independently licensed [qualified mental-health professional] or another independently licensed mental-health professional such as a psychiatrist, psychologist, or CRNP. The [associate licensed

counselor] cannot, however, complete suicide risk assessments or conduct follow-up examinations alone. The [associate licensed counselor's] progress toward licensure must be assessed every six months. If the [associate licensed counselor] has not reached 600 hours of supervised time toward licensure by the six-month assessment, 1,200 hours by the 12-month assessment, or achieved licensure by the 18-month assessment, the [associate licensed counselor] must no longer be considered or counted as an [qualified mental-health professional]. At all times, no more than 10 % of [qualified mental-health professionals] can be [associate licensed counselors] working towards their licensure as [licensed professional counselors]. *See id.* at § 2.2.3.2.5.

- All activity technicians to work two shifts per day during the week and at least one shift on weekends, *id.* at § 2.2.3.2.6.

- "ADOC and its mental-health vendor may substitute [qualified mental-health professionals] for psychologists on a facility-by-facility basis, provided that the total number of [qualified mental-health professionals] and psychologists is equal to or greater than the number would be if applying the consultants' ratios." *Id.* at § 2.2.3.2.7.

- "Implementation of the mental-health staffing ratios must be reviewed ¹²⁶⁷ by appropriately qualified experts agreed upon by the parties or selected by the EMT, with input and participation of the EMT as it deems appropriate. Upon completion of such review, the experts will make recommendations, if necessary, for revising those staffing ratios. The recommendations will be provided to the EMT and to the Parties. The EMT will receive input from the Parties and will determine whether and to what extent the experts' recommendations are to be implemented." *Id.* at § 2.2.2.2.

The defendants propose that, because of the progress they have already made, no remedial relief is necessary—including the relief that the court has already ordered—and that "[a]ny

oversight of mental-health staffing through reevaluation of mental-health staffing, reporting, and monitoring must also end." Defs.' Post-Trial Br. (Doc. 3367) at 60–64, 64.

In the alternative, they propose that ADOC's "mental-health vendor will fill the mental-health staffing positions at each ADOC major facility, by program, consistent with the mental-health staffing ratios recommended by [ADOC's consultants], within one hundred [and] twenty (120) days of the Effective Date [of the court's Phase 2A omnibus remedial order]" and that "[b]eginning one (1) year from the initiation of monitoring, the EMT shall review the assigned mental-health staffing ratios for the ADOC major facilities under monitoring ... and make recommendations, if necessary, for revising those staffing ratios." *Id.* at 60, 64–65.

Finally, both parties propose that ADOC shall continue to submit quarterly mental-health staffing reports to the court, and monthly reports to the plaintiffs, as required by the Phase 2A Order and Injunction on Mental-Health Understaffing. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 15.1-15.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 2.2.2-2.2.3.

b. The Court's Ordered Relief

¹² The court will order, as both sides propose, that ADOC must maintain levels of mental-health staffing consistent with or greater than those called for by its consultants' staffing ratios. To ensure that the ratios are accurate, the court will order, as the defendants propose, that the EMT must review the ratios beginning one year from the initiation of monitoring and, if necessary, make recommendations for revising them.⁶ In reviewing ADOC's compliance with the staffing ratios, the court notes that the EMT may allow ADOC to substitute qualified mental-health professionals for psychologists, and associate licensed counselors for qualified mental-health professionals, subject to the conditions that the

¹²⁶⁸plaintiffs propose.⁷ The court ^{*1268} credits Dr. Burns's testimony that these substitutions will not hamper the provision of care. *See* June 4, 2021 R.D. Trial Tr. at 48-51.

The court will also order that ADOC must achieve the staffing levels set forth in the staffing matrix previously approved by the court by June 1, 2025, *see* Phase 2A Order and Injunction on Mental-Health Staffing Remedy (Doc. 2688), subject to any subsequent modifications. The court orders this relief because, although in some of its facilities ADOC has, according to the staffing ratios, enough mental-health staff to serve its current inmate population, the evidence presented at the omnibus remedial hearings indicates that it will need more when intake returns to pre-pandemic levels, and that it may well need more currently, given its lack of correctional staff.

Finally, in order to provide the defendants with as much flexibility as possible while still providing a meaningful opportunity for oversight, the court will order ADOC to work with the EMT to develop report formats for mental-health staffing, and to submit reports to the court and the EMT on at least a quarterly basis. However, given the paramount importance of adequate mental-health staffing to remedying the violations found in the liability opinion, the court cannot allow ADOC to put oversight on hold as it reformulates its reports. Accordingly, until ADOC and the EMT have finalized a new report format or else concluded that the existing report format is adequate, ADOC shall continue providing mental-health staffing reports as required by the Phase 2A Order and Injunction on Mental-Health Understaffing (Doc. 2301 and Doc. 2301-1).

The court declines to adopt the majority of the plaintiffs' proposed provisions because it does not find them necessary on the basis of the current record. There is no evidence, for instance, that the staffing ratios fail to account for absences due to vacation or sick leave; that the CRNPs currently working as mental-health staff are not certified to

work in psychiatry; that the positions of Clinical Director of Psychiatry, Director of Mental-Health Services, Northern Regional Psychologist, Central Regional Psychologist, Southern Regional Psychologist, and Ombudsman are not currently filled; or that there are not two full-time-equivalent qualified mental-health professionals at each treatment hub. That said, the court takes seriously the concerns that motivate the plaintiffs' proposals--particularly the concern that there must be sufficient qualified mental-health professionals at each treatment hub to perform mental-health evaluations for all inmates who need them, and the concern that there must be sufficient activity technicians in each facility to facilitate the provision of out-of-cell time--and trusts that should they prove prescient, the EMT will bring the issue to its attention.

c. PLRA Findings

The court finds it necessary to order ADOC to maintain levels of mental-health staffing consistent with or greater than those called for by its consultants' staffing ratios because those ratios indicate the minimum number of staff required to ¹²⁶⁹treat any given inmate population. While ^{*1269} ADOC has provided mental-health staffing at the levels called for by the ratios in five of its 15 facilities, its limited progress does not obviate the need for relief, especially because its lack of correctional staff has prevented its mental-health staff from treating inmates as efficiently as ADOC's consultants assumed.

It is not enough, however, that ADOC maintain sufficient staff to treat its current, abnormally low population; it must also take steps to prepare for the increase in its inmate population that will occur when intake resumes to pre-pandemic levels. Therefore, the court finds it necessary to order ADOC to continue to work towards providing mental-health staffing at levels consistent with the staffing matrix, which the parties developed as an estimate of ADOC's long-term mental-health staffing needs.

Finally, the court finds it necessary to order ADOC to submit mental-health staffing reports on at least a quarterly basis so that the court and the EMT can effectively monitor its progress, and reduce the relief ordered today as appropriate.

Each of these provisions is also narrowly tailored and minimally intrusive. While ADOC must comply with the staffing ratios, the court affords it as much leeway as possible in making hiring decisions by allowing it to substitute qualified mental-health professionals for psychologists and associate licensed counselors for qualified mental-health professionals, as the plaintiffs propose. And while ADOC must work towards complying with the staffing matrix, it need not achieve compliance immediately. Finally, while the court requires ADOC to continue to submit quarterly mental-health staffing reports, it allows it the opportunity to work with the EMT to modify the format of those reports.

C. Restrictive Housing

ADOC's use of restrictive housing remains seriously problematic. The department has failed to define clearly the "exceptional circumstances" that, as its own policies require, must exist if an inmate with a serious mental illness is to be kept in restrictive housing. It thereby keeps inmates with serious mental illnesses in segregation under any circumstances it sees fit. Moreover, ADOC lacks a functioning process for identifying inmates as contraindicated for restrictive housing, and even when it does successfully identify signs of contraindication, it fails to take them into account when deciding whether to place inmates in restrictive housing. Then, once inmates are in segregation, it fails to provide sufficient out-of-cell time and does not conduct routine mental-health rounds, security checks, or periodic mental-health assessments as required by court order and internal policy. For all of these reasons, inmates in ADOC's restrictive housing units currently face an unacceptably high risk of decompensation, self-harm, and suicide.

I. Exceptional Circumstances

The concept of so-called "exceptional" or "extenuating" circumstances appears at various points in the parties' proposals and in the provisions adopted by the court today. Most importantly, it describes the circumstances in which an individual may be placed in segregation directly from suicide watch or despite a clinical contraindication for restrictive housing placement, including a serious mental illness. Beyond the definition of exceptional circumstances, there are further questions as to how long a person may remain in segregation when exceptional circumstances permit such placement and what conditions of confinement are required during that placement; those issues will be discussed below.

a. The Parties' Proposed Provisions

The parties' final proposals for the definition of exceptional circumstances are as follows:

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Plaintiffs: " 'Exceptional Circumstance' refers to a circumstance in which ADOC is unable to provide an appropriate alternative placement to restrictive housing (e.g., an SLU), due to a lack of bed space, for a prisoner with an SMI who needs to be placed in a closed cell for disciplinary, investigative, or preventative reasons, and whose placement in general population would create an unacceptable risk to the safety of any person." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.9.

Defendants: " 'Extenuating circumstance(s)' means, as an exception to the general rule disfavoring the placement of an inmate with a diagnosed SMI in restrictive housing, a situation where: (a) a safety or security issue exists preventing placement of the inmate in alternative housing (such as a SU, RTU, or SLU); or (b) a non-safety or non-security issue exists and transfer or transportation to alternative housing (such as a SU, RTU, or SLU) is temporarily unavailable. Examples of safety and security issues include an

inmate's known or unknown enemies in alternative housing or the inmate's creation of a dangerous environment (to the inmate, other inmates, and/or staff) by his or her presence in alternative housing. An inmate placed in a [restrictive housing unit] for safety and security issues for seventy-two (72) hours or longer will be offered at least three (3) hours of out-of-cell time per day (which may be congregate out-of-cell time) while he or she remains in a [restrictive housing unit]. An inmate placed in a [restrictive housing unit] for non-safety or non-security issues should be removed from the [restrictive housing unit] within seventy-two (72) hours." Defs.' Revised Definition of "Extenuating Circumstances" (Doc. 3314-1) at 2.

Both parties propose that inmates with serious mental illnesses may not be placed in restrictive housing absent an exceptional circumstance, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.2.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.2, and the plaintiffs offer the following additional provisions:

- "When a prisoner with an SMI is placed in [a restrictive housing unit] due to an Exceptional Circumstance, the person must be transferred to an SLU, or to a mental health inpatient bed (RTU or SU) if clinically indicated, within five (5) calendar days." *Id.* at § 12.2.2.
- "If a prisoner has an SMI and the need for placement in restrictive housing arises, but no Exceptional Circumstance exists, the prisoner must remain out of restrictive housing or be moved to Mental Health Observation in a crisis cell until transport can be arranged to an SLU, or to a mental health inpatient bed (RTU or SU) if clinically indicated. This transport must occur within five (5) calendar days." *Id.* at § 12.2.3.

b. The Court's Ordered Relief

¹³ The court will adopt the defendants' proposed definition of exceptional circumstances, subject to certain modifications, and will order, as both

parties propose, that inmates with a serious mental illness may not be placed in segregation unless an exceptional circumstance applies.

The court reaches this conclusion after considerable discussion with the parties and with defense expert Dr. Metzner, during which it became clear that both parties' proposed definitions would yield identical results in most instances. When a diversionary bed is available to the inmate at issue—that is, when there is a bed free, when immediate transportation to that bed is possible, and when placing the inmate in ¹²⁷¹ that diversionary unit would not present a safety or security risk—both parties' definitions would require the prisoner to be diverted from segregation. Alternatively, when no safe diversionary placement is readily available and the inmate presents a safety or security risk in his or her current housing, both parties would find that exceptional circumstances exist permitting temporary placement in segregation.

The main point of difference between the definitions would arise when no diversionary placement is available but it is safe to leave the inmate in their current housing—for example, when an inmate has enemies in the only diversionary unit with an available bed but could stay in general population without safety or security risk. In that situation, the plaintiffs' proposal would have the inmate remain in place until a different diversionary bed became available, while the defendants' proposal would permit ADOC to place the inmate in restrictive housing during that time. The reason for this disagreement, in Dr. Metzner's view, was the need for "accountability" for prisoners' misconduct. July 2, 2021, R.D. Trial Tr. at 5-9. As Metzner put it, "I don't think it's acceptable to say, okay. We know you did a rule violation. You just stay in your normal housing until we can get you to alternative housing. That's a free pass." *Id.* at 8.

An additional distinction is that the defendants' definition, unlike the plaintiffs', includes what is in effect an order: It requires that all segregation placements not caused by safety or security issues—for instance, placements resulting from the lack of immediately available transportation to a diversionary unit—be limited to 72 hours. See Defs.' Revised Definition of "Extenuating Circumstances" (Doc. 3314-1) at 2. Furthermore, ADOC would have to provide three hours of out-of-cell time per day to any inmate placed in segregation for safety- or security-related issues who remained there longer than 72 hours, in effect transforming the conditions of confinement to non-segregation. See *id.* Dr. Metzner testified that the rationale for these limitations was that he believes 72 hours is the amount of time that a person with serious mental illness can remain in segregation conditions without suffering serious psychological harm, although he also testified that inmates who are otherwise clinically contraindicated for segregation should not be placed there even "for one minute." July 1, 2021, R.D. Trial Tr. at 170-71.

It is difficult to square Dr. Metzner's testimony that inmates with serious mental illness are not harmed by segregation placements up to 72 hours with the circumstances surrounding the death of Casey Murphee, who had a serious mental illness and killed himself within a day of his placement in restrictive housing. The court also notes that plaintiffs' expert Eldon Vail testified that the accountability that Metzner described would become less important as correctional staff received more training. As he explained, "officers want to see people held accountable for bad behavior," and "[i]f they don't understand what drives that bad behavior in the case of someone who is mentally ill," they may resent diversionary measures and "feel like people aren't being held accountable. But the more they understand what goes on in treatment, which is accountability in some ways at a level that is far more powerful than putting someone in segregation, then they're

going [to] ... have a better understanding of what the range of their job has now become." June 1, 2021, R.D. Trial Tr. at 35-36.

14 Still, the court takes seriously Dr. Metzner's concern about ensuring accountability for misconduct. As such, the court will generally adopt the defendants' proposal, including the 72-hour time limit for ¹²⁷²placements unrelated to safety concerns and the requirement to offer at least three hours of out-of-cell time to any inmate to whom safety- or security-related exceptional circumstances apply who remains in restrictive housing longer than 72 hours. While this does not place a specific outer limit on the amount of time that a prisoner may stay in segregation under exceptional circumstances, the duration will of course be limited by the nature of the circumstance itself—once the exceptional circumstance is resolved, there is no further justification for keeping the inmate in segregation.

15 In addition, the court will require significant documentation of the out-of-cell time offered to prisoners who remain in restrictive housing longer than 72 hours under exceptional circumstances. Every week, ADOC will be required to file with the court and the monitoring team individual reports on each prisoner who has been in restrictive housing for longer than 72 hours under exceptional circumstances during that week. These individual reports should indicate the amount of out-of-cell time offered to the prisoner each day, the nature of the out-of-cell time (i.e., exercise, group therapy, etc.), the exceptional circumstance justifying the prisoner's continued segregation placement, and the date by which ADOC expects that exceptional circumstance to be resolved. The court frankly has serious doubts about ADOC's ability to offer the three hours of daily out-of-cell time required by the defendants' proposal given its present level of correctional understaffing, as ADOC is currently unable to consistently offer even the five hours of weekly out-of-cell required for all inmates in segregation. Close observation of this requirement is necessary to ensure that it

does not become—like many of ADOC's existing obligations to inmates it houses in segregation—a right enjoyed on paper but not in practice.

The court does not adopt the plaintiffs' proposal that, "If a prisoner has an SMI and the need for placement in restrictive housing arises, but no Exceptional Circumstance exists, the prisoner must remain out of restrictive housing or be moved to Mental-health Observation in a crisis cell." *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.2.3, because it is unnecessary in light of the court's present order that inmates with serious mental illnesses must remain out of restrictive housing absent an exceptional circumstance.

The court also does not adopt the plaintiffs' proposal that seriously mentally ill prisoners who are placed in restrictive housing due to an exceptional circumstance must be transferred to an SLU within five calendar days, because it is made largely redundant by the defendants' proposed definition of "exceptional circumstances." Although the defendants' definition allows seriously mentally ill prisoners who are placed in restrictive housing for exceptional circumstances related to safety to stay there for longer than five days, it also requires those prisoners to receive at least three hours of out-of-cell time per day—an amount of time that, according to Mr. Vail, alleviates the risk of decompensation significantly. *See* May 28, 2021, R.D. Trial Tr. at 24. Indeed, Vail testified that, when inmates receive more than two hours of out-of-cell time per day, they are not functionally in segregation. *See id.* at 18–19.

c. PLRA Findings

For all of the reasons discussed above, including ADOC's continued practice of transferring inmates from suicide watch to segregation and placing inmates in segregation when they are clinically contraindicated for such placement due to serious mental illness or otherwise, as well as the role this practice repeatedly played in recent suicides in ADOC facilities, the court finds that this

definition and provision are necessary to correct the segregation violations found by the court in its liability opinion. Because the defendants' definition of "exceptional circumstances" allows segregation placements for the maximum amount of time that the defendants' expert testified that he believed is safe, the court finds that it is narrowly tailored to correcting these violations. And because the definition and provision allow ADOC to continue placing inmates in segregation for reasons of accountability—again, the only point of disagreement between the parties with respect to the definition of exceptional circumstances—the court finds that the remedy it adopts is the least intrusive means of correcting the violations. Finally, because of the court's grave concerns about whether ADOC can in fact offer the three hours of daily out-of-cell time the defendants propose given the severity of its correctional understaffing, the court finds that the documentation requirement it imposes is necessary to correct the segregation violations, narrowly tailored to correcting those violations, and the least intrusive means of doing so.

2. Screening for Serious Mental Illnesses

a. The Parties' Proposed Provisions

With respect to ADOC's failure to identify inmates with serious mental illnesses and divert them from restrictive housing, both sides propose that prior to placement in a restrictive housing unit, each inmate must be screened by an RN or LPN who has been trained in the screening process, and that the screening must assess whether the inmate has been flagged as seriously mentally ill; whether the inmate is at imminent risk of suicide or serious self-harm; whether the inmate exhibits debilitating symptoms of a serious mental illness; and whether the inmate requires emergency medical care. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 12.1.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 12.1.1–12.1.2.

The plaintiffs propose, additionally, that any LPN conducting screening must be supervised by an RN, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.1.1; and that mental-health staff must have the authority to veto any inmate's placement in a residential housing unit if such placement is contraindicated by the inmate's screening, *id.* at § 12.1.3.

The parties agree that the results of the screening must be used to determine whether the inmate can be placed into restrictive housing or must be diverted to another location, and whether the inmate requires a medical and/or mental-health referral. *See id.* at § 12.1.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.1.3.

They agree, too, that there should be some mechanism for the removal of inmates who have become contraindicated for restrictive housing since their placement there, or who were put there by mistake. To that end, they propose the following provisions:

Plaintiffs:

- "Mental health staff have the authority to have any prisoner removed from a [restrictive housing unit] if it is determined that continued placement is contraindicated as evidenced by changes in the prisoner's mental state and functioning." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.3.1.

- "ADOC will affirmatively inform psychiatrists, psychologists, licensed mental health professionals, certified registered nurse practitioners, and registered nurses, in a manner that is documented, (1) that they have both the ¹²⁷⁴authority AND the obligation ^{*1274} to inform corrections when they have determined that a prisoner's likelihood of decompensation requires a transfer to an RTU, SLU, or SU; and (2) that such a determination is not merely giving advice to corrections, but that it will trump any decision to the contrary and will be carried out promptly." *Id.* at § 12.3.2.

- "If a prisoner in a [restrictive housing unit] has a newly diagnosed SMI or a [qualified mental-health professional] determines that continued placement in the [restrictive housing unit] is contraindicated, that prisoner must be removed from the [restrictive housing unit] within 72 hours. Removal must occur sooner if clinically indicated. The prisoner must be placed into housing appropriate to their mental health needs (*i.e.*, RTU, SU, SLU). Placement of a prisoner with an SMI into an SLU must take priority over a prisoner without an SMI." *Id.* at § 12.3.3.

Defendants:

- "Mental-health staff may advise correctional staff to remove an inmate from the [restrictive housing unit] if mental-health staff determines that continued placement of the inmate in restrictive housing is contraindicated as evidenced by changes in the inmate's mental state and functioning. In this situation, the inmate must be removed from the [restrictive housing unit] within seventy-two (72) or sooner if a psychiatrist, psychologist, CRNP, or counselor determines the need for removal of the inmate from the [restrictive housing unit] is urgent. An inmate removed by mental-health staff from the [restrictive housing unit] as a result of decompensation or contraindication will be transferred to a mental-health setting appropriate for the level of mental-health services required by the inmate." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.5.7.

b. The Court's Ordered Relief

The court will order that, prior to placement in a restrictive housing unit, inmates must be screened by an appropriately trained RN, or an LPN under an appropriately trained RN's supervision, and that the screening must assess the topics proposed by the parties. The court will also order that the results of the screening must be used to determine whether the inmate should be placed in restrictive housing and whether the inmate requires a medical and/or mental-health referral, and that an inmate

flagged by mental-health staff as contraindicated for restrictive housing must not be placed in restrictive housing absent documented exceptional circumstances. Finally, the court will adopt the defendants' proposed provision regarding the removal of inmates from the restrictive housing unit, with the caveat that ADOC need not remove an inmate from restrictive housing if an exceptional circumstance exists.

The court orders that inmates must be screened, and that the screening must assess certain topics, because it is seriously concerned by the evidence that screenings continue to miss signs of contraindication. Granted, ADOC has made progress in ensuring that inmates receive screenings prior to being placed in restrictive housing units. Given the heightened importance of ensuring that inmates with contraindications are not inadvertently placed in restrictive housing, however, and the fact that ADOC's progress, while encouraging, is a recent development, the court finds that it must require ADOC to conduct an adequate screening of each inmate entering restrictive housing. The court agrees that the screening must cover the topics proposed by the parties, because, according to Dr. Burns's uncontradicted testimony, those topics must be covered if the screening is to be effective. *See* June 3, 2021, R.D. Trial Tr. at 171-73. And in light of the evidence that LPNs have been unable to conduct adequate screenings of prisoners entering the general population, where the stakes are much lower, the court agrees with the plaintiffs that LPNs may not conduct screenings of prisoners entering segregation unless supervised. If ADOC sustains its progress with respect to screenings, however, the court may revisit this order at a later time.

The court orders that the results of the screening must be used to determine whether the inmate should be placed in restrictive housing and whether the inmate requires a medical and/or mental-health referral, in light of the evidence, described in the opinion on changed

circumstances, that ADOC staff routinely ignore the results of screenings and place inmates in segregation despite documented contraindications. The screenings are intended to keep contraindicated inmates out of restrictive housing, and to ensure that mentally ill inmates receive the care that they need. They can fulfill neither purpose if they are ignored.

Out of deference to ADOC, however, the court will not grant mental-health staff veto power over decisions to place inmates in restrictive housing. Rather, it will order that an inmate flagged by mental-health staff as contraindicated for restrictive housing may nevertheless be placed in restrictive housing, but only if correctional staff determine that an exceptional circumstance exists and document their reasons for reaching that decision. The court orders that such decisions be documented because, given the evidence that correctional staff routinely ignore the results of screenings and the recommendations of mental-health staff, the court finds that it must impose some mechanism for the EMT to monitor decisions by correctional staff to place inmates flagged as contraindicated in restrictive housing.

The court adopts the defendants' proposed provision regarding the removal of inmates from the restrictive housing unit because it agrees with both parties that, given the heightened risk of decompensation faced by inmates in restrictive housing and the imperfections inherent in even the best screening systems, there must be some mechanism for removing inmates from restrictive housing due to decompensation or an error in the initial screening process. Again, however, in an effort to provide ADOC with maximum flexibility, it will not provide mental-health staff with complete authority to determine the facilities in which inmates may be housed, but will instead order that ADOC may keep an inmate in restrictive housing over the objections of mental-health staff provided that an exceptional

circumstance exists. For the same reasons as before, that decision, and the reasons for it, must be documented.

Finally, the court does not adopt the plaintiffs' proposal that ADOC must affirmatively inform its mental-health professionals that they are required to inform corrections when they determine that a prisoner should be removed from restrictive housing, because there is little evidence that ADOC's mental-health professionals are failing to flag individuals as contraindicated for restrictive housing because they do not understand that they have a duty to do so. Rather, the evidence demonstrates that the ADOC's mental-health professionals are failing to flag individuals as contraindicated for restrictive housing because they do not conduct regular follow-up examinations. If the monitoring ¹²⁷⁶ team finds that mental-health staff fail to flag inmates as contraindicated for restrictive housing because they do not know that they are supposed to, however, the court may revisit the issue.

c. PLRA Findings

¹⁶ The court finds these provisions necessary for the reasons given above: Despite ADOC's progress in ensuring that inmates receive mental-health screening before entering restrictive housing, screenings continue to miss signs of contraindication, and their results are routinely ignored. To remedy these failures, and to account for the inevitable risk of decompensation in restrictive housing, the court finds that it must (1) order that each inmate receive a comprehensive screening that is performed by a competent mental-health professional, (2) order that correctional staff use the results of the screening to determine whether the inmate should be placed in restrictive housing and whether the inmate requires a medical and/or mental-health referral, and (3) order that mental-health staff may recommend the removal of inmates from

restrictive housing who were put there by mistake or who have decompensated since their initial screening.

These provisions are narrowly tailored, because each is designed to address only ADOC's failure to screen contraindicated inmates from restrictive housing, and to account for the risk of decompensation. They are also minimally intrusive. While the court requires that each screening address certain topics, it finds that, in light of Dr. Burns's uncontroverted testimony that screenings must address those topics, and the extreme risk that restrictive housing poses to seriously mentally ill inmates, it can order no less. And while the court orders that ADOC must use the results of the screening to determine whether inmates may be placed in restrictive housing, and that it must generally follow recommendations by mental-health staff to remove inmates from restrictive housing, it allows ADOC the flexibility to override recommendations by mental-health staff so long as it can document the existence of an exceptional circumstance.

3. Mental-Health Rounds

a. The Parties' Proposed Provisions

Both sides propose that mental-health rounds must be conducted by a qualified mental-health professional in each restrictive housing unit at least weekly, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.5.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.4.1, and that the rounds must include the following:

- A discussion with the post officer(s) concerning any behavior changes of an inmate in the restrictive housing unit;

A walk through the restrictive housing unit, stopping at each occupied cell to make visual contact with the inmate inside the cell;

* Attempts to verbally communicate with the inmate, including a brief inquiry into how the inmate is doing and whether the inmate has mental-health needs or a desire to speak with mental-health staff privately; and

- A brief assessment of the inmate's hygiene, behavior, affect, physical condition, and the condition of his or her cell (such as cleanliness, trash, food, bodily fluids, smoke, etc.).

See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 12.5.3, 12.5.3.2-12.5.3.5; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.4.2. The plaintiffs would require, additionally, that the rounds must include a review of duty post logs and segregation unit record sheets for information about prisoners' participation in recreation, showers, meal consumption and sleep patterns, see Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.5.3.1, and that prior to conducting mental-health rounds independently, new MHPs must shadow a senior MHP, psychiatrist, psychologist, or CRNP for three mental-health rounds in the restrictive housing unit, see *id.* at § 12.5.2, and receive certain training, see *id.* at § 13.4.

Both sides also agree that the rounds must be documented, and propose the following provisions:

Plaintiffs:

- "Documentation of Mental Health rounds requires notation of the date and time of entry and exit of the professional conducting the mental health round on the [restrictive housing unit] Correctional Officer Duty Post Log. Mental health professionals must also log a brief notation about each inmate in the [restrictive housing unit] on the Mental Health Rounds Form." *Id.* at § 12.5.4.
- "If there has been any significant change in the prisoner's condition or additional mental health follow-up is indicated, a brief progress note will also be entered in the specific prisoner's medical

record. The mental health rounds forms must be chronologically filed and maintained by the mental health manager." *Id.* at § 12.5.5.

Defendants:

- "A mental-health round will be documented on ADOC Form MH-038, *Mental-Health Rounds Log* (as amended), which will contain a notation about any mental-health needs expressed by an inmate in the [restrictive housing unit] or concerns identified by the [qualified mental-health professional] as to any inmate during the mental-health round. Each *Mental Health Rounds Log Form* completed during a mental-health round will be chronologically filed and maintained by the mental-health manager or other designated mental-health staff member." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.4.3.

b. The Court's Ordered Relief

17 The court will order that mental-health rounds must be conducted by a qualified mental-health professional in each restrictive housing unit at least weekly, and that they should generally include the kinds of interactions, inquiries, and assessments that both sides propose. It will also order, as the plaintiffs propose, that the rounds should include a review of duty post logs and segregation unit record sheets for information about prisoners' participation in recreation, showers, meal consumption and sleep patterns. Finally, the court will order that the rounds must be accurately and contemporaneously documented, and that that documentation must be filed chronologically and maintained by the mental-health manager or other designated mental-health staff member. Should ADOC continue its progress in conducting mental-health rounds, the court may revisit whether this relief is necessary.

The court orders that mental-health rounds must be conducted at least weekly in light of the heightened need for rounds in ADOC's understaffed facilities, and the fact that ADOC has

Part of the reason why
 yet to sustain its recent progress in conducting rounds. The rounds are an essential mechanism for ensuring that inmates receive the care they need in a timely fashion, and for identifying inmates who are deteriorating in segregation. *See* June 3, 2021, R.D. Trial Tr. at 176-78 (testimony of Dr. Burns); 1278 June 30, 2021, R.D. Trial *1278 Tr. at 68-69 (testimony of Dr. Metzner). If conducted properly, they can allow ADOC to prevent crises before they occur, and thereby allocate its resources more efficiently.

Although ADOC has made encouraging progress in ensuring that rounds occur regularly, it has yet to sustain that progress for any significant time. Indeed, until quite recently, its provision of mental-health rounds was seriously deficient. When Charles Braggs killed himself in July 2020, for instance, two months had passed since ADOC had conducted mental-health rounds in St. Clair. *See* Pls.' Ex. 4119 at 2. The reason given was "Lack of Security Staff." *Id.* Given the expectation that correctional understaffing will continue to inhibit the performance of mental-health duties in this area as in others, the court finds that it must order the performance of these rounds to ensure that they will, in fact, be conducted.

The court orders that the rounds *should generally* include the kinds of interactions, inquiries, and assessments that both sides propose, as well as a review of duty post logs and segregation unit record sheets for information about prisoners' participation in recreation, showers, meal consumption and sleep patterns, in light of Dr. Metzner's testimony that these measures are generally necessary to identify and address an inmate's mental-health needs and to gauge effectively whether an inmate's mental-health has deteriorated. *See* June 30, 2021, R.D. Trial Tr. at 68-69. It does not order that the rounds *must* entail these kinds of interactions, inquiries, and assessments, because it credits Dr. Metzner's testimony that the appropriate nature of the interactions involved in the mental-health rounds may vary according to how well the mental-health

professional conducting the rounds knows the prisoners she is monitoring, and how familiar the prisoners are with the process. *See id.* at 68. Dr. Metzner explained, for instance, that, if an inmate who has lived in the segregation unit for some time flashes a thumbs up sign, and the mental-health professional conducting the rounds knows that to be a sign that the inmate does not need assistance, the mental-health professional need not attempt to communicate verbally with the inmate. *See id.* He also explained, however, that a mental-health round must consist of "more than just walking by the cells and getting the thumbs up." July 2, 2021 R.D. Trial Tr. at 27. That is, if the mental-health provider conducting the rounds decides to forego verbal communication with an inmate, she cannot also forego discussions with post officers, a review of the post log, and observations of the inmate's hygiene, behavior, affect, physical condition.

Finally, the court orders that mental-health rounds must be documented accurately and contemporaneously, and that that documentation be filed chronologically, in order to provide some means of monitoring ADOC's progress, and to ensure that ADOC is able to track inmates' needs and mental-health statuses over time. Documentation is particularly appropriate in light of its past practice of conducting rounds that did not involve stops at each cell. *See* June 3, 2021 Trial Tr. at 183 (testimony of Dr. Burns). By tracking the time spent on each round, ADOC will provide the EMT with a means of ensuring that these "drive by" rounds no longer occur.

The court does not order, as the plaintiffs propose, that, "[p]rior to conducting mental health rounds independently, new MHPs must shadow a senior MHP, psychiatrist, psychologist, or CRNP" for three rounds, Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.5.2, or that they receive other training related specifically to the conduct of rounds, *see id.* at § 13.4, because 1279 there is no evidence *1279 in the record to suggest that the mental-health professionals who conduct

mental-health rounds are insufficiently trained. It also declines to adopt the plaintiffs' proposal that, "[i]f there has been any significant change in the prisoner's condition or additional mental health follow-up is indicated, a brief progress note will also be entered in the specific prisoner's medical record," because it is rendered redundant by the court's order that a progress note be created after every significant clinical encounter.

c. PLRA Findings

The court finds the provisions that it orders necessary because, as explained above, it is particularly important that ADOC conducts regular mental-health rounds, especially while its restrictive housing units remain understaffed, so that it can identify inmates who are decompensating and allocate its scarce resources to avert crises before they occur. Although ADOC has made recent progress in conducting rounds, it has yet to sustain its progress for long enough to obviate the need for monitoring. Additionally, the rounds generally must cover the topics proposed by both parties if they are to be consistently effective, and they must be documented so that the EMT can monitor ADOC's progress, and to ensure that ADOC is able to track inmates' mental-health needs and mental-health statuses over time.

These provisions are also narrowly tailored and minimally intrusive. While the court orders that the rounds should generally entail the kinds of interactions, inquiries, and assessments proposed by both sides, it allows ADOC the flexibility to forego verbal interactions when appropriate, and it does not require that the mental-health professionals conducting the rounds be trained in any particular way.

4. Mental-Health Assessments

a. The Parties' Proposed Provisions

With respect to ADOC's provision of mental-health assessments, both sides propose that inmates must receive a mental-health assessment by a psychiatrist, psychologist, CRNP, or

counselor within seven days of placement in a restrictive housing unit, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.6.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.5.1; that the assessment must be documented on ADOC's Mental-Health Assessment/Report form, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.6.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.5.4; and that the assessments must include a review or examination of the following topics:

- The inmate's past response to restrictive housing;
 - The inmate's general appearance or behavior;
 - Whether the inmate has a present suicidal ideation;
 - Whether the inmate has a history of suicidal behavior;
 - Whether the inmate is presently prescribed psychotropic medication;
 - Whether the inmate has a current mental-health complaint;
 - Whether the inmate is currently receiving treatment for a diagnosed mental illness;
 - Whether the inmate has a history of inmate and outpatient psychiatric treatment;
 - Whether the inmate has a history of treatment for substance abuse;
 - Whether the inmate has a history of abuse or trauma; and
- 1280*1280
- Whether the inmate is presently exhibiting symptoms of psychosis, depression, anxiety, or aggression.

See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 12.6.2-12.6.3; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.5.5. Both sides also propose that inmates

coded as mental-health code A must receive additional assessments at least every 90 days, and that inmates coded as mental-health code B or C must receive additional assessments at least every 30 days. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.6.5; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 12.5.2-12.5.3.

The plaintiffs propose, additionally, that each assessment must include a final disposition of one of the following: "(1) No mental health referral; (2) Routine referral to mental health; (3) Emergency referral requiring assessment within an hour; or (4) Referral for removal from segregation." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.6.4. The defendants, by contrast, would simply require that "the psychiatrist, psychologist, CRNP, or counselor [conducting the assessment] will consider the need for a mental-health referral and, if a mental-health referral is made, the priority of such mental-health referral (i.e., emergent, urgent, or routine)." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.5.6.

The plaintiffs also propose that, "[i]f a prisoner's [restrictive housing unit] placement continues after a periodic mental health assessment, then the clinical rationale for his or her continued placement must be documented." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.6.6.

b. The Court's Ordered Relief

18 The court will order that inmates must receive a mental-health assessment by a psychiatrist, psychologist, CRNP, or counselor within seven days of placement in a restrictive housing unit; that inmates must receive additional, periodic assessments at intervals consistent with their mental-health codes, as the parties propose; that assessments must be adequately documented; and that they must include a review or examination of the topics that the parties propose. It will also order, as the defendants propose, that the

psychiatrist, psychologist, CRNP, or counselor conducting the assessment must consider the need for a mental-health referral and, if applicable, the priority of such referral.

The court orders that ADOC must conduct periodic mental-health assessments because, as it has previously found, "periodic out-of-cell assessments are necessary not only to monitor for decompensation among those identified as mentally ill, but also to identify prisoners not on the mental-health caseload who may develop mental illness while in segregation." *Braggs*, 257 F. Supp. 3d at 1249. Although mental-health rounds fulfill a similar purpose, it is not true, as Dr. Metzner suggested during the omnibus remedial hearings, that the mental-health assessments and mental-health rounds are duplicious. *See* June 30, 2021 R.D. Trial Tr. at 66. Rather, as the court explained in the liability opinion, "while segregation rounds by mental-health staff are crucial for checking for signs of decompensation or crisis, they cannot replace out-of-cell clinical assessments of prisoners' mental-health status, because it is difficult to observe someone's behavior and accurately assess the prisoner's mental health through cell-front encounters." *Id.* at 1243 n.72.

Despite this finding, ADOC has persistently failed to provide periodic assessments. As explained in the court's findings on changed circumstances, Charles Braggs received only two assessments in the two years prior to his death, and Gary ¹²⁸¹Campbell ^{*1281}went for three years without receiving any. And while Dr. Burns testified that some inmates reported receiving initial mental-health assessments within seven days, *see* June 23, 2021 R.D. Trial Tr. at 208-09, spot audits in several facilities found that inmates continue to go without initial or follow-up mental-health assessments at alarming rates, *see, e.g.*, Pls.' Ex. 3258 (Bullock, 57.41 % compliance with 30- and 90-day assessments); Pls.' Ex. 3270 (Kilby, 68.60 % compliance); Pls.' Ex. 3276 (St. Clair, 66.29 % compliance); Pls.' Ex. 3320 (Ventress, 32.08 %

compliance); Pls.' Ex. 3272 (Limestone, 77.19 % compliance; noting that "[f]ollow-up of the 30/90 day assessments and treatment plans for inmates on the caseload need improvement").

The court therefore finds that it must order some relief, and it credits Dr. Burns' testimony, which accords with the recommendations of the American Correctional Association, that the topics proposed by the parties must be addressed if the assessments are to fulfill their intended purpose, and that the initial 7-day assessments and the periodic 30- or 90-day assessments proposed by both parties are necessary measures to keep inmates safe when they are initially placed in segregation and when they remain in segregation for protracted periods of time. *See* June 3, 2021 R.D. Trial Tr. at 188-91 (testimony of Dr. Burns).

The court also agrees with both parties that the mental-health assessments must include a determination of whether the inmate requires a referral—and, if so, how urgently—given the evidence that, when inmates do receive referrals based on the periodic mental-health assessments, mental-health staff often fail to follow up on them appropriately. A requirement that the evaluations conclude with clear recommendations will make it harder for mental-health staff to ignore their findings, and easier for the EMT to monitor ADOC's progress in putting the evaluations to good use.

The court declines, however, to order that, if ADOC keeps a prisoner in the [restrictive housing unit] after the prisoner has received a mental-health assessment, it must document its clinical rationale for doing so. Of course, if an inmate is found to be contraindicated for placement in restrictive housing, ADOC must document the existence of an exceptional circumstance if it is to keep him there. But requiring ADOC to provide a clinical rationale for keeping inmates without contradictions in restrictive housing is not necessary to address the violations identified in the liability opinion.

c. PLRA Findings

The court finds these provisions necessary given the evidence that ADOC has largely failed to ensure that inmates in restrictive housing units receive periodic mental-health assessments, despite the court's previous finding that those assessments are essential for preventing decompensation and suicide, and that, when inmates do receive assessments, the results of those assessments are often ignored. Moreover, to provide adequate protection to prisoners with mental-health needs in restrictive housing, including those who develop said needs during their time in segregation, these assessments must address the topics identified by both parties and occur at least as frequently as the parties propose.

These provisions are narrowly tailored and minimally intrusive to ensure that mental-health assessments adequately address the needs of prisoners in segregation. Although the court requires that the assessments cover certain topics and be conducted at certain intervals, it can order no less. As Dr. Burns credibly explained, these topics must be addressed if the assessments are to fulfill their intended purpose, and the intervals represent the minimum frequencies with which inmates can safely go without receiving assessments.

5. Out-Of-Cell Time

a. The Parties' Proposed Provisions

With respect to ADOC's failure to provide inmates in restrictive housing units with sufficient out-of-cell time, the plaintiffs propose that all inmates in restrictive housing must have the opportunity to exercise outside of their cells for at least five hours per week, during which time they may be shackled only if ADOC can identify a specific threat to institutional safety necessitating the shackling. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 12.7.2-12.7.2. The plaintiffs also propose that this time must be offered regardless of inclement weather, and that

ADOC must document (1) all days and times that out-of-cell time is offered, (2) any prisoner's decision to refuse out-of-cell time, and (3) the specific threat to institutional safety or security necessitating any use of shackles. *See id.* The defendants propose no provision regarding out-of-cell time for inmates in restrictive housing.

b. The Court's Ordered Relief

The court will order that all inmates in restrictive housing must have the opportunity to exercise outside of their cells for at least five hours per week, and that ADOC must document all days and times that out-of-cell time is offered, and any inmate's decision to refuse out-of-cell time. The court will also order that ADOC may refrain from offering out-of-cell time due to inclement weather, but only if a safe, alternative space for inmates to exercise is unavailable.

19 The court orders ADOC to offer all inmates in restrictive housing at least five hours of out-of-cell time per week because, as experts for both sides testified, five hours per week is the minimum amount of out-of-cell time that must be provided to inmates in restrictive housing to prevent decompensation. *See* June 4, 2021 R.D. Trial Tr. at 179-180 (testimony of Dr. Burns); June 30, 2021 R.D. Trial Tr. at 175-76 (testimony of Dr. Metzner). It is also the minimum amount of out-of-cell time recommended by the American Correctional Association and currently required by ADOC regulations. *See* June 4, 2021 R.D. Trial Tr. at 179-180.

Despite the importance of out-of-cell time to preventing decompensation, the evidence indicates that inmates in restrictive housing scarcely receive it. As explained previously, in the six months prior to his death, Charles Braggs was offered out-of-cell time on only four occasions. This was not an isolated occurrence; Dr. Vail testified that in reviewing the records for a total of 412 weeks of segregation time, he found only seven weeks during which an inmate received five hours of out-

of-cell time. May 27, 2021 R.D. Trial Tr. at 111-12. The court must therefore order ADOC to comply with its own regulation.⁸

⁸ During the omnibus remedial proceedings, the defendants' counsel suggested that the court may not order ADOC to provide out-of-cell time to all inmates in segregation, but "only to individuals with mental health illness." June 30, 2021 R.D. Trial Tr. at 176. The court rejects this argument, and directs defendants' counsel to its previous explanation of why it may order relief intended to prevent inmates who are not currently mentally-ill from becoming mentally-ill due to ADOC's failure to provide adequate care. *See Braggs v. Dunn*, 367 F. Supp. 3d 1340, 1357-58 (M.D. Ala. 2019) (Thompson, J.).

In order to provide ADOC flexibility in responding to the weather, the court does not require ADOC to offer outdoor out-of-cell time when inclement weather makes it impossible to do so safely. But to the extent that ADOC can offer ¹²⁸³out-of-cell time ^{*1283} in alternative, safe spaces—for instance, in a gymnasium—inclement weather will not excuse it from doing so.

Finally, because out-of-cell time is so important to preventing decompensation, and because ADOC has persistently failed to provide it, the court finds that it must order ADOC to document each time it offers out-of-cell time, so that the EMT can effectively monitor its progress. It is also essential that each inmate's treatment team know whether that inmate has not been offered out-of-cell time or, perhaps more importantly, refused it.

The court does not order, as the plaintiffs propose, that inmates may not be shackled during out-of-cell time, because there is insufficient evidence that inmates are currently being shackled.

c. PLRA Findings

The court finds these provisions necessary for the reasons given above: it must order ADOC to offer inmates in restrictive housing a minimum of five hours of out-of-cell time per week because that is the minimum amount of out-of-cell time necessary to prevent decompensation, and it must order ADOC to document its provision of out-of-cell time so that the EMT can monitor its progress, and so that treatment teams can effectively monitor inmates' mental-health. The court also finds these provisions to be narrowly tailored and no more intrusive than necessary, because they require no more than the minimum amount of out-of-cell time necessary, and allow ADOC the flexibility to not offer out-of-cell time when inclement weather makes it impossible to do so.

6. Security Checks

a. The Parties' Proposed Provisions

With respect to ADOC's failure to provide cell-by-cell security checks, the plaintiffs propose the following provisions:

- "ADOC must ensure that appropriate ADOC staff conduct security checks of every prisoner in restrictive housing by direct observation at least twice per hour, but no more than 40 minutes apart, on an irregular schedule. These security checks must be annotated on the duty post log.
- ADOC must ensure that such security checks are documented accurately and contemporaneously, and that correctional supervisors regularly verify that security checks are being conducted as required.
- The EMT will develop a process for supervisory review and confirmation of security checks, including documentation of such review and confirmation."

See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 12.9.1-12.9.4. The defendants propose simply that "[a] member of the correctional staff will conduct a security round in a [restrictive housing unit] at least every thirty

(30) minutes and document such security round in a duty post log." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 12.3.

b. The Court's Ordered Relief

20 The court orders that the security checks must be conducted at least twice per hour, but no more than 40 minutes apart, in light of Mr. Vail's testimony that the checks are most effective in preventing suicide and self-harm when conducted on an irregular schedule. See May 27, 2021 R.D. Trial Tr. at 179. It does not order that the checks *must* be completed on an irregular schedule, because it credits Vail's testimony that "doing them 30 minutes or twice an hour ... is close enough to ... a reasonable standard." May 27, 2021 R.D. Trial Tr. at 154-155. But it encourages ADOC to conduct the checks irregularly, and to that end ADOC will not be found in violation if it ¹²⁸⁴allows inmates in restrictive ^{*1284}housing to go more than 30 minutes (but less than 40) without receiving a security check.

The court orders that the checks must be documented accurately and contemporaneously, and that correctional supervisors regularly verify that security checks are conducted as required, in light of the ample evidence that ADOC is not conducting the checks as required, and that correctional officers are pre-filling their duty logs. ADOC's own audits reveal that security checks are scarcely conducted in a troubling number of facilities. See May 27, 2021 R.D. Trial Tr. at 154-189 (testimony of plaintiffs' expert Vail, describing results of audits of Donaldson, Easterling, Holman, Limestone, and St. Clair); see also Pls.' Exs. 2927, 2972, 3010, 3177, 4067. More worrying still, many of ADOC's duty logs seem to have been pre-filled, and may be inaccurate. See *id.* at 178-79 (testimony of plaintiffs' expert Vail). Thus, to the extent that ADOC's audits rely on data from the duty logs, they may have overestimated the frequency with which the check are conducted. Current relief is therefore necessary, and although the court leaves

to ADOC to determine the exact means by which it will ensure that the checks are documented accurately and contemporaneously, it will trust that the EMT will monitor ADOC's documentation and raise any concerns with the court.

The court does not order the EMT to develop a process for supervisory review and confirmation of security checks, because it has already tasked the EMT with devising procedures for monitoring ADOC's compliance with the court's orders.

c. PLRA Findings

The court finds these provisions to be necessary because, as explained above, ADOC has failed to ensure that security checks are conducted at least twice per hour, or that security checks are accurately and contemporaneously documented, thereby jeopardizing the lives of inmates in every unit that functions as restrictive housing. They are also narrowly tailored and minimally intrusive. The court does not require relief that goes beyond remedying ADOC's failure to provide security checks, and it does not specify the exact means by which ADOC must ensure that the checks are documented accurately and contemporaneously.

7. Restrictive Housing Cells

a. The Parties' Proposed Provisions

In addition to the provisions discussed above, the plaintiffs also propose several provisions regarding the physical condition of cells in the restrictive housing units. These include a provision that would require ADOC to clean every restrictive housing unit within one month of the entrance of the court's remedial order, to clean restrictive housing cells before they receive new occupants, and to provide individuals in restrictive housing cells with access to cleaning supplies to ensure that the cells are cleaned at least every two weeks, see Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.8.1; a provision requiring the EMT to "evaluate the condition of the [restrictive housing units] with

respect to the adequacy of natural light, square footage, ... the need for painting ... [and] the adequacy of access to out of cell exercise space during inclement weather, ... [and to] determine what steps should be taken to correct any deficiencies they identify," id. at § 12.8.2.2; and the following provisions regarding suicide resistance:

- "Within three months of this Order, ADOC must retain a consultant to evaluate whether ADOC's restrictive housing cells qualify as anti ligature and provide sufficient visibility for adequate monitoring as well as to make recommendations ¹²⁸⁵for correcting ^{*1285} any problems identified, including the existence of tie off points, inadequate visibility, and any other unreasonably dangerous condition identified in the course of the assessment. The consultant's findings and recommendations must be set forth in a written report completed within three months of ADOC's retention of the consultant. ADOC must provide to the court and the plaintiffs the consultant's written report, which must include findings and recommendations regarding the existence of tie off points, inadequate visibility, and any other unreasonably dangerous conditions identified in the course of the assessment." Id. at § 12.8.2.

- "No later than three months after preparation of the consultant's report as required above, ADOC must ensure that there is adequate visibility into restrictive housing cells, that all restrictive housing cells have anti ligature fixtures, that no restrictive housing cell has an open bar door and that any unreasonably dangerous condition identified in the reports has been corrected." Id. at § 12.8.2.1.

The defendants propose only one provision regarding the physical condition of cells in the restrictive housing units: that within one year of the effective date, it must repair or replace any damaged restrictive housing unit cell door or

Window that materially inhibits the observation of any inmate. Defs.' Proposed Omnibus Remedial Order (Doc. 3215) at § 12.6.

b. The Court's Ordered Relief

21 The court will order ADOC to clean the cells in the restrictive housing units within three months of the effective date, to clean restrictive housing cells before they receive new occupants, and to provide individuals in restrictive housing cells with access to cleaning supplies to ensure that the cells are cleaned at least every two weeks. It finds this relief necessary in light of its finding in the 2017 liability opinion that cells in the restrictive housing units were "often filled with the smell of burning paper and urine," and "extremely dirty with what appears to be dried excrement on the walls and floors," contributing to "a heightened risk of decompensation for mentally ill prisoners and a heightened risk of developing serious mental health needs for those who were initially healthy." *Braggs*, 257 F. Supp. 3d at 1238. There is little evidence that ADOC has improved the cleanliness of the cells since then. While the parties stipulated prior to the hearings that, "[a]ccording to Cheryl Price, ADOC's Assistant Deputy Commissioner for Operations, ADOC cleans or allows inmates to clean [restrictive housing units] units ... [and] cleans crisis cells between inmate placements," Joint Stipulation for the Evidentiary Hearing Regarding the Phase 2A Remedial Order (Doc. 3288) at ¶ 45, the plaintiffs refused to stipulate to the accuracy of Ms. Price's assertion, see June 14, 2021, R.D. Trial Tr. at 38, and the court heard no sworn testimony from Ms. Price on this matter. Moreover, at various points during the omnibus remedial hearings the court heard testimony from high level ADOC officials that turned out not to accurately reflect conditions on the ground. It therefore cannot conclude on the basis of Ms. Price's unsupported assertion that there have been any significant changes to the cleanliness of the restrictive housing units, and it finds that it must order ADOC to take steps to ensure that the cells in the restrictive housing units are clean. However,

if the EMT determines that ADOC is in compliance with this provision, the court will not hesitate to remove it.

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22 The court also agrees with the plaintiffs that something must be done to render cells in the restrictive housing units suicide resistant, including by ensuring that there is adequate visibility into the cells. As the court found in the liability opinion, visibility into the cells in the restrictive housing units is lacking, and "[m]any segregation cells have grates, sprinkler heads, and other structures that could be used as tie off points. Furthermore, during the facility tour, the court saw many segregation prisoners with ropes hanging across their cells as clothes lines." *Braggs*, 257 F. Supp. 3d at 1244. For inmates in restrictive housing, who already face a heightened risk of decompensation, such conditions can be deadly, especially because ADOC lacks sufficient correctional staff to effectively monitor inmates in segregation. Of the twelve men who recently committed suicide in ADOC facilities, eight did so by hanging themselves in a cell in a restrictive housing unit. See May 27, 2021 R.D. Trial Tr. at 147-149 (testimony of Eldon Vail). At least one of those men had obscured his cell window with paper before doing so. *Id.* at 150-51.

Rather than ordering ADOC to retain a consultant, however, the court will order that within six months of the effective date, ADOC must ensure that all cells in the restrictive housing units comply with the conditions set forth in the checklist developed by Lindsay M. Hayes (Doc. 3206-5). This checklist, which the parties previously agreed to the use to ensure that cells are suicide resistant, provides for the elimination of tie off points and other structural elements that facilitate suicide attempts, as well as the maintenance of adequate visibility into the cell to allow monitoring. See *Suicide Prevention Stipulations* (Doc. 2606-1) at 6 (providing that "[s]uicide watch cells shall be considered suicide

resistant if they meet the requirements set forth in section III(B) of the ADA Report"); ADA Transition Plan for Programs and Services Provided to Inmates (Doc. 2635 1) at 41 ("All crisis cells ... are to comply with the checklist developed by Lindsay M. Hayes."). The court finds the checklist to provide a sufficient set of criteria for determining whether a cell is suicide resistant, and it finds it necessary to order ADOC to comply with the checklist in light of the heightened risk of suicide in the restrictive housing units. While monitoring and security checks can reduce the risk of suicide, they cannot eliminate it, and additional measures must be taken to ensure that inmates do not kill themselves when observed.

The court declines, however, to order the EMT to "evaluate the condition of the [restrictive housing units] with respect to the adequacy of natural light, square footage, ... the need for painting ... [and] the adequacy of access to out of cell exercise space during inclement weather, ... [and to] determine what steps should be taken to correct any deficiencies they identify." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 12.8.2.2. While fresh paint, additional natural light, square footage, and access to exercise space may be desirable, the plaintiffs have failed to demonstrate that such measures are necessary to correct the constitutional violations identified in the liability opinion. Moreover, requiring such relief would be highly intrusive indeed, it is unclear whether ADOC could provide additional natural light and space in its restrictive housing units without substantial, highly costly modifications to its facilities.

c. PLRA Findings

The court finds these provisions necessary for the reasons given above: ADOC has failed to make the cells in its restrictive housing units suicide resistant, and it has failed to demonstrate any change in their cleanliness. As a result, inmates face an unacceptably high risk of suicide. These

provisions are also narrowly tailored and minimally intrusive. ADOC has previously agreed to use the Hayes checklist which indicates that the checklist is not unduly onerous and while the court orders ADOC to clean restrictive housing unit cells, it will not hesitate to rescind this requirement should the EMT conclude that ADOC is, in fact, regularly cleaning the cells.

8. Other Provisions Regarding Segregation

The plaintiffs also propose various provisions designed to ensure that inmates who live in units that function as segregation, but are not designated as such, receive the same care that ADOC is required to provide to inmates living in restrictive housing units. While the court acknowledges the plaintiffs' concern, it declines to order this relief. Elsewhere in its order, the court requires that inmates in the SU, RTU, and SLU receive 10 hours of structured, therapeutic out-of-cell time and 10 hours of unstructured out-of-cell time per week, unless clinically contraindicated. The court therefore expects that very few inmates outside the restrictive housing units will be in housed in conditions that are functionally equivalent to segregation. Should the its expectation prove wrong, the court trusts that the EMT will say so, and it will take appropriate action at that time.

D. Intake

Like its progress with respect to mental-health staffing, ADOC's progress in reforming its intake system is both commendable and incomplete. As described previously, ADOC has put great effort into ensuring that every inmate receives a mental-health screening at intake, and, as indicated this section, the court has declined to adopt a significant number of the plaintiffs' proposals for relief. Still, there are three issues remaining that require current relief. First, ADOC has persisted in using LPNs to conduct intake without supervision, despite the court's finding that LPNs are not qualified to conduct intake and have consistently failed to detect mental illnesses in inmates. Second, ADOC has failed to ensure that records of

inmates' intake screenings are made available to mental-health providers within its facilities. And, third, ADOC has failed to ensure that records relating to inmates' prior mental-health treatment are received and assessed by ADOC mental-health staff in a timely fashion, if at all.

I. Use of LPNs to Conduct Intake

a. The Parties' Proposed Provisions

With respect to ADOC's continued use of LPNs to conduct intake, the plaintiffs propose that "an RN with mental health training must conduct the screening in accordance with the [National Commission on Correctional Healthcare (NCCHC)] standard M-E-02." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 3.1.5; *see also* Pls.' Post-Trial Br. (Doc. 3370-1) at 88. The defendants propose the same, except that it would allow any qualified mental-health professional, and not just an RN, to perform the intake screening. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 3.1.1, 3.1.2; *see also* Defs.' Post-Trial Br. (Doc. 3367) at 65.

b. The Court's Ordered Relief

23 The court will order that all intake screening be conducted by qualified mental-health professionals, including RNs with mental-health training, but excluding LPNs. As the experts agreed, intake is a key component of a functioning mental-health care system; "[i]t starts everything," and it is vital that it be done and done well. (Dr. Burns testimony on 6/2, pg. 207-08 of the rough draft). Intake is also a function that, at least at ADOC, LPNs have proven unable to perform. Because ADOC has persisted in using LPNs to conduct intake, the court finds that it must forbid ADOC from doing so in order to ¹²⁸⁸correct the violations found in its liability opinion.

The court will not order, however, that only RNs may conduct intake screening, as the plaintiffs suggest. The current NCCHC standards allow screening to be conducted by any qualified mental-health professional. In deference to the

NCCHC's judgment, and so as to provide ADOC maximum flexibility in staffing intake, the court will allow any qualified mental-health professional besides an LPN to conduct intake. The court also will not require that intake be conducted according to NCCHC standard M-E-02, or any other standard. In the absence of any evidence indicating that ADOC is not complying with NCCHC standards or is otherwise conducting intake in an inadequate fashion (besides, that is, for its continued use of LPNs), and in light of testimony from Dr. Metzner that NCCHC standards are regularly updated, the court finds that any requirement that ADOC conduct intake according to a particular standard would be unnecessary and, in all likelihood, quickly outdated.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: because intake screening is a critical step in the provision of mental-health care, because LPNs have proven unable to identify inmates with mental illnesses, and because ADOC has proven unable to ensure that LPNs conducting screening are adequately supervised, the court must forbid ADOC from using LPNs to conduct intake screening. The provision is also narrowly tailored and minimally intrusive because it excludes only LPNs from conducting intake, but no other mental-health professionals, and imposes no additional procedural requirements.

2. Documentation of Intake Screening

a. The Parties' Proposed Provisions

With respect to ADOC's failure to ensure that records of inmates' intake screenings are made available to mental-health providers within its facilities, the plaintiffs propose that an ADOC Form MH-011 indicating the results of each inmate's intake screening be filed in the inmate's medical record. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 3.1.5.1. The defendants propose that the results of

the intake screening be documented on the same form, but would not explicitly require that the form be filed in the inmate's medical record. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 3.1.2.

b. The Court's Ordered Relief

24 The court will substantially adopt both parties' proposed provisions, and order that documentation of each inmate's intake screening—including an interpretation of the results of any psychological assessment—be filed in the inmate's medical record. Without such documentation, mental-health providers who later encounter the inmate cannot utilize the results of the intake screening to provide treatment. The inability of mental-health providers to access the results of intake screenings, including interpretations of any psychological tests, can have fatal consequences. Indeed, Wexford itself identified the failure to incorporate properly the results of intake screenings in inmates' treatment as a central concern in the autopsies it conducted after the suicides of Laramie Avery and Charles Braggs.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: without documentation of an inmate's intake screening, mental-health providers ¹²⁸⁹who later encounter ^{*1289} the inmate cannot effectively provide treatment. The provision is also narrowly drawn and minimally intrusive because it does not require mental-health providers to use the results of intake screenings in any particular way, but merely that the results of intake screenings be documented and made available for future use.

3. Inmates' Previous Records

a. The Parties' Proposed Provisions

With respect to ADOC's failure to ensure that records relating to inmates' prior mental-health treatment are received and assessed by ADOC

mental-health staff in a timely fashion, the plaintiffs propose the following provision:

"If the inmate reports receiving mental health services, and can correctly report the prior mental health provider, a records request from the prior provider must be made within three working days of the intake screening. If the inmate reports receiving mental health services and cannot remember or correctly identify the prior mental health provider, the mental health staff must reasonably attempt to locate their prior records."

Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 3.1.12. The plaintiffs also propose that all health records from each inmate's prior facility of incarceration be requested within 72 hours if they are not presented at intake. *See id.* at § 3.1.13. The defendants propose essentially the same provisions, except they do not propose that mental-health staff be required to reasonably attempt to locate the prior records of inmates receiving mental-health services who cannot remember or correctly identify their prior mental-health provider. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 3.1.9.

b. The Court's Ordered Relief

The court will adopt the plaintiffs' first proposed provision with the added requirement that a records request or reasonable effort to obtain records must be made if, either during *or after* intake, the inmate reports having previously received mental-health services. If the inmate reports having previously received mental-health services after intake, and can correctly report the prior provider, the records request must be made within three working days of the time the intake reported having previously received mental-health services. The court will also adopt the plaintiffs' second proposed provision—that all health records from each inmate's prior facility of incarceration be requested within three working days if they are not presented at intake.

¹²⁹⁰The court adopts the plaintiffs' first proposed provision because the evidence demonstrates that ADOC is failing to obtain the records of all inmates who have received prior mental-health treatment, and that this failure contributes to the violations found in the liability opinion in two ways. First, it has caused ADOC to fail to identify a substantial number of inmates with mental illnesses, including several who ultimately committed suicide. *See* June 2, 2021, R.D. Trial Tr. at 204 (testimony of Dr. Burns). Second, it has prevented ADOC from effectively treating those inmates that it has correctly identified as having mental illnesses, because, as Dr. Burns testified, "mental health diagnoses [and] conditions change over time, and you need to look at the longitudinal course of a person's illness to arrive at the correct diagnosis and then subsequently treatment." *Id.* at 218.

The evidence also demonstrates that inmates do not always report their prior treatment at intake. *See, e.g.,* May 24, 2021, R.D. Trial Tr. at 56–57 (testimony of Dr. Burns, noting that Marquell Underwood, who eventually committed suicide, reported prior treatment for bipolar disorder ¹²⁹⁰during a referral after intake). Therefore, ¹²⁹⁰the court finds it necessary to require ADOC to request records of an inmate's prior treatment, or to make a reasonable effort to obtain such records, if the inmate reports having received such treatment after intake has already been completed.

The court adopts the plaintiffs' second proposed provision for essentially the same reasons that it adopts the first. Wexford's own evaluation indicates that it does not consistently ensure that inmates' health records from the prior facility of incarceration are received and assessed at intake, despite the fact that those records often contain information about inmates' mental illnesses and mental-health treatment. *See* Marquell Underwood Psychological Autopsy, P-3316, at 15 (recommending "[i]mproved continuity of care ... between county jail and ADOC for any mental health patients or inmates who may have

presented with suicidal ideations or self-harming prior to transport"); June 2, 2021, R.D. Trial Tr. at 220 (testimony of Dr. Burns, explaining the importance of receiving an inmate's records from the prior facility of incarceration). To the extent that such records indicate inmates' mental illnesses and the "longitudinal course" of inmates' treatment, June 2, 2021, R.D. Trial Tr. at 218 (testimony of Dr. Burns), they are essential for identifying and treating inmates' mental illnesses, and ADOC must obtain them in a timely fashion in order to remedy the violations identified in the liability opinion.

c. PLRA Findings

The court finds that the plaintiffs' first provision--with the added requirement that ADOC request records of an inmate's prior treatment if the inmate reports having received such treatment after intake has already been completed--is necessary for the reasons given above: records of prior treatment, which ADOC is currently failing to obtain, are essential for identifying and treating inmates' mental illnesses. The provision is also narrowly drawn and minimally intrusive because it merely requires ADOC to seek the outside treatment records where possible. While the three-day time frame is specific, the court finds that it meets the need-narrowness-intrusiveness test because, given ADOC's continued failure to obtain these records within a reasonable time, setting a clear time frame is necessary to ensure compliance. It is also the time frame suggested by the defendants--a strong indication that it is reasonable and not overly intrusive.

The court finds the plaintiffs' second proposed provision to be necessary, given ADOC's failure to obtain health records from prior facilities of incarceration, despite the fact that those records often pertain to mental-health treatment. Like the first proposed provision, the plaintiffs' second proposed provision is narrowly tailored and minimally intrusive because it merely requires ADOC to request records. And again, although the

three-day time frame is specific, it is necessary, narrowly tailored, and minimally intrusive in light of ADOC's continued failure to obtain these records within a reasonable timeframe. Also, as before, it is the time frame suggested by the defendants.

4. Other Provisions Regarding Intake

The parties propose additional provisions unrelated, or indirectly related, to the three issues identified above. These include the following proposals by the plaintiffs:

- Each inmate entering or returning to ADOC custody must receive a mental-health screening no later than 12 hours after his or her arrival, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 3.1.1;
- Each inmate must receive a mental-health screening before being placed in a housing area that does not provide ¹²⁹¹ constant correctional officer observation, *see id.* at § 3.1.2;
- Mental-health staff conducting intake must review an inmate's transfer documentation before performing any screening evaluation, *see id.* at § 3.1.3;
- Intake evaluations must cover certain topics, *see id.* at §§ 3.2.2, 3.2.4;
- Mental-health screenings must be conducted in areas permitting inmate confidentiality and encouraging self-reporting, *see id.* at § 3.1.4;
- Intake must include a suicide risk screening, *see id.* at § 3.1.6;
- ADOC must take certain steps to ensure that inmates who are identified at intake as having mental-health needs are referred for treatment and appropriately placed within ADOC institutions, *see id.* at §§ 3.1.8, 3.1.14, 3.2.2, 3.2.3, 3.2.7, 3.3.1;
- Mental-health staff must report suspected abuse of inmates, *see id.* at § 3.1.9;

- Inmates arriving with trauma must be referred for appropriate treatment, *see id.* at § 3.1.10;

- ADOC must take certain steps to ensure that inmates prescribed mental-health medication prior to their arrival at ADOC facilities continue to receive such medication, *see id.* at § 3.1.11;

- Inmates must be provided at intake with certain information regarding mental-health services available in ADOC, *see id.* at §§ 3.3.2; 3.4.3; and

- Inmates must not be transferred to another facility before receiving a full intake screening or else must receive a full screening upon transfer, *see id.* at § 3.4.1, 3.4.2.

The court declines to adopt these provisions because the record does not show them to be necessary at this time. In fact, the record demonstrates that ADOC has made marked progress in preventing certain problems that these provisions are designed to remedy. For instance, Dr. Burns testified that intake staff were performing more comprehensive assessments of incoming inmates' suicide risk than she believed necessary. *See* June 7, 2021, R.D. Trial Tr. at 106-07. And, while there are obvious problems, as discussed previously, with the process of referring inmates for more thorough evaluations after intake, there is no evidence that those problems stem from failures by the staff members conducting intake to make referrals where necessary. Indeed, Dr. Burns indicated that she had seen evidence that inmates were being referred upon the identification of potential mental-health needs. *See id.* at 108.

In declining to adopt these provisions, however, the court assumes that ADOC is prepared to sustain its progress as COVID-19 wanes and thousands of inmates currently housed in city jails enter its facilities. Should that assumption prove unfounded, the court expects the EMT to raise the matter with the court. At that point, the court may consider additional relief.

E. Coding

While ADOC has put great effort into redesigning its coding system in the time since the liability opinion, two problems remain with how that system is used to track inmates. First, the evidence demonstrates that inmates are not always assigned mental-health codes and SMI indicators according to their needs. Second, even when inmates are coded appropriately, their codes are inconsistently and sometimes erroneously documented, making it difficult for providers who encounter inmates to discern accurately their mental-health needs.

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I. Assignment of Codes

a. The Parties' Proposed Provisions

To address the problem of inmates not being assigned mental-health codes and SMI indicators according to their needs, the plaintiffs propose that all inmates on the mental-health caseload must be coded and, if appropriate, assigned SMI flags, as required by the Revised Mental-Health Coding System. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 4.1. The defendants propose two similar provisions. First, they propose that ADOC or its mental-health vendor must assess all inmates through intake and/or through clinical encounters such as counseling sessions and treatment-team meetings and, to the extent clinically indicated, assign them SMI designations. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 4.1. Second, they propose that all inmates entering the system must be assigned mental-health codes. *See id.* at § 4.2. Under this proposal, a code of MH-A may be assigned by a qualified mental-health professional; a code of MH-B or above must be assigned by a psychiatrist, psychologist, or CRNP. *See id.*

b. The Court's Ordered Relief

26 The court, in substantial agreement with both parties, will order that all inmates be assigned mental-health codes and, if necessary, an SMI flag that is appropriate to address their mental-health needs, as determined by clinical judgment. The

court adopts this provision because it is uncontroverted that the coding system must accurately reflect inmates needs if it is to function as an effective way to track mentally ill inmates and facilitate care. Yet, as the court found in the liability opinion, ADOC "fails to classify the severity of mental illnesses accurately." *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1204 (M.D. Ala. 2017) (Thompson, J.). This failure manifests in two forms. First, some inmates simply do not receive codes at all. Second, some inmates receive codes that do not reflect clinical judgment. Indeed, Dr. Burns testified that she had seen instances of providers assigning inmates codes based on what the inmate requested or on the inmate's desire to seek employment, rather than on appropriate clinical factors. *See* May 23, 2021, R.D. Trial Tr. at 19; *id.* at 74–75. This provision addresses both failures: it ensures that inmates receive codes, and that codes reflect clinical judgment.

The court will not, however, attempt to prescribe the manner in which mental-health providers exercise their judgment when assigning codes. Nor will it dictate which mental-health providers may assign which codes, as the defendants propose, because the record does not suggest that ADOC's failure to code inmates appropriately is related to the professional qualifications of those individuals tasked with assigning codes (except, that is, to the extent that LPNs continue to conduct intake).

c. PLRA findings

The court finds this provision necessary because, as explained above, ADOC has persistently failed to assign inmates codes and to do so according to clinical judgment. The provision is narrowly drawn and no more intrusive than necessary because it simply directs ADOC to ensure that providers are drawing on their clinical judgment to code each inmate appropriately, while leaving it to ADOC to determine how it achieves that result.

2. Documentation of Codes

a. The Parties' Proposed Provisions

To address the problem of inmates' mental-health codes and SMI designations being incorrectly and inconsistently documented, the plaintiffs propose that each inmate's mental-health code must be documented in the inmate's medical record. *See* 1293*1293 Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 3.2.6. The plaintiffs also propose that each inmate be given an SMI designation separate from his or her mental-health code, and that that designation be indicated by a flag, warning signal, or some other type of signal within the electronic system. *See id.* The defendants propose no provisions addressing the manner in which it documents inmates' mental-health codes and SMI indicators.

b. The Court's Ordered Relief

Much as the plaintiffs suggest, the court will order that each inmate's mental-health code and SMI designation must be accurately and consistently indicated throughout all documents related to his or her care. The court orders this relief in light of the evidence that inmates' mental-health codes and SMI designations are often undocumented or inaccurately documented. That failure, in turn, undermines ADOC's entire system of treatment planning and provision; if treatment teams and mental-health providers are to perform their intended functions, they must be aware of inmates' mental-health statuses. Inmates with serious mental illnesses must also be easily identifiable as such, particularly when they are transferred between facilities, so that appropriate precautions may be taken to avoid self-harm or suicide.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: inmates' mental-health codes and SMI designations must be accurately documented for ADOC's system of treatment planning and provision to function, and inmates with serious mental illnesses must be easily

identifiable as such so that staff will be alert to their needs. Because ADOC has failed to ensure accurate documentation, the court must order relief. This provision is also narrowly drawn and no more intrusive than necessary because it simply directs ADOC to ensure that documentation is done correctly, without mandating a specific process for doing so.

F. Referral

As stated earlier, ADOC has made notable progress implementing a system by which both inmates and staff are equipped to refer inmates for mental-health services. ADOC has made similarly important progress in its development and implementation of a triage process to identify the urgency of requests for care. In light of ADOC's progress with respect to the making and triage of referrals, there are several areas in which the parties propose remedial provisions but the court will order no relief at this time.

At a high level, ADOC's referral process is a chain that begins with the identification of an inmate's need for mental-health services and should result in a clinical assessment or intervention by mental-health staff. Each referral is classified as either emergent, urgent, or routine, depending on the urgency of the inmate's need for responsive care. An "emergent" need means that there is "an imminent risk of injury to the inmate or others" or that mental-health services are "otherwise immediately necessary." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.10; *see also* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.8. An "urgent" need "means mental-health services should be provided in the near future, but not immediately." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.39; *see also* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.33. And a "routine" need "means that mental-health services should be provided in the ordinary course of business." Defs.' Proposed Phase 2A Remedial

Order (Doc. 3215) at § 1.31; *see also* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.27.

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Despite ADOC's progress, persistent failures in this process deny many inmates access to necessary mental-health care within acceptable timeframes. Sometimes a failure is attributable to errors or delays by the staff member making the referral. Most often, though, a referral is made, its urgency is identified, and then follow-up care is delayed far beyond what is acceptable—indeed, what is required by court order and ADOC's own policy—if it even happens at all. Because a failure at one link in the chain denies inmates access to timely—and in some cases, any—mental-health care irrespective of ADOC's improvements at other stages of the referral process, the court must order relief.

I. Making of Referrals

Both parties propose provisions for inmates to have the ability to complete self-referrals for mental-health services verbally or in writing. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.1.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 5.2.2. While there is extensive evidence that self-referrals are an essential component of the referral system, *see, e.g.*, June 3, 2021, R.D. Trial Tr. at 18-19 (testimony of Dr. Burns); May 26, 2021, R.D. Trial Tr. at 175-77 (testimony of Mr. Vail); June 29, 2021, R.D. Trial Tr. at 82-83 (testimony of Dr. Metzner), ADOC has already implemented a system for self-referrals, *see* June 23, 2021, R.D. Trial Tr. at 66-67 (testimony of Dr. Burns). Although Dr. Burns highlighted the troubling report that, in the two weeks prior to Charles Braggs's death, he requested mental-health services without a referral occurring, *see* May 24, 2021, R.D. Trial Tr. at 119-20, the mental-health records presented to this court reflect that inmates generally have been able to take this initial step toward receiving mental-health care.

This is also the case with respect to the staff-referral system. Both parties propose provisions for non-mental-health staff to refer inmates to mental-health staff for an assessment or intervention when a prisoner has informed the non-mental-health staff of a need for mental-health services or the non-mental-health staff has recognized such a need. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 5.2.1, 5.2.2, 5.2.3; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 5.2.1, 5.2.3. As with self-referrals, ADOC has implemented a staff-referral system, and evidence at the omnibus remedial hearings suggested that it is being successfully used. Dr. Burns noted multiple instances in which ADOC staff referred an inmate for mental-health services. *See, e.g.*, May 25, 2021, R.D. Trial Tr. at 177 (testimony of Dr. Burns, noting several recorded staff-referrals of inmate W.S.); June 8, 2021, R.D. Trial Tr. at 56-57 (testimony of Dr. Burns, noting that a warden and a classification specialist had referred Gary Campbell); June 10, 2021, R.D. Trial Tr. at 15-16 (testimony of Dr. Burns, noting that an ADOC employee had referred inmate K.W. for an evaluation). In light of these referrals, the evidence does not presently indicate that ADOC has failed to inform staff of their ability, and indeed responsibility, to refer inmates in need of mental-health services. Whether staff consistently notice and appropriately recognize mental-health needs is a critical but distinct issue, which is not addressed by the parties' proposed provisions regarding the referral process and may be incapable of being addressed completely until ADOC's understaffing is corrected. As Mr. Vail testified at the omnibus remedial hearings, reaffirming his testimony at the liability trial, without "enough staff to properly supervise the inmates," correctional staff will "miss a lot of behavior, including behavior related to mental illness." *See* May 26, 2021, R.D. Trial Tr. at 180-129581. Presently, the court will not order ¹²⁹⁵ relief with respect to the staff-referral system.

With respect to written referrals by both inmates and staff, both parties propose provisions requiring blank mental-health referral forms to be available in the healthcare unit, the mental-health unit, and designated shift offices within each ADOC major facility and designating locations for completed mental-health referral forms to be submitted. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.2.4; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 5.4. Dr. Burns testified that making the forms available in these enumerated locations is necessary "so that people know where to get them" and "can access them when necessary," and that the plaintiffs' proposed drop-off location, the box for medical referrals, would "simplif[y] the process ... so there's not different types of mailboxes all over the institution." June 3, 2021, R.D. Trial Tr. at 22. But Dr. Burns acknowledged that placing the forms in any central location would be "helpful" as long as "inmates have access to that central location," June 23, 2021, R.D. Trial Tr. at 69, and there is no evidence that ADOC's current locations for these forms are inadequate. The court finds that there is no need to order the proposed relief at this time.

The plaintiffs also propose multiple provisions specifying the information that must be included in these referral forms, including identifying information for the inmate, the referring individual, and the triage staff, the date and time that the referral form was completed and triaged, and the triage staff's determination as to whether the referral is emergent, urgent, or routine. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 5.2.5, 5.2.6. However, Dr. Burns acknowledged that this information is already incorporated in the referral form currently used by ADOC. *See* June 23, 2021, R.D. Trial Tr. at 70. Although Dr. Burns noted "multiple episodes in which the referral forms weren't completed," May 26, 2021, R.D. Trial Tr. at 17, most of the referral forms admitted in evidence did contain the information required by the plaintiffs' proposed

provisions. Should the incomplete referral forms highlighted by Dr. Burns turn out to be, or become, a systemic problem, the court expects that the EMT will be able to flag the issue for the court. But at this point, the court is confident that ADOC will continue to encourage its staff to engage in thorough documentation and ensure that these forms are fully completed.

2. Response to Referrals

a. The Parties' Proposed Provisions

With respect to all referrals, the defendants propose generally, "[a]n emergent, urgent, or routine referral will result in a timely clinical assessment and/or intervention by a psychiatrist, psychologist, CRNP, or counselor." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 5.1.

With respect to emergent referrals, the plaintiffs propose that an assessment by a qualified mental-health professional "must occur as soon as possible but no more than 3 hours from the triage staff's determination that the referral is emergent." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.5.1. In their definition of "emergent," the defendants propose that mental-health services will be provided "typically[] within four (4) hours." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.10.

The plaintiffs propose that "[u]rgent referrals must result in a clinical assessment and/or intervention by a [qualified mental-health professional] within 24 hours of referral." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.5.2. Likewise, the defendants' proposed ¹²⁹⁶definition ^{*1296} of "urgent" states that mental-health services should be provided "typically[] within twenty-four (24) hours." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.39.

The plaintiffs propose that "[r]outine referrals must result in a clinical assessment and/or intervention by a [qualified mental-health professional] within 14 calendar days of referral."

Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.6. Similarly, the defendants' proposed definition of "routine" states that mental-health services "should be provided in the ordinary course of business—typically, within fourteen (14) days." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.31.

b. The Court's Ordered Relief

27 In light of the parties' proposals, the court will adopt the following provisions: A referral must result in a timely clinical assessment and/or intervention by a psychiatrist, psychologist, CRNP, or counselor. Emergent referrals must result in a clinical assessment and/or intervention as soon as possible but no more than four hours from the determination that the referral is emergent. Urgent referrals must result in a clinical assessment and/or intervention within 24 hours of the time the referral was made. Routine referrals must result in a clinical assessment and/or intervention within 14 calendar days of the time the referral was made.

The court is concerned with the ongoing pattern of missed or unanswered referrals at all levels of urgency, which delay care and leave inmates to deteriorate without the treatment they need. ADOC's failures have affected inmates waiting on all levels of referrals. *See, e.g.*, May 25, 2021, R.D. Trial Tr. at 118-20 (inmate R.J. was not seen in response to an emergent referral for three days due to lack of staff to bring him out for an assessment); *id.* at 52 (inmate T.M. was not seen by a CRNP until three weeks after he set himself on fire and received an urgent referral); *id.* at 27 (inmate A.J. was not seen until May 2020 for a routine referral that was made in February 2020). These failures have persisted since the time of the liability trial in spite of a court order to which the defendants stipulated, *see* Phase 2A Order and Injunction on Mental-Health Identification and Classification Remedy (Referral), Attachment A (Doc. 1821-2) at §§ 2.1-2.3, and ADOC's own regulations and policies. While ADOC's

implementation of a triage system is admirable, it clearly is not sufficient to address the problem if the identified level of urgency does not correspond with the actual time in which responsive care is provided. The court finds it necessary to require that mental-health staff respond to referrals in a timely manner. Moreover, given ADOC's inability to improve even in the face of the liability finding, and in light of the unreasonable delays in care that have persisted in violation of a court order and ADOC's policy, it is necessary for the court to impose specific and concrete timeframes for mental-health staff to respond to referrals.⁹

⁹ The court discusses these timeframes that it will impose in its order against the backdrop of the court's general discussion of timeframes in Section IIE of Part II of the Phase 2A Omnibus Remedial Opinion. ADOC's history of noncompliance with these timeframes even after the defendants stipulated to be enjoined to comply with them, together with the testimony of experts for both sides, discussed below, strongly supports the necessity, narrowness, and minimal intrusiveness of these particular timeframes.

With respect to the time to respond to emergent referrals, the court adopts the language of the plaintiffs' provision but incorporates the defendants' proposed timeframe. Dr. Burns and Dr. Metzner gave conflicting testimony as to whether a three- or four-hour timeframe for responding to an emergent referral is necessary and reflective of the accepted standard of care. *See* May 25, 2021, R.D. Trial Tr. at 54 (testimony of Dr. Burns); June 3, 2021, R.D. Trial Tr. at 25, 33 (same); June 29, 2021, R.D. Trial Tr. at 83, 151, 204-05 (testimony of Dr. Metzner). In light of the distinct requirement that mental-health staff still must respond to an emergent referral "as soon as possible," the court will defer to the defendants' expert, Dr. Metzner, and adopt the four-hour timeframe.

With respect to urgent and routine referrals, Dr. Burns and Dr. Metzner agreed on the appropriate timeframes for mental-health staff to respond: 24 hours for urgent referrals and 14 days for routine referrals. See May 25, 2021, R.D. Trial Tr. at 54 (testimony of Dr. Burns); June 3, 2021, R.D. Trial Tr. at 26, 33 (same); June 29, 2021, R.D. Trial Tr. at 83, 151, 204-05 (testimony of Dr. Metzner). ADOC's continued failures and delays in providing mental-health services in response to these referrals, as well as emergent referrals, necessitate specific timeframes for an assessment or intervention following a referral. The court adopts the timeframes agreed upon by Dr. Burns and Dr. Metzner.

c. PLRA Findings

This relief is necessary to correct a referral process that remains "riddled with delays and inadequacies." *Braggs*, 257 F. Supp. 3d at 1203. ADOC still is not providing care to inmates in an acceptable timeframe after they have been referred, and the result is that the department's referral process, a cornerstone of its system for providing mental-health care, remains deficient. In light of ADOC's failure to correct this deficiency on its own, specific timeframes are necessary, narrowly tailored, and minimally intrusive to ensure ADOC's compliance and prevent further harms.

ADOC's longstanding violation in this area and the timeframes that the court finds necessary to correct this problem inform the court's consideration of the parties' other proposed provisions. Although failures to follow up on mental-health referrals appear to be the critical defect in ADOC's referral process, the evidence makes clear that problems earlier in the referral process have the same harmful effect of delaying necessary care, and additional relief is required.

3. Communication of Emergent or Urgent Referrals

a. The Parties' Proposed Provisions

To ensure that emergent or urgent referrals are communicated to mental-health providers with appropriate speed, the defendants propose that "[a]n emergent or urgent referral must be communicated verbally, in person or by telephone, to the mental-health staff as soon as possible, but in no case longer than (1) hour absent unusual circumstances which detain staff for an extended period of time such as a medical emergency or an incident involving safety or security of staff or inmates." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 5.1. During a conference call following the omnibus remedial hearings, defense counsel clarified that this provision would apply to a referring staff member who makes a preliminary determination that an inmate's mental-health need is emergent or urgent. At that time, the referring staff would have one hour, absent unusual circumstances, to communicate the referral directly (verbally or in person) to the triage staff.

The plaintiffs propose the following provision regarding the communication of emergent or urgent referrals by triage staff:

"If the triage staff is an RN and they determine that the referral is emergent or urgent, they must initiate contact ¹²⁹⁸ with the on-call MHP or psychologist within one (1) hour of receipt of the referral. If the triage staff is a [qualified mental-health professional] and is not the on-call MHP or psychologist, they must initiate contact with the on-call MHP or psychologist within one (1) hour of receipt of the referral. The on-call MHP or psychologist must determine whether further referral to the psychiatrist is warranted or whether a change in the status of the referral is warranted."

Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.5.

b. The Court's Ordered Relief

²⁸ The court will adopt the defendants' proposed provision and order that an emergent or urgent referral must be communicated verbally, in person

or by telephone, to the appropriate mental-health staff as soon as possible, but in no case longer than one hour from the time the referral is first identified as emergent or urgent, absent unusual circumstances which detain staff for an extended period of time such as a medical emergency or an incident involving safety or security of staff or inmates.

The court concludes that it must order compliance with this one-hour timeframe to ensure that emergent or urgent referrals lead to assessments or interventions within the timeframes that it has found necessary. Despite the urgency of these categories of referrals, they are not consistently received, much less responded to, in a timely manner, especially when they are initiated via written referral forms, rather than direct, verbal contact with mental-health staff. For instance, on the day before Jaquel Alexander committed suicide, a medical staff member made a written referral for him after he "[r]equested to be placed in a crisis cell." Pls.' Ex. 3297 at ADOC518191. The form was not received by the triage nurse for over 12 hours. *See id.* Although Alexander, due to a previous referral, met with a mental-health provider that morning, the 12-hour delay before triage staff even received a referral that was ultimately identified as urgent and that requested placement on suicide watch is a troubling sign that relief is necessary.

However, while emergent or urgent referrals must be communicated to mental-health staff with urgency, the court finds that it is appropriate for this provision to account for unusual circumstances that may make compliance with a strict one-hour requirement impossible. The court expects that the EMT, in monitoring ADOC's compliance with this provision, will evaluate whether ADOC applies this exception overbroadly.

The court will not order compliance with the plaintiffs' proposed provision at this time. The evidence presented at the omnibus remedial

hearings reflected that, after triage staff received emergent or urgent referrals from the referring staff, they generally triaged the referrals and notified appropriate mental-health staff within the plaintiffs' proposed timeframe.

c. PLRA Findings

The provision that the court orders is necessary to ensure that mental-health staff are notified promptly about the most time-sensitive referrals in order to provide urgent or emergent care to inmates without inappropriate delay. The evidence at the omnibus remedial hearings made clear that Alexander's referral was not unique in the delay before it was received and triaged. Subjecting emergent or urgent referrals to this delay prior to triage risks leaving inmates in potentially acute distress as they await necessary treatment or intervention for hours or longer. Requiring that such referrals be communicated to mental-health staff directly and with appropriate urgency is narrowly tailored to protect mentally ill inmates ¹²⁹⁹from this substantial ^{*1299}risk of harm. And, by affording flexibility to staff in the event of unusual circumstances, this relief is the least intrusive means that will address the violation.

4. Communication of Routine Referrals

a. The Parties' Proposed Provisions

The plaintiffs propose that "[r]outine referrals must be communicated to the mental health staff on the next business day by leaving the referral form in a designated location." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.6. The defendants' proposed provision is substantially the same, except that it uses permissive language. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 5.1.

b. The Court's Ordered Relief

²⁹ The court will adopt the parties' proposed provisions with a slight modification and order that routine referrals must be communicated to the mental-health staff by the next shift by leaving the

referral form in a designated location. As with emergent or urgent referrals, the court finds that relief is necessary with respect to routine referrals in light of the unreasonable delays in response times. These delays are exacerbated by the fact that referrals are frequently lost or delayed before they are ever communicated to mental-health staff, as Dr. Burns described with respect to the seven-day delay before a referral for Marquell Underwood was even received by mental-health staff. *See* June 2, 2021, R.D. Trial Tr. at 100. This provision is designed to address the problem by ensuring that referrals are communicated in a timely and reliable fashion.

c. PLRA Findings

As with the court's ordered relief regarding emergent and urgent referrals, this provision is necessary to address another facet of ADOC's deficient referral process. Inmates are not currently receiving responses to their routine referrals in a timely manner, and delays in communicating the referrals to mental-health staff contribute to that deficiency. Although routine mental-health needs generally do not pose the same immediate risks of injury as emergent or urgent needs, the failure to address them—especially over the protracted delays that currently infect ADOC's process for handling routine referrals—subjects inmates with mental-health needs to the risk of worsened symptoms or decompensation. Delays in handling routine referrals are particularly concerning in light of the risk that emergent or urgent needs may initially be misclassified as routine needs, leaving inmates with such needs to suffer without an intervention far longer than is acceptable. Indeed, failures in ADOC's provision of routine care have contributed to the inadequacy of care received by numerous inmates who committed suicide since the court's suicide prevention opinion.

A specific timeframe in which staff must communicate routine referrals is necessary to address the violation, given that ADOC has failed

to self-correct in this area. And the timeframe specified provides ADOC with ample time to fulfill the requirement. This provision is narrowly tailored to address only the underlying issue causing the violation. And it is no more intrusive than is necessary to ensure that delays are sufficiently short to ensure timely treatment of emergent or urgent needs that initially may be understood as routine needs. The provision preserves ADOC's flexibility to manage the means by which it will comply with this requirement, including its discretion to decide where routine referrals should be submitted and who should review them.

5. Triage of Referrals

a. The Parties' Proposed Provisions

Both parties propose a number of provisions relating to the process to triage referrals.¹³⁰⁰ The plaintiffs propose a provision requiring that triage not be completed by correctional staff. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.1. They further propose additional provisions regarding triage responsibility:

- Each ADOC major facility must designate one triage staff per shift, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.2;
- The triage staff must regularly monitor the designated area for completed mental-health referral forms and check the box for such forms at least once per shift, *see id.* at § 5.3.3; and
- The triage staff must determine whether each mental-health referral is emergent, urgent, or routine, *see id.* at § 5.3.4.

The defendants propose similar provisions, with the key distinctions being that their proposal would allow for multiple designated triage staff on a given shift and would require triage staff to check for completed referral forms at least once

per business day rather than once per shift. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 5.4, 5.5.1, 5.5.2, 5.5.3.

b. The Court's Ordered Relief

The court will not order that correctional staff cannot triage mental-health referrals, nor will it order that each ADOC major facility must designate one triage staff per shift. There is no evidence that, since ADOC's current triage system was developed, any triage was performed by correctional staff, so this relief is unnecessary. And while Dr. Burns testified that assigning triage responsibility to one person on a shift would avoid the confusion of "having multiple people trying to sort" the referrals, June 3, 2021, R.D. Trial Tr. at 23, the evidence at the omnibus remedial hearings did not reflect that ADOC's current allocation of responsibility for triage has caused such problems.

Similarly, although the parties' proposals that triage staff must determine whether each mental-health referral is emergent, urgent, or routine undoubtedly reflect a necessary and foundational component of the referral process, *see, e.g.*, June 29, 2021, R.D. Trial Tr. at 152 (testimony of Dr. Metzner, observing that "all referrals need to be triaged to determine whether they're urgent, emergent, or routine"); June 3, 2021, R.D. Trial Tr. at 33 (testimony of Dr. Burns, explaining that "[i]t is the standard of care that there be a triage person, that there be these referral levels"), the mental-health records admitted in evidence at the omnibus remedial hearings tended to show that, when referrals were received, they generally were assigned an urgency level by the triage staff in a timely manner. The more systemic problems were that referrals were not timely communicated and received prior to triage and did not lead to timely follow-up afterward. The court will not order this proposed relief. Even without this provision, the court fully expects that the EMT will review triage of referrals extensively and bring persistent issues to the court's attention if further relief is necessary.

However, the court will adopt the plaintiffs' proposed provision requiring the triage staff to monitor regularly the designated area for completed mental-health referral forms, at a minimum frequency of once per shift. The court credits Dr. Burns's testimony that that this frequency of monitoring for completed referral forms is necessary to ensure that written referrals, particularly those that may actually be emergent or urgent, are received, classified, and acted upon with appropriate speed. *See* June 3, 2021, R.D. Trial Tr. at 28. Although Dr. Metzner testified that ¹³⁰¹ triaging referrals once per day is sufficient ^{*1301} if staff are properly trained that emergent or urgent referrals "ought to be done by phone to alert people," June 29, 2021, R.D. Trial Tr. at 221; *see also id.* at 151 (testimony of Dr. Metzner, explaining that he would "require that emergent and urgent referrals be transmitted verbally as well as in writing," so that "you are not waiting for someone to pick up the referral slip"), the court finds that ADOC has not yet reached the point at which Dr. Metzner's reasoning is applicable. Because ADOC staff do not yet recognize inmates' emergent or urgent needs with the consistency to ensure that such referrals are transmitted directly to triage staff, the protection that the plaintiffs propose is necessary to avoid subjecting inmates in need of "immediate" or "urgent care center type" needs, *see* June 3, 2021, R.D. Trial Tr. at 25-26 (testimony of Dr. Burns), to long delays—longer than the court finds are permissible to go without an assessment or intervention—before their referrals are even picked up by a mental-health staff member.

c. PLRA Findings

Requiring that triage staff monitor the designated area for completed referral forms at least once per shift is necessary to protect inmates whose emergent or urgent needs may be initially misidentified by referring non-mental-health staff members prior to triage. While the court's ordered provision requiring the verbal communication of emergent or urgent referrals, combined with

ongoing mental-health training of ADOC staff, may offer partial protection to these inmates, it is not yet sufficient to keep inmates with pressing mental-health needs from falling through the cracks long enough to suffer decompensation, self-injury, or worse. Especially while severe understaffing continues to present the danger that correctional staff will miss or misidentify behavior related to mental illness, this additional safeguard is necessary to ensure that inmates receive timely treatment relative to their mental-health needs. Even this provision may not offer entirely adequate protection for inmates who could require intervention in as little as four hours. For comparison, ADOC's stated policy since 2018 requires triage staff to check for completed forms "a minimum of every hour and at the end of each triage nurse's shift." MH E-05.5 (D-3646) at ADOC475712. In light of ADOC's progress in the development and implementation of its triage process, however, the court will order this less restrictive provision, with the expectation that improvements to staffing, training, and the remainder of ADOC's referral process will all be necessary to provide adequate protection to inmates who experience emergent or urgent needs for mental-health services. The provision that the court orders is narrowly tailored and minimally intrusive to ensure that these inmates receive adequate protection and access to treatment.

6. Observation in Response to Emergent Referrals and Referrals for Suicide Watch

a. The Parties' Proposed Provisions

The plaintiffs propose that, "[f]ollowing an emergent referral, including referrals for suicide watch, custody or mental health staff must maintain constant, line of sight, observation of the prisoner until assessed by a [qualified mental-health professional]." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.3.5.1. In the context of intake, the defendants propose the similar provision that, "[i]f a psychiatrist or CRNP is not available to evaluate

an inmate with an emergent need, then the inmate will be placed on constant observation or close watch (as appropriate) until the inmate may be evaluated." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 3.1.12.

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With respect to referrals for suicide watch in particular, the plaintiffs propose the additional provision that, "[w]hen referring prisoners for suicide watch placement, the referring person must ensure that staff maintain constant, line-of-sight observation of the prisoner who is being referred until they are either transferred to appropriate correctional, medical, or mental health staff who takes over the responsibility to ensure an assessment by a triage nurse occurs or the prisoner is assessed by a triage nurse on an emergent referral." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.2.2.1.

b. The Court's Ordered Relief

30 The court will adopt the plaintiffs' first proposed provision. As discussed in the previous sections, ADOC has continued to perform inadequately in providing responsive care to inmates within acceptable timeframes following mental-health referrals. This failure is particularly unacceptable, and particularly dangerous, when the inmate has been identified as having an emergent need for mental-health care, including possible suicidality. To reiterate, an emergent referral indicates that an inmate is at serious and imminent risk of injury or other harm. *See* June 3, 2021, R.D. Trial Tr. at 25. However, even though the generally accepted standard in these cases is to provide care within three or four hours, there is evidence that these inmates must wait days to be seen—and that some are never seen at all. In at least one case that Dr. Burns identified, the inmate was not put on watch or given any additional support while waiting to be seen. *See* May 25, 2021, R.D. Trial Tr. at 118-20 (discussing the failure to place inmate R.J. on watch while he waited three days for an assessment following an

emergent referral). Leaving inmates in such acute distress without taking any steps to ensure their safety is plainly inadequate. When this failure is combined with delays in responding to the referral, as was the case for Casey Murphee, the result can be deadly. *See* May 24, 2021, R.D. Trial Tr. at 76-77. The court finds that this provision is necessary to address this grave danger and ensure that inmates remain safe while waiting to receive the basic care that they need.

However, the court will not adopt the plaintiffs' second proposed provision, which would place initial responsibility for ensuring this observation on the referring individual until the appropriate correctional, medical, or mental-health staff can assume that responsibility. While it is possible that this is an important practice in order to maintain constant supervision of inmates who have been referred for a suicide watch assessment, Dr. Metzner testified that this provision could have the effect of imposing responsibility for maintaining constant watch on an individual without the authority, ability, or qualifications to monitor the inmate properly. *See* June 29, 2021, R.D. Trial Tr. at 220-21. And there was no evidence presented at the omnibus remedial hearings that this requirement would be effective or necessary to protect inmates beyond the relief that the court does order, which still requires constant line-of-sight observation while preserving ADOC's discretion as to how to comply with this requirement.

c. PLRA Findings

The provision that the court adopts is necessary to address the dangers to inmates with emergent mental-health needs that are neglected, and indeed aggravated, as a result of the unconstitutional delays in ADOC's referral process. It is narrowly tailored to the dangers that ADOC's violations cause; it only imposes a requirement for constant observation until mental-health staff can initiate an assessment or intervention to determine the next steps that are appropriate. While the defendants

¹³⁰³And it is the least intrusive means to ^{*1303} protect the safety of inmates while they are awaiting necessary mental-health services.

7. Other Provisions Regarding Referrals

Finally, both parties propose provisions requiring the maintenance of a log of all mental-health referrals at each ADOC major facility. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 5.4.1, 5.4.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 5.3. The plaintiffs' proposal further prescribes information that must be included in these mental-health referral logs. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 5.4.2.1. However, Dr. Burns testified that ADOC is already keeping referral logs, and, because she did not review the most recent logs, she was unable to provide evidence as to whether these logs are deficient. *See* June 23, 2021, R.D. Trial Tr. at 75. Therefore, the court sees no reason to order relief at this time. However, given Dr. Metzner's testimony that these logs would be important to the EMT in fulfilling its monitoring responsibilities, *see* June 29, 2021, R.D. Trial Tr. at 224; July 1, 2021, R.D. Trial Tr. at 12-13, the court anticipates that the EMT may flag for the court any defects or other concerns regarding how these logs are being maintained should any deficiencies inhibit monitoring or impede the quality or continuity of mental-health care.

G. Confidentiality

As described previously, and as its own audit recognized, ADOC continues to struggle to provide inmates with the confidential treatment that is an "absolutely necessary condition" for the adequate provision of mental-health care. June 3, 2021, R.D. Trial Tr. at 14 (testimony of Dr. Burns). While the evidence shows that some prisoners do receive confidential treatment, too many do not. Out-of-cell spaces for confidential treatment are not always used, even when available. Inmates who refuse to leave their cells are simply not provided confidential treatment,

and a lack of staff prevents inmates who do wish to leave their cells from being escorted to confidential-treatment spaces.

a. The Parties' Proposed Provisions

To remedy ADOC's failure to provide confidential treatment, the plaintiffs propose that "[c]onfidentiality in mental health treatment and assessment must be a priority," Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 6.1, and that "[i]ndividual counseling sessions, medication management encounters, periodic assessments related to placement in an [restrictive housing unit], suicide risk assessments, and therapeutic groups must take place out-of-cell in a setting that provides for confidentiality, unless that is not possible due to safety concerns, based upon clinical determinations," *id.* at § 6.2. The plaintiffs further propose that, "[i]f confidentiality is not possible, then that fact, the reason, and the actions taken to maximize confidentiality must be documented in the progress note," and that all correctional staff will undergo certain training on confidentiality. *Id.*

The defendants offer similar provisions. They propose that "assessments, evaluations, examinations, individual counseling sessions, medication management encounters, therapeutic groups, and other mental-health services provided in this Phase 2A Remedial Order will take place out-of-cell in a setting that provides for confidentiality, unless that is not possible due to safety concerns or otherwise not appropriate (for example, psychoeducational groups may not necessarily need to be confidential and mental-health rounds in the [restrictive housing unit] may be appropriately conducted "cell-front"), based upon clinical determinations." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 6.1. And, like the plaintiffs, the defendants propose ¹³⁰⁴ that if confidentiality is not possible, "then the [qualified mental-health professional] will document that fact, the reason, and the actions taken to maximize confidentiality in a progress

note for that individual counseling session, medication management encounter, or therapeutic group." *Id.*; see also *id.* at 8.2.3 ("If a significant clinical encounter is at a cell-front, then the progress note should so indicate.").

Both parties also propose provisions concerning training on confidentiality. The plaintiffs would require all correctional staff members to be trained on confidentiality in a manner consistent with ADOC Administrative Regulation 604. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 6.2. The defendants, too, would require correctional staff to be trained in a manner consistent with Regulation 604, but would limit the requirement to correctional staff members assigned to medical or mental-health units or treatment teams, or who regularly receive protected health information. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 6.2. The defendants would also require correctional staff to sign a confidentiality agreement at the conclusion of the training in order to be assigned to a medical or mental-health unit or treatment team, or to receive protected health information. See *id.*

b. The Court's Ordered Relief

³¹ In substantial agreement with both parties, the court will order that individual counseling sessions, medication-management encounters, periodic assessments related to placement in restrictive housing, suicide-risk assessments, and therapeutic groups must take place in a setting that provides for confidentiality and that, if applicable, is out-of-cell. These services may be provided in a non-confidential location if confidentiality is not possible due to safety concerns or is otherwise not appropriate. The question whether confidentiality is not appropriate for reasons other than safety concerns must be made answered according clinical determinations. If confidentiality is not possible, then that fact, the reason for it, and the actions taken to maximize confidentiality must be documented in the progress note.

The court orders that mental-health treatment be conducted in confidential settings because, as it found in the liability opinion, such treatment is generally ineffective unless confidential. The court recognizes, however, that it is not always possible to provide mental-health services in a confidential setting. It will therefore allow ADOC to provide mental-health services in a non-confidential setting, but only when it is necessary to do so because of safety needs or other considerations. Such other considerations might arise, for instance, when an inmate refuses to come out of his or her cell, or when the need for mental-health care is urgent and confidentiality cannot be achieved rapidly. Because determinations about the necessity of non-confidential treatment under such circumstances will necessarily involve some analysis of inmates' mental-health needs, such determinations must be made according to clinical judgment. Finally, the court orders that providers document instances in which confidentiality is impossible, and the reason(s) that it is, because such information is highly relevant to inmates' care, and must be made available to treatment teams if they are to effectively monitor the course of each inmate's treatment.

The court declines, however, to adopt either of the parties' proposals concerning training. The evidence simply does not show that ADOC's failure to provide confidential treatment is caused by a lack of training, and so the court cannot find such relief necessary. Moreover, it assumes that ADOC and its mental-health vendor will inform their staff of their obligations regarding confidentiality, and that the EMT will notify it if they do not.

c. PLRA findings

The court finds this provision necessary because, as explained above, confidentiality is essential for the effective provision of mental-health services, and yet at no ADOC facility is treatment consistently provided in confidential settings. The court also finds this provision to be narrowly

tailored and no more intrusive than necessary because it focuses specifically on remedying the violation of confidentiality that was described in the liability opinion and continues today, and because it allows ADOC the flexibility to hold sessions in nonconfidential settings when necessary or appropriate.

H. Treatment Teams and Plans

32 Since the court's liability findings, ADOC has made much progress in ensuring that every inmate has a treatment team. However, as discussed previously, treatment teams often do not meet frequently enough, and when they do meet, they lack pertinent information and do not meet for long enough to substantively discuss inmates' needs and progress. As a result, the treatment plans that those teams are tasked with curating are often nonexistent or so vague as to be insufficient to address inmates' individual needs. Moreover, treatment plans are often not amended to address changes in inmates' needs and circumstances, a shortcoming that is exacerbated by the haphazard and poorly documented nature of ADOC's transfer process.

I. Frequency of Treatment-Team Meetings

a. The Parties' Proposed Provisions

With respect to the infrequency with which treatment teams meet, the plaintiffs propose that "treatment teams must meet at regular intervals as mandated by the patient's assigned mental-health code and appropriate level of psychotherapy in order to formulate/revise the patient's treatment plan, review progress notes, discuss the condition of the patient, and address the patient's progress." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 7.2.1. The defendants propose, similarly, that "treatment team meetings will occur at regular or clinically indicated intervals or after a major clinical event to prepare or to revise the inmate's treatment plan." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 7.2. Both parties also propose that treatment teams meet

according to prescribed timeframes. *See id.*; Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at App'x A, Table 2.

b. The Court's Ordered Relief

The court will adopt a hybrid of the parties' proposals, and order that treatment teams meet at regular intervals, to be determined based on the team chair's clinical judgment of what is appropriate given the inmate's assigned mental-health code, housing unit, and level of psychotherapy. As the court found in the liability opinion, treatment planning is essential to the provision of mental-health care, especially in the prison context, and it cannot occur absent regular meetings by treatment teams. *See Braggs*, 257 F. Supp. 3d at 1206. Because ADOC has failed to ensure that treatment teams meet regularly, the court must do so now to ensure that inmates receive the minimal level of care required by the Constitution.

The court omits from its order the plaintiffs' language regarding the substance of treatment-team meetings because there is no evidence that meetings fail to address necessary issues when they do occur and last long enough to be productive.

The court also declines to adopt the parties' proposed timeframes for treatment-team meetings.

¹³⁰⁶At this point, such a ¹³⁰⁶provision does not appear necessary. ADOC should have the opportunity to comply with the court's order for regular meetings before the court imposes such a granular scheduling requirement. The court is also confident that the EMT will monitor the frequency of treatment-team meetings and will alert the court if meetings continue to occur so infrequently as to prevent effective care.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: treatment planning is vital to the provision of mental-health care, and it cannot occur absent regular meetings. The court also

finds that this provision is narrowly tailored and no more intrusive than necessary because it leaves the decision of what to discuss during treatment-team meetings, and the decision of exactly how frequently to hold meetings, up to the chair of the team, thereby ensuring that ADOC maintains maximum flexibility to structure its operations.

2. Length of Treatment-Team Meetings

a. The Parties' Proposed Provisions

With respect to ADOC's failure to ensure that treatment-team meetings last long enough to be effective, the plaintiffs propose that the length of any given treatment-team meeting must be "based on whether there have been any significant clinical changes in the patient's condition since the last treatment team meeting." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 7.2.4. The defendants propose no provision regarding the length of treatment-team meetings.

b. The Court's Ordered Relief

The court will order simply that each treatment team meeting must last for an adequate period of time, based on the chair's clinical judgment. The court orders this relief in light of the evidence that treatment-team meetings for some inmates are lasting between one and six minutes, despite the fact that, as Dr. Burns testified, a normal follow-up treatment-team meeting, when "there are no changes and things are going just fine," should last at least 15 to 20 minutes. May 25, 2021, R.D. Trial Tr. at 135. Because the evidence also demonstrates that the appropriate length of treatment-team meetings will vary depending on inmates' needs, however, the court does not prescribe any particular length for treatment-team meetings.

c. PLRA Findings

The court finds this provision necessary because, as explained above, treatment teams are currently meeting for less time than is required to ensure that each inmates' treatment plan and progress are meaningfully analyzed. It is also narrowly tailored

and no more intrusive than necessary because it leaves the decision of exactly how long each meeting should last to the team chair, provided that the decision is based on clinical judgment.

3. Lack of Pertinent Information

a. The Parties' Proposed Provisions

With respect to treatment teams' frequent lack of pertinent information, the plaintiffs propose that "[a]ll members [of the treatment team] must have access to clinically relevant documents." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 7.2.6. The plaintiffs define "clinically relevant documents" as "documents related to the current condition of the patient," including the "most recent treatment plan, any treatment plan less than thirty (30) days old, [a] list of currently prescribed medication, documentation showing medication compliance within the last thirty (30) days, progress notes from the last thirty (30) days, and any other clinically relevant document determined necessary by the reviewing individual to inform clinical judgment." *Id.* at § 1.5. The ¹³⁰⁷ defendants propose no provision regarding treatment teams' access to information.

b. The Court's Ordered Relief

The court will order that all members of the treatment team must have access to clinically relevant documents related to the inmate, with "clinically relevant documents" defined as all documents related to the current and past condition of the inmate--including documents related to the inmate's housing status, disciplinary history, and interactions with other inmates--that are necessary to inform clinical judgment. The court orders this relief in light of the evidence that pertinent information about inmates' statuses has been consistently omitted from the files to which treatment teams have access, including information regarding violent interactions with other inmates and attempts at self-harm that could have alerted treatment teams to the suicidality of

several inmates who eventually killed themselves. For treatment teams to function adequately and prepare comprehensive treatment plans, they must remain informed of their patients' conditions and life circumstances. This provision is therefore needed to ensure that inmates receive adequate care.

To provide ADOC maximum flexibility, however, the court will not enumerate various types of clinically relevant documents, as the plaintiffs propose. Instead, the court will leave it to ADOC's mental-health providers to determine what documents are necessary to inform clinical judgment. The court trusts that the EMT will monitor treatment teams' access to documents, and that the EMT will alert the court if it becomes apparent that treatment teams are deprived of pertinent information.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: treatment teams cannot function effectively without access to information concerning inmates' past and current conditions, and yet ADOC has failed to ensure that treatment teams have access to such information. Accordingly, the court must order relief. The provision is also narrowly tailored and minimally intrusive because it simply directs ADOC to ensure that treatment teams have access to clinically relevant documents, while allowing ADOC's mental-health providers the flexibility to determine which particular documents are needed.

4. Nonexistent or Vague Treatment Plans

a. The Parties' Proposed Provisions

With respect to the nonexistence of treatment plans and the lack of detail and individualization in treatment plans that do exist, the plaintiffs propose that "[e]ach patient on the mental-health caseload must have a treatment plan created within the appropriate timeframe following his or her addition to the caseload, or more frequently if clinically appropriate," Pls.' Updated Proposed

1308 Omnibus Remedial Order (Doc. 3342) at § 7.3.1; see also *id.* at § 7.7.1, and that "each treatment plan must be individualized to each patient," *id.* at § 7.3.2. The plaintiffs also propose a list of specific information to be included in each treatment plan. See *id.* at § 7.3.3–7.3.3.5.

The defendants propose substantially similar provisions. They would require that each inmate have a finalized treatment plan within a prescribed timeframe, see Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 7.4.1, and that treatment plans be "individualized for each inmate," *id.* at § 7.4.2. And, like the plaintiffs, they propose specific information to be included in each treatment plan. See *id.*; see also *id.* at § 7.4.2.1–4 (proposing various categories of information that treatment plans "may" include).

b. The Court's Ordered Relief

The court will order that each inmate on the 1308 mental-health caseload must have a *1308 treatment plan that is adequately detailed and individualized to address his mental-health needs, based on clinical judgment. The court orders this relief in light of ADOC's ongoing failure to provide treatment plans that are sufficiently detailed and individualized to facilitate treatment. See May 26, 2021, R.D. Trial Tr. at 17–18 (testimony of Dr. Burns, describing letter from ADOC to Wexford indicating that treatment plans available for inspection "were often of poor quality, were left incomplete, or otherwise lacked necessary documentation"); *id.* at 155 (reporting that a recent audit of Fountain Correctional Facility found that there were only treatment plans for about half of the charts reviewed). This was a major violation identified in the liability opinion, and the court is seriously concerned that it continues today.

Just as it will not attempt to enumerate various types of clinically relevant documents, however, the court will not attempt to dictate the specific contents of treatment plans. Rather, it will leave it to ADOC's mental-health providers to determine

the information to be included in each treatment plan. Individual inmates' treatment plans may differ in their contents, for, as Dr. Metzner testified, "the nature of the individualized treatment plan [and its] comprehensiveness ... is going to significantly vary [based] on the level of care ... assigned." June 29, 2021, R.D. Trial Tr. at 158. Regardless of the level of care assigned to any particular inmate, however, ADOC must ensure that treatment plans are thorough enough to provide comprehensive portraits of inmates' mental-health needs, treatment history, and treatment goals. The court trusts that the EMT will monitor the contents of treatment plans, and that the EMT will alert the court if it appears that treatment plans continue to lack sufficient detail to fulfill their intended purpose.

Similarly, the court does not order, as the parties propose, that treatment plans be created within certain timeframes. The evidence does not indicate that treatment plans are not created promptly when they are created; rather, it indicates that too often, plans are not created at all. The court trusts that in following its order that each inmate have an individualized treatment plan, that ADOC will ensure that treatment plans are created within a reasonable timeframe, and that the EMT will bring the issue to the court's attention if it fails to do so.

c. PLRA Findings

The court finds this provision necessary given ADOC's ongoing failure to ensure that treatment plans are sufficiently individualized and detailed so as to facilitate the provision of an informed and consistent course of treatment. It is also narrowly tailored and minimally intrusive because it does not mandate the specific contents of treatment plans, nor the timeframe in which treatment plans must be completed.

5. Failure to Update Treatment Plans

a. The Parties' Proposed Provisions

With respect to ADOC's failure to update treatment plans when needed, the plaintiffs propose several provisions that would require ADOC to ensure that treatment plans are regularly amended to reflect changes in inmates' needs and circumstances. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 7.3.1 (proposing that each treatment plan must be "amended and updated as necessary until the patient is either removed from the mental health caseload or leaves ADOC custody"); *id.* at § 7.3.2 (proposing that "[t]reatment plans must reflect changes in goals, plans to achieve goals, changes in mental health status/symptoms, and amended timeframes to reach goals"); *id.* at § 7.4.2 (proposing that "treatment plans must be reviewed and amended, if necessary, contemporaneously with a change in the patient's mental health code"); *id.* at § 7.4.3 (proposing that "treatment plans must be amended contemporaneously with the treatment team's decision to pursue involuntary medication, [the] need for emergency administration of psychotropic medications, or [the] decision to discontinue all mental health medication").

The defendants propose that treatment plans must reflect "changes in treatment goals, ... changes in mental-health status or symptoms, and any revised timeframes for reaching treatment goals," Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 7.4.2, and that treatment plans may include information regarding "any effect of recent housing changes on the inmate's mental-health needs," *id.* at § 7.4.2.4. They also propose that treatment teams review and revise inmates' mental-health codes as clinically appropriate. See *id.* at § 4.3.

b. The Court's Ordered Relief

In substantial agreement with both parties, the court will order that treatment teams must review and revise each inmate's mental-health code as clinically appropriate, and must review and amend, if necessary, each inmate's treatment plan

after changes in the inmate's mental-health code, transfer to a new housing unit, or any other circumstance resulting from or likely to affect an inmate's mental health in a significant way. The court orders this relief in light of ADOC's internal audits of its own facilities, which reveal that treatment plans were rarely updated after major events, *see* Bullock RTU and SU Audit Results (P-3260) at 9 (showing 11.39 % compliance on major event movements); Bullock Outpatient Audit Results (P-3263) at 10-11 (2.92 % compliance); St. Clair Audit Results (P-3277) at 7 (7.14 % compliance), and by Dr. Burns's testimony to the same effect, *see* May 26, 2021, R.D. Trial Tr. at 18 (explaining that according to her review of inmate records, there were "not always [] treatment plan changes when there's a significant event, like removal or placement off watch or discharge into outpatient from a residential treatment unit"). In the liability opinion, the court noted that it is vital that treatment plans be regularly updated to address new developments in an inmate's conditions and circumstances. A treatment plan is ineffective if it does not address an inmate's current needs, and "rote repetition" of goals without acknowledgement of changes that have occurred presents a real "hazard[] to prisoners with mental illness." *Braggs*, 257 F. Supp. 3d at 1207. Because ADOC has failed to ensure that treatment plans are appropriately updated the court must order that it do so.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: treatment teams continue to produce plans that do not reflect relevant changes in inmates' individual circumstances, and therefore cannot fulfill their intended purpose. This provision is also narrowly tailored and minimally intrusive because, for the most part, it leaves it entirely to treatment teams to determine the circumstances under which treatment plans must be updated. While it does require that treatment plans be reviewed under two specific circumstances--changes in housing and changes in

mental-health codes--it imposes that requirement only because the evidence demonstrates that treatment planning must address changes in housing and mental-health codes to be effective.

6. Coordination of Transfers and Treatment

a. The Parties' Proposed Provisions

With respect to ADOC's failure to coordinate the transfer of prisoners among facilities ¹³¹⁰ with prisoners' treatment planning, the plaintiffs propose the following provisions:

- "In order to ensure continuity of care, the patient's mental health code and condition must be considered in making determinations concerning transfer." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 7.5.1.
- "Decisions regarding transfer of outpatient patients (MH Code B and C) will not occur without consultation with the treatment team. The treatment team must weigh the reason for the transfer against concerns about continuity of care. Patients with an SMI flag may only be transferred upon approval of the patient's treatment team. The transfer of patients in the RTU or SU will be permitted to accommodate a patient's change in level of care occasioned by an improvement or deterioration in mental health condition." *Id.* at § 7.5.2.
- "In the event of a transfer of a patient on the mental health caseload, there must be a transfer note written by the patient's MHP at the transferring facility to the patient's new MHP at the receiving facility. This transfer note will include a discussion of the patient's mental health background, current needs, and the next steps for treatment the transferring facility would have taken if not for the transfer. The transfer not for patients coded MH-D must be sent to the receiving facility prior to the patient's transfer. The transfer note for patients coded MH-B or MH-C must occur within five (5) business days of the patient's transfer." *Id.* at § 7.5.3.

- "The transfer note must be on the Mental Health Transfer Form. The purpose of the Mental Health Transfer Form is to eliminate, as much as possible, disruption in the patient's care. The Mental Health Transfer Form must include, at a minimum, the following information: (1) Any individualized treatment or compliance strategies that have been successful; (2) Individualized treatment or compliance strategies that have been unsuccessful; (3) Clinically relevant information about the patient's background, such as prior history of abuse, family history, or difficulties in the course of treatment or compliance; and (4) Any other information which may assist a new mental health provider in gaining insight and rapport with the patient." *Id.* at § 7.5.3.1.

- This transfer note requirement does not apply to patients being moved within the same ADOC facility or from one ADOC facility's holding cell to another ADOC facility's crisis cell. However, if a patient is transferred while on suicide watch, then mental-health staff at the sending facility must communicate with mental-health staff at the receiving facility consistent with the transfer note requirements. *Id.* at § 7.5.3.2.

The defendants propose no provision regarding coordination of prisoners' transfers with treatment planning.

b. The Court's Ordered Relief

The court will order, as the plaintiffs propose, that ADOC must consider inmates' mental-health codes and symptoms in making decisions concerning transfer between facilities. The court orders this provision in light of the evidence that transfer between facilities can be particularly destabilizing for inmates on the caseload, *see Braggs*, 257 F. Supp. 3d at 1241 n.67, and that ¹³¹¹ such transfers are excessively ¹³¹¹ frequent and disorganized, *see* May 25, 2021, R.D. Trial Tr. at 36, 39–40, 53 (testimony of Dr. Burns, describing frequent transfers for no apparent or documented reason). While the court recognizes that transfers are vital to the functioning of a prison system--and

in some cases even mandated by other provisions of this remedial order--ADOC's current approach demonstrates insufficient consideration of the effect transfers may have on mentally ill inmates. Accordingly, the court must order ADOC to consider inmates' mental-health codes and conditions when making determinations concerning transfers, so as to ensure that mental-health treatment is effective and not needlessly disrupted.

The court will also largely adopt the plaintiffs' third proposed provision, and order that in the event of a transfer of an inmate on the mental-health caseload, the staff member in charge of the inmate's care at the transferring facility must send a transfer note to the staff member in charge of the inmate's care at the receiving facility within a reasonable time after the transfer is initiated.¹⁰ The court orders this provision in light of the evidence that mentally ill inmates are frequently transferred between facilities with no notice, or insufficient notice, given to the receiving facilities about the inmates' diagnoses and treatment. As a result, these inmates do not receive continuous care and they decompensate, sometimes to disastrous effect. When Jaquel Alexander was transferred between facilities, for instance, his transfer form incorrectly indicated that he had no SMI designation, and the staff member who completed Alexander's risk assessment after his transfer, who indicated no familiarity with his prior risk factors, identified him as a "low" risk of harm to self. Alexander Psychological Autopsy, (P-3298) at 6. Days later, he killed himself. *Id.* Similarly, when inmate TM was sent to the RTU after setting himself on fire and threatening to do so again, there was "no transfer note indicating why" or explaining what kind of treatment he needed. May 25, 2021, R.D. Trial Tr. at 52–53. Thus, while it may be true, as Dr. Metzner testified, that the providers at the receiving facility are supposed to review an inmate's file upon his or her transfer and ask clarifying questions of his or her previous providers, *see* June 30, 2021, R.D. Trial Tr. at 23–

24, that procedure has proven either inadequate or unfulfilled. Because ADOC has failed to ensure that pertinent information about mentally ill inmates follows them from facility to facility, the court must order that transfer notes be written and sent.

¹⁰ Because the court orders that transfer notes must be written and sent only in the event that an inmate is transferred from one facility to another, it finds the plaintiffs' proposal that the "transfer note requirement does not apply to patients being moved within the same ADOC facility" to be unnecessary. The court does not limit its order, however, to exclude transfers from one ADOC facility's holding cell to another ADOC facility's crisis cell, as the plaintiffs suggest. For the reasons given above, it is essential that pertinent information regarding an inmate's mental health follow him or her from facility to facility, regardless of what type of cell he or she is in. The staff in charge of the inmate must be aware of the inmate's needs and vulnerabilities, particularly if the inmate is suicidal.

The court will not order, as the plaintiffs propose, that the treatment team be involved in all discussions concerning transfers or that it have veto power over transfers. Such a provision has not yet proven necessary; so long as ADOC follows the court's order and ensures that inmates' mental-health codes and conditions are factored into decisions about transfers, the court sees no reason to require that any particular entity make those decisions. However, the court notes that such additional relief may be necessary if the ¹³¹²EMT *1312 determines that ADOC is continuing to transfer inmates in ways that harm their mental health.

The court also declines to order that transfer notes include any particular information. Rather, the court will leave the decision as to what information to include, which will no doubt vary according to the individual needs of each inmate,

to the clinical judgment of ADOC's mental-health providers. Nor will it order that transfer notes be written on Mental Health Transfer Forms. The evidence does not demonstrate that such relief is necessary at this time, and the court trusts that ADOC will be able to determine itself the manner in which transfer notes must be prepared. Again, however, if the EMT finds, after a period of monitoring, that transfer notes continue to contain insufficient information, the court may choose to revisit the issue and order additional relief.

c. PLRA Findings

The court finds that its first ordered provision--that ADOC must consider inmates' mental-health codes and symptoms in making decisions concerning transfers between facilities--is necessary for the reasons given above: inmates are currently transferred between facilities in a frequent and haphazard fashion, despite the court's previous finding that such transfers can be detrimental to mental-health treatment. This provision is also narrowly tailored and minimally intrusive because it merely mandates that ADOC consider certain factors, but does not control ADOC's ultimate decisions regarding transfers.

The court finds that its second ordered provision--that in the event of a transfer of an inmate on the mental-health caseload, the staff member in charge of the inmate's care at the transferring facility must send a transfer note to the staff member in charge of the inmate's care at the receiving facility within a reasonable time after the transfer is initiated--is necessary because, as described above, ADOC has failed to ensure that pertinent information about mentally-ill inmates follows them from facility to facility, resulting in decompensation and death. This provision, too, is narrowly tailored and minimally intrusive because it asks no more of ADOC than what is necessary to ensure that inmates receive continuous care. It does not, for instance, require ADOC to prepare and send the transfer notes within any particular timeframe, so long as it does so within a

reasonable time after the decision to transfer the inmate. And it does not require the transfer notes to include any particular information.

7. Other Provisions Regarding Treatment Teams and Planning

Besides for the provisions discussed above, the plaintiffs propose several other provisions that the court does not adopt because there is insufficient evidence that they are currently necessary.

The first is elemental: the plaintiffs propose a provision requiring each inmate on the mental-health caseload to have a designated treatment team. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 7.1.1. Neither party's experts, however, identified any inmates on the caseload without a treatment team.

Second, the plaintiffs propose that the makeup of each treatment team be determined according to the inmate's assigned mental-health code and appropriate level of psychotherapy, *see id.* at § 7.1.2, and that, "[w]henver possible, all members of the treatment team must attend each team meeting, either in person or via videoconferencing," *id.* at § 7.1.2. The record does not indicate, however, that relevant personnel are not assigned to treatment teams, or that treatment-team members fail to attend meetings. To the contrary, ADOC has created new forms for treatment-team meetings that reinforce its policies ^{1313*}1313 on who should attend those meetings and appear to have been largely successful in ensuring that relevant staff are included. Also, Dr. Burns's review of treatment-team records indicated that most meetings are attended by all relevant staff members.

The court is concerned, however, by ADOC's contention, at oral argument, that it may be appropriate for the treatment-team coordinator to speak with team members separately instead of convening a meeting. *See* July 7, 2021, R.D. Trial Tr. at 261. While conditions may sometimes prevent the team from meeting or require a

decision before a full meeting can be assembled, this should not be common practice. Indeed, as the court found in the liability opinion, failing to have full treatment-team meetings "creates a risk of different providers having an inconsistent approach or course of treatment for the same patient because some of the treatment team are unaware that a new treatment plan has been put into effect." *Braggs*, 257 F. Supp. 3d at 1207. Once again, the court is confident that the EMT will carefully monitor the performance of treatment teams and will alert the court if further action appears necessary.

Third, the plaintiffs propose that inmates must be allowed to attend treatment-team meetings barring certain exceptions. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 7.2.5. The record does not indicate, however, that inmates are currently being excluded from their treatment-team meetings, particularly if they want to attend.

Fourth, the plaintiffs propose that "in the event the psychiatrist or CRNP (if applicable), the patient's MHP, or the patient is unable to attend a treatment team meeting, the meeting must be postponed and rescheduled for the next business day on which the prescriber, the patient's MHP, and the patient are available." *Id.* at § 7.2.7. As explained above, however, the record does not show that either inmates or staff members are absent from meetings.

Fifth, the plaintiffs propose that "[e]ach treatment team must be organized and chaired by the patient's assigned MHP or psychiatrist." *Id.* at § 7.1.3. While the court remains concerned about ensuring that treatment plans are individualized and carefully compiled, there is no evidence that the identity of the chair of the meeting has any bearing on whether that outcome is achieved.

Sixth, the plaintiffs propose that "[r]ecords of each treatment team meeting must be kept in the respective patient's mental-health record and must consist of the following: (1) The date of the

treatment team meeting; (2) The attendees of the treatment team meeting; (3) Notes about each treatment team meeting; and (4) Any changes to the patient's treatment plan as a result of the treatment team meeting." *Id.* at § 7.2.8. There is insufficient evidence, however, that ADOC is not currently keeping adequate records of treatment-team meetings.

Seventh, the plaintiffs propose that, "[i]f a member of a patient's treatment team, other than correctional staff, provides or is provided fourteen (14) days or more notice of voluntary resignation or involuntary termination, then the employee must, to the extent possible, prepare transfer notes on Mental Health Transfer Form for any patients under their care." *Id.* at § 7.6.1. While it is true that the departure of mental-health staff can be just as disruptive to an inmate's mental-health care as a transfer, there is insufficient evidence to suggest that staff departures are currently disrupting care. Also, as the defendants note, progress notes should already be written after every encounter, and in the event of a staff member's departure they should equip the replacement provider with enough information to continue the inmate's treatment without unnecessary disruption.

Eighth, and finally, the plaintiffs propose that "[v]acancies in treatment team members due to staff turnover, must be filled on the earlier of: a) thirty (30) days, or b) at least 24 hours before the date and time of the next regularly scheduled treatment team meeting for that patient." *Id.* at § 7.6.2. Without a doubt, ADOC should make every effort to fill vacant positions as soon as possible. However, while mental-health understaffing in general has an impact on the provision of care, there is no evidence that suggests that vacancies on treatment teams are persisting for excessive lengths of time or interrupting care.

Although it declines to adopt the above provisions, the court trusts that the EMT will be cognizant of the problems that they are meant to

address, and will monitor ADOC's performance accordingly.

I. Psychiatric and Therapeutic Care

33 The provision of psychiatric and therapeutic care is one of the areas of liability in which ADOC has made the least progress since the court's 2017 liability opinion. As described previously, ADOC's provision of such care is deficient in at least four respects. First, inmates have insufficient access to treatment. They often do not receive the treatment they are prescribed, and even when they do receive some treatment, group therapeutic sessions are not sufficiently accessible and individual therapeutic sessions are not held frequently enough, or long enough, to be effective. Second, inmates housed in ADOC's inpatient units receive insufficient out-of-cell time. Confined to their cells for extended periods, they decompensate and their social skills atrophy, thereby undermining the efficacy of any treatment they receive. Third, inmates not on the mental-health caseload who report or display symptoms are not given access to treatment. Fourth, progress notes are often incomplete, inconsistent, or nonexistent, making it more difficult for treatment teams to monitor inmates' progress, and preventing counselors from building on progress made in previous sessions.

I. Access to Treatment

a. The Parties' Proposed Provisions

With respect to ADOC's general failure to provide inmates with psychiatric and therapeutic care, the plaintiffs propose minimum frequencies with which each inmate must meet with psychiatrists, CRNPs, counselors, and mental-health nurses. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 8.1.3.

In addition to these minimum requirements, the plaintiffs propose that each inmate, including inmates in restrictive housing, must have access to the treatment prescribed by his or her treatment team. *See id.* at §§ 8.1.2, 8.1.5. To that end, the

plaintiffs propose that each outpatient mental-health facility must offer psychoeducational groups, individual therapy, group psychotherapy, and pharmacotherapy, *see id.* at § 8.1.9.1; that each SU, RTU, and SLU must offer those types of treatment in addition to activity therapy, *see id.* at § 8.1.9.2; and that "group psychotherapy must be offered on topics such as medication management, cognitive retraining, stress management, social skills, and anger management in sufficient quantity to accommodate the treatment services prescribed for the population of each facility," *id.* at § 8.1.9.3. The plaintiffs also propose that, "[i]f an intervention or program that is set forth in the treatment plan is not offered in the facility in which the patient is housed, either the patient will be moved to allow the patient to participate in that 1315 intervention, or the intervention will be *1315 offered in the facility where the patient is housed," provided that "no patient in need of residential care may be moved to a facility not offering residential care." *Id.* at § 8.1.10.

The defendants contend that, in general, no relief is warranted with respect to the provision of psychiatric and therapeutic care. In support of this position, they point to the fact that ADOC has hired more mental-health staff since the court's liability opinion, *see* Defs.' Post-Trial Br (Doc. 3367) at 93; that it has hired qualified staff, *see id.* at 94; and that Dr. Burns, "in reviewing records and instances of care in advance of the PLR hearing, observed instances of 'good' mental-health care," *id.* at 94-95, and evidence of inmates routinely receiving counseling sessions, *see id.* at 94.

Alternatively, the defendants propose that the court "approve[] [a] mental-health treatment guidance—a term of art in the medial and mental-health communities for a document aimed at guiding decisions and strategies in a particular practice area—[] for the provision of mental-health treatment to inmates in ADOC custody." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 8.1. ADOC includes a model mental-

health treatment guidance in its proposed order that suggests certain types and quantities of care for inmates depending on whether they are housed in an SU, RTU, SLU, or whether they are outpatients. *See id.* at § 8.4. It emphasizes, however, that "[t]he type, time, frequency, and location of any admission, appointment, assessment, discharge, evaluation, length of stay, and psychotherapy or treatment for an inmate by a qualified mental-health professional or treatment team should be determined by clinical judgment based on the needs of the inmate." *See id.* at § 8.3.2.

b. The Court's Ordered Relief

34 The court will order that each inmate must receive a certain minimal level of treatment according to his or her treatment category (*e.g.*, SU, RTU, etc.) and mental-health code. To that end, the court will adopt the defendants' proposed mental-health treatment guidance, set forth in Appendix A, establishing minimum frequencies with which inmates must meet with RNs, psychologists, counselors, psychiatrists, and CRNPs. The court will also order that treatment sessions must last for an adequate period of time, to be determined according to the clinical judgment of the inmate's mental-health provider; that, in addition to the minimal levels of treatment described above, each inmate—including those in restrictive housing—must receive any additional care prescribed by his or her treatment team; and that each housing unit must offer appropriate types and numbers of treatment groups. To the requirement that each inmate must receive any additional care prescribed by his or her treatment team, the court will add one caveat: while ADOC must provide inmates in restrictive housing with any medication or individual therapy prescribed by their treatment team, it need not provide inmates in segregation with other forms of care if they cannot be provided safely in the restrictive housing environment.

The court rejects the defendants' proposal to do nothing because, while ADOC has made encouraging progress in its hiring of mental-health staff, the evidence demonstrates that it is still failing to ensure that inmates have access to the care they need. Although Dr. Burns testified that, in her review of ADOC's records, she observed at least one instance of good mental-health care, *see* June 7, 2021, R.D. Trial Tr. at 105, she did not testify, as the defendants suggest, that most—or even a substantial number—of inmates who were identified as needing counseling routinely received it. Rather, she testified that "there were progress notes labeled counseling sessions" in ¹³¹⁶some inmates' records, ^{*1316} but that "some of them were really very brief interactions, a matter of moments," *id.* at 109, and that many inmates who were prescribed psychotherapy did not receive it at all, *see* May 25, 2021, R.D. Trial Tr. at 82, 87, 90, 192. ADOC itself has also recognized its inadequate provision of treatment: in a February 2020 letter to Wexford, it reported that its own audit of its mental health units "indicate[d] a pattern of failure of Mental Health staff to meet with their patients at required intervals and to conduct group therapies on a routine bases." P-3322 at 2.

The court orders that each inmate must receive a certain minimal level of treatment, according to the guidance proposed by the defendants, because the evidence indicates that across ADOC facilities inmates are, in the words of Dr. Burns, "falling through the cracks." June 3, 2021, R.D. Trial Tr. at 106–107 (testimony of Dr. Burns). This provision ensures that even if an inmate does not have a treatment plan (perhaps because the inmate has only recently been placed on the mental-health caseload), or has a treatment plan that does not specify the exact frequency with which the inmate must receive counseling, he will receive enough care to protect him from bodily injury or death. It also ensures that ADOC is able to provide care in a predictable and consistent fashion, thereby further reducing the risk that inmates are

inmate's mental-health code or recommending that the inmate be moved to a different treatment location. And, while the court requires treatment sessions to last for an adequate amount of time, it leaves the question of exactly how long each session should last to the inmate's mental-health provider. Finally, while the court orders that ADOC must provide inmates with the care prescribed by their treatment team, it does not dictate the manner in which ADOC does so, and it orders no more care than what each inmate's treatment team determines to be necessary.

2. Insufficient Out-Of-Cell Time

a. The Parties' Proposed Provisions

To remedy ADOC's failure to ensure that inmates housed in its inpatient units receive sufficient out-of-cell time, the plaintiffs propose that inmates in the SU, SLU, and RTU Level One and Two must receive 10 hours of structured, therapeutic out-of-cell time and 10 hours of unstructured out-of-cell time per week, unless clinically contraindicated; and that inmates in the RTU Level Three must receive 10 hours of structured, therapeutic out-of-cell time and 10 hours of unstructured out-of-cell time per week, or the same amount of unstructured out-of-cell time as other inmates of the same security level who are not mentally ill, whichever is greater. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 8.3.1, 8.3.2. The plaintiffs would make an exception to this requirement for inmates in the RTU Level Three who are housed in open dormitories rather than cells, and therefore cannot receive in-cell treatment. *See id.* at § 8.3.2. Those inmates, the plaintiffs propose, must receive the same amount of time outside their dormitory as inmates of the same security level who are not mentally ill. *See id.* The plaintiffs would also require that, for inmates arriving in the SLU, the provision of unstructured out-of-cell time must begin immediately. *See id.* at § 8.3.1.

The defendants propose no required amount of out-of-cell time of any type, but their proposed mental-health treatment guidance suggests that inmates in the SU and inmates in the RTU and SLU who are confined to a celled environment for more than 22.5 hours per day should receive 10^{1318*}1318 hours of structured and 10 hours of unstructured out-of-cell time per week, unless clinically contraindicated. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 8.4.

Both sides agree that an inmate's out-of-cell appointments with his or her treatment team, psychiatric provider, counselor, or a therapeutic group will count towards the applicable structured, therapeutic out-of-cell time. *See id.*; Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 8.3.3.

b. The Court's Ordered Relief

³⁵ The court will order that inmates in the RTU, SU, and SLU must have 10 hours of structured, therapeutic out-of-cell time and 10 hours of unstructured out-of-cell time per week, unless clinically contraindicated. Inmates in the RTU Level Three who are housed in open dormitories rather than cells, however, need not receive 10 hours of unstructured out-of-cell time per week. Also, as both sides agree, an inmate's appointments with his or her treatment team, psychiatric provider, counselor, or a therapeutic group will count as structured, therapeutic out-of-cell time.

The court orders this provision in light of ADOC's continued failure to provide inmates in the RTU, SU, and SLU with either structured or unstructured out-of-cell time. As Dr. Burns testified, and as the court has previously recognized, inmates in the RTU, SU, and SLU must receive both kinds of out-of-cell time if those units are to fulfill their intended therapeutic purposes. Structured out-of-cell time provides inmates with necessary support in managing their symptoms, and a respite from idleness. *See Braggs*, 257 F. Supp. 3d at 1214-15 ; May 25,

2021, R.D. Trial Tr. at 84-85. Unstructured out-of-cell time alleviates the intense pressure and stress that a highly regimented, celled environment can impose on mentally-ill inmates. *See id.* And both provide inmates the opportunity to practice socializing. *See id.* Without sufficient amounts of either type of time, inmates in the RTU, SU, and SLU are warehoused rather than treated, and face an unacceptable risk of decompensation. *See Braggs*, 257 F. Supp. 3d at 1214. The court therefore finds that it must order some relief, and it is convinced by Dr. Burns's testimony that 10 hours of each type of out-of-cell time is the minimum amount necessary--a recommendation bolstered by ADOC's mental-health treatment guidance, as well as the evidence presented at the liability hearing (by ADOC's mental-health expert, Dr. Patterson) that 10 hours of each type of out-of-cell time is standard practice in prisons throughout the country, *see Braggs*, 257 F. Supp. 3d at 1215.

The court recognizes that Dr. Metzner did not agree with the recommendations of Dr. Burns, Dr. Patterson, and ADOC's mental-health treatment guidance. He testified that inmates in the SLU should not be required to receive 10 hours of structured out-of-cell time because the SLU is an outpatient, rather than inpatient, facility, *see* June 30, 2021, R.D. Trial Tr. at 48, and that inmates in the SU should not be required to receive 10 hours of structured out-of-cell time because they are seldom in the SU long enough to benefit significantly from such treatment, and because they are often experiencing acute mental-health crises, and therefore may be unable to participate safely in structured group activities, *see* June 29, 2021, R.D. Trial Tr. at 163; June 30, 2021, R.D. Trial Tr. at 60-61.

While the court takes these concerns seriously, it does not find them convincing. As to Dr. Metzner's first concern, while the SLU is not an inpatient unit, the court finds that it should nevertheless be included in this provision. If inmates in the SLU were to receive only minimal

¹³¹⁹out-of-cell ^{*1319} time, there would be no practical

distinction between the SLU and restrictive housing, despite the fact that the SLU is designed to be a diversionary space for the treatment of inmates with mental-illnesses. As to Dr. Metzner's second concern, the court agrees that 10 hours of structured out-of-cell time may be inappropriate for some inmates in the SU. In light of the other experts' testimony that 10 hours is generally the minimum amount of structured out-of-cell time necessary for the effective treatment of inmates in the SU, however, it finds that the best way to address the problem by allowing ADOC to provide less than 10 hours of structured out-of-cell time if 10 hours is clinically contraindicated.

The court does not order that inmates arriving in the SLU must be provided with unstructured out-of-cell time immediately, as the plaintiffs propose, because there is no evidence that, when ADOC does provide inmates with unstructured out-of-cell time, it provides it too late. Nor does it order that inmates in the RTU Level Three must receive the same amount of unstructured out-of-cell time as other inmates of the same security level who are not mentally ill, if that amount is greater than 10 hours; or that inmates in the RTU Level Three who are housed in open dormitories must receive the same amount of time outside their dormitory as other inmates of the same security level who are not mentally ill. The evidence indicates that 10 hours of unstructured out-of-cell time is necessary for effective treatment, but not more, and there is no evidence that inmates must receive a particular amount of time outside their dormitories. The court therefore cannot conclude that such relief is warranted.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: despite its finding that "ADOC's mental-health units often fail to serve their therapeutic purpose due to insufficient out-of-cell time and scarce programming for their patients," *see Braggs*, 257 F. Supp. 3d at 1213-14, ADOC has done nothing to ensure that inmates in

the RTU, SU, and SLU receive the out-of-cell time they need. In light of this failure, the court finds that it must order ADOC to provide inmates with some amount of structured and unstructured out-of-cell time, and it defers to the view of the majority of the experts that 10 hours of structured out-of-cell time and 10 hours of unstructured out-of-cell time is the minimum amount necessary to protect inmates from decompensation, self-harm, and suicide. This provision is also narrowly tailored and minimally intrusive, because although it makes 10 hours of structured out-of-cell time and 10 hours of unstructured out-of-cell time the default requirement, it allows ADOC to provide less out-of-cell time to inmates on a case-by-case basis, based on clinical judgement. Also, ADOC's own Mental Health guidance proposes that inmates in the RTU, SU, and SLU receive 10 hours of structured out-of-cell time and 10 hours of unstructured out-of-cell time--a strong indication that the provision is not overly intrusive.

3. Monitoring of Inmates Not on the Mental-Health Caseload

a. The Parties' Proposed Provisions

With respect to ADOC's failure to provide treatment to inmates not on the mental-health caseload who report or display symptoms, the plaintiffs propose that "[p]atients who are not on the mental health caseload must be seen by mental health staff (either ADOC staff or vendor staff) in the event of a mental health crisis, after receipt of a mental health referral, or for follow up, as clinically indicated." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 8.1.1. The defendants propose no corresponding provision.

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b. The Court's Ordered Relief

The court will order, as the plaintiffs propose, that inmates who are not on the mental-health caseload must be seen by mental-health staff in the event of

a mental-health crisis or after receipt of a mental-health referral, as clinically indicated. The court orders this relief in light of Dr. Burns's testimony that ADOC has persistently failed to respond to requests for mental-health care by inmates in the general population, *see* May 25, 2021, R.D. Trial Tr., and the evidence that several of the recent suicides in ADOC facilities were by inmates in the general population who had exhibited warning signs but received no attention from mental-health staff.

c. PLRA Findings

36 The court finds this provision necessary because deterioration is a risk for all inmates, and because there are undoubtedly inmates in ADOC's general population who should be on the mental-health caseload but were missed at intake. ADOC must therefore ensure that inmates in the general population have access to care when they need it. This provision is also narrowly tailored and minimally intrusive. It simply orders ADOC to respond to inmates' demonstrated mental-health needs, but does not require it to follow any particular process or provide any particular care.

4. Inadequate Progress

a. The Parties' Proposed Provisions

With respect to ADOC's failure to provide adequate progress notes, the parties propose that after "significant clinical encounters," progress notes must be created and placed in inmates' mental-health record. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 8.4.1, 8.4.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 8.2.1.

The parties agree that a clinical encounter is significant, and therefore requires a progress note, if it consists of a "communication or interaction ... involving an exchange of information used in the treatment of the inmate, excluding any causal exchanges, administrative communications, or other communications which do not relate to the patient's mental condition or the ongoing mental

health treatment." See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.29; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.33.

They disagree, however, as to whether the encounter must be between an inmate and a qualified mental-health professional--*i.e.*, a mental-health professional who is qualified to provide therapy, counseling, or psychiatric services--to count as significant. The plaintiffs would define the term "significant clinical encounter" to include encounters between inmates and any mental-health staff, qualified mental-health professional or not. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.29. In their view, if a nurse interacts with an inmate while conducting routine charting duties and receives information implicating the inmate's treatment, that information should be recorded. The defendants, wary that the plaintiffs' approach would result in a deluge of unnecessary progress notes and disrupt the provision of care, would define the term to include only encounters between inmates and mental-health staff who are qualified mental-health professionals. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.33.

Both sides also propose that the progress note must be written in one of two specified formats, and that it include several specific pieces of information, including the name and signature of its author. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 8.4.3, 8.4.4; ¹³²¹ Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 8.2.2. The plaintiffs propose, additionally, that "[t]he note must be sufficiently detailed so that a treating mental health provider would be able to continue treatment using the information provided in the note," see Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 8.4.5, and that it address one or more problems identified in the inmate's treatment plan, *see id.* at § 8.5.

b. The Court's Ordered Relief

37 The court will adopt the defendants' definition of significant clinical encounter, and will order, as the defendants propose, that for each significant clinical encounter between an inmate and a qualified mental-health professional, a progress note must be created and placed in the inmate's mental-health record. It will also order that the note must be sufficiently detailed to facilitate treatment and ensure continuity of care.

The court orders ADOC to create progress notes and file them in inmates' medical records because ADOC has persistently failed to do so, despite the fact that documentation of inmates' care and symptoms is essential for treatment planning, which, in turn, is essential for the effective provision of care. It adopts the defendants' definition of significant clinical encounter because it anticipates that progress notes documenting interactions between inmates and qualified mental-health professionals, who both treat inmates and monitor their symptoms, will provide a sufficient bases for treatment planning. Although inmates might occasionally provide information about their symptoms to mental-health staff members who are not qualified mental-health professionals, the plaintiffs have presented no evidence that they do so frequently, or that, when they do so, the information is not relayed to a qualified mental-health professional. (Should the EMT discover such evidence, the court trusts that it will bring it to its attention.)

The court declines to order that progress notes be written in a particular format or contain particular information. Such a provision has not yet been proven necessary; so long as ADOC ensures that progress notes are sufficiently detailed so as to fulfill their intended purpose, the court need not dictate their precise contents. The court trusts that the EMT will monitor the contents of progress notes, and that the EMT will alert the court if ADOC continues to pre-write progress notes, or to

produce progress notes that are so inaccurate and incomplete as to stymie the effective provision of care.

c. PLRA Findings

The court finds these provisions necessary for the reasons given above: thorough documentation of inmates' care and symptoms is essential for the effective provision of care, and yet ADOC has failed to provide it. To remedy that failure, the court must order that ADOC create progress notes that document inmates' care and symptoms, that the notes contain a minimal level of detail, and that the notes be filed in inmates' mental-health records, where they can be found and utilized. These provisions are also narrowly tailored and minimally intrusive. They do not require ADOC to document encounters between inmates and all mental-health staff, but only encounters between inmates and qualified mental-health professionals, and they allow ADOC flexibility to determine the exact information contained in each progress note.

5. Other Provisions Regarding Psychiatric and Therapeutic Care

The plaintiffs also propose additional provisions that the court declines to adopt. These include the following:

- The relative timing of appointments with the psychiatric provider and the counselor must be determined by clinical judgment based on the needs¹³²² of the inmate, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 8.1.4;
- Placement in a restrictive housing unit must not be a basis for denying or delaying the inmate's access to the interventions prescribed in his or her treatment plan or for deferring prescription of such interventions until after the inmate is released from the restrictive housing unit, *see id.* at § 8.1.5;
- Mental-health treatment services must be tailored to adequately meet the clinical needs of each inmate considering the functional level,

readiness for treatment, insight into mental illness, and motivation for treatment, *see id.* at § 8.1.6;

- Treatment for inmates on suicide watch must consider and factor in the dynamic risk factors identified in the suicide risk assessment, along with any other relevant clinical factors, *see id.* at § 8.1.7;
- A psychiatric provider treating an inmate via telepsychiatry must be provided clinically relevant documents, as defined in this document, in advance of the telepsychiatry session, *see id.* at § 8.1.8;
- Placement of any inmate in the RTU or SU must be based on clinical judgment. Inmates assigned to restrictive housing who are not in need of RTU or SU level care are prohibited from being placed in the RTU or SU, *see id.* at § 8.2.1;
- Determinations regarding admissions to the RTU, SU, and SLU, lengths of stay, and discharge must accord with certain restrictions, *see id.* at §§ 8.2.2, 12.4.1; and
- Initial mental-health assessments must be conducted according to certain timeframes, *see id.* at § 8.2.3.

The court declines to adopt the provisions regarding the provision of treatment to inmates in restrictive housing units (§ 8.1.5), tailoring of mental-health services (§ 8.1.6), and treatment for inmates on suicide watch (§ 8.1.7), because the problems that these provisions are meant to address are dealt with in the sections of the court's omnibus remedial order concerning treatment planning, psychiatric and therapeutic care, and suicide prevention.

The court declines to adopt the remaining provisions because the evidence does not show them to be necessary. There is no indication that counselors and psychiatrists are not coordinating their care (§ 8.1.4); that providers of telepsychiatry are not currently provided with clinically relevant documents (§ 8.1.8); that

inmates are currently being placed in the RTU, SU, or SLU for disciplinary, rather than clinical, reasons¹¹ (§§ 8.2.1, 12.4.1), or otherwise admitted inappropriately (§§ 8.2.2, 12.4.1); that ADOC is failing to promptly assess inmates upon their arrival in treatment unit (§ 8.2.3); or that inmates are being kept in the RTU or SU for inappropriate periods of time, or discharged to inappropriate locations (§ 8.2.2).¹²

¹¹ In its liability opinion, the court found that ADOC routinely placed inmates without mental-health needs in its residential treatment units instead of placing them in restrictive housing. See *Braggs*, 257 F. Supp. 3d at 1212-13. According to Dr. Burns, ADOC has ceased this practice. See June 23, 2021, R.D. Trial Tr. at 170. The court commends it for doing so.

¹² Under the relief ordered today, inmates with serious mental illnesses may not be discharged from the RTU or SU into a restrictive housing unit absent an exceptional circumstance.

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J. Suicide Prevention

Suicide prevention is one of the areas in which failures to provide constitutionally adequate care and protection inflict the most drastic and visible harm on inmates with serious mental-health needs. Under the court's order requiring compliance with the parties' interim suicide prevention agreement (Doc. 2560-1), ADOC has made important progress in this area. ADOC's more consistent use of constant observation and close watch represents a critical improvement in its system for immediate suicide prevention. Likewise, ADOC's development and implementation of suicide risk assessments is an important step to identify inmates whose risk of self-harm requires intervention.

Where ADOC's system remains grievously inadequate is in the provision of care outside the relatively narrow windows of constant observation or close watch. Inmates' serious mental-health needs do not materialize and vanish with their placement on suicide watch and subsequent discharge. Neither should their mental-health care. Suicide risk assessments, discharge evaluations, and follow-up examinations are vital steps to ensure that inmates who have been placed on suicide watch are not then haphazardly (or worse, as a matter of course) thrown into circumstances that neglect their continued mental-health issues. And, when clinically indicated, referrals to higher levels of care and placements on the mental-health caseload are necessary to facilitate treatment that is commensurate with the seriousness of inmates' needs. ADOC's deficiencies in each of these processes inflict needless suffering on inmates with serious mental-health needs and effectively gamble that those who have demonstrated risk factors for suicidal behavior will not decompensate or attempt suicide or other self-injurious behavior during gaps between episodes of crisis treatment.

I. Immediate Response to Suicide Attempts

a. The Parties' Proposed Provisions

Both parties propose similar provisions that, if staff observe an inmate who is attempting suicide or who is unresponsive after apparently attempting or completing suicide, the staff must "immediately call for assistance." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.1.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 9.6.2.1, 9.6.2.2. They additionally propose that staff must "immediately respond" to an observed suicide threat or attempt "with efforts to interrupt the behavior or attempt." *Id.* The plaintiffs clarify these provisions with the proposed requirement that "[i]mmediate life-saving measures" must begin "as soon as there are two (2) correctional officers present and must continue until either paramedics arrive and assume

care, or a physician declares such measures are no longer necessary." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.1.2. The defendants' proposal sets the same endpoint for the performance of life-saving measures but would leave discretion for staff to start performing these measures "as soon as it is deemed safe by correctional staff to do so (typically, when at least two (2) correctional officers are present)." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.6.2.3.

To facilitate immediate responses to attempted hangings, the most commonly attempted suicide method in the evidence before the court, *see* June 7, 2021, R.D. Trial Tr. at 143, both parties propose provisions requiring the maintenance of cut-down tools, bladed instruments that can cut down individuals who have attempted to hang themselves and that are designed to be "safe but effective" in correctional facilities. May 28, R.D. Trial Tr. at 121 (testimony of Mr. Vail). The plaintiffs propose ¹³²⁴the requirement that a cut-down tool be maintained in each housing unit of each ADOC major facility, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.1.3, whereas the defendants would limit this requirement to each restrictive housing unit, stabilization unit, residential treatment unit, structured living unit, and crisis unit of each ADOC major facility, *see* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.6.2.4.

The plaintiffs also propose that, "[u]nless medically contraindicated, and when ADOC staff may safely proceed, after intervention during a suicide attempt, the prisoner must be moved to the medical or healthcare unit at the ADOC major facility for access to appropriate medical equipment and privacy." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.1.4. They further propose that, "[i]f a prisoner dies as [a] result of a suicide, his or her body must be moved to a private area outside of any occupied housing unit and outside the view of other prisoners as soon as possible." *Id.* at § 9.1.5.

b. The Court's Ordered Relief

3839 In substantial agreement with both parties' proposals, the court will order that, if staff observe an inmate who is attempting suicide or who is unresponsive after apparently attempting or completing suicide, the staff must immediately call for assistance, and, if staff observe a suicide threat or attempt, the staff must immediately respond with efforts to interrupt the behavior or attempt. The most recent suicides at ADOC facilities reflect systemwide failures to take necessary steps in the first minutes after discovering suicide attempts—minutes that are crucial to life-saving efforts. When Laramie Avery was discovered hanging in his cell, there was a 12-minute delay before CPR was initiated. *See* Incident Report (P-3299) at ADOC0504208. When a nurse and a correctional officer discovered Jamal Jackson hanging during a pill call, the nurse was dismissed from the scene before being called back three minutes later, contributing to a 12-minute delay before Jackson was even cut down. *See* Pls.' Ex. 3274. In both instances, correctional staff delayed cutting down the individual in order to take pictures. *See* May 24, 2021, R.D. Trial Tr. at 49; Pls.' Ex. 3274. And when ADOC staff cut down Gary Campbell, nursing staff subsequently arrived to find that the officers had not removed the ligature from his neck or initiated CPR. *See* Gary Campbell Psychological Autopsy (P-3292) at ADOC0546324. ADOC's failures in this regard are too widespread and longstanding to be dismissed as failures by individual staff, rather than a systemic problem. *See, e.g., Braggs v. Dunn*, 383 F. Supp. 3d 1218, 1231 (M.D. Ala. 2019) (in January 2019, correctional officers waited minutes for medical staff to arrive before removing the noose from around Daniel Gentry's neck and initiating CPR); *id.* at 1233-34 (in January 2019, 11 minutes passed between when staff discovered Roderick Abrams hanging in his cell and when staff cut him down); *id.* at 1238 (in

March 2018, ADOC staff waited more than 30 minutes to cut down Robert Martinez after he was found hanging).

With respect to the initiation and performance of life-saving measures, the court will order compliance with the defendants' proposed provision with a minor alteration. While every moment of delay carries monumental significance in responding to a suicide attempt, the court recognizes that it cannot predict all immediate safety risks that could require delay even after two correctional officers are present. With the understanding that the EMT will intently scrutinize ADOC's responses to any suicide attempts and its justifications for any delays due to immediate safety risks, the court will adopt ADOC's language that life-saving measures must ¹³²⁵begin as soon as ^{*1325}possible, typically, rather than always, once two correctional officers are present. With respect to the duration of life-saving measures, Mr. Vail observed that specifically requiring "paramedics" to assume care may not be appropriate in all instances. May 28, 2021, R.D. Trial Tr. at 118. With that in mind, the court substitutes the less restrictive term "paramedics or other appropriate medical personnel" in its adoption of the defendants' proposed provision.

The court will also order that each ADOC major facility must maintain an appropriate cut-down tool in each restrictive housing unit, stabilization unit, residential treatment unit, structured living unit, and crisis unit. Because the risk of suicide is most serious for inmates in these units, the court will limit relief to these units. Although the evidence does not indicate whether facilities currently lack cut-down tools, Dr. Burns and Mr. Vail both testified that maintenance of these tools is vital to saving the lives of inmates who attempt suicide by hanging. May 28, 2021, R.D. Trial Tr. at 121-22; June 4, 2021, R.D. Trial Tr. at 68-69. Due to the special importance of this issue and the fact that ADOC is still struggling with the procedure for interrupting suicides in progress, it is necessary to require ADOC to maintain these

tools. That said, the evidence suggests that ADOC's compliance with this provision should be a straightforward process. The court expects that monitoring this will be a minimal burden if ADOC maintains these tools where they are needed.

The court will adopt a modified version of the plaintiffs' proposal regarding the movement of inmates after suicide attempts. The court will order that, when continued medical care is necessary, an inmate who has attempted suicide must be moved to the medical or healthcare unit for continued medical care as soon as ADOC staff may safely move them, unless medically contraindicated. Dr. Burns testified that inmates in need of continued care should be moved to the infirmary, where there is greater access to medical equipment. See June 4, 2021, R.D. Trial Tr. at 69. However, Dr. Metzner noted that not all suicide attempts may require medical interventions. See June 30, 2021, R.D. Trial Tr. at 151. In light of his testimony, the court narrows the plaintiffs' proposed provision to tailor relief to the circumstances in which this measure is needed, when an inmate requires such care.

The court will adopt the plaintiffs' proposed provision that, if an inmate dies as a result of a suicide, his or her body must be moved to a private area outside of any occupied housing unit and outside the view of other inmates as soon as possible. Tommy McConathy's body remained in his cell within the stabilization unit for nearly five hours after he was pronounced dead. See May 24, 2021, R.D. Trial Tr. at 169; Incident Report (P-3308) at ADOC546330. This was "long enough that the rest of the institution knew that he was there, dead in his cell, and that he was being taken out by the coroner's office." June 22, 2021, R.D. Trial Tr. at 79 (testimony of Dr. Burns). Dr. Burns credibly testified that allowing a deceased inmate's body to remain longer than necessary in the same unit with inmates who may have known that individual risks "traumatizing" those other inmates. June 4, 2021, R.D. Trial Tr. at 70.

Requiring the body to be moved to a more private area as soon as possible is necessary to mitigate this risk of inflicting needless psychological harm and potentially prompting other suicidal behavior.

c. PLRA Findings

In addition to constant and close watch, quick intervention in suicide attempts is one of the most critically needed procedures to prevent suicides.

¹³²⁶Relief ^{*1326} is necessary to correct ADOC's unjustifiable delays in performing potentially life-saving actions with appropriate urgency. Although Dr. Burns identified several attempted interventions that appeared appropriate based on the available documentation, *see* June 7, 2021, R.D. Trial Tr. at 188-89; June 8, 2021, R.D. Trial Tr. at 159, this is not something that ADOC can afford to get right only some of the time, let alone with ADOC's current level of inconsistency.

The relief that the court orders is necessary and narrowly tailored to correct persistent problems in ADOC's immediate responses to suicide attempts. The ordered provisions narrowly address procedures in which the evidence reflects persistent delays: cutting down prisoners who have attempted suicide by hanging, initiating life-saving measures such as CPR, and moving prisoners or their bodies to locations that will facilitate medical care as needed and greater privacy. These provisions are the least intrusive means that can protect the life and safety of prisoners with serious mental-health needs when they or prisoners around them attempt suicide or other serious self-injurious behavior.

2. Suicide Watch Placement

a. The Parties' Proposed Provisions

In order to evaluate the needs of inmates who are placed on suicide watch, both parties propose that, following an inmate's initial placement on constant observation, the inmate must be evaluated using a suicide risk assessment to determine whether the individual is acutely suicidal, nonacutely suicidal, or not suicidal. *See*

Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.2.3; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.3.2. The plaintiffs further propose the requirement that inmates admitted to suicide watch must be considered for placement on the mental-health caseload and that, if they are not placed on the caseload, their medical chart must document the clinical rationale for that determination. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.2.1.

With respect to the procedure for placing inmates on suicide watch, both parties propose the restriction that a suicidal inmate must not (or should not, in the defendants' proposed provision) be handcuffed before such placement, unless the inmate's security level requires it or the inmate is engaged in "serious disruptive and dangerous activity" that requires the use of mechanical restraints. Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.2.4; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.3.1. The plaintiffs propose the additional requirement that, "[b]efore a prisoner is placed on suicide watch, a nurse must examine the prisoner and complete a body chart." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.2.2.

b. The Court's Ordered Relief

In agreement with the parties' proposals, the court will order that after each inmate's initial placement on constant observation, he or she must be evaluated using a suicide risk assessment. These assessments are a critical component of a functional system for suicide prevention. As Dr. Burns explained, they are necessary to place an inmate on a level of watch corresponding to his or her level of risk. *See* June 3, 2021, R.D. Trial Tr. at 201. Dr. Metzner emphasized that it is "too dangerous" not to complete these assessments or to conduct them poorly. July 1, 2021, R.D. Trial Tr. at 158.

ADOC's completion of these suicide risk assessments is inconsistent, even in the face of a court order requiring compliance. Completed suicide risk assessments were not found in the mental-health records of Jaquel Alexander for all 1327 11 of *1327 his placements on suicide watch. *See* May 24, 2021, R.D. Trial Tr. at 69-71; Jaquel Alexander Psychological Autopsy (P-3298) at ADOC0539039. Travis Jackson was not placed on suicide watch and did not receive a suicide risk assessment after he set his cell on fire. *See* May 24, 2021, R.D. Trial Tr. at 137; Travis Jackson Mental-Health Records (P-3314) at ADOC0547155; Travis Jackson Psychological Autopsy (P-3315) at ADOC0547208. The same was true for inmate T.M. after he set himself on fire. *See* May 25, 2021, R.D. Trial Tr. at 52, 54. Coupled with the failure to place inmates on constant observation prior to completion of the assessment, the problem of inconsistent, incomplete, or delayed suicide risk assessments permits inmates to be placed and remain in clinically inappropriate environments. In the absence of a suicide risk assessment after he set his cell on fire, Jackson was placed in segregation several days later, where he committed suicide the next month. *See* May 24, 2021, R.D. Trial Tr. at 144-46. And when Alexander verbalized suicidal ideation and mental-health staff decided to assess him the following morning, he was returned to his cell without any precautions, and he committed suicide hours later. *See id.* at 65-67. In light of the expert testimony and the harms that have resulted from delays and failures in this process, the court finds it necessary to order the completion of suicide risk assessments to address ADOC's failures to provide adequate protection to inmates with serious mental-health needs.

The court will also adopt the plaintiffs' proposed provision requiring that inmates admitted to suicide watch must be considered for placement on the mental-health caseload and that, if he or she is not placed on the caseload, the clinical rationale must be documented in his or her medical chart.

Just as the court found in the suicide prevention opinion, *see Briggs*, 383 F. Supp. 3d at 1281, ADOC persists in its failure to consider suicidal inmates for placement on the mental-health caseload. Dr. Burns highlighted multiple inmates who were not placed on the caseload, even temporarily, after multiple placements on suicide watch. Marquell Underwood was placed on acute suicide watch twice in the 6 months before he committed suicide, without any indication that he was considered for placement on the mental-health caseload. *See* May 24, 2021, R.D. Trial Tr. at 57. Travis Jackson was never placed on the caseload despite multiple suicide watch placements and the attempt to set fire to his cell. *See* June 2, 2021, R.D. Trial Tr. at 126-27. Jaquel Alexander was not added to the caseload until his fifth or sixth placement on suicide watch. *See* May 24, 2021, R.D. Trial Tr. at 68. Dr. Burns credibly testified that requiring the documented consideration of suicidal inmates for placement on the mental-health caseload is necessary to minimize the risk that inmates' serious mental-health needs will be neglected, despite potentially repeated mental-health crises. *See* June 3, 2021, R.D. Trial Tr. at 197-98.

The court will order compliance with the plaintiffs' proposal that, before an inmate is placed on suicide watch, a nurse must examine the inmate and complete a body chart. This examination is necessary to identify and address the immediate medical needs, as well as the mental-health needs, of an inmate who is placed on suicide watch. As Dr. Burns testified, inmates placed on suicide watch may be experiencing a number of medical issues that require attention, including overdose, substance use, or injuries from self-harm. *See id.* at 199. Completion of a body chart is necessary both to treat any such issues and to identify them for consideration in the inmate's mental-health care. Absent a body chart, the evidence reflects that these issues sometimes go undocumented for prisoners placed on suicide watch. For instance, 1328 Dr. Burns testified that a body *1328 chart

completed the day after Danny Tucker was released from nonacute suicide watch identified a wrist laceration that had required 10 staples, which was not reflected in any prior mental-health records. *See* May 24, 2021, R.D. Trial Tr. at 193-94. Because it is dangerous not to complete these body charts consistently, the court finds that relief is necessary.

The court will not order compliance with the parties' proposed provisions limiting the handcuffing of inmates prior to placement on suicide watch. While it is important to avoid punishing mentally ill inmates for accurately reporting their suicidality, which may discourage them from seeking appropriate care and protection, *see* June 3, 2021, R.D. Trial Tr. at 202 (testimony of Dr. Burns), the evidence presented to the court does not indicate what ADOC's current practice is or whether it is harming inmates with mental-health needs.

c. PLRA Findings

The ordered relief is necessary to ensure that inmates expressing suicidality are safely placed on suicide watch, that the level of monitoring and treatment they receive is sufficient to meet their risk of self-harm, and that they are considered for more regular mental-health care to address the risk of recurrent self-harmful behaviors. This relief is narrowly tailored and minimally intrusive to correct ADOC's failures to address adequately inmates' immediate suicidality and underlying mental-health needs.

3. Suicide Watch Cells

a. The Parties' Proposed Provisions

With respect to the physical condition of suicide watch cells, the plaintiffs propose the requirement that ADOC must make all suicide watch cells suicide-resistant. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.7.1. They propose the same requirement for cells in stabilization units. *See id.* at § 10.4. Under their proposal, the EMT would have the discretion to

determine whether cells are suicide-resistant, but cells that satisfy the conditions specified in Lindsay M. Hayes's Checklist for the "Suicide-Resistant" Design of Correctional Facilities (Doc. 3206-5) would necessarily meet this requirement. *See id.* at § 9.7.1. They further propose that ADOC must physically inspect all suicide watch cells on a quarterly basis to ensure that they remain suicide-resistant, *see id.* at § 9.7.3, and that, between inmate admissions, ADOC must clean and inspect these cells to eliminate biohazards and confirm that no contraband is present, *see id.* at § 9.7.5. The defendants propose no provisions regarding the condition and maintenance of suicide watch cells.

To ensure the availability of a sufficient number of suicide watch cells, the plaintiffs propose that ADOC must determine the appropriate number of suicide-resistant cells for each ADOC major facility and submit its numbers to the EMT for approval. *See id.* at § 9.7.2. To accommodate the possibility that more cells will be needed than are available, the plaintiffs propose that "ADOC may designate areas or cells where a prisoner could be temporarily placed when a suicide watch cell is unavailable, provided that the prisoner is on 'constant observation,' regardless of level of watch." *Id.* at § 9.7.4. The defendants similarly propose that ADOC may designate areas or cells for this temporary placement when a suicide watch cell is unavailable, except that constant observation would only be required for acutely suicidal inmates and close watch would be required for non-acutely suicidal inmates. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.2.

b. The Court's Ordered Relief

41 The court will order that all suicide watch and 1329 stabilization unit cells must *1329 be suicide-resistant. As explained in the court's discussion of ADOC's chronic understaffing, this will require that ADOC must physically inspect these cells for suicide-resistance prior to each use and conduct a

more comprehensive inspection every three months to ensure that the cells remain suicide-resistant. Cells shall be deemed suicide-resistant if they meet the requirements set forth in Lindsay M. Hayes's Checklist for the "Suicide Resistant" Design of Correctional Facilities (Doc. 3206-5).

It is effectively axiomatic that suicide watch and stabilization unit cells must be suicide-resistant. Suicide watch cells house individuals who are acutely or non-acutely suicidal. Stabilization units are designed to house "patients who are suffering from acute mental-health problems," including "conditions causing an acute risk of self-harm," and who "have not been stabilized through other interventions." *Braggs*, 257 F. Supp. 3d at 1183. The failure to ensure that these cells are suicide-resistant poses a grave danger to individuals who are experiencing suicidality or other serious mental-health issues.

In the absence of any proposal by ADOC to define what it means for cells to be suicide-resistant, the court finds that compliance with the conditions contained in the checklist developed by Lindsay M. Hayes (Doc. 3206-5) is sufficient for a cell to be considered suicide-resistant. This checklist provides for the elimination of tie-off points and other structural elements that facilitate suicide attempts, as well as the maintenance of adequate visibility into the cell to allow monitoring. The parties previously agreed to the use of this set of conditions to ensure that cells are suicide-resistant. See Suicide Prevention Stipulations (Doc. 2606-1) at 6 (providing that "[s]uicide watch cells shall be considered suicide resistant if they meet the requirements set forth in section III(B) of the ADA Report"); ADA Transition Plan for Programs and Services Provided to Inmates (Doc. 2635-1) at 41 ("All crisis cells ... are to comply with the checklist developed by Lindsay M. Hayes.").

The death of Tommy McConathy makes clear that suicide-resistance is not a one-time task. Roughly seven months after ADOC certified that it had

"effectively retrofitted all [stabilization unit] cells to ensure suicide resistance," Resp. to Phase 2A Order on Inpatient Treatment (Doc. 2880) at 4, McConathy hanged himself from the ventilation grate above the sink in his stabilization unit cell, see May 24, 2021, R.D. Trial Tr. at 153-54. Although Dr. Metzner testified, based on information reported to him by an ADOC official, that the grate had been suicide-resistant but for the fact that it was broken, creating a tie-off point, he could not say how long the grate was broken prior to McConathy's death. See July 1, 2021, R.D. Trial Tr. at 2-4. Even if McConathy broke the grate himself, it is deeply troubling that ADOC could place him in a cell that was required to be suicide-resistant without affirmative confirmation that there were no existing tie-off points. Moreover, even if prior inspection of the cell might not have prevented his death, it could have provided ADOC with crucial information about what happened and helped it to take remedial measures that would appropriately address the problem in the future.

With this evidence in mind, the court credits Dr. Burns's testimony that quarterly inspections are necessary to ensure that suicide watch and stabilization unit cells remain suicide-resistant over time and that changes that jeopardize the safety of the cell are addressed. See June 4, 2021, R.D. Trial Tr. at 78-79. But the court also agrees with Mr. Vail: "[E]very time" an occupant is changed out, an inspection prior to the next placement is the only way ¹³³⁰ "to make sure that the last person didn't somehow compromise that cell" by creating a tie-off point or introducing another potential hazard. May 28, 2021, R.D. Trial Tr. at 131. Independently, neither inspection is sufficient to correct the systemic problem that ADOC and this court must confront: At least with ADOC's continued severity of understaffing, preplacement inspections cannot feasibly occur with the necessary completeness, and quarterly inspections inherently do not occur with the necessary frequency.

Due to the nature of these inspections, the court will order that the quarterly inspections, but not the preplacement inspections, must be documented. Documentation of quarterly inspections, beyond verifying that the inspections occur, will enable ADOC and the EMT to track the hazards that are detected—hazards which, the court expects, may be less readily apparent than those that can be identified immediately prior to a placement.

With respect to preplacement inspections, the court will further order that, before placing an inmate in a stabilization unit or suicide watch cell, ADOC must clean the cell and remove any contraband. During the omnibus remedial proceedings, the court heard evidence of inmates in suicide watch cells who had access to contraband with which they could harm themselves. After cutting his arm and receiving sutures for the laceration, inmate M.H. was able to use a razor blade to reopen the wound while on acute suicide watch. *See* May 25, 2021, R.D. Trial Tr. at 43-44. Similarly, inmate M.W. cut himself with a razor blade that he brought into his crisis cell when he was placed on nonacute suicide watch. *See* May 25, 2021, R.D. Trial Tr. at 38. Dr. Burns also testified that multiple inmates informed her that they had been placed in crisis cells that contained the bodily fluids of previous inhabitants. *See* June 22, 2021, R.D. Trial Tr. at 90. This evidence reflects the need for ADOC to ensure that suicide watch and stabilization unit cells do not contain contraband with which an individual could engage in self-injurious behavior or unclean conditions that are dangerous or could otherwise cause adverse clinical consequences for an occupant's mental health.

The court will not order relief with respect to the quantity of suicide-resistant cells in each ADOC major facility. While it is necessary for suicide-resistant cells to be available at every ADOC major facility, *see* June 4, 2021, R.D. Trial Tr. at 77-78 (testimony of Dr. Burns), current evidence does not reflect the "chronic shortage of crisis

cells" that the court found in the liability opinion, *Braggs*, 257 F. Supp. 3d at 1222. As with the issue of inspections, the court is open to revisiting this area if ADOC stops having enough suicide-resistant cells to accommodate the need for them or if the monitoring team finds that prisoners are not being placed in safe suicide watch cells when they need to be. But the evidence before the court does not necessitate relief at this time.

The court will adopt the plaintiffs' proposal allowing ADOC to designate areas or cells where an inmate could be temporarily placed when a suicide watch cell is unavailable, provided that the inmate remains on constant observation during this time. For the most part, this provision is permissive rather than constraining. Consistent with both parties' proposals, the provision preserves ADOC's discretion in the temporary placement of an inmate awaiting the availability of a suicide-resistant cell. Where the parties disagree is whether inmates who are not acutely suicidal may be left in these areas on only close watch, rather than constant observation. For many of the same reasons that constant observation is necessary to protect inmates awaiting responses to ¹³³¹ emergent referrals, the ¹³³¹ court agrees with the plaintiffs that constant observation is necessary here as well. Even the temporary placement of a suicidal inmate in an environment that is not suicide-resistant is "quite dangerous." *Braggs*, 257 F. Supp. 2d at 1225. Until the inmate can be placed in a cell that is suicide-resistant, constant observation is essential to protect the inmate's safety in the event that he or she decompensates or his or her mental-health needs prove more serious than initially assessed. *See* June 4, 2021, R.D. Trial Tr. at 79-80 (testimony of Dr. Burns).

c. PLRA Findings

Suicide watch cells and stabilization unit cells house inmates when they are particularly vulnerable and in need of heightened protection. The relief that the court orders is necessary to protect the safety of these inmates when they are

suicidal or otherwise at a serious risk of self-harm. Before an inmate is placed in a suicide watch or stabilization unit cell, ADOC must be able to state confidently that the cell is, and remains, safe and suicide-resistant. The court finds that comprehensive quarterly inspections, coupled with visual preplacement inspections, are necessary to ensure that suicide watch and stabilization unit cells are suicide-resistant when they need to be. And, because potential hazards to an inmate's safety and mental health extend beyond the physical features of the cell itself to also its contents, including the presence of contraband or unsanitary conditions, preplacement cleaning and removal of contraband is necessary as well. The provisions that the court adopts are narrowly tailored to correct ADOC's failures to protect inmates against this range of dangers, from decompensation and self-harm through suicide attempts and death. These provisions are the least intrusive means that will sufficiently address these dire needs.

When an inmate is awaiting placement in a suicide-resistant cell, constant observation is necessary to protect against the same dangers that suicide-resistant cells are meant to protect against. Requiring constant observation is narrowly tailored to protect the inmate's safety until structural safeguards may permit a lower degree of monitoring as appropriate. This requirement is the least intrusive means that will suffice to keep inmates who may be experiencing varying levels of suicidality safe in a space that has not been specifically designed to be suicide-resistant.

4. Observation

a. The Parties' Proposed Provisions

Both parties propose that any inmate determined to be acutely suicidal must be monitored through a "constant observation" procedure, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.3 (defining "acutely suicidal"); Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.4.1, and that any inmate determined

to be nonacutely suicidal must be monitored through a "close watch" procedure that ensures monitoring at staggered intervals not to exceed 15 minutes, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 1.20 (defining "nonacutely suicidal"); Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.4.2. In addition to these provisions, the defendants specify that mental-health observation "will not be used as an alternate placement for inmates who should be placed on suicide watch." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.1.

Both parties propose that constant observation and close watch must be contemporaneously documented at staggered intervals not to exceed 15 minutes and that, upon an inmate's discharge from suicide watch, these observation records must be included in the inmate's medical record.

^{1332*}1332 *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.3.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.2. Additionally, the defendants' proposal provides for the creation of a "post-suicide watch summary" based on these records. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.2.

Both parties also propose that the mental-health staff must ensure the routine oversight of observers. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.3.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.4.3. The plaintiffs' proposal further specifies that the mental-health staff must evaluate the equipment that is available to observers to ensure that appropriate observation can occur. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.3.2.

b. The Court's Ordered Relief

42 The court will order that acutely suicidal inmates must be monitored through constant observation and non-acutely suicidal inmates must be monitored through close watch at staggered

intervals not to exceed 15 minutes. Observation is the last line of defense to protect inmates in crisis from attempting suicide or serious self-harm. Unequivocally, failure at this stage can be a matter of life or death. Consequently, as Dr. Metzner testified, it is "too risky" for these observation procedures not to happen "100 percent of the time." June 29, 2021, R.D. Trial Tr. at 142; *see also* July 2, 2021, R.D. Trial Tr. at 134-35.

Evidence presented at the omnibus remedial hearings reflects that ADOC has made improvements to the consistency of its observation practices. Internal audits of multiple facilities reflected positive changes in the area of "suicide watch monitoring," and the court received numerous observation logs that reflected observations on close watch at appropriately staggered intervals, *see* June 8, 2021, R.D. Trial Tr. at 90-92 (testimony of Dr. Burns). Even so, it remains necessary for the court to order compliance with these provisions to address the failures that do occur and to prevent reversion of ADOC's relatively recent progress. ADOC's progress in the area of observation is relatively recent, and, applying the compliance measure of ADOC's own expert, it remains incomplete. Moreover, according to Wexford, the improvements that have been made in this area have required it to divert resources away from the routine treatment of inmates with less acute needs, "disrupt[ing] all routine mental health caseload activities." Pls.' Ex. 3323 at 3 (emphasis omitted). While this tradeoff may be necessary in the short-term to avert some of the most severe harms, it surely does not reflect that ADOC has "completely and irrevocably eradicated" the constitutional violation of failing to protect suicidal prisoners. *Thomas v. Bryant*, 614 F.3d 1288, 1321 (11th Cir. 2010) (quoting *LaMarca v. Turner*, 995 F.2d 1526, 1542 (11th Cir. 1993)). In light of the need for ADOC reliably to apply constant observation and close watch procedures and the risk that ADOC's

progress will not be sustained in the absence of a court order, the court finds that relief remains necessary.

The court need not, however, order compliance with the defendants' proposed provision barring the use of mental-health observation as a substitute for suicide watch. Although ADOC's misuse of mental-health observation was a significant problem previously, Dr. Burns testified that she had not seen recent instances in which inmates in crisis were placed on mental-health observation instead of suicide watch. *See* June 8, 2021, R.D. Trial Tr. at 166. Moreover, this proposed provision is effectively redundant with the provisions that the court does order requiring ^{1333*}1333 suicidal prisoners to be monitored via constant observation or close watch.

Consistent with the parties' proposals and with the overall importance of ensuring that these observation procedures are followed, the court will order that both constant observation and close watch must be contemporaneously documented. In addition to confirming that these procedures are followed, contemporaneous documentation that is included in an inmate's medical file is necessary to ensure that information about the inmate's behavior can be factored into clinical decisions about treatment and appropriate levels of care. *See* June 3, 2021, R.D. Trial Tr. at 204-05 (testimony of Dr. Burns). However, the court will not order that this contemporaneous documentation must be accompanied by a post-watch summary, as the defendants propose. These proposed summaries may prove useful to both the monitoring team and inmates' treatment teams, but the court does not find that ordering completion of these summaries is necessary.

Finally, the court will order that ADOC must take appropriate steps to ensure that observers who monitor inmates on suicide watch perform their duties as required. In the suicide prevention opinion, the court found that, "[i]n none of the facilities" visited by experts for both sides "were

the "watchers" positioned appropriately to permit full visibility into the safe cells or constant visibility of the inmates being observed." *Braggs*, 383 F. Supp. 3d at 1259 (internal quotation marks omitted). While the court expects that continued training of observers will help to address this concern the court will also order that ADOC take other appropriate steps—such as routine oversight, see June 8, 2021, R.D. Trial Tr. at 93 (testimony of Dr. Burns, noting that "direct supervision of the observers" contributed to improvements in the consistency of staggered watches at the facilities she toured), or examination of the equipment available to observers, see June 3, 2021, R.D. Trial Tr. at 205 (testimony of Dr. Burns, noting that the chairs available to observers at some facilities she toured did not provide observers with "an unobstructed view" into the cells)—to ensure that observation is performed correctly.

c. PLRA Findings

Consistently applied constant observation and close watch procedures are fundamental to constitutionally adequate crisis-level care. Current relief is necessary to bring ADOC into full compliance with these essential requirements and to ensure that ADOC sustains compliance as it addresses the constitutional violations that have persisted throughout other facets of its system of mental-health care. Requiring ADOC to apply and document these procedures is narrowly tailored and minimally intrusive to protect suicidal inmates' immediate safety and to ensure their access to adequately informed treatment and care.

5. Suicide Watch Conditions

a. The Parties' Proposed Provisions

The plaintiffs propose the requirement that, unless clinically indicated otherwise, inmates on suicide watch must be provided with shower shoes or other footwear, socks, suicide-resistant toothbrushes, other specified hygiene products, and regular or sack meals with approved nutritional content and suicide-resistant eating

utensils. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.3.3. They further propose that inmates on suicide watch must receive the same privileges, such as visits, phone calls, or mail, afforded by their most recent housing assignment, as clinically appropriate. See *id.* at § 9.3.4. Finally, they propose that inmates housed in crisis cells or medical units must be provided appropriate out-of-cell activity after 72¹³³⁴ hours, unless such activity is contraindicated¹³³⁴ and the clinical rationale is documented in the medical record. See *id.* at § 9.3.5.

b. The Court's Ordered Relief

43 The court will order that inmates on suicide watch must receive suicide-resistant footwear, hygiene products, and nutritionally appropriate meals as clinically appropriate. During facility tours prior to the suicide prevention trial, experts for both parties saw that some inmates on suicide watch were not provided shower shoes for out-of-cell movement, forcing them to walk around prisons with bare feet. See June 3, 2021, R.D. Trial Tr. at 210 (testimony of Dr. Burns). Dr. Burns also noted that inmates on suicide watch were provided the same sack meal, or in some cases one of two sack meals, for every daily meal. *Id.* at 211. As Dr. Burns explained, these deprivations caused extended placements on suicide watch to be "frankly, punitive." *Braggs*, 383 F. Supp. 3d at 1270 (internal quotation marks omitted).

Requiring that inmates on suicide watch receive appropriate footwear, hygiene products, and meals as clinically indicated is necessary to prevent conditions in suicide watch cells from harming inmates' mental health during an important crisis intervention. The court credits Dr. Burns's testimony that these items are an important part of the "therapeutic" care that inmates on suicide watch receive. June 3, 2021, R.D. Trial Tr. at 211. Rather than require the provision of specific items, however, the court orders simply that the mental-health providers who are better positioned to

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 assess an inmate's mental-health needs and risks must exercise appropriate clinical judgment with respect to the items that are provided.

44 For the same reasons, the court finds it necessary to order that inmates on suicide watch must receive the same privileges afforded by their last housing assignment as clinically appropriate. As Dr. Burns explained, these privileges may have therapeutic value in the treatment of inmates who are placed on suicide watch, or they may have the potential to be harmful. *See* June 3, 2021, R.D. Trial Tr. at 211-12; June 23, 2021, R.D. Trial Tr. at 216-17. By assigning the determination of which privileges an inmate should and should not receive to the clinical discretion of treating mental-health staff, this provision ensures that the treatment of inmates on suicide watch will be adequately responsive to their individual mental-health needs.

45 The court will also order that inmates housed in crisis cells, medical cells, or the infirmary must be provided appropriate out-of-cell activity after 72 hours, unless such activity is clinically contraindicated. As observed in the context of restrictive housing, the experts for both parties, the American Correctional Association, and ADOC's own regulations all recognize the importance of out-of-cell time to prevent decompensation and other harms to prisoners' mental health. When crisis cells are functioning as designed, placements are generally short in duration, reducing the need for out-of-cell time. As experts for both sides explained at the liability trial, "crisis-cell placement is meant to be temporary and should not last longer than 72 hours, because the harsh effects of prolonged isolation in a crisis cell can harm patients' mental health." *Braggs*, 257 F. Supp. 3d at 1226. However, ADOC's use of crisis cells and medical cells frequently runs beyond 72 hours, amplifying the potential adverse effects of isolation. *See id.* During the suicide prevention trial, experts for both sides identified many inmates who remained on suicide watch for longer than 72 hours, in spite of an ADOC policy requiring referral to a higher level of care. *See*

¹³³⁵*Braggs*, 383 F. Supp. 3d at 1269. In ¹³³⁵ such situations where an inmate remains on suicide watch for longer than 72 hours, as in the context of restrictive housing, the court credits Dr. Burns's testimony that out-of-cell activity is a necessary component of the inmate's mental-health care, except when it is clinically contraindicated. *See* June 3, 2021, R.D. Trial Tr. at 212-13. However, the court will not order compliance with the plaintiffs' proposed requirement to document the clinical rationale when activity is not provided. The court finds that there is insufficient evidence to impose this additional requirement at this time.

c. PLRA Findings

Relief regarding the conditions of prisoners placed on suicide watch is necessary in light of the length of time that many inmates remain on suicide watch without being referred to a higher level of care and the potential for adverse mental-health consequences when inmates experiencing mental-health crises are subjected to clinically inappropriate conditions for extended periods of time. Some restriction on inmates' access to items and activities is appropriate, and indeed necessary, for suicide watch to function properly. Indiscriminate deprivation is not. The provisions that the court orders are necessary to redress the inadequate treatment of inmates with serious mental-health needs during crisis placements, when they have been identified as experiencing a heightened risk of self-harm. By deferring to the clinical judgment of mental-health staff, the provisions are narrowly tailored to require that inmates receive these basic items and privileges only to the extent that mental-health staff determine to be clinically appropriate. These provisions are the least intrusive means that will address the problem, as they avoid intruding on the details of prison administration beyond what is necessary to ensure that inmates on suicide watch receive adequate treatment.

6. Referral to Higher Level of Care

a. The Parties' Proposed Provisions

The plaintiffs propose the requirement that an inmate on suicide watch must be considered for referral to a higher level of care, such as a residential treatment unit, stabilization unit, or inpatient hospitalization, after remaining on watch for 72 hours and again after remaining on watch for 168 hours. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.4.1. They further propose, "If a patient remains on watch for 240 hours or longer and does not meet the criteria for discharge to outpatient mental health care, then the patient must be referred to a higher level of care as clinically appropriate." *Id.* The defendants propose similar provisions, except that they would limit these requirements to inmates on constant observation, rather than suicide watch generally. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 9.3.1, 9.3.2, 9.3.3. Their proposal also uses the phrase "different or higher level of care." *Id.* (emphasis added). Both parties propose that the clinical rationale for a decision not to refer an inmate to a higher level of care at each of these stages must be documented. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.4.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 9.3.1, 9.3.2, 9.3.3. The defendants further propose that documentation of a decision not to refer an inmate after 240 hours must be submitted to the mental-health vendor's director of psychiatry for review and evaluation. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.3.3.

Both parties additionally propose that any inmate who returns to suicide watch within 30 days of discharge from a previous watch or who receives 3¹³³⁶ watch placements^{*1336} within 6 months must be considered for referral to a higher level of care. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.4.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.3.4. If the inmate is not referred to a higher level of care, documentation of the clinical rationale must be provided to OHS immediately, under the

plaintiffs' proposal, or within 72 hours, under the defendants' proposal. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.4.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.3.4.

b. The Court's Ordered Relief

46 The court will adopt provisions requiring that inmates be considered for referral to a different or higher level of care at the times identified by both parties. As noted previously, ADOC's placement of inmates on suicide watch for extended periods of time without consideration for referrals to a higher level of care has been a longstanding problem. In the liability opinion, the court found that inmates were considered for transfer to treatment units "only in a small fraction of the crisis placements that last longer than 72 hours." *Braggs*, 257 F. Supp. 3d at 1226. This problem continued to the time of the suicide prevention trial, where experts for both sides identified "multiple instances in which people remained on suicide watch for longer than 72 hours without any indication that they were considered for a higher level of care." *Braggs*, 383 F. Supp. 3d at 1269. More recently, Dr. Burns and Dr. Metzner interviewed one inmate who spent almost a week on crisis placement in December 2020 without any indication that he was considered for referral to a higher level of care; he reported that 3 or 4 other inmates were housed in the crisis cell with him during that time. See May 25, 2021, R.D. Trial Tr. at 87-88; see also Pls.' Ex. 3943 at ADOC0540559.

Dr. Burns explained that this failure to consider referring inmates to a higher level of care contributes to long stays in "very restrictive" settings that may be clinically inappropriate to treat inmates' mental-health needs. June 3, 2021, R.D. Trial Tr. at 214. It also inhibits inmates' access to more meaningful, longer-term interventions that may be required to treat adequately their serious mental-health needs. See *id.* at 214-15.

To address this inadequate treatment of inmates on suicide watch, the court will order that, if an inmate remains on suicide watch for 72 hours, and again after 168 hours and 240 hours, he or she must be considered for referral to a different or higher level of care. In each instance, the clinical rationale for a decision not to refer the inmate to a different or higher level of care must be documented in the medical chart and tracked in the crisis utilization log or a similar tracking mechanism. The court will also adopt the defendants' proposal that such decisions after 240 hours must also be sent to the mental-health vendor's director of psychiatry for evaluation.

In most respects, the plaintiffs' and defendants' proposals impose identical obligations. Both proposals preserve clinical discretion at each of the three milestones for consideration of referral to a different or higher level of care and require documentation of decisions not to make this referral.¹³ The most substantial distinction is that the plaintiffs' proposal measures time on suicide watch, whereas ADOC's ¹³³⁷ proposal measures time on constant observation. Because constant observation and close watch both place inmates in restrictive settings, and because long-term placement on suicide watch in either form signals that an inmate may have substantial mental-health needs that are not being adequately addressed, the court finds that the plaintiffs' broader requirement is necessary.

¹³ Although the defendants use "different or higher level of care" and the plaintiffs specify "higher level of care," both parties offer the same three examples for their respective proposals—the residential treatment unit, the stabilization unit, and inpatient hospitalization or hospital-level care.

The court will also adopt the provision proposed by both parties that any inmate who returns to suicide watch within 30 days of discharge from a previous watch or who receives 3 watch placements within 6 months must be considered

for referral to a different or higher level of care, and that the clinical rationale for a decision not to refer an inmate to a higher level of care must be documented. This provision is necessary to address ADOC's failure to identify and adequately treat suicidal prisoners. As Dr. Burns explained, repeated crisis placements are a warning sign that an inmate's current level of care may be insufficient to meet his or her mental-health needs. *See* June 3, 2021, R.D. Trial Tr. at 216-17. Currently, however, this warning all too often goes unheeded. For instance, in addition to the delays in placing Jaquel Alexander on the mental-health caseload, he was never referred for a higher level of care despite his 11 crisis placements within a period of 6 months. *See* May 24, 2021, R.D. Trial Tr. at 68-70. Similarly, Marquell Underwood, Travis Jackson, and Danny Tucker also experienced multiple placements on suicide watch in the months before their deaths, without any indication that they were considered for referral to a higher level of care.

In ordering this provision, the court will adopt the defendants' language requiring that the clinical rationale for a decision not to refer an inmate to a different or higher level of care must be provided to ADOC's Office of Health Services within 72 hours of the decision. The court finds that there is insufficient evidence to impose the plaintiffs' proposed requirement for documentation to be provided immediately.

c. PLRA Findings

Current relief is necessary to correct the inadequate treatment of inmates who are placed on suicide watch, often repeatedly or for long periods of time. Suicide watch is an essential component of crisis intervention for suicidal inmates, but it is not a substitute for adequate mental-health treatment. Evidence since the liability trial reflects that failures to consider referring suicidal inmates for a different or higher level of care have

contributed to the inadequate treatment of many mentally ill inmates, including some who later committed suicide.

The provisions that the court orders are necessary to address this violation. The ordered provisions mirror the proposals of both parties with respect to the events that trigger the need to consider referral to a higher level of care. At the suicide prevention trial, experts for both parties agreed that these same events—placement on suicide watch for 72, 168, and 240 hours and two placements within 30 days or three placements within six months—necessitate consideration of referral to a higher level of care. *See Braggs*, 383 F. Supp. 3d at 1268-70. The court agrees. And in light of ADOC's history of violations and the need for continuity of care, the court finds that the requirement to document decisions not to refer is necessary as well. By requiring only that mental-health staff exercise their clinical discretion in response to these concrete warning signs that an inmate in crisis may require more intensive treatment and care, the ordered provisions are narrowly tailored and minimally intrusive to correct the ADOC's failure to provide adequate treatment to inmates on suicide watch.

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7. Discharge

a. The Parties' Proposed Provisions

The plaintiffs propose the provision, "Each patient placed on constant watch must be reduced to a close watch prior to release from suicide watch unless a clinician determines and documents the propriety of discharging a patient to a less restrictive setting to avoid unnecessarily continuing the confinement of the patient." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.5.1.1. They further propose that, prior to an inmate's discharge from suicide watch, the inmate must receive a confidential, out-of-cell evaluation or, if such an evaluation is not possible due to documented clinical concerns,

mental-health staff must consider whether referral to a higher level of care is appropriate. *See id.* at § 9.5.1.2. The defendants propose the similar provision, "An inmate may be discharged from suicide watch after an out-of-cell, confidential evaluation by a psychiatrist, psychologist, CRNP, or counselor, unless such evaluation is not possible due to documented clinical concerns which may result in the inmate being discharged from suicide watch to a different or higher level of care." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.4.1.

The plaintiffs propose that an inmate discharged from suicide watch must not be transferred to a restrictive housing unit unless there is a documented exceptional circumstance. *See Pls.*' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.5.2.1. Both parties propose that any such transfer must be approved by either the Deputy Commissioner of Operations for male-designated facilities, the Deputy Commissioner of Women's Services for female-designated facilities, or their designee. *See Pls.*' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.5.2.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.4.2.

b. The Court's Ordered Relief

47 The court will order that, prior to discharge from suicide watch, an inmate must receive a confidential, out-of-cell evaluation by a psychiatrist, psychologist, CRNP, or counselor, or, when such an evaluation is not possible due to documented clinical concerns, the evaluating mental-health staff must consider whether referral to a different or higher level of care is appropriate. At the liability trial, experts for both parties explained that "suicidal prisoners should be released only with the approval of a psychiatric provider (psychiatrist or nurse practitioner) who has made a face-to-face assessment that their condition was sufficiently stabilized to warrant it." *Braggs*, 257 F. Supp. 3d at 1230. As with the initial suicide risk assessment, this evaluation is

necessary to identify continued suicide risks and inform decisions regarding treatment and monitoring. *See* June 3, 2021, R.D. Trial Tr. at 218 (testimony of Dr. Burns).

ADOC's completion of this assessment prior to discharge remains a problem. Internal audits of numerous ADOC major facilities indicate that these assessments still are not completed for many prisoners. *See, e.g.*, Pls.' Ex. 3558 at 1, 25 (audit of Bullock, noting that 4 out of 16 inmates reviewed in March 2020 and 1 of 10 in November 2020 did not receive a discharge evaluation before release from suicide watch); Pls.' Ex. 3562 at 1 (audit of Hamilton, noting that 2 out of 6 inmates reviewed in March 2020 did not receive this evaluation); Pls.' Ex. 3626 at 1 (spot audit of Ventress, noting that the facility's compliance rate in the area of "suicide watch discharge" dropped from 76.5 % in December 2020 to 31.1 % in March 2021). While numerous audits reflect recent progress, *see, e.g.*, Pls.' Ex. 3559 at 1, 18, 28 (audit of Donaldson, finding that 7 of 20 inmates reviewed in March 2020 did not receive a ¹³³⁹*1339 discharge evaluation, but all inmates in the November 2020 and March 2021 samples did), the court remains concerned about the failures that have occurred despite a court-ordered obligation to conduct these evaluations. In light of the importance of these evaluations to ensure the adequate treatment of recently suicidal inmates and to prevent their placement in inappropriate settings, the court finds that it must continue to order that these discharge evaluations occur.

The court will not, however, order compliance with the plaintiffs' provision for the stepdown of inmates from constant observation to close watch before discharge. Dr. Metzner testified that, while this stepdown process is "generally a good practice," it is not necessary in all cases. June 30, 2021, R.D. Trial Tr. at 79. Dr. Burns similarly emphasized that the purpose of the provision is not to set a hard rule, but to "allow clinical discretion on whether a patient needs to be stepped down ... before being discharged." June 3, 2021,

R.D. Trial Tr. at 217. Because there is no evidence that mental-health staff do not recognize or exercise their clinical discretion in the decision to discharge an inmate from suicide watch, the plaintiffs' proposed provision is unnecessary.

48 With respect to the discharge of inmates directly from suicide watch to segregation, the court will adopt both of the plaintiffs' provisions, one of which the defendants also propose. The court will order that inmates discharged from suicide watch must not be transferred to segregation unless there is a documented exceptional circumstance and the transfer has been approved by the applicable ADOC official or a designee. Whatever may be said of ADOC's progress in the performance of discharge evaluations, in this area, ADOC persists in its unflinching failure to follow the court's order and its own policy, both of which already prohibit the discharge of inmates from suicide watch to a segregation unit absent an exceptional circumstance. After each of Travis Jackson's placements on suicide watch in 2019 and 2020, ADOC returned him directly to the restrictive housing unit without any documented exceptional circumstance. *See* May 24, 2021, R.D. Trial Tr. at 139-40. The psychological autopsy found that Jackson's depression and suicidal thoughts "appeared to coincide with [restrictive housing unit] placements" until he ultimately committed suicide in a restrictive housing unit in February 2021. Travis Jackson Psychological Autopsy (P-3315) at ADOC0547209. In a sample of emails approving discharge directly to segregation for 23 out of 24 inmates, Dr. Burns found that almost none of the emails included mention of purported exceptional circumstances or consideration of alternative placements. *See* May 26, 2021, R.D. Trial Tr. at 81. Many of these emails approved transfers to segregation within minutes of the request. Current evidence vindicates the assessment of a provider at Ventress: Inmates are transferred from suicide watch to segregation as "a matter of course." Pls.' Ex. 3320 at 1. ADOC's

practice since the liability trial makes clear that nothing short of a court order, coupled with aggressive monitoring, will suffice to obtain ADOC's compliance with these necessary protections.

c. PLRA Findings

Discharge from suicide watch represents a critical juncture in inmates' mental-health treatment. If handled without appropriate regard for their mental-health needs, discharge throws still vulnerable inmates into dangerous settings without adequate treatment or monitoring. The risk posed by these failures is at its apex when suicidal inmates are discharged directly to segregation, where most suicides occur. See June 29, 2021, ¹³⁴⁰R.D. Trial Tr. at 101 ^{*1340} (testimony of Dr. Metzner, noting the nationwide trend).

The ordered provisions are necessary and narrowly tailored to correct ADOC's continued failures to provide adequate treatment to inmates being released from suicide watch and to avoid discharging inmates from suicide watch to restrictive housing in the absence of exceptional circumstances. Requiring that discharge evaluations occur is the least intrusive means that will ensure the adequate placement and treatment of inmates who are discharged from suicide watch. And the combined protection of requiring that exceptional circumstances justifying placement in restrictive housing must be documented and approved is the least intrusive means that will correct ADOC's persistent failures to divert recently suicidal inmates away from segregation and toward safer alternatives.

8. Follow-Up

a. The Parties' Proposed Provisions

The plaintiffs propose that, upon an inmate's discharge from suicide watch, mental-health staff must conduct a follow-up examination with the inmate on each of the first three days after discharge, followed by a fourth follow-up on the tenth day. See Pls.' Updated Proposed Omnibus

Remedial Order (Doc. 3342) at § 9.6.1.1. The defendants propose that the inmate will receive follow-up mental-health examinations as clinically indicated. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.5.1. Both parties propose that these follow-up examinations must not take the place of other scheduled mental-health appointments but "may occur in connection with or contiguous with such appointments." See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.6.1.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.5.2. They further propose that these follow-up examinations must assess whether the inmate released from suicide watch is showing signs of ongoing crisis, whether he or she needs further follow-up examinations, and whether he or she should be added to the mental-health caseload or assigned a different mental-health code. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.6.1.3; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.5.2. The plaintiffs propose the further requirement that these examinations "must be conducted out-of-cell in a confidential setting, unless such an examination is not possible due to documented clinical concerns resulting in the patient being transferred to a higher level of care." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.6.1.1.

With respect to the transfer of inmates following suicide watch, the plaintiffs propose that, for 10 days following an inmate's discharge, ADOC may not transfer the inmate to another institution, except to return him or her from suicide watch to his or her sending institution prior to the commencement of follow-up examinations, without restarting the four follow-up examinations. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.6.1.4. After the four follow-up examinations have been completed, the plaintiffs propose that ADOC may transfer the inmate to any ADOC

facility without the requirement for further follow-up examinations, unless clinically indicated. *See id.*

b. The Court's Ordered Relief

49 The court will order that, upon an inmate's discharge from suicide watch, mental-health staff must conduct a follow-up examination on each of the first three days after discharge, unless there is a documented clinical determination that the inmate was not suicidal at the time he or she was placed on suicide watch and did not become suicidal during the watch placement. These follow-up examinations¹³⁴¹ must assess the substantive issues identified by the parties' proposals. They must occur in a confidential, out-of-cell setting, unless such an examination is not possible due to documented clinical concerns. And, consistent with the parties' proposals, the court will order that these examinations must not take the place of other scheduled mental-health appointments, although they may occur in connection with or contiguous with such appointments.

ADOC's current crisis-management approach to suicide prevention frequently neglects this crucial component of treatment for inmates with acute mental-health needs. For instance, inmate M.W. waited four days after his transfer from suicide watch before he received his first follow-up examination. *See* June 9, 2021, R.D. Trial Tr. at 39-40. Inmate J.B. received no follow-up at all after he attempted to overdose on antidepressants he had stockpiled, was placed on acute suicide watch with multiple identified suicide risk factors, and was taken off suicide watch the next day. *See* May 25, 2021, R.D. Trial Tr. at 50-52. Similar failures plagued the experiences of inmates who subsequently committed suicide. *See, e.g.*, May 24, 2021, R.D. Trial Tr. at 140-41 (Travis Jackson missed numerous follow-up examinations after his multiple crisis placements). In recognition of this problem, ADOC observed in a February 2020

letter to Wexford that "follow-up examinations were not conducted consistently at the required intervals." *See* Pls.' Ex. 3322 at 3.

These failures pose serious dangers to inmates who are discharged from suicide watch. An inmate's mental-health needs do not dissipate the moment he or she is discharged from suicide watch. Much to the contrary, as Dr. Burns testified, the initial transition period following suicide watch is a "dangerous" time for inmates who must adapt to more infrequent contact with mental-health staff. June 3, 2021, R.D. Trial Tr. at 222-23; *see also* Braggs, 383 F. Supp. 3d at 1267 (noting consistent testimony of ADOC's mental-health expert, Dr. Perrien, at the suicide prevention trial that "the period post watch is a vulnerable time"). Dr. Burns credibly testified that ADOC's persistent failures to provide follow-up examinations contributed to the inadequate treatment of inmates who later committed suicide. *See id.* at 152 (testimony of Dr. Burns, connecting these failures to the inadequacy of mental-health care received by Travis Jackson).

Current conditions mandate relief to ensure that inmates discharged from suicide watch receive constitutionally adequate care. The court finds that the specificity of the plaintiffs' proposal is necessary to address ADOC's continued failures to conduct follow-up examinations consistently. Even under a court order requiring compliance with the same timeframes proposed by the plaintiffs—timeframes which originated in the joint recommendations of both parties' experts at the suicide prevention trial, *see* Braggs, 383 F. Supp. 3d at 1266-67 —ADOC has continued to allow inmates being discharged from suicide watch to fall through the cracks at a particularly "dangerous" and "vulnerable" time. As the court observed in its suicide prevention opinion, it "cannot simply trust that ADOC will provide an adequate number of follow-ups without a court order." *Id.* at 1268. Requiring follow-up

examinations in the days immediately following an inmate's release from suicide watch is necessary to correct ADOC's continued violations.

Still, the court's ordered relief narrows that requested by the plaintiffs in two ways. First, the court incorporates Dr. Metzner's testimony that a documented clinical determination that an inmate was not and is not suicidal obviates the need for follow-up examinations. *See* June 30, 2021, R.D. Trial Tr. at 75-76. Second, the ¹³⁴² court does not order compliance with the requirement to conduct a fourth follow-up examination on the tenth day after discharge. Although Dr. Burns credibly testified that a follow-up examination after the immediate transition period is important to ensure that the inmate is "stable" after adjusting to a different environment, June 21, 2021, R.D. Trial Tr. at 63-64, she conceded that the "days immediately after release" from suicide watch present the most serious risk, June 23, 2021, R.D. Trial Tr. at 220. In light of this testimony, as well as the relatively limited evidence to support the requirement to conduct a follow-up examination specifically on the tenth day following discharge, the court leaves the provision of additional follow-up care after the first three examinations to the clinical judgment of ADOC's mental-health staff.

50 The court will further adopt the plaintiffs' proposal that an inmate's transfer from suicide watch to another institution prior to the completion of the three ordered follow-up examinations restarts the requirement to complete follow-up examinations on each of the three days following the transfer. ADOC's frequent transfers of prisoners with serious mental-health needs may be disruptive in any case, but the dangers are most pronounced immediately following an inmate's discharge from suicide watch. *See Braggs*, 383 F. Supp. 3d at 1267 (noting ADOC's expert's testimony that, when "someone is being moved, that increases the stress that an already vulnerable person experiences"). Transfers between facilities continue to jeopardize the continuity of mental-health care received by inmates immediately

following their discharge from suicide watch. For example, Dr. Burns testified that many of Travis Jackson's post-suicide watch follow-up examinations were missed as a result of his transfers between prisons. *See* May 24, 2021, R.D. Trial Tr. at 140-41. To address the dangers to inmates with serious mental-health needs when their follow-up care is interrupted, the court must require that ADOC's obligation to provide the three ordered follow-up examinations is reset when an inmate is transferred to another facility prior to completion of these examinations.

c. PLRA Findings

Meaningful follow-up care is a critical element of the protection and treatment of inmates who have expressed suicidality. The follow-up examinations that the court orders are necessary to protect vulnerable inmates in the dangerous transition period after their release from suicide watch into an environment in which their contacts with mental-health staff are more infrequent and there are fewer safeguards in place to prevent them from attempting suicide or other self-harm. By excluding inmates who are clinically determined not to have been suicidal, the ordered provisions are narrowly tailored to correct ADOC's ongoing failures to provide this necessary follow-up care to the inmates who require it. This relief is the least intrusive means that will ensure that inmates who are discharged from suicide watch receive adequate follow-up examinations to evaluate and treat any continued mental-health needs and to ensure that they remain stable following discharge.

9. Other Provisions Regarding Suicide Prevention

Both parties propose that suicide watch cells must not be designated as restrictive housing unit cells. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.2.5; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.1.1. The placement of segregation inmates in designated mental-health units was a "recurring" problem at the time of the liability opinion,

¹³⁴³undermining the usefulness of ^{*1343} these units to treat prisoners with serious mental-health needs. *Braggs*, 257 F. Supp. 3d at 1212-13. Recently, however, there is not evidence that ADOC has continued this harmful practice. Consequently, this relief is unnecessary.

Consistent with § V.J of ADOC Administrative Regulation 629, the plaintiffs propose the requirement that "ADOC and/or its vendor must debrief staff and prisoners after a completed suicide or self-injurious behavior that would have resulted in death if there had been no intervention." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.1.6. There is evidence to support the importance of this practice. Dr. Burns explained that suicides are "traumatic" for inmates and responding staff alike. June 22, 2021, R.D. Trial Tr. at 80. However, ADOC has already adopted this policy as a regulation, and there is evidence that ADOC has implemented this policy in its responses to at least some completed suicides. *See id.* The court will not order this relief at this time.

The defendants propose the provision that, after intake and after an inmate is transferred from one ADOC major facility to another, "the inmate will be provided any facility-specific information concerning mental-health services and the way to access those services for himself/herself or for another inmate." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 9.6.1. The court agrees that dissemination of this information is fundamental to inmates' ability to request and receive adequate mental-health care. However, given the lack of evidence that ADOC has not meaningfully informed inmates regarding access to mental-health services, the court need not order this relief.

The plaintiffs propose the provision that qualified mental-health professionals "may conduct suicide risk assessments, discharge evaluations, and follow-up examinations either in person or by telehealth." Pls.' Updated Proposed Omnibus

Remedial Order (Doc. 3342) at § 9.8. When these examinations are conducted by telehealth, the plaintiffs propose that an RN must be in the room with the inmate. *See id.* While the court is sensitive to the limitations of telehealth, *see* June 3, 2021, R.D. Trial Tr. at 229-30 (testimony of Dr. Burns), there is no evidence that, to the extent ADOC uses telehealth, its practice is inappropriate. Requiring a mental-staff member to be in the room with an inmate during telehealth sessions may be an important measure to prevent mental-health providers from missing important observations of an inmate's behavior or lacking information from an inmate's medical chart, but the court will not order this relief at this time.

The plaintiffs further propose that associate licensed counselors working toward licensure may not conduct suicide risk assessments or follow-up examinations on their own, although they may participate in suicide risk assessments conducted by qualified mental-health professionals. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 9.8. ADOC's mental-health vendor at the time of the liability trial employed mental-health providers who were not independently licensed, *see* June 4, 2021, R.D. Trial Tr. at 47-48. However, there is insufficient evidence as to whether ADOC or its current vendor employs associate licensed counselors and, if so, what tasks these associate licensed counselors currently perform to warrant relief at this time.

K. Higher Levels of Care

As described previously, ADOC has made progress in its provision of hospital-level care in general, although problems with timely access to care remain. Its progress with respect to inpatient units, however, is less encouraging; its supply of inpatient beds has decreased since the court's May ¹³⁴⁴2020 inpatient treatment opinion, ^{*1344} and it has failed to address the issue of heat management in inpatient facilities.

I. Timely Access to Hospital-Level Care

a. The Parties' Proposed Provisions

To remedy the lack of timely access to hospital-level care, the plaintiffs propose that the ADOC must comply with its own regulation regarding access to hospital-level care, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 10.1.1; that in the event a hospital refuses to admit an inmate referred for care, ADOC must attempt to obtain admission of the inmate at an alternative hospital, *see id.* at § 10.1.4; and that, until the EMT conducts its first audit, ADOC must notify the plaintiffs' counsel when there are delays in the provision of hospital-level care, *see id.* at § 10.1.4.

The ADOC regulation to which the plaintiffs refer--AR 640, Advanced Inpatient Mental Healthcare (Doc. 3206-6)--imposes a series of deadlines for the provision of hospital-level care, including, but not limited to, the following: if an inmate is identified as possibly requiring hospital-level care, his treating physician must complete a certain form and send it to the director of psychiatry within one working day of completion; within 72 hours of receiving the form, a separate administrator--the director of psychiatry services--must review the inmate's medical record and assessment; if the director of psychiatry services determines that hospital-level care is in the inmate's best interests, she must prepare a request for admission within eight hours, or document a recommendation of postponement of admission for an additional 48 hours; if the director of psychiatry prepares a request for admission, the inmate must be transported to a hospital within three business days. The regulation also requires ADOC to complete, in writing, an annual reassessment of its need for hospital beds, and to contract for more beds if necessary. The plaintiffs propose that ADOC must provide them with a copy of this annual reassessment. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 10.1.2.

The defendants propose no provision concerning the lack of timely access to hospital-level care.

b. The Court's Ordered Relief

51 The court will order that ADOC must ensure that inmates who require hospital-level care receive it within a reasonable period of time, as determined by clinical judgment. The court orders this relief in light of the evidence that since its liability opinion, ADOC has failed to ensure that inmates who require hospital-level care receive it promptly enough to prevent them from harming or killing themselves. Tommy McConathy's case provides a particularly stark example of this failure. In the last few months of his life, he found respite from acute suicidality only during the few weeks he spent in Citizens Hospital. Prior to his transfer to Citizens, McConathy had been on repeated suicide watches since December 2019, and saw no improvements in his mental health even in the most intensive care units offered in ADOC's facilities. He reported his "adamant ... desire to die" while in Bullock's SU, *see* Pls.' Ex. 3310 at ADOC546648, and he was sexually assaulted in Bullock's RTU and reported that he could not function there, *see id.* at ADOC546690. ADOC was not ignorant of McConathy's needs--after his sexual assault in Bullock, a mental-health provider assessed McConathy as "at high risk for continued suicide watch until [his] safety needs are addressed," and indicated that he would be considered for referral to Citizens. *See id.* Yet it took 30 days after that for McConathy to be transferred to Citizens. Inmate M.H. experienced a similar delay--he was referred to Citizens after ¹³⁴⁵cutting himself repeatedly and spending ^{*1345}several stints in the Bullock SU, but waited 10 days before he was actually transferred to the hospital. *See* May 25, 2021, R.D. Trial Tr. at 43--44. For inmates whose mental-illnesses are so acute as to require hospital-level care, such prolonged delays pose a needless and grave danger.

The court will not order, however, that ADOC must comply with the requirements of its own regulation regarding access to hospital-level care. While the detailed timing requirements imposed by the regulation might be desirable, the evidence does not show them to be necessary. As long as ADOC can ensure that inmates who require hospital-level care receive it promptly enough so that their health and lives are not jeopardized, the court need not dictate the precise manner in which it does so. The court also trusts that if ADOC proves unable to ensure timely access to hospital-level care, the EMT shall bring the matter to its attention.

As for the requirement that ADOC reassess its need for hospital beds, there is little evidence that ADOC's failure to provide timely access to hospital-level care is caused by a shortage of beds--indeed, as described previously, the plaintiffs agree that the 14 beds ADOC currently maintains at Citizens are adequate for the system's mental-health caseload. Rather, the problem seems to lie with ADOC's failure to ensure that inmates who require hospital-level care are timely transferred to available beds.

Nor will the court order that, in the event that a hospital refuses to admit an inmate referred for care, ADOC must attempt to admit the inmate to an alternative hospital. The record does not show that inmates whom ADOC has referred for hospital-level care are regularly turned away.

Finally, the court will not order that, until the EMT conducts its first audit, ADOC must notify the plaintiffs' counsel when there are delays in the provision of hospital-level care. Although prompt access to hospital-level care is a matter of utmost urgency that cannot be neglected prior to the EMT's first audit, the court trusts that ADOC will comply with the terms of its order.

c. PLRA Findings

The court finds this provision necessary for the reasons given above: ADOC has failed to ensure that inmates who require hospital-level care receive it in a timely fashion, despite the fact that without such care, those inmates are at serious risk of harming or killing themselves. This provision is also narrowly tailored because it is exclusively focused on the problem of unreasonable delays in care, and minimally intrusive because it leaves it entirely to ADOC to determine how it ensures that there are no unreasonable delays.

2. Inpatient Beds

a. The Parties' Proposed Provisions

To remedy ADOC's lack of inpatient beds, the plaintiffs propose that at all times ADOC must maintain enough beds to accommodate 15 % of its mental-health caseload, measured initially against the June 2020 caseload numbers. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 10.2.1. The plaintiffs also propose that ADOC must add new beds annually, if necessary, to reflect changes in its mental-health caseload, *see id.*; that it must provide new treatment space if it is needed to accommodate additional beds, *see id.* at § 10.3.1; and that all treatment spaces used to house inpatient beds must provide for confidentiality, *see id.*

The defendants maintain that no relief is necessary in light of Dr. Metzner's testimony that between 10 and 15 % of inmates on the mental-health caseload can be expected to require inpatient beds, and the ¹³⁴⁶fact that ADOC currently has 433 beds ^{*1346}available--enough to accommodate nearly 10 % of its June 2020 mental-health caseload.¹⁴ *See* Defs.' Post-Trial Br. (Doc. 3367) at 105-106.

¹⁴ The defendants claim that ADOC's inpatient beds, combined with the 14 hospital beds available to it at Citizens Hospital, are enough to accommodate 10.2 % of its June 2020 mental-health caseload. The beds at Citizens, however, are not

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 Among ADOC's inpatient beds, and should
 not be counted towards the 10 % target set
 by Dr. Metzner.

In the alternative, the defendants propose that within 180 days of the effective date ADOC must have enough beds to accommodate 10 % of its June 2020 caseload, and that within one year of the effective date it must reassess whether it needs more beds. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 10.2-3. The defendants also propose that ADOC's reassessment be based on the mental-health caseload as it existed at the end of the sixth month after the effective date, and that, if ADOC or any third-party has started construction on any prison facilities that will house mental-health beds, the EMT will take that fact into account in reassessing the need for more beds. See *id.* at § 10.3.

b. The Court's Ordered Relief

52 The court will order that ADOC must initially supply enough beds to accommodate 10 % of its mental-health caseload at the time of the effective date. However, ADOC must, on at least an annual basis, collaborate with the EMT to reassess (1) the number of inmates on its mental-health caseload, and (2) whether 10 % is in fact an accurate estimate of the percentage of the mental-health caseload requiring inpatient treatment. If ADOC determines that more than 10 % of the inmates on the mental-health caseload require inpatient beds, or that the mental-health caseload has grown, or both, it must adjust its number of inpatient beds accordingly. It must also ensure that inpatient beds are housed in treatment spaces that allow for confidentiality, including by creating new treatment spaces if necessary.

The court orders ADOC to ensure that it has enough beds to accommodate 10 % of the inmates on its mental-health caseload in light of Dr. Metzner's testimony that, at any given time, ADOC should expect at least 10 % of the inmates on its mental-health caseload to require access to inpatient beds. See June 30, 2021, R.D. Trial Tr. at

165. Despite this testimony from its own expert, ADOC has yet to provide enough beds to accommodate 10 % of the inmates on its mental-health caseload. Nor is it progressing towards that goal. When the court issued its remedial opinion, ADOC had 504 inpatient beds available for a caseload of 4,151 inmates. See *Briggs v. Dunn*, No. 2:14cv601-MHT, 2020 WL 2789880 at *6 n.4, *7 (M.D. Ala. May 29, 2020) (using December, 2019 caseload numbers). Since then, ADOC has allowed the number of inpatient beds to decrease, from 504 to 433. See Defs.' Post-Trial Br. (Doc. 3367) at 105. Meanwhile, as predicted, ADOC's mental-health caseload has grown, from 4,151 in December 2019, see Joint Report (Doc. 2705), to 4,564 in March 2021, see Defs.' Ex. 4079 at 43-44. That growth can be expected to continue, both because ADOC's capacity to recognize inmates who should be on its mental-health caseload will improve as it implements the court's orders regarding intake, and because admissions are expected to increase as the COVID-19 pandemic wanes. The need for more beds is therefore even more urgent today than it was at the time of the court's remedial opinion.

The court orders ADOC to use the caseload numbers at the time of the effective date as an initial reference point, as opposed to the June 2020 caseload numbers, to ensure that ADOC begins to ¹³⁴⁷make progress ^{*1347} immediately. ADOC's March 2021 caseload was significantly larger than its June 2020 caseload (which, according to ADOC's estimates, was approximately 4,382, see Defs.' Post-Trial Br. (Doc. 3367) at 105), and its caseload is only expected to grow. Were the court to allow ADOC to use its June 2020 caseload as an initial reference, it would allow ADOC to continue its insufficient provision of inpatient beds for up to a year. That will not do. At the same time, however, the court suspects that its order will be significantly more manageable for ADOC than the plaintiffs' proposal--that ADOC be required to provide enough beds to accommodate 15 % of its June 2020 caseload. The plaintiffs estimate that

their proposal would require ADOC to add 222 beds initially. See Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 10.2.1. The court cannot say how many beds its order will require ADOC to add initially, because the mental-health caseload at the time of the effective date has yet to be determined. But it will almost certainly be fewer than 222 by a large margin. To accommodate 10 % of its March, 2021 caseload, for example, ADOC would have to add only 23 beds. The number of additional beds needed to accommodate 10 % of ADOC's caseload at the time of the effective date will likely be far closer to 23 than 222.¹⁵

¹⁵ While ADOC may convert its SLU beds to serve as inpatient beds, it bears repeating that the SLUs do not currently help meet ADOC's need for inpatient beds, and ADOC may not double-count them as both inpatient units and outpatient diversionary units in the event that it converts them to inpatient units. Rather, if it chooses to convert the SLUs to inpatient units, it must find alternative facilities for outpatient diversion.

The court orders ADOC to regularly reassess the adequacy of its supply of inpatient beds because, although it orders today that ADOC need only provide enough beds to accommodate 10 % of the inmates on its mental-health caseload, it is seriously concerned that ADOC may in fact require more beds to correct the constitutional violations found in the court's 2017 liability opinion. Experts for both parties previously testified that approximately 15 % of inmates on the mental-health caseload will require inpatient beds at any given time. See *Braggs*, 2020 WL 2789880 at *4. Only Dr. Metzner testified otherwise. The court now defers to his expertise, but given the conflicting testimony on the number of beds needed, it finds that ADOC must be prepared for the possibility that more than 10 % of its mental-health caseload will require inpatient beds. ADOC must also be cognizant of its historic

failure to identify mentally ill inmates and place them on the mental-health caseload, and the high likelihood that as it implements the provisions of the court's present order regarding intake, its mental-health caseload will grow. Whatever number of beds are sufficient to accommodate ADOC's mental-health caseload at the time of the effective date may therefore soon prove inadequate.

Finally, the court orders that inpatient beds are housed in treatment spaces that allow for confidentiality because mental-health treatment must be confidential if it is to be effective. Indeed, the defendants themselves propose that treatment must take place in a setting that provides for confidentiality, see Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 6.1, and their expert testified as to his agreement with this provision, see June 30, 2021, R.D. Trial Tr. at 168 (testimony of Dr. Metzner); his only reservation was that he found it to state the obvious, see *id.* Because of the importance of this issue and the longstanding problems with confidential treatment space, however, the court finds it necessary to make clear what should be self-evident.

1348*1348

c. PLRA Findings

The court finds this provision necessary given the pivotal importance of the inpatient-bed supply to ADOC's entire mental-health system. As described in the liability opinion and reiterated in the remedial opinion, ADOC's lack of inpatient beds has "a downward-spiral effect on the rest of the system: those who do not get needed treatment often end up in crisis cells, frequently receive disciplinary sanctions, and may be placed in segregation, where they have even less access to treatment and monitoring." *Braggs*, 2020 WL 2789880 at *38 (quoting *Braggs*, 257 F. Supp. 3d at 1206). Ensuring adequate beds is therefore foundational to remedying the constitutional violations identified in the liability opinion, and, as described above, to the extent that beds are used

for mental-health treatment, they must be housed in spaces that allow for confidentiality if that treatment is to be effective. This provision is also narrowly tailed and minimally intrusive because it requires ADOC to provide only the absolute minimum number of beds necessary, according to the lowest estimate given by any of the parties' experts.

3. Temperature Regulation

a. The Parties' Proposed Provisions

To remedy ADOC's failure to ensure that its inpatient treatment units are suitably temperature-regulated, the plaintiffs propose that "ADOC must create a year-round heat management plan to address the risk of overheating by inmates in inpatient treatment units who are on psychotropic medications." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 10.2.1. The defendants propose no provision concerning temperature regulation.

b. The Court's Ordered Relief

53 In agreement with the plaintiffs, that court will order that ADOC must devise a plan and procedures to address the serious risk posed by high temperatures in the mental-health units, which it must submit to the court by May 2, 2022. In its May 2020 remedial opinion and order, the court imposed the same requirement, which it found to satisfy the requirements of the PLRA. *See Braggs*, 2020 WL 2789880 at *15. In a July, 2020 filing, the defendants purported to have complied with the court's requirement by installing HVAC systems in all of ADOC's mental-health treatment units. *See* Doc. 2880 at 4–5. Since then, however, Tommy Lee Rutledge died of hyperthermia in his cell in the Donaldson RTU, where the temperature reached 104 degrees. *See* May 25, 2021, R.D. Trial Tr. at 144–45. Plainly, ADOC has not done enough to ensure that temperatures in its inpatient treatment units do not become dangerously high. The court therefore must reiterate its May, 2020 order.

ADOC should specifically address how it happened that Rutledge's cell reached 104 degrees, causing him to die of hyperthermia, in a unit that was supposedly air conditioned, and how it will prevent that from ever occurring again. The latter inquiry will require ADOC to address, additionally, how it plans to determine whether a particular cell has reached dangerously high temperatures, and should such a finding be made, what measures it will take to ensure its occupant's safety. Because Rutledge died in a unit that was supposedly air conditioned, these inquiries must pertain to all mental-health units, regardless of whether they are airconditioned. (In this respect, the court's present order differs from its May 2020 order, which did not require ADOC to address heat management in the air conditioned mental-health units in Tutwiler and Bullock. *See Braggs*, 2020 WL 2789880 at *15.)

c. PLRA Findings

The court finds this provision necessary because ¹³⁴⁹addressing the risk of overheating ^{*1349} is essential to ensuring the safety of inmates in inpatient units. *See Braggs*, 2020 WL 2789880 at *15. ADOC itself recognizes as much—its own regulations require the Director of Treatment and Wardens to "ensure that measures to reduce sun/heat exposure risks for inmates taking psychotropic medication are initiated and maintained at all ADOC institutions." Joint Ex. 118, Admin. Reg. § 619 (Doc. 1038-141). This provision is also narrowly drawn and minimally intrusive, because it does not require ADOC to adopt any particular plan or implement any particular procedure. So long as ADOC can mitigate the risk of overheating, the manner in which it does so shall remain completely within its discretion. Finally, although the order requires ADOC to devise a heat management plan for facilities that are currently air conditioned, it extends no further than necessary, because as Rutledge's death illustrates, overheating remains a risk in all units, air conditioned or not.

4. Other Provisions Regarding Higher Levels of Care

In addition to the provisions described above, the plaintiffs propose two provisions that the court will not adopt, but will address briefly below.¹⁶

¹⁶ The plaintiffs also propose that all stabilization unit cells must be suicide-resistant. The court addresses this provision in its discussion of the parties' proposed provisions regarding suicide prevention.

First, the plaintiffs propose that, if an inmate under a sentence of death is determined to be a candidate for hospital-level mental-health care, ADOC must notify the plaintiffs' counsel, who must then notify the attorney responsible for that inmate's post-conviction appeal, if one exists. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 10.1.3. The court will not order this relief because the record does not show it to be necessary to remedy ADOC's failure to provide inmates with timely access to hospital-level care. To the extent the provision is intended to provide external oversight of ADOC's provision of care, it is redundant; oversight is the bailiwick of the EMT. To the extent the provision is intended to facilitate the development of post-conviction legal claims, it is beyond the scope of the Phase 2A omnibus remedial order.

Second, the plaintiffs propose that "ADOC must ensure that any new facilities are designed to include adequate mental health treatment space, including an adequate number of inpatient beds and confidential treatment space," and that in designing new facilities, ADOC should solicit input from "the health services staff, the [mental-health] vendor, and the EMT." *See id.* at § 10.3.2. The court will not order the first part of this provision, concerning treatment space in new facilities, because it is redundant. As explained above, the court will order that ADOC must maintain enough inpatient treatment beds to accommodate 10 % of its mental-health caseload,

and that those beds must be housed in spaces that allow for confidential treatment. That order applies to future and existing facilities alike--if ADOC chooses to house inpatient beds in a new facility, it must ensure that those beds are housed in such a manner so as to allow for confidential treatment. The court will not order second part of the plaintiffs' proposed provision--that ADOC be required to consult the health services staff, its mental-health vendor, and the EMT when designing new facilities--because the plaintiffs have not shown it to be necessary. Absent evidence that ADOC cannot comply with the court's order, the court finds that whom ADOC consults regarding the construction of new facilities should be entirely up to ADOC.

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L. Discipline

Despite some progress, ADOC continues to discipline inmates without due regard for their mental-health needs. While ADOC appears to have curtailed its unacceptable practice of punishing inmates for self-harm, its continued failure to obtain remotely meaningful mental-health consultations to the disciplinary process subjects inmates with serious mental-health needs to inappropriate sanctions that create the substantial risk of decompensation, worsened symptoms, and restricted access to necessary care.

ADOC's August 20, 2020, revision of Administrative Regulation 403 (Doc. 3206-7), regarding the procedures for handling rule violations, and Administrative Regulation 626 (Doc. 3206-8), regarding mental-health consultations to the disciplinary process, represents one important step toward correcting ADOC's deficiencies. The plaintiffs propose a provision requiring ADOC to comply with both updated regulations. *See* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 11.1. However, the court declines to follow the plaintiffs' approach. Considered in their entirety, the two regulations address numerous issues that

are disconnected from the constitutional violations before the court and contain provisions for which there is not sufficient evidence to find that ordering compliance would comply with the PLRA.

Instead of requiring across-the-board compliance, the court will consider relief that requires ADOC to comply with specific provisions of these regulations. By reviewing individual provisions, the court will better account for changed circumstances pertaining to inmate discipline and order relief that is necessary, narrowly tailored, and minimally intrusive in light of those conditions.

I. Mental-Health Consultations to the Disciplinary Process

a. The Relevant Provisions

Section V.B.2 of ADOC Administrative Regulation 626 provides:

"A mental health consultation may be sought at the time of the rule or regulation violation or after review of the disciplinary report. A mental health consultation must be sought if the inmate is on the mental health caseload and has a mental health code of C or higher and/or an SMI designation; or, even if the inmate has a lower mental health code or is not on the mental health caseload, where the inmate has an intellectual or developmental disability, or the inmate's behavior at the time of the alleged actions giving rise to the disciplinary or at any time prior to or during the disciplinary process demonstrates signs of psychological distress or mental impairment."

Section V.C.3.a lists the matters that the consulting mental-health staff must evaluate, including the inmate's current and then-existing mental state, the inmate's mental-health diagnosis or the presence of mental illness, the inmate's recent treatment history and medication, the inmate's recent crisis placements, whether the inmate's violative behavior directly resulted from or is related to mental illness, the likely impact of confinement to

restrictive housing and whether such confinement is contraindicated, the potential impact of other disciplinary sanctions and whether any such sanctions are contraindicated, alternative sanctions that are not contraindicated, and the need for mental-health staff to be present during the disciplinary hearing. And § V.C.3.d requires the documentation of the evaluation and its recommendations, including disciplinary sanctions that are contraindicated and alternative sanctions that are appropriate, to be provided ¹³⁵¹ to the disciplinary hearing officer and the inmate's treatment team.

b. The Court's Ordered Relief

⁵⁴ The court will order that ADOC must comply with these provisions of Administrative Regulation 626. The mental-health consultation process remains badly broken, and the court finds this relief necessary in light of ADOC's longstanding use of mental-health consultations as rubber stamps for the disciplinary process, to the grave detriment of inmates with serious mental-health needs.

Just as the court found in the liability opinion, the mental-health consultations are still limited to the point of meaninglessness. In the overwhelming majority of the hundreds of disciplinary reports that Mr. Vail reviewed, input by mental-health staff consisted of four yes/no answers: whether the inmate was competent, whether mental-health issues affected the inmate's behavior, whether mental-health issues needed to be considered in the disposition, and whether mental-health staff would be present at the hearing (always answered "no," see May 26, 2021, R.D. Trial Tr. at 203). See, e.g., Pls.' Ex. 2953 at ADOC492463.

These formalities are sufficiently perfunctory that consulting mental-health staff routinely fail to ensure that basic (and critical) information, such as whether the inmate is on the mental-health caseload, what the inmate's mental-health code is, and whether the inmate has an SMI, is actually reported. As noted in the section on current

conditions, the box on the consultation form to indicate whether an inmate is on the mental-health caseload is frequently marked with an error code, and there is no designated space to indicate that an inmate has a serious mental illness. Even when an inmate's mental-health status is appropriately noted, the cursory comment rarely offers the slightest indication of how the inmate's mental-health issues may be affected by possible sanctions, much less an affirmative recommendation that specific sanctions are appropriate or inappropriate. As Vail described one comment that "[inmate] has an SMI flag and has recently engaged in self-injurious behavior," such a comment "doesn't give the hearing officer sufficient information to really know what to do." May 26, 2021, R.D. Trial Tr. at 213-14.

Furthermore, discrepancies and omissions continue to plague these consultations, causing real harms to inmates by exposing them to sanctions that are inappropriate in light of their mental-health needs. In "one of the better comments" that Vail reviewed, May 26, 2021, R.D. Trial Tr. at 220, a consulting mental-health staff member noted, "[inmate] has a serious mental illness diagnosis. Long-term restrictive housing assignment contraindicated." Pls.' Ex. 2953 at ADOC492423. While this "better" comment still suffers from a lack of specificity as to the meaning of "long-term," see May 26, 2021, R.D. Trial Tr. at 220, the inmate was not sentenced to disciplinary segregation for the corresponding disciplinary report, see Pls.' Ex. 2953 at ADOC492425. Less than a month later, however, a consultation to a subsequent disciplinary proceeding for that inmate answered that there were no mental-health issues to consider, see Pls.' Ex. 2953 at ADOC492463, and the inmate was sentenced to 45 days in disciplinary segregation, see *id.* at ADOC492465.

The gravity of this issue is perhaps most apparent in the case of Jaquel Alexander, whose consultation had nothing to say about his serious mental illness, his previous contraindications for

restrictive housing, see Jaquel Alexander Mental-Health Records (P-3297) at ADOC518254, ADOC518487, or his suicide attempt one month earlier, see *id.* at ADOC518247. See Jaquel Alexander Institutional File (P-3296) *1352 at ADOC517817. As Vail observed, the consultation contained "no indication that this was anything out of the ordinary other than the fact that the person was on the caseload." May 27, 2021, R.D. Trial Tr. at 15. This consultation, identical to countless others in all but name and date, gave the hearing officer a green light to sentence Alexander to segregation, where he committed suicide.

ADOC's adoption of revised regulations is no answer to this sustained dysfunction. Even at the time of the liability opinion, ADOC had regulations in place pertaining to these consultations. ADOC has failed to improve this process at all in the four years since the liability opinion. As Vail testified, "[t]his process is far from being fully implemented." June 1, 2021, R.D. Trial Tr. at 44. Because ADOC has shown itself to be incapable of following its own regulations—it failed to do so in 2017 and it is failing to do so today—it is necessary for the court to order ADOC to comply with the central provisions of its regulations regarding the provision of adequate mental-health consultations to the disciplinary process. This area should be monitored especially closely by the EMT.

c. PLRA Findings

The provisions that the court orders are necessary to ensure that mental-health consultations are adequately informative to facilitate consideration of inmates' mental-health issues in the disciplinary process. Substantive mental-health consultations must occur, and they must provide the hearing officer with the necessary context of an inmate's mental-health status and history. A sequence of checkboxes that are filled out with variable accuracy is no substitute for meaningful deliberation and documentation by the consulting

mental-health staff, including comments and recommendations regarding appropriate and inappropriate punishments.

This relief is narrowly drawn to correct ADOC's continued deficiencies in the protection of inmates with the most serious mental-health needs in the disciplinary process. And it is the least intrusive means that will ensure that hearing officers are aware of necessary information regarding inmates' mental-health issues and their implications.

2. Consideration of Mental-Health Consultations

a. The Relevant Provisions

Section V.D.3 of Administrative Regulation 626 provides that "the disciplinary officer must consider the mental health consultation, including any evaluation, comments, or recommendations, in deciding an inmate's guilt or innocence and, if guilty, in imposing any disciplinary sanctions." Section V.D.6 further requires that the hearing officer must document this consideration of the mental-health consultation.

With respect to determinations of guilt, § V.A.1.a of Administrative Regulation 403 prohibits the discipline of an inmate "for symptoms directly related to his or her mental illness, including but not limited to issuing disciplinaries or applying disciplinary sanctions to inmates for engaging in conduct directly related to self-injurious behavior." Both parties propose provisions defining "symptoms directly related to [an inmate's] mental illness" to include "behaviors that would otherwise give rise to disciplinary proceedings or behavior citations but for the fact that they were directly caused by the inmate's mental illness," such as "violence toward other people, defiance of correctional staff, destruction of property, self-harm, and possession of contraband for the purpose of self-harm." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 11.2.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 11.2. They likewise propose provisions¹³⁵³ defining

"conduct directly related to self-injurious behavior" to include "engaging in self-harm; attempting suicide; possessing tools or instruments, such as razors, other sharp objects, and rope, for the purpose of using them to engage in self-harm; and destroying property, such as ripping apart a mattress or causing fire damage to a cell, in the process of self-harming or attempting suicide." Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 11.2.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 11.3. Additionally, § V.D.3.a of Administrative Regulation 626 specifies that, "[i]f the mental health staff member performing the mental health consultation concludes that the rule or regulation violation was a direct result of the inmate's mental illness, then the disciplinary hearing officer must find the inmate not guilty of the disciplinary action."

With respect to punishment, § V.D.3.b of Administrative Regulation 626 provides that, "[i]f the mental health staff member performing the mental health consultation concludes that the rule or regulation violation was related to, but not the direct result of, the inmate's mental illness, then the disciplinary hearing officer must take that conclusion into consideration in imposing any disciplinary sanctions." Section V.D.4 adds, in relevant part, that, "if the mental health staff member who conducted the mental health consultation determined that any specific disciplinary sanction is clinically contraindicated for the inmate, including confinement to restrictive housing for a medium- or high-level rule or regulation violation, then the decision of the mental health staff member who performed the mental health consultation will be outcome-determinative and binding on the disciplinary hearing officer, except where exceptional circumstances exist."

b. The Court's Ordered Relief

⁵⁵ The court will order that ADOC must comply with §§ V.D.3 and V.D.3.b, and the provision of § V.D.4 quoted above, of Administrative Regulation 626. With respect to the punishment of disciplinary violations, Dr. Burns, Dr. Metzner, and Mr. Vail all stressed the importance of considering an inmate's mental illness and mental-health needs. See June 4, 2021, R.D. Trial Tr. at 135-36, 154-56 (testimony of Dr. Burns); May 26, 2021, R.D. Trial Tr. at 207 (testimony of Mr. Vail); June 29, 2021, R.D. Trial Tr. at 178, 180-81 (testimony of Dr. Metzner). As explained previously, robust mental-health consultations are a necessary step in communicating this information to the hearing officers tasked with determining sanctions. But without meaningful consideration by hearing officers, mental-health consultations accomplish nothing, and mentally ill inmates are left without protection from inappropriate disciplinary sanctions.

Currently, hearing officers continue to discipline inmates without due regard for their mental illnesses and mental-health needs. While the continued inadequacy of the mental-health consultations that are provided plays a considerable role in perpetuating these violations, the evidence also indicates that hearing officers' consideration of the consultations that are provided is insubstantial. Vail testified that he has not seen documentation that a hearing officer ever contacted mental-health staff with any questions about the consultation, even when the consultation identifies relevant mental-health issues, see May 27, 2021, R.D. Trial Tr. at 14; the only documentation that a consultation was considered is an unexplained "yes," see *id.* at 15-16. The absence of any documented reasoning tying hearing officers' decisions to the mental-health consultations raises serious ¹³⁵⁴ concerns that the consultations are received and promptly disregarded.

The need for meaningful consideration of the mental-health consultation is at its most dire when mental-health staff have determined that certain

sanctions, most notably segregation, are clinically contraindicated. Dr. Burns testified that, in light of the mental-health staff's understanding of "the impact that disciplinary sanctions might have on [an inmate's] mental health" and "the impact of restrictive housing on persons with mental illness," it is necessary for mental-health staff to have the clear authority to divert inmates with serious mental-health needs from contraindicated punishments, particularly segregation. June 4, 2021, R.D. Trial Tr. at 135. Dr. Metzner similarly endorsed the ability for mental-health staff to veto placements in segregation. See June 29, 2021, R.D. Trial Tr. at 116 (testimony of Dr. Metzner). Currently, however, as Dr. Burns and Mr. Vail testified, the evidence reflects that mental-health staff do not recognize or do not exercise this authority in the disciplinary context. See May 26, 2021, R.D. Trial Tr. at 214-15 (testimony of Vail, stating the general conclusion); May 27, 2021, R.D. Trial Tr. at 6-7, 57 (testimony of Vail, noting the absence of any unequivocal contraindications of segregation in the consultations he reviewed); May 25, 2021, R.D. Trial Tr. at 41-42, 203-04 (testimony of Dr. Burns, discussing this lack of meaningful input by mental-health staff generally and with respect to the repeated failure to divert inmate T.C. from disciplinary segregation, despite her diagnosis with bipolar disorder); June 22, 2021, R.D. Trial Tr. at 124 (testimony of Dr. Burns, noting the absence of any recommendations for alternative sanctions in the consultations she reviewed). One incident outside of the consultation process that ADOC cites to rebut this testimony is telling. A progress note reviewed by Dr. Burns and Vail reported that, when two mental-health staff did determine that placement in segregation was contraindicated for an inmate, a captain responded that the inmate would be placed in the restrictive housing unit anyway. See May 25, 2021, R.D. Trial Tr. at 27, 204; May 27, 2021, R.D. Trial Tr. at 58-60. That the mental-health staff ultimately succeeded in diverting the inmate by placing him on suicide watch is not, as ADOC contends, evidence that

diversion is functioning properly. If anything, the incident is a sign that correctional staff are resistant to the few attempts to divert inmates from contraindicated punishments that do occur.

The current superficiality of the consultation process necessitates relief with respect to the conduct of both consulting mental-health staff and hearing officers. For mental-health consultations not to be useless, the court must order that they be considered as well as provided. And for clinical contraindications of sanctions not to be toothless, the determination of mental-health staff regarding contraindicated sanctions must be outcome-determinative in the absence of exceptional circumstances, *see supra* at 1269–72 (defining "exceptional circumstances").

At this time, however, the court will not order relief with respect to § V.A.1.a of Administrative Regulation 403 or § V.D.3.a of Administrative Regulation 626 regarding the conduct that may not be disciplined. Although there is evidence that ADOC continued to discipline inmates for self-injurious behavior after the liability opinion, *see, e.g.*, May 25, 2021, R.D. Trial Tr. at 38 (inmate M.W. lost 6 months of good time for cutting himself in November 2018), ADOC has more recently taken concrete steps toward correcting this problem. ADOC removed the Rule 505 violation that explicitly provided for the discipline of inmates who engaged in self-harm, and it asserts without contradiction that it has expunged ¹³⁵⁵such violations from the records ^{*1355} of inmates with serious mental illnesses or intellectual disabilities. *See* June 9, 2021, R.D. Trial Tr. at 34 (testimony of Dr. Burns, noting that she was unaware of any inmate who received a Rule 505 violation after it was eliminated); June 22, 2021, R.D. Trial Tr. at 126-28 (testimony of Dr. Burns, noting that she had not seen evidence that undermines ADOC's assertion that expungement is occurring). In itself, this change does not prevent the use of other rules to punish conduct related to self-injurious behavior; shortly after the Rule 505 violation was removed, an officer

initiated a disciplinary action for failure to obey an order against an inmate who was standing on his toilet with a piece of sheet tied around his neck and refused to untie the sheet and step down. *See* Pls.' Ex. 4181 at ADOC529996-ADOC529998; *see also* May 27, 2021, R.D. Trial Tr. at 47-49 (testimony of Vail, characterizing the disciplinary action as a "back handed way of punishing someone for a self harm attempt"). And it also does not address discipline for other behaviors directly related to an inmate's mental illness; Vail discussed one disciplinary report against an inmate for not taking her mental-health medication. *See* May 26, 2021, R.D. Trial Tr. at 217. But generally, it appears that ADOC's recent progress in this area is meaningful. Even without ordering relief with respect to these provisions, the court is confident that the EMT, in its review of the ongoing problems in mental-health consultations to the disciplinary process, will be able to flag for the court whether ADOC fails to adhere to its policy consistently moving forward.

Although Vail highlighted the hollowness of the current practice of documenting the hearing officer's consideration of the mental-health consultation in a single-word answer, always "yes," *see* May 27, 2021, R.D. Trial Tr. at 15-16, the court will not order compliance with § V.D.6 of Administrative Regulation 626. Instead, in light of Vail's testimony that such documentation will be "critical" to the EMT, June 1, 2021, R.D. Trial Tr. at 47, the court will leave to the EMT the task of determining what documentation is necessary to monitor ADOC's compliance with the relief that the court does order regarding the provision and consideration of substantive consultations.

c. PLRA Findings

The relief that the court orders is necessary to avoid imposing inappropriate and dangerous sanctions on inmates with serious mental-health needs. Absent meaningful consideration of the mental-health consultations, hearing officers will continue to make disciplinary decisions affecting

the placement and punishment of vulnerable inmates without appropriate regard for or understanding of their mental-health needs. And when the consulting mental-health staff concludes that certain sanctions are contraindicated by an inmate's mental-health issues, it is critical to the mental health and safety of the inmate that the hearing officer abide by that determination in all but exceptional circumstances. This relief, which preserves ADOC's discretion in such exceptional circumstances, is narrowly tailored to ensure that the disciplinary sanctions imposed on inmates are not medically inappropriate and do not subject them to the substantial risk of decompensation and worsened symptoms of mental illness. Ordering ADOC to comply with these regulations is the least intrusive means that will afford this necessary protection to inmates with serious mental-health needs in the disciplinary context.

3. Other Provisions Regarding Discipline

Administrative Regulations 403 and 626 include a number of other provisions addressing the consideration of mental-health issues in the disciplinary process.

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Administrative Regulation 403 contains provisions for low-level rule violations by certain inmates to be addressed outside of the formal disciplinary process or behavioral citation process. Sections V.E.4 and V.F.3 provide that such violations by inmates in a stabilization unit, residential treatment unit, or crisis placement "shall be handled in the mental health treatment planning process." Sections V.E.5 and V.F.4 provide that such violations by inmates in a structured living unit "may be handled through the [formal disciplinary process or behavior citation process] unless the mental health staff member performing the mental health consultation determines that the use of [that process] is clinically contraindicated," in which case the violation will be addressed through the mental-health treatment planning process. However, there

is no evidence that ADOC has failed to follow these procedures. Accordingly, the court will not order compliance with these provisions.

Section V.B.2.i of Administrative Regulation 403 and § V.D.1 of Administrative Regulation 626 provide that mental-health staff may attend the disciplinary hearing to assist the inmate. Although mental-health staff never attended the disciplinary hearings in the cases that Vail reviewed, *see* May 26, 2021, R.D. Trial Tr. at 203, there is no evidence that mental-health staff are prevented from attending. Rather, the evidence reflects that in the cursory mental-health consultations, the consulting mental-health staff routinely, if not always, decide that they will not be attending. Thus, to the extent that the failure of mental-health staff to attend disciplinary hearings contributes to the harms suffered by inmates with serious mental-health needs, these provisions do not address the root cause of these harms, so the court will not order compliance.

Other provisions of Administrative Regulation 403 that specifically address inmates with mental-health needs include:

- Sections V.A.1.e and V.A.1.f, which state when and how inmates with certain mental-health issues shall be provided notice of a disciplinary report;
- Section V.A.7.b, which states when disciplinary hearings must be postponed for inmates on suicide watch or other crisis placements; and
- Sections V.B.2.n and V.C.2.c, which state when and how inmates with certain mental-health issues shall be notified of the outcome of a disciplinary proceeding.

Dr. Burns and Vail credibly testified that these provisions protect inmate safety by involving mental-health staff in the disciplinary process to minimize the risk that aspects of the process will exacerbate an inmate's mental-health issues. *See* June 4, 2021, R.D. Trial Tr. at 117-21, 125-26 (testimony of Dr. Burns); May 27, 2021, R.D. Trial Tr. at 18-21, 25-28, 33-34 (testimony of

Vail). However, there is limited evidence that ADOC is currently failing to apply these provisions. *See* June 1, 2021, R.D. Trial Tr. at 54-57, 73-74 (testimony of Vail, conceding that he was unaware of recent violations of multiple of these provisions); June 22, 2021, R.D. Trial Tr. at 107-10 (testimony of Dr. Burns, noting that she had not seen recent violations of several of these provisions). Accordingly, the court will not order this additional relief.

M. Training

ADOC's recent work with Dr. Burns and Dr. Perrien to implement numerous trainings represents a significant improvement over prior conditions. Since ADOC developed training curriculums in coordination with its consultants, Dr. Burns confirmed that it has provided comprehensive mental-health training, suicide prevention¹³⁵⁷ training, and suicide risk assessment training to current and newly hired staff. *See* June 22, 2021, R.D. Trial Tr. at 48, 50-51, 53-55; June 23, 2021, R.D. Trial Tr. at 225-26. However, despite its major strides to ensure that current and newly hired staff are adequately trained, the evidence presented during the omnibus remedial hearings reflects lingering problems that require redress.

First, there is some evidence that ADOC's provision of training is incomplete. ADOC's Assistant Deputy Commissioner for Operations Cheryl Price testified in a deposition that she personally had not received the comprehensive mental-health training that stipulated remedial orders have required since 2018 for all staff who have any direct contact with inmates. *See* June 1, 2021, R.D. Trial Tr. at 42; Phase 2A Order and Injunction on Mental-Health Identification and Classification Remedy, Attachment A (Doc. 1821-1) at § 1.1. Moreover, as recently as March 2021, a spot audit of Ventress reflected that the facility's site program manager, who, as Dr. Burns testified, is "in charge of mental health services at [the

facility," May 26, 2021, R.D. Trial Tr. at 54, had not received the suicide risk assessment training. *See* Pls.' Ex. 3626 at ADOC565532.

Second, and more to the point, ADOC's failure to document its provision of training consistently renders it virtually impossible to know the extent of ADOC's progress. During her deposition, Assistant Deputy Commissioner of Operations Price further conceded that she did not know if everyone who required the comprehensive mental-health training had received it. *See* June 1, 2021, R.D. Trial Tr. at 42. Even Wexford, has acknowledged that its documentation of court-ordered trainings has been inconsistent. *See* Pls.' Ex. 3323 at 4-5. This lack of dependable documentation poses a challenge for ADOC in providing necessary training to new and current staff, and it suggests that the EMT may face similar challenges in monitoring ADOC's provision of this training.

As with nearly every area of liability, ADOC's provision of training and its related challenges are inseparable from its chronic correctional understaffing. To come into compliance with the court's omnibus remedial order and provide a constitutionally adequate standard of mental-health care, ADOC will need to hire significantly more correctional officers in the next three-and-a-half years. More officers means more training, more documentation, and more opportunities for staff to fall through the cracks. ADOC's slapdash approach to tracking which staff receive which trainings will not do. The trainings that ADOC has implemented in coordination with its consultants are the foundation for much of the relief that the court orders today, from adequate identification of inmates' mental-health needs at intake and through referrals, to appropriate placement of inmates with mental-health needs, to proper monitoring of inmates in segregation and crisis placements. They also represent a means of bridging the persistent gap between ADOC's policies and on-the-ground practice. The court, the

EMT, the men and women in ADOC's facilities, and ADOC itself must be sure that they are being carried out.

I. Documentation of Training

a. The Parties' Proposed Provisions

As an initial matter, the defendants assert that no relief is necessary with respect to training. *See* Defs.' Post-Trial Br. (Doc. 3367) at 134. The plaintiffs propose, and the defendants propose in the alternative, the following provisions requiring ADOC to provide training on:

- The Comprehensive Mental Health Training Curriculum, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.1;
- Suicide prevention, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.2; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.3.5;
- Confidentiality, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 13.3.1, 13.3.1.1; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 6.2;
- Mental-health rounds in restrictive housing units, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.4; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.3.5.1;
- Emergency preparedness, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.5; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.3.6;
- Discipline, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.6; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.2.1;

- Suicide risk assessments, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at §§ 13.7.1-13.7.3; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at §§ 14.3.1, 14.3.2;

- Correctional risk factors, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.8; Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.3.5.2; and

- Observation on suicide watch, *see* Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.9.

The defendants further propose that, within six months of the effective date, "ADOC and/or its mental health vendor will create or revise, as appropriate, any training materials required by this Phase 2A Remedial Order," subject to the approval of the compliance team. Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.4.

b. The Court's Ordered Relief

56 The court will order that ADOC must document its provision of training. Even though some evidence reflects that ADOC has implemented these trainings and provided them to current and new staff, the department's recent, and still-imperfect, implementation of these trainings does not provide assurance that ADOC will provide these trainings as it hires additional staff. Documenting these trainings is critical to facilitate monitoring of the steps that ADOC takes to train its staff to comply with the omnibus remedial order, and to gauge the extent to which ADOC's successes and failures in implementing certain provisions provide reason for the court to revisit them.

c. PLRA Findings

Requiring ADOC to document the training that it provides is necessary to enable the EMT to monitor training adequately and to ensure that the department actually does what it says it will do and trains new staff as they are hired. Without this documentation, the extent to which ADOC has

implemented these trainings--trainings that form the foundation for much of the other relief the court orders--will be unknowable.

The court cannot simply rely on the fact that ADOC has conducted these trainings recently to conclude that it will continue to do so in the absence of monitoring. In light of ADOC's grievous understaffing, and the fact that adding new staff will actually *increase* rather than decrease the initial demands on current staff in this area, ADOC's contention that it has achieved ¹³⁵⁹ compliance is illusory until its practices reflect that it can sustain compliance. The court must also make sure that training does not fall victim to the ADOC's practice of "robbing Peter to pay Paul," that is, the practice that, due to severe staffing shortage, it must divert staff from one remedy to address another.

Requiring merely that ADOC document the trainings that it says it will conduct is narrowly tailored to monitor ADOC's provision of training and to ensure that ADOC's staff are adequately and appropriately trained to implement the other relief that the court orders, all of which is necessary, narrowly tailored, and minimally intrusive to correct ADOC's violations. Moreover, this documentation requirement preserves ADOC's discretion in the manner by which it conducts these trainings, and so is the least intrusive means that will monitor that these trainings occur.

2. Emergency Preparedness Drills

a. The Parties' Proposed Provisions

With respect to emergency preparedness drills for suicide prevention, the plaintiffs propose the following provision:

"For training purposes, on a quarterly basis, ADOC and/or its mental-health vendor must conduct emergency preparedness drills at each ADOC major facility, including scenarios involving self-injury and suicide attempts. During the emergency preparedness drills, the trainers

must evaluate the correctional and medical staff response time to the emergency code and their preparedness for the emergency code (including, as appropriate, presence of an emergency bag, automatic external defibrillator (AED), and cut-down tool). Additionally, the emergency preparedness drill must include role-playing for participants to practice the response to an emergency, including, for example, using a cut-down tool, rendering first aid, and performing cardiopulmonary resuscitation (CPR)."

Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.5. The defendants propose essentially the same provision, except that they propose that these drills be required on an annual, rather than quarterly, basis and that the provision apply only to ADOC major facilities where the plaintiffs have proved that the emergency preparedness drills are necessary. *See* Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 14.3.6.

b. The Court's Ordered Relief

⁵⁷ The court will adopt the plaintiffs' proposed provision. As emphasized in the court's discussion of relief for suicide prevention, ADOC's immediate responses to suicide attempts continue to be plagued by delays in taking vital, potentially life-saving measures. ADOC's recurrent failures pose a grave danger to the life and safety of inmates with acute mental-health needs.

To address these problems, it is not enough for the court to order that ADOC's immediate responses to suicide attempts be carried out correctly. An adequate response to suicide attempts begins not in the moment that an attempt is detected, but well before that, when staff are trained and retrained on how to respond appropriately in an emergency situation. *See* May 28, 2021, R.D. Trial Tr. at 138 (testimony of Mr. Vail). Training is the foundation for immediate responses to suicide attempts, and overwhelming evidence supports the necessity of emergency preparedness, or "man-down," drills to prepare staff for these critical interventions. Dr.

Burns testified that these drills are necessary to respond appropriately to suicide attempts in progress. *See* June 4, 2021, R.D. Trial Tr. at 64-65. Vail elaborated that performing these drills regularly is "very important" because "the training doesn't really take until you're in a role playing situation." May 28, 2021, R.D. Trial Tr. at 138. ¹³⁶⁰The testimony of both ^{*1360} experts echoes the recommendations in several recent psychological autopsies for inmates who committed suicide in ADOC facilities; the psychological autopsy of Jamal Jackson, for instance, recommended that "[a]ll correctional and healthcare staff must be trained on this vital issue and training must be reinforced frequently through education and 'Man-Down' drills." Jamal Jackson Psychological Autopsy (P-3295) at ADOC0518575; *see also* Laramie Avery Psychological Autopsy (P-3302) at ADOC0518581; Casey Murphree Psychological Autopsy (P-3281) at ADOC0518572.

Citing to records of emergency preparedness drills dating back to October 2020, the defendants argue that ADOC's implementation of these drills obviates the need for a court order. *See* Defs.' Response to Pls.' Post-Trial Br. (Doc. 3378) at 281. The court disagrees. While these recent efforts represent an important step for ADOC, they do not undermine the need for relief to address the years of failures that the court has found in ADOC's immediate responses to suicide attempts. *See* May 25, 2021, R.D. Trial Tr. at 8, 11 (testimony of Dr. Burns, noting connections between the failures in the immediate responses to suicides that occurred before and after the suicide prevention opinion). Because effective training depends on regularity and consistency, relief remains necessary not only to bring ADOC into compliance, but to sustain compliance as ADOC contends with the continued challenges of understaffing.

c. PLRA Findings

ADOC's persistent failure to respond appropriately to suicide attempts in progress is a systemic problem, and it demands systemic relief. Requiring ADOC to conduct regular emergency preparedness drills is necessary to correct this longstanding threat to the safety of inmates who attempt suicide or other serious self-injurious behavior.

In light of the magnitude of this problem and the severity of its consequences, the court finds that quarterly, rather than annual, drills are necessary to address the violation. Vail credibly testified that a quarterly frequency provides "reasonable" time to plan these drills, *see* May 28, 2021, R.D. Trial Tr. at 138-39, and the court finds that quarterly drills are narrowly tailored and the least intrusive means that will correct ADOC's widespread failures in this area. Finally, and again, the court must also make sure that the emergency drills requirement does not fall victim to the ADOC's practice of "robbing Peter to pay Paul," that is, the practice that, due to severe staffing shortage, it must divert staff from one remedy to address another.

3. Training for Mental-Health Observers

a. The Parties' Proposed Provisions

With respect to the training of observers who conduct constant observation and close watch of inmates who are on suicide watch, the plaintiffs propose the follow provision:

"Observers must receive additional training related to observation obligations; access to medical, mental health, and correctional staff; conflict resolution; and facility-specific processes and procedures (including how to access assistance in an emergency, obtain observation relief for a break, and communicate with supervisory staff during nontypical work hours)."

Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 13.9. The defendants propose no equivalent provision.

b. The Court's Ordered Relief

58 The court will order that observers must receive additional training related to their observation obligations—including where they are to stand and sit—and how to obtain assistance if an inmate requires ¹³⁶¹ medical care or in the event of an emergency. The court finds this relief necessary in light of Dr. Burns's and Dr. Perrien's finding, upon inspecting ADOC facilities in 2019, that "[i]n none of the facilities ... were the 'watchers' positioned appropriately to permit full visibility into the safe cells or constant visibility of the inmates being observed." *Braggs*, 383 F. Supp. 3d at 1259 (quoting Report and Recommendations on Suicide Prevention in the Alabama Dep't of Corrections (Doc. 2416-1) at 26). Rather, the experts noted that observers were "seated far removed from the crisis cell, ... obscuring their view into the cell and of the inmate. This occurred even though the door and food/cuff port were closed and there was no apparent risk to the observer." Report and Recommendations on Suicide Prevention in the Alabama Dep't of Corrections (Doc. 2416-1) at 10. They further found that inmates on suicide watch reported having trouble accessing medical care and that "mental health staff ... were not notified timely when a serious suicide attempt or suicide occurred." *Id.* at 28. The court finds it troubling that these practices continued to occur well after its finding, in 2017, that ADOC's monitoring of suicidal prisoners was "woefully inadequate." *Braggs*, 257 F. Supp. 3d at 1229.

c. PLRA Findings

The court finds this provision necessary because it is dangerous not to provide adequate monitoring of inmates on suicide watch. Observers do not fulfill their purpose to protect the safety of inmates experiencing mental-health crises if they cannot actually see the inmates they are tasked with monitoring. Furthermore, inmates on suicide watch are denied adequate treatment and protection when observers fail to notify mental-

health staff when inmates who they are monitoring require medical attention, especially when the event giving rise to the need for medical attention is a suicide or serious suicide attempt. This provision is narrowly tailored and minimally intrusive, requiring only that observers receive training specifically to address the problems that Dr. Burns and Dr. Perrien identified in ADOC's current monitoring of inmates on suicide watch. Finally, and again, the court must make sure that the observers requirement does not fall victim to the ADOC's practice of "robbing Peter to pay Paul," that is, the practice that, due to severe staffing shortage, it must divert staff from one remedy to address another.

III. GLOBAL PLRA FINDINGS

Just as the areas of inadequacy identified in the court's 2017 liability opinion are interconnected, *see Braggs*, 257 F. Supp. 3d at 1192-93, so too are the remedial provisions the court enters today. Each addresses a failure that compounds with other failures; often, absent one provision, other provisions will not function adequately to protect prisoners' safety.

The experiences of the men who committed suicide since the court's liability opinion exemplify the multifaceted character of ADOC's deficiencies. For many of these individuals, the timeline of their incarceration reflects not a single moment in which ADOC failed them, but a string of serial failures that cumulatively denied them access to minimally adequate mental-health treatment and care and culminated in their tragic loss of life. No single provision could have saved them. An appropriate mental-health referral accomplishes nothing when it does not result in follow-up care. A clinical contraindication of placement in restrictive housing offers no protection if it is disregarded without exceptional circumstances. And without adequate correctional and mental-health staffing, the whole system collapses in on itself. Because of this ¹³⁶²interdependence, no provision ¹³⁶² that the court

adopts today necessarily renders any other provision unnecessary, and no subset of the provisions offers a constitutionally sufficient substitute for the ordered relief.

ADOC's severe shortage of correctional staff further underscores the need for the entirety of the relief that the court orders today. As explained previously, ADOC's lack of staff has reduced it and its mental-health vendor to a constant state of "robbing Peter to pay Paul"; to implement relief in one area, it must divert staff from another, all with the goal of triaging--that is, maximizing the number of surviving inmates. Given this history, the court finds that, despite ADOC's progress in some areas, it is an open and critical question whether it can not only achieve but also sustain adequate compliance in various areas *simultaneously*, and that all of the provisions it orders today are therefore necessary.

Thus, taken as a whole, as well as individually, and set against the backdrop of what ADOC is doing and failing to do to meet its constitutional obligations overall, the court finds that the provisions it enters today are necessary, narrowly tailored, and the least intrusive means to correct ADOC's systemic violations of the constitutional rights of prisoners with serious mental-health needs.

IV. CONCLUSION

Four years ago, this court found the mental-health care provided by the Alabama Department of Corrections "horrendously inadequate" for seven independent but interrelated reasons. *Braggs*, 257 F. Supp. 3d at 1267. It further found that "persistent and severe shortages of mental-health and correctional staff, combined with chronic and significant overcrowding, are the overarching issues that permeate each of the above-identified contributing factors of inadequate mental-health care." *Id.* at 1268.

Since then, ADOC's mental-health staffing has improved. Its correctional staffing has not. What was true four years ago is no less true today: ADOC does not have enough correctional staff to provide constitutionally adequate mental-health care to prisoners who need it.

The continued dearth of correctional staff is the fault at the heart of ADOC's system of mental-health care. The absence of security staff prevents people who need treatment from accessing it, stops those whose mental health is deteriorating from being caught before they lapse into psychosis or suicidality, and fosters an environment of danger, anxiety, and violence that constantly assaults the psychological stability of people with mental illness in ADOC custody.

It is therefore imperative that ADOC work with the EMT to develop realistic benchmarks for the level of correctional staffing it will attain in each of the next four years, with the goal of achieving in four years the level of staffing necessary to conduct normal operations safely. ADOC must also create its agency staffing unit and work with the Savages to update its staffing analysis as quickly as it can, and it must develop a proposal for its restrictive housing to function safely until it hires more correctional staff. These steps cannot wait. So long as ADOC's current staffing levels persist, people with serious mental-health needs are not safe in Alabama's prisons, but are at daily serious risk of deprivation, decompensation, and death.

With respect to the other constitutional violations identified in the court's liability opinion, ADOC's track record is mixed. In certain areas it has made great progress; in others, less. The critical question¹³⁶³ is whether it can sustain that progress, given¹³⁶³ its severe shortage of correctional staff, as it implements relief in other areas.

On the whole, though, the court is hopeful that in the not too distant future many, if not all, of the provisions it orders today may prove unnecessary. As ever, the endgame for everyone should be both

achieving and sustaining adequate compliance and bringing this phase of the litigation to a close as soon as is reasonably possible. Towards this end, the court will hold status conferences about every four months with the parties to discuss their progress and to make sure nothing falls through the cracks. As stated, when the amount of work ADOC must now put into achieving and sustaining adequate compliance is considered, the July 2025 deadline--when the department must meet the critical and core correctional staffing deadline--is just around the corner. Time is of the essence.

DONE, this the 27th day of December, 2021.

Appendix A

The Defendants' Mental-Health Treatment Guidance

Treatment Category Initial Assessment Subsequent Care

SU An RN will assess the inmate on an emergent basis after arrival to the cell and make any necessary arrangements on an emergent, urgent, routine, or another basis for a psychiatric clinical encounter assessment and/or counseling or CRNP.

RTU (Levels 1-3) An RN will assess the inmate on an urgent basis after arrival to the RTU and make any necessary arrangements on an emergent, urgent, routine, or another basis for a psychiatric assessment and/or counseling or CRNP.

SLU An RN will assess the inmate on an urgent basis after arrival to the SLU and make any necessary arrangements on an emergent, urgent, routine, or another basis for a psychiatric assessment and/or counseling or CRNP based on clinical judgment.

Outpatient A treatment team member will assess the inmate on a routine basis.

Psychiatrist or counselor: Every 90 days, unless otherwise clinically indicated.

PHASE 2A OMNIBUS REMEDIAL OPINION
PART III SUPPLEMENT

The court inadvertently omitted two subsections--one discussing the degree to which the EMT shall consider unexpected circumstances in monitoring the defendants' compliance with the court's omnibus remedial order, and the other discussing the defendants' promulgation of policies--from the third part of its Phase 2A Omnibus Remedial Opinion. These two subsections should have come after the subsection entitled "M. Training" in the section entitled "II. REMEDIAL PROVISIONS AND PLRA FINDINGS." These two subsections should have been subsections "N." and "O." These omitted subsections now follow:

N. Unforeseen Circumstances

Informed by the COVID-19 pandemic, the parties each propose provisions as to how, if at all, the remedial order and monitoring should be modified to accommodate unforeseen circumstances. In determining how unforeseen circumstances will affect the monitoring and measurement of compliance with the remedial order, the court need not make PLRA findings. The remedial order satisfies the PLRA's requirements, and this provision to accommodate unforeseen circumstances imposes no remedial obligations on the defendants.

The defendants propose to define "unforeseen circumstances" to mean "a situation in which an event or series of events (such as a natural disaster, fire, medical epidemic, pandemic, or outbreak, and lockdown) make performance under this Phase 2A Remedial Order inadvisable, impracticable, illegal, impossible, detrimental to the health and/or safety of inmates and/or staff, or detrimental to the public interest." Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 1.38. The plaintiffs agreed that this definition is reasonable, provided that the EMT retains the discretion to monitor how the definition is applied.

See July 7, 2021, R.D. Trial Tr. at 134-35. The court adopts the defendants' definition of "unforeseen circumstances."

As to how unforeseen circumstances will affect the remedial order, the plaintiffs propose:

"Remedial orders will not be modified to anticipate unforeseen circumstances, such as COVID-19. However, the EMT can evaluate reasons for not complying with this remedial order as well as ... any attempt to mitigate noncompliance in determining noncompliance."

Pls.' Updated Proposed Omnibus Remedial Order (Doc. 3342) at § 14.1.

The defendants propose separate provisions regarding COVID-19 and other unforeseen circumstances. With respect to COVID-19 specifically, they propose:

"The Court anticipates COVID-19 and potentially other unforeseen circumstances affecting performance of a variety of aspects of this Phase 2A Remedial Order as it affected performance of a variety of aspects of the Remedial Orders.... Consistent with the process identified in Section 13.2 below, during the development of audit tools related to this Phase 2A Remedial Order, the Compliance Team, in collaboration with OHS and ADOC's Resumption Committee, will evaluate the remedial measures in this Phase 2A Remedial Order affected by COVID-19, the propriety of waiving or adjusting performance of such remedial measures, and the anticipated timeframe for such waiver or adjustment of performance. For example, the Compliance Team may evaluate the impact of COVID-19 on mental-health group activities, out-of-cell time, and other mental-health services (including any activities and services continued by this Phase 2A Remedial Order that the State previously identified as 'unworkable'¹³⁶⁵1365 ...). Along with the audit tools ... the Compliance Team will submit an initial written report to the Court consistent with Section 13.2 below."

Def.'s Proposed Phase 2A Remedial Order (Doc. 3215) at § 13.1. And with respect to unforeseen circumstances generally, they propose:

"To ensure the durability of this Phase 2A Remedial Order, the Court authorizes the Compliance Team to temporarily waive or adjust performance of one (1) or more remedial measures provided in this Phase 2A Remedial Order. Before waiving or adjusting performance of any remedial measure in this Phase 2A Remedial Order, the Compliance Team, in collaboration with OHS and any other necessary person or entity such as the Alabama Department of Public Health, must evaluate the unforeseen circumstance and the effect on performance under this Phase 2A Remedial Order. The Compliance Team will submit a written report to the Court identifying the unforeseen circumstance, the remedial measures affected by the unforeseen circumstance, the reasons for the decision to waive or adjust performance of such remedial measures, and the anticipated timeframe for such waiver or adjustment of performance."

Id. at § 13.2.

The parties' proposals are similar in that both would have the EMT take circumstances like COVID-19 into account when measuring compliance. The court agrees with this approach. However, the court will not prescribe the manner in which the monitoring team must do so. Rather, the court will order that, in monitoring the defendants' compliance with the remedial order, the EMT shall consider unforeseen circumstances, their effects on the defendants' ability to comply with the remedial order, and the defendants' efforts to mitigate the effects of those circumstances. This approach is consistent with the recommendation of the defendants' expert, Dr. Metzner. *See* June 30, 2021, R.D. Trial Tr. at 195-97 (recommending that the remedial order should remain unchanged and that the EMT should determine whether there is a "valid reason" for noncompliance and whether the defendants have

conducted "reasonable mitigation"). This will afford the EMT the discretion to evaluate the defendants' performance in the context of unforeseen circumstances, without moving the goalposts fixed by the remedial order.

To the extent the defendants propose that the EMT should have the authority to waive performance of the court's orders, the court disagrees. Elsewhere in these proceedings, the defendants argued that it would be unlawful for the court to grant the EMT the authority to modify the court's orders, and the court agrees that giving that level of power to the EMT would be inappropriate.

Moreover, COVID-19 and similar conditions do not change what constitutes minimally adequate mental-health care. It may be the case that a failure to provide such care that would be deemed noncompliance under non-pandemic conditions should not be so while a prison system is adjusting to a pandemic. But the constitutional floor did not shift when the pandemic struck.

O. Policies

The plaintiffs contend that, if the court's omnibus remedial order is to have any effect, ADOC staff and inmates must know its contents--the staff so that they can follow its dictates, and the inmates so that they can hold the defendants to account if they fail to comply. To that end, they propose provisions requiring ADOC to (1) publish a single, comprehensive set of policies and procedures related to ADOC's provision of mental-health services to its inmate population, ¹³⁶⁶*see* Pls.' Updated Proposed ^{*1366} Omnibus Remedial Order (Doc. 3342) at § 16.1; (2) update its Inmate Handbook to summarize the court's omnibus remedial order and make a complete copy of the court's order available for review in the law library of each major facility, *see id.* at § 16.2; and (3) require its mental-health vendors to comply with its policies and procedures, *see id.* at § 16.3.

The defendants dispute the necessity of this relief, pointing to the fact that ADOC has previously updated its policies to reflect the terms of the courts' orders as evidence of its "readiness to develop and implement appropriate policies related to the provision of mental-health care without a court order requiring it to do so." Defs.' Post-Trial Br. (Doc. 3367) at 140. In the alternative, they offer a provision requiring ADOC to update its policies and procedures to reflect the terms of the court's omnibus remedial order. See Defs.' Proposed Phase 2A Remedial Order (Doc. 3215) at § 16.

While the court agrees with the plaintiffs that ADOC would be prudent to publish a single, comprehensive set of policies and procedures related to its provision of mental-health services, and to summarize at least certain provisions of the court's omnibus remedial order in its Inmate Handbook, and while the court would strongly encourage ADOC to do such, it declines to enmesh itself in the process of ongoing and detailed review of the adequacy of ADOC's published policies and handbooks. Rather than order the plaintiffs' requested relief, it simply notes that, if the EMT determines that ADOC is failing to inform inmates, its staff, or its mental-health vendor's staff of the contents of the court's omnibus remedial order, and that that failure impedes implementation of the order, it should work with ADOC to resolve the problem, and bring it to the court's attention if necessary.

DONE, this the 28th day of December, 2021.

PHASE 2A OMNIBUS REMEDIAL ORDER

In accordance with the three remedial opinions entered today, it is the ORDER, JUDGMENT, and DECREE of the court that defendants Jefferson S. Dunn and Deborah Crook, in their official capacities, are ENJOINED and RESTRAINED from failing to do the following:

1. Definitions

1.1. "ADOC" refers to the Alabama Department of Corrections. While the court refers to the ADOC often in this order, its order is directed to the defendants; thus, when the court says that "ADOC" shall take a certain action, it means that the defendants must ensure that it takes that action.

1.2. "ADOC major facility" refers to one or more of the major adult correctional facilities operated by or on behalf of ADOC, excluding any community-based facilities and community work centers. ADOC major facilities presently include Bibb County Correctional Facility, Bullock Correctional Facility, Donaldson Correctional Facility, Draper Correctional Facility, Easterling Correctional Facility, Elmore Correctional Facility, Fountain Correctional Facility, Hamilton Aged and Infirm Center, Holman Correctional Facility, Kilby Correctional Facility, Limestone Correctional Facility, St. Clair Correctional Facility, Staton Correctional Facility, Tutwiler Prison for Women, and Ventress Correctional Facility.

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1.3. "Effective date" refers to 42 days after the entry of this omnibus remedial order.

2. Staffing

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 2.1. Correctional Staffing

2.1.1. In accordance with the court's previous order (Doc. 1657) directing it to comply with the recommendations of Margaret and Merle Savage (Doc. 1813-1), ADOC must create an agency staffing unit that will "write policy, enforce the staffing decisions mandated by the court's order, and take steps so that another staffing analysis can be conducted for every facility," Doc. 1813-1 at 100.

2.1.2. ADOC must work with the Savages to update its staffing analysis.

2.1.3. Within 21 days of the effective date, the defendants are to submit to the court a proposal for specific dates by which each of the above two provisions can be accomplished.

2.1.4. By July 1, 2025, ADOC must fill all mandatory and essential posts at the level indicated in the most recent staffing analysis at that time.

2.1.5. By May 2, 2022, the defendants must develop in collaboration with the Savages, and submit to the court, realistic benchmarks for the level of correctional staffing ADOC will attain by December 31 of 2022, 2023, and 2024. These benchmarks must prioritize filling mandatory posts and staffing the mental-health hubs and intake facilities, and must put ADOC on track to fill all mandatory and essential posts by July 1, 2025.

2.1.6. ADOC must submit correctional staffing reports to the court and the EMT on at least a quarterly basis. It may work with the EMT to develop the format of these reports. However, until ADOC and the EMT have finalized a new report

format or else concluded that the existing report format is adequate, ADOC shall continue to provide mental-health staffing reports according to the format currently in place.

2.1.7. Ameliorating the Effects of Understaffing

2.1.7.1. ADOC must check SU, suicide watch, and RHU cells for suicide resistance whenever such cells receive new occupants.

2.1.7.2. ADOC must conduct a thorough check of all SU, suicide watch, and RHU cells at least once per quarter to verify that they satisfy every element of the Hayes checklist (Doc. 3206-5). These checks must be documented.

2.1.7.3. By May 2, 2022, the parties must submit proposals that will allow ADOC's RHUs--with the exception of the RHU at Tutwiler--to function safely with the correctional staff that ADOC currently employs. These proposals must address the following:

2.1.7.3.1. How ADOC shall address the serious risk of harm to inmates in restrictive housing caused by correctional staffing deficits so severe that the consistent provision of security checks, out-of-cell time and mental-health treatment is simply impossible.

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2.1.7.3.2. How ADOC will ensure that any inmates moved out of the RHUs do not end up in functionally identical units--that is, units that offer equivalently deficient levels of monitoring, out-of-cell time, and treatment.

2.1.7.3.3. How ADOC will ensure the safety of inmates in the RHUs who require protective custody, and, if it chooses to reduce the number of inmates in the RHUs, how it will manage the dangers posed by inmates who would present a significant safety or security risk in general population.

2.1.7.3.4. How this relief may be modified if ADOC meets the benchmarks for correctional staffing set forth above.

2.1.8. Correctional Staff Positions

2.1.8.1. Basic Correctional Officers (BCOs) cannot staff positions requiring firearms training, including, but not limited to, tower posts, perimeter posts, perimeter patrol posts, transportation posts, and armory posts.

2.1.8.2. Cubicle Correctional Operators (CCOs) cannot staff any position other than secure control room posts with no direct inmate contact.

2.2. Mental-Health Staffing

2.2.1. ADOC must maintain levels of mental-health staffing consistent with or greater than those called for by the staffing ratios developed by its consultants, subject to any subsequent modifications.

2.2.2. The EMT shall review the staffing ratios beginning one year from the initiation of monitoring and, if necessary,

make recommendations for revising them.

2.2.3. ADOC must achieve the staffing levels set forth in the staffing matrix previously approved by the court, *see* Phase 2A Order and Injunction on Mental-Health Staffing Remedy (Doc. 2688), subject to any subsequent modifications, June 1, 2025.

2.2.4. ADOC must submit mental-health staffing reports to the court and the EMT on at least a quarterly basis. It may work with the EMT to develop the format of these reports. However, until ADOC and the EMT have finalized a new report format or else concluded that the existing report format is adequate, ADOC shall continue to provide mental-health staffing reports according to the format currently in place.

3. Restrictive Housing Units

3.1. Exceptional Circumstances

3.1.1. Inmates with serious mental illnesses may not be placed in the RHUs unless a documented exceptional circumstance applies.

3.1.1.1. An "exceptional circumstance" exists where: (a) a safety or security issue prevents placement of the inmate in alternative housing (such as a SU, RTU, or SLU); or (b) a non-safety or non-security issue exists and transfer or transportation to alternative housing is temporarily unavailable. Examples of safety and security issues include an inmate's known or unknown enemies in alternative housing or the inmate's creation of a dangerous environment (to the inmate, other inmates,

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and/or staff) by his or her presence in alternative housing.

3.1.2. An inmate placed in a RHU for safety or security issues for 72 hours or longer will be offered at least three hours of out-of-cell time per day (which may be congregate out-of-cell time) while he or she remains in the RHU.

3.1.3. An inmate placed in a RHU for non-safety or non-security issues must be removed from the RHU within 72 hours.

3.1.4. Every week, ADOC must file with the court and the monitoring team reports on each prisoner who has been in restrictive housing for longer than 72 hours under exceptional circumstances during that week. These reports must indicate the amount of out-of-cell time offered to the prisoner each day, the nature of the out-of-cell time (*i.e.*, exercise, group therapy, etc.), the exceptional circumstance justifying the prisoner's continued segregation placement, and the date by which ADOC expects that exceptional circumstance to be resolved.

3.2. Screening for Serious Mental Illnesses

3.2.1. Before being placed in a RHU, each inmate must be screened by an RN, or an LPN under an RN's supervision. The screening must assess whether the inmate has been flagged as seriously mentally ill; whether the inmate is at imminent risk of suicide or serious self-harm; whether the inmate exhibits debilitating symptoms of a serious mental illness; and whether the inmate requires emergency medical care. The results of the screening must be used to determine whether the inmate should be placed in restrictive housing and whether the inmate requires a medical and/or

mental-health referral.

3.2.2. If mental-health staff determine that an inmate who has yet to be placed in restrictive housing is contraindicated for restrictive housing, that inmate must not be placed in restrictive housing absent a documented exceptional circumstance.

3.2.3. If mental-health staff determine that an inmate who has already been placed in restrictive housing is contraindicated for continued placement there, as evidenced by changes in the inmate's mental state and functioning, that inmate must be removed from restrictive housing within 72 hours--or sooner, if a psychiatrist, psychologist, CRNP, or counselor determines that the need for removal of the inmate from restrictive housing is urgent--absent a documented exceptional circumstance.

3.3. Mental-Health Rounds

3.3.1. Mental-health rounds must be conducted by a qualified mental-health professional in each RHU at least weekly, and should generally include a discussion with the post officer(s) concerning any changes in the behavior of inmates in the RHU; a review of duty

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post logs and segregation unit record sheets for information about inmates' participation in recreation, showers, meal consumption and sleep patterns; a walk through the RHU, with stops at each occupied cell to make visual contact with the inmate inside the cell; attempts to verbally communicate with each inmate, including a brief inquiry into how the inmate is doing and whether the inmate has mental-health needs or a desire to speak with mental-health staff privately; and a brief assessment of each inmate's hygiene, behavior, affect, and physical condition, and the condition of his or her cell.

3.3.2. Mental-health rounds must be appropriately documented. Such documentation must contain a notation of any mental-health needs expressed by inmates, or concerns identified by the qualified mental-health professional conducting the round as to any inmate. Documentation of rounds must be chronologically filed and maintained by the mental-health manager or other designated mental-health staff member.

3.4. Mental-Health Assessments

3.4.1. Each inmate must receive a mental-health assessment by a psychiatrist, psychologist, CRNP, or counselor within seven days of his or her placement in restrictive housing. Inmates coded as mental-health code A must receive additional assessments at least every 90 days, and inmates coded as mental-health code B or C must receive additional assessments at least every 30 days.

3.4.2. Each mental-health assessment must be appropriately documented.

3.4.3. Each mental-health assessment must include an examination or discussion of the following topics: the inmate's past response(s) to restrictive housing, if applicable; the inmate's general appearance or behavior; whether the inmate has a present suicidal ideation ; whether the inmate has a history of suicidal behavior; whether the inmate is presently prescribed psychotropic medication; whether the inmate has a current mental-health complaint; whether the inmate is currently receiving treatment for a diagnosed mental-illness; whether the inmate has a history of inpatient or outpatient psychiatric treatment; whether the inmate has a history of treatment for substance abuse; whether the inmate has a history of abuse and/or trauma; and whether the inmate is presently exhibiting symptoms of psychosis, depression, anxiety, and/or aggression.

3.4.4. Each mental-health assessment must include a determination of whether the inmate requires a referral and, if so, how urgently.

3.5. Out-Of-Cell Time

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 3.5.1. All inmates in RHUs must have the opportunity to exercise outside of their cells for at least five hours per week, subject to the following exception:

3.5.1.1. ADOC may refrain from offering out-of-cell time due to inclement weather, but only if a safe, alternative space for inmates to exercise--such as a gymnasium--is unavailable.

3.5.2. The days and times that out-of-cell time is offered, and any inmate's decision to refuse out-of-cell time, must be documented.

3.6. Security Checks

3.6.1. ADOC must perform security checks in RHUs at least twice per hour, but no more than 40 minutes apart.

3.6.2. Security checks must be documented accurately and contemporaneously.

3.6.3. Correctional officers must regularly verify that security checks are conducted as required.

3.1. Restrictive Housing Cells

3.1.1. Within three months of the effective date, the cells in the RHUs must be cleaned.

3.1.2. Cells in the RHUs must always be cleaned before they receive new occupants, and inmates must be provided access to cleaning supplies at least every two weeks.

3.1.3. Within six months of the effective date, all cells in the RHUs must comply with the conditions set forth in the

checklist developed by Lindsay M. Hayes (Doc. 3206-5).

4. Intake

4.1. Each intake screening must be conducted by a qualified mental-health professional.

4.2. Documentation of each inmate's intake screening--including an interpretation of the results of any psychological assessment--must be filed in the inmate's medical record.

4.3. Inmates' Previous Records

4.3.1. If, either during or after intake, an inmate reports having previously received mental-health services and can correctly report the prior mental-health provider, a records request to the prior provider must be made within three working days of the time the inmate reported having previously received mental-health services. If the inmate reports having previously received mental-health services and cannot remember or correctly identify the prior mental-health provider, the mental-health staff must reasonably attempt to locate records of the inmate's prior treatment.

4.3.2. All health records from each inmate's prior facility of incarceration must be requested within three working days of intake if they are not presented at intake.

5. Coding

5.1. Each inmate must be assigned a mental-health code and, if necessary, an SMI flag, that is appropriate to address his or her mental-health needs, as determined by clinical judgment.

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5.2. Each inmate's mental-health code and SMI flag must be accurately and consistently indicated throughout all documents related to his or her care.

6. Referral

6.1. A referral must result in a timely clinical assessment and/or intervention by a psychiatrist, psychologist, CRNP, or counselor. Emergent referrals must result in a clinical assessment and/or intervention as soon as possible but no more than four hours from the determination that the referral is emergent. Urgent referrals must result in a clinical assessment and/or intervention within 24 hours of the time the referral was made. Routine referrals must result in a clinical assessment and/or intervention within 14 calendar days of the time the referral was made.

6.2. Communication of Referrals

6.2.1. An emergent or urgent referral must be communicated verbally, in person or by telephone, to the appropriate mental-health staff member or members as soon as possible, but in no case longer than one hour from the time the referral is identified as emergent or urgent, absent unusual circumstances which detain staff for an extended period of time such as a medical emergency or an incident involving safety or security of staff or inmates. The mental-health staff member or members to whom the referral should be communicated will be determined by the mental-health staff.

6.2.2. Routine referrals must be communicated to the appropriate mental-health staff member or members, as indicated above, by the next shift by leaving the referral form in a location that ADOC has designated to the correctional and mental-health staff, and inmates, as appropriate. The monitoring team may alert the court if ADOC fails to clearly designate the location.

6.3. An appropriate triage or mental-health staff member or members must regularly

Part of the team should monitor any designated location for completed referral forms. Said staff must review and triage the completed referral forms at least once per shift.

6.4. After an inmate has received an emergent referral, including a referral for suicide watch, correctional or mental-health staff must maintain constant, line-of-sight observation of the inmate until the inmate has been assessed by an appropriate mental-health provider.

7. Confidentiality

7.1. Individual counseling sessions, medication-management encounters, periodic mental-health assessments of inmates in RHUs, suicide-risk assessments, and therapeutic group sessions must take place in settings that provide for confidentiality and that, if applicable, are out-of-cell, subject to the following exception:

7.1.1. Such services may be provided in a non-confidential setting if confidentiality is not possible due to safety concerns or is otherwise not appropriate.

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The question whether confidentiality is otherwise not appropriate must be answered according to clinical determinations.

7.1.2. If confidentiality is not possible, then that fact, the reason for it, and any actions taken to maximize confidentiality must be documented in a progress note.

8. Treatment Teams and Plans

8.1. Treatment teams must meet at regular intervals, to be determined based on the team chair's clinical judgment, taking into account each inmate's assigned mental-health code, housing unit, and level of psychotherapy.

8.2. Each treatment team meeting must last for an adequate period of time, based on the team chair's clinical judgment.

8.3. All members of each inmate's treatment team must have access to clinically relevant documents.

8.3.1. Clinically relevant documents are all documents related to the current and past condition of the inmate--including documents related to the inmate's housing status, disciplinary history, and interactions with other inmates--that are necessary to inform clinical judgment.

8.4. Each inmate on the mental-health caseload must have a treatment plan that is adequately detailed and individualized to address his or her mental-health needs, based on clinical judgment.

8.5. Treatment teams must review and revise each inmate's mental-health code as clinically appropriate, and must review and amend, if necessary, each inmate's treatment plan after changes in the inmate's mental-health code, transfer to a new housing unit, or any other circumstance resulting from or likely to affect an inmate's mental-health in a significant way.

8.6. Coordination of Transfers and Treatment

8.6.1. ADOC must consider inmates' mental-health codes and symptoms in making decisions concerning transfer

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between facilities.

8.6.2. In the event of a transfer of an inmate on the mental-health caseload, the staff member in charge of the inmate's care at the transferring facility must send a transfer note to the staff member in charge of the inmate's care at the receiving facility within a reasonable time after the transfer is initiated.

9. Psychiatric and Therapeutic Care

9.1. Access to Treatment

9.1.1. ADOC must comply with the Mental-Health Treatment Guidance set forth in Appendix A.

9.1.2. In addition to the Mental-Health Treatment Guidance set forth in Appendix A, each inmate must receive any additional care prescribed by his or her treatment team, subject to the following exception:

9.1.2.1. While ADOC must provide each inmate in restrictive housing with any medication or individual therapy prescribed by his or her treatment team, it need not provide

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other forms of care prescribed by an inmate's treatment team if those kinds of care cannot be provided safely in the restrictive housing environment.

9.1.3. Each treatment session must last for an adequate period of time, according to clinical judgment.

9.1.4. Each housing unit must offer appropriate types and numbers of therapeutic groups to accommodate the inmates housed there.

9.2. Out-Of-Cell Time

9.2.1. Inmates in the RTU, SU, and SLU must receive ten hours of structured, therapeutic out-of-cell time and ten hours of unstructured out-of-cell time per week, unless clinically contraindicated, subject to the following exception:

9.2.1.1. ADOC need not provide ten hours unstructured out-of-cell time per week to inmates in the RTU Level Three who are housed in open dormitories rather than cells.

9.2.2. An inmate's out-of-cell appointments with his or her treatment team, psychiatric provider, counselor, or therapeutic group will count as structured, therapeutic out-of-cell time.

9.3. Inmates who are not on the mental-health caseload must be seen by mental-health staff in the event of a mental-health crisis or after receipt of a mental-health referral, as clinically indicated.

9.4. Progress Notes

9.4.1. For each significant clinical encounter between an inmate and a

Part of the team
 member of his or her treatment team, or any qualified mental-health professional, a progress note must be created and placed in the inmate's mental-health record.

9.4.1.1. A significant clinical encounter consists of a communication or interaction between an inmate and qualified mental-health professional involving an exchange of information used in the treatment of the inmate, excluding any casual exchanges, administrative communications, or other communications which do not relate to the inmate's mental condition or ongoing mental-health treatment.

9.4.2. Progress notes must be sufficiently detailed to facilitate treatment and ensure continuity of care

10. Suicide Prevention

10.1. Immediate Response to Suicide Attempts

10.1.1. If ADOC or mental-health vendor staff observe an inmate who is attempting suicide or who is unresponsive after apparently attempting or completing suicide, the staff must immediately call for assistance.

10.1.2. If ADOC or mental-health vendor staff observe a suicide threat or attempt, the staff must immediately respond with efforts to interrupt the behavior or attempt.

10.1.3. Immediate life-saving measures must be performed by ADOC or vendor staff as soon as it is deemed safe by correctional staff to do so (typically, when at least two correctional officers are present), and must continue until paramedics

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or other appropriate medical personnel arrive and assume care or a physician declares such measures are no longer necessary.

10.1.4. Each ADOC major facility must maintain an appropriate cut-down tool in each RHU, SU, RTU, SLU, and crisis unit.

10.1.5. When continued medical care is necessary, an inmate who has attempted suicide must be moved to the medical or healthcare unit at the ADOC major facility for continued medical care as soon as ADOC staff may safely move the inmate, unless medically contraindicated.

10.1.6. If an inmate dies as a result of a suicide, the inmate's body must be moved as soon as possible to a private area outside of any occupied housing unit and outside the view of other inmates.

10.2. Suicide Watch Placement

10.2.1. After each inmate's initial placement on constant observation, the inmate must be evaluated using a suicide risk assessment to determine if the inmate is not suicidal or is either acutely suicidal or non-acutely suicidal.

10.2.2. An inmate who is admitted to suicide watch must be considered for placement on the mental-health caseload.

10.2.3. If an inmate admitted to suicide watch is not placed on the mental-health caseload, the clinical rationale for that decision must be documented in the inmate's medical chart.

10.2.4. Before an inmate is placed on suicide watch, a nurse must examine the inmate and complete a body chart.

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10.3. Suicide Watch Cells

10.3.1. All suicide watch and stabilization unit cells in ADOC major facilities must be suicide-resistant. On a quarterly basis during the term of this order, all suicide watch cells in ADOC major facilities must be physically inspected to determine whether they remain suicide-resistant.

10.3.1.1. Cells shall be deemed suicide-resistant if they meet the requirements set forth in Lindsay M. Hayes's Checklist for the "Suicide Resistant" Design of Correctional Facilities (Doc. 3206-5).

10.3.1.2. Before an inmate is placed in an SU or suicide watch cell, the cell must be cleaned and any contraband must be removed from the cell.

10.3.2. ADOC may designate areas or cells where inmates could be temporarily placed when a suicide watch cell is unavailable, provided that the inmate remains on constant observation during this time.

10.4. Observation

10.4.1. Any inmate determined to be acutely suicidal must be monitored through a constant observation procedure.

10.4.2. Any inmate determined to be non-acutely suicidal must be monitored through a close watch procedure that ensures monitoring at staggered intervals not to exceed 15 minutes.

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10.4.3. During constant observation or close watch, an observer must contemporaneously document his or her observations at staggered intervals not to exceed 15 minutes. Upon an inmate's discharge from suicide watch, his or her observation records must be maintained in his or her medical record.

10.4.4. ADOC must take appropriate steps to ensure that observers perform their duties as required.

10.5. Suicide Watch Conditions

10.5.1. Unless clinically contraindicated, inmates on suicide watch must be provided adequate suicide-resistant implements for hygiene and eating as clinically appropriate.

10.5.2. Inmates on suicide watch must receive the same privileges afforded by their last housing assignment as clinically appropriate.

10.5.3. Inmates housed in crisis cells, medical cells, or the infirmary must be provided appropriate out-of-cell activity, unless clinically contraindicated, after 72 hours.

10.6. Referrals to Higher Levels of Care

10.6.1. If an inmate remains on suicide watch for 72 hours, then he or she must be considered for referral to a different or higher level of care based on clinical judgment. If the inmate is not referred to a different or higher level of care, then the clinical rationale must be documented in the inmate's medical chart and tracked in the crisis utilization log or a similar tracking mechanism.

10.6.2. If an inmate remains on suicide watch for 168 hours, then the he or she must be considered for referral to a different or higher level of care based on clinical judgment. If the inmate is not referred to a different or higher level of care, then the clinical rationale must be documented in the inmate's medical chart and tracked in the crisis utilization log or a similar tracking mechanism.

10.6.3. If an inmate remains on suicide watch for 240 hours or longer and does not meet the criteria for discharge to outpatient mental-health care, then he or she must be considered for referral to a different or higher level of care based on clinical judgment. If the inmate is not referred to a different or higher level of care, then the clinical rationale must be documented in the inmate's medical chart and tracked in the crisis utilization log or a similar tracking mechanism, and documentation of the decision must be sent to the mental-health vendor's director of psychiatry for review and evaluation.

10.6.4. Any inmate who is returned to suicide watch within 30 days of discharge from a suicide watch and/or who has three suicide watch placements within six months must be considered for referral to a different or higher level of care based on clinical judgment.

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If the inmate is not referred to a different or higher level of care, the clinical rationale must be documented, and mental-health staff must notify OHS of the decision and provide the clinical rationale to OHS within 72 hours.

10.7. Discharge

10.7.1. Discharge Evaluation

10.7.1.1. Prior to being discharged from suicide watch, an inmate must receive an out-of-cell, confidential evaluation by a psychiatrist, psychologist, CRNP, or counselor, unless such evaluation is not possible due to documented clinical concerns.

10.7.1.2. If an out-of-cell, confidential evaluation is not possible due to documented clinical concerns, staff must consider whether referral to a different or higher level of care is appropriate.

10.7.2. Discharge to RHU

10.7.2.1. An inmate discharged from suicide watch must not be transferred to an RHU, unless there is a documented exceptional circumstance.

10.7.2.2. Any transfer of an inmate from suicide watch to an RHU must be approved by the Deputy Commissioner of Operations (for male facilities) or Deputy Commissioner of Women's Services (for female facilities) or their designee.

10.8. Follow-Up

10.8.1. After an inmate's discharge from suicide watch, mental-health staff must conduct a follow-up mental-health examination with the inmate on each of the

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 First three days following discharge, unless there is a documented clinical determination that the inmate was not suicidal at the time the inmate was placed on suicide watch and did not become suicidal during the watch placement.

10.8.2. Follow-up mental-health examinations must not take the place of other scheduled mental-health appointments, although they may occur in connection with or contiguous with such appointments.

10.8.3. Follow-up mental-health examinations must occur in a confidential, out-of-cell setting, unless such examination is not possible due to documented clinical concerns.

10.8.4. During the follow-up mental-health examinations, the mental-health staff conducting such follow-up mental-health examinations must assess whether the inmate released from suicide watch is showing signs of ongoing crisis, whether the inmate needs further follow-up mental-health examinations, and whether the inmate should be added to the mental-health caseload or assigned a different mental-health code.

10.8.5. An inmate's transfer from suicide watch to another institution prior to the completion of the three ordered follow-up examinations restarts the requirement to complete a follow-up mental-health examination on each of the three days following the transfer.

11. Higher Levels of Care

11.1. ADOC must ensure that inmates who require hospital-level care

receive it within a reasonable period of time, as determined by clinical judgment.

11.2. Inpatient Beds

11.2.1. ADOC must supply enough beds to accommodate 10 % of its mental-health caseload at the time of the effective date.

11.2.2. In collaboration with the EMT, ADOC must, on at least an annual basis, reassess (1) the number of inmates on ADOC's mental-health caseload, and (2) whether 10% is in fact an accurate estimate of the percentage of the mental-health caseload requiring inpatient treatment. If ADOC determines that more than 10 % of the inmates on the mental-health caseload require inpatient beds, or that the mental-health caseload has grown, or both, it must adjust its number of inpatient beds accordingly.

11.2.3. At all times, ADOC must ensure that inpatient beds are housed in treatment spaces that allow for confidentiality, including by creating any new treatment spaces if necessary.

11.3. ADOC must devise a plan and procedures to address the serious risk posed by high temperatures in the mental-health units, which it must submit to the court by May 2, 2022. The plan and procedures must address, specifically, how it happened that Tommy Lee Rutledge's cell reached 104 degrees, causing him to die of hyperthermia, in a unit that was supposedly air conditioned, and how the ADOC will prevent that from ever occurring again. The plan and procedures must also address how ADOC plans to determine whether cells in each of its facilities have reached dangerously high temperatures, and should such a finding be

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made, what measures ADOC will take to ensure their occupants' safety.

12. Discipline

12.1. ADOC must comply with §§ V.B.2, V.C.3.a, and V.C.3.d of ADOC Administrative Regulation 626, all of which are set forth in Appendix B.

12.2. ADOC must comply with §§ V.D.3 and V.D.3.b, and the excerpted provision of § V.D.4, of ADOC Administrative Regulation 626, all of which are set forth in Appendix B.

13. Training

13.1. ADOC must document its provision of training regarding the Comprehensive Mental-Health Curriculum, suicide prevention, confidentiality, mental-health rounds in restrictive housing units, emergency preparedness, discipline, suicide risk assessments, correctional risk factors, and observation on suicide watch.

13.2. For training purposes, on a quarterly basis, ADOC and/or its mental-health vendor must conduct emergency preparedness drills at each ADOC major facility, including scenarios involving self-injury and suicide attempts. During the emergency preparedness drills, the trainers must evaluate the correctional and medical staff response time to the emergency code and their preparedness for the emergency code (including, as appropriate, presence of an emergency bag, automatic external defibrillator (or AED), and cut-down

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tool). Additionally, the emergency preparedness drills must include role-playing for participants to practice the response to an emergency, including, for example, using a cut-down tool, rendering first aid, and performing cardiopulmonary resuscitation (or CPR).

13.3. Observers must receive additional training related to their observation obligations, including where they must be positioned and how to access assistance if an inmate requires medical care or there is an emergency.

14. Unforeseen Circumstances

14.1. "Unforeseen circumstances" refer to a situation in which an event or series of events (such as a natural disaster, fire, medical epidemic, pandemic, or outbreak, and lockdown) make performance under this omnibus remedial order inadvisable, impracticable, illegal, impossible, detrimental to the health and/or safety of inmates and/or staff, or detrimental to the public interest.

14.2. In monitoring ADOC's compliance with this omnibus remedial order, the EMT shall consider unforeseen circumstances, their effects on ADOC's ability to comply with the remedial order, and ADOC's efforts to mitigate the effects of those circumstances.

15. This order is not final and remains open in that the parties must still submit proposals for further and/or different relief and monitoring may warrant consideration and reconsideration of issues. The court also retains jurisdiction.

DONE, this the 27th day of December, 2021.

Appendix A

The Defendants' Mental-Health Treatment Guidance

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Treatment Category Initial Assessment Subsequent Care

SU An RN will assess the inmate on an emergent basis after arrival to the cell SU and make any necessary arrangements on an emergent, urgent, routine, or another basis for a psychiatric assessment and/or counseling or CRNP.

RTU (Levels 1-3) An RN will assess the inmate on an urgent basis after arrival to the RTU and make any necessary arrangements on an emergent, urgent, routine, or another basis for a psychiatric assessment and/or counseling or CRNP.

SLU An RN will assess the inmate on an urgent basis after arrival to the SLU and make any necessary arrangements on an emergent, urgent, routine, or another basis for a psychiatric assessment and/or counseling or CRNP based on clinical judgment.

Outpatient Psychiatrist or CRNP: Every 90 days, unless the inmate on a routine basis, clinically indicated.

Psychologist or counselor: Every 90 days, unless otherwise clinically indicated.

Appendix B

ADOC Administrative Regulation 626, § 1.B.2 :

"A mental health consultation may be sought at the time of the rule or regulation violation or after review of the disciplinary report. A mental health consultation must be sought if the inmate is on the mental health caseload and has a mental health code of C or higher and/or an SMI designation; or, even if the inmate has a lower mental health code or is not on the mental health caseload, where the inmate has an intellectual or developmental disability, or the inmate's behavior at the time of the alleged actions giving rise to the disciplinary

of at any time prior to or during the disciplinary process demonstrates signs of psychological distress or mental impairment."

ADOC Administrative Regulation 626, § V.C.3.a :

"A mental health staff member performing the mental health consultation will evaluate: (1) an inmate's current and then-existing ¹³⁸¹ (at the time of the incident) mental state, including the inmate's capacity to proceed with a disciplinary hearing; (2) an inmate's mental health diagnosis or, for an inmate not previously diagnosed, the presence of mental illness; (3) an inmate's treatment and medication (including any compliance issues) over the past six (6) months; (4) any crisis placements over the past six (6) months; (5) whether the inmate's behavior resulting in an ADOC rule or regulation violation is the direct result of or related to his or her mental illness; (6) the likely impact of confinement to restrictive housing on an inmate's mental health and, based on the likely impact, if confinement to restrictive housing for a medium- or high-level rule violation is contraindicated; (7) the potential impact of other disciplinary sanctions on the inmate's mental state, including whether any specific disciplinary sanction is clinically contraindicated for the inmate and, in such instances, what alternative sanctions are not clinically contraindicated; and (8) the need for mental health staff to be present during the disciplinary hearing."

ADOC Administrative Regulation 626, § V.C.3.d :

"The mental health staff member performing the mental health consultation will document his or her evaluation and provide any comments, notes, and recommendations in the ADOC computer module. A mental health staff member may identify disciplinary sanctions that are contraindicated for the inmate and any appropriate alternative disciplinary sanctions. A copy of the

mental health consultation evaluations and recommendations will be (a) provided to the disciplinary hearing officer for consideration and to maintain with the inmate's disciplinary action file, and (b) placed in the inmate's mental health record to ensure the inmate's treatment team may receive and review it."

ADOC Administrative Regulation 626, § V.D.3 :

"During the disciplinary hearing and/or before the disciplinary officer adjudicates the disciplinary action, the disciplinary officer must consider the mental health consultation, including any evaluation, comments, or recommendations, in deciding an inmate's guilt or innocence and, if guilty, in imposing any disciplinary sanctions."

ADOC Administrative Regulation 626, § V.D.3. b:

"If the mental health staff member performing the mental health consultation concludes that the rule or regulation violation was related to, but not the direct result of, the inmate's mental illness, then the disciplinary hearing officer must take that conclusion into consideration in imposing any disciplinary sanctions."

ADOC Administrative Regulation 626, § V.D.4 :

"[I]f the mental health staff member who conducted the mental health consultation determined that any specific disciplinary sanction is clinically contraindicated for the inmate, including confinement to restrictive housing for a medium- or high-level rule or regulation violation, then the decision of the mental health staff member who performed the mental-health consultation will be outcome determinative and binding on the disciplinary hearing officer, except where exceptional circumstances exist."

Officers

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Regional Representatives

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February 27, 2024

The Honorable Cory Booker
 Chairman
 Subcommittee on Criminal Justice and Counterterrorism
 Committee on the Judiciary
 224 Dirksen Senate Office Building
 Washington, DC 20510

Senator Booker:

Thank you for convening the hearing on February 28 to highlight the challenges state departments of correction are facing regarding the recruitment and retention of people who work in US prisons and jails.

State corrections directors are committed to running facilities that: a) protect the public; b) provide healthy and safe conditions for the staff and people incarcerated in these institutions; and c) prepare people for success when they return to the community. When systems are short-staffed, it is especially difficult to deliver on these goals. Many systems are struggling with high vacancy rates, which means correctional leaders must mandate overtime. This, in turn, can contribute to burnout and staff turnover, exacerbating staffing shortages.

Last year, the Correctional Leaders Association (CLA), whose members administer correctional agencies responsible for more than 400,000 employees and 8 million people under correctional supervision, convened a 50-state summit in Washington, D.C. among its members to focus on issues concerning corrections workforce issues. In advance of that meeting, CLA surveyed its membership.

Among the findings from the survey of directors of the 50 state departments of correction and the largest county jail systems: **Virtually every correctional leader said that workforce issues (e.g., vacancy rates, retention rates, and staff morale) are their top priority.** One out of five directors agreed with this statement: "Our workforce challenges have become so acute we have engaged – or are seriously considering engaging – the National Guard." Although prison closures have been common in states across the United States over the past 10 years, most

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directors anticipate the size of their prison population remaining steady or growing in the years ahead, putting additional pressure on their staffing challenges.

Thanks in part to the advocacy of CLA members, significant pay raises have been secured for correctional staff in virtually every state. But, recognizing that pay raises alone will not resolve their recruitment and retention challenges, corrections leaders everywhere are pursuing additional efforts: launching aggressive, targeted recruitment campaigns, using data to understand where their retention challenges are most acute; experimenting with technology to increase efficiency, piloting new approaches to working with incarcerated populations, which draw on successes of other countries, such as Norway; providing programs designed to improve staff wellness; and more.

CLA appreciates recent steps made by the Bureau of Justice Assistance (BJA) to help our field navigate these issues. As a result of a grant from BJA, CLA is partnering with the Keystone Restituee Justice Center, One Voice United, and Just Leadership USA, and other groups to highlight promising practices, develop tools, and develop new approaches that increase the health and safety of our corrections systems. We expect to distill best practices and illuminate the complex issues that gave rise to the workforce shortage and would be happy to share the findings with this Committee.

We welcome efforts by Congress to build on our momentum and greatly appreciate you bringing attention to the challenging job that corrections professionals do every day. We wish to share the following truisms about this issue. First, unlike the staffing shortages experienced in policing, education, and health, the public knows very little about the vital services provided by corrections and our workforce challenges. Second, despite the urgency of this problem, there is surprisingly little data regarding workforce trends in corrections, especially when compared to other public sector workforces, such as police officers, teachers, or nurses. Third, very little knowledge exists demonstrating what strategies are most effective in providing working and living conditions that increase retention rates. In light of this, CLAE makes the following recommendations to Congress:

1. Continue to raise awareness and increase visibility of the correctional staffing crisis. Correctional staffing issues should be treated with the same gravitas as workforce issues in health, policing and education.

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2. Assist with collecting and analyzing data across 50 states, so that we better understand trends in the correctional workforce and to ensure that the same sophistication applied to other public sector professions is applied to this challenge.
 3. Provide seed funding to test and evaluate new approaches to recruitment, on-boarding, training, and uses of technology, which will help states replicate new approaches and accelerate innovation.

Thank you again for the steps you and your colleagues are taking to support our efforts to ensure the health and safety of all people our systems touch. CLA stands ready to assist Congress in addressing the correctional workforce challenge.

Sincerely yours,


Kevin Kempf

Executive Director



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February 28, 2024

Chairman Cory Booker
Ranking Member Tom Cotton
U.S. Senate Committee on the Judiciary
Subcommittee on Criminal Justice and Counterterrorism
226 Dirksen Senate Office Building, Washington D.C. 20515

Dear Chairman Booker, Ranking Member Cotton, and Members of the Subcommittee:

My name is MaKayla Mount, and I am a 17-year-old senior at Hewitt Trussville High School in Trussville, Alabama. I am writing in hopes that my family's pain at losing my father to uncontrolled violence in an Alabama prison will help this committee understand the suffering experienced by thousands of Americans with incarcerated loved ones. In Alabama alone, 325 people died in state prisons in 2023. My father, Christopher Mount, who was 44 years old, was one of them. He was murdered while in a protective custody cell. This is my story.

"Chris is dead. He's been murdered," I heard my mother say, as she wailed in pain while on the phone with my grandmother. She didn't know I was listening. I dropped to my knees and had no feeling throughout my body. How could my dad be dead? That day, May 16, 2023, I experienced the worst pain of my short life, the kind of pain that feels like a punch to the gut. After I began to pull myself together all I could ask was: What happened to my daddy?

We met with a detective later that week, but he talked in loops and avoided telling us the truth. I was left with no answers, other than, "Your dad was in a fight. Got strangled and we're so sorry." In reality, my father was stomped on while laying down in a prison bunk, struck while vulnerable. The fight that killed him could have been stopped if the Alabama correctional officer, who was supposed to be watching the suicide cell, where my father and his killer were being kept, would have done their job.

Where was the officer? In the lobby chatting, according to what we learned from other incarcerated men there, all while my father was being beaten to death because he was snoring. Those other incarcerated men told us one officer later watched and laughed, another just walked by, saw my father's lifeless body. assumed it was "another overdose" and brushed it off. I question the morality of these people. Even if it was an overdose, it's someone's life in jeopardy. My father didn't receive care until 13 minutes after the altercation. He was pronounced dead on Sunday, May 14, 2023, and it took the prison two days to inform our family of my father's death.

One can only wonder what took place in that cell. I wonder as well. I suffer from night terrors now, and three or four times a week I see my dad so vividly in my dreams. I see the man who killed my father, William Lynn Smith, on top of my dad, and I watch as his life drains from him. My dad slowly turns over and pleads to me for help. "Please MaKayla. Help me, I need your help. Please don't leave me," my dad

says to me in those dreams as I'm forcefully taken away by employees of Easterling Correctional Facility. The prison is at 188 percent capacity; at least 3 other people died there the same month as my father.

The Alabama Department of Corrections doesn't want the details of my dad's death being released publicly, and added to the large number of deaths last year. I called Easterling Correctional Facility 27 times in May in an attempt to collect his property. I was always told "The guy you need to talk to isn't here today" or "Call back tomorrow" or "Try again later this week." I still haven't received any of his belongings, including the letters I wrote to him throughout his incarceration.

My father and I had big dreams. We dreamed of the day he would touch down in the real world again and come home to us, and we always talked about me graduating and breaking the generational curse that I was born into. That man gave the best advice, words meant especially for me and what I needed to hear to keep me going. He never wanted me to give up and was so excited to see me walk at graduation, to become a mom and all of life's achievements. No matter what, he was always proud of me, but all was all taken away from the both of us at the hands of another man. In reality, it was the Alabama Department of Corrections that took him from us. Mine and my father's biggest dreams will never come true. He will never come home to me or my mother, his true love for more than 18 years.

I now feel as if I have nothing to look forward to. I have not given up on those dreams, but my dreams feel empty now because a big part of them isn't here to watch them come true. So much was taken from our family. The little girl who would pray every night to watch over her daddy and keep him safe is in pain. The preteen who wrote letters to her dad every day is in pain. The girl I am today is in pain. It's been nine months since his death, and I will never understand the Alabama Department of Corrections and the lack of accountability at a massive state agency that is supposed to provide law enforcement and public safety.

Thank you for your work to address the uncontrolled violence in America's prisons and hopefully prevent future families of incarcerated people from experiencing what my family and so many others in Alabama experience.

Sincerely,

MaKayla Mount
Trussville, Alabama



Marsha R. Curry-Nixon – Executive Director

Timothy F. White Jr. – Director of Operations **Gregory Carter, Jr.** – Director of Programs & Development
David Curry – Admin. Assistant/Notary **Phylicia K. Carter** – Community Integration Manager

"Our Mission is to provide services and supports to individuals who are seeking to improve their quality of life for themselves and their families."

February 28, 2024

The Honorable Cory Booker
 Chairman
 Subcommittee on Criminal Justice and Counterterrorism
 Senate Committee on the Judiciary
 224 Dirksen Senate Office Building
 Washington, DC 20510

Dear Chairman Booker:

Thank you for inviting me to submit a letter on the topic of "The Nation's Correctional Staffing Crisis: Assessing the Toll on Correctional Officers and Incarcerated Persons." I am the Founder and Executive Director of Amira4sure, Inc., a ministry that provides reentry support services to people reentering society after incarceration. I also sit on the Executive Committee of the Council of State Governments Justice Center (CSGJC)'s Advisory Board. CSGJC is a national nonprofit, nonpartisan organization that serves state officials in all three branches of government and uses policy and research expertise to develop strategies for increasing public safety and strengthening communities. My work in both capacities is guided by my decades of experience in mentoring reentering individuals, along with my own lived experience as a formerly incarcerated person.

As you know, our nation's correctional facilities have been facing major challenges around recruiting and retaining staff for several reasons. For one, correctional officers face a higher risk of injury on the job compared to other professions. In 2011, 544 per every 10,000 correctional officers faced a work-related injury or illness that was serious enough to require an absence from work, ranking the job third for highest rate of nonfatal work injuries after police officers and security guards.¹ Additionally, correctional officers undergo severe stress, with studies finding that as many as 35 percent of correctional officers report high stress levels.²

These high-injury and high-stress working conditions can create a damaging cycle: the physical and mental toll to correctional officers can deter individuals from joining the correctional workforce, which only creates more difficult conditions for current officers, with higher ratios between officers and incarcerated people and higher turnover rates.³ Many states are also seeing low unemployment rates, which has shrunk the labor pool and placed some corrections departments on the losing end of a battle to offer competitive pay and benefits.⁴

The impacts of the correctional staffing crisis are far and wide, with both correctional professionals and incarcerated people being adversely affected. First, staffing shortages can exacerbate alarming conditions of

¹ Ferdik, F. V., & Smith, H. P. (2017). *Correctional officer safety and wellness literature synthesis*. National Institute of Justice. <https://www.ojp.gov/pdffiles1/nij/250484.pdf>

² Ibid.

³ Ibid.

⁴ Cameron, P. (2023, August 1). *Wisconsin jail staffing lowest in 15 years: here's why it matters*. The Cap Times. https://captimes.com/news/government/wisconsin-jail-staffing-lowest-in-15-years-heres-why-it-matters/article_e056e850-683d-5230-96ac-0f1ceb8c76e2.html



Marsha R. Curry-Nixon – Executive Director

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confinement. When I was incarcerated in Muncy State Correctional Facility in upstate Pennsylvania, there was no air conditioning, and the heat was unbearable. During times of extreme heat, staffing shortages in some facilities worsened these conditions through slowing the delivery of ice and water to cells without air conditioning, as well as delaying the transfer of people under heat stress to air-conditioned areas.⁵

Correctional staffing shortages can also reduce the number and quality of services and programs available to incarcerated people, as some facilities reassign programming staff as needed to fill shortages.⁶ Correctional officers already face the difficult task of keeping facilities safe and secure while balancing the wide variation in security levels, physical and mental health issues, and substance abuse issues of each incarcerated person. When correctional facilities are inadequately staffed, officers lack the resources to make placements and housing assignments based on risk and rehabilitation needs, let alone provide enough programming to keep each person occupied during their period of incarceration.⁷ Adequate programming and targeted services must be a priority for our correctional facilities. As a mother who gave birth to my son in prison, I understand firsthand the necessity of providing much-needed services and care for pregnant women, new mothers, and every incarcerated individual's specific needs.

Furthermore, the programming and mentoring that I received while in prison was vital to my healing and transformation. While the guidance and direction I received inspired me to provide mentoring and reentry support services for other people with similar life experiences, I also recognized there was a dearth of services for the incarcerated and formerly incarcerated. My organization, Amiracl4sure, provides services to people reentering their communities, including mentoring prevention programs, programs providing appropriate clothing and grooming for people reentering the workforce, housing financial assistance, transitional living support, family reunification support groups, cognitive behavioral intervention support groups, peer support groups, and after school programs. Through our reentry programs and services, I have seen countless lives restored, families reunited, and communities made safer—indicating the deep need and importance for adequate staffing, and in turn, adequate programming in our correctional facilities.

In response to the nationwide staffing crisis, states are responding creatively to address staffing shortages. Some are now recruiting through social media, walk-in hiring events, television, radio, and direct mail advertising.⁸ Others are focusing on providing wellness and mental health services for correctional officers, including peer counseling and in-house therapy, or providing tuition assistance and covering training costs.⁹ Congress can take steps to address the understaffing of jails and prisons by supporting these innovative state efforts to manage the shortage crisis, as well as reauthorizing and ensuring robust funding for strong reentry programs that Congress has invested in, including the Second Chance Act. With your support, states, localities,

⁵ Montgomery, D. (2023, June 6). *Prison staff shortages take toll on guards, incarcerated people*. Stateline. <https://stateline.org/2022/09/26/prison-staff-shortages-take-toll-on-guards-incarcerated-people/>

⁶ Toomer, L. (2024, January 22). *Basic inmate needs go unmet due to staff shortage in Colorado prisons, report says*. Colorado Newswire. <https://coloradonewswire.com/2024/01/22/inmate-needs-unmet-colorado-prisons/>

⁷ Ellison, J. M., & Gainey, R. (2020). An opportunity model of safety risks among jail officers. *Journal of Criminal Justice*, 66, 101632. <https://doi.org/10.1016/j.jcrimjus.2019.101632>

⁸ Corrections1 Staff. (2023, November 22). *Photo of the week: Wis. Doc graduates new class of cos*. Corrections1. <https://www.corrections1.com/corrections-training/articles/photo-of-the-week-wis-doc-graduates-new-class-of-cos-4gP5yNJ8cfBDNpho/>

⁹ Barrett, K., & Greene, R. (2023, July 10). *Solving the problem of understaffed jails and Prisons*. Route Fifty. <https://www.route-fifty.com/workforce/2023/07/solving-problem-understaffed-jails-and-prisons/388128/>



Marsha R. Curry-Nixon – Executive Director

Timothy F. White Jr. – Director of Operations **Gregory Carter, Jr.** – Director of Programs & Development
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and organizations can work together nationwide to create strong solutions for the correctional staffing crisis —ensuring that system-impacted people, correctional professionals, and communities across the country can have healthier and safer outcomes.

Thank you for your leadership on this important issue, and please do not hesitate to contact me if you have any questions.

Sincerely,

Marsha R. Curry-Nixon

Marsha R. Curry-Nixon, BS, MHS
Founder and Executive Director, Amiracle4sure, Inc.



Major County Sheriffs of America

www.mcsheriffs.com

February 27, 2024

The Honorable Cory Booker
 Chairman
 Subcommittee on Criminal Justice &
 Counterterrorism
 Senate Judiciary Committee
 Washington, DC 20510

The Honorable Tom Cotton
 Ranking Member
 Subcommittee on Criminal Justice &
 Counterterrorism
 Senate Judiciary Committee
 Washington, DC 20510

Dear Chairman Booker and Ranking Member Cotton:

We write to you on behalf of the Major County Sheriffs of America (MCSA), which represents the largest Sheriff's Offices in the country and over 130 million citizens who they serve in their jurisdictions. We appreciate the Senate Judiciary Committee's Subcommittee on Criminal Justice & Counterterrorism will hold a hearing on: "The Nation's Correctional Staffing Crisis: Assessing the Toll on Correctional Officers and Incarcerated Persons."

We encourage you to consider the following priority areas as you review efforts to recruit and retain qualified officers who can provide the necessary support to those who come into contact with the criminal justice system:

Recruitment & Retention

MCSA encourages Congress to prioritize legislation to support recruitment and retention of law enforcement in all areas, including patrol, corrections, investigations, and emergency communications. These proposals should incentivize individuals of all backgrounds to apply for job opportunities through new offerings, such as daycare, educational opportunities, and flexible scheduling.

Moreover, there is a pressing need for experienced individuals to address complex criminogenic, chronic care, and behavioral health needs of inmates. Support for the recruitment and retention of reentry navigators, recovery coaches, and mental health clinicians working in law enforcement agencies would be a meaningful contribution to the field.

Officer Wellness

Our personnel must be supported with high quality programming and tools to help them cope with the extreme stresses placed on them in the normal course of their jobs. Lawmakers should provide resources for effective officer safety and wellness, including mental health services and peer counseling among law enforcement to train officers to help their colleagues with stressful situations.

Congress should prioritize correctional officer wellness as they face stressors unique to their working environment. We encourage lawmakers to improve data collection and analysis of correctional officer suicide and burnout and to review national guidelines for the treatment of correctional officer burnout.

Training

Congress should provide resources for law enforcement agencies to provide high quality scenario-based training to enhance officers' ability to safely interact with the individuals they serve.

Mental Health/Substance Use Treatment

Increasing numbers of people suffering with mental illness and substance use disorders are coming into contact with the criminal justice system, which has stressed our ability to meet the needs of those in crisis. Additional resources are necessary to provide effective treatment for these individuals.

We encourage Congress to quickly take up and pass the *Supporting Treatment and Recovery Over Narcotics for Growth, Empowerment, and Rehabilitation Act*, which will reauthorize the Residential Substance Abuse Treatment for State Prisoners (RSAT) state formula grant program to support states and local governments in offering treatment to adults in prison and jail with a substance use disorder. The legislation includes important updates to the program, including allowing grantees to use RSAT funds to offer treatment to individuals pre-trial, ensuring continuity of care and access to medication assisted treatment after release, and assisting prisons and jails meet contemporary standards of medical care for substance use disorders.

MCSA also supports improvements in community behavioral health resources, especially those directed at greater upstream prevention that can divert individuals away from the criminal justice system and into treatment. Furthermore, MCSA supports the delivery of high-quality healthcare and treatment for those mentally ill and/or substance-addicted inmates who must remain incarcerated due to the severity of the crimes of which they have been charged or convicted.

Access to Federal Health Benefits

MCSA urges Congress to pass legislation to amend the Medicaid Inmate Exclusion Policy (MIEP) to improve care coordination and provide continued access to federal health benefits for eligible individuals in local jails.

The *Due Process Continuity of Care Act* would allow pre-trial detainees to receive Medicaid benefits at the option of the state and provide planning grant dollars to states for implementation. The *Reentry Act* would allow for Medicaid payment for medical services furnished to incarcerated individuals during the 30-day period preceding an individual's release.

Passage of this legislation would allow for improved care, lower costs to taxpayers, decreased crime, reduced recidivism, improved public safety, and better outcomes for the overall health of our residents.

Reentry

MCSA supports *Second Chance Act* programs, which promote evidence-based practices, specifically targeting reentry programs to aid individuals with more effectively reintegrating into society and reducing the potential of return to the criminal justice system in the future. Part of this process is ensuring that adequate substance use disorder treatment services and career training for employment opportunities are available as part of the continuum of care post-release for incarcerated individuals.

MCSA stands ready to provide technical feedback on proposals to reauthorize the *Second Chance Act*.

We appreciate the Senate Judiciary's Subcommittee on Criminal Justice and Counterterrorism focusing on this important issue and we look forward to continuing to serve as a resource. Should you need any further information or have any questions, please do not hesitate to contact us.

Sincerely,



Sheriff Bill Brown
Santa Barbara County Sheriff's Office
MCSA President



Megan E. Noland
Executive Director
Major County Sheriffs of America (MCSA)

Southern Poverty Law Center
 400 Washington Ave
 Montgomery, AL 36104
 splcenter.org



March 4, 2024

The Honorable Cory Booker
 Chair
 Subcommittee on Criminal Justice
 and Counterterrorism
 Senate Committee on the Judiciary
 U.S. Senate
 Washington, DC 20515

The Honorable Tom Cotton
 Ranking Member
 Subcommittee on Criminal Justice
 and Counterterrorism
 Senate Committee on the Judiciary
 U.S. Senate
 Washington, DC 20515

Dear Chair Booker and Ranking Member Cotton:

On behalf of the Southern Poverty Law Center, we write to provide our insights for your hearing on “The Nation’s Correctional Staffing Crisis: Assessing the Toll on Correctional Officers and Incarcerated Persons.” We appreciate this opportunity to share our expertise in this area and ask that this statement be included as part of the official hearing record.

The SPLC is a nonprofit advocacy organization working to serve as a catalyst for racial justice in the South and beyond. We work to dismantle white supremacy, strengthen intersectional movements, and advance the human rights of all people. We have deep expertise in the jail and prison systems in our five-state region, which includes Alabama, Florida, Georgia, Louisiana and Mississippi, through extensive litigation addressing prison conditions. Relatedly, the SPLC Action Fund advocates for laws and policies that would reduce reliance on mass incarceration while creating stronger and safer communities.

The crisis of correctional officer staffing shortages in many state prison systems, including those in the Deep South, eclipses that experienced by the federal Bureau of Prisons, and is a major contributor to high levels of preventable deaths. These deaths are caused not only by excessive violence, but also by the failure of prison systems to provide vital medical and mental health care, as well as basic safety measures, for incarcerated people. We offer the following details concerning the crises in two of our states, Alabama and Mississippi, to illustrate the devastating impact of continuing to operate grossly overcrowded prisons that are grossly understaffed.

Alabama

SPLC represents the plaintiff class of people with serious mental health needs in Alabama prisons. In 2017, the U.S District Court for the Middle District of Alabama found Alabama Department of Corrections (ADOC) officials liable for sweeping failures to provide minimally adequate mental

Honorable Cory Booker, Chair
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health care in a system it deemed “horrendously inadequate.”¹ The court further found that “persistent and severe shortages of mental-health staff and correctional staff, combined with chronic and significant overcrowding, are the overarching issues” permeating each of the mental health care failures it identified.² The severe shortage of correctional officers, the court concluded, was a key factor in the prison system’s failure to provide mental health counseling and psychiatric services to incarcerated people, as well as to provide the necessary oversight to prevent self-inflicted injuries and deaths by suicide. As the court explained, correctional staffing shortages inhibit delivery of adequate care by preventing incarcerated people from being able to access appointments with providers, hinders supervision of mentally ill people, diminishes officers’ ability to identify and refer potentially people needing treatment,³ and directly impacts mental health in that “[t]he combination of overcrowding and understaffing leads to an increased level of violence.”⁴ The court also found that inadequate monitoring of people held in segregation contributes to “a vicious cycle of isolation, inadequate treatment, and decompensation.”⁵ Perhaps most tragically, the Court decried a “skyrocketing suicide rate”⁶ that it attributed in large part to the lack of correctional staffing in ADOC’s badly overcrowded facilities.⁷

In 2021, the *Braggs* Court issued an omnibus remedial order.⁸ Despite the Court’s efforts during the preceding four years to cause ADOC officials to urgently address the correctional officer shortage, it found the dire “deficiency in correctional staff [] nearly unchanged in its severity and impact” since the 2017 liability order.⁹ Citing the testimony of ADOC’s own experts, the Court’s opinion noted that ADOC had filled “**less than half** of the mandatory and essential positions” that would be minimally necessary to safely operate facilities.¹⁰ Continuing to progress at the same rate, the Court opined, would put ADOC “on track to achieve sufficient staffing to safely conduct normal operations sometime in mid-2037.”¹¹

The Court also found that “understaffing continues to impede the provision of adequate mental-health care throughout the ADOC system.”¹² Noting that at least 27 more incarcerated people had died by suicide in ADOC facilities since the liability trial, the court stated that “the common thread among these tragedies is ADOC’s lack of correctional staff”¹³

¹ *Braggs v. Dunn*, 257 F.Supp.3rd 1171, 1267 (M.D. Ala. 2017).

² *Id.* at 1268.

³ *Id.* at 1200-04, 1258.

⁴ *Id.* at 1200.

⁵ *Id.* at 1243-45.

⁶ *Id.* at 1261.

⁷ *Id.*

⁸ *Braggs v. Dunn*, 562 F. Supp. 3d 1178 (M.D. Ala. 2021).

⁹ *Id.* at 1192.

¹⁰ *Id.* at 1224.

¹¹ *Id.*

¹² *Id.* at 1214.

¹³ *Id.* at 1192.

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Honorable Tom Cotton, Ranking Member
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[A]s at the time of the liability trial and opinion, the lack of correctional staff undermines the department's ability to meet the mental-health needs of its prisoners in numerous, insidious ways. Prisoners do not receive adequate treatment and out-of-cell time because of insufficient security staff to supervise these activities. They are robbed of opportunities for confidential counseling sessions because there are too few staff to escort them to treatment, forcing providers to hold sessions cell-side. They decompensate, unmonitored, in restrictive housing units, and they are left to fend for themselves in the culture of violence, easy access to drugs, and extortion that has taken root in ADOC facilities in the absence of an adequate security presence. The resulting sky-high rates of suicidality divert scarce mental-health resources from treatment provision to crisis management, exacerbating the deficiencies in care.¹⁴

In April 2019, the U.S. Department of Justice issued a report of its CRIPA investigation of Alabama's prisons for men, in which it concluded there was reasonable cause to believe ADOC was violating the constitutional rights of incarcerated people by failing to protect them from violence and sexual abuse and failing to provide safe conditions overall.¹⁵ DOJ identified severe overcrowding – a statewide occupancy rate of 182% of capacity at the relevant major facilities and rates as high as 320%¹⁶ - and “an egregious level” of correctional officer understaffing as critical factors.¹⁷ It cited an overall staffing rate of fewer than half of the authorized correctional officer positions, with three prisons operating with fewer than 20% of those positions filled and four others under 30%.¹⁸ The report quotes a former ADOC warden who stated that “the convicts are in extreme danger and the correctional officers working there are in extreme danger.”¹⁹

In 2020, DOJ filed a lawsuit against the State of Alabama and ADOC over its failures to prevent violence and sexual abuse and to provide safe conditions of confinement. DOJ cited two major factors contributing to these failures: overcrowding and the “dangerously low level of security staffing,”²⁰ drawing “a direct correlation between the shortage of correctional officers in Alabama's prisons for men and the violence, sexual abuse, and death.”²¹ In a long overdue effort to address its chronic shortage of correctional officers, ADOC announced substantial pay increases in March of 2023.²²

1. INCREASE IN STARTING SALARY FOR CORRECTIONAL OFFICER TRAINEES

¹⁴ *Id.*

¹⁵ <https://www.justice.gov/crt/case-document/file/1149971/download>

¹⁶ *Id.* at 8.

¹⁷ *Id.* at 9.

¹⁸ *Id.* 9-10.

¹⁹ *Id.* at 10.

²⁰ Complaint at 48.

²¹ *Id.* at para. 49.

²² [ADOC Commissioner Announces Pay Increases for Correctional Officers](#), ADOC, March 7, 2023.

Honorable Cory Booker, Chair
 Honorable Tom Cotton, Ranking Member
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 Page 4

\$55,855 at MAXIMUM SECURITY FACILITIES
 \$53,245 at MEDIUM SECURITY FACILITIES
 \$50,712 at WORK RELEASE / COMMUNITY WORK CENTERS

2. PAY GRADE/SALARY INCREASES FOR CURRENT CORRECTIONAL OFFICERS The new pay grades will allow additional steps for pay progression.

Unfortunately, the pay raises have so far brought only very modest improvements in staffing. Salaries at the federal Bureau of Prisons remain higher, and the violence in ADOC facilities remains extremely high.

Despite the immense harms being imposed on both incarcerated people and correctional staff in ADOC facilities by the combination of extreme overcrowding and extreme understaffing, and its longstanding inability to adequately address the latter problem, Alabama stubbornly refuses to take reasonable steps to address the former. Since the current chairperson of Alabama's parole board was appointed in October 2019, parole hearings and parole grants have all but stopped. In fiscal year 2022, the board granted parole to just 409 people while denying parole to nearly 3,600 others, continuing a precipitous decline.²³

	Year	Grant Rate
	2019	31%
	2020	20%
	2021	15%
	2022	10%

In 2023, a report from the ACLU of Alabama found that the rate had again declined, to just 7%.²⁴ These low rates fly in the face of the recommendations of the board's own staff, which typically recommends parole for many more people deemed to be low risk. Many of those denied parole are on "work release," meaning they are not seen as a risk to themselves or others and are permitted to leave ADOC facilities to go to jobs in places like fast food restaurants and manufacturing facilities.²⁵ Many others are elderly and/or disabled.²⁶

²³ Source: Alabama Bureau of Pardons and Paroles, [Monthly Statistical Reports](#).

²⁴ [Parole Watch Report](#), ACLU Alabama, Summer 2023, at 8.

²⁵ *Id.* at 18.

²⁶ [Hopeless: Parole Denial for Alabama Woman With Terminal Illness Highlights Injustice](#), Southern Poverty Law Center, April 7, 2023.

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Mississippi

In late 2019, violence erupted at several Mississippi prisons, resulting in riots and several deaths.²⁷ The violence and deaths continued in 2020. Disability Rights Mississippi,²⁸ through its access authority, increased monitoring at several facilities. In January 2021, following months of extensive monitoring and investigations, DRMS released a special report, *Cruel and Unusual Punishment in Mississippi Prisons: A Tale of Abuse, Discrimination & Undue Death Sentences*.

The report attributed the Mississippi Department of Corrections' (MDOC) problems to several systemic issues, including the inadequate staffing of correctional officers. Specifically:

- At the time of the report, Mississippi had over 19,000 people in custody. At “almost every MDOC facility, **the staff’s vacancy rate is just short of 50%**. Mississippi officials have known and commented on the astronomical ratio of [incarcerated people] to correctional officers in MDOC facilities. The staff’s high vacancy rate and correctional officer shortage presents many issues in regard to the facility’s security.”
- “Many believe that the shortage is attributed to the low starting salary of correctional officers, which is under \$25,000 a year compared to a national average of \$32,000 annually.”
- In 2020, the MDOC acknowledged that “it needed, at minimum, 500 officers to continue to fulfill its public safety mission, provide court-ordered programs and expand its re-entry efforts.”
- Incarcerated people are not receiving vocational programs, mental health counseling, alcohol and drug treatment programs, social services, educational programs, religious services, recreational services, and psychological and psychiatric services because of inadequate staffing.

Id. at 4. The MDOC staffing shortage extends to medical providers, leading “to a host of predictable problems with the delivery of medical care, including delays, failures to diagnose and

²⁷ Joseph Neff and Alysia Santo, *Mississippi Prison Killings: Five Factors Behind the Deadly Violence*, THE MARSHALL PROJECT (Jan. 8, 2020), <https://www.themarshallproject.org/2020/01/08/mississippi-prison-killings-five-factors-behind-the-deadly-violence>. In 2019, “between 44 and 50 percent of the jobs were vacant at the state’s three big publicly run prisons.” *Id.* Mississippi’s “low pay and tough work environment have led to high staff turnover, resulting in inexperienced workers poorly equipped to manage prisons in a volatile setting.” The prolonged understaffing has eroded public safety, exhausted and demoralized corrections officers, reduced programs and family visits, and led to lockdowns, where people are kept in cells for “almost 24 hours per day. Lockdowns can go on for months at a time, ratcheting up tensions among prisoners.” *Id.*

²⁸ Disability Rights Mississippi is the (DRMS) is the federally mandated protection and advocacy (P&A) agency for the state of Mississippi. DRMS has “extensive access authority . . . to investigate incidents of abuse and neglect, and to monitor service providers and facilities that care for Mississippians with disabilities, including care homes, medical facilities, and prisons.” <http://www.drms.ms/about>.

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treat, failures to follow-up, errors, and incomplete decisions to not treat seriously ill [people].” *Id.* at 5.

The United States Department of Justice’s two-year CRIPA investigation into the conditions at the Mississippi State Penitentiary (Parchman)²⁹ bolsters DRMS’ findings and provide a critical example of the severity of Mississippi’s correctional staffing crisis. In April 2022, the DOJ released *Investigation of the Mississippi State Penitentiary (Parchman)*,³⁰ a 59-page findings letter about its investigation. The DOJ concluded that the conditions at Parchman violated the Eighth and Fourteenth Amendments, and it provided notice of three conditions that violated the constitutional rights of incarcerated people at Parchman. One of those conditions—the MDOC’s failure to protect incarcerated people from violence at the hands of other incarcerated people³¹ is because of inadequate staffing, cursory investigate practices, and deficient contraband controls. *Id.* at 2.

The DOJ found that the “problems at Parchman are severe, systemic, and exacerbated by serious deficiencies in staffing and supervision. MDOC has been on notice of these deficiencies for years and failed to take reasonable measures to address the violations, due in part to non-functional accountability or quality assurance measures.” *Id.* at 2, 7-8.

“Years of MDOC’s deliberate indifference has resulted in serious harm and a substantial risk of serious harm to persons confined at Parchman,” including: “unlivable and unsanitary conditions throughout Parchman; violent murders and suicides on the rise; staffing plummeting to dangerous levels; and mounting concerns that gangs were filling the void left by inadequate staff presence and gaining increasing control of Parchman through extortion and violence.” *Id.* at 3. The DOJ also found correctional staff was “utterly overwhelmed” and “ultimately unable to adequately respond to fighting and significant injuries in multiple buildings” during a riot at Parchman. *Id.* MDOC’s staffing crisis and lack of supervision “essentially leaves individuals incarcerated at Parchman on their own,” and subjects them to “serious harm and an unreasonable risk of serious harm through grossly insufficient levels of security staff that result in lack of supervision and control.” *Id.* at 8.

²⁹ The DOJ’s investigation includes three other MDOC facilities: Southern Mississippi Correctional Institute; Central Mississippi Correctional Facility; and Wilkinson County Correctional Facility. Those investigations continue.

³⁰ <https://www.justice.gov/opa/pr/justice-department-finds-conditions-mississippi-state-penitentiary-violate-constitution>.

³¹ The DOJ’s other findings are: the MDOC’s failure to meet the serious mental health needs of incarcerated people, in part because of too few qualified mental health staff; and its failure to take adequate suicide prevention measures. This summary is limited to correctional staffing issues.

Honorable Cory Booker, Chair
 Honorable Tom Cotton, Ranking Member
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Despite recruitment efforts, Parchman has operated with half of the needed staff since 2018. *Id.* at 9. The staff vacancy rate is rising and resulting in the MDOC's failure to staff critical positions, ensure basic security, and maintain a presence inside dorms and housing units. *Id.* at 10.

The lack of visibility "prevents adequate supervision from outside the units, staff's general fear and willingness to enter the units, delays in response to critical incidents occurring on the housing units, and—incredibly—that incarcerated persons seemingly believe it is necessary to contact people outside the facility to get help." *Id.* at 11. Violence, homicides, and an "authority vacuum" have occurred because of the lack of supervision and staff fears. "Even when staff do observe an assault or emergency issue, the lack of available staff prevents from MDOC from responding effectively to critical incidents of harm." *Id.* at 11-12.

The department recommended minimal remedial measures that the MDOC should implement. The first measure, "Protection from Harm," focuses on correctional staffing. *Id.* at 51-54. The DOJ's numerous recommendations include:

- conducting a staffing study and ensuring that correctional staffing and supervision are appropriate to adequately supervise incarcerated people;
- contacting the National Institute of Corrections to discuss strategies and timeframes for increasing the number of officers and supervisors;
- properly screening, testing, hiring, and training officers, and determining how many are needed and assigned based on current vacancy rates;
- establishing competitive base salaries and benefits packages for officers;
- tracking turnover and reasons for departure annually, including cross-tabulating demographic data;
- improving opportunities for incarcerated people to participate in programming to reduce violence and abuse because of idle time;

Mississippi State Penitentiary
Staff Vacancy Rate

All Positions	Vacancy Rate
February 2018	43.1%
February 2019	38.9%
February 2020	47.0%

Security Positions*	Vacancy Rate
February 2018	47.5%
February 2019	43.4%
February 2020	53.5%

Correctional Officers	Vacancy Rate
February 2018	47.6%
February 2019	43.2%
February 2020	52.9%

DOJ's MSP Staff Vacancy Rate Table

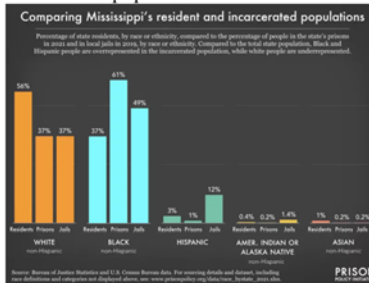
Honorable Cory Booker, Chair
 Honorable Tom Cotton, Ranking Member
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- adequately supervising housing units and common areas, and ensuring frequent, irregularly timed security rounds; and
- identifying and increasing security, surveillance, and screening, and deploying resources to staff.

Id. at 51-53.

One final note: the MDOC's correctional staffing crisis and long-troubled system is part of Mississippi's broader incarceration crisis. In 2022, Mississippi ousted Louisiana for the highest imprisonment rate in the country.³² From 1980 to 2022, Mississippi's prison population grew 396 percent because it implemented modest reforms that had short-lived gains or failed to fully implement reforms that could substantially reduce its incarcerated population.³³

According to Prison Policy Initiative, "Black and Hispanic people are overrepresented in the incarcerated population"³⁴ Two-thirds of incarcerated people in Mississippi are serving sentences of at least 10 years, but the parole grant rate has dramatically declined despite the passage of legislation that expanded parole eligibility.³⁵ In December 2022, *Mississippi Today* reported that "Mississippi—the world's leader in imprisoning people—will soon skyrocket past its capacity to hold them all," and that "Eldon Vail, an inspector of Mississippi prisons in recent years, called the alarming rate 'pouring gasoline on top of a fire that is already raging.'"³⁶



³² Jerry Mitchell, 'Foolishly sticking with failed system': Mississippi leads the world in mass incarceration, CLARION LEDGER (Aug. 13, 2022), <https://www.clarionledger.com/story/news/2022/08/13/mississippi-has-more-inmates-per-capita-than-any-state-nation/10317601002/>; FWD.us., *High Cost, Low Return: Mississippi's Ongoing Incarceration Crisis* (Nov. 2, 2022), <https://www.fwd.us/news/mississippis-ongoing-incarceration-crisis/>. FWD.us reports that Mississippi hands down thousands of new felony convictions annually, and these convictions have "hidden consequences such as excessive fines and fees, bans on employment, and the loss of voting rights.

According to one method of estimation, over 182,000 state residents (1 in 13) have a felony conviction. Felony convictions disproportionately affect Black people—1 in 7 Black Mississippians has a felony conviction." *Id.*
³³ *Id.* Additionally, Mississippi's jail incarceration rate is more than double the national average. *Id.* The "vast majority" of people jailed pretrial are charged with low-level misdemeanors and non-violent felonies, but they cannot afford bail and remain detained for lengthy periods of time. *Id.*

³⁴ PRISON POL'Y INITIATIVE, *Mississippi profile*, <https://www.prisonpolicy.org/profiles/MS.html>.

³⁵ FWD.us, *supra* note 3. One in five people in Mississippi's prisons have drug convictions. *Id.* The state's sentences for drug offenses are 34 percent, or 15 months longer, than the national average. *Id.*

³⁶ Jerry Mitchell, *Mississippi prisons may soon exceed capacity*, MISSISSIPPI TODAY (Dec. 6, 2022), <https://mississippitoday.org/2022/12/06/mississippi-prisons-capacity/>.

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Mississippi's incarceration crisis is fueled by its harsh and racially discriminatory laws, policies, and failed approach to crime, public safety, and reform. As one journalist opined, "[b]y locking away thousands in decrepit prisons that become breeding grounds for violence, Mississippi embodies the failure of mass incarceration – a criminal justice strategy experts have rightly denounced as a holdover of slavery."³⁷

In February 2024, the SPLC joined *Wallace, et al. v. Mississippi Department of Corrections, et al.*, a putative class action lawsuit challenging the Mississippi Department of Corrections' (MDOC) failure to provide adequate medical care, mental health care, and disability accommodations and services to people in the MDOC's custody. SPLC's interest in this case is driven by Mississippi's incarceration crisis—for example, several plaintiffs are being denied early release programs or have had their incarceration extended in the MDOC's horrific and inhumane facilities because of the challenged issues and systemic conditions—and failure to release people regardless of whether their convictions are violent or non-violent, or their medical, mental health, educational, rehabilitative, and other needs could be better served in the community.

The twin crises of overcrowding and understaffing in prisons across the U.S. are inflicting preventable despair, violence and death on incarcerated people on a daily basis. The U.S. should lead by example. Vigorously addressing these problems in federal Bureau of Prisons facilities through both improved recruiting and hiring practices and criminal legal system reforms that reduce reliance on mass incarceration while focusing on community safety is an important step that could ultimately provide a model for reform in the states. But unless and until such reforms take hold, the federal government must step up its intervention in the maintenance of unconstitutional, and deadly, conditions in state prisons. Congress should provide increased resources to the Department of Justice to conduct CRIPA investigations and enforce constitutional requirements, as well as to work with states through technical assistance and grant funding programs that target improved staffing and reduction of overcrowding.

³⁷ Ja'han Jones, *Mississippi prison embodies the failure of mass incarceration*, MSNBC (Apr. 21, 2022) <https://www.msnbc.com/the-reidout/reidout-blog/parchman-mississippi-doj-rcna25359> (noting that "Parchman has repeatedly been compared to a slave plantation due to its inhumane conditions and high population of Black people.").

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Thank you for holding a hearing on this important issue. If you have questions about this statement or need additional information, please contact Lisa Borden at lisa.borden@splcenter.org.

Sincerely,

A handwritten signature in black ink that reads "Sakira Cook". The signature is written in a cursive style with a large initial "S" and a distinct "C" for "Cook".

Sakira Cook
Federal Policy Director
Southern Poverty Law Center

🕒 10/01/2023 to 09/30/2024

Salary

\$57,911 - \$74,197 per year

Pay scale & grade

GL 08

Location

Prisons - Nationwide,

▶ MANY vacancies

Remote job

No

Telework eligible

No

Travel Required

Occasional travel - Training may be required for training and/or work related issues.