IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JOSHUA DUNN, *et al.*,

Plaintiffs,

v.

JEFFERSON DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections, *et al.*,

Defendants.

REDACTED - UNREDACTED VERSION FILED UNDER SEAL

CIVIL ACTION NO.
2:14-CV-00601-MHT-TFM

PLAINTIFFS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW REGARDING PHASE 2A

TABLE OF CONTENTS

TABLE OF AUTHORITIES

RULES AND REGULATIONS

INTRODUCTION

Prisoners in the Alabama Department of Corrections have brought this case to obtain a level of mental health care that does not violate the Eighth Amendment prohibition on Cruel and Unusual Punishment.

The (proposed) Mental Health Subclass are among the most vulnerable people in Alabama. They are in prison, mentally ill, easily victimized by other prisoners and by staff. They suffer pain that drives them to hurt themselves. They suffer from the voices in their heads. They suffer from depression. They suffer from an inability to behave as expected of them, resulting in punishment and further pain.

Defendants Ruth Naglich and Jefferson Dunn respond that each person has been seen by someone X number of times in Y number of months. They respond that the boxes indicating that a prisoner in segregation was seen have been filled in. They respond that a person who attempted suicide was placed in a safe cell until he declared that the desire to kill himself had passed. They respond that nurses – mostly Licensed Practical Nurses, unqualified to make any clinical assessments, assess prisoners' mental health status. They respond that there is some care provided and that, therefore, the care is good enough. It is not.

Defendants systematically underfund and understaff the mental health care system. They rely on under-licensed and unlicensed staff who are so overworked they cannot provide care, even if they were qualified to do so. They rely on cheap medications, even when they are not working or are causing side effects. They warehouse the mentally ill in mental health units that operate like segregation units and segregation units that shock the conscience. They forcibly medicate mentally ill prisoners without the niceties of due process. And then, Defendants fail to verify that care is, in fact, being provided. Inevitably, the care provided is far below the constitutional minimum.

I. PRELIMINARY FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. BACKGROUND FACTS

1. Alabama Department of Corrections and Defendants Commissioner Jefferson Dunn and Associate Commissioner Ruth Naglich

As of August 2016, there were 23,574 prisoners housed in facilities run by—and subject to the provision of mental health care provided by—the Alabama Department of Corrections (ADOC). Anticipated Trial Testimony of Ruth Naglich, Jefferson Dunn[1]; Pls. Tr. Ex. 121, August 2016 Monthly Report, Ala. Dep't of Corrections. ADOC prisons are operating at 177% of capacity. Tr. Test.

[1] Hereinafter, Anticipated Trial Testimony will be abbreviated as "Tr. Test."

of Ruth Naglich, Jefferson Dunn; Pls. Tr. Ex. 121, August 2016 Monthly Report, Ala. Dep't of Corrections (noting that minimum security work centers are at 150.9% of capacity; minimum security prisons are at 268.6% of capacity; medium security prisons are at 196.4% of capacity; and close security prisons are at 147.2% of capacity).

Defendant Jefferson Dunn is the Commissioner of the ADOC. Tr. Test. of Jefferson Dunn. He is the highest official of the ADOC. *Id*. Defendant Ruth Naglich is the Associate Commissioner for Health Services for the ADOC. Tr. Test. of Ruth Naglich. She heads the Office of Health Services ("OHS"). *Id*. Defendant Naglich is responsible for the administration of medical and mental health services to the incarcerated individuals in the ADOC. *Id*. Defendants Dunn and Naglich are sued in their official capacity only. Doc. 1.

2. Mental Health Care in the ADOC

There are thousands of prisoners in ADOC custody who suffer from a serious medical or mental health need. *See* Tr. Test. of Ruth Naglich, Teresa Houser, Dr. Craig Haney, Dr. Kathryn Burns; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016 (reporting 3,416 prisoners on the mental health caseload and 2,345 on psychotropic medication).[2]

[2] Because Trial Exhibit Numbers may be subject to change, Plaintiffs have included the description of the exhibits as well.

ADOC contracts with private providers, Corizon, Inc. ("Corizon") to provide medical and dental care, and MHM Services, Inc. ("MHM"), to provide mental health care to all prisoners in its custody. Tr. Test. of Ruth Naglich, Jefferson Dunn; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM; Doc. 734, Corizon-ADOC Medical Services Agreement. These contractual arrangements shift virtually all responsibility and risk from ADOC onto the private provider. *Id*. This risk-bearing model has promoted an overall trend of cost-cutting in the delivery of health care, despite significant increases in ADOC's prison population. Tr. Test. of Dr.Robert Hunter, Teresa Houser.

Ultimately, Commissioner Jefferson Dunn is responsible for health care and mental health care in ADOC facilities and Associate Commissioner Ruth Naglich and the Office for Health Services are responsible for monitoring the provision of health care in ADOC facilities. Tr. Test. of Jefferson Dunn, Ruth Naglich.

Under the leadership of Commissioner Dunn and Associate Commissioner Naglich, the provision of mental health care to ADOC prisoners suffers from numerous systemic deficiencies, including: inadequate mental health treatment; insufficient numbers and inadequate qualifications of mental health staff; understaffing of custodial staff, which prevents prisoners from accessing mental

health care; failure to identify prisoners with serious mental health needs in a timely fashion and, sometimes altogether; failure to respond timely, and sometimes altogether, to prisoner self-referrals; inadequate institutional staff referrals for mental health care; an inadequate system of classifying prisoners with serious mental illness; inadequate consideration of a prisoner's mental health state in disciplinary proceedings and in placement and monitoring in segregation; insufficiently appropriated facilities; poor record-keeping practices; and a failed system of medical grievances. Tr. Test. of Dr, Kathryn Burns, Dr. Craig Haney, Teresa Houser.

Other individuals involved in overseeing the provision of mental health care to prisoners in ADOC custody include: Teresa Houser, the Program Director for MHM in Alabama; Dr. Robert Hunter, the Chief Psychiatrist for MHM in Alabama; Laura Ferrell, Medical Systems Administrator for ADOC; Lynn Brown, Regional Clinical Manager for ADOC; and Brandon Kinard, Regional Clinical Manager for ADOC. Tr. Test. of Teresa Houser, Laura Ferrell, Lynn Brown, Brandon Kinard.

3. Contracts for the Provision of Mental Health Care

Defendants have contracted with private providers, Corizon and MHM, premising those contractual relationships on risk-bearing models that encourage decisions based on the cost of care and not the care itself. *See* Tr. Test. of Ruth

Naglich, Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. MHM is paid a fee for annual services and is entirely responsible for the actual cost of care. Tr. Test. of Jefferson Dunn, Kim Thomas, Ruth Naglich; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. This framework encourages providers to reduce their own costs by providing a minimum level of care. Tr. Test. of Dr. Robert Hunter, Teresa Houser.

In 2008, ADOC entered into a three-year contract with MHM Services, Inc. ("MHM") to provide mental health care in the ADOC facilities. Tr. Test. of Ruth Naglich, Kim Thomas; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. At that time, ADOC required the vendor to provide a total of 7.6 psychiatrists, 5 psychologists (with PhD's), 27.4 mental health professionals (counselors), 3 directors of nursing (registered nurses, or "RN's"), and 44.40 licensed practical nurses ("LPN") and specified how many of each should be assigned to each ADOC facility. Tr. Test. of Ruth Naglich, Kim Thomas; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. The vendor could substitute nurse practitioners for psychiatrists. Tr. Test. of Teresa Houser, Ruth Naglich. This was a substantial decline from the level of staffing set forth in the *Bradley* settlement. Tr. Test. of Dr. Kathryn Burns.

In 2009, MHM and ADOC amended the contract. Tr. Test. of Ruth Naglich; Pls. Tr. Ex. 128, 2009 Amendment to Mental Health Contract. The parties agreed that some of the responsibilities for the less seriously mentally ill prisoners would be transferred to the ADOC Psychological Associates, and the staffing by MHM would be reduced. *Id*. The transfer of responsibilities to ADOC Psychological Associates was referred to as Blending of Services. *Id*. The parties also eliminated the Contract Monitor position. *Id*.

In 2011, the contract was amended and extended for two additional years. Tr. Test. of Ruth Naglich, Kim Thomas, Teresa Houser; Pls. Tr. Ex. 671, Teresa Houser to Ruth Naglich, re changes related to Mental Health Services Agreement, April 14, 2011. At that time, the parties agreed to begin utilizing tele-mental health in outpatient treatment facilities; amend the method of invoicing and payment for psychotropic medication between Corizon, MHM, and ADOC; changed the minimum staffing levels; and reinstated the Contract Monitor position. *Id*.

The contract was again amended in 2012. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. In the 2012 amendment, the parties agreed that prisoners classified as Mental Health Code MH-1 would be seen only every ninety days rather than once a month and amended the criteria language for MH-1. Tr. Test. of Teresa Houser; Pls. Tr. Ex.

681, 2008 Mental Health Services Agreement and Amendments. The parties again amended the method of invoicing and payment for psychotropic medication between Corizon, MHM, and ADOC, changed the minimum staffing levels, and expanded the blending of services arrangement. *Id*.

In 2013, ADOC issued a Request for Proposals for a new mental health contract. Tr. Test. of Ruth Naglich, Teresa Houser; *see* Pls. Tr. Ex. 1092, MHM Proposal for Mental Health Services, re: RFP No. 2013-01, MHM025962-026465. The Request for Proposal indicated that the Minimum Required Staffing level was 144.95 full time employees. *Id*. MHM submitted a proposal, meeting the minimum staffing requirement. *Id*. ADOC informed MHM that MHM needed to bring down the price of the proposal. Tr. Test. of Teresa Houser. MHM submitted a new proposal with staffing of 126 full time employees. Tr. Test. of Teresa Houser.

ADOC and MHM entered into a three year contract for MHM to provide mental health care to ADOC prisoners. Tr. Test. of Ruth Naglich, Kim Thomas, Jefferson Dunn, Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. Although the numbers of people on the caseload had grown to 3,148, the total staffing under the contract was just 126 full time employees. *Id*.; Pls. Tr. Ex. 742, MHM Monthly Report, August 2013. Under the 2013 contract, MHM

was to provide just 6.2 psychiatrists and 3.5 psychologists for the entire ADOC system. *Id*. The 2013 MHM contract extended through the end of September 2016. *Id*.

The focus on cost savings has had the intended effect of significantly reducing the growth of the cost of healthcare over time, despite substantial growth and sickening of the prison population. Whereas the cost of medical and mental health services increased by 295% from 2000 to 2005, the average annual increase from 2006 to 2010 was only 6%. Tr. Test. of Kim Thomas, Ruth Naglich, Dr. Robert Hunter; Pls. Tr. Ex. 91, ADOC 2010 Annual Report, at 23, 27. Thereafter, the costs of medical and mental health care increased by just 7% over the entirety of Fiscal Year 2010 to Fiscal Year 2015. Tr. Test. of Kim Thomas, Ruth Naglich; Pls. Tr. Ex. 96, ADOC Annual Report 2015 at 24, Pls. Tr. Ex. 91, ADOC Annual Report 2010 at 27.

4. *Bradley v. Haley* Settlement Agreement

Sixteen years ago, in September 2000, ADOC entered into a settlement agreement that laid out, among other things, the threshold number of mental health staff at each level of education and experience to meet the mental health needs of the population of 20,619 male prisoners. Settlement Agreement, *Bradley v. Haley*, Civ. Action No 92-A-70-N (M.D. Ala., Sept. 28, 2000); Tr. Test. of Dr. Kathryn Burns, Ruth Naglich. ADOC admitted that the provisions set forth in the

settlement agreement were the requirements for an adequate mental health system. *Id*.

Mental health staffing levels in the most critical categories have fallen steadily since the implementation of the *Bradley* settlement in 2000:

	September 2000	**January 2012**	**January 2013**	**February 2016**
Prisoner census	20,619 *men only*	25,451	25,301	24,191
Psychiatric providers:	11	12.2	11.75	11.75
- Psychiatrists	8	6.75	5.5	4.95
- Nurse practitioners	3	5.45	6.25	7.05
Psychologists	10	5	3.25	3.5
MHPs	28	41.05	41.8	44.25*
RNs	3	3	3	3
LPNs	25	44.5	38.9	39.4
ATs	11	9	7.5	8
Clerical support	12.5	13.2	10.4	10.95

* This number includes 14 “site administrators” who are unlikely to carry a full caseload due to their other administrative responsibilities.
Abbreviations Key: Mental Health Professional (“MHP”), Registered Nurse (“RN”), Licensed Practical Nurse (“LPN”), Activities Technician (“AT”)

Tr. Test. of Ruth Naglich, Teresa Houser, Dr. Kathryn Burns; Settlement Agreement, *Bradley v. Haley*, Civ. Action No 92-A-70-N (M.D. Ala., Sept. 28, 2000); Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016.

As is clear from the above chart, the mental health staffing levels required by the *Bradley* settlement agreement are no longer being met for several categories of mental health staff and the staffing levels have not been adjusted to serve a larger prisoner population. Tr. Test. of Ruth Naglich, Jefferson Dunn, Teresa Houser. Notably, though the number of prisoners subject to these staffing numbers has risen by nearly 4,000[3], the number of psychologists has dropped from 10 to 3.5; the number of psychiatric providers has risen by only 0.75 and the number of psychiatrists has dropped from 8 to 4.95; the number of RNs has not changed; and the number of activities technicians has dropped by 3. Tr. Test. of Ruth Naglich, Teresa Houser, Dr. Kathryn Burns.

5. Distribution of Caseload Responsibilities between MHM and ADOC Mental Health Staff

In the 2009 amendment to the MHM-ADOC contract, the parties agreed that some of the responsibilities for the less seriously mentally ill prisoners would be

[3] The Bradley case addressed only male prisoners. The total population discussed in the Bradley settlement was the population of male prisoners. Tr. Test. of Dr. Kathryn Burns. The growth in population includes both changes to the total population and the inclusion of women in the total. Id.

transferred to ADOC Psychological Associates, and the staffing by MHM would be reduced. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. This transfer of responsibilities to ADOC Psychological Associates was referred to as Blending of Services. Tr. Test. of Teresa Houser, Kim Thomas, Dr. Kathryn Burns; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. Blending of Services was developed because MHM staff caseloads were growing too large but ADOC did not have the funds to pay MHM to hire more mental health staff. Tr. Test. of Teresa Houser.

There have been difficulties in implementing Blending of Services. Tr. Test. of Teresa Houser. For example, under the Blending of Services provisions in the contract, MHM site administrators are responsible for blending of services, but because site administrators do not have supervisory authority of ADOC psychological associates. *Id*. Instead, ADOC psychological associates report to the Wardens and Dr. David Tytell instead. *Id*. As a result, there has been conflict between site administrators and ADOC psychological associates. *Id*. Sometimes wardens wanted ADOC psychological associates to prioritize what they saw as more immediate job requirements rather than their mental health caseload. *Id*.

Blending of Services has also not been very effective in reducing MHM staff's caseloads because ADOC psychological associates have not taken on as

many cases as the Blending of Services arrangements allowed. Tr. Test. of Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 555, Email from T. Houser to R. Naglich, re For Discussion Blending of Services, July 17, 2015. For example, in December 2015, the two ADOC psychological associates at Elmore had only five prisoners between them on their caseloads while a part-time MHP was expected to serve 117 prisoners. Tr. Test. of Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 263, Email from A. Davis-Walker re Psych Associates at Elmore, Dec. 3, 2015.

MHM and ADOC have basically abandoned the attempt at Blending of Services. Tr. Test. of Teresa Houser. There are some facilities where it is officially not in practice. *Id*. In other locations, it is simply not effective. Tr. Test. of Teresa Houser.

Although MHM staff was reduced with the introduction of Blending of Services, MHM staff has not returned to its prior levels. Tr. Test. of Teresa Houser. To the contrary, staff has been reduced even further under the 2013 contract. Tr. Test. of Teresa Houser; *see* Staffing Levels Chart, at *supra* § I.A.4.

B. PLAINTIFFS' CLAIMS ARE JUSTICIABLE

1. Findings of Fact

a) Plaintiffs' Claims Are Continuing

All Named Plaintiffs have experienced continuing violations of their right to adequate mental health care. *See infra*, §II. All Named Plaintiffs and Mental

Health Subclass Members are at serious risk of receiving inadequate mental health care. *Id*. And all Named Plaintiffs experienced denials of adequate mental health care within the two-year statute of limitations period. *Id*.

b) Probationer Plaintiffs' Claims Are Not Moot

Since the filing of this lawsuit, Plaintiffs Businelle, Carter, Dunn, Dillard, and Moncrief have been conditionally released from ADOC's physical custody and remain subject to the conditions of probation. Tr. Test. of Richard Businelle, Howard Carter, Joshua Dunn, Robert Dillard, and Kenneth Moncrief.

Based on the high rates of recidivism among prisoners released from the ADOC, there is a reasonable likelihood—if not substantial—that they will return to the ADOC and be subject to ADOC's practices in the future. In fact, in the past, each of these named plaintiffs has returned to ADOC's physical custody after previously being released. *Id*. Recently, Plaintiff Joshua Dunn was released from ADOC's physical custody on May 20, 2016. Tr. Test. of Joshua Dunn. He is awaiting a hearing in Madison County Jail. *Id*. He is facing several new charges, as well as the possibility of probation revocation. *Id*. His case has been bound over to the grand jury. *Id*.

c) Plaintiffs Have Exhausted Available Administrative Remedies

A grievance process for prisoners with mental health grievances was not available during the relevant time period. A separate mental health grievance process that was not approved until July 12, 2016 applies to prisoners with mental health grievances and prisoners with medical grievances who are housed in RTUs. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 1091, Policy MHM-A11 (reviewed and approved on a July 12, 2016). That policy, however, was not in place during the relevant time period. *Id*.

Even if the July 2016 grievance policy was similar to a prior policy, if one existed, it is so confusing that neither prisoners nor MHM staff can understand it. Tr. Test. of Named Plaintiffs and Class Members, Teresa Houser. Prisoners learn of the mental health grievance process through a form entitled Orientation to Mental Health Service. Tr. Test. of Teresa Houser. That form states the following about mental health grievances: "If you believe the mental health services provided to you are inadequate, you may file an inmate grievance." Tr. Test. of Teresa Houser; Pls. Tr. Ex. 33, Inmate Orientation to Mental Health Services, at ADOC034315. There is no such thing as an inmate grievance. Tr. Test. of Ruth Naglich. It is unclear which form, if any, prisoners should use to submit a grievance, who they should give that form to, and what the appeal process is, if there is one. Tr. Test. of Named Plaintiffs and Class Members, Teresa Houser.

It is also unclear who is responsible for handling mental health grievances, and within what timeframe a response to a grievance must be communicated to a prisoner. Policy Number MHM-A11 specifies that "[u]pon receipt of a grievance related to mental health services, staff forward it to the Program Director or designee." Tr. Test. of Teresa Houser; Pls. Tr. Ex. 1091, Policy MHM-A11. After logging receipt of the complaint, the "Program Director or designee assigns a staff member to complete a face-to-face interview with the inmate and respond to the grievance in writing within the client's established time frame." *Id*. According to Ms. Houser, however, all grievances are initially taken to the site administrator, who determines what needs to happen next. Tr. Test. of Teresa Houser. It is unclear whether there is any specific amount of time given in the policy to respond to a grievance. *Id*.; Pls. Tr. Ex. 1091, Policy MHM-A11.

The mental health grievance process during the relevant time period was so opaque that prisoners do not know of its existence or understand it. Tr. Test. of Richard Businelle, Christopher Jackson. Thus, prisoners did not submit mental health grievances on a regular basis. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 168, Clinical Contract Compliance Review Report, March 2015. Although consideration of grievances is supposed to be part of Continuous Quality Improvement, not a single grievance was referenced in the MHM CQI meeting minutes prior to October 22, 2014. Tr. Test. of Teresa Houser; Pls. Tr. Ex., 670,

MHM CQI Quarterly Meeting Minutes, 2010-2015. Prior to that, the only mentions of the grievance process were to explain the process to staff. Tr. Test. of Teresa Houser; Pls. Tr. Ex., 670, MHM CQI Quarterly Meeting Minutes, 2010-2015, at MHM029503, 029506, 029517, 029519, 029550, 029552.

Further, MHM has itself recognized the rarity of mental health grievances. In MHM's annual audit of its services in ADOC, it stated:

> In order to assess the grievance process, reviewers interviewed MHM Site Administrators, reviewed the Grievance Log and the process for responding to grievances. All sites maintain a log but there were no entries in the log at Donaldson and Bullock and a single entry in 2013 but none in 2014 at Kilby. MHM Site Administrators indicated that they rarely receive grievances.

Tr. Test. of Teresa Houser; Pls. Tr. Ex. 105, ADOC Mental Health Services Implementation Review Report, April/May 2014, ADOC0140892, at 9. Similarly, in 2013, not every facility had a mental health grievance log, and of those that did, "many" listed no grievances. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 97, MHM Clinical Contract Compliance Report, 2013, ADOC0141610, at 13. There were three grievances logged at Tutwiler and two grievances at Limestone. *Id*.

If there is a mental health grievance procedure, it is unavailable due to correctional officers' inability or unwillingness to assist prisoners with the process or their intentional efforts to prevent prisoners from filing grievances. For example, Plaintiff Roger McCoy has been threatened if he fills out any grievance forms. Tr.

Test. of Roger McCoy. He has been told that if he writes particular officers' names on a grievance form, he will be put into segregation. *Id*. Plaintiff McCoy is aware of one individual who has been put in segregation as retaliation for filling out a grievance. *Id*.

Several areas of the RTUs are closed, with the prisoners locked up, much as they are in segregation. Tr. Test. of Dr. Craig Haney. These prisoners cannot obtain or submit grievance forms without the assistance of staff, creating further obstacles to grieving. *Id*.

Any absence of grievances in Plaintiffs' and Class Members' medical Records is not evidence that such grievances were not filed because Defendants' medical Records are incomplete and unreliable. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Dr. Raymond Patterson.

Despite the opacity of and obstacles to Defendants' mental health grievance process, some Named Plaintiffs have exhausted their mental health claims. Plaintiff Businelle filled out numerous sick calls asking for additional mental health treatment, which MHM considers to be grievances. Tr. Test. of Richard Businelle, Teresa Houser. And Plaintiff Moncrief submitted several requests regarding concerns about his mental health medications. Tr. Test. of Kenneth

Moncrief, which MHM likewise consider to be a grievance. Tr. Test. of Teresa Houser.

The administrative remedy for due process claims regarding involuntary medication is to appeal the decision to medicate. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 52, ADOC Admin. Reg. 621. Plaintiff Bui has exhausted his administrative remedies by filing such an appeal. Tr. Test. of Quang Bui. Plaintiffs Hartley, Dillard, Terrell, and McCoy have no avenue to obtain administrative relief because they cannot appeal the procedures in the involuntary medication hearings because they have not had hearings. Tr. Test. of Sylvester Hartley, Robert Dillard, Richard Terrell, and Roger McCoy.

2. Conclusions of Law

a) Plaintiffs' Claims Are Not Barred by the Statute of Limitations

Named Plaintiffs' claims are not barred by the applicable statute of limitations.

An "allegation of a failure to provide needed and requested medical attention constitutes a continuing tort, which does not accrue until the date medical attention is provided." *Lavellee v. Listi*, 611 F.2d 1129, 1132 (5th Cir.1980).

Where the Plaintiff complains of the continuing consequences of a violation of his constitutional rights, the statute of limitations is extended until the violation is remedied. *Baker v. Sanford*, 484 F. App'x 291, 293 (11th Cir. 2012).

Plaintiffs brought suit to terminate an ongoing systemic pattern and practice of failure to provide constitutionally adequate mental health care on the part of the ADOC and its contractual providers. Plaintiffs allege that the unlawful conduct was continuing as of the date the lawsuit was filed, and that it continues as of today. The particular episodes of deficient care alleged in the complaint are not invoked as separate claims for relief, seeking recovery on the basis of separate instances of compensable harm. They instead constitute examples of an ongoing pattern and practice of wrongful, unconstitutional acts and omissions reflecting deliberate indifference to the serious mental health needs of ADOC prisoners. *E.g.*, *Scott v. Clarke*, 64 F. Supp. 3d 813, 826 (W.D. Va. 2014).

The claims of Plaintiffs regarding inadequate mental health care are not barred by the statute of limitations due to the continuing nature of the violations, which continued after June 17, 2012.

b) Plaintiffs' Claims Have Not Been Made Moot by their Physical Release from Custody

The class claims of Plaintiffs Robert Dillard, Richard Businelle, Joshua Dunn, and Robert Moncrief are not mooted by their release from custody on

probation. While on probation, they each face a reasonable probability of re-incarceration.

Because they have mental health diagnoses that are of long duration, they will be subjected to the deficiencies in the mental health system if re-incarcerated.

The claims of Plaintiffs Robert Dillard, Joshua Dunn, and Robert Moncrief are not mooted by their release from custody, as they are "capable of repetition," but would evade review if considered moot.

c) Defendants Have Failed to Prove Plaintiffs Failed to Exhaust

Under the Prison Litigation Reform Act, failure to exhaust administrative remedies is an affirmative defense, which Defendants bear the burden of proving. *Woodford. v. Ngo*, 548 U.S. 81, 101 (2006); *Jones v. Bock*, 549 U.S. 199, 216 (2007); *Turner v. Burnside*, 541 F.2d 1077, 1082 (11th Cir. 2008).

Defendants have not established the affirmative defense of failure to exhaust administrative remedies.

Defendants' records are not sufficiently reliable to support the affirmative defense of failure to exhaust administrative remedies.

Defendants have not met their burden of proving the affirmative defense of exhaustion of administrative remedies because the inaccuracies in their records, including failure to maintain copies of grievances and inaccuracies in grievance tracking records, render the records insufficiently reliable. *See Spires v. Harbaugh*, 438 Fed. App'x 185, 187 n. 2 (4th Cir. 2011); *Alsobrook v. Alvarado*, 986 F. Supp. 2d 1312, 1323 (S.D. Fla. 2013); *Sheridan v. Reinke*, 2012 WL 1067079 (D. Idaho, Mar. 28, 2012); *Badwi v. Hedgepeth*, 2012 WL 479192 (N.D. Cal. Feb. 14, 2012); *Kress v. CCA of Tenn*., 2010 WL 2694986 (S.D. Ind., Jul. 2, 2010).

Exhaustion of administrative remedies is not required where, as here, an administrative procedure to obtain relief is unavailable. *Ross v. Blake*, 136 S. Ct. 1850, 1859 (2016).

An administrative procedure is unavailable where it operates as a dead end, with officers unable or consistently unwilling to provide any relief to aggrieved inmates.

An administrative procedure is unavailable when it is incapable of use, such as where the rules are so confusing that no reasonable prisoner can use them.

When considering exhaustion of remedies, the court must weigh a prisoner's inability to comply with administrative remedies due to a mental disability. *E.g.*,

Camplin v. Wexford Institutional, 2015 WL 9871635, at *3 (S.D. Ill., Dec. 21, 2015); *Peterson v. Hall*, 2012 WL 3111632, at *9 (E.D. Mich., July 2, 2012).

An administrative procedure is unavailable where prison officials thwart inmates' efforts to take advantage of the grievance process through machination, misrepresentation or intimidation.

There is no evidence to support the availability of a grievance process for prisoners housed in the RTUs at ADOC facilities.

The evidence does not support the availability of a functional grievance process for mental health services generally during the relevant period.

The 2016 mental health grievance policy submitted by Defendants is not relevant and does not support Defendants' assertion of failure to exhaust administrative remedies. Only the facts that existed at the time the complaint was filed are relevant to determining whether Plaintiffs have satisfied the exhaustion requirements under the PLRA. *Smith v. Terry*, 491 Fed. App'x 81, 83 (11th Cir. 2012).

To the extent a mental health grievance procedure arguably exists, it is so opaque and confusing as to be unavailable.

The plaintiff class has satisfied the PLRA's requirement of administrative exhaustion through vicarious exhaustion because one or more members of the class has exhausted administrative remedies with respect to each claim. *Chandler v. Crosby*, 379 F.3d 1278, 1287 (11th Cir. 2004).

Despite the inadequate availability of a mental health grievance process for prisoners in ADOC custody, Plaintiffs Dunn, Businelle and Moncrief successfully exhausted administrative remedies with regard to inadequate mental health care.

To the extent a grievance process is applicable to involuntary medication claims, Plaintiff Bui has successfully exhausted administrative remedies with regard to involuntary medication.

CLAIM 2 FACTUAL FINDINGS: DEFENDANTS ARE DELIBERATELY INDIFFERENT TO PLAINTIFFS' SERIOUS MENTAL HEALTH NEEDS

II. The Individually Named Mental Health Plaintiffs and Mental Health Subclass Members Have Serious Mental Health Needs

a) Plaintiff Edward Braggs

Plaintiff Edward Braggs has been diagnosed with anxiety, major depressive disorder, and PTSD. Tr. Test. of Edward Braggs. He takes medications for these conditions, but has received little other treatment. Tr. Test. of Edward Braggs. During most of the time he has been on the mental health caseload, he has been prescribed Tegretol, Remeron, and Trazodone. Tr. Test. of Edward Braggs; see

also Pls. Tr. Ex. 203, Braggs Med. Records, MR001618. Braggs made repeated efforts to get help with his medications because they made him sick. Tr. Test. of Edward Braggs. The only response he received to his many reports was that he could either take the medicine he was given or not take it. *Id*. No effort was made to address the side effects of Braggs' medications. Tr. Test. of Edward Braggs.

Plaintiff Braggs was not provided regular therapeutic meetings with a mental health provider even though mental health treatment plans purport to include them. Tr. Test. of Edward Braggs; see generally Pls. Tr. Ex. 203, E. Braggs Med. Records. Plaintiff Braggs was consistently prescribed psychotropic medications for his diagnosed mental health conditions but otherwise received little treatment. Tr. Test. of Edward Braggs; see generally Pls. Tr. Ex. 203, E. Braggs Med. Records. Such psychotropic medication management is the main treatment intervention provided by ADOC for mental health conditions. Tr. Test. of Dr. Kathryn Burns. Providing psychotropic medications without the necessary additional group and individual psychotherapy is generally considered to be ineffective. *Id*.

Plaintiff Braggs did not have meetings with a mental health provider to "discuss the benefits of positive self-talk, the consequences of his actions, and remaining goal-oriented" every 30 days, or "discuss stressors that lead to negative behavior" every 90 days, as the boilerplate language in his treatment plans directed. Tr. Test. of Edward Braggs; Pls. Tr. Ex. 203, E. Braggs Med. Records, at

MR001614, 001615, 001624, 001625, 001626; see generally Pls. Tr. Ex. 203, E. Braggs Med. Records. For long periods of time, the only meetings Plaintiff Braggs had with mental health providers were to discuss his medication compliance. Tr. Test. of Edward Braggs; Pls. Tr. Ex. 203, Med. Records of E. Braggs. Plaintiff Braggs did not receive regular therapeutic counseling, even while in segregation. Tr. Test. of Edward Braggs; Pls. Tr. Ex. 203, E. Braggs Med. Records.

Plaintiff Braggs received numerous disciplinaries and spent substantial amounts of time in segregation as a result of inadequate treatment for his mental health needs. Plaintiff Braggs also received disciplinaries and was subjected to segregation as a result of self-harm.

Treatment plans for Plaintiff Braggs were signed by licensed practical nurses ("LPNs") who received no registered nurse ("RN") supervision, and by ADOC's unlicensed site administrator. Tr. Test. of Dr. Kathryn Burns. Although LPNs are required to work under the supervision of an RN, only Bullock, Tutwiler and Bullock have an RN on mental health staff. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016. The very limited non-pharmaceutical treatment Plaintiff Braggs receives at Hamilton A&I is provided by unlicensed staff. Utilizing unlicensed mental health staff to provide psychotherapy to prisoners does not meet the standard of care. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson. Access to treatment other than medication for Braggs and

other prisoners with mental health needs at Hamilton A&I is severely limited by shortages in both mental health and custody staff, and by interference by custody staff.

Despite multiple diagnoses and the apparent need for several psychotropic medications, ADOC's mental health system classified Plaintiff Braggs as MH-1, a classification reserved for prisoners who are stabilized with mild impairment in mental function and can be housed in the general population or segregation. Tr. Test. of Dr. Kathryn Burns, Edward Braggs; Pls. Tr. Ex. 203, E. Braggs Med. Records, at MR000924. The mental health classification system at ADOC is flawed and does not correlate with the definition of serious mental illness, as evidenced by Plaintiff Bragg's continued classification as MH-1. Tr. Test. of Dr. Kathryn Burns.

b) Plaintiff Quang Bui

Plaintiff Quang Bui has been diagnosed with schizoaffective disorder, depressed type. Tr. Test. of Quang Bui; Pls. Tr. Ex. 1112, Q. Bui Med. Records, at MR043395.

In November 2007, Plaintiff Bui was first placed on an involuntary medication order. Tr. Test. of Dr. Robert Hunter, Quang Bui; Pls. Tr. Ex. 1112, Bui Med. Records, at MR002634-002635, 002633. Although the involuntary

medication request reviewed by the committee specified an order requiring an injection of 25 to 75 milligrams of Prolixin Decanoate, the notice provided to Plaintiff Bui did not specify the recommended medication that he would be subject to under the order, as required. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 1112, Q. Bui Med. Records, at MR002630-002635, 002810-002811.

Plaintiff Bui's involuntary medication order has been continuously renewed approximately every six months since November 2007. Tr. Test. of Dr. Robert Hunter, Quang Bui; Pls. Tr. Ex. 1112, Q. Bui Med. Records. Plaintiff Bui does not want to take the psychotropic medication he is involuntarily administered monthly via shot. Tr. Test. of Quang Bui.

As early as February 13, 2008, Plaintiff Bui's provider noted, "If he is awarded a continuation of the involuntary medications, I will probably titrate his dose of Haldol over the next several months." Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 1112, Q. Bui Med. Records, at MR002833. Two years later, the provider noted that Plaintiff Bui would be "a good candidate for discontinuing the involuntary medication order at next review." Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 1112, Q. Bui Med. Records, at MR002674-002675.

However, the involuntary medication committee has continually renewed the order since then, based on Plaintiff Bui's "lack of insight regarding his mental

illness," likelihood that he would stop taking medication if not forced, and recent gains from treatment. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 1112, Q. Bui Med. Records.

Plaintiff Bui has not been present at some of his involuntary medication hearings. Tr. Test. of Dr. Robert Hunter, Quang Bui; Pls. Tr. Ex. 1112, Q. Bui Med. Records.

On almost every occasion, Plaintiff Bui was not given notice of the recommended medication or the reason for the hearing, or both. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 1112, Q. Bui Med. Records.

For several of Plaintiff Bui's hearings, he did not receive timely notice. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 1112, Q. Bui Med. Records.

In several instances, Plaintiff Bui was not provided the assistance of a lay advisor to explain the purpose of the hearing and to assist in presenting objections to the order. Tr. Test. of Dr. Robert Hunter, Quang Bui; Pls. Tr. Ex. 1112, Q. Bui Med. Records.

Plaintiff Bui has repeatedly requested to be taken off of the involuntary medication order. Tr. Test. of Dr. Robert Hunter, Quang Bui; Pls. Tr. Ex. 1112, Q. Bui Med. Records.

c) Plaintiff Richard Businelle

Plaintiff Richard Businelle began having symptoms of mental illness as a teenager. Tr. Test. of Richard Businelle; Pls. Tr. Ex. 1117, R. Businelle Med. Records, at MR003214. Before coming to ADOC custody, he was housed in an inpatient psychiatric unit at Bryce Hospital. Tr. Test. of Richard Businelle, Dr. Craig Haney. Plaintiff Businelle has been diagnosed with paranoid schizophrenia, depression, and anxiety disorder. Tr. Test. of Richard Businelle, Dr. Craig Haney.

Plaintiff Businelle has been repeatedly subject to discipline for conduct related to his mental health status. Tr. Test. of Richard Businelle. Plaintiff Businelle fears retaliation or isolation if he complains to medical or mental health staff. Tr. Test. of Richard Businelle. When Plaintiff Businelle told his mental health counselor in the Bullock RTU that he was not doing well, he was put in isolation. Tr. Test. of Richard Businelle. The mental health stabilization unit in Bullock RTU is virtually identical to segregation units at other prisoners. Tr. Test. of Dr. Craig Haney.

Because Plaintiff Businelle fears segregation or isolation, he has denied experiencing mental health problems when asked by mental health counselors. Tr. Test. of Richard Businelle.

For Plaintiff Businelle, as is true throughout ADOC, residential and stabilization units have provided little treatment beyond psychotropic medication. Tr. Test. of Richard Businelle, Dr. Kathryn Burns. Individual contacts with mental health staff are brief, infrequent and often not conducted in confidential settings. Tr. Test. of Richard Businelle, Dr. Kathryn Burns. During his time in ADOC custody, the mental health treatment that Plaintiff Businelle has received has consisted primarily of medication administration and brief encounters with mental health staff. Tr. Test. of Richard Businelle, Dr. Craig Haney.

Plaintiff Businelle's prescription for mental health medications has changed repeatedly during his time in ADOC custody. Tr. Test. of Richard Businelle. Plaintiff Businelle takes a high dose of Prolixin decanoate. Tr. Test. of Richard Businelle; Pls. Tr. Ex. 1117, R. Businelle Med. Records, at MR003131, 003142. At times, he has been changed from an injectable to an oral dose of Prolixin. Tr. Test. of Richard Businelle. When Plaintiff Businelle does not receive the appropriate dose of Prolixin, he has auditory hallucinations. Tr. Test. of Richard Businelle, Dr. Edward Kern.

Counselors routinely spend no more than a few minutes with Plaintiff Businelle to provide purported "counseling." Tr. Test. of Richard Businelle. Even when Plaintiff Businelle sees mental health staff, the conversations with his counselor are cursory and involve little more than a brief conversation. Tr. Test. of

Richard Businelle; Pls. Tr. Ex. 1117, R. Businelle Med. Records. The interactions are nearly identical from one session to the next. Tr. Test. of Richard Businelle, Pls. Tr. Ex. 1117, R. Businelle Med. Records. The group therapy Plaintiff Businelle receives is equally inadequate. Tr. Test. of Richard Businelle.

Between November 2009 and May 2014, Plaintiff Businelle was classified with an MH3 mental health code for nearly three and a half years. Tr. Test. of Richard Businelle, Pls. Tr. Ex. 1117, R. Businelle Med. Records. An MH3 classification implies moderate impairment such as difficulty in social situations and/or poor behavioral control. Tr. Test. of Dr. Kathryn Burns. A person classified as MH3 should be housed in the RTU. *Id*. Plaintiff Businelle has not been eligible to have his security classification lowered because of his mental health status. Tr. Test. of Richard Businelle.

In mid-2014, Plaintiff Businelle's mental health code was lowered and he was moved to the main facility at Bullock, and then, at the end of 2014, to Bibb. Tr. Test. of Richard Businelle, Pls. Tr. Ex. 1117, R. Businelle Med. Records. At the main facility at Bullock and at Bibb, Plaintiff Businelle received even less counseling. *Id*. There were no groups for him to attend at Bibb.

He remained at Bibb until August 2016, when he was moved back to Bullock, shortly before his release on parole.

d) Plaintiff Howard Carter

Plaintiff Howard Carter has been diagnosed with Psychosis, Adjustment Disorder with Mood and Conduct Disturbance, Major Depressive Disorder, Borderline Personality Disorder, Schizoaffective Disorder, and Impulse Control Disorder. Tr. Test. of Plaintiff Howard Carter; Pls. Tr. Ex. 618, H. Carter Med. Records, at MR003240-003242.

Plaintiff Howard Carter has a long history of receiving psychotropic medications. Tr. Test. of Howard Carter. He has a history of repeated acts of self-harm, suicidal thoughts, and auditory hallucinations. Tr. Test. of Howard Carter; Pls. Tr. Ex. 618, H. Carter Med. Records. He received medications from a psychiatrist in the free world as early as 1993. Tr. Test. of Howard Carter. Upon entering ADOC custody, he was prescribed psychotropic medication. Tr. Test. of Howard Carter. At one time, Plaintiff Carter was prescribed Thorazine, but he did not wish to take because it made his heartbeat race. *Id*.

In September 2013, Plaintiff Carter was prescribed Tegretol and Remeron. Tr. Test. of Howard Carter; Pls. Tr. Ex. 618, H. Carter Med. Records, at MR003276, 003403. Both medications were abruptly discontinued by Dr. St. Phard. Tr. Test. of Howard Carter; Pls. Tr. Ex. 618, H. Carter Med. Records, at MR003276, 003403.

Plaintiff Carter's prescriptions were not reinstated for over a year. Tr. Test. of Howard Carter. Plaintiff Carter also went approximately a year in 2014 without seeing a psychiatrist. Tr. Test. of Howard Carter.

From 2011 until recently, Plaintiff Carter was continuously housed in segregation. Tr. Test. of Howard Carter; Pls. Tr. Ex. 618, H. Carter Med. Records. He was on "seg rotation," a practice whereby prisoners are rotated amongst segregation units at ADOC's maximum security facilities. Tr. Test. of Howard Carter, Lesleigh Dodd. Plaintiff Carter was not told why he was placed on seg rotation, and he has been attempting to come off since. Tr. Test. of Howard Carter. Plaintiff Carter has told mental health staff that he believes he has paranoia because of being in segregation. Tr. Test. of Howard Carter; H. Carter Med. Records, MR029623.

Plaintiff Carter has a long history of harming himself. Tr. Test. of Howard Carter. In July 2012, he reported to prison medical staff, "I am hearing voices, telling me to kill myself." Tr. Test. of Howard Carter; Pls. Tr. Ex. 618, H. Carter Med. Records, at MR00328. The plan for Plaintiff Carter's treatment was, "Release to DOC." Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 618, H. Carter Med. Records. In August 2012, a Body Chart was completed for Plaintiff Carter, because of a finding that he had a "potential for injury," but nevertheless recommending "Release to DOC." *Id*.

Plaintiff Carter often cuts himself with a razor when he is feeling suicidal or what he describes as "pressure building in me." Tr. Test. of Howard Carter. In 2014, he cut his arm with a razor while in a segregation cell. Tr. Test. of Howard Carter. Prior to cutting himself, he wrote to the mental health staff and told them that he was having suicidal thoughts. Tr. Test. of Howard Carter. No one from the mental health staff responded. Afterwards, he explained to the nurse that he was hearing voices and was subsequently placed on suicide watch. Tr. Test. of Howard Carter. In other instances, when he was able to speak with mental health staff about his suicidal feelings, he did not engage in self-injurious behavior. Tr. Test. of Howard Carter.

Plaintiff Carter has possessed razor blades in his segregation cell. Tr. Test. of Howard Carter. Plaintiff Carter sometimes swallows the razor blades that he uses to cut himself. Tr. Test. of Howard Carter. He is not always x-rayed when he reports he has swallowed a razor. Tr. Test. of Howard Carter.

On numerous occasions, Plaintiff Carter, like many prisoners, has been disciplined for cutting himself. Tr. Test. of Howard Carter, Lesleigh Dodd.

Plaintiff Carter's visits with mental health counselors are short and perfunctory. Tr. Test. of Howard Carter. Plaintiff Carter believes the mental health staff should speak with prisoners "more than once a month" and that those

meetings should include "making sure you're all right and coping." Tr. Test. of Howard Carter. He would like to see group mental health classes offered in segregation. Tr. Test. of Howard Carter.

ADOC staffing shortages have impacted Plaintiff Carter's access to mental health counseling. A number of Plaintiff Carter's mental health appointments have had to be rescheduled due to the "ADOC officer shortage." Tr. Test. of Howard Carter, Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 618, H. Carter Med. Records.

e) Plaintiff Robert Dillard

Plaintiff Robert Dillard was diagnosed with and received treatment for paranoid schizophrenia prior to his incarceration in ADOC. Tr. Test. of Robert Dillard.

In 2006, Plaintiff Dillard was transferred to the Bullock RTU. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 164, Dillard Class. & Move., at ADOC039023. Between 2006 and 2013, Plaintiff Dillard was shuttled between the Bullock main camp and the Bullock RTU. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 164, Dillard Class. & Move., at ADOC039023. During that time, his mental health code dropped from MH-3 in 2010 to MH-1[4] in 2012. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 112, Robert Dillard's Medical Records ("R. Dillard Med. Records"), at

[4] MH-1 is the lowest classification for a person to remain on the mental health caseload. Tr. Test. of Dr. Kathryn Burns.

MR004527. This change occurred despite Plaintiff Dillard's position that he did not want to reduce his mental health code or prescription dosage if it meant not getting the right treatment. Tr. Test. of Robert Dillard. In 2012, Plaintiff Dillard was released from the RTU to outpatient care at Bullock. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 164, Dillard Class. & Move., at ADOC039022. His mental health code, however, had increased to MH-2 by January 2013. Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR004666.

In 2014, Plaintiff Dillard's mental health code was again reduced to MH-1. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR004526. Plaintiff Dillard continued to hear hallucinatory voices, and as recently as May 2016 he reported during his individual counseling sessions that he continued to experience paranoia. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR048264. The level of care Plaintiff Dillard is receiving is inadequate for a person with continued auditory hallucinations and functional impairment. Tr. Test. of Dr. Kathryn Burns.

Since 2011, Plaintiff Dillard's regimen of psychotropic medications has changed frequently. Tr. Test. of Robert Dillard; *see also, e.g.*, Pls. Tr. Ex. 1120, R. Dillard Med. Records. Since 2011, Plaintiff Dillard has received different doses of Cogentin, Risperdal, and Haldol. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R.

Dillard Med. Records. Plaintiff Dillard was unaware of what medications he was taking. Tr. Test. of R. Dillard.

Plaintiff Dillard also does not know which conditions his medications treat. Tr. Test. of Robert Dillard. Although he has asked what the medications are for, medical and mental health staff do not answer. Tr. Test. of Robert Dillard. Similarly, when he has asked about the side effects of one of his medications, he has been told that he will be "alright" and that his medicine might make him only "a little dizzy." Tr. Test. of Robert Dillard.

Plaintiff Dillard's medications have had harmful effects on him. Tr. Test. of Robert Dillard. After Plaintiff Dillard started taking Zyprexa, he experienced dizziness, resulting in his falling out of his bunk and injuring himself. Tr. Test. of Robert Dillard. Though Dillard expressed his concerns about remaining on the medicine to medical staff, the doctor dismissed his concerns and continued to prescribe Zyprexa. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR040317, 040285, 048248.

Plaintiff Dillard takes medication that makes him sensitive to heat. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR022134. One result of overcrowding in ADOC facilities is that temperatures inside the facilities can be elevated to intolerable levels during summer months. Tr. Test. of Dr. Craig

Haney. At times, Plaintiff Dillard's dormitory has become overwhelmingly hot. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR043771. During extreme heat, Plaintiff Dillard has been unable to take his psychotropic medications because of his increased sensitivity to heat and resulting dizziness. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR043771.

On two occasions, Plaintiff Dillard has been given the wrong medicine. Tr. Test. of Robert Dillard. In early 2015, Plaintiff Dillard received the wrong medication at pill call. Tr. Test. of Robert Dillard. Approximately 15 minutes after taking the medication, he became dizzy and his head was "swimming around in circles." Tr. Test. of Robert Dillard. On another occasion in 2011, he was given the wrong medicine. Tr. Test. of Robert Dillard. That time, the nurse acknowledged that she gave him the wrong medication. *Id*. Plaintiff Dillard was brought to the infirmary, where he was given a shot and then brought back to his dormitory. *Id*. Plaintiff Dillard still felt "drained" the next day. *Id*. He could not get up or talk, so he slept until the effects of the medicine wore off. *Id*.

Plaintiff Dillard also has witnessed other prisoners receiving the wrong medication and being threatened with and sometimes subjected to force by corrections officers in order to compel them to take their medication. Tr. Test. of Robert Dillard. Plaintiff Dillard witnessed Emanuel James and Plaintiffs Robert

McCoy and Richard Businelle receive the wrong medicine, despite their protestations, on multiple occasions. Tr. Test. of Robert Dillard.

In one instance, Plaintiff Dillard witnessed Mr. James tell medical staff that he was given the wrong pills. Tr. Test. of Robert Dillard. Plaintiff Dillard saw officers grab Mr. James by the neck, throw him against the wall, and demand he take the medicine. Tr. Test. of Robert Dillard. Plaintiff Dillard also witnessed officers threaten Plaintiff McCoy that they would hold him down and force him to take his medicine. Tr. Test. of Robert Dillard. On several occasions, Plaintiff Dillard witnessed officers use physical force on Plaintiff McCoy to compel him to take his medication against his will. Tr. Test. of Robert Dillard.

Plaintiff Dillard's mental health treatment consists of little more than psychotropic medications. Tr. Test. of Robert Dillard. Plaintiff Dillard's "counseling" consists of occasional encounters that last no more than roughly five to ten minutes. Tr. Test. of Robert Dillard. The sessions are not individualized and progress notes are nearly identical for each encounter. Tr. Test. of Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med Records, at MR040321, 040325, 043768, 043775, 048261, 048273.

The progress notes consist mainly of documenting Plaintiff Dillard's statements rather than providing clinical observations. *See, e.g.*, Pls. Tr. Ex. 1120,

R. Dillard Med. Records, at MR004636, 004667, 004677, 040323. Plaintiff Dillard's access to group sessions or therapy is even less comprehensive. Tr. Test. of Robert Dillard. Also, while housed in the Bullock RTU, he was unable to exercise in the yard due to overcrowding.

f) Plaintiff Joshua Dunn

Plaintiff Joshua Dunn has a long history of mental illness and a history of inpatient mental health care. Tr. Test. of Joshua Dunn. He informed ADOC of this history upon arrival at ADOC in September 2012. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004937. He also informed ADOC that he was prescribed lithium at the time he entered custody. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004935, 004937.

Despite informing ADOC staff upon entry into custody of his history of mental illness and numerous subsequent self-harm incidents, Plaintiff Dunn was not placed on the mental health caseload. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records.

In June 2013, Plaintiff Dunn was placed in segregation. Starting in September 2013, Plaintiff Dunn began requesting to speak with mental health staff. Tr. Test. of Joshua Dunn. He made the requests on Inmate Request Slips because those were the only forms he could obtain for asking for help. Tr. Test. of Joshua

Dunn. Plaintiff Dunn also called to mental health staff and correctional officers out the window of his segregation cell, asking to speak with mental health staff. Tr. Test. of Joshua Dunn.

Between September 2013 and March 2014, Plaintiff Dunn cut himself with razors on five separate occasions. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004854, 004830, 004824, 004887, 004812. He threatened self-harm on another occasion, five days before actually engaging in self-harm. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004930. On each of these occasions, Plaintiff Dunn was placed in suicide watch. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004854, 004830, 004824, 004887, 004812, 004930. On a couple of these occasions, Plaintiff Dunn was attempting to kill himself, but did not know how to accomplish that. Tr. Test. of Joshua Dunn.

During the period Plaintiff Dunn was in segregation and engaging in self-harm, he repeatedly stated that he was suffering from stress and the need for social interaction. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004900-004907, 004893. Social isolation of the sort created by segregation is potentially very harmful to health and psychological well-being. Tr. Test. of Dr. Craig Haney. Many of Plaintiff Dunn's symptoms and behaviors are the kinds of

problems that have been well documented in studies on the effects of segregation. Tr. Test. of Dr. Craig Haney.

In the ADOC, there is supposed to be a crisis intervention treatment plan created within one working day every time a person is placed on suicide watch. ADOC Admin. Reg. 629(D). There was no treatment plan at all after Plaintiff Dunn's self-harm incidents on September 6, 2013 and February 11, 2014. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records.

There were treatment plans for his other crises, but most indicated that the persons who were supposed to participate in the treatment planning did not do so. Tr. Test. of Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004900-004907, 004893. Although treatment plans are supposed to be reviewed every day when a prisoner is in suicide watch, ADOC Admin. Reg. 630(5)(b), many of the days Plaintiff Dunn was on suicide watch, there was no updated plan or indication that his plan was reviewed. Tr. Test. of Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004893-004907. Several of the treatment plans do not indicate anything about what mental health staff will do to assist Plaintiff Dunn in addressing his mental health needs. Tr. Test. of Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004903-004907.

On September 16, 2013, after the first incident of self-harm, a mental health staff member acknowledged that Plaintiff Dunn had "limited coping skills" and needed to develop them. Tr. Test. of Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004908. No plan was created or implemented to help him do so. Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 631, J. Dunn Med. Records.

Plaintiff Dunn did not see mental health staff again until November 20, 2013 when he had threatened to engage in self-harm. Tr. Test. of Teresa Houser, Dr. Robert Hunter, Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004930.

While on suicide watch from November 20 to 22, 2013, Plaintiff Dunn had three brief encounters with mental health. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR004927-004930. Although he was recognized as "maladaptive," the mental health notes do not indicate anyone helped him or created a plan to develop better coping skills. Tr. Test. of Teresa Houser, Dr. Robert Hunter, Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records. The contacts appeared to be brief cell front contacts to ask Plaintiff Dunn whether or not he remained suicidal. *Id*.

Plaintiff Dunn returned to suicide watch on November 25, 2013. Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004845. He remained in the crisis cell until December 5, 2013. He had 10 brief encounters, mostly at cell front, with mental health staff. Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004902-004906, 004918-004926. No mental health staff attempted to help Plaintiff Dunn develop coping skills or better methods for dealing with his stress. *Id*. With the exception of a small number of contacts with the nurse practitioner, the contacts were brief cell front contacts to ask Plaintiff Dunn whether or not he remained suicidal. *Id*.

After his release from suicide watch on December 5, 2013, Plaintiff Dunn was not seen again by mental health staff until after he was placed on suicide watch on January 18, 2014 – after engaging again in self-harm. Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004830.

Plaintiff Dunn was not seen by mental health staff until January 20, 2014. Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004917, 004901. He remained in a crisis cell until January 22, 2014. Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004899. Plaintiff Dunn was seen by

mental health staff two more times while in the crisis cell. Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004899-004900. He was documented as reporting, "I'm losing my mind in seg. Can't talk to my wife. No phone calls in eight months" and that he could not "take being locked up." Tr. Test. of Joshua Dunn, Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004917, 004914. He told the nurse practitioner that he wanted to go to the mental health unit at Donaldson, and that he came to the crisis cells (i.e., engaged in self-harm), "so [he] could get his thoughts together." Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004914.

With the possible exception of the contact with the nurse practitioner, Plaintiff Dunn's contacts with mental health staff were brief cell front contacts to ask Plaintiff Dunn whether or not he remained suicidal. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004899-004900. Although nurse practitioner Coogan indicated that Plaintiff Dunn had poor coping skills and the treatment plans from this period indicated that Plaintiff Dunn "will identify and discuss coping strategies," no such discussions occurred. *Id*.

Plaintiff Dunn was not seen again by mental health staff until he was placed on suicide watch on February 11, 2014 after engaging again in self-harm. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at

MR004824. Plaintiff Dunn remained in the crisis cell from February 11th to 14th, 2014. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004791. He was not seen by any mental health staff until February 14. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004913. Plaintiff Dunn had no discussions with mental health staff about how to better deal with his stress. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004830. The only contact he had with mental health staff was a brief cell front contact to ask him whether or not he remained suicidal. *Id*.

Plaintiff Dunn did not see mental health staff again until March 17, 2014, three days after he cut himself so badly he had to be sent to the emergency room. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004812, 004893. On that occasion, Plaintiff Dunn was in the crisis cell from March 15 to 17, 2014. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR029658. For the first time, mental health staff documented discussion of a "more adaptive response, e.g. talking [with] counselor." Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records, at MR004895. Plaintiff Dunn was then returned to segregation and was not seen by mental health again until July 2014. Tr. Test. of Joshua Dunn, Teresa Houser; Pls. Tr. Ex. 621, J. Dunn Med. Records.

The short, cell-front check-ins during Plaintiff Dunn's crises, which were mostly limited to asking Plaintiff Dunn if he was suicidal, are consistent with the mental health crisis practices throughout the ADOC. Tr. Test. of Dr. Kathryn Burns. This is deficient treatment. *Id*. The follow-up care after release from crisis cells is also deficient system-wide and was deficient in Plaintiff Dunn's case. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson.

When a prisoner is in crisis, ADOC staff are required to observe the prisoner at irregular, unpredictable fifteen-minute intervals to ensure the prisoner is not in danger or harming himself. Tr. Test. of Dr. Kathryn Burns. These fifteen-minute observations are to be recorded contemporaneously. *Id*. ADOC did not conduct the required fifteen-minute observations of Plaintiff Dunn when he was in suicide watch. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 631, J. Dunn Med. Records.

g) Plaintiff Daletrick Hardy

Plaintiff Daletrick Hardy has been diagnosed with Borderline Personality Disorder, Depressive Disorder, Dysthymic Disorder with Post-Traumatic Stress Disorder. Tr. Test. of Daletrick Hardy; Pls. Tr. Ex. 177, D. Hardy Med. Records. His Dysthymic Disorder and Borderline Personality Disorder persist today. Tr. Test. of Daletrick Hardy. Plaintiff Hardy continues to suffer from depression and stress related to his conditions. *Id*.

Despite Plaintiff Hardy's long history of mental health issues, he was removed from the mental health caseload while he was in segregation in 2010. Tr. Test. of Daletrick Hardy. Mental health staff did not consult with Plaintiff Hardy before determining that he was stable enough to discontinue therapy. Tr. Test. of Daletrick Hardy. Mental health staff did not even inform Plaintiff Hardy of the decision to discontinue his sessions. Tr. Test. of Daletrick Hardy. Rather, Plaintiff Hardy only learned of the decision to remove him from the case load when he was not called from his segregation cell for his mental health counseling session. Tr. Test. of Daletrick Hardy. He learned about the decision when he saw a doctor briefly during segregation rounds. Tr. Test. of Daletrick Hardy. Plaintiff Hardy was taken off the mental health caseload because he was not prescribed psychotropic medication. Tr. Test. of Daletrick Hardy.

Plaintiff Hardy has a long history of self-harm. He was admitted to a crisis or suicide watch cell at least 18 times in six years between 2006 and 2012:

Date	Facility	Bates No.
February 7, 2012	Donaldson	MR006066
December 4, 2011	Donaldson	MR006207.22
April 20, 2010	Donaldson	MR006207.24
October 14, 2009	Donaldson	MR006207.25
June 25, 2009	Donaldson	MR006207.26
April 29, 2009	St. Clair	MR006197
April 13, 2009	St. Clair	MR006201
April 10, 2009	St. Clair	MR006202
April 8, 2009	St. Clair	MR006203

November 14, 2008	St. Clair	MR006205
September 12, 2008	Limestone	MR006207
May 25, 2008	Limestone	MR006207.440
April 25, 2008	Limestone	MR006207.27
April 8, 2008	Limestone	MR006207.27
July 18, 2007	Fountain	MR006207.450
May 4, 2007	Fountain	MR006207.461
January 23, 2007	Fountain	MR006207.466
August 17, 2006	Fountain	MR006207.467

Tr. Test. of Daletrick Hardy; Pls. Tr. Ex. 177, D. Hardy Med. Records; Pls. Tr. Ex. 153, D. Hardy Class. & Move. History.

Since being removed from the mental health caseload, Plaintiff Hardy has attempted to hurt himself numerous times. Tr. Test. of Daletrick Hardy; Pls. Tr. Ex. 177, D. Hardy Med. Records, at MR006066, MR006207.22. Even after those incidents of self-harm, he was not put back on the mental health caseload. Tr. Test. of Daletrick Hardy, Dr. Craig Haney.

Even when Plaintiff Hardy was on the mental health caseload, he did not receive any mental health treatment other than medication, even in the RTU at Bullock. Tr. Test. of Daletrick Hardy. Plaintiff Hardy did not have the opportunity to participate in counseling sessions or groups while on the caseload but rather would just briefly encounter mental health staff. *Id*.

Plaintiff Hardy would like to be on the mental health caseload again. Tr. Test. of Daletrick Hardy. Plaintiff Hardy believes he would particularly benefit from counseling to help address his mental health needs. Tr. Test. of Daletrick

Hardy. Yet as far as Plaintiff Hardy knows, the only way he can access mental health treatment at all is if he takes medication. Tr. Test. of Daletrick Hardy. While he is open to doing so to address symptoms that still affect him, the medications make Plaintiff Hardy tired and slow. Tr. Test. of Daletrick Hardy.

h) Plaintiff Sylvester Hartley

Plaintiff Sylvester Hartley was diagnosed with schizophrenia prior to January 18, 1984. Tr. Test. of Dr. Robert Hunter, Sylvester Hartley. Plaintiff Hartley has had disturbed sleep cycles since at least 1994. Tr. Test. of Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR027116, 028611-028616. He has been on Prolixin shots since at least March 2007. Tr. Test. of Dr. Robert Hunter, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR027090 (Mar. 20, 2007), 028564 (noting consent to Prolixin on Jan. 20, 2009), 028553 (Aug. 10, 2010), 028503 (Nov. 25, 2011). He has complained about the Prolixin shots. Tr. Test. of S. Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR028516 (Apr. 15, 2011), 028573 (Mar. 4-5, 2010). However, Plaintiff Hartley was still taking Prolixin shots as of April 2016. Tr. Test. of Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records at MR028573.

Plaintiff Hartley has also complained of shaking caused by his shots. Tr. Test. of Dr. Robert Hunter, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR028573, 028567, 028564, 028514. Plaintiff Hartley requested to

switch to a different medication, Resperidol, that he believed would not make him shake. Tr. Test. of Dr. Robert Hunter, Sylvester Hartley; Pls. Tr. Ex. 1140, at MR028573. He has also asked for more Cogentin, a medication that is supposed to reduce the shaking. Tr. Test. of Dr. Robert Hunter, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records at MR028562, 028563. But Plaintiff Hartley's Cogentin dosage had to be decreased because he has renal problems and the Cogentin affected his sodium levels. Tr. Test. of Dr. Robert Hunter, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR028570 (Mar. 26, 2010).

Plaintiff Hartley has auditory and visual hallucinations. Tr. Test. of Sylvester Hartley. He was classified as MH-3 from June 13, 2012 to February 14, 2013, and again starting on October 3, 2013 through at least August 27, 2015. Tr. Test. of Dr. Robert Hunter, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR006209, 006211, 044256, 044265. Since his transfer to St. Clair Correctional Facility on March 31, 2004, he has been placed in a crisis cell 89 times. Tr. Test. of Jefferson Dunn, Ruth Naglich, Sylvester Hartley; Pls. Tr. Ex. 166, S. Hartley Class. & Move., at ADOC038905-038917.

Plaintiff Hartley believes that the reason he engages in self-harm is his use of marijuana and other drugs. Tr. Test. of Sylvester Hartley. But his treatment plans do not address his marijuana abuse and resultant dysfunction. Tr. Test. of

Dr. Robert Hunter, Teresa Houser, Dr. Raymond Patterson; Pls. Tr. Ex. 1140, S. Hartley Med. Records. Interventions to adequately address Plaintiff Hartley's chronic marijuana abuse and the resultant mental dysfunction including his aggression and agitation, and self-injurious behaviors have not been included in his treatment, and he continues to abuse marijuana infrequently. Tr. Test. of Dr. Raymond Patterson, Sylvester Hartley. The last time Plaintiff Hartley was told he should attend a substance abuse program ("SAP") was in 1991. Tr. Test. of Sylvester Hartley.

Plaintiff Hartley's treatment plans often repeat problem statements, interventions, and goals without noting changes in Hartley's mental status and behaviors. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR044246-044253, 048490. Plaintiff Hartley's treatment team meetings are not attended by the required participants. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR006836-006840, 006842-006843, 006857.

The large majority of Plaintiff Hartley's contacts with mental health staff include no or minimal counseling. Tr. Test. of Sylvester Hartley, Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 1140, S. Hartley Med. Records.

On at least one occasion, Plaintiff Hartley's mental health counseling session was cancelled because the ADOC was using the room for interviews. Tr. Test. of Sylvester Hartley, Teresa Houser; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR029807. Plaintiff Hartley's mental health contacts have also been cancelled due to a shortage of correctional officers. Tr. Test. of Sylvester Hartley, Teresa Houser; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at, MR006948.

From January 1, 2016 through May 3, 2016, Plaintiff Hartley was seen by mental health staff ten times. Tr. Test. of Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR048491-048501. Of the ten occasions on which Plaintiff Hartley was seen by mental health staff from January 1, 2016 through May 3, 2016, six were solely for the purpose of giving Plaintiff Hartley an injection of Prolixin. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR048491, 048492, 048497, 048499, 048501. One occasion was a check-in while he was in a crisis cell. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR048500. During this four-month period, he had only two "monthly" counseling sessions, and one visit to the nurse practitioner for a medication check. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR048500, 048498, 048496.

On February 22, 2016, Plaintiff Hartley was seen by the mental health staff in a crisis cell. Tr. Test. of Teresa Houser, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR048500. But no psychiatrist, licensed psychologist, or member of the ADOC psychology staff released Plaintiff Hartley from the crisis cell. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR048491-048501, 048429.

Plaintiff Hartley was in segregation from August 31, 2000 through August 25, 2005. Tr. Test. of Sylvester Hartley, Grantt Culliver; Pls. Tr. Ex. 166, Hartley Class. & Move., at ADOC038917-038918. Plaintiff Hartley was required to remain in segregation after finishing his segregation term because there was no bed for him to move to. Tr. Test. of Grantt Culliver, Teresa Houser, Sylvester Hartley; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR028576 (Feb. 9, 2010). On at least six occasions, Plaintiff Hartley has been transferred to a bed that already contained another prisoner. Tr. Test. of Grantt Culliver; Pls. Tr. Ex. 166, S. Hartley Class. & Move., at ADOC038912, 038910, 038907, 038906.

i) Plaintiff Christopher Jackson

Plaintiff Christopher Jackson has been classified as a mental health code MH-1 throughout his incarceration, despite having been diagnosed with schizo-type 1 personality disorder and mood disorders with severe behavioral disturbances. Tr. Test. of Teresa Houser, Christopher Jackson; Pls. Tr. Ex. 150, C.

Jackson Med. Records, at MR007585-007586, 044469. His mental health code was increased to MH-2 in January 2016. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 150, C. Jackson Med. Records, at MR048590. He has been prescribed multiple mental health medications throughout his incarceration, including Haldol, Cogentin, Remeron, and Tegretol. Tr. Test. of Teresa Houser, Dr. Robert Hunter; Pls. Tr. Ex. 150, C. Jackson Med. Records, at MR007623. Plaintiff Jackson stopped taking Haldol because it was making him shake and feel slow. Tr. Test. of Christopher Jackson. Mental health staff were aware that he was experiencing these side effects, but did not offer to change his medications or inform him that there were other antipsychotic medications that do not have the same side effects. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Christopher Jackson.

Plaintiff Jackson has a history of suicidal ideation. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Christopher Jackson; Pls. Tr. Ex. 150, C. Jackson Med. Records, at MR007716, 007760, 007736. He also has reported having "visions." Tr. Test. of Christopher Jackson. He has been placed in suicide watch or mental health observation on multiple occasions and as recently as September 2015. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Christopher Jackson; Pls. Tr. Ex. 150, C. Jackson Med. Records, at MR007618, 007620, 007622, 044516. Mental health staff do not regularly check on him when he is in the crisis cell. Tr. Test. of Christopher Jackson.

Plaintiff Jackson has had limited access to mental health treatment other than medication management. Tr. Test. of Christopher Jackson. While mental health counselors do come by his cell, "they rush through" and only want to know if the prisoners are suicidal. Tr. Test. of Christopher Jackson. He has also missed mental health appointments because of ADOC security issues and correctional staffing shortages. Tr. Test. of Christopher Jackson; Pls. Tr. Ex. 150, C. Jackson Med. Records, at MR007749, 007752, 007874, 030812. He has not participated in any group counseling since around the end of 2013. Tr. Test. of Christopher Jackson.

For several years, Plaintiff Christopher Jackson has been on "segregation rotation," meaning that he is frequently transferred from one facility's segregation unit to another's. Tr. Test. of Christopher Jackson, Jefferson Dunn; Pls. Tr. Ex. 152, Jackson Class. & Move., at ADOC038929-038937. Segregation has taken a toll on Plaintiff Jackson's mental health, increasing his anxiety. Tr. Test. of Christopher Jackson.

During the pendency of this lawsuit, Plaintiff Jackson was released to general population. Tr. Test. of Christopher Jackson. In April 2016, he was beaten by correctional officers, and placed back in segregation. Tr. Test. of Christopher Jackson. Starting in the early summer of 2016, Plaintiff Jackson repeatedly requested to meet with mental health staff, but has not seen them, with the

exception of segregation rounds. *Id*. Plaintiff Jackson feels that he is in need of mental health treatment and at risk of acting out. *Id*.

j) Plaintiff Brandon Johnson

Plaintiff Brandon Johnson has been in ADOC custody since 1996 and has been at Donaldson Correctional Facility for all but a few months of that time. Tr. Test. of Brandon Johnson, Grantt Culliver; Pls. Tr. Ex. 151, Johnson Class. & Move.

Plaintiff Johnson has difficulty following conversation and answering questions. Tr. Test. of Brandon Johnson. He is aware of his cognitive difficulties and gets frustrated by them. Tr. Test. of Brandon Johnson.

Plaintiff Johnson does not read or write well. Tr. Test. of Brandon Johnson. ADOC officials have approved Johnson for work as a "laborer," and he washes dishes in the kitchen. Tr. Test. of Brandon Johnson.

Because Plaintiff Johnson is easily confused and does not read and write well, he often seeks help from others. His uncle, Bobby Gene Carter, who is also in custody at Donaldson and worked in the law library there for years, regularly gives Plaintiff Johnson advice and assistance. Tr. Test. of Brandon Johnson. Plaintiff Carter and others at Donaldson write sick call requests and other documents for Plaintiff Johnson. Tr. Test. of Brandon Johnson. Plaintiff Carter has completed the

majority of Plaintiff Johnson's sick call slips as well as other written documents, including post-conviction filings and grievances. Tr. Test. of Brandon Johnson. Other prisoners working in the prison law library at Donaldson have assisted Plaintiff Johnson in these tasks as well. *Id*. Plaintiff Johnson often hand-copies documents written by others verbatim, including sick call requests and legal materials, rather than submitting those documents in others' handwriting. *Id*.

Although some prisoners are helpful to Plaintiff Johnson, he is mistreated by others. Tr. Test. of Brandon Johnson. Plaintiff Johnson is also mistreated by prison staff. He has been hit and pushed by correctional staff. Tr. Test. of Brandon Johnson. And there are times when Plaintiff Johnson cannot understand orders from correctional staff, and correctional staff refuse to help him understand the rules at Donaldson. Tr. Test. of Brandon Johnson.

During his pre-conviction evaluation, Taylor Hardin psychiatric staff recognized that Plaintiff Johnson was depressed, possibly psychotic, and potentially incompetent to stand trial. Tr. Test. of Brandon Johnson, Dr. Robert Hunter; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR047700. And during his intake mental health screening at Donaldson, staff noted that Plaintiff Johnson "[l]acks insight," is "antisocial" and "depressed," and needs "reality therapy," "values clarification," treatment for "depression," and programming to help him develop "self-concept enhancement" and "healthy use of leisure" and "to reduce

distress/assist with adjustment to incarceration." Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR008246-008248.

Nevertheless, Plaintiff Johnson's first encounters with mental health staff did not occur until around the time he was placed on suicide watch in November 2015, nearly twenty years after he entered ADOC custody. Tr. Test. of Dr. Robert Hunter, Brandon Johnson; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR047665, 047666, 047667, 047698, 047700-047752. While Plaintiff Johnson was on suicide watch in November 2015, Dr. Hunter observed that he was experiencing "paranoia & possible delusions." Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR047700. Dr. Hunter also found it noteworthy that Plaintiff Johnson had not been on the mental health caseload despite the conclusions made in his Taylor Hardin evaluation. *Id*. The psychiatrist, MHM's Chief Psychiatrist Dr. Robert Hunter, expressed optimism that Plaintiff Johnson's involvement in the instant lawsuit might afford him some relief related to his mental health status: "He is now involved with SPLC to perhaps go to court given the beforementioned." *Id*.

When Plaintiff Johnson was released from suicide watch and placed in segregation, he was provided no mental health follow-up or counseling, despite mental health staff's recognition that he might need mental health treatment. Tr. Test. of Brandon Johnson, Dr. Craig Haney. Weeks after he was released from

suicide watch, Plaintiff Johnson was referred for mental health treatment in January 2016. Tr. Test. of Brandon Johnson; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR047699. However, he did not actually receive any subsequent mental health treatment. Tr. Test. of Brandon Johnson; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR047699; Pls. Tr. Ex. 142, B. Johnson Med. Records (showing no further evidence of mental health care). Other than those few visits with mental health staff in 2015 and 2016, Plaintiff Johnson has received no mental health care while in ADOC custody. Tr. Test. of Brandon Johnson, Dr. Craig Haney; Pls. Tr. Ex. 142, B. Johnson Med. Records.

Despite his mental health issues and disability, Plaintiff Johnson has been placed in administrative or disciplinary segregation on multiple occasions. Tr. Test. of Brandon Johnson; Pls. Tr. Ex. 151, Johnson Class. & Move. On one occasion, Plaintiff Johnson was placed in segregation after flooding his cell because his niece had recently died, causing him to feel overwhelmed. Tr. Test. of Brandon Johnson. Plaintiff Johnson was once held in administrative segregation for seven months. Tr. Test. of Brandon Johnson, Dr. Craig Haney. When in segregation, Plaintiff Johnson is only allowed to go to the exercise yard once a month, and is only visited very briefly by mental health staff once every week or two. Tr. Test. of Plaintiff Brandon Johnson.

k) Plaintiff Roger McCoy

Plaintiff Roger McCoy has been housed at seven different facilities within the ADOC since his entry into Kilby on May 2, 1994. Tr. Test. of Roger McCoy; Pls. Tr. Ex. 165, McCoy Class. & Move., at ADOC039087.

Plaintiff McCoy is delusional. Tr. Test. of Roger McCoy, Cassandra Lee, Dr. Kathryn Burns; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR010011. He has been diagnosed as having schizophrenia and "delusional beliefs." Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR010011. Plaintiff McCoy regularly experiences symptoms of depression. Tr. Test. of Roger McCoy.

Despite Plaintiff McCoy's acute mental health needs, he has spent the vast majority of time in custody receiving an outpatient level of care. Tr. Test. of Roger McCoy, Grantt Culliver; Pls. Tr. Ex. 165, McCoy Class. & Move., at ADOC039087-039090. From 1994 to 2014, Plaintiff McCoy spent just over two years total in residential mental health treatment. *Id*. Plaintiff McCoy requires a higher level of care than the outpatient care available in ADOC. Tr. Test. of Dr. Kathryn Burns.

During his time in ADOC, Plaintiff McCoy's mental health case code has fluctuated from MH-2 to MH-5. Pls. Tr. Ex. 1121, R. McCoy Med. Records, at

MR048816 (showing Plaintiff McCoy's mental health code ranging between MH2 and MH5 between 2009 and 2015). In ADOC, a person coded as MH-2 is defined as having "mild impairment in mental functioning" and can be housed in general population or segregation. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 19, ADOC Admin. Reg. 602, Mental Health Definitions and Acronyms, at 7. People coded as MH-5 are defined as having "[s]evere impairment, such as hallucinations and delusions or inability to function in most areas of daily living." The regulations mandate that they be housed in the stabilization unit. *Id*. at 8.

Before entering ADOC custody, Plaintiff McCoy received mental health treatment in the form of medication and counseling. Tr. Test. of Roger McCoy. Since Plaintiff McCoy was first incarcerated in 1994, he has received inconsistent mental health treatment. Tr. Test. of Roger McCoy. Instability has an impact on Plaintiff McCoy's mental health. Tr. Test. of Cassandra Lee, Dr. Robert Hunter; Pls. Tr. Ex. 1121, R. McCoy Med. Records, MR044932. Plaintiff McCoy has been housed at seven different ADOC facilities since his entry into Kilby on May 2, 1994. Tr. Test. of Roger McCoy, Grantt Culliver; Pls. Tr. Ex. 165, McCoy Class. & Move., at ADOC039087. During that time, he has been moved between facilities fifteen times. *Id*. Between August 2008 and April 2014, he has been housed in at least 21 beds and moved between facilities four times. *Id*. The only treatment offered to Plaintiff McCoy to accommodate his illness was that the

counselor "explained the importance of [Plaintiff McCoy] being more flexible." Tr. Test. of Roger McCoy; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR044932.

The doctor Plaintiff McCoy sees has changed repeatedly. Tr. Test. of Dr. Kathryn Burns, Roger McCoy. During his time in ADOC, his visits with doctors and counselors have been inconsistent. Tr. Test. of Roger McCoy, Dr. Kathryn Burns. Plaintiff McCoy typically sees his psychiatrist only at his request. Tr. Test. of Roger McCoy. As of January 19, 2016, Plaintiff McCoy had not seen a psychiatrist or nurse practitioner since October 2015. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR044944. Even when Plaintiff McCoy was placed in a crisis cell, he was not seen by medical or mental health staff until the next day. Tr. Test. of Roger McCoy.

Plaintiff McCoy does not understand his prescriptions, what they are, or why they change. Tr. Test. of Roger McCoy. Although Plaintiff McCoy has asked about the purpose and contents of the medications, neither mental health staff nor medical staff have explained what the medications do or why he receives them. Tr. Test. of Roger McCoy. The only person who explained the medication to Plaintiff McCoy is another prisoner. Tr. Test. of Roger McCoy.

Plaintiff McCoy's treatment plans are frequently reviewed and altered outside of his presence and without his input. *See, e.g.*, Pls. Tr. Ex. 1121, R. McCoy Med. Records, MR010021, 010026. He does not believe he has ever attended a treatment team meeting. Tr. Test. of Roger McCoy. Because of the side effects of the psychotropic medications he takes, Plaintiff McCoy receives Abnormal Involuntary Movement Scale ("AIMS") tests periodically. Tr. Test. of Roger McCoy, Dr. Kathryn Burns. However, Plaintiff McCoy's AIMS tests are not always completed. Tr. Test. of Anna Davis-Walker, Teresa Houser; Pls. Tr. Ex. 1121, R. McCoy Med. Records, MR009869.

Plaintiff McCoy has refused his psychotropic medication shot. Tr. Test. of Roger McCoy. Despite his refusal, he has been forced to take the shot. Tr. Test. of Roger McCoy. Signatures purporting to represent his informed consent for medication have been forged. Tr. Test. of Roger McCoy; Pls. Tr. Ex. 1121, R. McCoy Med. Records, MR009863 (dated Jan. 25, 2012), 009864 (Jan. 25, 2012), 009795 (Oct. 30, 2013), 009801 (Dec. 11, 2012), 009959 (Jan. 10, 2013), 009965 (Dec. 14, 2014), 010011 (July 18, 2012), 010014 (May 23, 2014), 010025 (Jan. 31, 2012), 010028 (Dec. 14, 2011), 010029 (Jan. 20, 2012), 010030 (June 30, 2011), 010035 (Nov. 1, 2012), 010039 (Apr. 26, 2012) (documents reflecting signatures purporting to belong to Plaintiff McCoy that he confirmed were not signed by him).

Around 2009, after Plaintiff McCoy's transfer to Bullock, he was subjected to violence by correctional officers because he refused to take his shot. Tr. Test. of Roger McCoy, Grantt Culliver; Pls. Tr. Ex. 165, McCoy Class. & Move., at ADOC039088 (showing custody at Bullock from Aug. 2008 to Dec. 2009). He has also been threatened with segregation if he does not take the shot. Tr. Test. of Roger McCoy. On at least one occasion, within the year prior to McCoy's February 2015 deposition, he was placed into an isolation cell as a result of refusing to take his medication. Tr. Test. of Roger McCoy.

Plaintiff McCoy has not been subject to an involuntary medication order since 2005. Tr. Test. of Roger McCoy, Dr. Robert Hunter; *see also* Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR024517-23. At that time, committee stated it considered four factors to determine if Plaintiff McCoy should be medicated against his will: "Danger to self"; "Danger to others"; "Substantial risk of significant property damage"; "Being unable to provide for essential physical needs"; and "Experiencing severe repeated and escalating deterioration." Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR024518. The only evidence the involuntary medication committee considered of Plaintiff McCoy's "severe repeated and escalating deterioration" was his sentence, more than a decade earlier, in his criminal case and his history of mental illness. *Id*. The only reported evidence of Plaintiff McCoy's "[d]anger to others" was his "[h]ostile

behavior, sentence for murder." *Id*. The only reported evidence of Plaintiff McCoy's "[d]anger to self" was his "refusing medications." *Id*.

Plaintiff McCoy suffers side effects from the psychotropic medication he receives. Tr. Test. of Roger McCoy. He has pain in his arm at the injection site and sometimes pain and stiffness throughout his body. Tr. Test. of Roger McCoy; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR009802, 044940, 048835. He also experiences spells of dizziness. Tr. Test. of Roger McCoy. Although he has asked for treatment for the side effects of his medications, he has been refused. Tr. Test. of Roger McCoy. Plaintiff McCoy has not been offered a change in medications. Tr. Test. of Dr. Robert Hunter, Roger McCoy; Pls. Tr. Ex. 1121, R. McCoy Med. Records.

Plaintiff McCoy has constant pain in his arm caused by his psychotropic medication. He visits the healthcare unit frequently to seek treatment. Tr. Test. of Roger McCoy. Plaintiff McCoy has tried to get sick call slips from the medical staff at Bibb, but the medical staff refuse. Tr. Test. of Roger McCoy. At the time of his deposition, he had requested a sick call form and been refused approximately nine times. Tr. Test. of Roger McCoy. Plaintiff McCoy is told that "there ain't nothing wrong with me, get out of there" and sent away. Tr. Test. of Roger McCoy. Plaintiff McCoy has also been refused treatment because he does not have money on his account. Tr. Test. of Roger McCoy.

Plaintiff McCoy receives little mental health treatment other than medication. In August 2015, he was transferred from Bibb to the Bullock RTU. Tr. Test. of Roger McCoy. At the time, his transfer form indicated that he was receiving no treatment other than medication. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR044947. Beyond medication, there is little to no mental health programming available to Plaintiff McCoy. Tr. Test. of Roger McCoy.

Plaintiff McCoy has taken every program available to him. Tr. Test. of Roger McCoy, Teresa Houser; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR044932 (noting that Plaintiff McCoy reported that he had "taken every program ya'll have had to offer" at the Bullock RTU). Plaintiff McCoy has asked why more programming is not available and was told to "[m]ind [his] own business." Tr. Test. of Roger McCoy.

Plaintiff McCoy has been threatened by ADOC staff if he fills out any grievance forms. Tr. Test. of Roger McCoy. He has been told that if he writes particular officers' names on a grievance form, he will be put into segregation. Tr. Test. of Roger McCoy. Plaintiff McCoy is aware of one individual who has been put in segregation as retaliation for filling out a grievance. Tr. Test. of Roger McCoy. Plaintiff McCoy has been retaliated against while in ADOC custody. Tr. Test. of Roger McCoy.

Despite his severe mental illness, Plaintiff McCoy has been repeatedly placed in segregation units for extended periods of time, even against the clinical opinion of the mental health staff. Tr. Test. of Dr. Edward Kern, Dr. Kathryn Burns, Roger McCoy, Grantt Culliver; Pls. Tr. Ex. 165, McCoy Class. & Move., ADOC039087. At times, Plaintiff McCoy has spent weeks in segregation units even on disciplinary charges of which he was ultimately found not guilty. Tr. Test. of Roger McCoy.

l) Plaintiff Kenneth Moncrief

On May 5, 2010, Plaintiff Kenneth Moncrief was evaluated by psychiatrist Dr. Robert Hunter, who assigned him a mental health code of MH-0. Tr. Test. of Kenneth Moncrief, Dr. Robert Hunter; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR017579. On the same day, Plaintiff Moncrief was evaluated by a psychologist or psychological associate who assigned him an MH-1 code. Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR017580. When Plaintiff Moncrief requested his diagnosis, a nurse concluded that MH-0 was the appropriate code. Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR017597.

Plaintiff Moncrief's diagnosis was changed to bipolar disorder in January 2015. Tr. Test. of Teresa Houser, Kenneth Moncrief; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR045083. At that time, his mental health code was MH-1. *Id.* In July 2015, Plaintiff Moncrief was transferred to Bullock's Residential Treatment

Unit. Tr. Test. of Kenneth Moncrief, Teresa Houser. His mental health code was increased from MH-1 to MH-3. Tr. Test. of Teresa Houser, Kenneth Moncrief; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR045083. In September 2015, Dr. Edward Kern noted that Plaintiff Moncrief's diagnosis was changed to bipolar after "he self-reported reading about it and said [symptoms] fit." Tr. Test. of Dr. Edward Kern; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR045124.

Plaintiff Moncrief did not regularly receive individual and group counseling. Tr. Test. of Kenneth Moncrief. Plaintiff Moncrief often missed mental health counseling sessions because the prison was on lockdown. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR049066. Further, Plaintiff Moncrief did not attend group counseling sessions before August 2015. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, K. Moncrief Med. Records. He also did not attend any group counseling while at Limestone. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, K. Moncrief Med. Records. At Bullock, Plaintiff Moncrief saw a counselor five or six times in the span of a year. Tr. Test. of Kenneth Moncrief. Although he has met with his treatment team and signed his treatment plan, he "[does not] really know what is on it." Tr. Test. of Kenneth Moncrief.

Plaintiff Kenneth Moncrief reached out to mental health staff on numerous occasions to report problems he was having with pill call and medication side

effects. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex., 633, K. Moncrief Med. Records, at MR010519, 010511, 010505, 010499, 010498, 040554, 040555, 049074, 045137, 045133. He also complained that he did not feel like his treatment was helping. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR010510.

Plaintiff Moncrief did not consistently receive his mental health medications between August 2014 and January 2015. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, Med. Records of Kenneth Moncrief, at MR010459-010623, 017563-017619, 040515-40583, 045083-045139, 049013-049084.

Throughout his incarceration, Plaintiff Moncrief told medical and mental health staff that he wanted to stop taking medications because the pill call lines were too long. Tr. Test. of Kenneth Moncrief. Plaintiff Moncrief attempted to find a way to continue taking his medication by requesting a different pill time so that the pill call wait would be shorter. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR010498, 010499. Mental health staff were well aware that Plaintiff Moncrief did not want to take medications because of these issues with pill call. Tr. Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR010479, 010490, 010493. At one point, Plaintiff Moncrief asked to be taken off Prozac because of the difficulties with pill call, despite doing well on the medication. Tr.

Test. of Kenneth Moncrief, Teresa Houser; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR010491.

Plaintiff Moncrief also repeatedly complained of side effects associated with certain mental health medications, including low energy, decreased appetite, hand shaking, and feeling like he had been in a car wreck. Tr. Test. of Kenneth Moncrief; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR010476, 010511, 045133, 040555. These side effects resulted in his not wanting to take his medication. Tr. Test. of Kenneth Moncrief; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR045139 ("[T]he medication makes me sleep too hard and I can't take it."). Additionally, Plaintiff Moncrief stopped taking his medications in July 2015 because he believed taking them would prevent him from being granted parole. Tr. Test. of Kenneth Moncrief; Pls. Tr. Ex. 633, K. Moncrief Med. Records, at MR045135.

m) Plaintiff Leviticus Pruitt

Plaintiff Leviticus Pruitt has been diagnosed with depression, antisocial personality disorder, and schizophrenia. Tr. Test. of Leviticus Pruitt; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012030. He was on Haldol but is not any longer. Tr. Test. of Leviticus Pruitt. Plaintiff Pruitt found the Haldol helpful. Tr. Test. of Leviticus Pruitt. He believes he needs to be on mental health medications for his depression and other symptoms. Tr. Test. of Leviticus Pruitt.

Plaintiff Pruitt has a long history of attempts at self-harm. On multiple occasions, Plaintiff Pruitt has received disciplinaries for creating a "security, safety or health hazard" when he injured himself. Tr. Test. of Leviticus Pruitt.

During the six-month period beginning in December 2013, Plaintiff Pruitt was admitted to a crisis cell at least five times. Tr. Test. of Leviticus Pruitt; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012040, 012031, 012032, 012030, 012027. During that period, Plaintiff Pruitt was not seen by a psychiatrist or nurse practitioner. Tr. Test. of Leviticus Pruitt, Teresa Houser, Lesleigh Dodd; Pls. Tr. Ex. 646, L. Pruitt Med. Records. The crisis cells at Holman, where Plaintiff Pruitt was housed, are located on death row. Tr. Test. of Leviticus Pruitt, Dr. Craig Haney, Ruth Naglich. In December 2013, while Plaintiff Pruitt was on suicide watch, prisoners on death row threw burning fabric through the bars into Plaintiff Pruitt's suicide watch cell. Tr. Test. of Leviticus Pruitt, Dr. Craig Haney. The balled-up fabric landed on Plaintiff Pruitt's leg and burned his leg. Tr. Test. of Leviticus Pruitt, Dr. Craig Haney. Plaintiff Pruitt was not removed from his cell until approximately 45 minutes after the incident occurred. Tr. Test. of Leviticus Pruitt, Dr. Craig Haney, Lesleigh Dodd; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR011889.

On December 5, 2013, Plaintiff Pruitt was admitted to a safe cell, reporting that he was going to cut himself. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd; Pls.

Tr. Ex. 646, L. Pruitt Med. Records, at MR012040. His counselor set his treatment plan for daily review by his treatment team. *Id*. The treatment team in the safe cell consisted of a psychologist, mental health nurse, and counselor. *Id*. Plaintiff Pruitt remained in a safe cell for 11 days. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012041 (December 6, 2013), 012039 (December 9, 2013), 012038 (December 10, 2013), 012037 (December 11, 2013), 012036 (December 12, 2013), 012035 (December 13, 2013), 012034 (December 16, 2013). During that time, Plaintiff Pruitt was not seen by a psychiatrist, psychologist, or nurse practitioner. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd, Teresa Houser; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012034-012039, 012041. While in the suicide cell, another prisoner threw disinfectant in Plaintiff Pruitt's face. Tr. Test. of Leviticus Pruitt; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR011878-79.

Less than three weeks after his December 16, 2013 release, Plaintiff Pruitt was readmitted to a crisis cell because of thoughts of self-harm. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012031. The treatment team responsible for his care included a psychiatrist, psychologist, counselor, and nurse. Tr. Test. of Lesleigh Dodd, Teresa Houser; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012031. The treatment team set his treatment plan for daily review. *Id*. Nonetheless, neither a psychiatrist nor

psychologist ever signed off on Plaintiff Pruitt's care. *Id*. The nurse practitioner did not evaluate Plaintiff Pruitt's care for seven weeks after he was admitted to the crisis cell. *Id*.

On February 25, 2014, Plaintiff Pruitt was admitted to a safe cell again because of suicidal ideations. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd, Teresa Houser; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012032-012033. During that admission to the safe cell, Plaintiff Pruitt was not seen by a psychiatrist, psychologist, or nurse practitioner. *Id*.

On March 7, 2014, Plaintiff Pruitt was admitted to suicide watch because he was suicidal. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012030. He remained on suicide watch until March 11, 2014. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd;Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012028 (March 11, 2014), 012029 (March 10, 2014).

On June 6, 2014, Plaintiff Pruitt was admitted to a safe cell on suicide watch because of suicidal ideations. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012027. He returned to the safe cell just three days later after he cut both of his arms with a razor. *Id.* at MR012024-012025. No one noticed that Plaintiff Pruitt had hurt himself until officers

discovered him bleeding in his cell when they came around during pill call later that evening. Tr. Test. of Leviticus Pruitt.

Following that incident, he was returned to a crisis cell for a week, during which time he continued to have suicidal ideations. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012024, 012023, 012022, 012021.

Although Plaintiff Pruitt has spent considerable time in crisis cells, he has not received adequate follow-up from mental health staff upon discharge from those crisis cells. Tr. Test. of Leviticus Pruitt, Lesleigh Dodd, Dr. Kathryn Burns. After suffering burns, Plaintiff Pruitt requested counseling. Tr. Test. of Leviticus Pruitt. Despite the serious trauma he suffered and his request for counseling, he got no response. *Id*.

Since 2010, Plaintiff Pruitt has repeatedly requested mental health help. Tr. Test. of Leviticus Pruitt. Nonetheless, he has not received individual counseling or medications for his mental health conditions. Tr. Test. of Leviticus Pruitt. As recently as January of 2015, Plaintiff Pruitt's requests for help went unanswered. Tr. Test. of Leviticus Pruitt.

Plaintiff Pruitt believes he would benefit from individual counseling sessions. Tr. Test. of Leviticus Pruitt. However, despite his repeated requests for

counseling, he has been consistently put off and told that mental health will see him when they have time. Tr. Test. of Leviticus Pruitt. The only time Plaintiff Pruitt saw mental health staff in the two years preceding his deposition was during segregation rounds. Tr. Test. of Leviticus Pruitt. Although mental health staff remove individuals from segregation cells for one-on-one counseling in the day room, Plaintiff Pruitt has not been taken out of his cell for such counseling. Tr. Test. of Leviticus Pruitt. The only encounters that Plaintiff Pruitt had with mental health staff while in segregation were brief check-ins that lasted no more than a few minutes. Tr. Test. of Leviticus Pruitt.

n) Plaintiff Richard Terrell

Plaintiff Richard Terrell has been diagnosed with paranoid schizophrenia and began treatment for his mental illness prior to entering the ADOC. Tr. Test. of Richard Terrell, Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 1118, R. Terrell Med. Records, at MR014284. Plaintiff Terrell also has a cognitive disability and can barely read or write. Tr. Test. of Richard Terrell.

Plaintiff Terrell has received Haldol shots and Benadryl. Tr. Test. of Richard Terrell, Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 1118, R. Terrell Med. Records. The medications he received were not consistently effective. Tr. Test. of Richard Terrell. Haldol prevented Plaintiff Terrell from sleeping well and caused him to have nightmares. Tr. Test. of Richard Terrell. Plaintiff Terrell was

not offered a change in medications. Tr. Test. of Richard Terrell, Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 1118, R. Terrell Med. Records.

Plaintiff Terrell is often asked to sign paperwork acknowledging that he understands information about his medication when it is clear that he can barely read and write. Tr. Test. of Richard Terrell. He took special education courses throughout his childhood. Tr. Test. of Richard Terrell. Despite his cognitive disability, staff members do not read the documents to him. *Id*.

Plaintiff Terrell has received inadequate mental health counseling while in the ADOC. On the occasions where he met with mental health staff, it was only for "about five minutes." Tr. Test. of Richard Terrell. Plaintiff Terrell was only seen by mental health staff about two times per month over a five year period while housed in the RTU. Tr. Test. of Richard Terrell. In the RTU, a unit intended for the most severely mentally ill prisoners, treatment should be provided daily. Tr. Test. of Dr. Kathryn Burns. Instead, in the RTU, like everywhere in the ADOC, psychotropic medication management is virtually the only treatment intervention provided, and such was the case for Plaintiff Terrell. Tr. Test. of Dr. Kathryn Burns, Richard Terrell.

Plaintiff Terrell has received inadequate mental health treatment due to misclassification while in the ADOC. For example, in January 2013, Plaintiff

Terrell's mental health code was lowered to a MH-1. Pls. Tr. Ex. 1118, R. Terrell Med. Records, at MR014361. He remained an MH-1 despite the fact that for several months after having his code lowered he was exhibiting signs of deterioration (*e.g.*, rambling, tangential speech, auditory hallucinations). *Id.*; Pls. Tr. Ex. 1118, R. Terrell Med. Records, at MR014362, 014357, 014355, 014354, 014352, 014349, 014345, 014344. In September of 2013, a counselor finally noted, "Inmate displayed no signs of distress from symptoms of auditory hallucinations and paranoia but reported that both are on the increase since his transfer to main camp." Pls. Tr. Ex. 1118, R. Terrell Med. Records, at MR014354.

According to Defendants' own standards, a patient who experiences severe impairment such as hallucinations should be classified as a MH-5. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 19, ADOC Admin. Reg. 602, Mental Health Definitions and Acronyms, at 7. ADOC's coding system for mentally ill prisoners is flawed and fails to classify prisoners, including Plaintiff Terrell, based on whether or not they have a serious mental illness. *Id*.

o) Plaintiff Jamie Wallace

Plaintiff Jamie Wallace has been in ADOC custody since approximately 2011 and has been housed in the mental health units of Bullock and Donaldson. Tr. Test. of Jamie Wallace; Pls. Tr. Ex. 156, Wallace Class. & Move., at ADOC039215. He asserts he is not receiving the "right treatment" for his

numerous physical and mental health conditions. Tr. Test. of Jamie Wallace; Pls. Tr. Ex. 626, J. Wallace Med Records, at MR016220.

Plaintiff Wallace has been diagnosed with Bipolar 1 Disorder and Mild Mental Retardation. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns, Teresa Houser, Jamie Wallace; Pls. Tr. Ex. 626, J. Wallace Med. Records, at MR015834-015835. In 2012, one of Plaintiff Wallace's psychotropic medications, lithium, was discontinued without explanation. Tr. Test. of Jamie Wallace; Pls. Tr. Ex. 626, J. Wallace Med. Records, at MR016210. The doctor at Donaldson also discontinued Plaintiff Wallace's mental health medication, Wellbutrin, though it worked well for Plaintiff Wallace and prevented him from hearing voices. Tr. Test. of Jamie Wallace. When Plaintiff Wallace inquired as to why he had been taken off Wellbutrin, the doctor responded that ADOC "couldn't afford it." Tr. Test. of Jamie Wallace.

Plaintiff Wallace does not receive adequate mental health counseling. Tr. Test. of Jamie Wallace. For example, Wallace was in suicide watch in October 2012. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 626, J. Wallace Med. Records, at MR016248. Plaintiff Wallace inquired about being released from the suicide cell and was observed as having blood on his forehead. *Id*. Nothing in the progress note indicates a reply to Plaintiff Wallace's question or further steps taken to check on Plaintiff Wallace's bleeding head. *Id*. The mental health nurse merely wrote,

"will continue with current treatment plan." *Id*. Even when he is suicidal and requests to be placed in a safe cell, his treatment plan is to "work on positive coping skills and patience for an appointment." Tr. Test. of Teresa Houser, Jamie Wallace; Pls. Tr. Ex. 626, J. Wallace Med. Records, at MR030318.

Plaintiff Wallace's access to mental health professionals is very limited. When not actively suicidal, Plaintiff Wallace only sees mental health professionals "every two months." Tr. Test. of Jamie Wallace, Dr. Craig Haney. Plaintiff Wallace was unable to be seen by a counselor in February 2015 due to "limited officers on the unit per DOC." *Id*. at MR030337. On August 3, 2014, Plaintiff Wallace specifically requested to see the doctor or a counselor, but the RTU nursing notes indicate "no complaint" by Plaintiff Wallace. *Id*. at MR030477.

In addition to Plaintiff Wallace's mental health issues, he possesses a limited ability to read and write. Tr. Test. of Jamie Wallace. He has not had the opportunity to take literacy classes or received any type of adaptive behavior training. Tr. Test. of Jamie Wallace.

Plaintiff Wallace has received nine disciplinaries for harming himself by cutting his wrist. Tr. Test. of Jamie Wallace.

p) Plaintiff Robert "Myniasha" Williams

Plaintiff Robert "Myniasha" Williams has ADHD and a mood disorder, as well as a history of trauma from multiple instances of sexual abuse and self-mutilation. Tr. Test. of Myniasha Williams. As early as age six or seven, Plaintiff Williams was treated by a psychiatrist for sexual abuse and diagnosed with ADHD. Tr. Test. of Myniasha Williams. In 2007, she was diagnosed with "mood disorder," prescribed Risperdal and other medications, and provided inpatient care from Hillcrest Behavioral Health Services. Tr. Test. of Myniasha Williams.

When Plaintiff Williams entered ADOC on November 30, 2012, she went through a mental health screening, conducted by an LPN at Kilby Correctional Facility. Tr. Test. of Teresa Houser, Myniasha Williams; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017083. At intake, she informed the LPN about this history of mental health treatment, as well as past suicide attempts and substance abuse treatment. *Id*. The LPN referred Plaintiff Williams for a mental health evaluation, noting her mental health history, previous suicide attempts, and past diagnosis at Draper Correctional Facility. Tr. Test. of Teresa Houser, Myniasha Williams; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017084, MR017089-017090. Despite her history, Plaintiff Williams was evaluated on December 3, 2012 and assigned a mental health code of MH-0. Tr. Test. of Teresa

Houser, Myniasha Williams; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017085-017086; *see also id*. at MR017087.

Plaintiff Williams was not placed on the mental health caseload. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, Med. Records of R. M. Williams. The only time that she was seen by mental health staff prior to March 2014 was on February 27, 2014 because of a PREA complaint she had previously filed. Tr. Test. of Teresa Houser, Myniasha Williams; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017093, 017082.

In February 2014, Plaintiff Williams was placed in segregation at Fountain. Tr. Test. of Myniasha Williams, Grantt Culliver; Pls. Tr. Ex. 163, Class. & Move. Records of Robert "Myniasha" Williams.

On March 2, 2014, Plaintiff Williams cut herself twice, and on March 11, 2014 she committed three additional instances of self-mutilation—for a total of five instances of cutting in March 2014. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017091, 017093. Dr. Robert Hunter referred Plaintiff Williams for a mental health evaluation because of her self-mutilation. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Myniasha Williams; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017077. On March 3, Plaintiff Williams explained that she harmed herself

because she had a history of being raped and had "recently reported an incident to PREA . . . that [she] wanted to speak to [her] attorney about." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017093. Later on March 3, she was released by mental health from the safe cell with no plan for follow-up, despite a note that "[inmate] may benefit from therapy focusing on sexual abuse history." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017079.

Plaintiff Williams was seen on March 6 by Ms. Nichols, a mental health associate, because of the PREA complaint, not as follow-up after her recent, triple instances of self-harm. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017077-017078. She was not placed on the mental health case load. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017091. The meetings with Ms. Nichols during March 2014 were for "a very, very short period of time . . . approximately five, six minutes at the most." Tr. Test. of Myniasha Williams.

The nursing staff who monitored Plaintiff Williams in the safe cell on March 2 and 3, 2014 were not mental health staff and were not offering her mental health services. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017062-63.

On March 28, 2014, Ms. Nichols completed a 30-day review of Plaintiff Williams' placement in segregation. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017081. Contrary to Plaintiff Williams' assessment of the impact that segregation has on her mental state, Ms. Nichols found that segregation was an appropriate placement and was "not impacting [her] mental health." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017081.

Plaintiff Williams' third, fourth, and fifth instances of self-mutilation in March 2014 took place on March 11, 2014. Plaintiff Williams was seen by Ms. Nichols, and she told Nichols that she was "going to keep doing it." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017075. Forty-five minutes later, Plaintiff Williams was brought back to the medical unit after cutting herself, and she told medical staff, "I'm just gone [sic] do it again. I used a razor." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR016909. Just over thirty minutes later, Plaintiff Williams was again brought to the medical unit for cutting. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR016908.

On March 11, 2014, Ms. Nichols developed a mental health treatment plan for Plaintiff Williams' "crisis intervention" that listed one goal—"Inmate will learn

to cope without cutting"—with "72 hours" listed as the "target date for resolution." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017067. The treatment plan provided two interventions: (1) "placed on [mental health] observation" and (2) "reinforce coping skills." *Id*. This treatment plan was not effective for Plaintiff Williams, and though she asked to be prescribed medication, she was not. Tr. Test. of Myniasha Williams.

In March 2014, Plaintiff Williams was disciplined twice and given additional days in segregation for cutting herself while in segregation, allegedly a violation of Rule #505 "Intentionally Creating a Security / Safety / Health Hazard." Tr. Test. of Myniasha Williams, Grantt Culliver; Pls. Tr. Ex. 163, Class. & Move. Records of Robert "Myniasha" Williams.

On August 18, 2014, Plaintiff Williams was seen by Ms. Nichols regarding a PREA referral about another prisoner who was sexually harassing her. Tr. Test. of Teresa Houser, Myniasha Williams; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR039739. She "reported situational depression" and a mild depression related to the occurrence and to her placement. *Id*. at MR039739.

On April 16, 2015, Plaintiff Williams, who was housed in segregation at the time, requested to see mental health staff, stating that since she had been in segregation she had been having suicidal thoughts. Tr. Test. of Myniasha Williams,

Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046481. The mental health staff who met with her noted that despite having a history of mood disorder, Plaintiff Williams was not on the mental health case load. *Id*. The staff member determined that no follow-up would be needed. *Id*. Plaintiff Williams again sought help from mental health on April 20, 2015, expressing her desire for assistance. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046480. She requested assistance again on April 23, 2015, reiterating concerns about her placement in segregation. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046479. On April 23, Plaintiff Williams requested medication, and Ms. Nichols responded that she could not prescribe medication "due to [her] educational level." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046478-046479.

On May 2, 2015, Plaintiff Williams attempted to hang herself, stating that she wanted to be removed from segregation. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046474. Plaintiff Williams reported that she was not suicidal on May 4, 2015 while she was still on suicide watch, just two days after her suicide attempt. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046476, 046445.

After not being on the mental health case load for over two years, Plaintiff Williams was evaluated on May 5, 2015 and diagnosed with, among other things, Mood Disorder and Intermittent Explosive Disorder with a history of Polysubstance Abuse. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046471. Plaintiff Williams was assigned an MH-1 mental health code. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046471. On May 5, Plaintiff Williams was discontinued from suicide watch, and a treatment plan was established providing that she would be seen again in 30 days. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046471, MR046472.

By the time Plaintiff Williams was evaluated for psychotropic medication on June 4, 2015, nurse practitioner Burden noted several concerns about Plaintiff Williams' mental state, including that Plaintiff Williams was "easily agitated," "hyper verbal," and "man[i]c like." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046468. The nurse practitioner confirmed Plaintiff Williams' mood disorder, history of polysubstance abuse, and personality disorder and started Plaintiff Williams on Remeron, but she kept Plaintiff Williams' mental health code at MH-1. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med.

Records, at MR046468. About a month later, Plaintiff Williams was taken off Remeron and subsequently made threats to kill herself. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046464.

On August 18, 2015, Plaintiff Williams reported to nurse practitioner Burden that she continued to feel depressed and experience mood swings. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046459. After she was prescribed Depakote on August 18, 2015, Plaintiff Williams expressed a desire to be on a lower dosage, but nonetheless informed nurse practitioner Burden that she was not receiving the medicine. Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046455 ("[T]hey haven't been giving me Depakote . . . ."). Shortly thereafter, on September 5, 2015, Plaintiff Williams again engaged in self harm, including "sticking sharp objects in arm, lacerations on [right] leg and [left] arm." Tr. Test. of Myniasha Williams, Teresa Houser; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR046440.

Plaintiff Williams maintains that she has not received adequate mental health care while incarcerated at ADOC. Tr. Test. of Myniasha Williams. Specifically, Plaintiff Williams never received group counseling, and she contests

the adequacy of the individual counseling she has received while in ADOC custody. Tr. Test. of Myniasha Williams.

q) Class Member REDACTED

Mental Health Subclass MemberREDACTED is housed at Tutwiler. Tr. Test. ofREDACTED .REDACTED has a long history of mental illness and is on the mental health caseload and has a mental health code greater than MH-1. Tr. Test. of REDACTED has struggled with self-harm and suicidality. *Id*.

REDACTED had been taking medications for at least a year at the time she entered ADOC custody, but she had to wait several weeks after her arrival at Tutwiler before receiving those medications. Tr. Test. ofREDACTED . At the time of her incarceration, REDACTED had been on some medications, which she no longer receives, since she was nine years old. Tr. Test. ofREDACTED .

REDACTED is not currently taking any medications. Tr. Test. of RED R ACTEE REDAC TED Some of the medications she needs or has taken previously are not prescribed to her because they are non-formulary or were not effective. Tr. Test. of REDACTED . Other medications REDACTED is prescribed give her side effects like severe eye twitching, numbness, violent feelings, and hallucinations. Tr. Test. of REDACTED . WhenREDACTED has complained of side effects, she has been told her dosage will not be lowered. Tr. Test. of REDACTED .

When REDACTED took medications, she would often have to wait outside in the pill call line for over two hours without sitting. Tr. Test. of REDACTED . She has had to wait between one to two weeks for a medication refill before. Tr. Test. of REDACTED . There were instances when REDACTED was threatened with being restrained and forcefully medicated if she did not comply with taking her medication. Tr. Test. of REDACTED .

REDACTED has been placed in suicide crisis cells several times. Tr. Test. of REDACTED . She has been able to take a razor with her into a suicide cell because she was not searched. *Id.* REDACTED has also been placed in a conference room for up to three hours, with no one checking on her, while waiting for a crisis cell. Tr. Test. of REDACTED

REDACTED has been disciplined for engaging in acts of self-harm and attempted suicide. Tr. Test. of REDACTED . While in disciplinary segregation, REDACTED has been visited by mental health staff twice a week, "cell-side," and she speaks with mental health staff for only about five minutes. Tr. Test. of REDACTED REDACTED These cell-side check-ins consist of no more than staff asking REDACTED if she is okay, without any follow-up regardless of her answer. Tr. Test. of REDACTED REDACTED Wanting privacy, REDACTED has asked to speak with mental health staff outside of her segregation cell, but is not always allowed to, so she sometimes does not speak to anyone from mental health. Tr. Test. of REDACTED .

Sometimes it takes up to three hours for someone to respond to REDACTED , reports to correctional officers that she is having a crisis. Tr. Test. of REDACTED . She has harmed herself by cutting several times while in a crisis cell, and sometimes it takes several days for correctional officers to notice. Tr. Test. of REDACTED .

REDACTED meets with her counselor for only about five to ten minutes at a time. Tr. Test. of REDACTED . Her treatment team meetings while on suicide watch are about the same length, and she is not given the opportunity to provide input during those meetings. Tr. Test. of REDACTED .

r) Class Member REDACTED

Mental Health Subclass Member REDACTED is housed at REDACTED . Tr. Test. of REDACTED . He was placed on the mental health caseload in 2012 due to REDACTED *Id*. In 2013, Mr. REDACTED was prescribed Prozac. *Id*.

In 2012 and 2013, Mr. REDAC saw a counselor weekly for about ten minutes; sometimes a correctional officer was present during his counseling sessions. Tr. Test. of REDACTED In 2014, Mr. REDACTED was transferred from Ventress to Holman. *Id*. At Holman, he received monthly counseling sessions that lasted about five minutes. *Id*. A correctional officer was in the room during those sessions. *Id*. In 2016, Mr. REDACTED was placed in segregation twice for about five months. *Id*.

While he was in segregation, he saw a counselor for no longer than ten minutes a session while a correctional officer was present. *Id*.

s) Class Member REDACTED

Mental Health Subclass Member REDACTED is housed at REDACTED. Tr. Test. of REDACTED. During his time in ADOC custody, REDACTED has been housed at Kilby, Staton, Bibb, St. Clair, Donaldson, and Bullock. *Id*. He has been diagnosed with paranoid schizophrenia. *Id*. REDACTED has been prescribed Haldol, first in pill form and then as a shot. *Id*.

While at Donaldson, REDACTED informed Nurse Coogan that he did not wish to receive Haldol shots anymore because he did not like how they made him feel and did not believe they were helping him. *Id*. When REDACTED told Nurse Coogan he did not want his shot, he was held down by correctional officer and forced to receive the shot; he was then sent to segregation for a week. *Id*.

REDACTED has attended several involuntary medication hearings, at which he states that he does not want to receive the Haldol shot and is told that he has to stay on the medication because he is doing well. *Id*. He has appealed his involuntary medication order twice to no avail. *Id*.

While he was housed at Donaldson, REDACTED saw a counselor about every four months for about twenty minutes. *Id*. REDACTED CTED meetings with

his counselor last less than twenty minutes. *Id.* R E has tried to participate in mental health groups since that is a part of his treatment plan, but none of the mental health staff have helped him get into a group though he has asked. *Id*.

t) Class Member REDACTED

Mental Health Subclass Member REDACTED has been in custody at numerous ADOC facilities. Tr. Test. of REDACTED Prior to his incarceration, REDACTED was diagnosed with REDACTED . *Id*.

REDACTED met one or two times with a counselor in 2012 and was thereafter prescribed Zyprexa and Remeron to treat his manic depression. *Id*. However, at REDACTED :TED receiving his medication irregularly. *Id*. He was told by the nurses at pill call that they would bring him his medicine later in the day, but the nurses failed to bring his medicine to him the same day and sometimes at all. *Id*.

When he does not receive his medicine, REDACTED suffers painful withdrawals that prevent him from sleeping and eating and make him paranoid. *Id*. Because of the withdrawals he experiences when he does not receive his medication on time or at all, REDACTED has stopped taking his medication altogether. *Id.* R E wants to take his medicine but does not want to suffer the withdrawal symptoms that occur when he is not provided his medicine. *Id*.

REDACTED did not have a mental health counselor at Bullock or Elmore. *Id*.

After an incident in his dorm, REDACTED was transferred to protective custody. *Id*. REDACTED refused to return to general population because he was afraid; after refusing, he was beaten by several officers and placed in REDACTED

REDACTED received only one or two meals a day, was not allowed to go outside, only left his cell for shower, and received no mental health services other than medication. *Id*. REDACTED

REDACTED physically and emotionally. *Id*.

u) Class Member REDACTED

Mental Health Subclass Member REDACTED has been in ADOC custody for about twenty-two years. Tr. Test. of REDACTED . REDACTED has been housed at Bibb, Bullock, Fountain, Draper, and Staton. *Id*.

REDACTED has been on the mental health caseload nearly the entire time he has been in ADOC custody and has been diagnosed with REDACTED . *Id*. He tried to kill himself with a razor in February 2016, necessitating 16 staples. *Id*. He was told by a correctional officer that he needed to cut up his arm rather than across and received a disciplinary. *Id*. REDACTED has received disciplinaries for hurting himself about five other times. Tr. *Id*.

While in the infirmary after his suicide attempt, REDACTED saw mental health staff only once in about a month. *Id*. REDACTED sees a mental health counselor once a month for about five to ten minutes; the longest he has spent with a counselor is about fifteen minutes. *Id*. REDACTED sees a psychiatrist once every 90 days. *Id*. He has not seen his treatment plan and does not know what it says. *Id*. Since leaving Bullock, REDACTED has not been allowed to participate in mental health groups, though he believes that would be helpful. *Id*.

REDACTED is prescribed Benadryl, Cogentin, and what he thinks is Prolixin. *Id*. At Bibb, REDACTED had to wait four hours for pill call a few times. *Id*.

v) Class Member REDACTED

Mental Health Subclass REDACTED was housed at REDACTED from 2007 to 2016. Tr. Test. of REDACTED . REDACTED is prescribed psychotropic medication. *Id*.

While at REDACTED REDACTED saw mental health Nurse Coogan once a month for five minutes. *Id*. He saw a counselor once a month for five to ten minutes. *Id*. When REDACTED asked to see a psychiatrist, he was told that the psychiatrist did not see prisoners in segregation. *Id*. REDACTED never met with a treatment team at St. Clair, and no one explained his treatment plan to him. *Id*. At

St. Clair, REDACTED did not have the opportunity to join any mental health groups. *Id.* REDACTED has cut himself in order to get mental health attention. *Id.*

REDACTED experiences involuntary tongue movements caused by his psychotropic medication. *Id.* If REDACTED received the wrong medication, the nurse would take it but never bring him the correct medication. *Id.*

w) Class Member REDACTED

Since his ADOC custody began in August 2015, Mental Health Subclass Member REDACTED has been housed in at least five different facilities, including Kilby, Bibb, Elmore, Holman, and Bullock. Tr. Test. of REDACTED

When REDACTED arrived at Kilby for intake in August 2015, he was recommended for a psychiatric evaluation due to his history of mental illness. *Id.* He did not receive an evaluation until four months later. *Id.* REDACTED is now assigned a mental health code of MH-2. *Id.*

At times during his incarceration, REDACTED has had no mental health counselor. *Id.* Once he requested a counselor while at Bibb but only saw her once before she was fired. *Id.* He also saw a mental health provider one time while at Elmore for less than five minutes. *Id.* REDACTED treatment team has never explained his treatment plan to him. *Id.*

REDACTED is prescribed Haldol, a psychotropic medication. *Id.* REDACTED experiences shaking and other side effects caused by the Haldol. *Id*. He tells the nurse at pill call whenever he does not want to take his Haldol. *Id*. When he has refused his Haldol shots because he did not like the side effects they caused, he has been threatened with segregation and physical violence. *Id*.

Every time he is transferred to a different facility, which happens often to REDACTED, he goes without his medication for about a week. *Id*. Once when he was transferred and temporarily off his medications, he cut himself because he was depressed and wanted to be seen by mental health. *Id*. REDACTED did not see a counselor after this incident, and was given a disciplinary. *Id*. He was placed in a suicide cell for three days but was not seen by mental health staff. *Id*.

x) Class Member REDACTED

Mental Health Subclass Member REDACTED has been housed at Draper, Limestone, Fountain, and Camden Work Release during his time in ADOC custody. Tr. Test. of REDACTED. He has been prescribed medication for depression and anxiety, but when he went to Camden Work Release he was told he could not take medication. *Id*. When he returned to Fountain, he was not re-prescribed medication. *Id*.

While at Fountain, REDACTED saw a mental health staff member, Ms. Herrington, every 90 days. *Id*. In July 2015, before he was taken off the mental health caseload, REDACTED to kill himself four times, but was told by Ms. Herrington's replacement, Ms. Harvey, that she thought he was acting up. *Id*. Thereafter, Ms. Harvey, removed REDACTED from the mental health caseload and told him she did not have time to deal with him. *Id*.

In September 2015, REDACTED was transferred to segregation in Limestone. *Id*. While in Limestone segregation, REDACTED girlfriend died, and he put in a request to speak to someone from mental health. *Id*. He received no response for two weeks, and tried to kill himself again. *Id*. REDACTED was returned to the mental health caseload after his suicide attempt at Limestone, but only saw a counselor once or twice a month for about ten to fifteen minutes at cell-front. *Id*.

During one period of segregation, REDACTED set his cell on fire and cut himself. *Id*.

In February 2016, REDACTED was put back on mental health medication for REDACTED after seeing a psychiatrist via telemedicine. *Id*. He was told by the psychiatrist he would see a counselor, but he did not. *Id*.

y) Class Member REDACTED

Mental Health Subclass Member REDACTED has been housed at Bullock, Bibb, and Donaldson during his time in ADOC custody. Tr. Test. of REDACTED. He has been diagnosed with REDACTED and is on the mental health caseload. *Id*.

While at Bullock, REDACTED saw his counselor, Ms, McCarthy, four or five times in a four-month period. *Id*. He usually only met with Ms. McCarthy for a minute or two. *Id*. If he requested to see Ms. McCarthy, he would not be able to see her for about a week. *Id*.

REDACTED has been asked to sign his treatment plan, sometimes without explanation of the plan, but has never met with his treatment team. *Id*.

z) Class Member REDACTED

Mental Health Subclass Member REDACTED is currently housed at REDACTED Tr. Test. of REDACTED is on the mental health caseload and has been suffering with paranoid schizophrenia for about 40 years. *Id*. He has been treated in a psychiatric hospital in the past. *Id*.

REDACTED was on the mental health unit at Bullock for about eight years and, during that time, he saw a counselor every two weeks, usually for less than a minute each time. *Id*. Around June 2015, REDACTED ' mental health code

dropped from MH-3 to MH-2, and he was moved out of the mental health unit to the main camp at Bullock. *Id*. His mental health code then dropped again to MH-1, but he does not know why. *Id*.

While at the main camp, REDACTED was only seen by a counselor every three to four months for about two minutes at a time. *Id*. REDACTED made numerous verbal and written requests at the main camp to be seen by a psychologist or counselor because he was hearing voices and experiencing paranoia, but he received no response. *Id*.

After three months of no mental health treatment, REDACTED attempted suicide by cutting himself because he was hearing voices and had not received mental health treatment. *Id*. REDACTED received a disciplinary for attempting suicide. *Id*. When REDACTED was taken to the suicide cell, he was not searched and had razors with him. *Id*. While on suicide watch, REDACTED had no health-related check-ups except for pill call. *Id*. When REDACTED is on suicide watch, he usually only sees a psychiatrist to determine if he can be released from suicide watch, but does not receive any mental health consultation other than cell-side visits that last a few minutes. *Id*.

REDACTED meets with his treatment team every six months, but they have never explained his treatment plan with him and act negatively toward him when he asks to read the plan before signing it. *Id*.

REDACTED has refused to take his Haldol because it gives him lock jaw and muscle spasms. *Id*. He has been threatened with segregation unless he took the Haldol. *Id*. REDACTED is currently prescribed Prolixin. *Id*. His Prolixin is sometimes unavailable. *Id*. He has gone weeks without his medication before, and when he is without his medication, he suffers withdrawals. *Id*. REDACTED has also been administrated the wrong medication about 10 times in the last two years. *Id*.

aa) Class Member REDACTED

During his time in ADOC custody, Mental Health Subclass Member REDACTED has been housed at Bibb, St. Clair, Bullock, and Kilby. Tr. Test. of REDACTED REDACTED has been diagnosed with REDACTED *Id*. He is on the mental health caseload and has a mental health code of MH-2. *Id*.

REDACTED has been prescribed Prolixin, Cogentin, and Prozac. *Id*. He sometimes misses pill call because the line is too long. *Id*. Sometimes the wait for pill call is over an hour and a half long. *Id*.

REDACTED has met with his counselor about twelve times in the span of a year and a half; their meetings generally last about five minutes, or ten minutes at the longest. *Id*. During their meetings, REDACTED counselor only asks if REDACTED anything new to tell him. *Id*. REDACTED sees a psychiatrist via telemedicine every four months; she only asks him if his medication is working. *Id*. When REDACTED was housed at St. Clair, he did not have a counselor or participate in mental health groups; he only saw a psychiatrist ever couple of months. *Id*.

bb) Class Member REDACTED

During his time in ADOC custody, Mental Health Subclass Member REDACTED has been housed in the REDACTED RTU. Tr. Test. of REDACTED REDACTED has been diagnosed with REDACTED . *Id*.

When REDACTED meets with a psychiatrist, a correctional officer always stands outside the open door. *Id*. He does not have the opportunity to participate in any mental health groups. *Id*. He has not met with a treatment team in about one year. *Id*. REDACTED has been on suicide watch several times. *Id*.

REDACTED was prescribed Prolixin shots after he started hearing voices. *Id*. REDACTED was subject to involuntary medication for one or two years is not any longer. *Id*.

cc) Class Member REDACTED

During his time in ADOC custody, Mental Health Subclass Member REDACTED REDACTED has been housed at Donaldson, Holman, and Kilby. Tr. Test. of REDACTED REDACTED is prescribed Haldol. *Id*. His Haldol shots are often administered to him two weeks late. *Id*.

REDACTED sees his psychiatrist every 90 days for about ten minutes. *Id*. Mr. REDACTED only meets with his counselor for about ten minutes at a time. *Id*. When he requests to see his counselor, he is not scheduled for an appointment. *Id*. Mr. REDACTED has never met with his treatment team and has not seen his treatment plan since 2014 at Holman. *Id*. REDACTED has not participated in any mental health groups because he has not received information about when and where they take place. *Id*.

REDACTED placed on suicide watch on a Friday during the summer of 2014; he was not seen by mental health staff until the following Monday, and mental health staff did not complete mental health checks. *Id*. One time when Mr. REDACTED was in segregation, no mental health staff visited him to provide counseling. *Id*.

dd) Class Member REDACTED

During his time in ADOC custody, Mental Health Subclass Member REDACTED REDACTED has been housed at Draper, Elmore, Bibb, Bullock, and Donaldson. Tr. Test. of REDACTED .

REDACTED is prescribed Prolixin and Cogentin shots, which he receives once every two weeks. *Id*. REDACTED has been involuntarily medicated for five years. *Id*. He meets with Dr. Hunter once every six months via telemedicine for his involuntary medication hearing. *Id*. He tells Dr. Hunter that he does not want to receive Prolixin and Cogentin shots, but Dr. Hunter tells him to give it more time. *Id*.

REDACTED meets with his treatment team about once a month for fifteen minutes. *Id*. His treatment team meetings and shot administration are the only times he sees mental health staff; he does not receive one-on-one counseling. *Id*. He wants to be transferred to a mental health camp so that he can receive counseling and participate in mental health groups, which he has not had the opportunity to participate in at Draper or Elmore. *Id*.

ee) Class Member REDACTED

During his time in ADOC custody, Mental Health Subclass Member REDACTED has been housed at Bibb, Kilby, and Bullock. Tr. Test. of REDACTED REDACTED is on the mental health caseload. *Id*.

REDACTED is prescribed a daily pill that a psychiatrist told him is intended to help him sleep. *Id*. REDACTED does not want to take the pill because it makes him sick and he does not think he needs it. *Id*. He takes his pill, however, because he will be placed in lock-up if he does not. *Id*. He was been placed in lock-up for not taking his pill while at Bullock; he has also received a disciplinary twice for not taking his pill. *Id*.

REDACTED is supposed to see a counselor twice a week, but he only sees one once a week. *Id*. His meetings with his counselor last only about one minutes, and involve only his counselor asking if REDACTED is taking his medication, if he is hearing voices, and if he is going to hurt himself. *Id*. REDACTED sees a psychiatrist via telemedicine who also only asks him the same three questions his counselor does and nothing else. *Id*. REDACTED is not currently participating in any mental health groups, but he would like to. *Id*.

ff) Class Member REDACTED

Mental Health Subclass Member REDACTED has been diagnosed with REDACTED. Tr. Test. of REDACTED. He was assigned a mental health code of MH-3 that was lowered to MH-2 in June 2016. *Id.* REDACTED hears voices and experiences paranoia and depression. *Id*.

REDACTED has been prescribed multiple medications, including Haldol, Prolixin, Thorazine, and Remeron. *Id*. Haldol makes REDACTED head and hands shake, and it makes him restless and unable to sleep. *Id*. Prolixin also makes Mr. REDACTED shake and gives him dry mouth and blurry vision. *Id*. In Mr. REDACTED experience, the medication to curb the side effects of his Prolixin is not effective. *Id*.

Mr. REDACTED was placed on suicide watch after cutting himself. *Id*. Mr. REDACTED self-inflicted cut required fifteen staples. *Id*. He was not searched before being placed in the suicide cell. *Id*. While in suicide watch, Mr. REDACTED t only saw a mental health professional twice a week for about twenty minutes at cell front, and was only checked on by officers once an hour. *Id*. Mr. REDACTED removed the staples from his wound and cut himself again with a razor. *Id*. He received a disciplinary for cutting himself and thirty days in segregation. *Id*.

When REDACTED speaks with a mental health professional or psychiatrist in the RTU, an officer is always present, and it makes him feel uncomfortable. *Id*. One mental health group REDACTED participates in involves playing video games and sometimes going outside. *Id*. The group is led by a prisoner, not the activity technician. *Id*.

gg) Class Member REDACTED

Mental Health Subclass Member REDACTED was frequently on suicide watch while she was incarcerated at Tutwiler Prison for Women. Tr. Test. of REDACTED REDACTED She was placed in REDACTED several times while incarcerated. *Id*.

Like others in the ADOC, REDACTED treatment was primarily medication. *Id*. When she saw counselors or providers, the interactions were brief. *Id*.

REDACTED has been doing well since she left the ADOC. *Id*. With adequate mental health care, she has stabilized. *Id*.

hh) Class Member REDACTED

Mental Health Subclass Member REDACTED has been diagnosed with REDACTED, for which he received treatment prior to his incarceration. Tr. Test. of REDACTED. REDACTED has been on the mental health caseload since he entered ADOC custody. *Id*.

REDACTED was placed in lock-up for a period of about four years at Holman and Easterling. *Id*. During that time, he was only allowed out of his single-man cell for about an hour and to shower, but sometimes he spent the entire day in his cell. *Id*. REDACTED experienced the lock-up unit to be loud and chaotic, with prisoners yelling, officers spraying pepper spray at prisoners who threw urine on them, and a prisoner committing suicide. *Id*.

While he was in lock-up, REDACTED saw a counselor about once a week, through the window in his cell. *Id*. The counselor stayed for about a minute, long enough to ask REDACTED if he was alright. *Id*. When REDACTED is housed in general population, he receives counseling every ninety days via telemedicine, but he would feel more comfortable sharing his feelings with someone in person. *Id*.

ii) Class Member REDACTED

Mental Health Subclass Member REDACTED has been housed at Donaldson, Bullock, and Kilby during his time in ADOC custody. Tr. Test. of REDACTED. He has been diagnosed with ADHD since age 15, and is prescribed Vivance, Trazodone, and Seroquel. *Id*. He is not, however, on the mental health case load and never has been. *Id*.

REDACTED was placed in lock-up for five and a half months while at Bullock. *Id*. Other prisoners in lock-up threw feces and urine. *Id*. Ms. Collins, a

psychologist, came to REDACTED ' cell window every Friday to ask if he was okay, but he did not feel comfortable talking to her with people around. *Id*. When the psychologist meets with him cell-front, she only stays for about three to four minutes. *Id*.

In March 2016, after spending about four months in lock-up, REDACTED attempted suicide. *Id*. Though he asked to be placed in a suicide cell, he was returned to his cell. *Id*. REDACTED has not spoken to any mental health staff since he left Bullock. *Id*.

jj) Class Member REDACTED

Mental Health Subclass Member REDACTED is in ADOC custody at Tutwiler. Tr. Test. of REDACTED . She is on the mental health caseload. *Id*. She was on medication before arriving at Tutwiler, but after arriving, she was not placed on the mental health caseload for two months and went without medication for that entire period. *Id*.

REDACTED ' treatment plan team has not discussed her treatment plan with her, and she is not even sure who is on her team. *Id*. REDACTED sometimes waits up to two hours to see a mental healthcare provider ("MHP"). *Id*. REDACTED ' meetings with the MHP last only ten to fifteen minutes; the MHP does not respond when REDACTED expresses violent or unhappy feelings. *Id*.

When REDACTED has expressed suicidal thoughts, she has been laughed at. *Id*. One time when REDACTED was placed in a suicide cell, no one came to check on her for seventy-two hours. *Id*.

REDACTED has had to wait in the pill call line for up to an hour and a half. *Id*. Sometimes up to ninety days pass between REDACTED ' visits with her medication prescriber. *Id*. She has informed her MHP and medication prescriber that her medication is not working, causes mood swings, and makes her feel like a zombie. *Id*. REDACTED doctor changes her medication every few months without explaining why. *Id*. Each time this happens, she goes for two days without medication. *Id*.

REDACTED has been threatened with a disciplinary for refusing to take her medication. *Id*. She has received a disciplinary for cutting herself. *Id*. She has also been disciplined for behavior resulting from the mood swings her medication causes. *Id*. Such discipline has included being placed in segregation from 45 days to up to four months. *Id*. While in segregation, REDACTED is visited by mental health staff for less than a minute at a time. *Id*. She has asked to see an MHP while in segregation but not been allowed to see one. *Id*.

III. Defendants Systematically Fail to Provide Adequate Mental Health Care

A. Overview of the Mental Health Caseload

Prisoners in ADOC are given a mental health code. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 36, ADOC Admin. Reg. 613, Pls. Tr. Ex. 37, ADOC Admin. Reg. 613-1, Pls. Tr. Ex. 38, ADOC Admin. Reg. 613-2. A code of MH0 means the person is not on the mental health caseload. MH1 and MH2 both indicate "Mild impairment in mental functioning, such as depressed mood or insomnia," and that the person can be housed in general population or segregation. *Id*. MH3 indicates "Moderate impairment in mental functioning, such as difficulty in social situations and/or poor behavioral control" and a person so classified can be housed in a Residential Treatment Unit (*see infra*, § III.D.5. for description of Residential Treatment Units or RTUs). *Id*. A classification of MH4 is indicative of "Moderate impairment in mental functioning, such as difficulty in social situations and/or poor behavioral control" and the patient can be housed in a closed RTU. *Id*. A classification of MH5 is for persons who have a "Severe impairment in mental functioning, such as delusions, hallucinations, or inability to function in most areas of daily living," and who should be housed in the Stabilization Unit. (*see infra*, § III.D.5. for description of Stabilization Units or SUs). *Id*. Finally, a classification of MH6 indicates "Severe debilitating symptoms, such as persistent danger of hurting self or others, recurrent violence, inability to maintain minimal personal

hygiene, or gross impairment in communication," and that the ADOC is seeking commitment to a state hospital. *Id*.

As of February 2016, 3,416 prisoners, 14.2% of Alabama's prison population, were on the mental health caseload. Tr. Test. of Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319152. About 9% of the prison population, 2,345 prisoners, was on psychiatric medication. *Id*. Of those, over 700 have a diagnosis of schizophrenia or schizoaffective disorder, almost 500 have a diagnosis of bipolar disorder, and 313 have a diagnosis of psychosis or psychotic features to some disorder.[5] Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 678, Mental Health Caseload Appointments for All Facilities. For the 12-months ending in February 2016, prisoners in ADOC were receiving an average of 1,253 prescriptions for antipsychotic or antimanic medications. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319166.

As of February 2016, nine prisoners were housed in stabilization units ("SU's") and 376 were housed in residential treatment units ("RTU's"). Tr. Test. of Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319155, 0319156. There were just 17 prisoners with a mental

[5] Many of these individuals are diagnosed with schizophrenia or schizoaffective disorder and bipolar disorder, or with bipolar disorder and some iteration of psychosis or psychotic features. There is little overlap in the numbers for schizophrenia and psychosis. Pls. Tr. Ex. 678, Mental Health Caseload Appointments for All Facilities.

health code of MH4 or higher. Tr. Test. of Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319152. In February 2016, there were 180 crisis cell placements for either precautionary watch or suicide watch. Tr. Test. of Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319153, 0319155, 0319156. The longest stay in a crisis cell during the February 2016 reporting period lasted 696 hours, or 29 days, with the next longest stays lasting 515, 490, and 406 hours. *Id*.

As of February 2016, 70 prisoners subject to involuntary medication orders –30 classified as outpatient, 37 housed in an RTU, and 3 housed in an SU. Tr. Test. of Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319153, 0319155, 0319156. Nine of the prisoners subject to involuntary medication orders were housed at St. Clair where there is no psychiatrist assigned full-time. Tr. Test. of Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319153.

In the 2015 fiscal year, six prisoners in ADOC custody committed suicide, and 54 prisoners made serious suicide attempts. Tr. Test. of Teresa Houser, Jefferson Dunn, Ruth Naglich, Dr. Robert Hunter, Dr. Charles Woodley; Pls. Tr. Ex. 127, ADOC Monthly Statistical Report, September 2015, at 11. A serious suicide attempt is one that results in a person being sent out to the hospital. Tr. Test. of Teresa Houser.

B. Defendants Have Inadequate Staffing

1. Inadequate Mental Health Staffing

The mental health staff within ADOC is inadequate both in number and qualification. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker. Inadequate mental health staffing reduces the quality of the mental health care that is provided to prisoners and much of the time is a complete obstacle to the provision of mental health care. *Id*.

a) Inadequate Numbers of Mental Health Staff

Since 2000, the size of the prisoner population had increased to 24,100 by February 2016. Tr. Test. of Jefferson Dunn, Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319152. Likewise, there has been an increase in the number of prisoners on the mental health case load. Tr. Test. of Dr. Robert Hunter; *compare* Pls. Tr. Ex. 764, MHM Monthly Report, June 2013, at ADOC044140 (reporting 3,094 prisoners on the mental health caseload), *with* Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319152 (reporting 3,416 prisoners on the mental health caseload).

Attendant with this increased number of prisoners is an increased need for mental health staff. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 554, Email from T. Houser to R. Naglich, re Contract amendment, June 24, 2015; Pls. Tr. Ex. 890, MHM Multidisciplinary Minutes, Easterling, June 9, 2014, at MHM030039

("Mental Health's caseload is rapidly growing. The caseload has gone from 200 to 212, in less than 1 month. There are 189 MH-1's and 23 MH-2's. Elba Work Release has 3 prisoners coded MH-1."). With this increase in the case load, there has been a concomitant increase in numbers of prisoners with severe mental illness. Tr. Test. of Dr. Robert Hunter.

Nonetheless, ADOC has been progressively decreasing the size of its mental health staff since 2009. Tr. Test. of Teresa Houser. The minimum staffing requirements decreased with the 2008 MHM contract despite the fact that "caseloads were growing." *Id*. Mental health staff was cut even further in the 2013 contract with MHM. Tr. Test. of Teresa Houser, Dr. Kathryn Burns.

Psychologists

The *Bradley* settlement required 10 psychologists. Tr. Test. of Ruth Naglich, Teresa Houser, Dr. Kathryn Burns; Settlement Agreement, *Bradley v. Haley*, Civ. Action No 92-A-70-N (M.D. Ala., Sept. 28, 2000). As of February 2016, there were 3.5 MHM-employed psychologists providing services to the entire ADOC population. Tr. Test. of Ruth Naglich, Teresa Houser, Dr. Kathryn Burns; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016. With fifteen major prisons in Alabama, a single psychologist is expected to provide on-

going and meaningful treatment to a caseload of prisoners and/or provide consultation and assistance with diagnostic formulations in nearly five prisons. This is not possible. Tr. Test. of Dr. Kathryn Burns. This reduction in the number of psychologists has nearly completely hindered psychologists' ability to provide services to prisoners. Tr. Test. of Dr. Kathryn Burns.

Licensed MHPs

The contract between ADOC and MHM requires that each MHM mental health professional ("MHP"), be licensed, certified, or registered in their field of expertise. Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. Despite this provision, MHM often relies on unlicensed MHPs to provide counseling. Tr. Test. of Dr. Kathryn Burns. MHM describes the licensure of counselors as "N/A" on its monthly report to ADOC. Tr. Test. Teresa Houser, R. Naglich, Dr. Woodley; Pls. Tr. Ex. 737-787, MHM Monthly Reports, 2012-2016. Thus, the number of licensed counselors employed by MHM does not even satisfy the terms of the contract. Though the number of MHPs employed by MHM has technically increased from 28 in 2000 to 44.25 in February 2016, 14 of those MHPs are site administrators who either case only a partial caseload or no caseload at all. Thus, the size of MHPs caseloads' has not decreased in proportion to the number of additional MHPs hired. Tr. Test. of Dr. Kathryn Burns.

Of the MHPs and Site Administrators on MHM's February 2016 staffing list, the following are not currently licensed in counseling or social work: Pamela Babers, April Badea, Juan Bailey, Willie Bell, Jennifer Biggers, LaSandra Buchanant, Kairis Bonella, Jeremy Clauswell, Amber Cooper, Jim Corbitt, Carl Damone, Lesleigh Dodd, Shemekia Foster, Toshia Harrison, Shywon Hatcher, Nicole Henderson, Bianca Holcombe, Monica Jackson, Cassandra Lee, Claudia Mayes, O'Jammeca McCarther, Lesheshundrea Miller, Isaac Moore, Quincy Pearson, James Prescott, Vanerettee Robertson, Natasha Smith, Wayne Smith, Deborah Thomas, Kenton Turner, Lara Walker Whitfield, LaQuanda Wiggins, Ninette Woods. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 754, MHM Monthly Report, at ADOC0319157-0319162; Ala. Bd. of Examiners in Counseling, *Licensure Roster Search*, http://abec.state.al.us/licensee.aspx; Ala. St. Bd. of Social Work Examiners, Licensure Search, http://socialwork.alabama.gov/search.aspx.

RNs

MHM relies almost exclusively on licensed practical nurses ("LPNs") rather than registered nurses ("RNs"). Tr. Test. of Dr. Kathryn Burns. LPNs must be supervised by RNs, but there are only 3 RNs employed by MHM, one each at Tutwiler, Donaldson, and Bullock, and they all work only day shifts. *Id*. Thus, LPNs at Tutwiler, Donaldson, and Bullock are working without RN oversight at night and on weekends, and LPNs at other facilities are completely unsupervised

by an RN. *Id*. Furthermore, though the Alabama prison population now includes nearly 4,000 more prisoners than the population considered in the *Bradley* settlement agreement, the number of RNs employed by MHM has not changed – it has remained at 3. Tr. Test. of Ruth Naglich, Teresa Houser, Dr. Kathryn Burns; Settlement Agreement, *Bradley v. Haley*, Civ. Action No 92-A-70-N (M.D. Ala., Sept. 28, 2000); Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016.

b) Inadequately Qualified and Supervised Mental Health Staff

Within ADOC, the trend has been to (1) reduce the number of staff positions for psychiatrists and psychologists, (2) maintain the RN staffing level at 3 full-time RNs, and (3) increasingly rely on mid-level nurse practitioners, LPNs, and often-unlicensed MHPs. Tr. Test. of Dr. Kathryn Burns. In addition, Defendants, the ADOC Office of Health Services, MHM, and site administrators and other supervisors within MHM have failed to provide adequate supervision of the increasingly less qualified mental health staff. *Id*.

Nurse Practitioners

Nurse practitioners now outnumber physicians providing mental health care in the prison system, functioning no longer as physician extenders, as they are intended to be by state law, but physician replacements. Tr. Test. of Dr. Kathryn

Burns. By February 2016, psychiatrists filled less than five full-time mental health positions while nurse practitioners filled more than seven. Tr. Test. of Dr. Kathryn Burns. Dr. Robert Hunter, MHM's Chief Psychiatrist, acknowledges that the nurse practitioners act as "psychiatrist[s] by proxy." Tr. Test. of Dr. Robert Hunter.

The few and overburdened psychiatrists have limited capacity to supervise nurse practitioners as they are required to do. Tr. Test. of Dr. Kathryn Burns. Nurse practitioners do not receive adequate guidance or supervision from their supervising psychiatrists. Tr. Test. of Dorothy Coogan, Cheryl Harvey, Anna Davis-Walker; Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031226 ("I supervise 3 nurses and it is a challenge for me because I do a lot of direct services, and tele-video collaboration is not allowed.").

In fact, some ADOC facilities have only nurse practitioners and no psychiatrists present. Tr. Test. of Dr. Kathryn Burns. With nurse practitioners performing work they are not qualified either at all or without supervision to perform, there is a heightened risk of inaccurate or missed diagnoses and inadequate medication management. *Id.*; Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042185-042188 (finding delinquent AIMS tests and lab work for prisoners on the Easterling mental health caseload).

LPNs

MHM relies almost exclusively on LPNs rather than RNs. Tr. Test. of Dr. Kathryn Burns. LPNs must be supervised by RNs, but there are only 3 RNs employed by MHM, one each at Tutwiler, Donaldson, and Bullock, and they all only work day shift. *Id*. Thus, LPNs at Tutwiler, Donaldson, and Bullock are working without RN oversight at night and on weekends, and LPNs at other facilities are completely unsupervised by an RN. *Id*.

MHM's overuse of LPNs violates Alabama law and creates a serious risk of substantial harm to prisoners. *Id*. LPNs are often used in the reception screening process to make diagnoses, though they are not qualified to do so. *Id*. Allowing LPNs to identify individuals with mental illness increases the risk of psychological suffering, suicide, self-harm, and other behaviors that put prisoners and staff at risk because serious mental illnesses go unidentified or underestimated. *Id*.

Psychological Associates and MHPs

Psychological associates employed by ADOC rather than MHM are responsible for facilitating mental health groups, providing counseling to low-level mental health prisoners, participating in segregation reviews, and making segregation rounds. Tr. Test. of Ruth Naglich. ADOC's psychological associates

are not required to be licensed, and the minimum degree requirement is a bachelor's in any behavioral science. *Id*.

The contract between ADOC and MHM requires that each MHP be licensed, certified or registered in their field of expertise. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 681, 681, 2008 Mental Health Services Agreement and Amendments. Despite this provision, MHM often relies on unlicensed MHPs to provide counseling. Tr. Test. of Dr. Kathryn Burns.

MHPs are directly supervised by site administrators who are also MHPs rather than a licensed psychologist. Tr. Test. of Dr. Charles Woodley. For example, Lesleigh Dodd, a site administrator at Holman, is an unlicensed MHP who is responsible for supervising a clerk, an LPN, a nurse practitioner, an MHP, and a psychologist. Tr. Test. of Lesleigh Dodd. Unlicensed mental health providers are generally required to be supervised by licensed providers. Tr. Test. of Dr. Kathryn Burns. This use of unlicensed mental health staff to provide mental health care and to supervise others who provide mental health care does not meet the standard of care. Tr. Test. of Dr. Kathryn Burns.

Furthermore, MHPs and site administrators receive no meaningful supervision. Tr. Test. of Dr. Kathryn Burns, Cassandra Lee. For example, Dr. Woodley provides input only when they come to him with an issue that needs

clarification or a consultation. Tr. Test. of Dr. Charles Woodley. As a site administrator at Holman, Ms. Dodd supervises mental health staff only by making sure the staff do their jobs and complete their paperwork and providing trainings. Tr. Test. of Lesleigh Dodd. The supervision of Ms. Dodd by Dr. Woodley and Teresa Houser consists of a monthly meeting with Dr. Woodley and all the other site administrators and *ad hoc* phone calls between Ms. Dodd and Dr. Woodley or Ms. Houser if there is a problem. *Id*.

Felicia Greer is an MHM site administrator at Tutwiler. Tr. Test. of Felicia Greer. She supervises MHPs by doing chart reviews, making sure they have an adequate scheduling system in place, and assessing their feelings and emotions about their job performance. *Id*. MHPs at Tutwiler manage their own counseling schedules. *Id*. Ms. Greer primarily looks at the charts to make sure prisoners have been seen by MHPs but does not assess the quality or content of MHPs' counseling. *Id*. Ms. Greer is not a licensed counselor. *Id*.

c) Inadequate Supervision by ADOC and OHS Staff

Associate Commissioner Ruth Naglich heads the ADOC Office of Health Services ("OHS"). Tr. Test. of Ruth Naglich. Laura Ferrell is the OHS Director of Medical Services. Tr. Test. of Ruth Naglich. Brandon Kinard and Lynn Brown are OHS regional coordinators. Tr. Test. of Ruth Naglich, Lynn Brown.

Ms. Brown is responsible for ADOC intake centers and female prisoners' medical and mental health care, and she acts as the liaison between medical and mental health care, and as the policy and procedure liaison with the Department of Public Health. Tr. Test. of Ruth Naglich, Lynn Brown. Ms. Brown, Mr. Kinard and Ms. Ferrell all have significant responsibilities regarding the oversight of medical care. Tr. Test. of Ruth Naglich.

Dr. Tytell is the chief psychologist employed by ADOC. Tr. Test. of Ruth Naglich. Dr. Tytell is responsible for providing clinical oversight of the ADOC-MHM contract, supervising the drug program supervisor, reviewing MHM's review of a prisoner's treatment (or lack thereof) after a suicide or serious suicide attempt, and providing clinical support to ADOC-employed psychologist associates and psychologists. Tr. Test. of Ruth Naglich. Dr. Tytell is not a medical doctor or nurse practitioner, but is responsible for auditing and providing clinical oversight of, among other things, the administration of drugs. Tr. Test. of Ruth Naglich. There is no one with the training or licensure for prescribing medication in the Office of Health Services. *Id*.

Generally, OHS fails to adequately oversee MHM's provision of mental health care. Tr. Test. of Dr. Kathryn Burns. For example, prisoners in segregation continue to be placed in mental health treatment beds, and prisoners with mental illness continue to be placed in segregation with virtually no access to mental

health treatment, and OHS has done nothing to stop these practices. Tr. Test. of Dr. Kathryn Burns, Ruth Naglich.

Additionally, Defendant Naglich, Ms. Ferrell, Ms. Brown, Mr. Kinard, and Dr. Tytell are responsible for conducting audits to monitor compliance with the MHM-ADOC contract and the provision of mental health care. Tr. Test. of Ruth Naglich. The small size of OHS staff and the fact that each staff member has so many responsibilities has an impact on the frequency, quality, and accuracy of the audits and their ability to follow through on any problems identified through the audits. Tr. Test. Dr. Kathryn Burns.

The Blending of Services strategy implemented in the 2009 MHM-ADOC contract amendment also created supervisory problems. Tr. Test. of Teresa Houser. For example, under the Blending of Services provisions in the contract, MHM site administrators are responsible for blending of services, but because site administrators do not have supervisory authority over ADOC psychological associates, who report to the Wardens and Dr. David Tytell instead, there has been conflict between site administrators and ADOC psychological associates. *Id*. Sometimes wardens want ADOC psychological associates to prioritize other tasks over psychological associates' mental health caseloads. Tr. Test. of Teresa Houser.

d) Problems Caused by Inadequate Mental Health Staff

The decrease in the number of mental health staff within ADOC has negatively impacted the mental health services provided at numerous facilities. Tr. Test. of Dr. Kathryn Burns, Teresa Houser.

(1) Delays in the Provision of Mental Health Care

Mental health staffing shortages have led to increased caseloads for MHM counselors, psychiatrists, nurse practitioners, and ADOC psychology associates. Tr. Test. of Dr. Kathryn Burns, Teresa Houser. The staffing shortages cause delays in the provision of mental health care. Tr. Test. of Dr. Kathryn Burns, Teresa Houser; Pls. Tr. Ex. 235, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015 (listing delinquent appointments); Pls. Tr. Ex. 282, Email from A. Davis-Walker re Ventress Audit Findings from Nov. 24, Dec. 2, 2015, at MHM042007-04200 (same). MHM Chief Psychiatrist, Robert Hunter, has also observed the impact of staffing shortages on the mental health care within ADOC. Tr. Test. of Dr. Robert Hunter.

(2) Inadequate Identification of Mentally Ill Prisoners

Due to staffing shortages, LPNs play the important role of classifying prisoners at intake and triaging requests for care. During the intake process, LPNs determine whether prisoners should be referred for additional psychiatric evaluation. Tr. Test of Dr. Kathryn Burns, Teresa Houser. LPNs are not qualified

to do these tasks. Tr. Test. of Dr. Kathryn Burns, Teresa Houser. Utilizing LPNs to screen for mental health issues leads to a failure to identify and treat seriously mentally ill individuals because they are not qualified to do so. Tr. Test. of Dr. Kathryn Burns.

(3) Inadequate Counseling and Treatment Planning

The inadequate number of psychiatrists has impacted their ability to provide services to prisoners. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker. For example, the shortage of MHM psychiatrists required Dr. Hunter to take on full responsibility for all psychiatric medication refills for RTU prisoners so that Dr. Kern, another psychiatrist, could focus on the SU population. Tr. Test. of Robert Hunter, Anna Davis-Walker; Pls. Tr. Ex. 252, Email from A. Davis-Walker re Medication Refills, Delays in Provider Appts in Bullock RTU, Dec. 29, 2015, at MHM0044269. And a November 2015 spot audit at Easterling found that 75 prescription provider (psychiatrists and nurse practitioners) appointments were delinquent. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042185-042188.

Additionally, the few and overburdened psychiatrists have limited capacity to supervise nurse practitioners as they are required to do, which results in nurse practitioners performing work they are not qualified to perform at all or without supervision. Tr. Test. of Dr. Kathryn Burns. This leads to a heightened risk of

inaccurate or missed diagnoses and inadequate medication management. *Id*.; Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042185-042188 (finding delinquent AIMS tests and lab work for prisoners on the Easterling mental health caseload).

Likewise, MHPs do not provide meaningful and regular counseling to prisoners. Counseling sessions are brief, cursory, and irregular. Tr. Test. of Richard Businelle, Robert Dillard, Richard Terrell, REDACTED . These brief, irregular, cursory interactions are not counseling sessions, but rather "drive-bys." Tr. Test. of Dr. Craig Haney. Even very seriously mentally ill prisoners receive only "drive-by" check-ins, rather than regular, meaningful counseling. Tr. Test. of Dr. Craig Haney. Short, cursory meetings with mental health staff do not constitute counseling or psychotherapy. Tr. Test. of Dr. Kathryn Burns.

When prisoners do meet with counselors, their conversations are often nearly identical each visit, and counselors' progress notes are superficial and rote. Tr. Test. of REDACTED , Roger McCoy; Pls. Tr. Ex. 1121, R. McCoy Med. Records, at MR039983 (containing brief notes from multiple counseling sessions, some of which are identical).

Additionally, treatment planning is inadequate. Treatment plans are often out-of-date. For example, one spot audit at Bibb found that 204 treatment plans (out of 214 total prisoners on the mental health caseload) were outdated or required review; a spot audit at Easterling found that 40 out of 195 treatment plans were out-of-date or needed review; and a spot audit at Donaldson found 185 out of 210 treatment plans were outdated or needing review. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 221, Email from A. Davis-Walker re Bibb Audit Findings from Dec. 1, 2015, Dec. 2, 2015, at MHM042009-042011; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042185-042188; Pls. Tr. Ex. 229, Email from A. Davis-Walker re Donaldson Deficiencies to Address, Nov. 23, 2015, at MHM042355. And in January 2016, Teresa Houser reviewed the mental health database for St. Clair and found forty out-of-date treatment plans. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 628, Email from T. Houser to A. Davis-Walker re St. Clair database, January 5, 2016, at MHM048867-048872.

Often, prisoners do not know what their treatment plans say, and no one explains their treatment plans to them. Tr. Test. of REDACTED

Also, prisoners' treatment plans often contain boilerplate language. Tr. Test. of Dr. Raymond Patterson; Pls. Tr. Ex. 203, E. Braggs Med. Records, at MR001614, 001615, 001624, 001625, 001626; Pls. Tr. Ex. 1140, S.

Hartley Med. Records, at MR044246-044253, 048490; Pls. Tr. Ex. 626, J. Wallace Med. Records, at MR030318 (showing that even when Plaintiff Wallace is suicidal and requests to be placed in a safe cell, his treatment plan is to "work on positive coping skills and patience for an appointment").

Treatment plans are often not signed by the required mental health staff. Tr. Test. of Anna Davis-Walker; *see also e.g.*, Tr. Test. of Edward Braggs, Leviticus Pruitt; Pls. Tr. Ex. 203, E. Braggs Med. Records, at MR001614, 001615, 001624, 001625, 001626; Pls. Tr. Ex. 646, L. Pruitt Med. Records, at MR012034-012039, 012041 (showing that no psychiatrist, psychologist, or nurse practitioner ever signed off on Plaintiff Pruitt's treatment plan during the time he was in a safe cell). Additionally, treatment plan meetings are often not attended by the required participants, including the prisoners themselves. Tr. Test. of Dr. Raymond Patterson; Pls. Tr. Ex. 1140, S. Hartley Med. Records, at MR006836-006840, 006842-006843, 006857; Pls. Tr. Ex. 1121, R. McCoy Med. Records, MR010021, 010026 (showing that Plaintiff McCoy's treatment plans were reviewed and altered outside of his presence and without his input).

While many prisoners' treatment plans include participation in mental health groups, such groups are often not available to prisoners. Anticipated Trial Testimony of Dr. Kathryn Burns; Tr. Test. of REDACTED, Daletrick Hardy, REDACTED. For example, due to the mental

health staffing shortage, staff are no longer able to conduct groups for prisoners in segregation at Holman. Tr. Test. of Lesleigh Dodd. When mental health groups are available, they often consist of seemingly trivial activities, such as watching television or playing video games, or repeat topics. Tr. Test. of Richard Businelle, REDACTED ; Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031218 (noting repeating group topics was a problem).

Finally, inadequate mental health staffing levels have had an impact on the thoroughness and accuracy of MHM's recordkeeping. Defendants' expert, Dr. Patterson, noted several problems with missing Records, including: (1) the "failure to document medication refusals in the medical Records and failure to document counseling therein"; (2) "incomplete documentation of mental health treatment plans, including ordering AIMS testing and individualized treatment plans and updates"; and (3) missing "documentation of clinical acknowledgement of serial refusals of medication, especially regarding psychotropic medications." Tr. Test. of Dr. Raymond Patterson, Dr. Kathryn Burn.

Anna Davis-Walker noted such problems during spot audits at various ADOC facilities. Tr. Test. of Anna Davis-Walker, Dr. Craig Haney, Brenda Fields; Pls. Tr. Ex. 235, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015, at MHM041863-041865; Pls. Tr. Ex. 282, Email

from A. Davis-Walker re Ventress Audit Findings from Nov. 24, Dec. 2, 2015, at MHM042007-04200.

e) Inadequate Correctional Staff

As far back as 2009, ADOC recognized its shortage of custody officers. In its annual report for 2009, ADOC admitted that it had only 3,043 of the authorized 3,928 Correctional Staff, for a shortage of about 23%. Tr. Test. of Richard Allen, Jefferson Dunn; Ex. 117, ADOC FY 2009 Annual Report, at 21. At the same time, there were 2,650 authorized Correctional Officers, and 2,087 actual Correctional Officers. Tr. Test. of Eldon Vail. The in-house population at the end of FY 2009 was 25,575. Tr. Test. of Eldon Vail. If the ADOC had had all the authorized Correctional Officers, there would have been a Correctional Officer to Inmate ratio of 1:12. Tr. Test. of Richard Allen, Jefferson Dunn; Ex. 117, ADOC FY 2009 Annual Report, at 21. It was not uncommon for a single Correctional Officer to be supervising up to 250-300 medium or higher level prisoners for an extended period of time. Tr. Test. of Richard Allen, Jefferson Dunn; Ex. 117 ADOC FY 2009 Annual Report, at 21. At that time, the average Correctional Officer to Inmate ratio in surrounding states was 1:6. Tr. Test. of Richard Allen, Jefferson Dunn; Ex. 117, ADOC FY 2009 Annual Report, at 21.

As of August 2016, ADOC had 3,565 Correctional Officers authorized, but had only 1,656 Correctional Officers. Tr. Test. of Jefferson Dunn; Ex. 121 ADOC

Monthly Report, August 2016, at 15. The shortage from the authorized number was approximately 54%. Tr. Test. of Jefferson Dunn; Ex. 121, ADOC Monthly Report, August 2016, at 15. The in-house population in August 2016 was 23,574. Tr. Test. of Jefferson Dunn; Ex. 121, ADOC Monthly Report, August 2016, at 2. Thus, there are now far fewer Correctional Officers per inmate than there were in 2009.

ADOC has a chronic shortage of correctional staff. Tr. Test. of Eldon Vail. In 2006, ADOC had a shortage of 444 correctional officers. *Id*. The staffing levels have been in a near-constant decline ever since. *Id*. In 2013, ADOC was operating at a 43.3% shortage. *Id*. As of the end of August 2016, ADOC was operating with less than half its authorized correctional officers. *Id*. This problem has long been known by Defendants, and it directly impacts the provision of healthcare. Tr. Test. of Eldon Vail, Richard Allen.

(1) Problems Caused by Inadequate Custodial Staff

Defendants' inadequate correctional officer staffing impacts mental health care in several ways. Mental health counseling has been delayed because of a lack of custodial staff. Tr. Test. of Cheryl Harvey, Dr. Kathryn Burns, Dr. Craig Haney. Inadequate correctional staff has also resulted in the cancellation of group counseling. Tr. Test. of Brenda Fields, Teresa Houser, Dr. Haney; Pls. Tr. Ex. 206, Email from A. Davis Walker re Conducting Groups without Corrections Staff,

Feb. 16, 2016; Pls. Tr. Ex. 225, Email from A. Davis-Walker re Conducting Groups without Security, Feb. 17, 2016; Pls. Tr. Ex. 269, Email from A. Davis-Walker re Security Staffing Shortage for Groups, Feb. 19, 2016; Pls. Tr. Ex. 429, Email from R. Naglich to T. Houser re conducting groups without security, February 18, 2016; Pls. Tr. Ex. 512, Email from T. Houser re conducting groups without security, February 17, 2016; Pls. Tr. Ex. 513, Email from T. Houser re conducting groups without security, February 17, 2016; Pls. Tr. Ex. 536, Email from T. Houser to R. Naglich re Inadequate Security Staff to Provide Groups at Fountain, Feb. 19, 2016. Lack of security has impeded pill call. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 314, Email from D. Crook to R. Naglich re: violence at St. Clair, January 22, 2015; Pls. Tr. Ex. 385, Email from R. Naglich re Impact of Staffing Shortage at St. Clair, June 18, 2015. Also, the lack of security in at least one dorm has resulted in numerous incidents of self-harm and the need for crisis cell placements. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 222, Email from A. Davis-Walker re Bibb Dorm B (hot dorm), March 2, 2016.

Insufficient numbers of custodial staff have impacted the treatment of persons housed in SU or RTU. Tr. Test. of Teresa Houser, Dr. Kathryn Burns, Dr. Craig Haney; Pls. Tr. Ex. 459, Email from T. Houser re Corrections Obstacles to SU Programming, Aug. 20, 2015. ADOC does not always provide enough officers in the SU or RTU to allow programming to proceed. Tr. Test. of Teresa Houser.

At the Bullock Stabilization Unit ("SU"), the only male SU in the ADOC, mental health staff cannot provide treatment because there are insufficient officers to get inmates out of their cells in the Stabilization Unit and supervise them during group activities. Tr. Test. of Dr. Kathryn Burns.

Prisoners with serious mental illness in the RTU at Donaldson cannot come out of their cells to access the very care they have been sent there to receive because of lack of correctional staff. Tr. Test. Dr. Kathryn Burns. This has been a problem for years at Donaldson. Tr. Test. Dr. Kathryn Burns; Pls. Tr. Ex. 135, Audits by MHM Corporate Team; Pls. Tr. Ex. 168, Clinical Contract Compliance Review Report, March 2015; Pls. Tr. Ex. 115, ADOC-MHM Clinical Compliance Review Report, Feb. 2016. Correctional officer shortages have led to delays in counseling for prisoners housed in segregation. Pls. Tr. Ex. 1033, Multidisciplinary Minutes, St. Clair Correctional Facility, Sept. 25, 2014, at MHM029962.

Lack of custodial staff has also meant that prisoners on death row do not receive counseling. Tr. Test. of Lesleigh Dodd, Teresa Houser. Prisoners in segregation or on death row at Holman must be brought to mental health by a two-man escort and mental health staff cannot see them if there are not enough staff. *Id*. Segregation rounds are often delayed because of security staff shortages. Tr. Test. of Teresa Houser.

The unavailability of correctional staff is an obstacle to mental health treatment. Prisoners have missed mental health appointments because correctional officers have not been available to take them. Just after Plaintiff Jackson was sentenced to Life without the Possibility of Parole, a time when prisoners are particularly at risk for self-harm, his mental health appointment was cancelled due to a shortage of officers. Tr. Test. of Dr. Kathryn Burns, Dr. Robert Hunter; Pls. Tr. Ex. 150, C. Jackson Med. Records, at MR007874. Mental health staff has documented several other occasion when Plaintiff Jackson's appointments have been cancelled due to officer shortages or institutional lockdowns. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 150, C. Jackson Med. Records, at MR007749, MR007752, MR030810, MR030812. MHM has cancelled other Plaintiffs' appointments as well, due to officer shortages or institutional lockdowns. Tr. Test. of Howard Carter, Joshua Dunn; Pls. Tr. Ex. 618, H. Carter Med. Records, at MR003391, 003394, 003405, 029622, 029619; Pls. Tr. Ex. 631, J. Dunn Med. Records, at MR043865

C. Inadequate Identification & Classification of Prisoners with Mental Illnesses

Prisoners with mental health needs in ADOC custody are routinely not identified or classified appropriately. Due to the inadequate identification and classification of prisoners with mental illnesses, a number of prisoners are not on the mental health caseload even though they should be. Tr. Test. of Dr. Kathryn

Burns, Dr. Craig Haney. And prisoners with serious mental health needs are not appropriately classified and thus are not receiving the level of mental health care they need. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney.

ADOC's systemically inadequate identification and classification of prisoners with mental illnesses is evident when the mental health caseload numbers are compared with data from elsewhere in the country. ADOC and MHM report lower prevalence rates of mental illness than other prisons and prison systems throughout the country. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney. The February 2016 MHM Monthly Report indicates that 14.2% of the prison population was on the mental health caseload, and 9.7% of prisoners were prescribed psychotropic medications. Pls. Tr. Ex. 752, MHM Monthly Report, Feb. 2016, at ADOC0319152. Only 1.3% of prisoners were identified as suffering more than a "mild impairment." *Id*.

In contrast, the Bureau of Justice Statistics Special Report on Mental Health Problems of Prison and Jail Inmates found 73% of female prisoners and 55% of male prisoners reported mental health problems. Tr. Test. of Dr. Kathryn Burns. And Plaintiffs' Expert Dr. Kathryn Burns estimates that mental illness prevalence rates in state prisons are approximately 25-30% for male prisoners, with 10-15% having serious mental illnesses, and as much as 80% for female prisoners, with 30% having serious mental illnesses. *Id*. ADOC is grossly underidentifying the

number of prisoners with mental illness and specifically the number of prisoners with serious mental illnesses. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney.

a) Inadequate Screening and Identification at Reception

Nearly all prisoners come into ADOC at either Tutwiler Prison for Women if they are women or Kilby Correctional Facility if they are men. Tr. Test. of Ruth Naglich, Jefferson Dunn. Men who have been sentenced to death go through reception at Holman Correctional Facility. *Id*. They all go through two parallel processes for evaluating their mental health at the time of reception into ADOC custody. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns.

One process is conducted by ADOC psychology staff who interview the incoming prisoners and complete a four-page Psychological Evaluation form. Tr. Test. of Dr. Scott Holmes, Dr. Kathryn Burns. The information obtained during that process, however, is not later used by ADOC or MHM staff for assessment or treatment planning. Tr. Test. of Dr. Kathryn Burns.

However, all incoming prisoners also go through a separate MHM reception screening process. Tr. Test. of Dr. Scott Holmes, Dr. Kathryn Burns. In MHM's reception screening process, LPNs screen prisoners for mental health and psychotropic prescription histories. Tr. Test. of Dr. Scott Holmes, Dr. Kathryn Burns. LPNs then determine whether to refer a prisoner for further psychiatric

evaluation, though they are not qualified to do so. Tr. Test. of Dr. Kathryn Burns, Teresa Houser. In other correctional systems, RNs or master's-level counselors perform mental health screening and referral. Tr. Test. of Dr. Kathryn Burns. Allowing LPNs to identify individuals with mental illness increases the risk of psychological suffering, suicide, self-harm, and other behaviors that put prisoners and staff at risk because serious mental illnesses may go unidentified or underestimated. *Id*.

As a result of ADOC's inadequate screening and identification processes, prisoners who should be are not placed on the mental health caseload at the time they enter custody. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson. Prisoners who need mental health care but are not on the mental health caseload are at serious risk of harm because they receive little or no mental health care. *Id*. Such prisoners may suffer mental health symptoms including suicide and disciplinary actions due to inadequate treatment. *Id*.

b) Inadequate Identification When Prisoners Demonstrate Mental Healthcare Needs

Prisoners' mental health needs continue to go unidentified or underestimated throughout their time in ADOC custody. Despite their displaying severe and even dangerous manifestations of mental illness, many prisoners remain at low mental health codes or not on the mental health caseload at all. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney.

For example, at intake, Plaintiff Myniasha Williams informed the LPN about her history of mental health treatment, as well as past suicide attempts and substance abuse treatment. Tr. Test. of Myniasha Williams; Pls. Tr. Ex. 1119, R. M. Williams Med. Records, at MR017083. Despite her history of mental illness and past suicide attempts, Plaintiff Williams was assigned a mental health code of MH-1 after receiving a mental health evaluation. *Id*. at MR017085-017086; *see also id*. at MR017087. Despite numerous instances of self-harm, Plaintiff Williams was not placed on the mental health caseload until March 2014. Tr. Test. of Myniasha Williams; *see generally* Pls. Tr. Ex. 1119, R. M. Williams Med. Records.

Likewise, despite informing ADOC staff upon entry into custody of his history of mental illness and numerous subsequent self-harm incidents, Plaintiff Joshua Dunn was not placed on the mental health caseload. Tr. Test. of Joshua Dunn; Pls. Tr. Ex. 631, J. Dunn Med. Records. While in segregation for 9-months, Plaintiff Dunn decompensated and engaged in self-harm repeatedly. *Id*. He was placed in suicide watch each time, but was not provided with counseling while on watch or any follow-up afterwards. *Id*. The last time he harmed himself, he had to be sent to the hospital, where he required 23 staples in his arm. *Id*.

Additionally, MHM and correctional staff sometimes respond slowly or not at all when prisoners self-identify as needing mental health services. When staff

do not respond to written or verbal requests to see mental health, prisoners are led to engage in harmful behavior, such as self-injury, suicide attempts, setting fires, and property damage, in order to receive mental health treatment. Tr. Test. of Dr. Kathryn Burns.

c) Inadequate Classification of Prisoners with Mental Healthcare Needs

Prisoners with mental illness are also inappropriately classified. For many, the acuity of their illness is not recognized by correctional, medical, or mental health staff. This is due in part to the fact that the ADOC mental health coding or classification system does not correlate with the definition of serious mental illness. Tr. Test. of Dr. Kathryn Burns. The ADOC mental health codes, defined in ADOC Admin. Reg. 602, classify prisoners by their presumed housing needs (outpatient, residential treatment, or stabilization unit – dormitory or cell) as opposed to whether or not they have a serious mental illness. *Id.*

Furthermore, the MHM-ADOC contract incentivizes understating the severity of mental illness so that more expensive residential treatment and stabilization unit beds are underutilized. Tr. Test. of Dr. Kathryn Burns, Teresa Houser. MHM monthly reports repeatedly demonstrate under-utilization of SU and RTU bed space. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 737-787, MHM Monthly Reports. The February 2016 MHM Monthly Report showed only 79% of

the male RTU beds and 57% of the Tutwiler beds filled at the end of the month. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016, at ADOC0319155. And in February 2016, there were only 9 inmates in the 30-bed Bullock SU and no women in the 8-bed Tutwiler SU. *Id*. at ADOC0319156.

ADOC's flawed mental health coding system and contract incentives result in prisoners who are heavily medicated and displaying serious mental illness being classified as only MH-1 or MH-2. *Id*.; Tr. Test. of Dr. Craig Haney. Plaintiff Robert Dillard, for example, has recently been classified as an MH-1, despite a history of acute mental illness and ongoing auditory hallucinations and paranoia. Tr. Test. of Dr. Kathryn Burns, Robert Dillard; Pls. Tr. Ex. 1120, R. Dillard Med. Records, at MR048264. Others like Plaintiff Dillard, including Plaintiffs Christopher Jackson, Sylvester Hartley, and Roger McCoy and Class Member REDACTED, have displayed hallucinatory or delusional symptoms that have gone un- or under-identified by mental health staff. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Christopher Jackson, Sylvester Hartley, Roger McCoy, R REDACTED.

Prisoners who engage in self-harm or self-report mental health crises are also routinely not identified as needing more mental health care. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Teresa Houser. Such prisoners include Plaintiffs

Christopher Jackson, Sylvester Hartley, Joshua Dunn, and Myniasha Williams. Tr. Test. of Christopher Jackson, Sylvester Hartley, Joshua Dunn, Myniasha Williams. One prisoner, REDACTED , had a history of self-injury, specifically head-banging. Tr. Test. of Brandon Kinard, Dr. Robert Hunter; Pls. Tr. Ex. 1223, Email from B. Kinard, re REDACTED need for treatment, June 30, 2014. On July 29, 2015, he reported being stressed and feeling suicidal. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 224, Email from A. Davis-Walker re REDACTED Suicide Attempt Tracking Sheet. He was discharged from suicide watch on August 3, 2015 by nurse practitioner Coogan. *Id*. On September 29, 2015, he committed suicide by hanging himself. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 1228, Email from R. Naglich, re information about REDACTED , Sept. 29, 2015.

D. Inadequate Mental Health Treatment

1. Inadequate Treatment Planning

Treatment planning is critical to the provision of mental health care. Tr. Test. of Dr. Kathryn Burns. Treatment plans should be individualized. Tr. Test. of Brenda Fields, Dr. Raymond Patterson, Dr. Kathryn Burns; Pls. Tr. Ex. 54, ADOC Admin. Reg. 622. They should be multidisciplinary, including a psychiatrist and other members of the patient's treatment team. Tr. Test. of Dr. Raymond Patterson, Brenda Fields, Dr. Kathryn Burns; Pls. Tr. Ex. 54, ADOC Admin. Reg. 622. The patient should participate in treatment planning, and should know the

identified problems and goals. Tr. Test. of Brenda Fields, Dr. Kathryn Burns; Pls. Tr. Ex. 54, ADOC Admin. Reg. 622. Treatment plans should be reviewed and updated to reflect the progress of the patient. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson; Pls. Tr. Ex. 54, ADOC Admin. Reg. 622.

Treatment plans in the ADOC are frequently not signed by all members of the treatment team. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson, Brenda Fields, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626, 631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley. Even when signed, they are often signed on different days, indicating that they were not completed through a collaborative meeting process. Tr. Test. of Dr. Raymond Patterson, Brenda Fields, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626, 631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley. In many cases, there is no psychiatrist on the treatment team, although a psychiatrist is supposed to be the chairperson of the treatment team. Tr. Test. of Dr. Raymond Patterson, Brenda Fields, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626,

631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley. When a psychiatrist or nurse practitioner does sign the treatment plan, that signature is often days or weeks after all other signatures. Tr. Test. of Dr. Raymond Patterson, Brenda Fields, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626, 631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley.

Frequently, the patient does not sign the treatment plan. Tr. Test. of Dr. Raymond Patterson, Brenda Fields, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626, 631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley. Patients do not know what is in their treatment plans. Tr. Test. of Joshua Dunn, Sylvester Hartley, Richard Businelle, REDACTED , Roger McCoy, REDACTED

The treatment plans are not individualized. Tr. Test. of Dr. Raymond Patterson, Dr. Kathryn Burns, Brenda Fields, Dr. Robert Hunter, Teresa Houser,

Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626, 631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley. They are not tied to the individual problems experienced by individual patients. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson, Brenda Fields, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626, 631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley. Moreover, they do not change over time, regardless of the improvement or lack thereof in the patient's condition. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson, Brenda Fields, Dr. Robert Hunter, Teresa Houser, Anna Davis-Walker; Pls. Tr. Ex. 150, 177, 203**,** 618, 626, 631, 633, 646, 1112, 1117-1121, 1140, Med. Records of C. Jackson, D. Hardy, E. Braggs, H. Carter, J. Wallace, J. Dunn, K. Moncrief, L. Pruitt, Q. Bui, R. Businelle, R. Terrell, R. M. Williams, R. Dillard, R. McCoy, S. Hartley.

2. Overreliance on and Inadequate Management of Medication

For many in ADOC custody, medication is virtually the only mental health treatment provided. Tr. Test. of Dr. Kathryn Burns. And even the provision of medication is riddled with inadequacies including: an overreliance on harmful

long-acting psychotropic medications; clinical decisions that are budget-driven; a failure to obtain adequate informed consent to medication; a failure to provide timely follow-up appointments, monitoring, and lab work; errors in medication administration resulting in missed or incorrect medication; and medication administration obstacles and errors that result in missed or incorrect medication.

a) Medication as the Only Treatment

Throughout the ADOC – for outpatients as well as persons living in mental health units – psychotropic medication is the main, often the only, treatment intervention provided. Tr. Test. of Dr. Kathryn Burns, Dr. Robert Hunter. It is well established that mental health treatment is more than psychotropic medication. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson. Some mental health conditions do not require treatment with medication at all; other conditions require medication but improve to a greater extent when treatment with medication is combined with other treatment modalities including group and individual psychotherapy. Tr. Test. of Dr. Kathryn Burns.

Medication is virtually the only mental health treatment many prisoners in ADOC custody receive. Prisoners on the outpatient caseload have little or no access to group counseling. *See infra* § III.D.4. And there is simply no group therapy for prisoners on the outpatient caseload housed in segregation. *Id*. Many prisoners also do not receive counseling at all or, if they do, their sessions are brief

and perfunctory. *See infra* § III.D.4, 5, 6 (discussing inadequate mental health treatment at the various levels of care); Tr. Test. of Roger McCoy. At Donaldson, for example, people living in the closed Residential Treatment Unit report that they are locked in their cells with minimal opportunity to participate in treatment interventions other than medication. *See infra*, § III.B.1.d.3; Tr. Test. of Richard Terrell.

Throughout the ADOC system, including in the RTUs and SUs, there is an over-reliance on psychotropic medication as the primary, and sometimes the only, treatment intervention consistently available. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns. Specifically, there is an over-reliance on long-acting haloperidol (Haldol) and fluphenazine (Prolixin) injections. These particular medications, and others like them, impact normal movement and can cause severe restlessness (akathisia) and painful muscle spasms (acute dystonic reaction) and also lead to permanent, irreversible movement disorders that include tremors, involuntary movements of the tongue and mouth (tardive dyskinesia), and Parkinsonism. Tr. Test. of Dr. Kathryn Burns. Many prisoners on the mental health caseload show signs of or report these side effects. Tr. Test. of Dr. Kathryn Burns, Q. Bui, REDACTED, Richard Businelle, Sylvester Hartley, REDACTED. Although other medications are less likely to cause these problems, prisoners are not offered

these other medications. Tr. Test. Dr. Burns, Christopher Jackson, Quang Bui, Sylvester Hartley.

Another side effect of a number of psychotropic medications is heat sensitivity. Tr. Test. of Dr. Craig Haney, Dr. Robert Hunter, Robert Dillard. Yet a number of ADOC facilities are not air conditioned and become extremely hot during the summer months. *Id*. This causes prisoners with increased heat sensitivity to experience adverse effects such as dizziness and, in some cases, prisoners are forced to not take their medication because they cannot bear the side effects. *Id*.

b) Budget-Driven Clinical Decisions

The cost of certain pharmaceuticals affects treatment decisions. Tr. Test. of Dr. Robert Hunter. MHM Monthly Reports track the amount of money spent each month on three "Target Medications": Abilify, Thorazine, and Tegretol. Tr. Test. of Teresa Houser, Anna Davis-Walker, Dr. Robert Hunter; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016, at ADOC0319165. At MHM CQI meetings, MHM's concerns over the cost of these medication particularly and the cost of medications generally are regularly discussed. Tr. Test. of Teresa Houser, Lynn Brown; Pls. Tr. Ex. 670, CQI Quarterly Meeting Minutes. After a price jump for Thorazine, the MHM Chief Psychiatrist, Dr. Robert Hunter, asked clinicians to take prisoners off Thorazine. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Lynn Brown; Pls.

Tr. Ex. 670, CQI Quarterly Meeting Minutes, at MHM031217. Similarly, when providers keep the medication expenditures low, they are praised by their employer. *Id*. Patients have been told they cannot use medications that have worked for them in the past because they are too expensive. Tr. Test. of Jamie Wallace, REDACTED

Additionally, the provision of mental health medication within ADOC is affected by inadequate supervision of mid-level mental health professionals – another side-effect of focusing on cost-minimization. The few and overburdened psychiatrists have limited capacity to supervise nurse practitioners as they are required to do, which results in nurse practitioners performing work they are not qualified to perform at all or without supervision. Tr. Test. of Dr. Kathryn Burns. This leads to a heightened risk of incorrect clinical decisions and inadequate medication management. *Id*.; Tr. Test. of Anna Davis-Walker.

c) Failure to Obtain Informed Consent

Mental health staff also fail to obtain informed consent to medication. *See* § VI.D. Signed consent forms are not always present in prisoners' mental health Records and are sometimes forged. Tr. Test. of Roger McCoy, Anna Davis-Walker; Pls. Tr. Ex. 577, Emails from A. Davis-Walker re Audit results 6.28.15, June 29, 2015, at MHM041863. Many prisoners are asked to sign informed

consent forms though it is clear that they cannot read and write well, or at all. Tr. Test. of Richard Terrell.

Mental health staff also do not adequately educate prisoners about the purposes and side effects of their medications. Tr. Test. of Robert Dillard, Roger McCoy, Richard Terrell. Many prisoners do not know which medications they take or what their medications are intended to treat. *Id*.

Prisoners are also often involuntarily medicated through threats, coercion, and even the use of force. Tr. Test. of Dr. Kathryn Burns, Quang Bui, Roger McCoy, REDACTED *See also infra* § VI.D. Some are threatened with disciplinaries if they refuse to take their medications. Tr. Test. of Robert Dillard. Some are threatened with forced injections if they refuse their medication. Tr. Test. of Dr. Kathryn Burns. And others are threatened with and actually subjected to violence if they refuse their medications. Tr. Test. of Roger McCoy, Robert Dillard, REDACTED .

d) Failure to Provide Timely Follow-Up Appointments, Monitoring, and Lab Work

Due to the side effects, Abnormal Involuntary Movements Scale ("AIMS") testing must be performed every six months on prisoners who take certain psychotropic drugs. Tr. Test. of Anna Davis-Walker, Dr. Robert Hunter. This testing is not performed regularly and timely. Spot audits conducted by Anna

Davis-Walker revealed overdue AIMS testing at a number of facilities. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 235, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015, at MHM041863; Pls. Tr. Ex. 282, Email from A. Davis-Walker re Ventress Audit Findings from Nov. 24, Dec. 2, 2015, at MHM042007; Pls. Tr. Ex. 576, Email from A. Davis-Walker re mental health caseload at Bibb, December 2, 2015, at MHM042010; Pls. Tr. Ex. 223, Email from A. Davis-Walker re Bullock Outpatient Deficiencies to Fix Before Audit, Nov. 18, 2015, at MHM042327; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042187; Pls. Tr. Ex. 238, Email from A. Davis-Walker re Hamilton Audit 6.22.15, June 29, 2015, at MHM41899.

Like AIMS testing, regular lab work is necessary for medication management. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 42, ADOC Admin. Reg. 616. However, lab work for prisoners on psychotropic medications is often delinquent or not appropriately recorded. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 282, Email from A. Davis-Walker re Ventress Audit Findings from Nov. 24, Dec. 2, 2015, at MHM042007; Pls. Tr. Ex. 576, Email from A. Davis-Walker re mental health caseload at Bibb, December 2, 2015, at MHM042010; Pls. Tr. Ex. 223, Email from A. Davis-Walker re Bullock Outpatient Deficiencies to Fix Before Audit, Nov. 18, 2015, at MHM042327; Pls. Tr. Ex. 295, Email from A. Davis-

Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042187; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042187; Pls. Tr. Ex. 238, Email from A. Davis-Walker re Hamilton Audit 6.22.15, June 29, 2015, at MHM41899.

Similarly, weight or BMI monitoring is necessary for patients on psychotropic medications, and such monitoring is often overdue or not conducted at all. Tr. Test. of Dr. Robert Hunter, Anna Davis-Walker; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042187; Pls. Tr. Ex. 238, Email from A. Davis-Walker re Hamilton Audit 6.22.15, June 29, 2015, at MHM41899.

Prisoners on psychotropic medications are required to meet with their medication provider – either a psychiatrist or a nurse practitioner – at least every 30 days for prisoners housed in an RTU and at least every 90 days for prisoners receiving outpatient care. Tr. Test. of Dr. Robert Hunter, Felicia Greer; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. However, such provider appointments are often overdue. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 235, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015; Pls. Tr. Ex. 282, Email from A. Davis-Walker re Ventress Audit Findings from Nov. 24, Dec. 2, 2015; Pls. Tr. Ex. 576, Email from A. Davis-Walker re mental health caseload at Bibb, December 2, 2015; Pls. Tr. Ex. 223,

Email from A. Davis-Walker re Bullock Outpatient Deficiencies to Fix Before Audit, Nov. 18, 2015; Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015.

Likewise, according to ADOC's Request for Proposals for mental health providers, mental health follow-up appointments are to be provided to prisoners on psychotropic medication at least every 60 days. Tr. Test. of Dr. Kathryn Burns. However, follow-up appointments for prisoners on psychotropic medication are infrequent, brief, and frequently not conducted in a confidential area. Tr. Test. of Dr. Kathryn Burns.

e) Medication Administration Obstacles and Errors Resulting in Missed or Incorrect Medication

Prisoners sometimes do not receive their medication for weeks at a time when they are transferred to a new facility or housing unit or first entering ADOC custody. Tr. Test. of REDACTED ; Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031192 (reporting that at Donaldson a prisoner went without medication for six days because his medication administration report did not transfer with him to segregation). Other prisoners do not receive their medication regularly due to medical staff failures or the medication running out without being timely renewed. Tr. Test. of Kenneth Moncrief, REDACTED . This is particularly

problematic for individuals who experience withdrawals or rapid deterioration when they do not take their medication. Tr. Test. of REDACTED

One reason prisoners miss medications is the lengthy wait times for pill call. Tr. Test. of Kenneth Moncrief, REDACTED

Prisoners have had to wait as long as four hours in the pill call line to receive their medications. *Id*. One reason for the lengthy pill call waits is a lack of correctional staff. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 314, Email from D. Crook to R. Naglich re: violence at St. Clair, January 22, 2015; Pls. Tr. Ex. 385, Email from R. Naglich CC J. Dunn et al re Impact of Staffing Shortage at St. Clair, June 18, 2015.

Prisoners are also sometimes given the wrong medication, even despite their protestations. Tr. Test. of Robert Dillard, REDACTED , Dr. Robert Hunter; Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031192 (reporting medication errors at Kilby, including "wrong names on 8 packages. Ms. Hanzes handled with Mitchell of Corizon. An inmate's meds were on the wrong MAR for Tegretol; inmate who was to be given the meds pointed out to them: he wasn't even on any meds.").

Prison medical staff do not consistently and accurately record instances of missed medications and non-compliance. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 223, Email from A. Davis-Walker re Bullock Outpatient Deficiencies to Fix Before Audit, Nov. 18, 2015, at MHM042327 (49 prisoners with serious mental illness diagnosis missing medication notation); Pls. Tr. Ex. 295, Email from A. Davis-Walker, re Easterling Audit 11.25, Dec. 2, 2015, at MHM042187; Pls. Tr. Ex. 238, Email from A. Davis-Walker re Hamilton Audit 6.22.15, June 29, 2015, at MHM41899 (noting missing evidence "of weekly medication compliance monitoring by nurse" and missing evidence "that medication non-compliance is addressed"); Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031199 (reporting that at Kilby "[m]ed rrors are happening every day, and we are not filling out the forms every time. We have been using a lot of stock because the inmates aren't getting their meds."); *see also generally* Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes (discussing during multiple meetings problems with non-compliance reporting and remind staff document non-compliance).

3. Inadequate Mental Health Care Provided to Prisoners Who Are Not on the Mental Health Caseload

Due to the inadequate identification and classification of prisoners with mental illnesses and MHM's actively removing prisoners from the caseload, a

number of prisoners are not on the mental health caseload even though they should be. Tr. Test. of Dr. Kathryn Burns.

Prisoners not on the mental health caseload are at serious risk of harm because they receive little to no mental health care. *Id.* Plaintiff Brandon Johnson, for example, did not receive any mental health treatment in his nearly twenty years in ADOC custody until he was placed on suicide watch in November 2015. Tr. Test. of Brandon Johnson; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR047665, 047666, 047667, 047698, 047700-047752. Dr. Hunter found it noteworthy that Plaintiff Johnson had never been on the mental health caseload despite the findings of his pre-conviction psychiatric evaluation at Taylor Hardin that he was depressed and possibly psychotic. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 142, B. Johnson Med. Records, at MR047700. Dr. Robert Hunter, expressed optimism that Plaintiff Johnson's involvement in the instant lawsuit might afford him some relief related to his mental health status: "He is now involved with SPLC to perhaps go to court given the beforementioned." *Id*.

Prisoners who are not on the mental health caseload often deteriorate to the point of crisis due to the lack of mental health care provided to them. Plaintiff Daletrick Hardy, for example, was removed from the mental health caseload in 2010 but was admitted to a crisis or suicide cell at least twice subsequently and has attempted to harm himself numerous times. Tr. Test. of Daletrick Hardy, Dr. Craig

Haney; Pls. Tr. Ex. 177, D. Hardy Med. Records, at MR006081, 006207.22, 006066. And Mental Health Subclass Member REDACTED was removed from the mental health caseload in July 2015, despite multiple previous suicide attempts. Tr. Test. of REDACTED . After his removal from the caseload, he requested to speak with someone from mental health but received no response. Tr. Test. of REDACTED He attempted suicide again in September 2015. *Id*.

Prisoners released from suicide or crisis watch are not routinely placed on the mental health caseload and thus do not receive adequate follow-up from mental health staff. Tr. Test. of Dr. Kathryn Burns. For example, Plaintiffs Joshua Dunn, Leviticus Pruitt, and and Myniasha Williams were all placed in suicide watch or a crisis cell but not added to the mental health caseload after their release. Tr. Test. of Joshua Dunn, Leviticus Pruitt, Myniasha Williams, Dr. Kathryn Burns; *see* §§ III.D.7, II.f, m, p. They each subsequently engaged in self-harm again. *Id*.

Additionally, though all prisoners in segregation are supposed to receive daily mental health contacts, even if they are not on the mental health caseload, they often do not or these contacts are brief, cursory, and not confidential. Tr. Test. of Teresa Houser, Dr. Robert Hunter, Dr. Craig Haney.

4. Inadequate Mental Health Care Provided to Prisoners on the Outpatient Mental Health Caseload

Prisoners who are on the outpatient mental health caseload also receive inadequate mental health care, such as little to no counseling, irregular psychiatric appointments, outdated and boilerplate treatments, and little to no access to group therapy. Tr. Test. of Dr. Kathryn Burns. Mental health staff provide little to no counseling to prisoners in outpatient care, though ADOC Admin. Reg. 623 requires at least monthly counseling. As with counseling in other settings throughout ADOC, counseling in the outpatient setting is infrequent, brief, and often not confidential. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney; *see also* Tr. Test. of REDACTED Lesleigh Dodd, for example, provides only 15 to 20 minute counseling sessions to "pop inmates," or prisoners not housed in the RTU at Holman. Tr. Test. of Lesleigh Dodd, Sharon Trimble, LaSandra Buchanant.

Anna Davis-Walker noted overdue counseling appointments in a number of spot audits at facilities that generally do not house prisoners on the in-patient mental health caseload. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 235, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015, at MHM041863-041865 (noting overdue MHP appointments at Fountain); Pls. Tr. Ex. 231, Email from A. Davis-Walker re Easterling Findings from Nov. 25, 2015, Dec. 2, 2015, at MHM042012-042013 (noting overdue MHP appointments at

Easterling); Pls. Tr. Ex. 282, Email from A. Davis-Walker re Ventress Audit Findings from Nov. 24, Dec. 2, 2015, at MHM042007-04200 (noting overdue MHP appointments at Ventress).

Likewise, prisoners receiving outpatient care are often overdue for psychiatric appointments, which are supposed to occur at least every 90 days, and AIMS testing, which is supposed to occur every six months for prisoners on antipsychotics. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns Anna Davis-Walker; Pls. Tr. Ex. 235, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015, at MHM041863-041865 (noting untimely psychiatric and AIMS testing appointments at Fountain); Pls. Tr. Ex. 231, Email from A. Davis-Walker re Easterling Findings from Nov. 25, 2015, Dec. 2, 2015, at MHM042012-042013 (noting untimely psychiatric and AIMS testing appointments at Easterling); Pls. Tr. Ex. 282, Email from A. Davis-Walker re Ventress Audit Findings from Nov. 24, Dec. 2, 2015, at MHM042007-04200 (noting untimely psychiatric and AIMS testing appointments at Ventress).

Treatment planning for prisoners on the outpatient mental health caseload is inadequate. Tr. Test. of Dr. Kathryn Burns, Dr. Haney, REDACTED . During spot audits at various facilities that generally only house outpatient mental health prisoners, Anna Davis-Walker noted significant numbers of outdated treatment plans. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 235, Email from A.

Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015, at MHM041863-041865 (noting outdated treatment plans at Fountain); Pls. Tr. Ex. 231, Email from A. Davis-Walker re Easterling Findings from Nov. 25, 2015, Dec. 2, 2015, at MHM042012-042013 (noting outdated treatment plans at Easterling). Treatment plans for outpatient prisoners also contain boilerplate language that is not tailored to the individual needs of the prisoner. Tr. Test. of Dr. Craig Haney.

Many prisoners on the outpatient caseload do not know what their treatment plans say and have not met with their treatment teams, and no mental health staff person has explained their treatment plans to them. Tr. Test. of REDACTED

.

Prisoners on the outpatient caseload have little or no access to group counseling. Tr. Test. of Myniasha Williams, REDACTED

, Dr. Kathryn Burns. And there is simply no group therapy for prisoners on the outpatient caseload housed in segregation. Tr. Test. of Dr. Kathryn Burns.

ADOC's February 2016 Clinical Contract Compliance Review Report noted that only one to four groups were offered weekly at Bullock, Holman and Limestone for outpatient caseload sizes of 305, 80, and 290 prisoners respectively. Tr. Test. of Dr. Kathryn Burns, Ruth Naglich; Pls. Tr. Ex. 115, ADOC-MHM

Clinical Compliance Review Report, Feb. 2016, at MHM 040597; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016, at ADOC 0319153. And due to security and space shortages, no outpatient groups were being conducted at Staton, St. Clair and Donaldson even though there were 682 total prisoners on the outpatient mental health caseloads at those facilities. *Id*.

One reason for the unavailability of therapeutic groups, in addition to the lack of adequate mental health and custodial staff, is the lack of adequate space. Tr. Test. of Dr. Raymond Patterson, Teresa Houser; Pls. Tr. Ex. 115, ADOC-MHM Clinical Compliance Review Report, Feb. 2016, at MHM 040597 (listing inadequate security staffing and space as reasons why therapeutic groups were not being conducted); Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031191 (noting "lack of security, space" as impediments to conduct groups and noting specifically that groups were not being conducted at Kilby because of lack of space), MHM031226 (reporting that there was no physical space for groups at Staton and Donaldson).

5. Inadequate Residential Mental Health Care Provided to Prisoners Who Are Housed in Residential Treatment Units and Stabilization Units

a) Location and Description of Residential Treatment Units and Stabilization Units

A Residential Treatment Unit ("RTU") is a mental health housing unit within the ADOC that is intended to provide mental health treatment in a supportive environment while assisting the patients in developing the coping skills necessary for placement in general population. Tr. Test. of Dr. Robert Hunter, Ruth Naglich, Dr. Kathryn Burns; Pls. Tr. Ex. 68, ADOC Admin. Reg. 633. The RTUs have a "level" system. A person comes into the RTU at Level 1. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 68, ADOC Admin. Reg. 633, Appendix C. This is the most restricted level, in which the person is kept in a cell and has little interaction with staff or other inmates. At Level 2, the person remains housed in the cell, but is supposed to come out more often and for longer times, and have more interaction. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 68, ADOC Admin. Reg. 633, App'x C. At Level 3, the person is housed in an open dormitory in the RTU, and is supposed to have more activities and interactions. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 68, ADOC Admin. Reg. 633, App'x C. At Level 4, the person is preparing to return to general population. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 68, ADOC Admin. Reg. 633, App'x C.

A Stabilization Unit ("SU") is a mental health housing unit intended to provide intensive treatment to persons experiencing acute mental health problems when brief crisis interventions at other institutions have been unsuccessful in assisting the person in achieving prior levels of functioning. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 66, ADOC Admin. Reg. 632. Treatment on an SU is structured to provide stabilization as quickly as possible and return the patient to a less restrictive environment. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 66, ADOC Admin. Reg. 632. The treatment requirements of the ADOC are: a Psychiatrist completing cell rounds daily, Monday through Friday, and that the psychiatrist meet with each patient in the SU in a confidential setting no less than once a week; the treatment coordinator has at least 15 minutes of contact with the patients daily, Monday through Friday, and a weekly confidential counseling session; a Mental Health Nurse has contacts with the inmate each shift during the first seven days on the SU and daily nursing rounds thereafter. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 66, ADOC Admin. Reg. 632.

If, at the end of one month, the patient continues to exhibit risk issues, acute psychosis and/or serious distress and has not responded to SU treatment, the patient is supposed to be referred to a state psychiatric hospital for impatient care

and a Sanity Commission Hearing conducted. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 66, ADOC Admin. Reg. 632.

There is an RTU for men at Donaldson and another at Bullock. Tr. Test. of Dr. Robert Hunter. There is an RTU for women at Tutwiler. Tr. Test. of Dr. Robert Hunter. There is an SU for men at Bullock and for women at Tutwiler. Tr. Test. of Dr. Robert Hunter.

As of the last day of February 2016, there were 73 men in the Donaldson RTU, 201 men in the Bullock RTU, and 17 women in the Tutwiler RTU. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016. There were 9 men in the Bullock SU and no women in the Tutwiler SU. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016.

At Bullock, the RTU and SU are in a building separate from the main facility at Bullock, often referred to as the "blue building". Tr. Test. of Dr. Robert Hunter, Teresa Houser. It has separate mental health staff from the main Bullock building. Tr. Test. of Dr. Robert Hunter, Teresa Houser.

Persons on Levels 1 and 2 in the Bullock RTU are housed in the cells on one side of a large room in the mental health building. There is another wall of cells in that room that usually houses prisoners placed in segregation by the ADOC and are not mental health patients in the RTU. The RTU cells are located in housing unit

H8, the segregation cells are located in housing unit H9. There are 30 cells in H8, and the same number in H9. Tr. Test. of Teresa Houser, Lasandra Buchanant. H9 is also the housing unit for the SU. Tr. Test. of Teresa Houser, Lasandra Buchanant. Persons on Levels 3 and 4 are housed in dormitories H1-H7 in the RTU. Tr. Test. of Teresa Houser, Lasandra Buchanant. The dormitories range from 10 people to 50 people. Tr. Test. of Dr. Craig Haney, Teresa Houser, Lasandra Buchanant. Offices for the mental health staff and rooms for conducting groups are located between the celled area of housing units H8 and H9 and the dormitory area of housing units H1-H7. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Lasandra Buchanant.

The RTU at Tutwiler is contained within the main building. Tr. Test. of Teresa Houser, Felicia Greer. It is housing unit H. Tr. Test. of Teresa Houser, Felicia Greer. Persons in Levels 1 and 2 of the RTU are housed in cells off a hallway next to the main dormitory of the RTU. Tr. Test. of Teresa Houser, Felicia Greer. There are 8 cells. Tr. Test. of Teresa Houser, Felicia Greer. These cells are used for the SU, as crisis cells (suicide watch and mental health observation) and for RTU Levels 1 and 2. Tr. Test. of Dr. Hunter, Teresa Houser. Persons in Levels 3 and 4 of the RTU are housed in a 30-bed dormitory. Tr. Test. of Dr. Hunter, Teresa Houser, Felicia Greer. There is an area that is used for groups in the big room that holds the 30 beds, and a smaller room for holding

group activities. Tr. Test. of Dr. Hunter, Teresa Houser, Felicia Greer. There are several offices for mental health staff within the unit and a small waiting area. Tr. Test. of Dr. Hunter, Teresa Houser, Felicia Greer. The mental health staff works with both the RTU patients and the other women on the mental health caseload. *Id*.

At Donaldson, the RTU is divided between closed, semi-closed and open. Housing unit S is the closed RTU, T is the semi-closed and R and U are the open RTUs. Tr. Test. of Dr. Hunter, Teresa Houser, Dr. Kathryn Burns, Dr. Craig Haney. In each of the RTU housing units at Donaldson, the patients are housed in cells. Tr. Test. of Dr. Hunter, Teresa Houser, Dr. Kathryn Burns, Dr. Craig Haney In the S and T units, the patients remain in their cells nearly all the time. Tr. Test. of Dr. Craig Haney, Jamie Wallace, REDACTED , In the S unit, when patients leave their cells, they are handcuffed. Tr. Test. of Dr. Craig Haney, Jamie Wallace,REDACTED In the R and U units, the open RTU, patients sleep in their cells but are permitted to be out of their cell much of the day, in R and U housing units. Tr. Test. of Dr. Craig Haney, Jamie Wallace,REDACTED .

In the RTUs, although these are the persons identified sufficiently mentally ill that they need to be living in a mental health unit, there is almost no individual counseling. At Level 1, all the ADOC requires is "[d]aily cell-front interaction by the Psychiatrist when on-site . . . Daily documented cell-front interaction by a Mental Health Nurse, [and] Daily documented cell-front interaction by the RTU

Treatment Coordinator." Tr. Test. Dr. Hunter, Teresa Houser; Pls. Tr. Ex. 68, ADOC Admin. Reg. 633. There is no requirement for any out of cell counseling. *Id*. There is no requirement for how long any of these interactions last. *Id*. For patients at Level 2, the individual contacts required by the ADOC are: "Weekly documented assessment by the Psychiatrist, Daily cell-front interaction by a Mental Health Nurse, [and] Weekly documented individual counseling by the RTU Treatment Coordinator." *Id*. For patients at Levels 3 and 4, the requirements for individual contacts consists of a monthly assessment by a psychiatrist, "daily rounds" by the RTU Treatment Coordinator and "documented individual counseling by the RTU Treatment Coordinator" every other week. *Id*.

b) Inadequate Treatment in Residential Mental Health Units

In the RTUs, patients do not receive adequate mental health monitoring or treatment. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns. Individual contacts with mental health staff are brief, infrequent and often not conducted in confidential settings. Tr. Test. Dr. Burns, Dr. Haney, J. Wallace, REDACTED R. Businelle, REDACTED R. Terrell, R. McCoy, R. Dillard, REDACTED Moncrief, REDACTED . Seriously mentally ill prisoners, including those with prior mental hospitalizations and documented instances of self-harm and suicidality, are seen infrequently by mental health staff, have little if any access to meaningful treatment or therapy of any kind, and are barely being monitored in the truly

abysmal and dangerous living conditions where they are housed. Tr. Test. Dr. Burns, Dr. Haney, J. Wallace, R. Businelle, R. Terrell, R. McCoy, R. Dillard, REDACTED , K. Moncrief.

The cell-front interactions with the treatment coordinator and psychiatrist serve only as check-ins, essentially determining whether the patient has decompensated. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, J. Wallace, R. Businelle, R. Terrell, R. McCoy, R. Dillard, REDACTED ; Pls. Tr. Exs. 626, 1117, 1118, 1120, 1121, Med. Records of J. Wallace, R. Businelle, R. Terrell, R. McCoy, R. Dillard. The mental health nurse interactions are simply the process of an LPN passing out medications. Tr. Test. Dr. Burns, Dr. Haney, J. Wallace, R. Businelle, R. Terrell, R. McCoy, R. Dillard, REDACTED

Pls. Tr. Exs. 626, 1117, 1118, 1120, 1121, J. Wallace, R. Businelle, R. Terrell, R. McCoy, R. Dillard.

The individual counseling is also too quick to be of substance, again amounting to nothing more than a check-in. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, L. Buchanant, R. Businelle, R. Terrell, R. McCoy, R. Dillard, REDACTED R REDACTED REDACTED . Many of the counselors working on the RTUs are unlicensed. Tr. Test. Teresa Houser, L. Buchanant, F. Greer. ADOC requires the counselors to be licensed. Tr. Test. of Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 170, Contract Review Report for

contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. MHM describes the licensure of counselors as "N/A" on its monthly report to ADOC. Tr. Test. Teresa Houser, R. Naglich, Dr. Woodley; Pls. Tr. Ex. 737-787, MHM Monthly Reports, 2012-2016.

At Bullock, in the open RTU, patients are housed in dormitories and so have some opportunity for social interaction with one another, but do not receive other forms of treatment. The treatment area that adjoins the housing unit in the Bullock RTU is relatively large and provides adequate space for a number of possible therapeutic activities. However, there are few mental health groups and activities offered to the patients in the Bullock RTU. Tr. Test. of Dr. Burns, Dr. Haney, Teresa Houser, Lasandra Buchanant, K. Moncrief, R. Dillard, R. Businelle, R. McCoy, R. Terrell; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016.

At Donaldson, like at Bullock, there was little evidence of any kind of meaningful treatment program underway, and little or no space in which to conduct it. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Teresa Houser. Indeed, when the brief and infrequent mental health contacts do occur, they take place in the hallways outside the housing units and, because they are closely monitored by custody staff, who stand nearby, are non-confidential. Tr. Test. of Dr. Craig Haney, Jamie Wallace, REDACTED

c) Non-Therapeutic Environments for Residential Treatment

At Donaldson, the housing blocks of the RTU are barely distinguishable from the Segregation Units. Tr. Test. of Dr. Craig Haney. They have nearly the same architectural design, with the same oppressive atmosphere created inside. Tr. Test. of Dr. Craig Haney. The RTU is filthy and rat-infested. Tr. Test. of Dr. Craig Haney, Brenda Fields; Pls. Tr. Ex. 689, MHM Corrective Action Plan, Donaldson Correctional Facility, May 2013. There are no functional group programming spaces in these mental health units. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns.

In residential settings at Bullock and Donaldson, group treatment interventions are lacking as a result of insufficient numbers of both mental health treatment staff and the shortage of security staff to provide escort and inmate supervision. Tr. Test. of Dr. Burns, Dr. Haney; Pls. Tr. Ex. 714, MHM CQI Meeting Minutes, 1st Quarter 2015; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015. At Donaldson Correctional Facility, for example, the staffing problem resulted in the termination of certain forms mental health treatment. Tr. Test. Dr. Haney, Brenda Fields. There are very few mental health groups or therapeutic activities in the Donaldson RTU. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Jamie Wallace, REDACTED ; Pls. Tr. Ex. 754, MHM Monthly Report, February 2016.

Further, for patients in the closed RTUs or the SUs, there is very little out of cell time. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Jamie Wallace, REDACTED . This does not meet the standard of care. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Teresa Houser; Pls. Tr. Ex. 1092, MHM Proposal for Mental Health Services, re: RFP No. 2013-01, Aug. 7, 2013.

The male RTUs are not a therapeutic environment. In addition to the physical structure in Donaldson's RTU and in the Bullock closed portion of the RTU looking like segregation, the guards frequently act as though they are segregation units, rather than mental health units. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 227, Email from A. Davis-Walker re Custody Staff Interference with Injection, July 15, 2015; Pls. Tr. Ex. 431, Email from R. Naglich, re: Seeing inmates at Donaldson, Sep. 10, 2015; Pls. Tr. Ex. 515, Email from T. Houser re Requesting a Meeting, Sep. 30, 2015.

Moreover, ADOC custody staff place people in the RTUs on their own, without mental health staff determining that the people should be in the RTU. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 717, MHM CQI Meeting Minutes, 2nd Quarter 2015. The cells in H9 are generally used for segregation, meaning that the housing unit is split between the most acutely mentally ill men in the system (those housed in the SU and Levels 1 and 2 of the RTU) and people

who may have no mental health conditions at all but are being punished by their placement there. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Dr. Charles Woodley; Pls. Tr. Ex. 718, MHM CQI Meeting Minutes, 3rd Quarter 2013; Pls. Tr. Ex. 719, MHM CQI Meeting Minutes, 3rd Quarter 2014; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015. In the dormitory section of the Bullock RTU, there are also placements unrelated to mental health. Tr. Test. of REDACTED REDACTED Custody officers also place people in the RTU at Donaldson for reasons unrelated to mental health. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 393, Email from R. Naglich re Corrections Staff Placed People in RTU, July 10, 2015; Pls. Tr. Ex. 410, Email from R. Naglich re Removing Prisoner from RTU, Oct. 20, 2015.

Additionally, custody staff in the RTUs and SUs are insensitive to mental health issues and sometimes abusive to patients. Tr. Test. of Dr. Robert Hunter, Dr. Charles Woodley, Brenda Fields, Dr. Kathryn Burns, Richard Businelle, Roger McCoy, Richard Terrell, REDACTED ; Pls. Tr. Ex. 715, MHM CQI Meeting Minutes, 2nd Quarter 2013; Pls. Tr. Ex. 716, MHM CQI Meeting Minutes, 2nd Quarter 2013 (nonduplicate). These environments are not therapeutic. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney.

6. Lack of Access to Inpatient Care

Inpatient care is a psychiatric hospital level of care. Tr. Test. of Dr. Kathryn Burns. Inpatient, hospital level of care is not provided by ADOC, but rather through transfer to a state psychiatric hospital, Taylor Hardin. Tr. Test. of Dr. Robert Hunter.

Many persons in the custody of ADOC require a higher level of care than can be provided in ADOC facilities. Tr. Test. of Dr. Kathryn Burns. ADOC is unable to provide an inpatient level of treatment activities due to having insufficient security staff available and insufficient MHM staffing to provide intensive psychiatric treatment, psychiatric nurses or technicians. Tr. Test. of Dr. Kathryn Burns.

Pursuant to ADOC Admin. Reg. 632, if a patient continues to exhibit risk issues, acute psychosis and/or serious distress and has not responded to SU treatment, the patient is supposed to be referred to Taylor Hardin. Tr. Test. of Dr. Robert Hunter, Teresa Houser; Pls. Tr. Ex. 66, ADOC Admin. Reg. 632. Nonetheless, ADOC rarely refers patients to the state psychiatric hospital. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns; Pls. Tr. Ex. 736-787, MHM Monthly Reports (noting on SU Activity Reports the number of transfers to the state psychiatric hospital). ADOC has people in its custody that its mental health staff does not know how to treat. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 284,

Email from A. Davis-Walker re Weekly Report, July 24, 2015; Pls. Tr. Ex. 380, Email from R. Hunter to R. Naglich, et al., re Treatment Decisions for Catatonic Prisoner, Oct. 9, 2015; Pls. Tr. Ex. 411, Email from R. Naglich re Request for Commitment Order, Aug. 8, 2014; Pls. Tr. Ex. 560, Email from T. Houser, re: COMMITMENT - REDACTED), Jan. 23, 2015; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015.

ADOC has numerous patients in its custody who remain acutely psychotic for extended periods of time but are not transferred to the state psychiatric hospital. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Teresa Houser; Pls. Tr. Ex. 339, Email from L. Brown re: enemy situations and access to care, September 11, 2014; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015 (discussion of RED ACT ED). In one recent instance, ADOC and the mental health staff was aware for well over a year that they did not know how to treat or manage a patient. Tr. Test. of Dr. Robert Hunter, Ruth Naglich; Pls. Tr. Ex. 1223, 1215 (regarding REDACT ED). They did not refer him to the state psychiatric hospital. Tr. Test. of Dr. Robert Hunter, Ruth Naglich. In September 2015, this patient killed himself in the closed RTU at Donaldson. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 1227.

Most of the individuals who ultimately do get referred for treatment at Taylor Hardin are being referred at the end of their sentence. Tr. Test. of Dr.

Edward Kern. The criteria for referring a person to Taylor Hardin at the end of a sentence is essentially the same as for referring a person during his or her prison term. *Id*.

7. Inadequate Mental Health Crisis Management

When a person in custody develops a mental health condition that creates risks of danger to himself or others, that person should be placed on a mental health watch. Tr. Test. of Dr. Kathryn Burns; Pls. Tr. Ex. 64, ADOC Admin. Reg. 630. In the ADOC, there are two types of watch: Suicide Watch and Precautionary Watch. Tr. Test. of Dr. Kathryn Burns, Dr. Robert Hunter, Ruth Naglich; Pls. Tr. Ex. 64, ADOC Admin. Reg. 630. Persons on these two types of watches are supposed to be placed in crisis cells. *Id*. In addition, ADOC has what it calls Mental Health Observation, for persons who are not believed to represent an expressed or perceived risk of harm to themselves or others, but whose mental health condition requests that they be housed in a crisis cell. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 74, ADOC Admin. Reg. 638.

When on suicide watch, according to ADOC policy, a person should be monitored be correctional officers every 15 minutes and evaluated by the treatment coordinator or assigned mental health staff Monday through Friday. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 64, ADOC Admin.

Reg. 630. The person's crisis treatment team should include a psychiatrist, mental health nurse, and an MHP or treatment coordinator. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 64, ADOC Admin. Reg. 630. The treatment team is supposed to finalize a crisis treatment plan within one working day of the person's placement on suicide watch, to be reviewed every business day the person remains on suicide watch. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 64, ADOC Admin. Reg. 630. If the person's mental health crisis does not begin to resolve within 72 hours, the person is to be transferred to the SU. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 64, ADOC Admin. Reg. 630. The only staff that can discharge a patient from suicide watch are a psychiatrist, a supervising psychologist, or an ADOC psychologist or psychological associate. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 64, ADOC Admin. Reg. 630.

Precautionary watches can be ordered only by a psychiatrist and only for prisoners housed in SUs. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 64, ADOC Admin. Reg. 630. Mental Health Observation can be ordered only after a crisis evaluation and only by a psychiatrist or other mental health staff. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 74, ADOC Admin. Reg. 638. A person on precautionary watch or mental

health observation may be monitored every 15 or 30 minutes. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich; Pls. Tr. Ex. 64, 74, ADOC Admin. Regs. 630, 638.

Crisis cells are located in the medical units at some facilities, including Fountain, St. Clair, Ventress, Staton, Bibb. At Holman, the crisis cells are on death row. At Easterling and Kilby, they are on segregation units. At Donaldson, Bullock, and Tutwiler, cells in the closed RTU are used as crisis cells. Tr. Test. of Dr. Craig Haney.

Treatment for prisoners on suicide watch or other forms of crisis watch is deficient. Mental health treatment is generally limited to brief cell front contacts by MHP staff asking the prisoner whether or not he remains suicidal. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney. This does not meet the standard of care. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Teresa Houser; Pls. Tr. Ex. 1224. Rarely are prisoners on suicide watch or other crisis watch taken out of their cell for an actual confidential counseling session. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Joshua Dunn, Jamie Wallace, REDACTED

, Robert “Myniasha” Williams, Richard Businelle, REDACTED

Leviticus Pruitt, REDACTED

.

Further, prisoners who have attempted suicide or been released from suicide or crisis watch are not routinely placed on the mental health caseload. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Joshua Dunn, Jamie Wallace, REDACTED , Robert "Myniasha" Williams, Richard Businelle, REDACTED Leviticus Pruitt, REDACTED . They do not receive adequate follow-up from MHPs or other mental health staff. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Dr. Raymond Patterson, Joshua Dunn, Jamie Wallace, REDACTED , Robert "Myniasha" Williams, Richard Businelle, REDACTED Leviticus Pruitt, REDACTED .

Security staff make jokes about suicide to prisoners who express that they are suicidal. Tr. Test. of Dr. Robert Hunter. Security staff have suggested people in crisis follow through with threats to harm themselves. *Id*. In some cases, staff have egged the person on or provided a razor. *Id*. In some cases custody staff have challenged the person to make good on their threats of self-harm and the prisoners in fact engaged in self-harm. *Id*. In some cases, the prisoners were sent back to their housing units without an assessment by qualified mental health staff and then hurt themselves more. Tr. Test. of Dr. Robert Hunter,

Custody staff and mental health staff have been dismissive or abusive to people who are in a crisis and have engaged in self-harm. Tr. Test. of REDACTED

REDACTED, Joshua Dunn, REDACTED ; Pls. Tr. Ex. 714. Sometimes ADOC personnel do not inform MHM personnel promptly of people engaging in self-harm. Tr. Test. of Teresa Houser. In at least one instance, a person committed suicide and his ability to accomplish that may have been in part a result of MHM not being informed by custody staff of his mental health crisis. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 717, 718, MHM CQI Meeting Minutes, 2nd Quarter 2015 & 3rd Quarter 2013.

Additionally, monitoring of prisoners in crisis is also inadequate. Tr. Test. Dr. Burns. People on suicide watch should be checked on at irregular intervals of no more than 15 minutes. Tr. Test. of Dr. Kathryn Burns, Brenda Fields. Custody officers do not do this. Tr. Test. of Dr. Kathryn Burns, Brenda Fields, REDACTED , Joshua Dunn, Leviticus Pruitt; Pls. Tr. Ex. 631, 646. ADOC and MHM do not have a process to ensure constant watch when a prisoner is actively suicidal. Tr. Test. of Dr. Kathryn Burns, Teresa Houser. The form on which ADOC Records officer observations of inmates on watch contains pre-printed 15-minute intervals. Tr. Test. of Dr. Kathryn Burns, Brenda Fields. The exact time of observation must be recorded contemporaneously with the observation, and the intervals should be irregular rather than at precise 15-minute intervals. Tr. Test. of Dr. Kathryn Burns, Brenda Fields, Dr. Robert Hunter. Observations made at predictable and regular intervals increase the risk that the prisoner on watch has

adequate time and opportunity to attempt and complete suicide in between observations. Tr. Test. of Dr. Kathryn Burns. Predictable and regular intervals undermine the purpose of placing the inmate on watch status and the monitoring process. Tr. Test. of Dr. Kathryn Burns, Brenda Fields. Prisoners in crisis are sometimes placed in inappropriate locations such as offices or libraries rather than in safe cells. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Teresa Houser, Dr. Robert Hunter, Lynn Brown. The placement of persons in crisis in such locations increases the risk of self-harm and suicide. Tr. Test. of Dr. Kathryn Burns.

ADOC and MHM do not adequately protect mentally vulnerable persons in segregation. Tr. Test. of Dr. Craig Haney, Dr. Robert Hunter. Dr. Hunter, MHM's Chief Psychiatrist has discussed the risks of segregation and the correlation between segregation and suicides in the ADOC with the ADOC, but nothing has been done to address the problem of placing vulnerable prisoners in segregation. Tr. Test. of Dr. Craig Haney, Dr. Robert Hunter.

The risk of suicide is increased in prisons with overcrowding, a lack of staffing, drugs, assaults, and a lack of meaningful programming. Tr. Test. of Teresa Houser, Dr. Craig Haney; Pls. Tr. Ex. 1224. Five people committed suicide in the ADOC during the year from October 2014 to September 2015. Tr. Test. of Dr. Robert Hunter, Ruth Naglich, Teresa Houser. This is higher than national rates in prisons. Tr. Test. of Teresa Houser.

Despite the rise in suicides and the existence of many risk factors regarding suicides in ADOC, ADOC does not evaluate or screen all prisoners in segregation, either in advance of their placement or regularly during the course of it, in order to determine whether their mental state precludes such confinement or warrants their removal to a more psychologically appropriate and tolerable setting. Tr. Test. Dr. Haney, Dr. Hunter.

ADOC routinely disciplines prisoners for cutting themselves. Tr. Test. of Lesleigh Dodd, Dr. Robert Hunter, Teresa Houser. Mental health staff can act as an advocate for a prisoner who is to be placed in segregation if they feel it is detrimental to the person's mental health, recommending no segregation or a reduced segregation, Tr. Test. of Teresa Houser. However, MHM staff are not always given the opportunity to participate in disciplinary hearings. Tr. Test. of Dr. Craig Haney, Teresa Houser. And no one is aware of whether or how often MHM actually intervenes in this way. Tr. Test. of Teresa Houser.

8. Inadequate Mental Health Care Provided to Prisoners Who are Housed in Segregation

Isolated confinement in Segregation Units is a widely overused disciplinary tool throughout ADOC. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns. Such confinement is generally characterized by isolation in one's cell for up to 23 hours a day or more with extremely limited or no opportunities for social contact. Tr.

Test. of Dr. Craig Haney. Prisoners spend weeks, months, and even years in segregation. Tr. Test. of Christopher Jackson, Brandon Johnson, Roger McCoy, REDACTED , Myniasha Williams, REDACTED

The overuse of segregation is typical of large prison systems that lack resources to meet prisoners' basic needs or control their behavior through more positive means. Tr. Test. of Dr. Craig Haney. Throughout ADOC, prisoners are placed in segregation units that are in deplorable condition. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Eldon Vail, Jefferson Dunn. While in segregation, prisoners receive little to no adequate mental health care, and those with pre-existing mental illnesses decompensate, sometimes to the point of suicidality. *Id*.

a) Harmful Effects of Segregation

The harmful psychological effects of segregation have been widely documented by numerous studies. Tr. Test. of Dr. Craig Haney. While these effects are experienced by prisoners without mental illness, they are amplified for prisoners with mental illness. *Id*.

The psychological harms of segregation result from the lack of opportunities for meaningful social interaction, enforced idleness and inactivity, oppressive surveillance and security procedures, and the physical and structural elements of segregation units. *Id*. Symptoms of such harms have been found to include:

appetite and sleep disturbances, anxiety, loss of control, withdrawal, hypersensitivity, ruminations, cognitive dysfunction, hallucinations, loss of control, irritability, aggression, rage, paranoia, hopelessness, a sense of impending emotional breakdown, self-mutilation, and suicidal ideation and behavior. *Id*. The prevalence of these symptoms among prisoners in segregation has been documented to be as high as two-thirds in some instances. *Id*.

ADOC's segregation units produce both sensory deprivation and sensory overload. Tr. Test. of Dr. Craig Haney, Dr. Robert Hunter. Prisoners are both deprived of ordinary social contact and subjected to incessant screaming, taunting, and banging. *Id*. Exposure to such conditions over long periods of time can damage or distort prisoners' social identities, destabilize their sense of self and, for some, destroy their ability to function normally in free society. Tr. Test. of Dr. Craig Haney. Within ADOC, prisoners sometimes accumulate very long periods of segregation time, resulting in even more helplessness, hopelessness, and despair. Tr. Test. of Dr. Craig Haney, Dr. Robert Hunter.

Generally, self-mutilation and suicidality are more prevalent among prisoners housed in segregation. Tr. Test. of Dr. Craig Haney. During the period from October 2014 through September 2015, there were 6 completed suicides in the ADOC. Tr. Test. of Dr. Robert Hunter, Teresa Houser. That year, the suicide rate was dramatically higher than the prison suicide rate nationally. Tr. Test. of

Teresa Houser; Pls. Tr. Ex. 1224, Email from T. Houser, re comparison of suicide rates, Oct. 1, 2015. In October 2015, MHM Chief Psychiatrist Dr. Robert Hunter attended a meeting organized and attended by ADOC staff, including Defendant Naglich. Tr. Test. of Dr. Robert Hunter. This meeting was prompted by the increased number of suicides within ADOC. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 387, Email from R. Naglich re Agenda for Mtg re Suicide Prevention Meeting, Oct. 7, 2015, at MHM043865-043866. A common denominator among the suicides discussed during the October 2015 meeting with ADOC was placement in segregation or the prospect of placement in segregation. Tr. Test. of Dr. Robert Hunter. Though Dr. Hunter shared this finding with the attendees at the meeting, little follow-up action was taken by either ADOC or MHM to address the mental health implications of segregation or revise ADOC's segregation policy. Tr. Test of Dr. Robert Hunter.

b) Deplorable Conditions of ADOC Segregation Units

ADOC's segregation units are generally in deplorable condition. Tr. Test. of Dr. Craig Haney, Eldon Vail. They are dark, dirty and foul smelling. Tr. Test. of Dr. Craig Haney, Leviticus Pruitt, Howard Carter, REDACTED

, Robert "Myniasha" Williams. The segregation units at Holman, Bibb, and Kilby, for example, smell of

burning paper or some other material because prisoners resort to setting fires in order to receive mental health attention. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Leviticus Pruitt, REDACTED

, Robert "Myniasha" Williams. Some units are very loud due to prisoners' screams and banging. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Leviticus Pruitt, REDACTED

, Robert "Myniasha" Williams. Some units have no lights in the cells. Tr. Test. of Dr. Craig Haney, Leviticus Pruitt, REDACTED . And urine is puddled on the floor outside some of the cells. Tr. Test. of Dr. Craig Haney.

At Easterling, segregation cells are small, cramped, and poorly ventilated. Tr. Test. of Dr. Craig Haney. At Bullock, the segregation unit has a dank odor, and mattresses are laid out in the hallway because one of form of punishment is to deny prisoners' access to their mattresses during the day. *Id*. At Bibb, the segregation units are very dark. *Id*. And at St. Clair, food and food trays lined the floor. *Id*. Also at St. Clair, prisoners in segregation have been forced to sleep outside in the prison yard due to lack of space in the segregation unit. *Id*.

c) Inadequate Mental Health Care Provided to Prisoners in Segregation

The mental health services provided to individuals in segregation are even more inadequate than those offered to individuals housed elsewhere. Interactions with mental health staff, when they happen are generally limited to a few minutes at cell-front, where the counselor asks if everything is okay. Tr. Test. of Dr. Craig Haney, Dr. Kathryn Burns, Dr. Robert Hunter, REDACTED

There is no reliable recordkeeping of when and for how long these cell-front check-ins, also known as segregation rounds, occur. Tr. Test. of Brenda Fields, Dr. Craig Haney. These check-ins are cursory. Tr. Test. of Lesleigh Dodd, REDACTED , Leviticus Pruitt, REDACTED

There is no mental health therapy or group counseling for prisoners housed in segregation. Tr. Test. of Dr. Kathryn Burns, Lesleigh Dodd. The shortage of mental health and custody staff means that segregated inmates often receive no mental health counseling at all. Tr. Test. of Dr. Craig Haney, Lesleigh Dodd, Felicia Greer, REDACTED , Pls. Tr. Ex. 1034, Multidisciplinary Minutes, St. Clair Correctional Facility, September 25, 2014; Pls. Tr. Ex. 1051, Multidisciplinary Meeting, Tutwiler Prison, February 25, 2014.

Prisoners in segregation sometimes have to wait hours to see a mental health provider even when they are in crisis. Tr. Test. of REDACTED .

Despite the recognized risk of segregation, people in segregation have almost no interaction with mental health staff other than the cursory segregation rounds. In February 2016, there were 1,231 prisoners in segregation on the last day of the month. Tr. Test. of Teresa Houser, Jefferson Dunn; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016. Of those 1,231 people, 214 were on the mental health caseload. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 754, MHM Monthly Report, Feb. 2016. There were just 68 mental health interventions provided to prisoners in segregation during the month. *Id*.

Despite the rise in suicides and the existence of many risk factors regarding suicides in ADOC, ADOC does not evaluate or screen all prisoners in segregation, either in advance of their placement or regularly during the course of it, in order to determine whether their mental state precludes such confinement or warrants their removal to a more psychologically appropriate and tolerable setting. Tr. Test. Dr. Craig Haney, Dr. Robert Hunter.

Mental health staff can act as an advocate for a prisoner who is to be placed in segregation if they feel it is detrimental to the person's mental health, recommending no segregation or a reduced segregation, Tr. Test. of Teresa

Houser. However, MHM staff are not always given the opportunity to participate in disciplinary hearings. Tr. Test. of Dr. Craig Haney, Teresa Houser. And no one is aware of whether or how often MHM actually intervenes in this way. Tr. Test. of Teresa Houser.

One practice within ADOC, known as "Seg Rotation," involves the periodic transfer of prisoners who are placed in segregation for long periods of time between the segregation units at St. Clair, Holman, and Donaldson. Tr. Test. of Teresa Houser, Brandon Kinard, Lesleigh Dodd. The group of prisoners on segregation rotation includes prisoners with mental illness and who are on the mental health caseload; their mental health care is disrupted with each transfer. Tr. Test. of Dr. Kathryn Burns, Howard Carter, REDACTED .

The dearth of mental health services in segregation exacerbates the deterioration caused merely by placing mentally ill individuals in segregation. Plaintiff Myniasha Williams experienced the harm caused by several placements in segregation. In March 2014, after being placed in segregation at Holman, Williams cut herself. The nurse called Dr. Hunter, who declined to put Williams in a safe cell; Williams was sent back to segregation where she cut herself again with a razor that was sitting on her sink. Tr. Test. of Myniasha Williams. Many other prisoners have decompensated while in segregation, engaging in self-harm and/or

becoming suicidal. *See, e.g.*, Tr. Test. of Dr. Craig Haney, Joshua Dunn, REDACTED

9. Disciplinaries for Mental Health-Related Behaviors

Mental health and correctional staff respond to individuals at risk for suicide with indifference and punishment. Tr. Test. of Joshua Dunn,REDACTED . Staff often assume that prisoners who hurt themselves do so for non-mental health reasons. Pls. Tr. Ex. 720, MHM CQI Meeting Minutes, Feb. 5, 2014, at MHM029579 ("We are increasingly dealing with inmate making suicidal threats due to drug debts. Dr. Hunter is taking a hard line on these cases … Asking our staff to get the message out to medical staff: be prepared to discuss IM prior history, medication, history of threats? Dr. Hunter will call their bluff and take the gamble."); *id*. at MHM029583 (discussing serious suicide attempts: an inmate "swallowed blades and was sent out to hospital to have surgically removed. He did it because he was mad at DOC: they wouldn't let him eat his sack lunches in the dorm. It was over a power struggle"; an inmate "wanted out [of a program], so he cut his neck and was bleeding profusely. He was stitched up and sent back out. This inmate was just looking for attention and screwed up"; an inmate "hung herself and almost succeeded. She was having girlfriend/family issues"; another inmate "tried strangling herself. She had a girlfriend issue; this was a manipulation for attention and wanted out of seg"); Pls. Tr. Ex. 849, Multidisciplinary Meeting,

Bullock Correctional Facility, November 18, 2013, at MHM029841 ("Inmates who superficially cut themselves in the Bullock Outpatient Unit should be sent to a hot cell for about three hours and then sent back to the OP Unit. In this case, the inmate would stop doing this because they are thinking that we are always going to keep them in SU for a period of time. But if an inmate cuts himself for real due to a mental reason then let's do extensive care."); *id*. at MHM029840 (notes from Captain Babers, stating that an "inmate who cuts himself superficial for admission to SU but what we should do is send him right back to OP upon stabilization").

Prisoners are frequently given disciplinaries or placed in segregation for conduct that is a manifestation of their mental illness. Tr. Test of Dr. Kathryn Burns, Richard Businelle, Brandon Johnson, REDACTED . This has resulted in an overrepresentation of prisoners with mental illness in segregation. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney.

Specifically, prisoners are frequently disciplined for self-harm and suicide attempts. Tr. Test. of Lesleigh Dodd, Howard Carter, Leviticus Pruitt, Jamie Wallace, Myniasha Williams, REDACTED

.

Untimely and inadequate responses to prisoners' requests for mental health care lead prisoners to engage in increasingly desperate acts to get the attention of

correctional and mental health staff. Tr. Test. of Dr. Kathryn Burns. Such acts include infliction of self-injury, property damage, fire setting and suicide attempts. *Id*. These behaviors often result in disciplinary action and placement in segregation where mental health treatment is even more difficult to access. *Id*.; Tr. Test. of Joshua Dunn, Leviticus Pruitt, REDACTED .

E. Inadequate Monitoring of the Mental Health Program

Defendants do not monitor the performance of MHM, although they have a constitutional obligation to provide adequate care and a contractual right to monitor.

ADOC could audit MHM's performance itself. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM, Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. However, it has done so only once and in only one location since 2008, in the spring of 2013 in the Donaldson RTU. Tr. Test. of Ruth Naglich, Teresa Houser. After ADOC conducted its sole audit of MHM's performance in the spring of 2013, it did not go back to re-audit to determine whether the problems found had been addressed. Tr. Test. of Ruth Naglich, Teresa Houser, Lynn Brown. In February 2016, MHM discovered that many of the problems had not been addressed and had, instead, worsened. Tr. Test. of Brenda Fields.

In late 2015, ADOC piloted new mental health audit tools at Donaldson, but it considered the pilot a test of the audit tools, not of MHM's performance. *Id*. As of April 2016, ADOC had not provided information to MHM about the results of the pilot. Tr. Test. of Teresa Houser.

Moreover, ADOC does not have a psychiatrist on the staff who can participate in the audits. Tr. Test. of Ruth Naglich. ADOC thus does not have the capability to meaningfully audit psychiatric medication practices. Tr. Test. of Dr. Kathryn Burns.

ADOC could also review any documentation from MHM regarding MHM's review of its own performance. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. MHM conducts corporate audits every year and provides information from the audits to Defendants. Tr. Test. of Teresa Houser. ADOC does not request MHM's Corrective Action Plans ("CAP") to determine whether MHM is responding to the problems identified in the MHM Corporate Contract Compliance Reviews. Tr. Test. of Lynn Brown, Teresa Houser. If it did, it would have been aware that the same problems recur, year after year, and the same failed corrective action plans are issued year after year. *Id*. When problems with performance are discussed in MHM CQI meetings, attended

by representatives of ADOC, ADOC does not follow up to find out if or how such issues are resolved. *Id*.

Defendant Ruth Naglich has affirmatively decided not to review mortality reviews and other internal quality assurance documentation of MHM. Tr. Test. of Ruth Naglich. ADOC does not request internal MHM audit information. Tr. Test. of Ruth Naglich, Lynn Brown, Teresa Houser.

ADOC also does not review performance reviews, hiring documentation, or licensure of the mental health staff. Tr. Test. of Ruth Naglich, Lynn Brown, Teresa Houser. Although ADOC contractually requires that all professional coverage be provided by licensed and qualified personnel, ADOC has not requested any information regarding MHM's repeated representation that they need not report licensure information for its Mental Health Professionals ("MHP") to ADOC. *Id*.

IV. Defendants Have Been Deliberately Indifferent to Inadequate Mental Health Care

A. Defendants Have Subjective Knowledge of Substantial Risk of Serious Harm from Inadequate Mental Health Care

Defendants have subjective knowledge of the substantial risk of serious harm from inadequate mental health care in the ADOC. In addition to the actual knowledge, they have been placed on notice of the risks, but chosen not to act upon

such notice. Defendants have actual knowledge of the inadequacy of mental health care in the ADOC and the risk it creates.

Defendants are aware of the requirements of an adequate system of mental health care. Tr. Test. of Ruth Naglich, Dr. Kathryn Burns, Dr. Robert Hunter, Teresa Houser. Defendants are aware that they are not meeting those requirements. Tr. Test. of Ruth Naglich, Dr. Kathryn Burns, Dr. Robert Hunter, Teresa Houser.

Additionally, Defendants are aware of specific information indicating inadequacies and risks. For example, in April and May 2013, ADOC conducted its only audit of MHM's performance since 2008. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 424, Email from R. Naglich to L. Brown et al., re Meeting with MHM staff at Donaldson; Pls. Tr. Ex. 1101, OHS Audit at Donaldson, April 2013.

In the course of that audit, Defendants were informed that MHM staff might be fearful of retaliation if they reported custody staff who interfered with treatment. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 424, Email from R. Naglich to L. Brown et al., re Meeting with MHM staff at Donaldson. Defendants learned that psychiatrists were behind in managing their caseloads. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 1101, OHS Audit at Donaldson, April 2013. Defendants learned that treatment plans were not signed by the

persons who should have been participating in treatment planning. *Id*. Defendants learned that there was no consideration of alternative medications. *Id*. Defendants found indications that the Medication Administration Records ("MARs") were pre-signed, rather than being signed at the time medication was distributed. *Id*. Defendants learned that mental health groups were not held at all or were infrequently held due to lack of custody staff. *Id*. Defendants learned that mental health activities were also rare. *Id*. Defendants further learned that the RTU and the people living in it were very dirty, and there was a strong smell of urine in several cells. *Id*. Defendants learned of a rat infestation in the RTU. *Id*. Defendants learned that there was a backlog for transferring people out of the RTU back to general population or to the stabilization unit at Bullock. *Id*. Defendants learned that there might be prisoners assigned to the RTU for disciplinary segregation instead of for mental health purposes, and that the mental health staff did not know whether there were any non-mental health prisoners in the RTU. *Id*. Defendants learned there were difficult barriers to prisoners accessing mental health care. *Id*.

Defendants are also aware of the inadequacy of staffing level and the risks it poses. Tr. Test. of Ruth Naglich, Teresa Houser, Lynn Brown, Dr. David Tytell; Pls. Tr. Ex. 532, 533, 538-541, 544, 545, 546, 547, 553, 555, 558, Emails from T. Houser to R. Naglich. Defendants have repeatedly been informed of the ADOC's

inability to manage persons in mental health crises. Tr. Test. of Ruth Naglich, Teresa Houser, Lynn Brown, Dr. David Tytell; Pls. Tr. Ex. 430, Email from R. Naglich, re: ADOC Annual Contract Compliance Review, Mar. 15, 2013; Pls. Tr. Ex. 549, Email from T. Houser to R. Naglich, et al., re Holman Concerns with Crisis Cells, Segregation, Step Down, May 8, 2015; Pls. Tr. Ex. 550, Email from T. Houser to R. Naglich, et al., re weekly report, Nov. 6, 2015; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016; Pls. Tr. Ex. 717, MHM CQI Meeting Minutes, 2nd Quarter 2015; Pls. Tr. Ex. 718, MHM CQI Meeting Minutes, 3rd Quarter 2013; Pls. Tr. Ex. 719, MHM CQI Meeting Minutes, 3rd Quarter 2014; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015.

Defendants have repeatedly been informed of persons being held in crisis cells for extended periods without being considered for transfer to a higher level of care. Tr. Test. of Ruth Naglich, Teresa Houser, Dr. Robert Hunter, Lynn Brown; Pls. Tr. Ex. 430, Email from R. Naglich, re: ADOC Annual Contract Compliance Review, Mar. 15, 2013; Pls. Tr. Ex. 527, Email from T. Houser to R. Naglich et al. re 2014 ADOC MH Implementation Review Report; Pls. Tr. Ex. 532, Email from T. Houser to R. Naglich forwarding March 2015 Contract Compliance Review Report, Apr. 10, 2015; Pls. Tr. Ex. 545, Email from T. Houser to R. Naglich re Short Staffing and Long Crisis Cell Stays, June 3, 2015; Pls. Tr. Ex. 718, MHM

CQI Meeting Minutes, 3rd Quarter 2013; Pls. Tr. Ex. 719, MHM CQI Meeting Minutes, 3rd Quarter 2014; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015.

Defendants have repeatedly been informed of the overrepresentation of the mentally ill in segregation at some facilities. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 430, Email from R. Naglich, re: ADOC Annual Contract Compliance Review, Mar. 15, 2013; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016.

Defendants have repeatedly been informed of the lack of mental health groups throughout the ADOC, as well as other out-of-cell activities for persons in celled mental health units. Tr. Test. of Ruth Naglich, Teresa Houser, Lynn Brown, Dr. David Tytell; Pls. Tr. Ex. 430, Email from R. Naglich, re: ADOC Annual Contract Compliance Review, Mar. 15, 2013; Pls. Tr. Ex. 527, Email from T. Houser to R. Naglich et al. re 2014 ADOC MH Implementation Review Report; Pls. Tr. Ex. 532, Email from T. Houser to R. Naglich forwarding March 2015 Contract Compliance Review Report, Apr. 10, 2015; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015.

Defendants have repeatedly been informed of custody staff shortages resulting in the inability to provide mental health services. Tr. Test. of Ruth Naglich, Teresa Houser, Lynn Brown, Dr. David Tytell; Pls. Tr. Ex. 430, Email from R. Naglich, re: ADOC Annual Contract Compliance Review, Mar. 15, 2013; Pls. Tr. Ex. 512, Email from T. Houser re conducting groups without security, Feburary 17, 2016; Pls. Tr. Ex. 527, Email from T. Houser to R. Naglich et al. re 2014 ADOC MH Implementation Review Report; Pls. Tr. Ex. 532, Email from T. Houser to R. Naglich forwarding March 2015 Contract Compliance Review Report, Apr. 10, 2015; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015.

Defendants have repeatedly been informed of failings in treatment planning at all levels of care in the ADOC. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 430, Email from R. Naglich, re: ADOC Annual Contract Compliance Review, Mar. 15, 2013; Pls. Tr. Ex. 527, Email from T. Houser to R. Naglich et al. re 2014 ADOC MH Implementation Review Report; Pls. Tr. Ex. 532, Email from T. Houser to R. Naglich forwarding March 2015 Contract Compliance Review Report, Apr. 10, 2015; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016.

Defendants have repeatedly been informed that having segregation in the SU at Bullock has a negative impact on the treatment for the most acutely mentally ill men in the ADOC. Tr. Test. of Ruth Naglich, Teresa Houser, Lynn Brown, Dr. David Tytell, Dr. Charles Woodley; Pls. Tr. Ex. 430, Email from R. Naglich, re: ADOC Annual Contract Compliance Review, Mar. 15, 2013; Pls. Tr. Ex. 512, Email from T. Houser re conducting groups without security, February 17, 2016; Pls. Tr. Ex. 527, Email from T. Houser to R. Naglich et al. re 2014 ADOC MH Implementation Review Report; Pls. Tr. Ex. 532, Email from T. Houser to R. Naglich forwarding March 2015 Contract Compliance Review Report, Apr. 10, 2015; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015.

Defendants have repeatedly been informed that self-referrals are not being triaged for urgency. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 527, Email from T. Houser to R. Naglich et al. re 2014 ADOC MH Implementation Review Report; Pls. Tr. Ex. 532, Email from T. Houser to R. Naglich forwarding March 2015 Contract Compliance Review Report, Apr. 10, 2015; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016; Pls. Tr. Ex. 721, MHM CQI Meeting Minutes, 4th Quarter 2015.

Defendants have been informed that persons in the SU for over 30 days are not considered for inpatient hospitalization. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 532, Email from T. Houser to R. Naglich forwarding March 2015 Contract Compliance Review Report, Apr. 10, 2015; Pls. Tr. Ex. 558, Email from T. Houser, re: Alabama Contract Compliance Report 2016, Mar. 7, 2016.

Defendants have been informed of every suicide in the ADOC, including the seven that occurred between October 2014 and March 2016. Tr. Test. of Dr. Robert Hunter, Teresa Houser, Ruth Naglich, Steve Brown; Pls. Tr. Ex. 1093, MHM Psychological Reconstruction, Mar. 17, 2016; Pls. Tr. Ex. 1220, Email from T. Houser, re Suicide Prevention Meeting, Oct. 1, 2015; Pls. Tr. Ex. 1227, Email from T. Houser, re REDACTED suicide, Sept. 29, 2015.

B. Defendants Have Affirmatively Declined to Review Information that Would Provide Additional Knowledge

Defendants have a contract with MHM that allows Defendants to review all clinical files and all corporate files to include, but not be limited to, payroll Records, licensure certification Records, training, orientation and staffing schedules, logs, MAC, PTT and CQI meeting minutes, physician billing, hospital or other outside service invoices, or any other contract entered into by Vendor for the purposes of carrying out the requirements of the contract. Tr. Test. of Ruth Naglich, Jefferson Dunn; Pls. Tr. Ex. 170, Contract Review Report for contract

between ADOC and MHM, and October 2013 Contract between ADOC and MHM. Defendants have explicitly reserved the right to fine MHM $4,000 per document per day for the failure to provide requested documents. *Id*. Defendants gave examples of documents that might be requested, including morbidity and mortality/death summary reviews, general population immunization history Records, pharmacy inventory, results of inmate medical consultations, payroll Records, and institutional staffing sign-in sheets. *Id*.

Further, Defendants have contracted to have ADOC participation in the mortality review process. Tr. Test. of Ruth Naglich, Jefferson Dunn; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM.

However, Defendants have affirmatively decided not to review the care provided by MHM. Defendants have declined to review the following:

MHM mortality reviews;

MHM internal quality assurance documentation;

Internal MHM audit information;

MHM's Corrective Action Plans ("CAP");

Performance reviews;

Hiring documentation;

Licensure of the mental health staff.

Tr. Test. of Ruth Naglich, Lynn Brown, Teresa Houser.

Further, ADOC could audit MHM's performance itself. Tr. Test. of Ruth Naglich, Teresa Houser. As discussed above, ADOC has audited just one location, just one time, since 2008. *Id*. Although the audit showed serious problems, ADOC did not follow up on the audit or audit MHM's performance in other facilities. *Id*.; Pls. Tr. Ex. 689, MHM Corrective Action Plan, Donaldson Correctional Facility, May 2013. In February 2016, MHM found that the problems discovered in 2013 had persisted or worsened. Tr. Test. of Brenda Fields.

Moreover, ADOC has chosen not to have a psychiatrist on the staff who can participate in the audits. Tr. Test. of Ruth Naglich. ADOC thus does not have the capability to meaningfully audit psychiatric medication practices – the primary treatment intervention in the ADOC. Tr. Test. of Dr. Kathryn Burns.

C. Defendants Have Disregarded the Risk of Harm to the Class in an Objectively Unreasonable Manner

Defendants' response to the risk of harm created by the inadequate mental health care system is objectively unreasonable.

After Defendants learned of the deficiencies identified in the only performance audit they performed during MHM's 2008 contract, they did not

conduct a follow-up audit to determine whether the problems were fixed. Tr. Test. of Ruth Naglich, Lynn Brown, Teresa Houser.

ADOC entered into another contract with MHM for a further three years of mental health services just months after the performance audit indicated there were serious problems with the provision of mental health care. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM.

When ADOC put forth its request for proposals for the mental health contract, it indicated the minimum staffing requirements. Tr. Test. of Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. MHM made a proposal meeting those staffing requirements. *Id*. ADOC informed MHM that it needed to reduce the cost of the proposal. *Id*. MHM and ADOC came to an agreement that cut the staffing levels from the Minimum Staffing Requirements by 13%. *Id*.

Starting in June 2015, MHM repeatedly requested that ADOC revise the contract to provide for more staff, as MHM could not provide the needed services with the staff it had. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 391, 392, 396, Emails

from Ruth Naglich; Pls. Tr. Ex. 533, 535, 539-541, Emails from Teresa Houser. As of April 2016, ADOC had not approved the needed amendments. Tr. Test. of Teresa Houser.

ADOC has been short of correctional officers for many years. Tr. Test. of Jefferson Dunn, Eldon Vail; Pls. Tr. Ex. 119, Alabama Department of Corrections Fiscal Year 2014 Budget Briefing. The shortage has grown worse year after year. Tr. Test. of Jefferson Dunn, Eldon Vail; Pls. Tr. Ex. 119-127, ADOC Statistical Reports. The shortage has, as discussed above, impeded the provision of mental health care, and ADOC has been repeatedly been informed of this. Yet, ADOC has not taken the steps necessary to fill the correctional officer vacancies. *Id*.

ADOC has been informed of abusive conduct by correctional officers for years. See *supra*, Parts III.B.2, III.C.2, IV.H. ADOC has not taken the steps necessary to prevent such conduct. Tr. Test. of Jefferson Dunn, Eldon Vail.

ADOC took no steps to limit access to razor blades until Plaintiffs brought a preliminary injunction motion regarding this issue. Tr. Test. of Kim Thomas, Ruth Naglich. Even after entering into a settlement agreement regarding the availability of razor blades is sensitive areas of the prisons, ADOC has allowed razors to remain available. Tr. Test. of Dr. Craig Haney; Pls. Tr. Ex. 1125, Spreadsheet of Suicide Attempts and Suicides in ADOC (excel and native).

Following a spike in suicides in 2015, ADOC called a meeting to discuss ways to address the issue. Tr. Test. of Dr. Robert Hunter, Ruth Naglich. The proposals discussed at the meeting had not been implemented as of the end of discovery. Tr. Test. of Dr. Robert Hunter.

ADOC entered into a contract worth more than $12 million per year with MHM for MHM to provide mental health services in the ADOC. Tr. Test. of Jefferson Dunn, Ruth Naglich, Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. ADOC has the right to review MHM's performance and require corrections actions. Tr. Test. of Ruth Naglich, Jefferson Dunn, Teresa Houser. ADOC has chosen not to do so. Tr. Test. of Ruth Naglich, Teresa Houser. It has chosen not to do so even when problems with MHM's performance have been brought to its attention. Tr. Test. of Ruth Naglich, Teresa Houser.

V. Defendants' Policies and Customs Led Directly to Violations of the Class's Right to Adequate Mental Health Care

ADOC's policies and customs regarding cutting costs have resulted in the violations of the Plaintiffs' and all ADOC prisoners' right to adequate mental health care.

In 2008, ADOC entered into a contract with MHM in which the contract price was dependent solely on the number of prisoners in the ADOC. Tr. Test. of

Ruth Naglich, Kim Thomas; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. The amount MHM would be paid would not change if everyone in the ADOC was receiving mental health care, nor would it change if no one was. Tr. Test. of Ruth Naglich, Kim Thomas; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. It would not change if people were seen by a psychiatrist once a week or once a year. Tr. Test. of Ruth Naglich, Kim Thomas. It would not change if mental health treatment groups were offered daily or if treatment groups were never offered. Tr. Test. of Ruth Naglich, Kim Thomas. Essentially, this contract was structured such that the more care provided, the less profit MHM would make and the less care provided, the more profit.

Additionally, MHM was responsible for the cost of psychiatric medications. Tr. Test. of Ruth Naglich, Kim Thomas; Pls. Tr. Ex. 681, 2008 Mental Health Services Agreement and Amendments. This meant that if an MHM prescriber ordered an expensive medication, it would cut directly into MHM's profits. Tr. Test. of Teresa Houser, Dr. Robert Hunter.

In 2009, ADOC requested to reduce the size of the contract price. Tr. Test. of Ruth Naglich, Kim Thomas, Teresa Houser; Pls. Tr. Ex. 128, 2009 Amendment to Mental Health Contract. MHM and ADOC renegotiated the contract and reduced the price and the number of mental health staff MHM would provide. Tr.

Test. of Ruth Naglich, Kim Thomas, Teresa Houser; Pls. Tr. Ex. 128, 2009 Amendment to Mental Health Contract.

In 2013, MHM and ADOC entered into a new contract. Tr. Test. of Ruth Naglich, Kim Thomas, Teresa Houser; Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and MHM. This contract, like the prior contract, set a contract price dependent entirely on the number of prisoners in the ADOC. *Id*. The agreement reached included fewer staff than under the prior contract, and fewer staff than ADOC had identified as the Minimum Staffing Requirement. *Id*; Pls. Tr. Ex. 128, 2009 Amendment to Mental Health Contract.

MHM cannot meet the needs of seriously mentally ill ADOC prisoners with the staffing allocations of the new contract. Tr. Test. of Teresa Houser, Dr. Kathryn Burns, Dr. Craig Haney. Appointments with counselors, psychiatrists and nurse practitioners are chronically late or missed. Tr. Test. of Teresa Houser, Dr. Kathryn Burns, Dr. Craig Haney, Anna Davis-Walker; Pls. Tr. Ex. 207, 208, 220, 221, 223, 229, 231, 235, 236, 238-241, 249, Spot Audit Reports from Anna Davis-Walker. The mental health does not have the capacity to do multidisciplinary treatment team meetings. Tr. Test. of Dr. Raymond Patterson, REDACTED , Howard Carter, REDACTED , Robert Dillard. When MHM

staff do meet with patients, the encounters are brief "drive-bys" that occur infrequently. Tr. Test. of Dr. Kathryn Burns, Dr. Craig Haney, Joshua Dunn, REDACTED , Jamie Wallace, REDACTED

Kenneth Moncrief, Robert Dillard, REDACTED Lasandra Buchanant, Sharon Trimble, Cassandra Lee.

Further, medication decisions are driven by the cost of medications rather than the needs of the patients. Tr. Test. of Dr. Robert Hunter, Teresa Houser. Prisoners in the ADOC who require antipsychotic medications are predominantly prescribed the older, cheaper medications that carry a significant risk of side effects. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns, Quang Bui, Christopher Jackson, Sylvester Hartley, REDACTED Robert Dillard, REDACTED . Even when the patients develop the side effects related to these medications, they are not offered the newer, more expensive medications that are not associated with the same side effects. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns, Quang Bui, Christopher Jackson, Sylvester Hartley, REDACTED Robert Dillard, REDACTED .

Additionally, ADOC policies and customs have made the provision of care difficult. There are perennial shortages in custody staff. Tr. Test. of Kim Thomas, Jefferson Dunn, Ruth Naglich, Eldon Vail. These shortages make it difficult to accomplish the tasks required of MHM by the ADOC, such as seeing people in segregation or holding mental health groups or letting people out of their cells in the SU or closed RTUs. Tr. Test. of Teresa Houser, Anna Davis-Walker.

There are also insufficient spaces to provide mental health care. Providers have to share office space. Tr. Test. of Teresa Houser, Dr. Craig Haney. There is inadequate space for therapeutic groups. Tr. Test. of Teresa Houser, Dr. Craig Haney, Dr. Kathryn Burns. There are insufficient crisis cells. Tr. Test. of Teresa Houser, Dr. Craig Haney, Dr. Robert Hunter. There are insufficient numbers of beds in the SUs. Tr. Test. of Teresa Houser, Dr. Craig Haney, Dr. Robert Hunter.

ADOC does not oversee the care provided by MHM. As discussed above, it does not audit MHM's performance, nor does it review MHM's internal audits, corrective action plans or other quality assurance documentation. Tr. Test. of Teresa Houser, Ruth Naglich, Lynn Brown.

ADOC has chosen to create contractual incentives to keep staffing low and to use only cheap medications. It has made it difficult to provide care. At the same

time, it has failed to keep watch over its provider to ensure that constitutional care is provided. The resulting failure of care is essentially inevitable.

Moreover, ADOC has failed to fill the many vacancies for correctional officers. It has not determined what it needs to do to fill the vacancies. Having more than half the correctional officer positions is an objectively obvious need that ADOC has failed to address.

CLAIM 2 CONCLUSIONS OF LAW: DEFENDANTS ARE DELIBERATELY INDIFFERENT TO PLAINTIFFS' SERIOUS MENTAL HEALTH NEEDS

The Plaintiffs Have Serious Mental Health Needs

To have standing to bring a claim under the Eighth Amendment for inadequate mental health care, a person must allege that he was in defendant's custody during the relevant time period, had a serious mental health needs, received inadequate care for that need, and that defendant was deliberately indifferent to the need and the harm or substantial risk of harm resulting from inadequate care.

A serious mental health 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. *Jacoby v. Baldwin County*, 596 Fed. App'x 757, 763 (11th Cir. 2014).

Every Named Plaintiff in the Mental Health subclass has demonstrated that he suffers from serious mental health needs.

Defendants Naglich and Dunn Are Responsible for Providing Constitutionally Adequate Mental Health Care

Defendants Naglich and Dunn, in their official capacities, are obligated to provide constitutionally adequate mental health care to prisoners in ADOC custody.

The acts and omissions of Defendants Naglich and Dunn, in their official capacities, are the acts and omissions of Defendants ADOC.

Any inadequacy of care provided by MHM is attributable to ADOC. Contracting out prison mental health care does not relieve the State of its constitutional duty to provide adequate care to those in its custody, nor does it deprive the State's prisoners of the means to vindicate their Eight Amendment rights. *West v. Atkins*, 487 U.S. 42, 56 (1988); *Ancata v. Prison Health Services*, Inc., 769 F.2d 700 (11th Cir. 1985).

MHM's policies and practices in the provision of mental health care to prisoners in ADOC custody constitute State action and are fairly attributable to the Defendants. *Ancata*, 769 F.2d 700.

Defendants' Mental Health Care System is Deliberately Indifferent to the Risk of Harm It Creates

To prevail on a challenge to the adequacy of mental health care under the Eighth Amendment prohibition on cruel and unusual punishment, plaintiffs must show defendants have created a substantial risk of serious harm. *Farmer v. Brennan*, 511 U.S. 825, 828 (1994). Plaintiffs must further show that defendants have been deliberately indifferent, that is they have knowledge of that risk and have disregarded it through conduct that is more than mere negligence. *Farrow v. West*, 320 F.3d 1235, 1245 (11th Cir. 2003). Where the claim is made against a governmental entity, plaintiffs must show that the existence of policies or customs that are deliberately indifferent. *Laube v. Haley*, 234 F. Supp. 2d 1227, 1249 (M.D. Ala. 2002) (J. Thompson). Finally, Plaintiffs must show that the policies or customs caused the risk of harm. *McDowell v. Brown*, 392 F.3d 1283, 1289 (11th Cir. 2004).

Proof of systemic inadequacies that create a significant risk of serious harm.

To prevail on a challenge to the adequacy of mental health care under the Eighth Amendment prohibition on cruel and unusual punishment, plaintiffs must show defendants have created a substantial risk of serious harm. Plaintiffs must further show that defendants have knowledge of that risk and have disregarded it through conduct that is more than mere negligence. Where the claim is made

against a governmental entity, plaintiffs must show that the existence of policies or customs that are deliberately indifferent. Finally, Plaintiffs must show that the policies or customs caused the risk of harm.

Deliberate indifference may be shown by proving repeated examples of acts that disclose a pattern of conduct by prison officials and staff. *Ruiz v. Estelle*, 503 F. Supp. 1265 (5th Cir. 1980); *Ramos v. Lamm*, 639 F.2d 559 (10th Cir. 1980).

Proving the frequent and widespread occurrence of past violations is a common and accepted way of showing continuing constitutional violations that support declaratory and prospective injunctive relief. *Brown v. Plata*, 563 U.S. 493, 523 (2011).

Deliberate indifference may be shown by proof of systemic and gross deficiencies in staffing, facilities, or procedures that effectively deny the inmate population access to adequate care. *Ruiz v. Estelle*, 503 F. Supp. 1265 (5th Cir. 1980); *Ramos*, 639 F.2d 559; *Anderson v. City of Atlanta*, 778 F.2d 678 (11th Cir. 1985); *Hill v. Dekalb Regional Youth Detention Center*, 40 F.3d 1176 (11th Cir. 1994).

Evidence of a systemic failure to provide adequate mental health services can demonstrate deliberate indifference. *LaMarca v. Turner*, 995 F.2d 1526, 1544 (11th Cir., 1993).

Even when some care has been provided, the following conduct may still be actionable as deliberate indifference: (a) grossly inadequate care, (b) decisions to take easier but less efficacious courses of treatment, (c) medical care that is so cursory as to amount to no treatment at all, or (d) a delay in treatment. *West v. Higgins*, 346 Fed. App'x 423, 427 (11th Cir. 2009).

A core principle of Eighth Amendment jurisprudence in the area of medical care is that prison officials with knowledge of the need for care may not, by failing to provide care, delaying care, or providing grossly inadequate care, cause a prisoner to needlessly suffer the pain resulting from his or her illness. *McElligott v. Foley*, 182 F.3d 1248, 1257 (11th Cir.1999).

The quality of psychiatric care received can be so substantial a deviation from accepted standards as to evidence deliberate indifference to serious mental health needs. *Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996).

Systemic failures to provide necessary counseling or therapeutic treatment can constitute deliberate indifference to a serious mental health care need. *Harris v. Thigpen*, 941 F.2d 1495, 1544 (11th Cir. 1991).

Defendants have maintained a constitutionally inadequate system for the provision of mental health care to prisoners in ADOC custody.

In order to demonstrate deliberate indifference, Plaintiffs need not show that they suffered harm, but that they faced a substantial risk of serious harm. *Farmer*, 511 U.S. at 828.

The objective component of an Eighth Amendment violation is satisfied by showing a sufficiently serious condition that denial of needed care would result in the unnecessary infliction of pain or pose a substantial risk of serious harm. *Farmer*, 511 U.S. at 834.

The subjective component of an Eighth Amendment violation is satisfied by showing that defendant was deliberately indifferent to the risk of harm. *Farmer*, 511 U.S. at 834; *Helling v. McKinney*, 509 U.S. 25 (1993).

For injunctive relief, the plaintiffs must show that the defendants were, at the time of the suit, "knowingly and unreasonably disregarding an objectively intolerable risk of harm and that they will continue to do so." *Farmer*, 511 U.S. at 846.

The failure to provide a constitutionally adequate system of mental health care results in unnecessary pain, suffering, worsening of mental health conditions, and improper disciplinary actions for prisoners in ADOC custody.

The maintenance of an inadequate system for the provision of mental health care results in unreasonable delays in care, subjecting prisoners in ADOC custody to substantial risk of harm.

Defendants' maintenance of an inadequate system for providing mental health care places all prisoners with serious mental health needs at a substantial risk of serious harm.

The Eighth Amendment prohibits deliberate indifference not only to inmates' current serious health needs, but also to conditions of confinement that are very likely to cause future serious illness and needless suffering. *Helling*, 509 U.S. at 33.

1. Inadequate access to care

Systemic deficiencies in staffing which effectively deny inmates access to qualified medical personnel for diagnosis and treatment of serious health problems violate constitutional requirements. *Newman v. Alabama*, 349 F. Supp. 278 (M.D. Ala. 1972); *Gates v. Collier*, 349 F.Supp. 881 (N.D.Miss.1972), *aff'd*, 501 F.2d 1291 (5th Cir. 1974).

Deliberate indifference to may be manifested not only by medical providers failing to respond to a prisoner's needs, but also by custody officers intentionally

denying or delaying access to medical care or intentionally interfering with treatment. *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976).

A system for psychological or psychiatric care in a jail or prison is constitutionally inadequate where inmates with serious mental or emotional illnesses or disturbances are not provided reasonable access to medical personnel qualified to diagnose and treat such illnesses or disturbances. *Inmates of the Allegheny County Jail v. Pierce*, 612 F.2d 754, 762 (3rd Cir. 1979).

Courts must consider the effect of each challenged condition of confinement in its context, "especially when the ill-effects of particular conditions are exacerbated by other related conditions." *Wright v. Rushen*, 642 F.2d 1129, 1133 (9th Cir. 1981).

Defendants have failed to provide and maintain sufficiently qualified mental health staff to provide constitutionally adequate care.

The use of LPNs to conduct intake screenings for mental health increases the likelihood that prisoners will be improperly classified, increasing the risk of harm to those with serious mental health needs.

Defendants have failed to provide and maintain a sufficient number of mental health staff to provide constitutionally adequate care.

Defendants have failed to provide and maintain a sufficient number of custody staff to facilitate access to constitutionally adequate care.

The gross and systemic overcrowding of ADOC facilities contributes substantially to the deficiencies in the provision of mental health care found by the court. The effects on the provision of mental health care that flow from overcrowding form the basis of the violation of Eighth Amendment rights. *See, e.g.*, *Hoptowit v. Ray*, 682 F.2d 1237, 1249 (9th Cir. 1982).

Inadequate space within ADOC facilities results in failure to provide adequate therapeutic care to prisoners with serious mental health needs.

2. Inadequate identification of serious mental health needs.

Mental health intake screening processes at ADOC are inadequate to properly identify prisoners in need of mental health care.

Mental health intake screening and classification processes at ADOC are inadequate to properly classify prisoners and assign them to the level of care minimally required for their serious mental health needs.

Due to overcrowding of ADOC facilities, the mental health classification process is improperly manipulated to allow for the housing of prisoners in

available space in facilities or units that are not equipped to provide appropriate mental health care for prisoners' real mental health needs.

Defendants fail to provide meaningful mental health treatment to prisoners in ADOC custody.

Systemic overcrowding in ADOC facilities contributes to the failure to provide adequate individual and group therapeutic treatment and activities.

Mental health treatment provided to prisoners in ADOC custody is constitutionally deficient at each level.

3. Inadequate Medication Management

The maintenance of an inadequate system for the provision of mental health care results in overreliance on psychotropic medications.

Overcrowding and inadequate facilities within ADOC contribute to the overreliance on psychotropic medications for prisoners with mental health needs because the strain on available resources results in ADOC being unable to provide appropriate counseling or therapeutic treatment.

Defendants' policy or practice of using outdated first-generation psychotropic medications, combined with inadequate monitoring and follow up,

subjects prisoners with serious mental health needs to an unreasonable risk of substantial harm.

Defendants' policy or practice of using outdated first-generation psychotropic medications, instead of newer medications that are more effective and/or are associated with fewer or less severe side effects, is based upon improper cost considerations and is deliberately indifferent.

The constitutional deficiencies in the system of mental health care for ADOC prisoners includes medication decisions made on the basis of improper cost considerations.

Inadequate medication management processes, including the "pill call" process, create unacceptable barriers for prisoners to properly receive and comply with their prescribed medications.

Inadequate medication management practices result in ADOC prisoners needlessly suffering from serious medication side effects.

Defendants' failures to adequately respond to prisoners' complaints concerning medication side effects constitute deliberate indifference.

Prisoners in the custody of ADOC are improperly threatened with and subjected to disciplinary actions in order to coerce them to take medications.

Defendants' policy or practice of failing to maintain adequate supplies of prescribed medications results in serious harm, and/or substantial risk of serious harm, for prisoners who experience significant delays in receiving needed medications.

4. Lack of treatment other than medication.

Mental health treatment, other than medication, provided for ADOC prisoners is also constitutionally inadequate.

Individual therapeutic or counseling services for prisoners in ADOC custody who have serious mental health needs are systemically and grossly deficient.

Group therapeutic services for prisoners in ADOC custody who have serious mental health needs are systemically and grossly inadequate.

Mental health treatment planning for ADOC prisoners with serious mental health needs is inadequate.

Outpatient mental health treatment for ADOC prisoners on the mental health caseload is inadequate.

Mental health treatment in the Residential Treatment Units is inadequate.

5. Suicide prevention.

Defendants' policy or practice of failing to maintain adequate supplies of prescribed medications constitutes deliberate indifference.

Defendants' policies and practices with respect to suicide prevention are constitutionally inadequate.

Defendants' policy or practice of failing to engage in adequate suicide prevention measures is deliberately indifferent.

Defendants' failures to adequately respond to suicide attempts, self-harm and threats of self-harm constitute deliberate indifference.

Defendants' failure to properly undertake review of completed suicides and suicide attempts, and to address deficiencies identified by such review, constitutes deliberate indifference.

Defendants' policy or practice of permitting custody staff to goad or mock inmates who engage in self-harm or threaten suicide or self-harm is deliberately indifferent.

6. Overreliance on and inadequate treatment in segregation.

Defendants' policies and practices with respect to placement of mentally ill inmates in segregation are deliberately indifferent.

Seriously mentally ill prisoners should not be placed in segregation as a disciplinary sanction.

Defendants' failure to provide adequate monitoring of mentally ill inmates in segregation is deliberately indifferent.

Defendants' failure to provide adequate mental health services and adequate monitoring for all inmates in segregation constitutes deliberate indifference to the heightened risk of suicide.

Defendants' policy or practice of housing segregation prisoners in stabilization and crisis cells is deliberately indifferent to the needs of mentally ill prisoners.

Defendants' policy or practice of imposing discipline for acts of self-harm is deliberately indifferent to the mental health care needs of prisoners.

Defendants' Policies and Customs Caused the Violations of the Class's Right to Be Free from Cruel and Unusual Punishment

1. Capitated Contract Model.

The terms of the ADOC contract with mental health care vendor MHM create an improper financial incentive to provide inadequate care in order to reduce costs and increase profits.

By entering into a contract for the provision of mental health care services that is based upon improper consideration of cost, ADOC displaced its constitutional obligation to provide adequate care. *See Scott v. Clarke*, 61 F. Supp. 569, 581 (W.D. Va. 2014).

In the case of a private for-profit corporation hired to perform a public function, there is an increased risk that the corporation's actions will diverge from the public interest. Unlike public officials, corporate officers and employees are hired to serve the interests of the corporation and, more specifically, its stockholders, whose principal interest is earning a financial return on their investment. Indeed, corporate officers owe a fiduciary duty to advance stockholders' interests, but they owe no such fiduciary duty to the public at large. When a private corporation is hired to operate prison medical or mental health care, there is an obvious temptation to skimp on civil rights whenever it would help to maximize shareholders' profits. *Manis v. Corr. Corp. of Am.*, 859 F.Supp. 302, 305 (M.D.Tenn.1994); *accord Hartman v. Corr. Medical Servs., Inc.*, 960 F.Supp. 1577, 1581 (M.D.Fla.1996).

Defendants' acts of negotiating and entering into a contract that provides grossly inadequate funding for the provision of mental health care to ADOC prisoners is deliberately indifferent.

The grossly underfunded contract causes the inadequate staffing that in turn causes many of the other inadequacies in the ADOC's mental health care system.

The grossly underfunded contract further causes MHM to rely on less expensive medications to treat seriously ill patients, even where a different medication is clinically indicated.

2. Cost considerations.

When prison officials are sued solely in their official capacities, the lack of funds available to them is not an adequate defense to a finding of a constitution violation on their part. Official-capacity law-suits are, "in all respects other than name, ... treated as a suit against the entity." *Kentucky v. Graham*, 473 U.S. 159, 166, 105 S. Ct. 3099, 3105, 87 L. Ed. 2d 114 (1985).

"A lack [of funds] ... will not excuse the failure of correctional systems to maintain a certain minimum level of medical service." Financial considerations need not be considered in determining the reasonableness of inmates' mental health care. Lack of funds cannot be used by "`poor states' to deny a prisoner the minimally adequate care to which he or she is entitled." *Harris*, 941 F.2d at 1509.

Defendants have allowed cost considerations to trump seriously mentally ill prisoners' need for mental health care.

3. Failure to oversee provision of mental health care.

A prison's failure to require or undertake correction action and a "hands-off" attitude toward its mental health care contractor, resulting in the provision of sub-standard care, is sufficient to support a finding of deliberate indifference. *Lynch v. Wexford*, Civil Action No. 2:13-CV-01470, (S.D. W. Va., May 20, 2016).

Defendants have failed to adequately oversee the provision of mental health care by contractor MHM.

Defendants' failure to oversee the provision of mental health care, particularly pursuant to a contract that creates incentives for the contractor to improperly delay or deny care to enhance profits, constitutes deliberate indifference.

Defendants have knowledge of the constitutional inadequacies in the ADOC mental health care system.

Defendants' failure to address the constitutional inadequacies in the ADOC mental health care system constitutes deliberate indifference.

Defendants' failure to monitor and respond to deficiencies identified in MHM's quality improvement process is deliberately indifferent to the harms and risks of harm caused by those deficiencies.

Defendants' failure to monitor the quality of mental health care provided to prisoners in ADOC custody is deliberately indifferent.

Defendants' policy of underfunding of the mental health system, coupled with Defendants' failure to monitor the care provided, caused the constitutional violations suffered by serious mentally ill prisoners in the ADOC.

CLAIM 3 FINDINGS OF FACT: DEFENDANTS INVOLUNTARILY MEDICATE MENTALLY ILL PLAINTIFFS' WITHOUT DUE PROCESS

VI. Plaintiffs and Class Members Are Medicated Against Their Will Without Appropriate Determinations That They Should Be

The facts regarding Individual Plaintiffs, Mental Health Subclass Members, and Systemic Inadequacies, §§ II, III are hereby incorporated, to the extent applicable, for purposes of Plaintiffs' involuntary medication claim.

A. Defendants Violate the Rights of Plaintiffs Who Have a Hearing to Authorize Involuntary Psychiatric Medication

Administrative Regulation 621 sets forth the procedures for involuntary psychiatric medication in the ADOC. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 52, 53, ADOC Admin. Reg. 621 & 621-1. Under their contractual agreement with ADOC, MHM implements the involuntary medication program. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. Pls. Tr. Ex. 170, Contract Review Report for contract between ADOC and MHM, and October 2013 Contract between ADOC and

MHM. Since 2002 or 2003, the number of prisoners receiving medications involuntarily has grown from "a handful" to around 70 or 80. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 683, MHM Alabama Regional Report (showing the increase in involuntary medication orders from 20 in 2005 to 71 in 2014).

Under Administrative Regulation 621, there are certain prerequisites that must be met and procedures that must be followed before ADOC may issue an involuntary medication order. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 52, ADOC Admin. Reg. 621. Once an involuntary medication order has been issued, the individual must be provided notification "concerning his/her option to appeal the decision within one working day after receipt." *Id*. Furthermore, the policy states that "[t]he Staff Advisor will assist the inmate in submitting an appeal if the inmate desires to do so. An inmate's appeal will be reviewed and the decision rendered in writing by the institution's Medical Director or designee within one working day of its receipt." *Id*.

B. At Involuntary Medication Hearings, Defendants Do Not Determine Whether Patients Are Currently Sufficiently Ill to Warrant Involuntary Medication

The Involuntary Medication Committee does not base its determinations on whether a prisoner is currently a danger to himself or others; rather, they rely on past conduct, such as a prisoner's conviction or behavior displayed years ago, to justify involuntary medication. Tr. Test. of Dr. Charles Woodley.

For instance, Plaintiff Quang Bui's involuntary medication review committee continues to base its determination that Plaintiff Bui is a danger to himself and others on nine-year-old behavioral observations and the fact that Plaintiff Bui was convicted of murder in 1986, despite the fact that Bui has been found by his mental health providers and Defendants' own expert to have shown improvement. *E.g.*, Tr. Test. of Quang Bui, Dr. Kathryn Burns, Raymond Patterson; Pls. Tr. Ex. 1112, Q. Bui Med. Record, at MR002535, MR002660, MR002674-2675 (finding that Bui is a good candidate for discontinuing involuntary medication), MR002920 (Involuntary Medication Request listing his 1986 crime as only evidence of "danger to others"). And the committee bases its continuing conclusion that Plaintiff Bui is a danger to himself solely on the fact that Plaintiff Bui maintains he is not sick and does not need medication. *E.g.*, Pls. Tr. Ex. 1112, Q. Bui Med. Record, at MR002920 (Involuntary Medication Request listing "lack of insight and acceptance of diagnosis" as only evidence of "danger to self"). Plaintiff Bui is not medicated due to "aggression or violence." Tr. Test. of Dr. Robert Hunter.

Likewise, the only evidence the Involuntary Medication Committee considered of Plaintiff Roger McCoy's "severe repeated and escalating deterioration" was his sentence, more than a decade earlier, in his criminal case and his history of mental illness. Pls. Tr. Ex. 1121, R. McCoy Med. Records, at

MR024518. The only reported evidence of Plaintiff McCoy's "[d]anger to others" was his "[h]ostile behavior, sentence for murder." *Id*. The only reported evidence of Plaintiff McCoy's "[d]anger to self" was his "refusing medications." *Id*. Plaintiff McCoy has only had one involuntary medication hearing during his time in ADOC though he regularly refuses his medication. Tr. Test. of Roger McCoy.

Additionally, involuntary medication orders are frequently continued on the basis that the prisoner is doing well on the medication, such as in Plaintiff Quang Bui's and Class Member REDACTED cases. Tr. Test. of Dr. Robert Hunter, Quang Bui, REDACTED .

Mental health staff also do not attempt adequate alternative means of stabilizing prisoners so that they can avoid involuntary medication orders. First, the involuntary medication process requires that a prisoner be transferred from his facility to Bullock. Several weeks pass between this transfer and the prisoner's involuntary medication hearing. Tr. Test of Dr. Kathryn Burns, Dr. Robert Hunter. This transfer and lapse in continuity of care are de-stabilizing and work to ensure that the prisoner is deemed to require voluntary medication. Tr. Test. of Dr. Kathryn Burns. Next, as discussed above, mental health treatment is generally inadequate. *See* § III. And specifically, once a prisoner is subject to an involuntary medication order, he is not provided additional meaningful mental health treatment other than forced medication. Tr. Test. of Dr. Kathryn Burns, REDACTED ,

Quang Bui. Class Member REDACTED , for example, does not have the opportunity to participate in one-on-one counseling or mental health groups, though he has been subject to an involuntary medication order for five years. Tr. Test. of REDACTED .

Further, involuntary medication continues past the expiration of involuntary medication orders. Tr. Test. of Dr. Robert Hunter, Anna Davis-Walker; Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031193 (reporting delinquent involuntary medication reviews). Under the policy, the Involuntary Medication Committee is required to review the continuation request before the initial order expires. Tr. Test. of Dr. Robert Hunter, Anna Davis-Walker; Pls. Tr. Ex. 52, ADOC Admin. Reg. 621, Pls. Tr. Ex. 53, ADOC Admin. Reg. 621-1. However, prisoners continue to be involuntarily medicated after their orders have expired, and are often not informed that their orders have expired. Tr. Test. of Dr. Kathryn Burns, Quang Bui, REDACTED .

C. Defendants Fail to Provide Appropriate Procedural Protections in Hearings for Involuntary Medications

Involuntary medication review hearings are primarily paper reviews of the medication request and medical record, and sometimes questions are posed to the prisoner. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns. The hearings almost

always result in an involuntary medication order. Tr. Test. of Dr. Robert Hunter, Dr. Kathryn Burns. There are numerous procedural deficiencies.

1. Defendants Fail to Provide Adequate Notice of Hearings

Prisoners subject to involuntary medication hearings often receive inadequate notice of those hearings. Some prisoners simply do not receive notice. Tr. Test. of Dr. Kathryn Burns. Others receive late and/or deficient notice. Tr. Test. of REDACTED, Quang Bui.

Plaintiff Bui consistently receives deficient notice prior to his involuntary medication hearings. As shown in the following chart, the notices fail to include essential information such as the reason for the hearing and the recommended medication, and they are provided to him late, sometimes the day before or the day of his hearing.

Date	Notice Missing Reason for Hearing or Identification of Medication	Late Notice	Ex.__, Q. Bui Med. Records,
May 2015	X	X	MR043418-043419, 043420
Oct. 2014	X		MR029594, 029590
May 2014	X	X	MR002948-002949, 002909
Nov. 2013	X	X	MR002917-002918,

			002916
Apr. 2013	X		MR002935-002936, 002937
Oct./Nov. 2012	X		MR002535, 002508
Apr. 2012	X	X	MR002514-002515, 002513
Nov. 2011	X		MR002520-002521, 002522
June 2011	X		MR002924-002925, 002926
Jan. 2011	X		MR002582, 002583
July 2010	X		MR002596-002597
Jan. 2010	X		MR002674, 002602
July 2009	X	X	MR002700-002701, 002696
Jan. 2009	X		MR002723-002724, 002722
July 2008	X	X	MR002747, 002625
Feb. 2008	X		MR002640-002641, 002639
Nov. 2007	X		MR002634-002635, 002633

Pls. Tr. Ex. 1112, Q. Bui Med. Records.

Specifically, Plaintiff Bui's medical Records also contain hearing notices in which dates appear to be have been changed or were apparently provided on the same day and even sometimes after the hearing, raising questions as to whether the

required twenty-four hour notice of the hearing was provided to Bui. *See, e.g.*, Pls. Tr. Ex. 1112, Q. Bui Med. Records, at MR002625 (notice of Jul. 14, 2008 hearing, date appears to have been altered), 002696 (notice of Jul. 16, 2009 hearing, date changed/unclear), 002513 (notice for Apr. 25, 2012 hearing, signed by Bui on same date as hearing), 002916 (notice for Nov. 14, 2013 hearing, dated one day after hearing itself took place), 002909 (notice for May 8, 2014 hearing, provided on same day as hearing), 043420 (notice for May 7, 2015, dates appear to have been changed).

2. Prisoners Are Not Permitted to Speak on Their Own Behalf or Question Witnesses

At the hearings, prisoners who attempt to speak on their own behalf are quickly dismissed. Tr. Test. of REDACTED, Quang Bui. Relevant witnesses are often not allowed or required to testify at hearings, depriving the prisoner the opportunity to examine or cross-examine certain witnesses. For example, ADOC Admin. Reg. 621 does not require that the psychiatrist or nurse practitioner who is treating the prisoner and recommending involuntary medication be present at the hearing. Tr. Test. of Dr. Kathryn Burns. This means that the prisoner does not have any opportunity to question witnesses on the basis for the recommendation. Tr. Test. of Dr. Kathryn Burns, REDACTED.

Additionally, because involuntary medication hearings, especially initial hearings, take place at Bullock, the psychiatrist and other members of the treatment team that initiated the evaluation for involuntary medication are generally not present. Tr. Test. of Dr. Kathryn Burns.

3. Although Prisoners Are Informed They Can Be Unmedicated for Their Hearing, They Often Cannot

Prisoners often are not allowed to appear at their hearings unmedicated. For example, Plaintiff Bui's involuntary medication committee has not observed him unmedicated since his involuntary medication order was first issued in November 2007, nearly nine years ago. Tr. Test. of Quang Bui. Plaintiff Bui's Haldol shots last for a month, and he receives his shot every month and has never missed a month's dosage. Tr. Test. of Quang Bui. Thus, it is impossible for Plaintiff Bui to be unmedicated at a hearing and for medical personnel to observe him unmedicated unless he is allowed to remain unmedicated for some amount of time longer than one month. Likewise, Class Member REDACTED receives his psychotropic medication shots every two weeks and has remained subject to an involuntary medication order for five years. Tr. Test. of REDACTED .

4. Prisoners Are Not Provided with a Lay Advisor to Assist Them at the Hearing

Though ADOC Admin. Reg. 621 requires that prisoners be provided a staff advisor for their involuntary medication hearings, they often are not. Tr. Test. of

Quang Bui, REDACTED , Dr. Edward Kern. After nine years of twice-yearly hearings, Plaintiff Bui does not know what a staff advisor is and no one has ever explained to him what or who the advisor is. Tr. Test. of Quang Bui. Plaintiff Bui is often not provided a lay advisor at his involuntary medication review hearings. Pls. Tr. Ex. 1112, Q. Bui Med. Records, at MR002948-002949, 002909, 002917-002918, 002916, 002535, 002508, 002514-002515, 002513, 002520-002521, 002522, 002924-002925, 002926.

Moreover, there is nothing in the policy that requires that the lay advisor, if there were one, be knowledgeable about the issues relating to the involuntary medication hearing or be independent. Tr. Test. of Teresa Houser; Pls. Tr. Ex. 52, ADOC Admin. Reg. 621. The sole criteria for adequacy of the advisor is that the advisor is "not currently involved in the inmate's treatment". *Id*.

5. The Involuntary Medication Committee Includes Staff Involved in the Treatment of the Prisoners whose Orders They Are Considering

Finally, though the involuntary medication committee is not supposed to include providers on the prisoner's treatment team, members of a prisoner's treatment team effectively make the decision to involuntarily medicate him. Generally, the Involuntary Medication Committee consists of individuals who are not on the prisoner's treatment team, typically Dr. Robert Hunter, chief psychiatrist for MHM, Dr. Charles Woodley, MHM's director of training, and MHM's director

of nursing. Tr. Test. of Robert Hunter, Charles Woodley, Teresa Houser. However, nurse practitioner Dorothy Coogan is the primary involuntary medications requestor for prisoners at St. Clair. *See, e.g.* Pls. Tr. Ex. 1112, Q. Bui Med. Records, at MR002507. And Ms. Coogan's collaborating physician is Dr. Hunter. Tr. Test. of Robert Hunter, Dorothy Coogan. Thus, Dr. Hunter, who is responsible for the supervision of Ms. Coogan's clinical decisions, is responsible both for her recommendation of involuntary medication as a treatment provider and the "impartial" decision whether to involuntarily medicate a prisoner. Likewise, Dr. Woodley, supervises all MHPs, who sit on the treatment teams requesting involuntary medication, but also sits on the "impartial" Involuntary Medication Committee. Tr. Test. of Charles Woodley, Robert Hunter, Teresa Houser.

6. There Is No Meaningful Appeals Process

MHM's implementation of the appeals process does not provide prisoners with an adequate opportunity to contest involuntary medication decisions. First, "staff advisors," who are designated by Admin. Reg. 621 to assist with appeals, are often not appointed, or prisoners are not made aware of their identity. Pls. Tr. Ex. 52, ADOC Admin. Reg. 621(V)(J); Tr. Test. of Dr. Edward Kern. Furthermore, appeals of an involuntary medication order are almost never successful. Tr. Test.

of Robert Hunter, Quang Bui,[REDACTED] . In Dr. Hunter's tenure as the MHM Medical Director, he does not remember one successful appeal. *Id*.

D. Defendants Involuntarily Medicate Prisoners Without Any Process

Many prisoners are involuntarily medicated without any due process whatsoever. This generally occurs through threats, coercion, and even the use of force by correctional and medical staff when prisoners refuse to take their medications. Tr. Test. of Dr. Kathryn Burns. Other times, medical staff do not obtain adequate consent to medication from prisoners. Tr. Test. of Richard Terrell, Sylvester Hartley, Roger McCoy, Robert Dillard.

1. Threats, Coercion, and Use of Force

Prisoners who have tried to refuse medication have been subjected to severe consequences. Prisoners are threatened with, or actually placed in, segregation for refusing to take their medication. Tr. Test. of Quang Bui, Roger McCoy, [REDACTED]

, Dr. Kathryn Burns. On at least one occasion, Plaintiff Roger McCoy was placed into an isolation cell as a result of refusing to take his medication. Tr. Test. of Roger McCoy. Others are threatened with or given disciplinaries, such as Plaintiff Robert Dillard, who has been told that if he did not take his Haldol shot, he would be written up. Tr. Test. of Robert Dillard.

Prisoners are threatened with or given forced injections if they refuse to take their scheduled oral or injectable medication. Tr. Test. of Dr. Kathryn Burns, REDACTED Roger McCoy, Robert Dillard, REDACTED

2. Inadequate Consent to Medication

In addition to the coercive practices described above, Defendants often simply fail to obtain patients' knowing and voluntary consent for administration of psychiatric medications. Tr. Test. of Richard Terrell, Roger McCoy, REDACTED

In conducting spot audits of various facilities, MHM noted failures to obtain informed consent to medications. Tr. Test. of Anna Davis-Walker; Pls. Tr. Ex. 235, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015, at MHM041863.

CLAIM 3 CONCLUSIONS OF LAW: DEFENDANTS INVOLUNTARILY MEDICATE MENTALLY ILL PLAINTIFFS' WITHOUT DUE PROCESS

Named Plaintiffs Bui, Hartley, Dillard, Terrell, and McCoy and members of the Mental Health Subclass have been and continue to be at serious risk of being involuntarily medicated in violation of their Fourteenth Amendment substantive and procedural due process rights.

Involuntary Medication Without Substantive Due Process

Prisoners have a constitutional liberty interest in being free from involuntary administration of psychotropic drugs "absent a finding of overriding justification and a determination of medical appropriateness." *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

Alabama prisoners also have a state-created liberty interest arising from the Alabama Department of Corrections' regulations regarding involuntary psychotropic medication. Pls. Tr. Ex. 52, ADOC Admin. Reg. 621; *Washington v. Harper*, 494 U.S. 210, 221-22 (1999) (recognizing that prisoners possessed liberty interests arising from both the Due Process Clause and Washington state prison regulations regarding involuntary medication).[6]

Involuntarily administered psychotropic drugs implicate protected liberty interests because of the "serious, even fatal side effects" that psychotropic drugs can cause. *Harper*, 494 U.S. at 229.

Finding a liberty in interest in being free from involuntary psychotropic medication, the Supreme Court set forth basic due process requirements for the involuntary medication of mentally ill prisoners. Under *Washington v. Harper*, substantive due process is satisfied if the inmate being involuntary medicated (1)

[6] ADOC's regulations regarding involuntary medication are modeled after the Washington state regulations considered in *Harper*. Tr. Test. of Dr. Kathryn Burns.

has a serious mental illness; (2) is gravely disabled or dangerous to himself or others; and (3) the treatment is in the inmate's medical interest. *Harper*, 494 U.S. at 227.

Because the Involuntary Medication Review Committee bases its determinations that prisoners, including Plaintiffs Bui and McCoy, are dangerous to themselves or others and that involuntary medication is in their medical interest on outdated evidence, including prisoners' immutable crimes of conviction, their substantive due process rights have been and are continuing to be violated. *Harper*, 494 U.S. at 227.

And because prisoners, including Plaintiffs Robert Dillard, Roger McCoy, and Sylvester Hartley, have been involuntarily medicated through threats, coercion, or use of force without any determination as to whether they are gravely disabled or pose a danger to themselves or others and that involuntary medication is in their medical interest, their substantive due process rights have been and are continuing to be violated. *Harper*, 494 U.S. at 227.

Involuntary Medication Without Procedural Due Process

Generally, in determining whether adequate procedural due process has been provided, courts weigh three factors: the private interests at stake in a

governmental decision, the governmental interests involved, and the value of procedural requirements. *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)

The private interest at stake with regard to involuntary medication is very important due to the "serious, even fatal side effects" that psychotropic drugs can cause. *Harper*, 494 U.S. at 229.

Defendants have no interest in not following the psychotropic medication consent and involuntary medication procedures already set forth in their own regulations. Pls. Tr. Ex. 52, ADOC Admin. Reg. ADOC Admin. Reg. 616, 621.

The value of procedural protections with regard to involuntary medication is therefore high. *See generally Harper*, 494 U.S. 210.

To satisfy procedural due process requirements prior to involuntary medication administration in the prison context, (1) the prisoner must receive notice of an adversarial hearing; (2) the prisoner must have the right to be present at the hearing; (3) the prisoner must have the right to present witnesses and cross-examine witnesses; (4) the decision-maker must be a neutral one who is not involved in the prisoner's treatment; and (5) the prisoner must be provided with a lay advisor who understands the psychiatric issues. *Harper*, 494 U.S. at 229-36 (considering the three factors set for in *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)).

The inmate must have the opportunity to contest the staff's position "at a meaningful time and in a meaningful manner." *Id*. at 235 (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965)).

The Supreme Court recognized the provision of "an independent lay advisor who understands the psychiatric issues involved" as an important protection for due process rights. *Harper*, 494 U.S. at 236 (citing *Vitek v. Jones*, 445 U.S. 480, 498 (1980)).

"The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 270, 110 S. Ct. 2841, 2847, 111 L. Ed. 2d 224 (1990).

In the prison context, the right to consent implicates constitutional issues: "In order to consent, Plaintiffs must waive their liberty interest in refusing antipsychotic medication. Any waiver of a constitutional right must be a knowing and voluntary." *Hightower by Dahler v. Olmstead*, 959 F.Supp. 1549, 1569 (N.D. Ga. 1996) (citing *Dunkins v. Thigpen*, 854 F.2d 394, 398 (11th Cir.1988)).

Where no procedural due process is provided at all or where prison officials use coercion or the "threat of violence to compel an inmate to ingest a drug, particularly where no medical professional has authorized forced medication," a

prisoner's rights are violated. *Roland v. McMonagle*, No. 12-cv-6331, 2015 WL 5918179 at *4 (S.D. N.Y. Oct. 9, 2015) (finding that an issue of fact remained as to whether officers made threats of violence to compel medication).

ADOC's involuntary medication regulation prescribes a number of specific procedural requirements. Pls. Tr. Ex. 52, ADOC Admin. Reg. ADOC Admin. Reg. 621.

1. Denial of Procedural Due Process Protections in Formal Involuntary Medication Proceedings

Because prisoners in ADOC custody, including Plaintiff Quang Bui, have been involuntarily medicated without adequate and timely notice, the opportunity to be unmedicated at hearings, a lay advisor at each hearings, and the opportunity to cross-examine relevant witnesses, their procedural due process rights have been and are continuing to be violated.

Because prisoners, including Plaintiff Quang Bui and Class Member REDACTED , have been deprived access to a meaningful appeals process, including access to a lay advisor, their procedural due process rights have been and are continuing to be violated. Tr. Test. of Quang Bui, REDACTED , Dr. Robert Hunter.

Prisoners' procedural due process rights are violated when their involuntary medication continues past the expiration of their involuntary medication orders.

See, e.g., Pls. Tr. Ex. 670, MHM CQI Quarterly Meeting Minutes, at MHM031193 (reporting delinquent involuntary medication reviews); Tr. Test. of Dr. Kathryn Burns, Quang Bui, REDACTED .

2. Denial of Procedural Due Process Protections to Prisoners who Are Not Afforded Formal Involuntary Medication Hearings

When a mental health provider administers medication, the individual receiving the medication must either consent to the medication, or be provided with due process prior to involuntarily medication. *See Harper*, 494 U.S. at 229 ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."). Consent must be knowing and voluntary. *Hightower by Dahler*, 959 F.Supp. at 1569 (N.D. Ga. 1996) (citing *Dunkins v. Thigpen*, 854 F.2d 394, 398 (11th Cir.1988).

ADOC Administrative Regulation 616 governs informed consent for psychotropic drugs and requires that informed consent be obtained from an inmate when a psychotropic drug is first prescribed and anytime the prescription is changed. Pls. Tr. Ex. 42, ADOC Admin. Reg. 616.F.

ADOC's regulation requires the treating psychiatrist to "inform inmates of the potential risks and benefits of the prescribed medication, including possible side effects, and alternative treatments." *Id*. The regulation further provides that informed consent becomes inactive when the inmate withdraws his consent. *Id*.

Prisoners, including Plaintiffs Sylvester Hartley, Robert Dillard, Richard Terrell, have not been meaningfully informed of the benefits and side effects of their psychotropic medications prior to signing informed consent forms, but they have nevertheless been medicated. Their procedural due process rights have been violated. Tr. Test. of Sylvester Hartley, Robert Dillard, Richard Terrell.

Prisoners, including Plaintiff Roger McCoy, have not signed informed consents forms at all, or their informed consent forms have been forged, but they have nevertheless been medicated. Their procedural due process rights have been violated. Tr. Test. of Roger McCoy; *see also* Pls. Tr. Ex. 235, Doc. 734, Ex. 141, Email from A. Davis-Walker re Fountain Audit Findings from June 18, June 29, 2015, at MHM041863.

Prisoners – including Plaintiffs Quang Bui and Roger McCoy and Class Members REDACTED – have withdrawn their consent by refusing medication, but they have nevertheless been medicated through threats, coercion, and the use of force. Their procedural due process rights have been violated. Tr. Test. of Quang Bui, Roger McCoy, REDACTED , Dr. Kathryn Burns.

VII. DAUBERT CHALLENGES

A. Standard for Admissibility of Expert Testimony

Federal Rule of Evidence 702 allows an expert to testify about events that he or she has not personally experienced if the expert's "specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue." Fed. R. Evid. 702(a). Testimony of proffered experts is admissible if:

> (1) [T]he expert is qualified to testify competently regarding the matters he intends to address; (2) the methodology by which the expert reaches his conclusions is sufficiently reliable as determined by the sort of inquiry mandated in *Daubert*; and (3) the testimony assists the trier of fact, through the application of scientific, technical, or specialized expertise, to understand the evidence or to determine a fact in issue.

Seamon v. Remington Arms Co., LLC, 813 F.3d 983, 988 (11th Cir. 2016) (citing *City of Tuscaloosa v. Harcros Chems., Inc.*, 158 F.3d 548, 562 (11th Cir. 1998)). The party proffering an expert witness bears the "burden of establishing qualification, reliability, and helpfulness" of the testimony of the proffered expert. *United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004).

1. Qualification

A determination that an expert witness is qualified may be based on "knowledge, skill, experience, training, or education." Fed. R. Evid. 702. Such

qualification may be based on "scientific training or education." *Frazier*, 387 F.3d at 1261; Fed. R. Evid. 702, 2000 Comm. Notes.

The opinions of an expert witness must be limited to areas in which the witness possesses specialized knowledge, skill, experience, training, or education. *See Cordoves v. Miami-Dade Cnty.*, 104 F. Supp. 3d 1350, 1358 (S.D. Fla. 2015); *cf. City of Tuscalossa v. Harcros Chems., Inc.*, 158 F.3d 548, 562 (11th Cir. 1998) (noting that the Federal Rules require an expert to be "qualified to testify competently regarding the matters he intends to address"). The fact that an expert is qualified to testify on certain matters does not give that witness carte blanche to testify about all issues relevant to the case, even outside the witness's area of expertise. *See Cordoves*, 104 F. Supp. 3d at 1358 ("[E]xpert testimony regarding matters outside of the witness's expertise is inadmissible, even if the expert is qualified to testify about other matters.").

In some cases, "experience alone . . . may [] provide a sufficient foundation for expert testimony." *Frazier*, 387 F.3d at 1261; Fed. R. Evid. 702, 2000 Comm. Notes. But if an expert witness relies "solely or primarily on experience, then the witness must explain how that experience leads to the conclusion reached, why that experience is a sufficient basis for the opinion, and how that experience is reliably applied to the facts." *Id*.

Where there is an "insufficient nexus" between a proposed expert's experience and his opinion, a court may properly exclude the proffered testimony. *Frazier*, 387 F.3d at 1265-66. The Court's role in probing the witness's expertise is consequential: "The trial court's gatekeeping function requires more than simply 'taking the expert's word for it.'" *Id*. (quoting Fed. R. Evid. 702, 2000 Comm. Notes).

2. Reliability

An expert's testimony be "based on sufficient facts or data" and "the product of reliable principles and methods." Fed. R. Evid. 702(b), (c). And an expert must reliably apply "the principles and methods to the facts of the case." Fed. R. Evid. 702(d).

In evaluating the reliability of a proffered expert's testimony, courts must assess "whether the reasoning or methodology underlying the testimony is scientifically valid and . . . whether that reasoning or methodology properly can be applied to the facts in issue." *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 592-93 (1993).

"Exactly *how* reliability is evaluated may vary from case to case . . . " *Frazier*, 387 F.3d at 1262. Courts generally consider, in addition to any other relevant factors:

> 1) whether the expert's theory can be and has been tested; (2) whether the theory has been subjected to peer review and publication; (3) the

> known or potential rate of error of the particular scientific technique; and (4) whether the technique is generally accepted in the scientific community.

Quiet Tech. DC-8, Inc. v. Hurel-Dubois UK Ltd., 326 F.3d 1333, 1342 (11th Cir. 2003). These same considerations may also be used to assess the reliability of non-scientific, experience-based testimony. *Frazier*, 387 F.3d at 1262 (citing *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999)).

Where proffered testimony amounts to nothing more than "unreliable *ipse dixit*, resting on an utterly insufficient evidentiary foundation," the Court can properly exclude the testimony. *See Witt v. Stryker Corp. of Michigan*, 648 F. App'x 867, 872-73 (11th Cir. 2016) (finding that the district court's decision to exclude an expert opinion that "lacked *any* explanation, foundation, or support, and therefore had to be excluded because of its unreliability" fell within the court's gatekeeping authority).

In evaluating an expert's reliability, the court ensures that "an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the practice of an expert in the relevant field." *McDowell v. Brown*, 392 F.3d 1283 (11th Cir. 2004).

3. Helpfulness

Expert testimony is determined to be "helpful" if "it concerns matters that are beyond the understanding of the average lay person." *Frazier*, 387 F.3d at

1262. "Proffered expert testimony generally will not help the trier of fact when it offers nothing more than what lawyers for the parties can argue in closing arguments." *Id*. at 1262-63 (citing 4 Weinstein's Federal Evidence § 702.03[2][a]).

B. Findings of Fact and Conclusions of Law Regarding the Admissibility of Plaintiffs' Phase 2A Experts' Testimony

Defendants have challenged the admissibility of one of Plaintiffs' Phase 2A experts' testimony –Dr. Kathryn Burns. Doc. 807, Dfs. Mem. of Law in Opp. to Class Cert., at 172 *et seq.*[7]

The "qualification, reliability, and helpfulness" of Dr. Burns's proffered testimony is readily apparent. *See United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004). Moreover, she appropriately applied the standards of care for her field of care –mental health.

1. Dr. Burns's Qualifications

Dr. Kathryn Burns is a Medical Doctor licensed in the state of Ohio. She is Board Certified in the practice of General Psychiatry and Forensic Psychiatry. She also has a Master's Degree in Public Health. Tr. Test. of Dr. Kathryn Burns. She is

[7] It is Plaintiffs' understanding that all *Daubert* objections have already been raised in conjunction with class certification and summary judgment briefing. To the extent Defendants' seek to raise any new *Daubert* objections at trial, Plaintiffs' request the opportunity to fully brief and argue such objections. *See* Doc. 529, Phase 2 Pretrial and Motion Deadlines Order.

a Distinguished Fellow of the American Psychiatric Association and Board Certified by the American Board of Psychiatry and Neurology ("ABPN") in General Psychiatry and Forensic Psychiatry. *Id*. She has served both as a Board Examiner for the ABPN general adult psychiatry oral examination and on the forensic psychiatry committee, writing examination questions and preparing the forensic psychiatry board examinations. *Id*.

Dr. Burns is currently the Chief Psychiatrist for the Ohio Department of Rehabilitation and Correction, a position she also held from May 1995 to August 1999. *Id*.

Dr. Burns has been recognized by courts around the country as a well-qualified expert and has decades of experience as a top expert in correctional mental health care. *Id*. In fact, Dr. Burns evaluated ADOC's provision of mental health care as an expert in a previous case –the *Bradley v. Hightower* litigation that settled in 2000. *Id*.

Defendants' own mental health expert Dr. Raymond Patterson recognized Dr. Burns as a "top nationally recognized expert[] in the field of correctional mental health" when they served as experts together. Tr. Test. of Dr. Raymond Patterson, Dr. Kathryn Burns; Rep. on Suicides Completed in the California Dept.

of Corr. and Rehab., *Coleman v. Brown*, No. 2:90-cv-00520 (E.D. Cal. Mar. 13, 2013), ECF No. 4376, at 1.

Furthermore, Dr. Burns's opinions regarding the impact of correctional staffing levels on the provision of mental health within ADOC are informed by her experience in correctional mental health for decades. Tr. Test. of Dr. Kathryn Burns. As the Chief Psychiatrist for the Ohio Department of Rehabilitation and Correction, Dr. Burns supervises the director of quality improvement. *Id*. Dr. Burns reviews and contributes to relevant policies and procedures. *Id*. She also sits on a number of internal committees. *Id*. Through Dr. Burns's professional role and decades-plus of experience in correctional mental health, she has been involved in evaluating and informing internal operations of correctional systems. *Id*.

2. Dr. Burns's Reliability

Dr. Burns is a psychiatrist and mental health correctional expert who considered the evidence in this case from a medical, not legal, perspective. Tr. Test. of Dr. Kathryn Burns. As a licensed physician, Dr. Burns formed her opinion in this case based on the same sources of information that she and other experts in correctional mental health rely upon: her experience, interviews, observations, documents, and site visits. Tr. Test. of Dr. Kathryn Burns.

Dr. Burns evaluated ADOC's system of providing mental health care as a whole. Tr. Test. of Dr. Kathryn Burns. Dr. Burns's opinions about systemic deficiencies were informed by the accounts of numerous class members. Tr. Test. of Dr. Kathryn Burns. Her opinion was informed by the experiences of individual prisoners because they transfer throughout numerous facilities during their time in ADOC. Tr. Test. of Dr. Kathryn Burns.

Her opinions are further supported by ADOC and MHM's acknowledgement of some of the deficiencies she identified. Tr. Test. of Dr. Kathryn Burns.

In forming her opinions, Dr. Burns considered information gathered and observations made during site visits at the following prisons on the indicated dates:

- Tutwiler Prison for Women – May 13, 2015
- Bibb Correctional Facility – May 14, 2015
- St. Clair Correctional Facility – May 15, 2015
- Holman Correctional Facility – August 17, 2015
- Fountain Correctional Facility– August 18, 2015
- Donaldson Correctional Facility – September 8-9, 2015
- Kilby Correctional Facility – September 10-11, 2015
- Bullock Correctional Facility – March 14-15, 2016
- Easterling Correctional Facility – March 16, 2016

Tr. Test. of Dr. Kathryn Burns.

Her site visits consisted of observations of prisoner housing units, including segregation; observations of mental health program areas; crisis watch cells; mental health housing units; brief non-confidential cell front conversations with some prisoners; and individual out-of-cell and interviews with prisoners identified from the mental health caseload roster. *Id*. She conducted individual interviews with 77 prisoners and spoke with another 25 prisoners very briefly at cell front as permitted by the agreement between the parties. *Id*. She reviewed mental health Records and logs when they were made available to her. She observed the medication administration practice at one facility when permitted to do so. *Id*. This methodology (document review, site visits, interviews and observations) is the same as that used by other experts in the field to assess correctional mental health care and that she have used in assessing other correctional facilities and systems. *Id*.

Dr. Burns's methodology is the model relied upon by experts in her field. Tr. Test. of Dr. Kathryn Burns, Dr. Raymond Patterson, Dr. Robert Greifinger.

3. Dr. Burns's Helpfulness

Dr. Burns highlights the systemic deficiencies that plague the ADOC. The evidence put forth by Dr. Burns, combined with countless other evidence of

systemic failings in this case, is relevant and helpful to the Court's deliberate indifference inquiry. *See LaMarca v. Turner*, 995 F.2d 1526, 1544 (11th Cir. 1993).

Dr. Burns's opinions constitute evidence that "the quality of psychiatric care . . . [is] so substantial a deviation from accepted standards as to evidence deliberate indifference to those serious psychiatric needs." *See Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996) (citation omitted).

C. Findings of Fact and Conclusions of Law Regarding the Inadmissibility of Defendants' Phase 2A Experts' Testimony

Plaintiffs challenge the admissibility of the testimony of the following expert witnesses included on Defendants' Phase 2A Trial Witness List: Robert Greifinger, Catherine Knox, Robert Morgan, Raymond Patterson to the extent he relied on the audits discussed herein, and Robert Ayers. Doc. 901, Ex. A.

1. Dr. Robert Greifinger

Dr. Robert Greifinger has been offered to opine on "the delivery of medical services in the correctional environment, the medical care provided to prisoners incarcerated in the ADOC system, . . . and any conclusions reached related to his review of the delivery of medical care within the ADOC system and the ADOC's oversight and management of such activities within its facilities." Doc. 840, Ex. 91, Defendants' Expert Disclosure, at 2-3; Tr. Test. of Dr. Robert Greifinger.

Dr. Greifinger intended to examine clinical outcomes of medical care provided to prisoners within the ADOC. Tr. Test. of Dr. Robert Greifinger. Dr. Greifinger oversaw and participated in the audit of certain aspects of medical care at six ADOC facilities in May 2016, discussed below. *Id*. He also read or skimmed portions of Dr. Puisis's report. *Id*. He toured four facilities in two days in May 2015. *Id*.

Dr. Greifinger's opinions are unreliable because they are based entirely on a flawed audit process. *See* § VII.C.6. His opinions based on those audits are inadmissible.

2. Catherine Knox

To the extent Defendants offer Catherine Knox to render an opinion as to the adequacy of mental health care, including mental health care provided by licensed physicians and psychologists, Ms. Knox is not qualified to do so and such testimony would be unreliable.

Plaintiffs do not dispute that Ms. Knox, a registered nurse with experience in corrections health care, is qualified to render an opinion on certain aspects of nursing care. Tr. Test. of Catherine Knox. However, Ms. Knox is not qualified to offer opinions on the adequacy of care that she herself is not licensed to provide and has no history of providing.

Ms. Knox demonstrates none of the "knowledge, skill, experience, training, or education" to offer expert opinions as to the adequacy of mental health care. Fed. R. Evid. 702(a). She is not a licensed physician; she is a registered nurse (RN). Tr. Test. of Catherine Knox. In order to assess both the quality of overall mental health care provided throughout ADOC and the quality of mental health care provided to individual Plaintiffs, Ms. Knox requires a medical degree. Her opinions on the overall adequacy of mental health care is outside her scope of practice and licensure are unreliable. *See Cordoves*, 104 F. Supp. 3d at 1358 ("[E]xpert testimony regarding matters outside of the witness's expertise is inadmissible, even if the expert is qualified to testify about other matters.").

Furthermore, Ms. Knox was not disclosed to Plaintiffs as a mental health expert. Doc. 840, Ex. 91, Defendants' Expert Disclosures, at 2 ("The State generally expects Ms. Knox to offer expert testimony regarding the delivery of medical services in the correctional environment, the medical care provided to prisoners incarcerated in the ADOC system, including, without limitation, the Named Plaintiffs, the policies and procedures relating to the medical care provided to prisoners in the ADOC system and any conclusions reached related to her review of the delivery of medical care within the ADOC system and the ADOC's oversight and management of such activities within its facilities."). For that reason,

Ms. Knox cannot be allowed to testify to an area of expertise for which she was not designated.

Finally, to the extent Ms. Patterson's opinions are based on the flawed audit process discussed in § VII.C.6., they are unreliable and inadmissible.

3. Dr. Robert D. Morgan

Dr. Robert Morgan has been offered to opine on "mental health care and medical care provided to prisoners in the ADOC system and the interaction of custody practices with mental and physical health of prisoners and the delivery of medical and mental health care to prisoners." Doc. 586, Alabama Department of Corrections Disclosures of Experts ("ADOC Disclosure of Experts"); Tr. Test. of Dr. Robert Morgan.

a) Dr. Morgan Has No Expertise in Corrections

Although Dr. Morgan has no expertise in corrections, he was retained to investigate the conditions of confinement in the ADOC, including confinement in segregated housing. Tr. Test. of Dr. Robert Morgan. To the extent Defendants offer Dr. Morgan to provide conclusions and opinions related to correctional practices and standards, he is unqualified to do so. *See Cordoves*, 104 F. Supp. 3d at 1358 ("[E]xpert testimony regarding matters outside of the witness's expertise is inadmissible, even if the expert is qualified to testify about other matters.").

Dr. Morgan meets none of the Rule 702 bases for expertise in the conditions of confinement or correctional practices or standards. He has no education in corrections at all. Tr. Test. of Dr. Robert Morgan. Similarly, he has no training or professional experience in correctional security, administration, or policy. *Id*.

To the extent Dr. Morgan relies on other experiences as the basis for his opinions about conditions of confinement or correctional practices or standards, he fails to articulate those experiences, or to demonstrate "how [his] experiences [led] to [his] conclusion[s] reached, why that experience is a sufficient basis for [his] opinion[s], and how that experience is reliably applied to the facts" in this case. *See Frazier*, 387 F.3d at 1244 (quoting Advisory Comm. Notes to Fed. R. Evid. 702, 2000 Amends.). Indeed, Dr. Morgan asks the Court to do exactly what the Advisory Committee warned against: to essentially take his word for it.

At a minimum, any opinion of Dr. Morgan's regarding ADOC's current "improvements and renovations" would be wholly outside his purported expertise and therefore inadmissible.

b) Dr. Morgan's Opinion Is Unreliable

Dr. Morgan's opinions are unreliable because he freely applies legal standards even when he cannot define those standards or the source of law. Tr. Test. of Dr. Robert Morgan.

Dr. Morgan's opinions are also unreliable because though he purports to have conducted a thorough investigation into ADOC's capacity and capability to meet the mental health needs of prisoners confined in the ADOC, his investigation lacked any hallmarks of reliability. *Id*. The methodology he employed in this case is readily distinguishable from the standards generally accepted in the field or even in his own practice. *Id*. His methodology in this case was limited based on time and availability to conduct a more thorough assessment or evaluation of what is occurring within the Alabama Department of Corrections with regard to mental health care. *Id.* He did not have an opportunity to interview prisoners. *Id.* He did not have an opportunity to review mental health files. *Id*. He relied primarily on facilities tours, policies and procedures, interviews with staff, and the limited Records that he did have because he did not have time to interview prisoners and review files. *Id.*

To the extent Dr. Morgan derives his understanding of ADOC's practices almost exclusively from information reported to him by correctional, medical, and mental health staff during facility visits, such an understanding is unreliable. *Id.* He routinely made no effort to verify these reports or to test the veracity of claims made by staff. *Id*. He was frequently unable to even identify which staff made particular assertions. *Id*.

For example, Dr. Morgan's proffered opinion that DOC's understaffing "does not prohibit plaintiffs and other class members from receiving mental health services" is based entirely on staff reports. Doc. 671-1, Morgan Rep., at 10; Tr. Test. of Dr. Robert Morgan. Likewise, another proffered opinion of his, that MHM staffing levels are adequate to meet the mental health needs of prisoners on the mental health caseload, is based exclusively on a comparison between the number of prisoners on the mental health caseload and the number of mental health staff available. *Id*. He did not review any documents or Records to determine staffing levels but instead relied exclusively on data reported to him by staff at the facilities. Tr. Test. of Dr. Robert Morgan. And another proffered opinion of Dr. Morgan's –that "ADOC has developed a clearly defined mental health delivery services system, with policy and procedures consistent with national standards of practice, such that the ADOC is not acting with systemic deliberate indifference to prisoners' mental health needs" –necessarily relies on the expectation that ADOC's policies and procedures are actually implemented. Doc. 671-1, Morgan Rep., at 10; Tr. Test. of Dr. Robert Morgan. He did nothing to confirm that these policies and procedures are actually being implemented other than receiving reports from staff. Tr. Test. of Dr. Robert Morgan.

Beyond his overreliance on staff reports, Dr. Morgan also insists on methodologies that he himself did not adopt in this case. Dr. Morgan asserts that an

expert may assess adequacy of care only by reviewing medical Records. *Id*. Similarly, Dr. Morgan acknowledges that an interview with the prisoner may be a necessary element to assessing the adequacy of care. *Id*. Yet Dr. Morgan decided to "go forward" in developing his opinions without those sources of information. Though Dr. Morgan acknowledges that reviewing medical Records and interviewing prisoners are important to describing the adequacy of care, he nevertheless proffers the opinion that the care is adequate without reviewing a single record meant to chronicle that care. *Id*.

c) Dr. Morgan Applies His Methodology Unreliably

Dr. Morgan's application of his methodologies to the facts in this case is similarly flawed. Dr. Morgan's opinions regarding staffing levels rely heavily on the application of a staffing ratio, but he cannot point to the source of that ratio other than remembering that he discovered it through an internet search. Tr. Test. of Dr. Robert Morgan.

In fact, Dr. Morgan cannot cite *any* staffing ratios advocated for by any organization, including those propounded by the American Psychiatric Association, contained in the *Bradley* agreement that was implemented in Alabama. *Id*.

Even in areas where Dr. Morgan is aware of the generally accepted standard in his field of purported expertise, he dismisses it based, entirely, on his own

outlier perspective. This rejection of generally accepted standards renders wholly unreliable Dr. Morgan's opinion that ADOC's provision of mental health care to segregated prisoners is not deliberately indifferent. Tr. Test. of Dr. Robert Morgan.

The National Institute of Justice, the American Correctional Association, the National Commission on Correctional Health Care, and the Department of Justice all provide authoritative opinions around mental health and correctional facilities. Tr. Test. of Dr. Robert Morgan; Pls. Tr. Ex. 1097, NCCHC Isolation Position. Each of those organizations, along with the American Psychiatric Association and the United Nations, has taken the general position that segregation is overused in correctional facilities throughout the United States, that segregation can cause significant harm to prisoners, and that the use of segregation should be discouraged for prisoners with mental illness. Tr. Test. of Dr. Robert Morgan; Pls. Tr. Ex. 129, APA Position on Segregation. Despite the overwhelming consistency of the statements and the uniformity of opinion throughout the psychological, correctional, and human rights fields, Dr. Morgan insists that the positions are all at least slightly misguided because they do not conform to his own outlier view. Tr. Test. of Dr. Robert Morgan.

Dr. Morgan's reliance on unsound or untested methodologies that are plagued by errors and are not generally accepted in correctional mental health, or more broadly in corrections, psychiatry, or psychology, undermines his credibility

and diminishes the value of his testimony. His opinions are inadmissible because they are unreliable.

4. Robert Ayers

Mr. Robert Ayers has been offered to provide rebuttal testimony with respect to the reports of Plaintiffs' experts Dr. Craig Haney and Mr. Eldon Vail. Tr. Test. of Robert Ayers. Mr. Ayers's report and testimony fail to meet the threshold requirements of Rule 702 or *Daubert*, 509 U.S. 579 (1993); *Kumho Tire Co.*, 526 U.S. 137 (1999), and their progeny.

While Mr. Ayers has a distinguished background as a corrections official in California, his testimony is not based on sufficient facts or data, Fed. R. Evid. 702(b), and is not the product of reliable principles and methods, Fed. R. Evid. 702(c). Furthermore, he has not reliably applied such principles and methods to the facts of this case. Fed. R. Evid. 702(d).

Any "conclusions" stated by Mr. Ayers that are merely his reporting of what he was told by Defendants and their staff do not constitute expert opinion. On the whole, Mr. Ayers simply accepted what he was told in brief meetings with site staff at ADOC facilities, willfully ignoring all other available evidence. Tr. Test. of Robert Ayers. Mr. Ayers did not, in his work for Defendants, employ "the same level of intellectual rigor that characterizes the practice of an expert" in the operation of correctional facilities. *Kumho Tire*, 526 U.S. at 152.

Mr. Ayers's opinions are unsupported by facts and data. Mr. Ayers relied primarily on Administrative Regulations and Standard Operating Procedures, and a handful of other documents, before making site visits to six ADOC facilities in late July. Tr. Test. of Robert Ayers. Mr. Ayers did not select the facilities to be visited, nor did he select the site staff with whom he met while at each facility. *Id*. He does not know why those selections were made the way they were. *Id*. He did not seek specific documents for review, including documents cited by the experts whom he was engaged to rebut. *Id*.

Mr. Ayers did not review, or seek to review, materials such as meeting minutes, documentation of medical, mental health and segregation rounds, shift rosters, MHM contract compliance reviews and corrective action plans, and other documents that were available to him, and that contain direct evidence of the very problems he has concluded do not exist. Tr. Test. of Robert Ayers. He failed to do so even when those documents were cited and relied upon in the reports of Dr. Haney or Mr. Vail, whose reports he was hired to rebut. *Id*. Moreover, Mr. Ayers did not review the deposition testimony of ADOC, MHM, or Corizon employees in which they testified about those matters - again, even when their testimony was cited and relied upon by Dr. Haney or Mr. Vail. *Id*.

In addition to brief tours of each facility, Mr. Ayers spoke with the ADOC, medical, and mental health staff presented to him. Rather than form an opinion

about compliance with policies, procedures, and regulations based upon the broad range of evidence that he himself testified would be needed, Mr. Ayers blindly accepted broad, general statements by ADOC, Corizon, and MHM staff that they were routinely in compliance. Tr. Test. of Robert Ayers. He accepted these statements even in the face of a nearly complete dearth of documentary evidence to support them. *Id*. Almost without exception, the site staff with whom he spoke told him that they were complying with policies, procedures, and regulations with respect to medical and mental health rounds and segregation rounds. *Id*. Site staff also told him that there were only minor and easily resolved problems with prisoners missing appointments, that sick calls and pills calls were occasionally delayed in emergency situations but never cancelled, and that a functioning grievance process was in place at every facility. *Id*.

However, Mr. Ayers saw no documentation confirming that these staff reports of compliance were accurate. *Id.* What little documentation he did review regarding compliance with all the regulations, policies, and procedures he purported to be reviewing was "scant" and "minimal." *Id*. Since documentation was generally not present to substantiate compliance, Mr. Ayers simply accepted staff assurances regarding compliance. *Id*. Since many of the activities and programs he discussed with site staff during his facility visits were either not

documented or not well documented, he relied on site staff's assurances that those things were being done in forming his opinions. *Id*.

Mr. Ayers did not include prisoner interviews in most of his facility visits. *Id*. At Bibb and Holman, he only spoke briefly with a few unidentified prisoners who happened to be in the area he was touring. *Id*. However, he agrees that interviewing prisoners would be an important part of such an investigation. *Id*. He also did not review most of the prisoner interviews conducted by plaintiffs' experts. *Id*.

Mr. Ayers agrees with Plaintiffs' Experts Dr. Haney and Mr. Vail that ADOC facilities are both overcrowded and understaffed. *Id*. However any opinions expressed by Mr. Ayers about the extent of those problems, and whether they prevent the delivery of adequate care to prisoners, are inadmissible. In addition to the problem of Mr. Ayers's reliance solely on staff reports, as discussed herein, his opinions are unfounded because he did nothing to examine the issues of overcrowding and understaffing. *Id*. He did not investigate the actual capacity of any ADOC facilities, and he did not determine how many custody staff positions were vacant or review shift rosters to evaluate security staff coverage for the number of prisoners present. *Id*.

Similarly, Mr. Ayers has reached opinions on a number of topics, including: the adequacy of ADOC's documentation of compliance with its policies and

procedures, health care staff's confidence in their ability to coordinate with correctional staff to deliver care; problems with the delivery of mental health care; and the overall adequacy of care. All of these opinions are based almost exclusively on statements made by ADOC, MHM, and Corizon staff and not on a review of any documentation. *Id*.

Mr. Ayers's methods in forming his opinions in this matter are unreliable, since he deliberately chose to rely on the assertions of facility staff while ignoring available documentation that contradicted (or, at the very least, failed to support) those statements.

On the rare occasion when Mr. Ayers did attempt to examine the specific issues raised by plaintiffs' experts, he continued to rely entirely upon general staff assurances that all is well. Tr. Test. of Robert Ayers. For example, in his report Dr. Haney repeatedly referred to prisoners in segregation being unmonitored and unchecked for extended periods of time and one prisoner as telling him he had not been seen by any mental health official for 30 days even after repeated requests. Mr. Ayers's "rebuttal" of this finding consisted of asking mental health, medical, and security staff at all prisons if this could happen, to which he was told without exception, "no." Tr. Test. of Robert Ayers; Doc. 672-1, Ayers Rep., at 31. He did not know at which facility that prisoner was housed, and made no effort to find out. Tr. Test. of Robert Ayers. He did not make any inquiries about the particular

prisoner who was quoted. *Id*. Further, he did not actually read any of the other interviews conducted by Dr. Haney, and was unaware that at least twenty prisoners in many different facilities made similar statements. Tr. Test. of Robert Ayers, Dr. Craig Haney.

In addition, Mr. Ayers repeatedly criticizes Dr. Haney and Mr. Vail for not having interviewed staff or reviewed written policies or procedures and any proof of practice, despite the fact that both Dr. Haney and Mr. Vail stated in their reports that they had been largely prohibited from speaking with site staff, or were able to do so only in passing, and listed the numerous policy and procedure documents they reviewed (which Mr. Ayers did not, in fact, review). Tr. Test. of Robert Ayers; Doc. 555-6, Haney Rep. at 16-17, 47; Doc. 555-2, Expert Report of Eldon Vail ("Vail Rep."), at 13. Mr. Ayers not only failed to confirm his own criticism of Mr. Vail and Dr. Haney, but also had not reviewed the array of compliance-related documentation that plaintiffs' experts took the time and care to include in their analyses. Tr. Test. of Robert Ayers.

The methods used by Mr. Ayers in this matter are completely unbefitting the role of an expert witness. Mr. Ayers did not make any effort to review the documentation maintained by ADOC that would constitute its "proof of practice," even though he stated in his report and at his deposition that such review is necessary. Tr. Test. of Robert Ayers. He accepted broad, general statements by

facility staff that they were in compliance with ADOC policies and procedures, inquiring no further, even when the "scant" documentation presented to him did not support those assertions. *Id*. He did not interview prisoners at most facilities (and when he did, he did so only in passing), even though he believes prisoner interviews would constitute an important part of any systemic review. *Id*. He did not review the deposition testimony of pertinent ADOC, MHM and Corizon personnel. *Id*. He failed to even completely review the reports of the plaintiffs' experts he was engaged to rebut. *Id*. As a result, he erroneously criticized them for not having included policies, procedures, and the input of ADOC, MHM, and Corizon staff in their analyses. Mr. Ayers's opinions are woefully lacking the required support of sufficient facts and reliable methods, and should be excluded.

E. Dr. Raymond Patterson

Defendants' proposed expert Dr. Raymond Patterson is expected to testify regarding:

> the delivery of mental health services in the correctional environment, the mental health care provided to prisoners incarcerated in the ADOC system, including, without limitation, the Named Plaintiffs, the policies and procedures relating to the mental health care provided to prisoners in the ADOC system and any conclusions reached related to his review of the delivery of mental health care within the ADOC system and the ADOC's oversight and management of such activities within its facilities.

Doc. 840, Ex. 91, Defendants' Expert Disclosures, at 3.

To the extent Dr. Patterson's opinions are based on the flawed audit process discussed in §VII.C.6, they are unreliable and inadmissible.

5. Ms. Knox, Dr. Morgan, and Mr. Ayers'ss Legal Conclusions Are Inadmissible

"An expert witness may not testify as to his opinion regarding ultimate legal conclusions." *United States v. Long*, 300 F. App'x 804, 814 (11th Cir. 2008) (citing *Montgomery v. Aetna Cas. & Sur. Co.*, 898 F.2d 1537, 1541 (11th Cir. 1990)); *see alsp Cook ex rel. Estate of Tessier v. Sheriff of Monroe Cnty., Fla.*, 402 F.3d 1092 (11th Cir. 2005) (finding that an expert's opinion on the constitutionality of the medical care provided to a prisoner in a detention center was a "purely legal conclusion" that was properly excluded under the Federal Rules of Evidence).

While Federal Rule of Evidence 704 allows experts to offer opinions as to the ultimate issues, courts "must remain vigilant against the admission of legal conclusions." *United States v. Milton*, 555 F.2d 1198, 1203 (5th Cir. 1977). Such conclusions are the province of the Court, not untrained experts. *See City of Tuscaloosa v. Harcos Chems., Inc.*, 158 F.3d 548, 565 (11th Cir. 1998) (noting that a statistician expert's opinions regarding legal standards "are outside of his competence and must be excluded"); *see also Specht v. Jensen*, 853 F.2d 805, 808 (10th Cir. 1988) (holding that an expert's testimony on an "array of legal

conclusions touching upon nearly every element of the [§ 1983 claim] supplant[ed] both the court's duty to set forth the law and the jury's ability to apply this law to the evidence").

In their reports, for example, Ms. Knox, Dr. Morgan, and Mr. Ayers all opine about whether certain care (or lack thereof) demonstrated deliberate indifference or was "constitutional." *See, e.g.*, Doc. 679-8, Knox Rep., at 12, 31, 42 and 49; Doc. 671-1, Morgan Rep., at 1, 10, 16, 32-22; Doc. 672-1, Ayers Rep., at 22, 25, 37.

None of the Defendants' Proposed Experts are trained in the legal standards applicable in this case. Even if they were adequately qualified, legal conclusions are inadmissible under the Federal Rules of Evidence. Any opinions offered that rely on legal conclusions should be excluded. *Id*.

6. All Expert Opinions Based on the Unreliable Audits Are Inadmissible

In May 2016, Defendants' proposed experts Dr. Greifinger, Dr. Keldie, Ms. Knox, Dr. De Lap, and Dr. Patterson conducted audits of medical Records in six facilities. Tr. Test. of Dr. Robert Greifinger, Catherine Knox, and Dr. Raymond Patterson. Each of their expert reports is based in some part on these audits. *Id*. These audits, created by Dr. Greifinger, are an extraordinary example of a methodology that should be excluded as unreliable.

a) The Audit Process Has Not Been and Cannot Be Tested

First, the audit process created to assess the system of delivery of care in the ADOC has never been tested, and cannot be, as it evolved and changed over the audit process in this case. Tr. Test. of Dr. Robert Greifinger, Dr. Raymond Patterson. The audit process has also not been tested in other cases. Tr. Test. of Dr. Robert Greifinger.

b) The Audit Process, as Used Here, Has Not Been Subject to Peer Review

The audit tool process was described in a peer reviewed article by Dr. Greifinger. Tr. Test. of Dr. Robert Greifinger; Doc. 840, Ex. 119, Independent Review of Clinical Health Services for Prisoners, 8 Int. J. Prisoner Health 3/4 (2012). However, the article is presented as a "conceptual paper with a viewpoint" that acknowledges frankly that portions of the article are based not on science, but on "'wisdom and experience,' as unreliable as this might be." Tr. Test. of Dr. Robert Greifinger; Doc. 840, Ex. 119, Independent Review of Clinical Health Services for Prisoners, 8 Int. J. Prisoner Health 3/4 (2012), at 141.

Despite presenting Dr. Greifinger's point of view, the process undertaken by Dr. Greifinger and the other experts to assess care in the ADOC deviated significantly from the process described in the article. Tr. Test. of Dr. Robert Greifinger. As an initial matter, the audit process described in the article is a

"quality management tool" for the purpose of trying to improve patient safety and limit risk of harm. Tr. Test. of Dr. Robert Greifinger; Doc. 840, Ex. 119, Independent Review of Clinical Health Services for Prisoners, 8 Int. J. Prisoner Health 3/4 (2012), at 144. There is no indication as to whether such an audit process could be an appropriate method for assessing the constitutional adequacy of a system of care. Tr. Test. of Dr. Robert Greifinger.

Additionally, the audit process described by Dr. Greifinger in the article would be done by an "[i]ndependent external review." Tr. Test. of Dr. Robert Greifinger; Doc. 840, Ex. 119, Independent Review of Clinical Health Services for Prisoners, 8 Int. J. Prisoner Health 3/4 (2012), at 141. As used by Dr. Greifinger, "'[e]xternal' can mean wholly independent or 'corporate,' that is, review by agency staff that has no vested interest in the findings at the individual facility." *Id*.

Here, however, employees of Corizon and a member of the ADOC Office of Health Services conducted the pre-audit, which included all of the selection of the medical charts that were to be reviewed to assess the care provided by Corizon, MHM, and the ADOC. Tr. Test. of Dr. Robert Greifinger. To the extent the documents were in fact reviewed by the external experts, the experts also have a vested interest in the findings: they are being paid by the ADOC for their efforts in this case. *Id*.

Perhaps the greatest deviation from the methodology described in the article is the set of audit tools used. In the article, Dr. Greifinger included 30 audit tools. Tr. Test. of Dr. Robert Greifinger; Doc. 840, Ex. 119, Independent Review of Clinical Health Services for Prisoners, 8 Int. J. Prisoner Health 3/4 (2012), at 146-50. There were only about 20 audit tools used in the audits in the ADOC. Tr. Test. of Dr. Robert Greifinger.

Dr. Greifinger actually omitted several tools from the ADOC audits that are relevant to the assessment of a complete system of care and are relevant to the issues in this case. For example, the template attached to the article includes audit tools on suicide screening, urgent care, x-rays, chronic disease registries, credentialing, complaints and grievances, mortality reviews, medical recordkeeping practices, and treatment of disability. Tr. Test. of Dr. Robert Greifinger; Doc. 840, Ex. 119, Independent Review of Clinical Health Services for Prisoners, 8 Int. J. Prisoner Health 3/4 (2012), at 146-50. None of this was included in the audits conducted by the experts in this case. Tr. Test. of Dr. Robert Hunter; Pls. Tr. Ex. 134, Doc. 840, Ex. 120, Audit Tools, May 2016, ADOC0341307-03421640.

Dr. Greifinger did not opine on one of these areas –mortality reviews – because they had not been audited. Tr. Test. of Dr. Robert Greifinger. Notably, Dr. Greifinger was aware that the quality of mortality reviews was at issue at the time

he was revising the set of audit tools, but decided to omit that tool. Tr. Test. of Dr. Robert Greifinger; Pls. Tr. Ex. 591, Doc. 840, Ex. 117, Greifinger Invoice, March 28, 2016, ADOC0341944.

c) There Is No Known Potential Rate of Error in These Audits

Dr. Greifinger bases his claim that the audits are a reliable assessment on the fact that the audit results were not excellent across the board. Tr. Test. of Dr. Robert Greifinger. He does not believe the medical Records used for audits were strategically selected to create certain results because, if that had been the case, he would have expected certain things to not have shown up in the course of the audit. *Id*.

Besides the entirely speculative nature of this test of reliability, Dr. Greifinger acknowledges that knowledge of the process is likely to make for better audit results. Tr. Test. of Dr. Robert Greifinger. However, a key member of the pre-audit team that selected the Records has worked with Dr. Greifinger on clinical performance measurement for almost ten years and is well-versed in his methods for the validity of record selection and the reliability of findings. *Id*. She is also an employee of Corizon, one of the entities being assessed. Tr. Test. of Dr. Robert Greifinger.

Though there is no evidence that this employee did, in fact, inform staff of the expectations and instruct the pre-audit team to select Records in a manner that would improve results without rendering them excellent across the board, the fact that she could have is proof that Dr. Greifinger's "test" for reliability does nothing to ensure the audit results are indeed valid. Given the lack of any objective reliability testing, a person armed with the knowledge of how Dr. Greifinger determines that audits are reliable, gaming the system would not be difficult.

Additionally, Dr. Greifinger acknowledges that what these audits are measuring is not the overall adequacy of care. Tr. Test. of Dr. Robert Greifinger. Rather, the audits looked, for the most part, at whether tests were performed and documented, rather than whether appropriate actions were taken in response to the results of the tests. *Id*. Given the lack of fit between what was challenged – the adequacy of care in the ADOC – and what the audits were measuring, the concept of an error rate is not even applicable or relevant. Most of the measurements, whether right or wrong, do not address the issues in the case.

d) Dr. Greifinger's Audit Process Is Not Generally Accepted in the Field

Dr. Greifinger's methodology is not generally accepted. The only other expert in the field who uses a similar process inherited it from Dr. Greifinger. Tr. Test. of Dr. Robert Greifinger.

e) The Application of the Audit Methodology Was Also Unreliable

Even if there had been a reliable methodology, the audits were conducted in a haphazard manner, eliminating any trace of reliability. For example, with regard to the pre-audit team's actions, different experts report significant differences. Dr. Greifinger reports that the pre-audit teams marked the pages in the medical Records for the experts to review with sticky notes to allow efficient review by the expert audit team members. Tr. Test. of Dr. Robert Greifinger. Dr. Keldie reported that the pre-audit team did not mark the Records with sticky notes or in any other way. Tr. Test. of Dr. Robert Greifinger.

Further, the review of medical Records in the audits was quick and performed in a manner that did not allow the experts to go back to their data to verify their results when forming their opinions. Tr. Test. of Dr. Robert Greifinger, Catherine Knox, Dr. Robert Morgan. Further, it is unknown who actually reviewed the medical Records for the audits. Dr. Greifinger estimates that only eighty to ninety percent of the charts reviewed for the audits were reviewed by any expert at all. The remainder were reviewed solely by a member of the pre-audit team. Tr. Test. of Dr. Robert Greifinger. Dr. Greifinger cannot identify which charts were not reviewed by an expert. *Id*.

f) Individual Experts' Unreliable Involvement in the Audit Process

In addition to the overall problems with the audits described above, there are significant problems with Dr. Greifinger's involvement in the process. Dr. Greifinger was offered to opine on "the delivery of medical services in the correctional environment, the medical care provided to inmates incarcerated in the ADOC system, . . . and any conclusions reached related to his review of the delivery of medical care within the ADOC system and the ADOC's oversight and management of such activities within its facilities." Pls. Tr. Ex. Doc. 840, Ex. 91, Defendants' Expert Disclosure, at 2-3. Dr. Greifinger's opinions are based almost in their entirety on the audits of medical Records he organized and oversaw. Tr. Test. of Dr. Robert Greifinger.

Dated:

Respectfully Submitted,

Maria V. Morris
One of the Attorneys for Plaintiffs
Southern Poverty Law Center
400 Washington Avenue
Montgomery, AL 36104

Rhonda Brownstein (ASB-3193-O64R)
Maria V. Morris (ASB-2198-R64M)
Ebony G. Howard (ASB-7247-O76H)
Latasha L. McCrary (ASB-1935-L75M)
Brooke Menschel (ASB-7675-Z61K)
Jaqueline Aranda Osorno (ASB-3296-A17H)
Natalie Lyons (ASB-1108-D63Y)

SOUTHERN POVERTY LAW CENTER
400 Washington Avenue
Montgomery, AL 36104
Telephone: (334) 956-8200
Facsimile: (334) 956-8481
rhonda.brownstein@splcenter.org
maria.morris@splcenter.org
ebony.howard@splcenter.org
latasha.mccrary@splcenter.org
brooke.menschel@splcenter.org
jaqueline.aranda@splcenter.org
natalie.lyons@splcenter.org

Miriam Haskell* (FL. Bar No. 069033)
SOUTHERN POVERTY LAW CENTER
P.O. Box 370037
Miami, FL 33137
Telephone: (786) 347-2056
Facsimile: (786) 237-2949
miriam.haskell@splcenter.org
**admitted pro hac vice*

Eunice Cho* (GA. Bar No. 632669)
Kristi L. Graunke* (GA. Bar No. 305653)
SOUTHERN POVERTY LAW CENTER
1989 College Avenue NE
Atlanta, GA 30317
Telephone: (404) 221-5842
Facsimile: (404) 221-5857
eunice.cho@splcenter.org
**admitted pro hac vice*

William Van Der Pol, Jr. (ASB-2112-114F)
J. Patrick Hackney (ASB-6971-H51J)
Glenn N. Baxter (ASB-3825-A41G)
Alabama Disabilities Advocacy
Program Box 870395
Tuscaloosa, AL 35487
Telephone: (205) 348-4928
Facsimile: (205) 348-3909

wvanderpoljr@adap.ua.edu
jphackney@adap.ua.edu
gnbaxter@adap.ua.edu

Lisa W. Borden (ASB-5673-D57L)
William G. Somerville, III (ASB-6185-E63W)
Andrew P. Walsh (ASB-3755-W77W)
Dennis Nabors
Patricia Clotfelter (ASB-0841-F43P)
Baker, Donelson, Bearman, Caldwell & Berkowitz PC
420 20th Street North, Suite 1400
Birmingham, AL 35203
Telephone: (205) 328-0480
Facsimile: (205) 322-8007
lborden@bakerdonelson.com
wsomerville@bakerdonelson.com
awalsh@bakerdonelson.com
dnabors@bakerdonelson.com
pclotfelter@bakerdonelson.com

Gregory M. Zarzaur (ASB-0759-E45Z)
Anil A. Mujumdar (ASB-2004-L65M)
Diandra S. Debrosse (ASB-2956-N76D)
Zarzaur Mujumdar & Debrosse
2332 2nd Avenue North
Birmingham, AL 35203
Telephone: (205) 983-7985
Facsimile: (888) 505-0523
gregory@zarzaur.com
anil@zarzaur.com
diandra@zarzaur.com

ATTORNEYS FOR THE PLAINTIFFS

CERTIFICATE OF SERVICE

I hereby certify that I have on this 14th day of November, 2016, filed under seal the foregoing with the clerk of the court and electronically served the following:

David R. Boyd, Esq.
John G. Smith, Esq.
John W. Naramore, Esq.
Balch & Bingham LLP
Post Office Box 78
Montgomery, AL 36101-0078
dboyd@balch.com
jgsmith@balch.com
jnaramore@balch.com

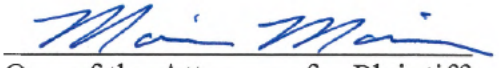
Michael L. Edwards, Esq.
Steven C. Corhern, Esq.
Christopher F. Heinss, Esq.
Jenelle R. Evans, Esq.
Balch & Bingham LLP
Post Office Box 306
Birmingham, AL 35201-0306
medwards@balch.com
scorhern@balch.com
cheinss@balch.com
jevans@balch.com

William R. Lunsford, Esq.
Melissa K. Marler, Esq.
Stephen C. Rogers, Esq.
Christopher S. Kuffner, Esq.
Michael P. Huff, Esq.
Maynard, Cooper & Gale, P.C.
655 Gallatin Street, SW
Huntsville, AL 35801
blunsford@maynardcooper.com
mmarler@maynardcooper.com
srogers@maynardcooper.com
ckuffner@maynardcooper.com
mhuff@maynardcooper.com

Mitesh Shah, Esq.
Mitchell D. Greggs, Esq.
Bryan A. Coleman, Esq.
Evan P. Moltz, Esq.
Luther M. Dorr, Jr., Esq.
Maynard, Cooper & Gale, P.C.
1901 6th Avenue North, Suite 2400
Birmingham, AL 35203
mshah@maynardcooper.com
mgreggs@maynardcooper.com
bcoleman@maynardcooper.com
emoltz@maynardcooper.com
rdorr@maynardcooper.com

Anne Hill, Esq.
Elizabeth A. Sees, Esq.
Joseph G. Stewart, Jr., Esq.
Alabama Department of Corrections
Legal Division
301 South Ripley Street
Montgomery, AL 36104
anne.hill@doc.alabama.gov
elizabeth.sees@doc.alabama.gov
joseph.stewart@doc.alabama.gov

Deana Johnson, Esq.
Brett T. Lane, Esq.
MHM Services, Inc.
1447 Peachtree Street, N.E., Suite 500
Atlanta, GA 30309
djohnson@mhm-services.com
btlane@mhm-services.com



One of the Attorneys for Plaintiffs