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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

EDMUND G. BROWN, Jr., et al.,

Defendants.

Case No. Civ S 90-0520 LKK-JFM

CORRECTED PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO TERMINATE UNDER THE PLRA AND TO VACATE UNDER RULE 60(b)(5)

Judge: Hon. Lawrence K. Karlton
Date: March 27, 2013
Time: 10:00 a.m.
Crtrm.: 4

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ACA	American Correctional Association
APP	Acute Psychiatric Program
ASH or Atascadero	Atascadero State Hospital
ASP or Avenal	Avenal State Prison
ASU	Administrative Segregation Unit
BCP	Budget Change Proposal
CAL or Calipatria	Calipatria State Prison
CCC	California Correctional Center
CCCMS	Correctional Clinical Case Manager System
CCI	California Correctional Institution
CCPOA	California Correctional Peace Officers Association
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEN or Centinela	Centinela State Prison
CIM	California Institute for Men
CIW	California Institute for Women
CMC	California Men's Colony
CMF	California Medical Facility
CMO	Chief Medical Officer
COR or Corcoran	California State Prison/Corcoran
CPR	Cardiopulmonary Resuscitation
CRC	California Rehabilitation Center
CSH or Coalinga	Coalinga State Hospital
CTC	Correctional Treatment Center
CTF	California Training Facility/Soledad
CVSP or Chuckwalla	Chuckwalla Valley State Prison
DMH	Department of Mental Health
DSH	Department of State Hospitals
DOT	Direct Observation Therapy
DVI or Deuel	Deuel Vocational Institute
EOP	Enhanced Outpatient Program
EOP ASU Hub	Enhanced Outpatient Program Administrative Segregation Unit
FOL or Folsom	Folsom State Prison
HDSP or High Desert	High Desert State Prison
ICF	Intermediate Care Facility
ISP or Ironwood	Ironwood State Prison
KVSP or Kern Valley	Kern Valley State Prison
LAC or Lancaster	California State Prison/Lancaster
LVN	Licensed Vocational Nurse

LOB	Lack of Bed
MCSP or Mule Creek	Mule Creek State Prison
MHCB	Mental Health Crisis Bed
MHOHU	Mental Health Outpatient Housing Unit
MHSDS	Mental Health Services Delivery System
NKSP or North Kern	North Kern State Prison
OHU	Outpatient Housing Unit
OIG	Office of the Inspector General
PBSP or Pelican Bay	Pelican Bay State Prison
PCP	Primary Care Provider
PLRA	Prison Litigation Reform Act
PSH or Patton	Patton State Hospital
PSU	Psychiatrist Services Unit
PVSP or Pleasant Valley	Pleasant Valley State Prison
R&R	Reception and Receiving
RC	Reception Center
RJD or Donovan	Richard J. Donovan Correctional Facility
RN	Registered Nurse
RVR	Rules Violation Report
SAC or Sacramento	California State Prison/Sacramento
SATF	California Substance Abuse Treatment Facility (II)
SCC or Sierra	Sierra Conservation Center
SHU	Segregated Housing Unit
SM	Special Master in the *Coleman* case
SNY	Special Needs Yard
SOL or Solano	California State Prison/Solano
SQ or San Quentin	California State Prison/San Quentin
SVPP	Salinas Valley Psychiatric Program
SVSP or Salinas Valley	Salinas Valley State Prison
TB	*Tuberculosis*
TTA	Triage and Treatment Area
UHR	Unit Health Records
VSPW or Valley State	Valley State Prison for Women
VPP	Vacaville Psychiatric Program
WSP or Wasco	Wasco State Prison
ZZ Cell	Makeshift Temporary Cells Outside of Clinic Areas

INTRODUCTION

If only it were true.

In their filing on January 7, 2013, and in speeches, press conferences, radio and TV appearances and interviews on the following days, the defendants, Governor Brown, Secretary Beard and other top state officials responsible for the state prison system, proudly announced that California has "transform[ed] its prison mental health care system into one of the best in the nation," (Defendants' Memorandum In Support of Motion to Terminate and Vacate, Docket No. 4275-1 ("Defs. Motion") at 1:8-9), that "California's system is now so good that it not only meets constitutional standards, but often meets and even exceeds mental health care offered in non-correctional, community settings," (Defs. Motion at 3:11-13), and that "[t]here is no justifiable reason for the continued intrusive and costly oversight of California's prison system." (Defs. Motion at 3:27-4:1.)

Nothing that they have asserted can be doubted or challenged because "[a]ll evidence confirms that there are no system-wide deficiencies in the State's mental health care programs, or that the State systematically ignores inmates' serious mental health care needs." (Defs. Motion at 10:1-3.) The rare problems that defendants' "nationally prominent experts" discovered, "in some cases paradoxically resulted from the State's efforts to comply with time-consuming demands and reporting requirements of the special master and plaintiffs' counsel." (Defs. Motion at 10:11-13.) In fact, this almost perfect mental health system will "provide even better care…when it is no longer obligated to devote resources to responding to the numerous obligations imposed by the special master that exceed constitutional requirements." (Defs. Motion at 10:14-16.)

If only it were true.

If Defendants' claims were true, the *Coleman* class, our clients, would have achieved victory. Plaintiffs' counsel, the Special Master and his team of experts, and this Court, would join Defendants in acknowledging this "win-win" outcome. The plaintiff class would be receiving timely and appropriate mental health care, would be housed in settings that contribute to their recovery and rehabilitation and would be supported by

custodial practices that facilitate the delivery of mental health care. The State would have demonstrated its ability to successfully manage a system that complied with basic constitutional rights and would no longer require judicial supervision.

But it is not true. The truth is that Defendants are still acting with deliberate indifference to the staffing and resources needed to provide minimally humane mental health care to the *Coleman* class. The effects of Defendants' systemic deliberate indifference are visible in severely understaffed mental health programs throughout the state where devoted and overworked clinicians struggle to provide care in dangerous conditions and without the support they deserve. They are visible on the faces of *Coleman* patients waiting in segregation units and holding cells for scarce treatment beds to free up. They are visible in a persistently high rate of suicides in California prison, the vast majority of which are avoidable and foreseeable, and in the long list of persons who have died unnecessarily in suicidal mental health crises in the year and half since Defendants ignored and buried the common-sense suicide prevention recommendations of their own nationally-recognized suicide prevention expert. The facts on the ground demonstrate that life-threatening constitutional violations are current and ongoing. Defendants' termination motion must be denied.

Plaintiffs' response to Defendants' termination motion, which demands that this Court "terminate its jurisdiction and the remaining remedial orders," (Defs. Motion at 28:6-7), is multi-faceted and comprehensive. The stakes for our class members are very high. Five eminently qualified experts, on short notice, were retained, and have invested an extraordinary amount of time, effort and skill in investigating the current conditions of the California prison system: reviewing medical and correctional records, inspecting 11 major CDCR prisons, and reviewing numerous CDCR and Department of State Hospitals ("DSH") documents. Dr. Pablo Stewart, a forensic psychiatrist, testified in the three-judge court trial in this case, and was cited several times in the Supreme Court's decision in *Brown v. Plata*. The same is true of Dr. Craig Haney, a psychologist and professor, who also testified in the 1993 *Coleman* trial. Dr. Edward Kaufman is a psychiatrist with

extensive experience in corrections, who also testified in the 1993 *Coleman* trial. Jeanne Woodford, the former Acting Secretary of CDCR and Warden of San Quentin Prison, testified at the three-judge court trial, and was also cited several times by the Supreme Court. Eldon Vail, is the former Secretary of the Washington State Department of Corrections, with 35 years of experience. These experts have each prepared and filed written testimony which sets forth their opinions, grounded not only in their experience and background but in their current observations, interviews of prisoners and CDCR staff, review of documents, photographs, records and testimony. The ultimate question is, of course, left to this Court to decide, but the opinions of these five experts are that serious and dangerous deficiencies and shortages in the still overcrowded CDCR persist at all levels, and the barriers to delivery of minimally adequate mental health care remain in place. Unnecessary and avoidable pain, suffering and death result all too frequently.

Plaintiffs also initiated limited and focused discovery through depositions of defendants' termination experts, Secretary Beard, other senior CDCR officials, as well as Lindsay Hayes, a suicide prevention consultant who had been hired by defendants in 2010 to help improve its dismal performance, and Dr. John Brim, a psychiatrist presently employed by defendant DSH at the Salinas Valley Psychiatric Program. Mr. Hayes and Dr. Brim each provide critical and undisputed evidence of current systemic deliberate indifference to the serious medical needs of the *Coleman* class.

The factual support for defendants' Termination Motion, it turns out, is extremely thin and weak, as it relies almost exclusively on the seriously flawed opinions of their four experts. Plaintiffs have filed herewith evidentiary objections to the termination experts' reports, and to the declarations of Dr. Toche, Dr. Belavich, Mr. Johnson and Ms. Ceballos. We respond here to Defendants' creative but unsupported legal argument, which misstates the burden of proof, and manages the extraordinary feat of avoiding citation to the Supreme Court's decision in this very case even once. The burden of proof is on Defendants to prove the absence of constitutional violations, but Plaintiffs' showing, in any event, provides more than sufficient evidence for this Court to find ongoing, systemic

constitutional violations. For that reason, we also will seek, based on the Court's findings, additional affirmative relief in several critical and life-saving areas that defendants have deliberately and knowingly refused to remedy.

ARGUMENT

I. DEFENDANTS FAILED TO ADDRESS THE EIGHTH AMENDMENT DELIBERATE INDIFFERENCE STANDARD.

The Eighth Amendment prohibits not only individual acts of cruelty and deliberate indifference to basic human needs, but also systemic acts and omissions that expose prisoners to unreasonable risks of harm from deficient medical and mental health care. The Supreme Court explained the applicable standard in this very case two years ago. *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011). Prisoners may be deprived of rights that are fundamental to liberty. *Id.* Yet they "retain the essence of human dignity inherent in all persons." *Id.* The Eighth Amendment prohibition against cruel and unusual punishment extends to "failure to provide sustenance" to persons whose incarceration prevents them from providing for themselves. *Id.* Failure to provide for basic sustenance can "produce physical torture or lingering death." *Id.* "Just as a prisoner may starve if he is not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society." *Id.*

The record before the Supreme Court, which met the extraordinarily high standards demanded for a population cap, did not focus on acts of cruelty or deliberate indifference by individual clinical or custody staff. The record that the Supreme Court found to constitute deliberate indifference consisted entirely of systemic violations, in the form of staffing and resource shortages that prevented dedicated staff from attending to basic human needs. *See Plata*, 131 S. Ct. at 1924 (suicidal inmates held in cages due to shortage of beds); *id.* at 1926 (population exceeding staffing and space capacity); *id.* at 1933 (inmates held in segregation while awaiting transfer to scarce treatment beds); *id.* at 1933 n. 6 (suicide among persons waiting for transfer); *id.* at 1934 (suicides in unconverted

inpatient cells that could not be taken off line for conversion due to high demand); *id.* (impact of lockdowns on mental health treatment and medication delivery).

This is not to downplay the subjective component of the Eighth Amendment. Subjective deliberate indifference is required. *Farmer v. Brennan*, 511 U.S. 825, 844 (1994). On this record, subjective deliberate indifference has always been and remains predominately present in the higher-level management decisions to understaff, under-resource and overcrowd the system.

Defendants and their termination consultants have lost sight of the systemic deliberate indifference at issue in this case. The termination consultants' methodology consisted almost entirely of making one- or two-day, previously announced visits to 13 prisons to determine whether the prisoners were receiving some care, or at least enough care for the termination consultants to announce that individual clinical staff were not being deliberately indifferent toward them. (Dvoskin, Moore, Scott, Clinical Evaluation of California's Prison Mental Health Delivery System, Docket No. 4275-5 ("Defs.' Joint Report" or "Joint Report")) at 8; Declaration of Michael W. Bien In Support of Plaintiffs' Opposition to Defendants' Motion to Terminate Under the PLRA and to Vacate Under Rule 60(b)(5) ("Bien Decl.") Ex. 89 (Scott Dep. at 243:20-249:3); Ex. 83 (Dvoskin Dep. at 224:5-10) (constitutional "if they're trying hard").) The termination experts made no attempt to account for patients who had not made it to the right level of care. The termination experts ignored data they received about measurement of care for patients they did not directly observe on their previously announced prison visits. (Bien Decl. Ex. 89 (Scott Dep. at 121:25-125:10; 128:1-129:10; 132:23-138:4; 141:12-145:5).) Mental health treatment in the twenty prisons they did not tour was largely, if not completely, ignored. (Bien Decl. Ex. 88 (Moore Dep. at 137:23-138:5).)

Defendants' top officials, Dr. Tim Belavich, a psychologist, and Dr. Diana Toche, a dentist, testified that they have never personally observed CDCR personnel ignoring an inmate's serious mental health needs. (Docket No. 4277 at 10:9-11; 4275-3 at 4:3-5.) Governor Brown, just a few days ago, made a similar point: "People who say prison

officials are willfully looking on as inmates commit suicide are so far removed from reality they are not credible. They are wrongly accusing civil servants who are honest, hardworking employees trying to do a job." (Bien Decl. Ex. 109, ("Gov. Jerry Brown says federal prison oversight a waste of money," *Sacramento Bee*, March 12, 2013).) The evidence shows, however, that these same two officials, and others even more senior, including Governor Brown himself, demonstrated deliberate indifference in their decisions to understaff, under-resource and overcrowd the system in a manner that prevents any effective remedy for the long-standing constitutional violations in this case, and that continues to cause needless injury and death to class members. These high-level, knowing and intentional decisions to lay off thousands of CDCR employees, to freeze and restrict hiring and overtime, to cancel building projects and to ignore and bury life-saving recommendations of numerous experts to fix a broken and dangerous system, have left the exhausted and dedicated CDCR clinical and custody staff with impossible choices in terrible conditions.

Defendants' experts' methodology of visiting a few prisons, looking at a few patients, and opining as to whether the patients in front of them are currently receiving care, leaves out a core Eighth Amendment violation found in this case during the overcrowding trial, and affirmed by the Supreme Court. The Eighth Amendment is not only violated in the moment that a person is injured or killed due to deliberate indifference. It is violated when prisoners are required to live under an unreasonable risk of harm due to inadequate medical and mental health care. *See Plata*, 131 S. Ct. at 1925 n. 3 (Constitution prohibits systemic deficiencies that subject mentally ill prisoners to "substantial risk of serious harm"); *Helling v. McKinney*, 502 U.S. 25, 33-34 (1993) (Eighth Amendment prohibits knowing exposure of inmates to unreasonable risk). The termination motion evidence ignores the widespread unreasonable risks imposed on class members who have not reached the treatment beds inspected by the termination experts, either because their needs have not been identified due to systemic deficiencies such as short-staffing and poor record keeping, or because their needs still cannot be met due to

lack of beds, and lack of adequate staffing and policies to move the right inmate to the right bed.

A. Although Defendants Do Not Dispute The Basic Constitutional Standards For Mental Health Care, They Have Not Achieved Them.

Defendants concede that in order to be constitutional, a prison mental health program must provide the six minimal elements of care identified in *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995), and *Balla v. Idaho*, 595 F. Supp. 1558 (D. Idaho 1984). The minimum elements of a constitutional prison mental health system are:

> (1) a systematic program for screening and evaluating inmates to identify those in need of mental health care; (2) a treatment program that involves more than segregation and close supervision of mentally ill inmates; (3) employment of a sufficient number of trained mental health professionals; (4) maintenance of accurate, complete and confidential mental health treatment records; (5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (6) a basic program to identify, treat, and supervise inmates at risk for suicide.

Coleman, 912 F. Supp. at 1298 n. 10. The evidence developed not only by Plaintiffs' expert inspections, but also by Defendants' own termination experts, shows that Defendants continue to act with deliberate indifference to these basic elements. Deficiencies in screening for mental health needs remain unaddressed. *See* Section IV.K below. The system is still plagued by overuse of segregation in harsh and non-therapeutic conditions as a substitute for life-saving mental health treatment. *See* Section IV.H below Chronic understaffing has gotten worse as Defendants have deliberately chosen to use Realignment to maximize budget savings with no regard for preserving the basic mental health system. *See* Sections IV.C and IV.L below. Defendants' new records system, the eUHR, is currently more of an obstacle to care than the paper system it replaced. *See* Section IV.I below. Overcrowding, understaffing and poor training hampers safe medication administration. *See id.* Defendants have ignored and suppressed their own consultant's report on necessary suicide prevention measures, have resisted and delayed common sense measures such as providing beds for persons on suicide precautions, and,

after six years, have not implemented remedies for failures in suicide risk evaluations. *See* Section IV.F below. On this last point, the remediation of poor suicide risk evaluations, Defendants have attempted to mislead this Court, submitting sworn declarations that a program was implemented when Defendants' internal documents prove that, at some institutions, it had not been implemented at all. *See id.*

B. Defendants' Compliance With The Remedial Measures In This Case Is Relevant To The Court's Evaluation Of Their Deliberate Indifference.

Defendants were and are free to stop these violations by means of their own choosing—compliance with the many remedial orders of this Court—or through alternative appropriate means if they prefer. *See Horne v. Flores*, 557 U.S. 433 (2009). The course they have chosen, however, is to do neither—to fail to implement the remedial measures, and to fail to develop any alternatives. The Court is faced with evaluating whether current and ongoing failures in mental health care are the result of systemic deliberate indifference. Defendants' deliberate decisions to short-staff, delay and under-resource their own remedial plans are relevant to this determination.

The best evidence of remedial plan compliance in this case is the Special Master's body of reports. Because Defendants do not like the reports' particular message, however, they are attacking the messenger. They contend that the Special Master reports on too many policies and procedures and in too much detail, and that such reporting requirements are no longer equitable and should be terminated under Rule 60(b)(5). (Defs. Motion at 26-27.) Defendants' objections give the wholly false impression that the Special Master is scoring them against their voluntarily adopted "best practices" unconnected to constitutional violations. If that warped version of the history of this case were true, then perhaps the Special Master's monitoring could be called excessive or unfair. But it is not true.

The policies and procedures monitored by the Special Master were developed in response to not just one finding of a constitutional violation, but dozens of such findings in Court orders stretching from 1995 through 2012. This Court allowed Defendants to

develop these policies and procedures themselves as an alternative to even closer forms of judicial supervision that this Court would have been well justified to undertake at many stages of this case, when State correctional authorities repeatedly failed to remedy life-threatening conditions.

Each of the policies and procedures is necessary to achieve the minimum components of a constitutional prison mental health system. These minimum components are not items Defendants undertook to develop on their own, or agreed to in a consent decree. Rather, these minimum components—and Defendants' failure to provide them—were established through substantial evidence in a contested trial and ordered as part of a contested injunctive remedy in 1995, in numerous additional evidentiary and contested proceedings throughout this litigation, and established again as part of the overcrowding trial in 2008. *Plata*, 131 S. Ct. at 1933-36; *Coleman*, 912 F. Supp. 1282. After the Court found these components to be both necessary to and absent from the California prison system, Defendants demanded that the Court set forth a precise set of plans and guidelines for their establishment. *Coleman*, 912 F. Supp. at 1301. The Court properly declined to specify "the exact mechanisms" for achieving compliance, but rather exercised due deference to Defendants' penological expertise, "leaving the matter to the creation of protocols, standards, procedures and forms to be developed by defendants in consultation with court appointed medical experts." *Id.* at 1302.

The policies and procedures now being monitored by the Special Master are precisely those Defendants themselves developed through the deferential remedial process set forth by this Court in 1995 and mandated one year later by the United States Supreme Court in *Lewis v. Casey*, 518 U.S. 343, 362-63 (1996). In areas where Defendants' initial policies and procedures proved inadequate to reduce the serious risk of harm to class members, the Court has, over the years, provided more specific direction, but always gave Defendants additional opportunities to develop their own remedies. (*See, e.g.*, Docket No. 4003, Apr. 25, 2011) (Ninth Circuit affirming court order re expedited SVPP admissions, noting Defendants' repeated failures to provide a remedy, and finding that the "court has

not 'enmeshed [itself] in the minutiae of prison operations' beyond what is necessary to vindicate plaintiffs' federal rights") (citing *Lewis*, 518 U.S. at 362).)

Contrary to Defendants' assertions, they are not shackled to their chosen remedial measures, the *Coleman* mental health program guides, as they exist today. Defendants have amended them numerous times during this litigation, and can amend them as needed, on fourteen days' notice. (Docket Nos. 1749 at 11, 1968, 3954.) This is not a case where a federal decree binds state officials to one way of remedying federal violations. The state officials here are free to remedy violations "by new means that reflect new policy insights and other changed circumstances." *Horne*, 557 U.S. at 439. What they are not free to do is to ignore, short-staff, under-resource or otherwise undermine remedial measures that remain necessary to remedy federal violations, and for which they have not come forward with any substitutes.

II. DEFENDANTS HAVE MET NEITHER THE LEGAL STANDARDS FOR RELIEF UNDER THE PLRA NOR FOR RELIEF UNDER RULE 60(b)(5).

A. Defendants Have The Burden Of Proof To Show That Federal Violations Are No Longer Current And Ongoing.

Defendants' motion is governed by the termination subsection of the PLRA, which makes prospective relief "terminable" after two years, subject to the limitation set forth in 18 U.S.C. § 3626(b)(3):

> Prospective relief shall not terminate if the court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation of the Federal right, extends no further than necessary to correct the violation of the Federal right, and that the prospective relief is narrowly drawn and the least intrusive means to correct the violation.

Under controlling Ninth Circuit authority, Defendants, as the party moving for termination under 18 U.S.C. § 3626(b), have the burden of proof to demonstrate that federal violations are no longer current and ongoing. *Graves v. Arpaio*, 623 F.3d 1043, 1048 (9th Cir. 2010); *Gilmore v. California*, 220 F.3d 987, 1007 (9th Cir. 2000); *Clark v. California*, 739 F. Supp. 2d 1168, 1175 (N.D. Cal. 2010). Defendants claim that there is some kind of tension within Ninth Circuit cases regarding the burden of proof. (Defs.

Motion at 11-12.) This claim is false. The two cases from which Defendants divine this "tension" were not termination cases. *Mayweathers v. Newland*, 258 F.3d 930 (9th Cir. 2001), concerned standards for extending preliminary injunctive relief beyond the 90-day limit set by 18 U.S.C. § 3626(A)(2). *Hallett v. Morgan*, 296 F.3d 732 (9th Cir. 2002), concerned a motion by plaintiffs to extend jurisdiction of a consent decree beyond the decree's express termination date. In both *Mayweathers* and *Hallett*, plaintiffs were the moving parties for prospective relief. *Mayweathers*, 258 F.3d at 933; *Hallett*, 296 F.3d at 738. The Ninth Circuit properly placed the burden in those cases on the moving parties to demonstrate that relief was warranted under the PLRA. *Mayweathers*, 258 F.3d at 936; *Hallett*, 296 F.3d at 743-44. Similarly here, Defendants have moved for relief under the PLRA, and as such, bear the burden of demonstrating that termination of prospective relief is warranted.

Both *Hallett* and *Mayweathers* compared the standard for prospective relief under Section 3626(a)(1)(a) with the standard for terminating prospective relief under Section 18 U.S.C. § 3626(b)(2)—both noting that a party seeking prospective relief must show a "current and ongoing" violation. *Mayweathers*, 258 F.3d at 336; *Hallett*, 296 F.3d at 743. This comparison, however, says nothing about which party bears the burden on a termination motion—an issue not before the court in *Hallett* and *Mayweathers*. Thus, neither case calls into question the holding in *Gilmore*, which the Ninth Circuit reaffirmed three years ago in *Graves*: defendants bear the burden of proof in a PLRA termination motion. *Graves*, 623 F.3d at 1048; *Gilmore*, 220 F.3d at 1007.

Defendants cite several out-of-circuit cases for the proposition that Plaintiffs have the burden of proof. (Defs. Motion at 12.) These out-of-circuit cases do not provide any authority for this Court to disregard the holdings of *Gilmore* and *Graves*, which have not been disturbed by any subsequent Ninth Circuit *en banc* decision. Defendants' out-of-circuit list is also exaggerated, as it piles on several cases that make no holding at all regarding burden of proof. Of the five circuit court of appeal cases they cite, three concern only the entitlement to an evidentiary hearing, and have no holding whatsoever regarding

burden of proof. *Benjamin v. Jacobson*, 172 F.3d 144, 166 (2d Cir. 1999) (en banc); *Loyd v. Alabama Dept. of Corr.*, 176 F.3d 1336, 1342 (11th Cir. 1999); *Cagle v. Hutto*, 177 F.3d 253, 258 (4th Cir. 1999). To hold that a party is entitled to present evidence or demonstrate facts at a hearing is not the same thing as to say that party has the ultimate burden of proof. *See Texas Dep't of Community Affairs v. Burdine*, 450 U.S. 248 (1981). The cases holding that plaintiffs are entitled to present evidence at a hearing are compatible with the Ninth Circuit's *Gilmore* holding that Defendants bear the burden of proof. Defendants have the burden to submit proof with their termination motion, which Plaintiffs then have the opportunity to rebut in their submission and/or at an evidentiary hearing.

In any event, even if the burden of proof were placed on Plaintiffs in this case, Plaintiffs would have no difficulty meeting that burden based on the overwhelming evidence that prisoners with serious mental illness are still being harmed by systematic and deliberate deficiencies in the prison mental health system.

B. Defendants Cannot Rely On Future Planned Projects And Future Mental Health Staffing Plans.

Defendants cite but fail to appreciate the significance of cases holding that the pertinent time frame for a PLRA termination motion is the time at which the motion is decided, not some point in the future. (Defs. Motion at 11.) While paying lip service to the PLRA's "current and ongoing" provision, Defendants paper over the current and ongoing deficiencies in their system by pointing to plans that remain unfulfilled, have already been delayed for years, and for which completion remains in the future. Defendants' termination experts found systemic clinical staffing shortages, but dismissed them because CDCR "was in the process of hiring." (Defs.' Joint Report at 15; Bien Decl. Ex. 83 (Dvoskin Dep. at 236:11-238:13).) Seriously mentally ill prisoners are held in segregation, an environment that the termination experts found "non-therapeutic," but the problem is dismissed because of vaguely referenced but never identified efforts by CDCR to address the problem. (Defs.' Joint Report at 18, 19, 21, 23, 36.) Patients in crisis have

to live in cells with no beds, but "they were expecting them [beds] shortly." (Bien Decl. Ex. 83 (Dvoskin Dep. at 167:13-19).) The termination experts found clinicians struggling to use an inadequate records system that blocks access to much of a patient's medical history, but dismiss the problem because of new systems that "were to have been completed" after their inspections. (Defs.' Joint Report at 27-28.) Defendants' termination experts frequently identified serious problems on their inspections, and dismissed them with statements like this: "As of the writing of this report, this situation has been rectified." (*Id.* at 21.) On examination, however, the termination experts admitted that they had no direct personal knowledge as to whether the problems had been rectified. (Bien Decl. Ex. 83 (Dvoskin Dep. at 202:9-203:6; 255:14-256:13); Ex. 88 (Moore Dep. at 112:2-12; 142:6-143:10).) Plaintiffs demonstrate herein, and in the concurrently filed Plaintiffs' Evidentiary Objections to Defendants' Expert Reports and Declarations, that key foundational assumptions relied upon by Defendants' termination experts were false.

The termination motion also relies heavily on construction projects that have not been finished and many that have not even begun. The current state of Defendants' long-delayed construction projects is reviewed below in Section III.C.

C. "Current and Ongoing" Violations Include Current and Deliberate Decisions to Understaff, Under-Resource and Overcrowd Programs in Ways that Create a Serious Risk of Harm to Class Members.

Defendants' statement of the PLRA legal standards, if accepted, would improperly remove this Court's equitable power to address Eighth Amendment violations. Defendants contend that the Court must turn a blind eye toward "likely future violations," citing cases from the Third, Eleventh and Fifth Circuits. (Defs. Motion at 11.) No Ninth Circuit case is cited for this proposition. Even if the out-of-circuit cases were controlling, they do not stand for the proposition that the Court must ignore imminent risks of harm to the class. *Para-Professional Law Clinic at SCI-Graterford v. Beard*, 334 F.3d 301, 306 (3d Cir. 2003), involved an injunction requiring maintenance of a legal clinic that a Pennsylvania prison had opened under an access-to-courts consent decree. The court held that PLRA

termination could not be denied based on a prediction that the clinic would be closed, with no evidence that it would be closed in a way that could violate the access to courts. *Id.* *Para-Professional Law Clinic* turned partly on "the particular constitutional right involved, namely the right of access to courts," a right not violated unless an inmate could show a non-frivolous legal claim had been frustrated. *Id.* at 305 (citing *Lewis*, 518 U.S. at 350). Enforcement of the Eighth Amendment right to mental health care, by contrast, does not require waiting until an inmate is seriously injured or dead—this particular constitutional right is a right to be free from unreasonable risks of harm caused by systemically inadequate care. *Plata*, 131 S. Ct. at 1925 n. 3 (Constitution prohibits systemic deficiencies that subject mentally ill prisoners to "substantial risk of serious harm"); *Helling*, 509 U.S. at 33-34 (Eighth Amendment prohibits knowing exposure of inmates to unreasonable risk).

Defendants other two out-of-circuit cases provide no additional support for ignoring serious risks of imminent harm to class members. *Cason v. Seckinger*, 231 F.3d 777, 784-785 (11th Cir. 2000), did not discuss any showing of imminent harm, but merely a "potential future violation." *Castillo v. Cameron County*, 238 F.3d 339, 354 (5th Cir. 2001), likewise involved a "prediction of future activity," the possible arrest of hundreds of persons still in the community, that might occur if the overcrowding injunction there were lifted, with no showing of the current conditions in the covered facilities. Here, by contrast, Plaintiffs make an extensive showing of the current and ongoing conditions in CDCR's prisons and the substantial risk of harm these conditions create.

The only Ninth Circuit case to address the question of risk of harm in PLRA termination motions is *Gilmore v. California*, 220 F.3d 987 (9th Cir. 2000). Gilmore held that although Congress appears to have intended "to deprive courts of jurisdiction to continue relief" where "reversion to unlawful past practice is indeed imminent," such a reading of the statute would present "a serious separation of powers claim." *Id.* at 1009 n. 27. The Ninth Circuit did not reach the separation of powers issue, remanding to allow the district court to determine whether the termination motion could be resolved without

addressing it. *Id.* In this very case, the Supreme Court has cautioned against reading the PLRA in a manner that would prevent federal courts from remedying violations of constitutional rights, as such a reading "would raise serious constitutional concerns." *Plata*, 131 S. Ct. at 1937.

Moreover, the harm presented here does not arise from potential, predicted, or even imminent future actions by Defendants (as was the case in *Para-Professionals*, *Cason*, *Castillo*, and *Gilmore*), but from their current and ongoing deliberate decisions to understaff, under-resource, and overcrowd the prison mental health system.

D. Defendants Make No Attempt To Show That Prospective Relief In This Case Is Not Necessary, Narrowly Drawn, And The Least Intrusive Means To Correct The Violations.

The termination motion is premised entirely on an attempt to show that there are no current and ongoing violations. Defendants make no attempt to address the needs/narrowness/intrusiveness part of Section 3626(b)(3) for any particular prospective relief order. Plaintiffs have demonstrated that for each current and ongoing violation, the existing orders that have not already been complied with or mooted by changed circumstances, remain necessary, narrowly tailored, and the least intrusive means to correct the violation. In addition to the evidence submitted with this Opposition, Plaintiffs concurrently submit a Separate Statement addressing the prospective relief issued since the three-judge court trial.

E. Defendants Have Not Shown A Significant Change In Factual Conditions Or Law To Meet Their Burden Under Rule 60(b)(5).

The Supreme Court set forth the applicable standard in *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367 (1992). First, the party seeking modification of an injunction "bears the burden of establishing that a significant change in circumstances warrants revision of the decree." *Rufo*, 502 U.S. at 383. The party "may meet its initial burden by showing a significant change either in factual conditions or in law." *Id.* at 384. If the moving party meets that initial burden, "the district court should determine whether the proposed modification is suitably tailored to the changed circumstance." *Id.* at 391. Here,

Defendants do not meet the first part of their burden, and do not even address the second part. *Horne v. Flores* did not change the *Rufo* standard, but reaffirmed it. 557 U.S. at 453-54.

An examination for "changed circumstances" requires attention to the choice of time period from which to measure change. Based on Defendants' instructions to their termination experts, and the resulting reports, it is clear that Defendants chose to measure change from the period before the original 1993 trial. (Defs. Motion at 3; Defs.' Joint Report at 14-15.) This may be a good tactical choice by Defendants, as nearly any deployment of staff and resources to the prison mental health system will appear to be an improvement over the pitiful conditions that prevailed before the 1993 trial. Much of the prospective relief that they seek to end, however, has been issued well after the 1993 trial and 1995 permanent injunction, based on much more recent findings of systemic constitutional violations throughout the state prison system. *See Plata*, 131 S. Ct. at 1924-25, 1930-32.

Defendants string together federalism quotes from *Horne* to create the impression that any time a state agency moves for relief from a federal injunction, the motion must be granted to avoid undue federal interference with state affairs. (Defs. Motion at 13.) Defendants are looking at only one side of the federalism coin. The other side prohibits federal courts from turning away when a state government violates the federal constitution: "Courts may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration." *Plata*, 131 S. Ct. at 1928-29.

III. DEFENDANTS' EVIDENCE, PRESENTED LARGELY THROUGH THEIR TERMINATION EXPERTS, FALLS FAR SHORT OF THEIR BURDEN TO SHOW THAT FEDERAL VIOLATIONS HAVE ENDED.

A. Defendants' Flawed Termination Motion Addresses Only The 1995 Order And Ignores All Subsequent Findings And Orders Including Orders Of Three-Judge Court And The Supreme Court.

Defendants, despite their bravado and bluster, have failed to meet their burden of demonstrating that the ongoing constitutional violations in the California prison system,

identified most recently by the three-judge court in August 2009, and affirmed by the Supreme Court in May 2011, have been remedied. In a bizarre strategy, Defendants and their termination experts pretend that the pernicious and pervasive effects of a massively overcrowded prison system on the delivery of medical and mental health care are of no moment and should not be considered by this Court or the experts in forming their opinions. Defendants did not ask their termination experts to look at overcrowding as a factor, and the termination experts clearly did not consider the three-judge court's findings as relevant to their analysis. (Bien Decl. Ex. 83 (Dvoskin Dep. at 191:8-192:6); Ex. 88 (Moore Dep. at 32:13-33:11); Ex. 89 (Scott Dep. at 24:16-27:18).)[1]

Under this creative but defective reasoning, the *only Coleman* order that *is* relevant to understanding the fundamental constitutional violations that Defendants were obligated to remedy was the first, which was issued by this Court in 1995. *See, e.g.*, Defs. Motion at 3:19-21 ("the State meets and exceeds every important benchmark articulated by the Court in 1995"), Defs. Motion at 27:27-28:2 ("The State has remedied all of the deficiencies this Court found in 1995, and brought the prison mental health system into compliance with all applicable federal and constitutional standards"). None of the subsequent remedial orders, including the August 2009 findings and order of the three-judge court, are even referenced and, under this flawed theory, these unpleasant and difficult findings about extreme overcrowding and horrific constitutional violations in the delivery of medical and mental health care can and should be ignored completely.

The Supreme Court's decision in this case, *Plata*, affirming each and every finding and order of the three-judge court, *does not even merit a single citation or reference* in Defendants' 28-page Memorandum. The State only reluctantly concedes, in a single

[1] One of Defendants' termination experts, Steve Martin, claims to be uniquely qualified to investigate and report on issues of prison overcrowding and the question of whether the CDCR can deliver appropriate mental and medical care at current crowding levels. Defendants, however, chose *not* to ask Mr. Martin to investigate any crowding issues or to form an opinion on the subject. (Bien Decl. Ex. 86 (Martin Dep. at 12:6-14:7).)

footnote, that the three-judge court "ruled that California can only deliver constitutionally adequate medical and mental health care by decreasing its prison population to 137.5% of institutional design capacity" but argues, yet again, "that [the] order was premised on outdated evidence." (Defs. Motion at 15, n. 7.) This claim was soundly rejected by the Supreme Court: "[T]he record and opinion make clear that the decision of the three-judge court was based on current evidence pertaining to ongoing constitutional violations." *Plata*, 131 S. Ct. at 1936.

By limiting their analysis to the single original order issued in 1995, and ignoring all unpleasant intervening events in the past 17 years, Defendants, with an ostrich-in-the-sand view of reality, then assert that the "State has complied with the Court's remedial orders and corrected the constitutional deficiencies addressed in the Court's initial judgment." (Defs. Motion at 6:7-9.)

The sorry truth for both Plaintiffs and Defendants is that the three-judge court found, after a full trial on the merits, that California prisoners have suffered and died needlessly and unnecessarily due to the deliberate indifference of Defendant public officials who overcrowded California's prisons and failed to provide minimally adequate medical and mental health care and safe and appropriate housing. By ignoring the issue of ongoing overcrowding in the CDCR and the resulting barriers to the remedial process in *Coleman* and *Plata*, Defendants' termination motion fails to address the fundamental issue that must be decided here: Have Defendants met their burden of proving that they have remediated the constitutional violations found to exist in 2009 through the population reduction to date and Defendants' substantive efforts to remediate specific deficiencies in their mental health care delivery system?

Defendants' wishful theory of the case also ignores all of the other substantive remedial orders issued by this Court concerning, for example: clinical staffing levels, suicide prevention, use of force, disciplinary hearings, construction of necessary specialized mental health beds, administrative segregation, emergency response, access to inpatient care, and the program guides. In this Court's July 23, 2007 order, 77 of these

substantive orders were referenced. (Docket No. 2320 at 4:13-17 & n. 3 (stating that "there are simply too many orders to list").) Since then, due to Defendants' inability or unwillingness to remedy the ongoing violations, many more have been required and Defendants' compliance with these orders is anything but complete.

The reality is that Defendants are knowingly and currently in violation of numerous fundamental, critical and life-saving orders of this Court. These violations of fundamental remedial orders of this Court, necessary to establish a minimally adequate level of mental health care, are powerful evidence of Defendants' ongoing deliberate indifference to the serious need for mental health care of the more than 32,000 *Coleman* class members currently identified in the CDCR.

B. Defendants' "Nationally Prominent" Termination Expert Reports Are Unreliable And Their Opinions Should Not Be Considered By This Court.

The opinions of defendants' "nationally prominent" termination experts should be given little or no weight in this proceeding. Plaintiffs have filed separate Evidentiary Objections to Defendants' Experts' Reports, which includes a thorough analysis of the issues and the applicable legal and professional standards.

C. Defendants' Declaration Evidence Regarding Construction Confirms That Adequate Facilities Are Still Years Away.

As noted above, Defendants cannot rely on future predictions of new capacity to meet their burden to show that federal violations have ended. *See* Section II.B above.

With their termination motion, Defendants set forth a laundry list of self-professed accomplishments involving construction and renovation in California prisons. What the State fails to mention is that many of these projects are years – even *decades* – delayed and have moved toward completion only after repeated court orders and, at times, over Defendants' vociferous objections. The State cites several projects that CDCR "is finishing," "is building," or for which CDCR "expects to seek establishment." (Defs. Motion at 7:6, 19, 26.) The sad reality of CDCR's construction record is that for years Defendants' promises and forecasts have fallen by the wayside. Projects are routinely "re-

scoped," canceled, or delayed indefinitely. Meanwhile, many urgent projects needed to address the dearth of treatment, office, and bed space for *Coleman* class members remain in pre-planning stages.

First and foremost, more than half of the projects cited in the Declaration of Director of the Facility Planning, Construction and Management Division Chris Meyer have not even opened to patients yet. (Meyer Decl., Docket No. 4278.) Some do not even have a projected completion date. Incomplete and hypothetical projects are irrelevant to the Court's inquiry into *current and ongoing* constitutional violations. Moreover, the history of CDCR construction projects suggests there is reason for skepticism as to when and whether these projects will be completed, properly licensed, staffed and open for patient care.

The 50-bed Mental Health Crisis Bed unit at California Men's Colony (CMC) is a case in point. Defendants' motion states that CDCR "is finishing" the project. (Defs. Motion at 7:6-7.) Defendants do not, however, mention that the Court ordered them to submit a plan "for the delivery of a MHCB level of care to inmates in California Men's Colony" *more than ten years ago*, in October 2002. (Docket No. 1431.) In October 2006, the court again ordered Defendants to submit a consolidated plan, including the CMC project, "to meet projected populations by June 30, 2011." (Docket No. 1998.)

In June 2012, Mr. Meyer submitted a declaration to the court attesting that the 50-bed MHCB project at CMC was under *construction* and the first inmate-patient admission was scheduled for December 11, 2012. (Docket No. 4196-5 ¶ 5.) December 11, 2012 has come and gone. Acknowledging "the slip on CMC," Mr. Meyer now estimates that inmate admission will start "between July and October 2013." (Bien Decl. Ex. 87 (Meyer Dep. at 113:15-114:14); Docket No. 4278 ¶ 10.) In the meantime, acutely ill prisoners are suffering from a major shortage of MHCBs. (Expert Declaration of Pablo Stewart, M.D. ("Stewart Expert Decl.") ¶ 41 (discussing "the use of 'alternative housing' locations for suicide watch because there are no MHCB beds available"); ¶ 101 (discussing impact of "the scarce MHCB beds in the CDCR"), Docket No. 4381.)

The same is true of Dewitt Nelson Correctional Annex, which Defendants describe as a "soon-to-be renovated" project that will provide more mental health care beds. Again, Defendants' brief does not cite the Court's order of more than two years ago requiring Defendants to set a schedule that "reflects patient admissions completed to full occupancy by 2013" at Dewitt. (Docket No. 3761.) By Defendants' own account, 2013 will pass without a single *Coleman* class member setting foot in Dewitt. Current projections reflect that the building will be fully occupied on May 31, 2014, but there is cause for concern as to Defendants' ability to meet that deadline. Mr. Meyer testified about several "issues associated with that project that [he is] concerned about" and stated that he is not "ready" to decide whether the current activation date is "going to be impacted." (Bien Decl. Ex. 87 (Meyer Dep. at 80:13-81:1).) More broadly, Mr. Meyer testified that "the actual completion date of a project is always a guess" and noted that there are "hundreds, if not thousands, of variables that can impact [a] completion date." (*Id.* at 37:13-38:12; 114:15-115:9.)

Defendants also rely on the future projected completion of the California Health Care Facility in Stockton. Full activation of that facility is projected for December 31, 2013, approximately nine months from now. (Docket No. 4278 ¶ 5.) That date depends on nothing going wrong with the extensive remaining construction, fire marshal approval, licensing and the hiring of massive numbers of clinicians, including scarce psychiatrists, any one of which could throw the project off by months or years.

Defendants even take credit for projects for which there is not an activation schedule or even a projected completion date. Among those is the health care facility improvement project at Mule Creek State Prison. (Docket No. 4278 ¶ 17.) When questioned, Mr. Meyer admitted the long list of steps to be taken before the MCSP project even breaks ground – including "hire a designer," "hire the various consultants," possibly "start the CEQA [California Environmental Quality Act] process," and "have stakeholder meetings." (Bien Decl. Ex. 87 (Meyer Dep. at 74:25-75-18).) Mr. Meyer concluded that "we can't establish exactly how long it's going to take and when we expect it to activate."

(*Id.*) The same is true of the health care facility improvement project at CMC, for which Mr. Meyer testified that he did not know even a "conceptual date of completion." (*Id.* at 78:19-79:6.)

Even construction projects nearing completion are vulnerable to cancellation, downsizing, and major delay. At CCWF, which was the most overcrowded of all the California prisons in February 2013 when Plaintiffs' expert visited, things are moving in the wrong direction for *Coleman* class members. Despite a recent spike in population due to the closure of Valley State Prison for Women, a long-planned project to create treatment and office space for the EOP general population was "re-scoped" and *reduced* in size. (Docket No. 4289 (Special Master's 25th Round Report) at 43.) Construction of the new facility was scheduled to begin seven months ago, in August 2012, but the project had not broken ground when Plaintiffs' expert visited. (Expert Declaration of Edward Kaufman, M.D. ("Kaufman Expert Decl.") ¶ 55, Docket No. 4379.) Indeed, CDCR's most recent activation schedule indicates that even the working drawings for the site will not be completed until September 2013. (Bien Decl. Ex. 93 (Defs. Monthly Activation Schedule Report for February ("Activation Report, Feb. 25, 2013") at 34.) Mr. Meyer confirmed that the project is now "back to square one," and "there is no construction schedule for the re-scoped project." (Bien Decl. Ex. 87 (Meyer Dep. at 125:10-126:3).) He described the re-scoping as a "waste of money" and noted that "you just move the starting point again and go through the same process." (*Id.*)

Similarly, due to "re-scoping" at LAC, EOP general population patients will not benefit from a long-planned project to create office and treatment space. The project was scheduled for completion and full activation by September 12, 2012, but since has been re-scoped and delayed. Under the new plan, the recently constructed building will be used for EOP administrative segregation, and in order to achieve that mission, additional construction is required. Patient admissions are now scheduled to begin on March 31, 2014, more than a year and a half after they were initially intended to commence. (Bien Decl. Ex. 93 (Activation Report, Feb. 25, 2013) at 21.) Mr. Meyer stated that he believes

some of the office space is currently in use, but the treatment space is not. (Bien Decl. Ex. 87 (Meyer Dep. at 68:24-69:16; 70:10-70:19).) Consequently, the photos of gleaming treatment spaces attached to Mr. Meyer's declaration depict spaces that are *not* available to patients and will remain empty for at least another year. (Docket No. 4278-13 at 70, 72 ("Treatment Hallway" and "Therapy Room"); *see also* Bien Decl. Ex. 93 (Activation Report, Feb. 25, 2013) at 21.) Yet this is somehow Defendants' evidence that there are no *current* or *ongoing* constitutional violations.

At San Quentin, a long-planned project that would have added mental health treatment facilities on death row was canceled abruptly by the Governor in April 2011. (Expert Declaration of Jeanne Woodford ("Woodford Expert Decl.") ¶ 36, Docket No. 4380.) Mr. Meyer testified that the funding, preliminary plans, CEQA approval, design, and working drawings had all been completed for the project at the time it was canceled. (Bien Decl. Ex. 87 (Meyer Dep. at 152:14-154:25).) Mr. Meyer had no advance notice that the project would be canceled. (*Id.*) When asked if all construction projects are subject to sudden cancelation by the Governor, Mr. Meyer stated, "[h]e wants to cancel it, it gets canceled." (*Id.*)

In the meantime, while CDCR construction projects are abruptly canceled, frequently delayed or re-scoped, existing facilities are woefully inadequate to serve the needs of *Coleman* class members. At LAC, where the project to construct EOP treatment and office space was canceled, EOP patients are "spread out in various ad hoc spaces," including visiting rooms and classrooms, and "there is not enough space" for groups. (Stewart Expert Decl. ¶ 358.) At CCWF, where the project for EOP treatment and office space has been downsized and delayed, EOP patients share a unit with non-caseload Reception Center inmates, with a red line of tape down the middle of the unit to separate the populations. (*See* Kaufman Expert Decl. ¶ 53 & Photo Ex. B.) The Special Master observed that EOP groups are "conducted on the dayroom floor, which limited confidentiality and was noisy." (*See* Special Master's 25th Round Report at 412.) CCWF's internal Management Report identified lack of adequate group space for EOPs as

an "obstacle[] to providing mental health services and adherence to Program Guide Requirements." (*See* Bien Decl. Ex. 26 (CCWF 25th Round Management Report), at 3 of 17).)

The State has conceded, in a Budget Change Proposal submitted to the State of California, that "[e]xisting medication distribution facilities do not allow for safe, efficient and effective distribution of medications and do not allow for compliance with federal and state infection control standards." (Bien Decl. Ex. 94 (Capital Outlay Budget Change Proposal ("COBCP")) at 1.) The proposal notes that "inadequate space and the insufficient lighting leads to errors in medication preparation and administration" which, in turn, "can lead to deterioration of a patient's medical condition." (*Id.* at 2.) The State's proposal to renovate and build medication distribution facilities is scheduled to conclude in May 2015, but Mr. Meyer testified that "until we do the site assessments and get into the detail, we have no basis" to predict a completion date. (Bien Decl. Ex. 94 (COBCP) at 7); Ex. 87 (Meyer Dep. at 143:1-144:3).)

At some institutions, the need for renovation is even more dire. The Office of the Inspector General concluded in 2008 that "if funding is not dramatically increased, CIM's condition will reach a level of degradation by 2014 that independent facilities management experts throughout the industry would recommend demolishing and replacing the entire institution." (Bien Decl. Ex. 10 (November 2008 OIG Report) at 2.) Mr. Meyer agreed that "there is a need for some infrastructure repair and maintenance" at CIM, while stating that "there are institutions that are worse than CIM." (Bien Decl. Ex. 87 (Meyer Dep. at 158:4-23; 159:16-21).) No renovation projects for CIM were mentioned in Defendants' filing. At Corcoran, the Chief Psychologist told Plaintiffs' expert that "[t]his prison was built 25 years ago. We don't have the infrastructure for much medical and mental health care." (Expert Declaration of Craig Haney ("Haney Expert Decl.") ¶¶ 175, 178, Docket No. 4378.) At CIM, the Reception Center clinician bluntly stated of the makeshift nature of their clinical space: "The guy who designed this place should be horsewhipped[.] [I]t's just not built right." (*Id.* ¶ 131.)

IV. PLAINTIFFS' OVERWHELMING EVIDENCE OF ONGOING AND PERVASIVE CONSTITUTIONAL VIOLATIONS

Plaintiffs have provided the Court, in connection with this Opposition Brief, overwhelming evidence of the ongoing constitutional violations in CDCR prisons which continue to be plagued by a high level of overcrowding and shortages of resources.

A. Plaintiffs' Expert Witnesses

Plaintiffs offer the testimony of five eminently qualified retained expert witnesses:

Pablo Stewart, M.D., is a psychiatrist and holds a Clinical Professorship at the Department of Psychiatry at the University of California, San Francisco, School of Medicine. He has served as Director of Forensic Psychiatric Services for the San Francisco Jail and also served for ten years as a psychiatric expert working for the court-appointed neutral Mediator in the remedial phase of *Gates v. Deukmejian*, a class action concerning, among other issues, mental health care at the California Medical Facility. Dr. Stewart was an expert witness in the overcrowding trial in this matter in 2008. Dr. Stewart has extensive clinical, research, and academic experience in forensic mental health including consultations involving prison and jail systems in other jurisdictions. His expert declaration is filed at Docket No. 4381 (hereinafter "Stewart Expert Decl.").

Edward Kaufman, M.D., is a licensed psychiatrist and former Professor of Psychiatry, who has practiced psychiatry in treatment centers, chemical dependency treatment programs, and correctional settings. Dr. Kaufman served as the Chief of Psychiatric Services at the Lewisburg Federal Penitentiary and the Director of Psychiatry for Prison Mental Health Services of the City of New York. He is widely published and has taught and lectured extensively in the areas of prison mental health and the treatment of substance abuse. Dr. Kaufman previously has been qualified and testified as an expert in prior *Coleman* proceedings. His expert declaration is filed at Docket No. 4379 (hereinafter "Kaufman Expert Decl.").

Craig Haney, Ph.D., is a Professor of Psychology and former Chair of the

Department of Psychology at the University of California at Santa Cruz who has studied and published about institutional environments, including prisons, for 35 years. Dr. Haney has toured, inspected, and analyzed conditions of confinement at numerous state and federal prisons across the country and around the world. Dr. Haney has been qualified and testified as an expert in various state and federal courts, and served as a testifying expert in both the *Gates v. Deukmejian* and the *Coleman* trials, and has evaluated and testified about the psychological effects of overcrowded conditions of confinement at the California Men's Colony, San Quentin, and Soledad prisons, as well as in other state prison systems. Dr. Haney testified in the overcrowding trial. In 2012, Dr. Haney testified before the United States Senate Judiciary Sub-Committee on the psychological effects of isolated confinement. He is currently a member of a National Academy of Sciences Committee on the Causes and Consequences of High Rates of Incarceration in the United States. His expert declaration is filed at Docket No. 4378 (hereinafter "Haney Expert Decl.").

Jeanne Woodford is the Executive Director of Death Penalty Focus and a Senior Fellow at the Berkeley Center for Criminal Justice. She was formerly a *Coleman* defendant as Acting Secretary in charge of all California prisons, after a long career at San Quentin during which she served in a range of positions from correctional officer to warden. Ms. Woodford has also served as the Chief Adult Probation Officer for the San Francisco Adult Probation Department, and has taught, written, and lectured extensively on criminal justice topics. Ms. Woodford testified in the 2008 overcrowding trial. Her expert declaration is filed at Docket No. 4380 (hereinafter "Woodford Expert Decl.").

Eldon Vail is former Secretary of the Washington State Department of Corrections, having served in the top management of the department for over a decade. Mr. Vail's corrections career spans 35 years of service in line and supervisory positions. Mr. Vail served as superintendent of the McNeil Island Corrections Center, where he designed and opened the state's program for mentally ill inmates. He assumed direct oversight of the entire state prison mental health system when he was elevated to Assistant Director of Prisons. His expert declaration is filed at Docket No. 4385 (hereinafter "Vail Expert

Decl.").

Plaintiffs' experts inspected 11 CDCR prisons in a five-week period from January 28 through February 26, 2013: Mule Creek State Prison (MCSP), Salinas Valley State Prison (SVSP), California Institute for Men (CIM), California State Prison–Corcoran (COR or Corcoran), California State Prison–Sacramento (SAC), California Correctional Institution (CCI), California State Prison–Los Angeles County (LAC), Central California Women's Facility (CCWF), Kern Valley State Prison (KVSP), San Quentin State Prison (SQ), and R.J. Donovan (RJD). In addition, Dr. Haney and Mr. Vail recently toured two additional CDCR prisons in connection with their work as expert witnesses on the *Mitchell* case challenging CDCR's racial lockdown policy: Solano State Prison and High Desert State Prison.

B. Recent Findings and Orders by the *Coleman* and *Plata* Courts, and Reports of the Special Master and the *Plata* Receiver Evince Ongoing Constitutional Violations

In addition to the evidence set forth herein, Plaintiffs rely on the extensive evidence already set forth in the record of this case and the related *Plata* case, including the reports of the Special Master and Receiver, this Court's findings and orders, the three-judge court's findings and orders, and the Supreme Court's decision in *Plata*. The Special Master's recently filed 25th Report, Report on CDCR Suicides in 2011, and Report on CDCR Suicides for the First Half of 2012, provide an unequaled comprehensive review of the current operations and serious ongoing deficiencies of CDCR's and DSH's operations. The *Plata* Receiver recently filed his 22nd Tri-Annual Report on the Delivery of Health Care Services to California Prisoners, and a response to *Plata* defendants' objections to that report. (*Plata* Docket Nos. 2525, 2547.) Plaintiffs incorporate by reference and herein rely on their Opposition to Defendants' Objections and Motion to Strike the Special Master's 25th Report, and declarations in support (Docket Nos. 4324, 4325), and their Opposition to Defendants' Objections and Motion to Strike the 2011 Suicide Report, and declarations in support, (Docket Nos. 4350, 4350-1.)

C. Current Staff Shortages Throughout CDCR Prisons Make the Delivery of Adequate Mental Health Care Impossible

Defendants have knowingly and intentionally taken steps that put the lives and safety of the *Coleman* class at risk through their decisions to achieve budget savings by sacrificing progress towards a remedy to the ongoing constitutional violations in the delivery of mental health care in the prisons. The population reduction order provided Defendants with an opportunity to move the remedial process forward by alleviating overcrowding and taking steps to implement the State's own 2009 Staffing Plan. Instead, Defendants have chosen to balance the budget on the backs of the California prisoners with mental illness. Defendants have further put dedicated and hard-working clinical staff in an impossible situation. Mental health care providers must now manage caseloads beyond their (or anyone's) professional abilities and in violation of professional and licensing standards, as they are forced to decide how to ration mental health care in a crisis in which all of their patients need and deserve their help.

Due to the Governor's February 15, 2011 Statewide Hiring Freeze, and his decision to order massive layoffs associated with Realignment, Defendants have failed to address the significant mental health staffing deficiencies that impede the provision of an essential mental health program, including critical suicide prevention measures. (Docket Nos. 4350-1 Exs. A & C; 4325-1 ¶¶ 6(f), (g) (noting impact of staff shortages in specific suicides).) Defendants' expert Dvoskin characterized the significant mental health staffing shortages as "unavoidable," because Defendants could not hire mental health clinicians due to the requirements of "state personnel law," noting, "I suppose you could change the law, but that's what the law is." (Bien Decl. Ex. 83 (Dvoskin Dep. at 236:11-23).) Although Defendants have sought many waivers of state law from this Court, they did not seek a waiver from the state personnel laws that they now claim have prevented them from hiring the mental health staff necessary to implement their Court-ordered staffing plan. (*See, e.g.*, Docket Nos. 4120, 3866, 3748.)

Defendants know very well the minimum number of clinical staff required to

deliver constitutionally adequate mental health care. The current staffing ratios for clinical positions in the CDCR were developed by Defendants themselves after a thorough study and were "deemed necessary to meet the needs of the inmate-patient populations. *Where positions are not filled, the implication is that clinical need is not being met*." (Special Master's 25th Round Report at 46-47 (emphasis added).) Defendants' staffing plans were developed during a period of extreme financial crisis and were represented to the Legislature as necessary to meet minimum constitutional standards. (Docket No. 4325 ¶ 16, Ex. K (Mental Health Staffing Ratio Budget Change Proposal 2010-2011).) Defendants' staffing plan and ratios, without objection or appeal, have been incorporated into orders of this Court. (*See, e.g.*, Docket Nos. 3666, 1774, 1772.) Defendants have knowingly and intentionally failed to comply with these orders—disregarding their own projections as to staffing needs—by not actively funding these positions and allocating them to prisons that required additional staff. Nor have they effectively recruited and hired for their vacant clinical positions. Layoff notices, hiring freezes, complex and delayed "freeze exemption" procedures, Realignment confusion, and delays in mission planning all have resulted in the serious and dangerous staffing shortages that put the lives and health of the *Coleman* class at risk today. (*See* Bien Decl. Ex. 90 (Toche Dep. at 138:25-139:14; 151:3-11).)

Defendants, as they must, admit the existence of the extreme staffing shortages, but take no responsibility for the crisis that they have created and managed. (Toche Decl., Docket No. 4275-3, ¶¶ 6-8.) Blame is cast on the *Plata* Receiver, Realignment, the Special Master's monitoring and requirements, the "market for psychiatrists," "nationwide shortages," and even state public employee law. Defendants, including CDCR Secretary Beard, go even further, disavowing their own studies of the minimum necessary clinical staffing, and this Court's orders, claiming that they provide a "very rich" staffing level (Bien Decl. Ex. 80 (Beard Dep. at 110:19-113:20), and that their clinicians just have to "step up" and "do more than they usually do." (Bien Decl. Ex. 81 (Belavich Dep. at 146:1-149:21).) Dr. Toche cavalierly conceded that Defendants have decided not to fund

what she and Defendants deem "non-critical positions at each institution" for the sole purpose of "providing salary savings." (Toche Decl., Docket No. 4275-3, ¶ 6.)

Mental health staff working on the ground, meanwhile, are forced to bear the significant burdens that result from that choice. (*See* Haney Expert Decl. ¶¶ 52, 96 (noting that MCSP chief psychologist stated that his "responsibilities were substantial, and that the hiring of a second Chief Psychologist would be very helpful")). The shortages are now so severe that even when patients are transferred to higher levels of care, they are receiving inadequate and inappropriate psychiatric care that does not meet their needs. (Stewart Expert Decl. ¶¶ 285-347 (documenting severe problems with delivery of care in 5 EOP ASU programs visited), ¶¶ 431-451 (describing severe problems in DSH inpatient care programs at SVPP), ¶¶ 51-56 (discussing staffing shortages in DSH programs providing inpatient care to CDCR prisoners).)

As a result of these staffing shortages and waitlist pressures, Plaintiffs' experts found significant numbers of unstable and seriously ill patients in CDCR prisons during their recent inspections. (*See, e.g.*, Stewart Expert Decl. ¶¶ 433, 436-445, 448 (class members were suffering from deficient treatment as a result of these staffing shortfalls); Kaufman Expert Decl. ¶ 24 ("The mental health staff at each institution described significant shortages of staff that hindered their capacity to deliver even basic mental health care."), ¶¶ 27, 28, 29 (CCWF unable to offer group treatment to EOP prisoners housed in segregation unit due to staffing shortage), ¶¶ 30, 31 (Prisoner B only seen every other week because case manager told her that her caseload is too big; clinical contact "occurred cell front to manage the large influx of MH patients in ASU while understaffed"), ¶ 32 (Prisoner C seen cell front by her clinician because the prison was "short of staff escorts," and denied mental health treatment "because of custody issues"), ¶ 36 (medium-size cage-like cells filled with eight to ten prisoners left cuffed and waiting for several hours for their health care appointments), ¶ 39 (five CIM prisoners on the mental health caseload placed in ASU due to shortage of appropriate beds and could not get a response to repeated requests to meet with custody counselors due to staff shortage as

confirmed by CDCR doctor), ¶ 42 (Corcoran staff psychiatrist referred to shortage of psychiatrists and its adverse impact),¶ 44 (escort staff shortage noted in Corcoran's internal management report, and confirmed by the 32.7 vacant escort officer positions), ¶ 45 (staff shortages mean patients receive an inadequate amount of treatment and also lower the quality of treatment); Haney Expert Decl. ¶ 52 (staff shortages impact the delivery of mental health treatment at each institution visited), ¶ 95 (Mule Creek mental health staffing "remained a problem"), ¶¶ 100-101 (Chief Psychologist reported that although MCSP has space to provide the treatment to EOPs, they are short the staff to use it), ¶ 136 (CIM faced staffing shortages that reduced treatment, most evident in psychiatry vacancies), ¶ 138 (Defendants' expert Moore found CIM had insufficient staff to provide discharge planning for two-thirds of CCCMS prisoners "due to caseload"), ¶ 188 (Corcoran's allocated mental health staff cut substantially despite the mental health caseload remaining steady), ¶ 189 (77% staff psychiatry vacancy rate at Corcoran, MHCB doctor acknowledged that "we are so short of psychiatrists that they cover as best they can"), ¶ 190 (Corcoran staffing shortages have gotten worse since August 2012), ¶ 195 (staffing has gotten worse, not better at Corcoran, "we are just keeping our heads above water. We just don't have the staff."), ¶¶ 237-239 (CCI staffing shortages significantly impact on delivery of care); Stewart Expert Decl. ¶ 64 (other related staffing problems noted on tours included frequent turnover in key clinical positions, difficulties associated with registry workers), ¶ 72 (staffing vacancies impacted medication management, transfers to higher levels of care, delivery of EOP care), ¶¶ 77-80 (SAC impacted by the current statewide hiring freeze, required to apply for exemption for each position, lapses in medication consents, lack of presence at IDTTs related to shortage of psychiatrists); ¶¶ 83, 88-90 (unable to deliver more than five hours of weekly treatment to its EOP prisoners due to staffing shortages), ¶¶ 104, 109 (staffing shortages at LAC contribute to the ongoing inability to delivery adequate structure therapy hours to EOP prisoners); Woodford Expert Decl. ¶ 43 (insufficient custody staff to provide escort for routine mental health services and emergency treatment).)

D. Defendants' Facilities Suffer from an Ongoing Lack of Minimally Adequate Treatment Space

Section III.C above, addresses Defendants' misplaced reliance on *future* building plans in a motion about current and ongoing conditions. The current and ongoing deficiencies in treatment spaces at CDCR facilities are not just cosmetic. Defendants continue to tolerate punitive, non-confidential, and anti-therapeutic settings that discourage mental health patients from participating in treatment. By forcing patients who access care to jeopardize their safety by talking about sensitive and personal information in front of other prisoners, CDCR erects dangerous barriers to mental health treatment. Indeed, Defendants' expert Moore testified that the problem with non-confidential treatment settings is that "the inmate will not be as truthful or forthcoming with their issues," which "affect[s] treatment." (Bien Decl. Ex. 88 (Moore Dep. at 163:20-164:1).)

Plaintiffs' experts found inadequate treatment space at nearly every institution they toured. (*See* Haney Expert Decl. ¶¶ 75-78 (MSCP EOP ASU treatment space is "an environment that is not only congested and inhospitable but not at all conducive to meaningful therapy"; similar observations by the Special Master), ¶ 232 (observing "extremely serious space limitations that compromised the delivery of adequate mental health care" that "were acknowledged by the staff members" at CCI); Kaufman Expert Decl. ¶¶ 48-56 (describing "inadequate," noisy, and non-confidential settings for groups and noting high incidence of cell-front clinical contacts at CCWF), ¶¶ 57-60 (observing adverse impact of inappropriate treatment space on patient participation in therapy), ¶¶ 61-64 (describing treatment spaces with "temporary half-walls" and no "auditory privacy" in a converted gym at Corcoran); Stewart Expert Decl. ¶ 75 (recounting comments by SVSP's Acting Chief of Mental Health about the shortage of office and treatment space for confidential interviews with class members), ¶¶ 112-114 (observing that EOP Ad Seg patients must meet their clinicians "in non-confidential areas on the crowded, noisy, chaotic dayroom floors in the housing units" at RJD and LAC).)

Moreover, Defendants rely on temporary, emergency, unlicensed, and inadequate

facilities for a major portion of the most critical higher levels of care in the system. These "bad" and "ugly" beds were ordered to be opened and operated only until minimally adequate and appropriate facilities for inpatient psychiatric care could be constructed. All of these "bad beds" are consistently filled to capacity in today's overcrowded system. These inpatient beds are: CIM MHCB (34 beds), CMC MHCB (40 best), SAC MHCB (20 beds), SVPP ICF (242 beds), CMF ICF and APP (88 acute/MHCB and 140 ICF beds). (Declaration of Rick Johnson ("Johnson Decl."), Docket No. 4276-2, Ex. 2.)

Widespread deficiencies in the treatment spaces are inseparable from deficiencies in the sufficiency of mental health care. Medication management is rendered much more difficult – and in some cases, dangerously ineffective – when patients lack confidential settings in which to communicate concerns about side effects and ask questions about their medications. (Kaufman Expert Decl. ¶ 75.) Inadequate treatment spaces exacerbate problems with staff retention because they add to clinicians' challenges providing meaningful treatment to their patients. (Stewart Expert Decl. ¶ 114.) Even basic suicide prevention measures can be frustrated by chronic inadequacies in treatment settings." (Kaufman Expert Decl. ¶ 47.)

Finally, the severe problem of inadequate treatment space in segregation units is discussed further detail in Section IV.H.4.b below.

E. Delays in Transfers to Higher Levels of Care and Waitlists

Defendants claim that the State's mental health delivery system provides for "inmates' serious mental health needs through a continuum of services across all custody levels in both inpatient and outpatient programs." (Toche Decl., Docket No. 4275-3, ¶ 10; Belavich Decl., Docket No. 4277, ¶ 5.) But this claim is demonstrably false. Significant and ongoing shortages of MHCB beds, EOP placements, and inpatient psychiatric hospital beds remain. Clinicians fill these critical beds to capacity. Additional *Coleman* class members who need these resources are held in cages, punitive administrative segregation units, barren outpatient housing units and other harsh and unsafe locations in lieu of receiving the care they need.

Defendants lack sufficient beds to transfer all the *Coleman* class members requiring EOP or CCCMS placements and use "bad beds" for those who are waiting for transfer. (Stewart Expert Decl. ¶¶ 278, 282; Haney Expert Decl. ¶¶ 44-46.) Defendants collect data weekly that documents this shortfall, yet have failed to adequately address it. During the week of February 11, 2013 (the most recent data provided by Defendants), CDCR institutions requested the transfer of 234 EOP prisoners to appropriate EOP programs throughout the system; only 32 prisoners (13.7%) could be transferred. (Bien Decl. Ex. 2.) During the same week, of the 1435 CCCMS prisoners for whom transfer to an appropriate bed was requested, just 271 (18.9%) could be transferred. Defendants' weekly EOP data from January 2011 to December 2012 show similar backlogs. (Bien Decl. Ex. 72.)

Despite the clearly documented and long-existing bed shortages (*see* Bien Decl. Ex. 72 (Comparison of EOP Male Beds Requested and Beds Provided Jan. 2011 through Jan. 2013)), Defendants acknowledge that they have not yet made efforts to focus on the needs of the *Coleman* class, nearly two years in to Realignment. (Bien Decl. Ex. 85 (Johnson Dep. at 178:1-179:18) (Chief of the Health Care Placement Oversight Program (HC-POP) stating, in his February 25, 2013 deposition, *"so we're just beginning to – even though it's been the plan to do this, we're finally at the point where we can now address the mental health alignments*." (emphasis added)); *id.* at 204:25-205:19 (first meeting to address the issue had not yet occurred as of February 25); *id.* at 205:20-206:13; *id.* at 206:14-207-1.)

Defendants' continuing indifference to these bed shortages has caused pain and suffering to *Coleman* class members, many of whom cannot get to an appropriate program to meet their mental health needs. (Kaufman Expert Decl. ¶ 95 (at every prison toured, prisoners on the mental health caseload housed in ASUs due to shortage of appropriate beds), ¶¶ 97-99 (Prisoner L housed in ASU due to SNY status waiting for transfer more than nine months; increasingly depressed and despairing); Haney Expert. Decl. ¶¶ 44-50, 107-114, 141-162, 217-227, (many prisoners suffering and languishing for weeks or months in a "bad bed," such as ASU or OHU waiting for transfer), ¶ 281 (segregated

housing used to house prisoners waiting for SNY transfer despite awareness that many ASU suicides involved such prisoners).)

1. Waitlists for DSH Beds Persist Despite Defendants' Efforts to Redefine Waitlist

Inpatient waitlists still exist. Defendants have tried to disguise the inpatient waitlist problem by redefining how to count the waitlist—specifically, by using the date of acceptance by DSH instead of the date of referral, contrary to Program Guide provisions (Bien Decl. Ex. 106 (Program Guide Section 12-1-16))—and have thus undercounted the number of days that a mentally ill prisoner has been waiting for transfer to psychiatric hospital level care. Although Defendants contended there was no waitlist for DSH care, when Dr. Stewart toured the intermediate inpatient DSH programs at SVPP on January 28, 2013, staff kept mentioning the "waiting list," and then correcting themselves and describing it as the "accepted referral list." (Stewart Expert Decl. ¶ 383.) Similarly, Dr. Brim, a treating psychiatrist at SVPP, testified that the Executive Director told the psychiatry staff earlier this year that there were 20 or so patients on the waitlist, making it difficult to restrict admissions. (Bien Decl. Ex. 82 (Brim Depo. at 38:25-39:3).) Rick Johnson, former Chief of HC-POP, testified that there was no prisoner waiting for inpatient care as of December 17, 2012, but he also conceded that he relied on a summary report from DSH and had never seen the actual DSH Bed Utilization Report. This report, which is filed under seal with this Court, lists all patients' referral dates, acceptance dates, and transfer dates, if transferred. (Bien Decl. Ex. 85 (Johnson Dep. at 25:22-26:5; 59:3-14); Confidential Declaration of Jane Kahn in Support of Plaintiffs' Opposition to Defendants' Motion to Terminate ("Kahn Under Seal Decl.") Exs. 43-44.). The data for December 2012 and January 2013 (Bien Decl. Ex. 73) shows that the majority of the patients currently housed in the DSH programs waited longer than transfer timeframes to get to those inpatient programs, and the vast majority of the patients accepted for a DSH bed in December 2012 and January 2013 were on the waitlist longer than the court-ordered transfer timelines. (Bien Decl. Ex. 106 (Program Guide 12-1-16 Transfer Timelines).)

Secretary Beard acknowledged at his deposition on March 5, 2013, that the waitlist for APP acute psychiatric beds was so substantial that DSH and CDCR had met to plan the opening of another temporary emergency wing in CMF's L-wing. Moreover, this waitlist continues to grow notwithstanding DSH administrative efforts to reduce it by pressuring staff at DSH hospitals to prematurely discharge patients. (Stewart Expert Decl. ¶ 433-434.)

2. Prisoners Requiring Crisis Level Care Are Still Being Placed in Miserable Alternative Cells and Cages

Defendants' policies require that a prisoner in need of suicide observation be referred immediately to an MHCB and placed within 24 hours. (Bien Decl. Ex. 106.).) This standard, developed by Defendants to meet their constitutional obligations, is constantly flouted, due in large part to the ongoing shortage of MHCBs. Defendants rely on the use of alternative placements (including holding cages) and unlicensed infirmaries referred to as Outpatient Housing Units ("OHUs") to house prisoners who should be placed in an MHCB. In December 2012, Dr. Belavich authorized the continued use of OHUs and alternative housing for prisoners who require an MHCB but for whom no bed is available. (Belavich Decl. ¶ 14, Docket No. 4277.) His memorandum lists various types of alternative units which can be used, including holding cells with and without toilets, and even small holding cages where a prisoner can only sit on the ground or stand. (*Id.* Ex. 3 at 2-3.)

Dr. Belavich testified that, in order to operate the CDCR's mental health delivery system with the resources he was provided, CDCR has to use these small cages. (Bien Decl. Ex. 81 (Belavich Dep. at 233:4-9).) Figure 1, below, is the photograph Dr. Belavich was testifying about. It is a photograph of a holding cage, which was taken at RJD on February 12, 2013:

Figure 1 (Bien Decl. Ex. 102.)

This is exactly the sort of holding cage that the Supreme Court found shocking in *Plata*. *See* 131 S. Ct. at 1924 ("Because of a shortage of treatment beds, suicidal inmates may be held for prolonged periods in telephone-booth sized cages without toilets." (attaching photo to Court's decision)).

The use of unsafe alternative placements is pervasive. During the last 32 weeks of 2012 (from May 18, 2012, through December 27, 2012), there were a total of 2,429 such alternative placements systemwide. (Bien Decl. Ex. 51.) 729 of those alternative placements lasted for more than 24 hours, in contravention of the *Coleman* Program Guide standard. These alternative placements continued in significant numbers through the last week of December 2012, the last week for which data have been made available. (Stewart Expert Decl. ¶¶ 199-206.) Many of the alternative placements are physically unsafe for suicidal prisoners; all are harsh and punitive. (*Id*. ¶¶ 200-202.)

Defendants also use unlicensed OHUs to house prisoners who report suicidal ideation but cannot be placed into an MHCB due to the lack of an available bed. Between May and December 2012, a total of 1,120 prisoners were placed in an OHU; only 354 of those prisoners were ever transferred to an MHCB. (Bien Decl. Ex. 74.) Conditions in OHUs are terrible. Lindsay Hayes, a suicide consultant for CDCR, toured three of

Defendants' OHUs prior to issuing his August 2011 report. He found conditions in all three concerning. Regarding the OHU at DVI, he noted:

> I remember [it] distinctly because there was this very foul smell when we walked around the unit. And it was – I was told it was the aftermath of pepper spray that was dispensed on the – in the administrative Seg side of it. But it had filtered on to the overflow unit … they were very dangerous cells. There might have been some minor lighting, but that could have been just the light from the outside cell block. You could not see very clearly into the cells. They were not suicide-resistant … the bunks were very dangerous, and there were unsafe ventilation grates.

(Bien Decl. Ex. 84 (Hayes Dep. at 82:19-84:18).)

When Plaintiffs' expert Craig Haney toured the MCSP OHU on February 7, 2013, he noted that it remained relatively unchanged since his last visit in 2007, with completely barren cells that require a prisoner to sit and sleep on the floor. (Haney Expert Report ¶ 111 & Photo Ex. M.) Dr. Haney also toured the CCI OHU on February 22, 2013. Conditions in this OHU are similarly harsh, with men lying on the floor in barren cells and being placed in cages regardless of their security status. (Haney Expert Decl. ¶¶ 245-247, 274-275 & Photo Exs. DD, EE, KK.) Mr. Hayes was especially concerned that the harsh conditions in these OHUs would be a deterrent for prisoners to tell someone when they were in psychiatric crisis. (Bien Decl. Ex. 84 (Hayes Dep. at 65:20-66:17).)

Clinicians systemwide have been instructed for many years to contact HC-POP if they need assistance finding an available MHCB for a patient, either because their prison has no MHCB unit or its MHCB unit is full. (Bien Decl. Ex. 95.) These requests have been tracked by HC-POP, and were documented on a chart prepared by Plaintiffs for the overcrowding trial in Plaintiffs' Exhibit P-263. (Bien Decl. Ex. 75 (Copy of Ex. P-263).) At the time of the trial in August 2008, there were 322 prisoners referred to HC-POP by local clinicians for an available MHCB; of these 322 prisoners, 135 were placed in an MHCB by HC-POP. (*Id.*) In the most recent report provided by Defendants showing January 2013 data, there were 332 MHCB prisoners referred to HC-POP by local clinicians seeking an available MHCB, of which only 155 were placed. (Bien Decl. Ex. 66.) Very little has changed in the past four years for local clinicians seeking to find

an available MHCB for their patients who need critical crisis bed care. These clinicians are forced to place their suicidal patients in cages, holding cells, and unlicensed infirmaries due to unavailable MHCBs. This has become the new "normal," one far removed from the constitutional standard.

F. Severe Clinical Staffing Shortages In DSH Are Making Delivery Of Care Impossible, And Staff Are Pressured to Prematurely Discharge Still Sick Patients

Defendants' psychiatric inpatient hospital programs are experiencing a dangerous shortage of clinical staff that has undermined the ability of DSH clinicians to provide minimally adequate care to their CDCR patients. DSH hospitals, unable to hire staff due to the Governor's Hiring Freeze and budget cutting and, at the same time, under pressure to reduce their waitlists for the purposes of this termination motion, have been providing inadequate care to patients and discharging them prematurely. These current and ongoing violations are just the latest entries in Defendants' long and sordid history of denying, delaying or otherwise interfering with timely access to inpatient psychiatric hospitalization for members of the *Coleman* class.

Defendants, for at least a year and perhaps longer, have allowed SVPP and other state hospital programs serving *Coleman* class members to become dangerously understaffed. DSH also apparently slowed or stopped efforts to replace employees who retired or transferred elsewhere and limited the use of contractors. (Stewart Expert Decl. ¶¶ 51-56.) DSH also chose to pursue "cost savings" by reducing the ratio of clinical staffing in its programs, without informing this Court and with great detriment to patient health and safety. (Bien Decl. Ex. 108.)

The result has been extreme levels of understaffing which have transformed the DSH programs from places where CDCR patients receive critically necessary intensive treatment to dangerous locations where clinicians are so overloaded that they can provide only crisis and emergency care. And even crisis care has proven difficult for the limited staff, as shown by an avoidable and horrific suicide at SVPP in late November 2012. (*See* Stewart Expert Decl. ¶¶ 436-444, 448; Kahn Under Seal Decl. Ex. 42 (Prisoner A Suicide

Report) (filed under seal).) Dr. John Brim, an SVPP psychiatrist who testified on March 1, 2013, confirmed that patients at SVPP are receiving approximately one hour a day of group treatment—less than what they received in the past; the SVPP program is designed to provide 20 to 35 hours of treatment each week. (Bien Decl. Ex. 82 (Brim Dep. at 91:6-92:18).) Staff and patient assaults at SVPP have increased significantly as a direct result of understaffing and the inability of the overwhelmed clinical staff to spend enough time with the patients. (Bien Decl. Ex. 82 (Brim Dep. at 77:14-80:14; Bien Decl. Ex. 107).)

After their multiple requests to management for help went unanswered, each of the nine psychiatrists at SVPP signed and sent a letter to the Executive Director of SVPP on January 23, 2013, stating that current staffing was not safe or appropriate and that given their large careloads, "patient safety was at stake." When that went unanswered, SVPP psychiatrists signed and sent second letter on February 12, 2013, stating that the SVPP psychiatrist staff shortage had "devolved" to a "crisis level" and demanding that DSH take steps to hire additional staff and use contractors to protect the health and safety of the patients. (*See* Bien Decl. Exs. 111 & 112.) The psychiatrists requested that pending the hiring of additional clinical staff, SVPP be closed to new admissions, so that they could address the needs and ensure the safety of the existing patients. Dr. Brim testified that the psychiatrists continue to be:

> … under pressure from administration to move the old people out—the old patients out and take in new patients so as to keep our waiting list down. And many of the psychiatrists—well, I would say all—felt that this was resulting in shorter stay for patients than historically had been the case. And they felt that it was getting to the point that people were not staying in all cases at least as long as they needed to. There was pressure from administration to get them out quickly so that new people could be brought in.

(Bien Decl. Ex. 82 (Brim Dep. at 17:25-19:4).)

Dr. Brim also testified that there were shortages of other disciplines of clinicians at SVPP, such as social workers, psychologists and rehab therapists, and they too were experiencing shortages and had complained to management. (*Id.* at 23:7-19, 24:11-25:9, 25:13-22).) He also confirmed reports that to save money, CDCR and DSH had even

stopped supplying clean clothes, laundry service, bedding, coats and clothing to the CDCR patients in SVPP. (*Id.* at 61:13-62:7.) Plaintiffs' expert Dr. Stewart found severe problems with DSH treatment related to staff shortages. (Stewart Expert Decl. ¶¶ 51-56, 431-451.)

A critical piece of Defendants' termination motion is their claim that the SVPP waitlist no longer exists. Johnson Decl. ¶ 3, Docket No. 4276-2. Plaintiffs' counsel, several times in 2012, raised the issue of clinical understaffing of the DSH programs with Defendants. The monthly staffing information provided by Defendants, plus reports from *Coleman* class members, indicated that there was a serious problem. Each time Plaintiffs raised the issue, however, Defendants assured the Special Master and Plaintiffs' counsel that there was no problem, there were errors in their own monthly staffing data, and that the programs were, in fact, fully staffed. Plaintiffs' counsel raised the issue again in December 2012, after the horrific November 2012 suicide, and was again told that there was nothing to worry about and that the program was properly staffed. (*See* Bien Decl. ¶ 105 & Ex. 105.)

Plaintiffs' experts discovered many prisoners in MHCB and other CDCR units that had recently returned from DSH programs, but were quite unstable. (*See* Stewart Expert Decl. ¶ 433 (listing seven cases of apparently premature DSH returns to CDCR encountered in various CDCR prisons during recent inspection tours).) CDCR clinicians repeatedly expressed their belief that they were seeing premature discharges from DSH. (Stewart Expert Decl. ¶ 398 (discussing barriers and delays in access to inpatient care), ¶¶ 399-400 (discussing patients labeled as "DSH failures"), ¶¶ 406, 409, 411, 433.) A recent suicide in 2013 of a CDCR prisoner within weeks of his discharge from ASH raises the issue again. (Kahn Under Seal Decl. Ex. 46; *see also* Stewart Expert Decl. ¶¶ 92, 95, 97, 231-251.)

This Court has ordered that Defendants continue operating all of the temporary, emergency inpatient and MHCB programs unless and until they can demonstrate that they are no longer necessary. (Docket No. 1800.) Yet Defendants have made presentations at

SVPP (and, in all likelihood, at ASH and CMF as well), recruiting for the new Stockton facility and explaining that it will soon replace the temporary emergency units at CMF and SVPP. The message was clear: half of the staff will be laid off, but there would be openings at Stockton later in 2013. The result was that numerous DSH staff have retired, transferred or given notice and have not been replaced. (Bien Decl. Ex. 82 (Brim Dep. at 20:13-23:6).) Defendants are currently violating the Court's order and the order requiring them to maintain their staffing ratios, and have been misleading the Court and the Special Master.

This Court has been required to issue numerous orders over many years requiring Defendants to provide prompt access to appropriate levels of inpatient psychiatric hospitalization. The current DSH staffing crisis is powerful evidence of ongoing constitutional violations as to a critical part of the mental health delivery system for *Coleman* class members. It is also evidence of systemic deliberate indifference at the highest levels of CDCR, DSH, and the Governor's Office.

G. Defendants' Suicide Prevention and Emergency Response Practices Violate the Eighth Amendment by Putting Lives at Serious Risk.

It is undisputed that California prisoners commit suicide at a rate far above the national average prison suicide rate. The Special Master's expert, a nationally recognized authority on suicide prevention, found that more than 70% of the suicides in 2011 were foreseeable and/or preventable. (Special Master's Report on CDCR Suicides in Calendar Year 2011 (hereinafter "2011 Suicide Report") at 3, Docket No. 4308, Jan. 25, 2013.) For the first half of 2012, 73% of the 15 suicides were determined to be either foreseeable or preventable. (Special Master's Report on Suicides Completed in the CDCR January 1, 2012 – June 30, 2012 (hereinafter "First Half 2012 Suicide Report") at 4, Docket No. 4376, Mar. 13, 2013.) Moreover, both CDCR's overall suicide rate and the percentage of CDCR's suicides that are foreseeable and/or preventable have remained high for several years. (*Id.* at 7.) During the first six months of 2012, a CDCR inmate died by suicide every 11.4 days on average. (*Id.* at 2.)

1. Defendant Officials Have Refused to Implement Life-Saving Suicide Prevention Measures Recommended by Their Own Experts.

Defendants claim to "have fully implemented programs to identify, treat, and supervise inmates at risk for suicide" and assert that their experts found "[e]specially impressive" the State's system wide attention to suicide prevention. (Defs. Motion at 22-23.) The truth is that they have deliberately and intentionally ignored the recommendations of the Special Master, this Court's orders, and the analysis of their own suicide prevention consultant, Lindsay Hayes. (*See* First Half 2012 Suicide Report at 22-23 ("The same recommendations have been made repeatedly… It is absolutely unacceptable that such recommendations have not been implemented and realized by CDCR.").)

Mr. Hayes' consultancy with CDCR on suicide prevention speaks volumes about Defendants' purported "massive and admirable commitment in suicide prevent." (Defs' Joint Report at 37.) In 2010, Defendants hired Mr. Hayes to provide "Suicide Expert Consultant Services for CDCR's Suicide Prevention Program." As articulated by CDCR, "[Mr. Hayes]'s experience (more than 25 years) with correctional suicide prevention programs will allow the CDCR to make immediate, short-term, and long-term changes in its suicide prevention program to begin to decrease the overall rate of suicide over the long-term. This consultation will allow the CDCR to implement a more effective suicide prevention policy and demonstrate to the *Coleman* court its resolve to deal with an issue that impedes its ability to resolve the litigation." (Bien Decl. Ex. 113 at 1.) As CDCR's suicide prevention consultant, Mr. Hayes came to California, toured three prisons, met with CDCR officials, reviewed policies, procedures, and practices, and analyzed suicide reports for 25 of the 35 suicides that occurred in 2010. Then, as required by the contract, Mr. Hayes provided CDCR with his preliminary recommendations on January 30, 2011, followed by a final report with his recommendations on August 16, 2011. (*Id.*) The contract provided for one- and two-year follow ups, and then a consultation in year three, to be followed by an additional final report including recommendations for long-term

changes. (*Id.* at 3.)

Mr. Hayes' August 2011 report set forth the statistics on suicides in California prisons, an analysis of the causes and contributing factors to the high suicide rate, and a number of straightforward recommendations. After Mr. Hayes submitted his August 16, 2011 report to Defendants, however, CDCR "buried" the report and has not requested any additional services from him despite the significant further steps contemplated by the contract. (*See* Order, Document No. 4341, at 5:3-7, Feb. 14, 2013; Bien Decl. Ex. 28 (e-mail from Robert Canning to Mr. Hayes stating that "[o]bviously when your report landed it was not roundly applauded and in fact was buried.")) Mr. Hayes' August 2011 Report and Recommendations were also hidden from the Special Master and this Court, as well as from Defendants' own experts, by orders that came from the highest levels of state government. (Bien Decl. Ex. 81 (Belavich Dep. at 28:10-14 (noting that individuals above Dr. Toche made the decision about whether to continue to use Hayes' consulting services after his report was issued)); Ex. 80 (Beard Dep. at 192: 16-23; 194:1-7 (stating that he was provided Hayes report by Ben Rice, Chief Counsel, but told it was an attorney-client privilege and not to talk to the Special Master about it); Ex. 83 (Dvoksin Dep. at 49:24-50:11 (stating that he was not provided the Hayes report until 2013)).

Defendants, rather than implement the life-saving recommendations that have been repeatedly put forward by nationally-recognized experts and consultants, resort to unacceptable excuses and explanations for their failures. They claim that they "have done all they can do," or that these avoidable and unnecessary deaths can be ascribed to causes "beyond our control." The suicide rate is attributed by these officials, as well as Defendants' termination experts, to "gangs," the ethnicity of CDCR prisoners, and even to Realignment. (Response to Special Master's Report on 2011 Suicides, by Joel Dvoskin, Docket No. 4326-6, Feb. 11, 2013 at 5; Defs.' Objs. & Mot. to Strike Portions of Special Master's Report on 2011 Suicides at 8:23-9:3, Docket No. 4326 ("So while the overall prison population has decreased, the offenders most prone to committing suicide have remained in prison.").) If anything, Defendants' strange demographic-based excuses for

their high suicide rate is further evidence of deliberate indifference. They claim to have knowledge of higher risks in certain groups, but nonetheless have come forward with no plan to address such higher risks. (*See* First Half 2012 Suicide Report at 15.)

At the same time as they have shirked responsibility for suicide prevention measures, Defendants have implemented punitive practices in their MHCBs and the alternative placements (cages and barren cells with no beds) where prisoners linger while waiting for an MHCB, all of which discourage individuals experiencing suicidal ideation from coming forward for assistance. (Kaufman Expert Decl. ¶ 90; Stewart Expert Decl. ¶¶ 192-262; Bien Decl. Ex. 50 (Hayes 08/16/2011 Report) at 5.) Plaintiffs' experts have expressed great concern about excessive and unnecessary punitive practices in these settings, commenting that such practices can cause patients to become more suicidal, but "nonetheless to conceal their suicidal ideation in order to avoid feeling dehumanized in the treatment setting." (Kaufman Expert Decl. ¶ 90.) Indeed, Defendants' own experts agree with Mr. Hayes' recommendations. (Bien Decl. Ex. 83 (Dvoskin Dep. at 173:2-174:7); Ex. 88 (Moore Dep. at 196:8-197:2, 258:13-259:15).) Yet Defendants' harsh and dangerous practices persist.

CDCR's resistance to follow important recommendations for suicide prevention is in keeping with its past practice. CDCR has chronically failed to implement suicide prevention measures recommended by the Special Master's suicide expert, who noted that:

> The same recommendations have been made repeatedly, beginning as early as the 1999 Suicide Report and up to and including the most recently submitted 2011 Suicide Report. It is absolutely unacceptable that such recommendations have not been implemented and realized. No matter how many times these recommendations are reiterated, they continue to go unheeded year after year, while the suicides among CDCR inmates continue unabated, and is worsening, as manifested by suicide rates that inch ever higher over the past several years.

(First Half 2012 Suicide Report at 22.) For almost two decades of review, the Special Master has found failures by CDCR clinicians in the area of suicide prevention. The installation of suicide-resistant beds in MHCBs is a case in point. Despite advice from their suicide consultant regarding the impact of these punitive measures, Defendants

vigorously resisted the Special Master's recommendation to install suicide-resistant beds in their MHCBs so that suicidal men and women would not be forced to sleep on the floor. Those beds were installed in MHCBs only after this Court ordered Defendants to do so. Order, Docket No. 4044, July 27, 2011.

More recently, the Special Master has reported that Defendants have failed to implement other critical life-saving measures in administrative segregation units, including 30-minute welfare checks for all segregation prisoners, mental health screening, and basic elements of mental health care such as confidential mental health interviews. (Special Master's 25th Round Report at 36-38.) The suicide rate among CDCR's administrative segregation population in 2012 was 157 per 100,000, the same as it was in 2007, and increased from 2011. (*See* Kahn Decl. ¶ 8 & Ex. I, Docket No. 4325, Feb. 11, 2013.) Although the ASU population is about 5.8 percent of the overall prison population, 26.5 percent of the 2011 suicides and 34 percent of the 2012 suicides occurred in ASUs. (*See id*.)

The 2011 Suicide Report also found that in 50% of the suicides, suicide risk evaluations were either not done, or were done inadequately. As a result, interventions that could have saved lives were not implemented. (2011 Suicide Report at 3.) The suicide risk evaluation ("SRE") is a checklist utilized by a clinician to assess the level of risk of suicide when a prisoner expresses current suicidal ideation, makes a suicide threat or attempt, when a prisoner is admitted or discharged from higher levels of care, and any time a newly arriving prisoner indicates a current or significant history of suicide risk factors. Kahn Decl. ¶ 10, Docket No. 4350-1.

Defendants' most recent plan to address these failures, the August 2010 Updated Report, includes their Proctor-Mentor Program ("PMP"), which Dr. Belavich, then acting Deputy Director of Mental Health, testified had been developed and implemented at all prisons. (Kahn 2/11/13 Decl., Docket 4325, Ex. A; Belavich Decl. ¶ 24.) Defendants have failed to fully implement this program more than two years later. (Kaufman Expert Decl. ¶ 93.) Documents produced by Defendants in the last few weeks demonstrate that, in fact,

steps toward implementation of this process were delayed, rushed, and appear to be litigation-focused. For example, on January 19, 2013, ten days prior to Plaintiffs' expert visit to CSP-Sacramento, Shama Chaiken, the Chief of Mental Health at CSP-Sacramento, along with other Mental Health Chiefs, received an email from the Supervisor of the Proctor-Mentor Program telling them that: "Suicide remains 'the low hanging fruit' for coleman. [sic] Please MAKE SURE your SRE Mentor Program is up and running." In response, Dr. Chaiken wrote that the proctor-mentor program had "been on the back burner" and promised to "come up with an implementation plan next week." (Bien Decl. Ex. 61 (Emails re: Status of Proctor-Mentor SRE Program, January 2013).) Later, she sent an email to her staff suggesting that the mentoring program was being implemented more for the benefit of litigation than for its substance, noting that "for experienced staff, it takes about an hour," and that "the folks who are mentored … can then become mentors for others the following week." She then told them that "we need to make some progress by the time the plaintiff attorneys come out the following" week. (*Id.*; *see also* Haney Expert Decl. ¶¶ 115-117 (MCSP SRE training "kick off" eight days before Plaintiffs' expert tour).)

It is of constitutional significance that Defendants continue to ignore essential suicide prevention steps identified as necessary by their own consultants, to delay implementation, and to deliberately short-staff their system. These deliberate actions contradict the termination experts' characterization of a "passionate interest in preventing suicide." (*See* Defs.' Joint Report at 2.) Rather, the evidence shows that in every area of suicide prevention CDCR is starving the system of resources, putting more lives at risk.

2. CDCR's Emergency Response Practices Fall Far Short of Constitutional Minima

"The constitutional requirement that defendants provide inmates with a system of ready access to adequate medical care" includes an "adequate system for responding to emergencies." *Coleman*, 912 F. Supp. at 1308 (citations and internal quotation marks omitted). Defendants make only a passing reference to this important constitutional

obligation in their motion. (*See* Defs. Motion at 22-23.) Unfortunately, and with lethal consequences, Defendants again ignore reality. Defendants' performance on emergency response is woefully inadequate and has contributed to the high risk of serious harm and death.

Defendants' expert Moore testified that she conducted a review of CDCR's emergency response practices, recognizing it as a component of an effective suicide prevention program. She testified that she found problems with emergency response in suicides she reviewed for the years 2010, 2011, and 2012. (Bien Decl. Ex. 88 (Moore Dep. Tr. 195:5-198:14).) Moore reviewed specific cases involving emergency response during her tours. At CSP-LAC, for example, she reviewed seven (7) cases involving emergency response and found "inadequate emergency response time" in five (5) of those cases. She testified that this finding was consistent with what she observed at "many" of the CDCR institutions she toured. (*Id.* (Moore Dep. 198:19-201:21).) In fact, *Moore disagreed with her own report's finding* on "Suicide Prevention" (Defs.' Joint Report at 31, Section B, Subsection 3) that the "response to mental health-related emergencies was timely and appropriate in each institution." (Bien Decl. Ex. 88 (Moore Dep. at 244:14-20).)

Other experts who have reviewed the issue agree. In his review of CDCR suicides in 2010, CDCR suicide prevention consultant Lindsay Hayes found that 28% of 2010 suicides involved problems with the emergency response. (Bien Decl. Ex. 50 (Hayes 08/16/2011 Report) at 2.) Moore agreed with Mr. Hayes' findings. (Bien Decl. Ex. 88 (Moore Dep. at 196:8-197:2).) Dr. Patterson, the Special Master's expert, found that, in 16 of the 34 suicides (47.1%) that occurred in CDCR in 2011, emergency response was not performed in a timely and/or appropriate manner. (2011 Suicide Report at 3.) Twenty-seven percent of CDCR prisoner suicides from the first half of 2012 involved the same deficiency in emergency response. (First Half 2012 Suicide Report at 4.)

All the evidence demonstrates that Defendants are nowhere near meeting their constitutional obligations with respect to emergency response; human lives almost certainly have been, and will continue to be, the cost of their failure.

H. Segregation (Administrative Segregation Units (ASUs) and Security Housing Units (SHUs))

Segregation units continue to be extremely high-risk settings for all prisoners, with an astronomical risk of suicide, needless psychological suffering, and pervasive constitutional violations. (*See* CDCR Suicide Rates: ASU vs. Systemwide Chart, *Coleman* Docket No. 4325, Ex. I (showing that suicide rate in CDCR ASUs since 2007 has been between 129 and 229 per 100,000 – that is, between six (6) and nine (9) times greater than the already high CDCR systemwide suicide rate); 2011 Suicide Report at 10.) This problem has persisted for years. (Special Master's Report on Suicides Completed in CDCR in Calendar Year 2004 at 12, Docket No. 1806, May 9, 2006 (finding that, in 2004, 69.2% of suicides (18 of 26) occurred in administrative segregation, up from an already high 48.5% in 2003 (17 of 35), and that a majority of the suicides completed in administrative segregation involved inmates who were not on the mental health caseload at the time of their deaths (11 in 2003; 10 in 2004)); Order, Docket No. 1830, June 8, 2006 (directing Defendants to develop a plan for "dealing with the escalating percentage of suicides occurring in administrative segregation units" and to "provide adequate resources of mental health and/or custody staff, create sufficient confidential interview space and/or enhance the quality of mental health services provided in administrative segregation units," as appropriate).)

There is no dispute in this case that CDCR's segregation units continue to be an exceedingly high-risk, non-therapeutic environment for every person placed in those units. Defendants' experts, staff, and consultants are all in agreement. (*See* Defs.' Joint Report at 35-36 ("Administrative Segregation Units (including ASU/EOP hubs) remain a high-risk environment, including inmates who were not previously identified as mental health clients, as well as inmates who were assigned to the CCCMS and EOP levels of care."); Bien Decl. Ex. 3 (CDCR Suicides: Results of Recent Analysis, dated Jan. 25, 2013) at 1 (CDCR Suicide Prevention Coordinator's internal memorandum finding that "Segregated settings have traditionally been considered higher risk settings when it comes to

suicide.")); Bien Decl. Ex. 50 (Hayes 08/16/2011 Report) at 2 (finding that "there is a disproportionate number of inmate suicides occurring within ASU cells").) The Special Master and Plaintiffs' experts have reached the same conclusion. (*See* First Half 2012 Suicide Report at 16, Docket No. 4376 (finding the rate of suicide in segregated housing to be "staggering"); Special's Master Report on Defs.' Review of Suicide Prevention Policies, Practices, and Procedures at 9, Docket No. 3918, Sept. 27, 2010 (noting "elevated risk of suicide found in administrative segregation and other secured housing units"); Haney Expert Decl. ¶¶ 36-43; Stewart Expert Decl. ¶¶ 178-183, 274-282, 285-347; Kaufman Expert Decl. ¶¶ 95, 125-26.)

Defendants now assert, *without* citing to specific evidence or providing any discussion, that "[t]here is no evidence that mentally ill inmates housed in [segregation] settings are being denied appropriate treatment." (Defs. Motion at 23.) The evidence establishes the complete falsity of this statement. Needless suffering and death continue to plague segregation units through the CDCR system: (1) prisoners are being placed in harsh segregation for non-disciplinary reasons, such as safety concerns and "lack of beds" appropriate to meet individual mental health and security needs; (2) mentally ill prisoners are languishing in segregation for excessive periods of time; (3) Defendants continue their dangerous "psych-and-return" practice of placing mentally ill and highly vulnerable prisoners in segregation immediately upon discharge from MHCB or DSH inpatient units, without regard for the high risk of psychological harm; (4) Defendants are failing to provide minimally adequate treatment in appropriate treatment settings for prisoners in segregation; (5) Defendants are failing to implement the minimal standard for conducting welfare checks for all prisoners housed in segregation to address the exceedingly high risk of psychological damage and suicide; and (6) Defendants persist in inflicting constitutional harms on mentally ill prisoners in CDCR's Security Housing Units (SHUs). Any one of these problems would be deeply problematic. Together, they constitute a haunting picture of deliberate indifference and constitutional inadequacy.

1. Defendants' Harsh Segregation Units Create an Unacceptable Risk to Prisoners Housed There for Non-Disciplinary Reasons (*i.e.*, Safety Concerns or "Lack of Beds").

There is an enormous and unacceptable risk for the many prisoners housed in segregation for *non-disciplinary* reasons, such as for their own safety or because there is no appropriate bed available in the system that meets their mental health, medical, and security needs. On this issue, there is no debate. (Bien Decl. Ex. 3 (CDCR Suicide Prevention Coordinator noting that "[M]any inmates who housed in ASU at the time of their deaths are placed there not for disciplinary reasons, but for safety reasons…. [P]lacement in ASU of already fearful inmates may only serve to make them even more fearful and anxious, which may precipitate a state of panicked desperation, and the urge to die."); Bien Decl. Ex. 22 ("Suicide Prevention in Administrative Segregation Units: What is Missing" article (CMC psychologist's February 2013 article finding that: "Prisoners placed in the administrative segregation unit for their safety face similar stressors related to being isolated. They also may experience anxiety, fear, and paranoia associated with the initial safety concerns that led to their placement on this unit.")) at 3.)

Defendants' own experts recognized the grave harm that results from placement of prisoners in administrative segregation for non-disciplinary reasons. For example, Defendants' expert Moore reported observing several EOP prisoners placed in the ASU at CIM solely because there was a lack of appropriate beds in the system. She found that these men were "very sick … they were hearing voices or … were having auditory hallucinations or that one inmate was seeing signs of his grandmother. They were sick inmates; they needed to be somewhere else." (Bien Decl. Ex. 88 (Moore Dep. at 166:4-168:9).) Defendants' expert Martin testified that there is "no need" to impose segregation conditions on a prisoner who "doesn't otherwise represent a threat to anybody, but somebody is a threat to him" and that "if there are onerous or punitive conditions, a de facto type of punishment when the offender hasn't done anything [there would be] [d]ue process implications, if nothing else. If not Eighth Amendment …. If the effect of that is corporally, you know, punitive, then I think there's an issue." (Bien Decl. Ex. 86 (Martin

Dep. at 44:8-47:13).)

Defendants' former-suicide prevention consultant Lindsay Hayes likewise agreed. He recalled a 2006 conference with CDCR officials about addressing the risk of suicides in CDCR segregation settings:

> [T]here were non-disciplinary inmates being housed within the Ad-Seg units. And the concern was that they were being managed as if they were disciplinary inmates.
>
> In other words, there was very little movement. In other words, lack of out-of-cell time. Their property was limited. So they were being treated as if they were disciplinary inmates, but they did not have disciplinary orders.
>
> . . . [T]here was a discussion that this could also be one reason why there's a disproportionate number of suicides in the Ad-Seg unit, because inmates in these units were very frustrated, and their mental health was deteriorating, and their stress level was increasing because they're there for reasons other than discipline, and yet they're being treated it as if they were disciplinary inmates and being locked down up to 24 hours a day and not being given yard and normal property.
>
> . . . I think it was a general agreement amongst the folks that were at [the 2006 CDCR] summit conference that this – this could perhaps be one of the reasons why there was this disproportionate number of suicides within the Ad-Seg unit.

(Bien Decl. Ex. 84 (Hayes Dep. at 45:9-46:18).) Yet Defendants have done little to nothing to remedy these grave and dangerous policies and practices.

Defendants' experts made several recommendations in their Joint Report addressing the danger of placing CDCR prisoners in segregation, particularly those housed in segregation solely because they are waiting for a non-segregation EOP bed to open for them. They recommended that, "whenever an inmate is housed in an Administrative Segregation Unit pending transfer to an Enhanced Outpatient Program, that inmate should, in our opinion, be placed at the front of any waiting list for transfer to the next available and appropriate bed." (Defs.' Joint Report at 36.) *Defendants explicitly disagreed and refused to implement their own experts' recommendation*.[2] (Bien Decl. Ex. 92 (Defs.'

[2] Defendants also refused to consider a "non-disciplinary segregation" unit that is less (footnote continued)

Suicide Compendium, dated Jan. 27, 2013) ("Dvoskin Report" section).)

Plaintiffs' experts discovered scores of prisoners held in segregation because there was no appropriate bed for them to be placed. (Because Defendants for some reason do not "count" these prisoners as being in ASU, even though they obviously are, Plaintiffs have no way of knowing the complete magnitude of this practice.) At CIM Plaintiffs' experts observed a giant housing roster board in one segregation unit, on which the vast majority of prisoners were marked "LOB" – "Lack of Beds." (Haney Expert Decl. ¶ 143 & Photo Ex. S.) All these men – many with diagnosed mental illness – were held in segregation not for a disciplinary reason, but because CDCR had nowhere else to put them.[3] (Haney Expert Decl. ¶¶ 143-53; Stewart Expert Decl. ¶¶ 278-282.) Defendants' expert Dvoskin observed the "LOB" problem during his tours, and testified to his concerns about the practice as follows: "That's not okay. Put signs on the door. Figure it out. You shouldn't lock me down if I didn't do anything. It's not fair … It ain't right." (Bien Decl. Ex. 83 (Dvoskin Dep. at 260:22-262:5).) This problem is by no means unique to CIM; in fact, the problem of prisoners housed in dangerous segregation due to "lack of beds" pervades the system. (Haney Expert Decl. ¶¶ 107-110 (MCSP); ¶¶ 217-227 (COR);

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harsh and more conducive to therapeutic objectives for prisoners who are currently being placed in administrative segregation for no reason related to discipline or alleged misconduct. (Bien Decl. Ex. 92 (Defs.' Suicide Compendium, dated Jan. 27, 2013 (second page of chart)).)

[3] This situation is doubly shocking because prisoners housed in the ASU as "LOB" inmates are, for some reason, *not* provided the thirty-minute welfare checks (for the first 21 days) or the pre-placement questionnaire that ***all*** prisoners are supposed to receive when they are placed in ASU. These critical mental health-related practices are, of course, designed to protect the safety and well-being of all prisoners who are placed in the harsh segregation environment and to identify those who are at risk of suicide. Yet, CIM does not designate these prisoners as "ASU prisoners" (as if the designation is what matters), and thus does not provide the suicide prevention safeguards that are critical to keeping vulnerable individuals safe from psychological harm and suicide. (Kaufman Expert Decl. ¶ 98; Haney Expert Decl. ¶ 151.) Such a practice plainly constitutes deliberate indifference to a serious risk of harm, and is frankly unconscionable.

¶¶ 248-257 (CCI); Kaufman Expert Decl. ¶¶ 95-126 (CCWF, CIM, and COR).)

Defendants are gambling with the lives of prisoners who they place in segregation solely because no appropriate beds are available, particularly to prisoners with mental illness. (*See, e.g.*, Stewart Expert Decl. ¶¶ 205, 281.) Almost half of suicides that occurred in Administrative Segregation Units between 2007 and 2012 were by prisoners placed in segregation for "safety" concerns, or awaiting transfer to an appropriate bed in the system. (*See* Kahn Under Seal Decl. Ex. 6; Stewart Expert Decl. ¶¶ 278-279; *see also* First Half 2012 Suicide Report at 65-72 (Inmate L suicide in ASU while awaiting transfer to appropriate bed), *id.* at 80-86 (Inmate N suicide after being placed in segregated housing for his own safety).) That dozens of human beings are dying in segregation after being placed there for their own "safety" should set off loud alarm bells that something must be done. (Stewart Expert Decl. ¶¶ 278-279; Kahn Under Seal Decl. Ex. 6.) Yet Defendants have chosen to do nothing. Such inaction constitutes deliberate indifference.

CDCR's segregation units have potentially dangerous and devastating effects on anyone who is placed in them, and it is unconscionable to expose prisoners, especially those with mental illness, to such dangers simply because the system cannot place them in an appropriate bed. (*See* Haney Expert Decl. ¶¶ 44-50, 280-83; Stewart Expert Decl. ¶¶ 278-82; Kaufman Expert Decl. ¶¶ 95-118.) Defendants' harsh segregation units have long been the storm center for CDCR suicides, and the situation is not improving. A constitutional system that "provide[s] humane conditions of confinement" and "take[s] reasonable measures to guarantee the safety of the inmates," *Farmer*, 511 U.S. at 832, simply does not do this. Yet Defendants have not taken – and refuse to take – necessary steps (even those recommended by their own experts and consultants) to remedy the exceedingly high rate of suicide among CDCR's segregation population, even as the Court has given them multiple opportunities to develop and implement a plan to do so. (*See, e.g.*, Order, Docket No. 3836, Apr. 14, 2010 (directing Defendants to review their suicide prevention policies and practices to address the problem of inmate suicides); Order, Docket No. 2158, Mar. 12, 2007 (directing Defendants to complete a review process to,

inter alia, "examine more effective ways for reducing the lengths of stay of EOP inmates in administrative segregation"); Order, Docket No. 2139, Feb. 12, 2007 (provisionally approving Defendants plan to address problem of suicides in administrative segregation); Order, Docket No. 1830, June 8, 2006; Order, Docket No. 1559, Jan. 12, 2004.)

This practice continues to create an unacceptable risk of harm on the *Coleman* class, and violates the Eighth Amendment.

2. Mentally Ill Prisoners Are Languishing in Segregation for Excessive Periods of Time, Leading to Acute Mental Illness and Elevated Risk of Harm, Including Death.

CDCR houses prisoners with mental illness in segregated housing units for long terms even though lengthy stays in segregation units can be damaging and dangerous for mentally ill prisoners; they are neither safe nor therapeutic places. (*See* Stewart Expert Decl. ¶¶ 274-347.) Defendants' own experts agree. (*See* Bien Decl. Ex. 83 (Dvoskin Dep. at 73:12-15 (agreeing that "long term housing in segregation does cause psychological harm"); Ex. 86 (Martin Dep. at 272:11-273:7); Ex. 88 (Moore Dep. at 166:4-168:9).) Their Joint Report states it clearly:

> Segregation is not a particularly therapeutic environment to house inmates with serious mental disorders, even when EOP level care is provided. We realize that it is sometimes necessary to house inmates with serious mental disorders in an Administrative Segregation Unit in order to ensure the safety of the inmate, other inmates, or staff. *In those cases, housing inmates with serious mental disorders should be as brief as possible and as rare as possible*.

(Defs.' Joint Report at 23 (emphasis added).)

The American Psychiatric Association has found that "[p]rolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates." (Bien Decl. Ex. 14.) Defendants' segregation units continue to be extremely harsh, non-therapeutic places that drive innumerable mentally ill and vulnerable prisoners to mental health crisis and even suicide. (Haney Expert Decl. ¶¶ 36-50, 69-94 (discussing damaging effects of long stays in segregation among mentally ill at MCSP), ¶¶ 143-53 (same at CIM), ¶¶ 217-227 (same at COR), (same

at CCI) ¶¶ 248-68 (same at CCI); ¶¶ 284-86; Kaufman Expert Decl. ¶¶ 119-126 (discussing harmful effects of long-term placements in administrate segregation), ¶¶ 127-38 (discussing harmful effects of excessive SHU terms in extreme isolation); Stewart Expert Decl. ¶¶ 178-83 (discussing high percentage of CDCR suicides in administrative segregation units), ¶¶ 274-77 (discussing need to limit mentally ill prisoners' stay in toxic segregation environment).)

3. Defendants Persist in Their Dangerous "Psych-and-Return" Practice of Placing Mentally Ill Prisoners Back in Segregation Immediately after Discharge from MHCB or DSH Inpatient Units, without Regard for the High Risk of Psychological Harm.

Experience has shown, again and again, that returning mentally ill prisoners who have discharged from MHCB crisis-level care or DSH inpatient care directly back to segregation settings is a dangerous proposition. Defendants, however, regularly do so without regard for the high risk of psychological harm, and suicide, that can result. This practice flouts the requirements in the Court-ordered Program Guide (that Defendants developed to remedy constitutional deficiencies) and violates the Eighth Amendment. (*See* Bien Decl. Ex. 16 (Program Guide 12-5-27 & 28); Ex. 17 (Program Guide 12-6-13).)

In January 2013, a *Coleman* class member with serious mental illness died at SVSP after spending nearly one year at ASH for inpatient psychiatric hospitalization. He was placed directly in segregated housing at SVSP despite clinical documentation that his pre-hospitalization segregation stay was responsible for symptoms that led to his ASH admission. Eight (8) days later, this man was dead. (*See* Kahn Under Seal Decl. Ex. 46.)

In a 2011 case, an 18-year old man admitted for MHCB crisis care "overwhelmed by a series of major losses and stresses," was discharged after 15 days. His clinician recommended that he be placed in an EOP program. The discharging psychiatrist called clinical staff at the institution where this young man had been placed in ASU prior to his MHCB admission to alert them of his need for EOP level of care upon his return. He was instead placed back in the ASU (which had no EOP programming). Fifteen (15) days later, this man committed suicide in the ASU. (2011 Suicide Report, Prisoner N; *see also*

Stewart Expert Decl. ¶ 347 (identifying 4-5 cases where inmate-patients were returned directly from DSH or MHCB to segregation, and finding that "the highly restrictive, anti-therapeutic environments of administrative segregation" "are almost certain to undermine the increased level of functioning and treatment compliance generally achieved through an inpatient placement"); Haney Expert Decl. ¶¶ 119-121 (Prisoner B returned from DSH, placed on suicide observation and then discharged to ASU at MCSP based on odd finding that "[g]iven base rate of 15-20 suicides per 100,000, inmate-patients annually in CDCR, in light of current low risk, per Bayesian analysis, suicide in the foreseeable future secondary to an Axis I disorder not likely"), ¶¶ 165-67 (Prisoner W cycling several times since October 2012 between ASU (safety concerns) and MHCB at CIM); ¶¶ 226 (Prisoner JJ cycling between ASU and MHCB at COR, feeling "suicidal and homicidal all the time," with clinician reporting that Prisoner JJ has "been here too long" and "debating" whether to send him back to DSH).)

4. Defendants Do Not Provide Remotely Adequate Treatment in Appropriate Settings for Mentally Ill Prisoners in Segregation.

Deficiencies in the staffing, clinical space, and quality of mental health services for treatment of mentally ill prisoners in segregation are longstanding, well-documented and (unfortunately for the *Coleman* class) still without a remedy despite past court orders. (*See, e.g.*, Special Master's 25th Round Report at 36-38 & 44-48; Order, Docket No. 1830, June 8, 2006.)

a. Staffing Shortages Make the Delivery of Necessary Mental Health Services in Segregation Impossible.

The inadequacy of clinical and custody staff in segregation units is conspicuous, is in some cases worsening, and has prevented the delivery of adequate mental health care to *Coleman* class members housed in those units. (*See also* Section IV.C above.) For example:

- At CCWF, "[t]he warden said CCWF has been unable to fully accomplish its new mission as an EOP administrative segregation 'hub' because of inadequate clinical

staff; she also noted that the institution does not have 'the authority to hire' the necessary additional staff to fulfill its mission." There are waitlists for ASU treatment groups, and clinicians must do therapy at cell-front due to escort officer staff shortages. (Kaufman Expert Decl. ¶¶ 28-31.)

- At CIM, the ASU faces treatment challenges due to lack of psychiatrists. (Kaufman Expert Decl. ¶ 37.) The institution reported that CIM's ASU "was significantly impacted by staffing issues created by the AB 109 mission change," with "disrupted continuity and chronic understaffing of the program" resulting. (Bien Decl. Ex. 19, at 8 of 21 (CIM 25th Round Management Report).)
- At COR, the Special Master reported that the "insufficient numbers of access to care officers" has made it difficult for clinicians to see their patients and resulted in a lack of group therapy in segregation units. (Special Master's 25th Round Report at 220-21.) Plaintiffs' experts were informed that the institution has "no mainline or Ad Seg groups for CCCMS inmates because of staff shortages." (Haney Expert Decl. ¶¶ 192-94; Kaufman Expert Decl. ¶¶ 43-44.)
- At CCI, a single clinician is responsible for providing treatment to 46 ASU inmate-patients (each of whom she is supposed to have substantive clinical contact with each week). She is also charged with doing all RVR mental health assessments at the prison. She said that, on average, she does 10-12 one-to-one contacts per day, severely limiting the time and quality of the treatment she can provide. (Haney Expert Decl. ¶ 239.)
- At MCSP, staffing shortages appear to play a role in the inadequate suicide risk evaluations being done, and in the lengthy delay in beginning (much less completing) the SRE training program developed by Defendants in 2010. Suicide risk assessments and suicide prevention efforts in the ASU were extremely problematic. (Haney Expert Decl. ¶¶ 115-21.)
- At LAC, staffing shortages are negatively impacting the delivery of treatment in the EOP ASU. (Stewart Expert Decl. ¶¶ 104, 109, 323.)
- At SAC, staffing shortages are negatively impacting the delivery of treatment in the EOP ASU. (Stewart Expert Decl. ¶¶ 87-88, 313-15.)

Despite the Court's June 8, *2006* order aimed at this issue, staffing shortages still prevent the delivery of minimally adequate, constitutional mental health care to class members in segregation.

b. Inadequate Clinical Space to Provide Appropriate, Confidential Treatment in Segregation

Given the inappropriate clinical space necessary to provide privacy and confidentiality, any treatment that is being provided in segregation units is seriously

compromised. (*See* Special Master's 25th Round Report at 37 ("Patient candor is necessary to a successful clinical interaction, but no patient can reasonably be expected to communicate openly unless he or she is afforded a private treatment setting. All [segregation] hub institutions must look critically at their own space resources and maximize their own capacities to provide a private, confidential environment for patients to communicate openly with clinicians and fellow therapeutic group members.")).

Clinical space problems persist across the system's segregation units. (*See* Bien Decl. Ex. 88, Moore Dep. Tr. at 162:11-164:5 (expressing concern about use of non-confidential space for clinical contacts in segregation unit and opining that it affects treatment); Haney Expert Decl. ¶¶ 74-75 & Photo Ex. A (inadequate treatment space in MCSP's EOP ASU with planned treatment space construction still a fenced-off, weed-filled, vacant lot), ¶ 135 & Photo Ex. Q (oppressive treatment space in CIM's ASU and its impact on inmate-patients' participation in treatment), ¶¶ 179-81 & 185-86 (COR's ASU and SHU treatment space in "property/supply storage" room and other inadequate spaces), ¶ 240 & Photo Ex. CC (CCI's ASU and SHU group treatment conducted in a row of cages in old dining hall that is cold and has very loud blower or industrial fan); Kaufman Expert Decl. ¶¶ 56-58 & Photo Ex. C (group treatment space deficiencies in segregation units at CCWF and CIM), ¶¶ 61-64 & Photo Ex. E (at COR, treatment provided in converted space with no auditory privacy and in dirty concrete room with exposed pipes, a broken computer, and very harsh light); Stewart Expert Decl. ¶¶ 74, 300-301 (EOP ASU treatment space problems at SVSP), ¶ 112 & Appx. B, C, D, E (inadequate office and treatment space in EOP ASU at RJD), ¶ 113 & Appx. F, G (treatment space deficiencies in EOP ASU at LAC).)

To the extent Defendants claim to be working to build and/or improve clinical space for mentally ill prisoners in segregation units, *see* Defs. Motion at 6-7, this necessary step towards providing constitutional treatment is many years away. (*See* Section III.C above.)

c. Lack of Meaningful, Therapeutic Mental Health Treatment in Segregation

Defendants' provision of meaningful, therapeutic mental health treatment in segregation units also remains shockingly inadequate and unconstitutional.

First, Defendants persist in their prolific use of cages for treatment of all prisoners in segregation, regardless of whether they are there for disciplinary reasons, safety concerns, or simply because there is no appropriate bed available for them in CDCR's system. This essentially universal use of treatment cages in segregation units, even when there is no documented need for them, is counter-therapeutic and inhumane, particularly for mentally ill prisoners. (Kaufman Expert Decl. ¶ 86.) Indeed, the harmful effects on mental health and counterproductive effect on treatment are unmistakable. (Haney Expert Decl. ¶ 83 (Prisoner F, in ASU for safety concerns, stating "I don't like the [treatment] cages. I feel like a dog, like an animal—so I don't usually go out; if I see my clinician, I see her at my cell front"), ¶ 133 (discussing very high refusal rate for caged treatment at CIM); ¶ 149 (Prisoner Q, in CIM ASU due to "Lack of Bed," stating "who wants to come out for 'therapy' in a cage? You feel non-human."), ¶ 179 (COR ASU inmate-patient stating "when I am in a cage I feel like an animal"), ¶ 182 & Photo Ex. Z & AA (COR officer first refusing Plaintiffs' expert's request to take photographs from inside of treatment cage during tour, and his supervisor explaining "you know, our officers don't like to get inside those things"); *see also* Haney Expert Decl. Photo Exs. B, E, Q, CC.)

Defendants' expert Jacqueline Moore stated that she had worked in no prisons outside of California that used treatment cages (euphemistically called "therapeutic modules") for individual treatment. The first time she saw them in a California prison, at CSP-SAC, she wrote "cages – terrible hard metal stools. Hard to be in cage for two hours." (Bien Decl. Ex. 88 (Moore Dep. at 154:10-156:21).) Defendants' expert Dvoskin also found that it was "not necessary for all inmates to be in a module" to receive treatment." He stated that "[i]f somebody's in ad seg for their personal protection, it makes no sense whatsoever to me to require them to be in a module." (Bien Decl. Ex. 83

(Dvoskin Dep. at 283:15-284:10).) Yet Defendants do just that.

The experts for *both* parties also identified issues with the substance of the treatment provided to *Coleman* class members. Defendants' experts "observed some groups that appeared to consist primarily of showing the inmate a movie or entertainment video.… We understand that recreation and entertainment may be an appropriate aspect of group therapy, so long as the majority of group therapy time is devoted to psycho-therapeutic, rehabilitative, skill building, and psychoeducational activities." (Defs.' Joint Report at 17-18.) Yet the overuse of "recreation and entertainment" in place of meaningful treatment, and treatment delivered by non-clinical staff, is apparent in many segregation units. (*See* Kaufman Expert Decl. ¶¶ 150-53; Haney Expert Decl. ¶¶ 76, 79-83 & Photo Ex. D (MCSP, with photograph of EOP ASU treatment area with *Titanic* video), 140 (inadequate CIM ASU treatment), 202-03, (COR EOP ASU and SHU treatment deficiencies), 207-09 (COR SHU, including Plaintiffs' expert observing treatment group that consisted of showing inmate-patients a commercial film), 240-41 (CCI ASU and SHU treatment deficiencies).) Such activities may be useful and important to humane treatment in generally harsh isolation settings. But they do not substitute for meaningful mental health treatment, which remains painfully lacking in segregation units.

Defendants' mental health system fails to provide a sufficient amount of structured therapeutic activity in segregation units even in the eyes of Defendants' experts, much less as is required under Program Guide standards. (Bien Decl. Ex. 88 (Moore Dep. at 237:25-238:24); Bien Decl. Ex. 83 (Dvoskin Dep. at 259:1-20); Special Master's 25th Round Report at 37 ("Another concerning finding at the hubs was that ten of the 11 hubs failed to offer at least ten hours per week of structured therapeutic activity per week [as required by the Program Guide]).) Only CIW was able to meet that benchmark. Structured therapeutic activity is a critical part of EOP care in general. This is particularly true in segregation units, where the group dynamic and interaction with others can help ameliorate the anti-therapeutic effects of isolation on the mentally ill patient."); Stewart Expert Decl. ¶¶ 312-313 (quoting special master); ¶ 315 (CSP-SAC EOP ASU averaging 5.4 hours of treatment

attended per week), ¶ 323 (LAC EOP ASU averaging 6.3 hours attended per week), ¶ 333 (RJD EOP ASU providing only one group per weekday).) At some CDCR institutions, access to structured therapeutic activity is breathtakingly low for hundreds of *Coleman* class members. (*See, e.g.*, Haney Expert Decl. ¶ 242 (finding that class members at CCI, including hundreds of CCCMS and EOP segregation prisoners, receive on average approximately .034 hours of group therapy per week).)

All experts – the Special Master's experts, Plaintiffs' experts and Defendants' experts – that have looked at the setting, quantity, and quality of mental health treatment for class members in segregation have identified significant deficiencies. Contrary to Defendants' assertions, there is overwhelming evidence that mentally ill inmates housed in these settings are being denied appropriate treatment.

5. Defendants' Failure to Implement the Minimal Standard for Conducting Welfare Checks for All Prisoners Housed in Segregation Is Putting Thousands of Human Beings at Serious Risk of Psychological Damage and Suicide.

The American Correctional Association Standard 4-4257 for Welfare Checks requires that all inmates in administrative segregation be personally observed by a correctional officer at least every 30 minutes at an irregular schedule. (*See* Declaration of Lindsay M. Hayes Support of Pls.' Objs. to Defs.' Plan to Address Suicide Trends in ASUs ¶ 10, Docket No. 2011, Oct. 31, 2006.) This nationally accepted standard (outside California) is based on the "realization that inmates housed in these locked units are at greater risk of suicide, mental health and medical problems and other security issues. The majority of state departments of correction throughout the country, as well as the Federal Bureau of Prisons, have implemented and maintained policies regarding thirty minute Welfare Checks in their respective prison systems." (*Id.*)

In October 2006, the issue of implementing "welfare checks" (a "living and breathing" check that involves a cell-front observation by a custodial officer who stands long enough at the cell-door to see some movement of the inmate that indicates that he or she is alive (*i.e.*, leg, head, chest movement) was raised with CDCR by a team of experts.

Defendants rejected it; Plaintiffs brought the matter before the Court. (Pls.' Objs. to Defs.' Plan to Address Suicide Trends in ASU at 12, Docket No. 2006.) Defendants then issued a memorandum that welfare checks should be provided "to newly placed ASU inmates by Correctional Officers at least every 30 minutes, at staggered intervals, for the first three weeks of ASU placement." *See* CDCR Memorandum, Docket 2061-4, December 1, 2006. Over the Plaintiffs' objections that just three weeks of checks was insufficient, the Court provisionally approved Defendants' plan. (Order, Docket No. 2139, Feb. 12, 2007.)

More than six (6) years later, CDCR's half-measure on the provision of welfare checks of newly placed ASU inmates *for the first 21 days only* remains out-of-step with the rest of the nation, and has had fatal consequences. While prisoners are at enormous risk of suicide in the first days and weeks after being placed in segregation, that risk does not abate after 21 days. (Vail Expert Decl. ¶¶ 124-125) (CDCR outlier among U.S. prison systems); *see also* Bien Decl. Ex. 14 (American Psychiatric Association's Position Statement on Segregation of Prisoners with Mental Illness) (finding "prolonged segregation" creates risk of harm).) Defendants' recent analysis of segregation unit suicides since 2007 found that more than half of CDCR suicide victims who died in segregation had been in segregation for *more* than 21 days at the time of their death. (*See* Kahn Decl. Ex. 6 (filed under seal).) The Special Master's expert found that in five CDCR suicide cases occurring in 2011, "*rigor mortis* had already begun prior to the discovery of the inmate's body. In three of these five cases, the inmate was housed in administrative segregation at the time of the suicide. The onset of *rigor mortis* indicates that in these five cases, at least two to four hours had passed since the time of death before the bodies were discovered, underscoring the importance of timely welfare checks and custodial checks." (2011 Suicide Report at 2.) One of those three inmates found in *rigor mortis* after committing suicide in the ASU died on the *22nd day of his ASU placement* (which was not disciplinary-related, and instead stemmed from concerns about the inmate's safety in his

previous placement). (*Id.* at 268 Appx. F (Inmate EE, died December 6, 2011).)[4] Defendants are well aware of these risks to life, and they ignore them.

Thirty-minute welfare checks for all prisoners in any administrative segregation unit is an essential standard, and one that is endorsed by experts on all sides in this litigation. (*See* Bien Decl. Ex. 88 (Moore Dep. at 223:14-224:25); Bien Decl. Ex. 84 (Hayes Dep. at 41:2-14); Stewart Expert Decl. ¶ 475.) The logs of these welfare checks reviewed by Plaintiffs' expert Dr. Pablo Stewart on his tours were not properly staggered in virtually every administrative segregation unit where checked. (Stewart Expert Decl. ¶¶ 241-254.) Lives continue to be lost because Defendants deliberately ignore what is obvious: lives could be saved if Defendants come into line with the national correctional standard on this issue. (Bien Decl. Ex. 83 (Dvoskin Dep. at 244:5-12, 247:22-248:1).)

6. Defendants Essentially Ignore the Constitutional Harms Inflicted on Mentally Ill Prisoners in CDCR's Security Housing Units (SHUs).

Defendants' experts had very little to say about the SHUs, having not looked at all at two of the three largest SHUs housing *Coleman* class members (CCI and CIW) in the system. They found only that inmate-patients "routinely knew" the name of their psychiatrist and primary clinician, their medications, and the "process for arranging an earlier appointment with their psychiatrist if they wanted one." (Defs.' Joint Report at 23.) The Joint Report is completely silent as to the adequacy of that "process" or of SHU inmate-patients' treatment generally. Defendants' experts also stated that they found (1) "few, if any, inmates who needed a higher level of care and were not identified"; (2) that

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[4] In reviewing a June 2012 suicide at the Avenal State Prison segregation unit, the Special Master's expert found that "welfare checks either did not occur at least every 30 minutes and/or were not done properly" given the apparent onset of *rigor mortis* by the time the victim's body was found. (First Half 2012 Suicide Report at 152 (Inmate N).) The prisoner had just recently been placed in the ASU (again, not disciplinary-related, but due to safety concerns). This suicide highlights the need not only for a systemwide policy of welfare checks for all prisoners in segregated housing, but also for *actual implementation* of welfare check procedures, which was found to be lacking in this case.

psychiatric technician rounds were conducted on a daily basis, and (3) that "[i]n those situations where the inmate's clinician determined that a private setting is clinically appropriate, the SHU had a private setting available and clinicians were able to meet with inmates privately." (*Id.* at 24.)

Defendants' experts' findings are shallow, misleading, and in error. First, Plaintiffs' experts identified a very substantial number of mentally ill prisoners in the SHU population suffering from serious and acute mental illness that either was not properly identified or was not adequately treated. (*See* Haney Expert Decl. ¶¶ 185-86 & 206-214 (discussing CSP-Corcoran SHU), ¶¶ 258-68 (discussing CCI SHU); Kaufman Expert Decl. ¶¶ 127-38 (discussing CSP-Corcoran SHU).)

Second, Defendants' experts themselves identified "variation in the quality of Licensed Psychiatric Technician rounds" and recommended steps to "improve[e] the qualitative nature of these rounds." Defs. Joint Report at 24. A policy of conducting daily rounds in segregation is of little worth if the quality of those rounds – essential to identifying acute mental illness and protecting mentally ill prisoner safety – is deficient.

Defendants' experts downplay the importance of confidentiality for clinical contacts, endorsing clinical interviews in full hearing of other inmates and custody officers. (Docket No. 4314-1 at p. 6 (Dvoskin "disagree[s] with the premise that all clinical and/or therapeutic contacts must occur in confidential settings.").) This is at odds with safe clinical practice. (*See* Kaufman Expert Decl. ¶ 47; Special Master's 25th Round Report at 37.) Defendants' experts try to dress up the lack of confidential treatment space in a veneer of clinical discretion—asserting that only certain "situations" call for a private setting. This issue is not clinical discretion. Systematic severe space and custody shortages impose non-confidential treatment on the clinicians. The prevalence of non-confidential treatment is not the result of clinical discretion but of deliberate indifference to the resources needed to exercise such discretion.

Defendants' evidence that mentally ill prisoners in SHU are receiving minimally adequate mental health treatment that meets the constitutional requirement falls on its own

weight. In reality, far too many *Coleman* class members in SHU are "isolated, lonely, and struggling with serious psychological conditions," and the "long-term isolation to which these individuals have been exposed is dangerous, harmful, and anti-therapeutic." (Kaufman Expert Decl. ¶ 127; *see also* Haney Expert Decl. ¶ 287.) The excessive risk of psychological harm and suicide violates the Eighth Amendment.[5]

I. Severe Medication Management and Medical Records Problems Continue to Interfere With the Delivery of Appropriate Mental Health Care to Class Members.

Defendants' mental health care delivery system continues to be severely compromised by ongoing medication management and medical records problems that endanger the health of class-members and undermine the efficacy of their treatment.

1. Medication Management Remains Severely Dysfunctional in Critical Areas.

A constitutional mental health care system requires an adequate system to administer and manage necessary medications to those with mental illness. This Court long ago found serious inadequacies with respect to the supervision of the use of medication, timely provision of prescriptions, prevention of medication hoarding, ensuring continuity of medication, monitoring of inmates on psychotropic medication, and sufficient staffing to provide medication safely and appropriately. *Coleman*, 912 F. Supp. at 1309.

Too many of these medication management problems persist in Defendants' system, creating serious and – in a well-run system, avoidable – risks for *Coleman* class

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[5] There has for many years been an exclusion for prisoners with serious mental illness from placement in the SHU at Pelican Bay State Prison and in the standalone ASUs, critical measures for protecting the mentally ill from the high risk of psychological harm linked to placement in these units. (*See* Bien Decl. Ex. 15, Program Guide 12-8-1 through 12-8-3 (PBSP SHU exclusion); Bien Decl. Ex. 77 (Program Guide 12-7-11 (stand-alone ASU exclusion)).) The dangerous conditions and persistent lack of adequate staffing, programming, and treatment space in the other SHUs (at Corcoran, CCI, CIW and SAC) demonstrate a need for similar exclusionary criteria for the mentally ill from those equally dangerous units.

members. Even Defendants' experts found areas of significant concern:

(a) Clinical Staff Shortages Hamstring Medication Management.

Topping the list is staffing shortages, which have had a profound and negative impact on medication management for *Coleman* class members. At multiple institutions, Defendants' own experts identified medication management problems, each time connecting them to insufficient clinical staff. (Defs.' Joint Report at 31 (Corcoran's staffing shortages for psychiatrists made it difficult to complete audits and to meet required time frames for medication follow-up appointments, CIM's "significant staffing shortages" made it difficult to maintain required follow up appointments, SATF's "significant staffing shortages" limited ability to meet required time frames for psychiatric follow up and led to "sparse documentation").) Defendants' expert report chooses to downplay the negative effects of such staffing shortages, without any detail or analysis.

But Plaintiffs' psychiatric experts *do* engage in a thorough analysis, and find that these "significant staffing shortages" are in fact compromising patient care with respect to medication management. For example, Dr. Kaufman found that staffing shortages hamstrung psychiatrists' ability to properly manage their patients' medications. He expressed grave concern that such staffing shortages require delegation of important medication management-related tasks to other staff, who are often not familiar with side effects of psychotropic medications (as discussed below). The risk to patient safety is enormous: without measures to monitor patients for signs of side effects, a patient's medication regime can be rendered ineffective, physically harmful, or psychologically damaging. (Kaufman Expert Decl. ¶ 76 (finding that, at Corcoran, there are only 6.5 staff psychiatrists treating 1,441 prisoners on psychotropic medications, requiring delegation of tasks to nurses who Defendants' expert Moore found unfamiliar with side effects information); *see also* Stewart Expert Decl. ¶ 134 (psychiatric technicians distributing medications without asking about side effects).)

(b) Dangerous Lack of Awareness and Monitoring of Side

Effects to Psychotropic Medications.

Awareness of, and inquiry into, potential side effects of psychotropic medications is a critical element of a well-run medication management system. (*See* Stewart Expert Decl. at ¶ 134; Kaufman Expert Decl. ¶¶ 75-76). On this element of mental health care, Defendants again unfortunately continue to miss the mark. Although Defendants' experts noted that Defendants have "medication protocols in place" (Defs.' Joint Report at 26), they are completely silent as to whether or not those nursing protocols are adequate or are appropriately implemented. In fact, Defendants' expert Moore, who was in charge of this component of the expert trio's review, found serious concerns with the basic training and competence of CDCR nursing staff. (Bien Decl. Ex. 88 (Moore Dep. at 180:10-181:12 (finding that the nurses at all but one institution were unfamiliar with the side effects of psychiatric medications, and agreeing that awareness of side effects is important to ensure the safety and well-being of inmate-patients); *id.* at 182:3-8 (noting that if she had written the nursing section of the report "I would have made a recommendation that nursing education emphasize the side effects of the medication and that they have handouts or signs available where they dispense the medications so these things would be in front of them all the time.").) Drs. Stewart and Kaufman observed the same sort of problem, finding that nurses and psychiatric technicians did not ask patients about possible side effects of their psychotropic medications. (Stewart Expert Decl. ¶¶ 134, 141; Kaufman Expert Decl. ¶ 76.)

(c) Deficiencies that Cut Across Nearly All Aspects of Medication Management.

Despite the gloss that Defendants' experts put on medication management issues affecting the mentally ill in California's prisons, Plaintiffs' experts and the Special Master have uncovered *many* current, ongoing, and widespread problems with CDCR institutions' medication distribution and management practices, including:

Failures to complete "appropriate identification, documentation, referral and response to inmate medication non-compliance." (Special Master's 25th Round Report at

68 (19 prisons failing to comply with requirements). Since "for many chronically mentally ill individuals, periods of medication non-compliance are an aspect of their disease process," serious harms result when the process for addressing such non-compliance is not functioning appropriately. (*See* Stewart Expert Decl. ¶¶ 123, 142 (discussing problems with responses to medication non-compliance at CSP-Sacramento).) Dr. Kaufman identified a high frequency of dangerous medication refusal that indicates a "fundamental breakdown of trust and communication between clinicians and patients." (Kaufman Expert Decl. ¶¶ 74-75.) Plaintiffs' experts attribute the high rates of medication refusal in part to deficient practices such as non-confidential clinical contacts and express concern that these refusals are receiving an extremely untimely response from clinical staff. (*See id.* at ¶ 74-75, 77; *see also* Stewart Expert Decl. ¶ 153 (RJD responded appropriately to just 30% of medication non-compliance cases in December 2012 and January 2013).

Failures to order appropriate laboratory testing for prisoners on psychotropic medications and follow up on results. (*See* Special Master 25th Round Report at 69-70 (problems at half the prisons monitored.) Monitoring psychiatric medications for side effects is critical: "many psychotropic medications have very significant side effects including kidney failure, diabetes, heat stroke, increased cholesterol, and suicidality, to name but a few…" (Kaufman Expert Decl. ¶ 25.) CDCR's laboratory testing practices are also problematic. (*See* Stewart Expert Decl. ¶¶ 139, 144, 149, 164.)

Failures to conduct Abnormal Involuntary Movement Scale (AIMS) testing as required. Inadequate AIMS testing, critical for identifying and treating Tardive Dyskinesia, is evident. (*See* Stewart Expert Decl. ¶¶ 130, 150, 157-163.)

Failures in obtaining appropriate informed consents. (Special Master 25th Round Report at 69.) Defendants' experts observed serious problems in this area as well.

Failures in providing medication renewals. (Special Master 25th Round Report at 68.) Failures with respect to medication renewals affected care at several prisons with large mental health programs, including CMF, MCSP, CSP-Sacramento and SVSP. Plaintiffs' experts identified cases in which medication renewal processes were highly

problematic. (*See, e.g.*, Kaufman Expert Decl. ¶ 66; Stewart Expert Decl. ¶ 145.)

Inadequate medication distribution facilities. Defendants concede that "existing medication distribution facilities do not allow for safe, efficient and effective distribution of medications … and can lead to deterioration of a patient's medical condition." (Bien Decl. Ex. 94 (COBCP) at 1-2.)

2. Defendants' Medication Records System Remains Deeply Problematic, Makes Clinicians' Jobs Even Harder, and Jeopardizes Patient Care.

Compounding the medication management problems across CDCR's mental health care system are serious medical records problems. Defendants' experts found that the electronic heath records system currently in use negatively impacts medication management because it is "particularly cumbersome and time demanding in regard to tracking basic labs and progress notes" and because "laboratory and other medication monitoring results [are] not uniformly scanned into the system or [are] scanned into random sections of the eUHR system." (Defs.' Joint Report at 29.) Defendants' experts were very critical of the eUHR system in their report. In deposition, Dr. Dvoskin called the system "difficult to use," "time-consuming" and "a disaster." (Bien Decl. Ex. 83 (Dvoskin Dep. at 210:25-213:8).)

Plaintiffs' experts also noted severe problems. First, because many or most of the CDCR's "electronic" medical records are merely copies of handwritten notes (often scanned with poor quality), they are frequently illegible. (*See* Kaufman Expert Decl. ¶ 82 (in CCWF's MHCB, expert and nurse unable to decipher the psychiatrist's handwriting, even as to the patient's primary diagnosis); *see also* Bien Decl. Ex. 83 (Dvoskin Dep. at 211:24-212:14) (describing records as "difficult to read" because so many of them are handwritten).)

Second, delays in scanning records often require clinical staff to rely on paper records or do without records during the gap between when a patient's records are submitted for scanning and when they appear in the eUHR system. (*See* Stewart Expert Decl. ¶ 91.) And even to the extent medical records are timely entered into the electronic

records system, limited or non-existent access to computers in CDCR facilities leaves clinicians without access to basic patient information, including diagnoses and case history. Dr. Dvoksin acknowledged that this is a near universal problem in the CDCR, and stated that he "quit asking about that early on." (Bien Decl. Ex. 83 (Dvoskin Dep. at 212:15-213:8.) Of course, Defendants' experts said very little about this issue in their report, and immediately minimized its importance.

Yet appropriate access to a patient's record is an extremely serious matter. Clinicians need access to up-to-date, accurate medical records while performing their clinical contacts with patients; this basic aspect of competent care has not been achieved. At MCSP, for example, staff working in the EOP ASU housing units did not know how to access patient records, or even sign onto the electronic database. (*See* Haney Expert Decl. at ¶ 92.) A psychiatrist at CSP-Sacramento was so worried that "something could happen" to his patients while he was without access to their records (including when "the computers are down," he explained) that he painstakingly maintained his own printed copy of each patient's record. (Stewart Expert Decl. ¶ 91; *see also* Bien Decl. Ex. 89 (Scott Dep. at 108:23-109:8) (contrasting CDCR's system to "an immediate electronic system where [records] would just appear").) In the course of his records review, Dr. Kaufman encountered a medical record stating that the patient's "UHR was not available for review" by the clinician. (Kaufman Expert Decl. ¶ 83; *see also* Haney Expert Decl. ¶ 93 (eight volumes of medical and psychiatric records lost for a class member with traumatic brain injury).) These problems are not just inconveniences for already stressed and overburdened clinical staff; they are clinically dangerous to patients.

Moreover, Plaintiffs' experts observed the medical records themselves to be of very poor quality – "formulaic," "superficial," and "sparse." (Kaufman Expert Decl. ¶ 79.) Dr. Kaufman found that the medical records "provided very little insight into a given patient's condition" and with few exceptions reflected no real process of mental health treatment. (*Id.*) In the records of one very mentally ill patient, Dr. Stewart observed that seven treatment plans, completed over the course of approximately 16 months, were

virtually or substantially identical. (Stewart Expert Decl. ¶ 361.)

Adequate and accessible medical records are central to clinicians' work and to patient care. As Dr. Kaufman notes, "[t]his reliance is heightened in circumstances like the ones I observed, in which: (1) clinicians do not see their patients often or meaningfully enough to be familiar with them and their conditions, and (2) high rates of sick leave and turnover frequently require new clinicians to familiarize themselves with patients' conditions." (Kaufman Expert Decl. ¶ 79.) The low quality of Defendants system of mental health and medical records reflects a lack of substantial and meaningful treatment for *Coleman* class members. One hopes that it is improving, but there is certainly a long way to go before constitutional adequacy is achieved.

3. Medication Management and Records Deficiencies Plague DSH Programs Serving the Very Mentally Ill.

There are also serious medication management and medical records issues affecting care in the SVPP programs run by DSH. Dr. Brim, an SVPP psychiatrist, testified in deposition concerning the alarming state of the DSH inpatient programs at SVPP, and the impact of severe understaffing there on the medication management, quality of care, and staff safety:

> [W]hen the psychiatrists have gotten together in their meetings, there has been ongoing discussion of the increasing dangerousness of the situation, and a number of different psychiatrists have touched upon the fact that [recently staff] injuries appear to be up, relate that to the staff not having the time they once had to maintain contact with the patients, monitor how they're doing, keep us informed so that we can do what we can with their medication to help stabilize them.

(Bien Decl. Ex. 82 (Brim Dep. at 79).) Dr. Brim also indicated that the cell-front contacts required by CDCR custody restrictions for newly arrived patients preclude adequate privacy for clinical contacts, including presumably counseling and questioning when conducting medication distribution. (*Id.* at 61.)

Shockingly, DSH clinicians are not permitted to access and review the CDCR's electronic medical records for their SVPP patients because the CDCR is unwilling to give

them passwords for the system. (*Id.* at 90.) As Dr. Brim explains, such a practice puts the well-being of prisoners with serious mental illness at serious risk: "[I]t's dangerous not to have access to the old [CDCR] records because there are potentially relevant things in the old records that are not necessarily included in the referral packet." (*Id.*)

J. Defendants Act with Deliberate Indifference to the Mental Health Needs of *Coleman* Class Members on San Quentin's Death Row

Defendants' experts visited both San Quentin, home to nearly 700 condemned male inmates, and CCWF, home to roughly 20 condemned female inmates. Approximately 200 of the individuals on California's death rows are *Coleman* class members. Yet Defendants' January 7 filings do not contain the word "condemned," and the only references to "death row" are within their experts' curricula vitae. Defendants' expert reports do not specifically discuss *anything* about their visit to San Quentin, beyond the fact that it occurred. When Defendants argue that the entire CDCR system is a smoothly functioning machine that adequately screens, treats, and transfers inmates in need of mental health care, they do so without any consideration of the significant population of mentally ill individuals on death row.

The average length of stay on California's death row is 25 years. (Woodford Expert Decl. ¶ 24.) Over the course of these long decades, condemned inmates generally experience few changes in custody status and housing, and are almost never transferred between prisons. (*Id.*) There is thus little opportunity for them to be screened or observed for signs of mental health deterioration during screenings that CDCR may perform in connection with transfers. In the absence of such screening opportunities, CDCR has not established any organized practice of routinely re-evaluating condemned inmates to determine their mental health status and needs. Ms. Woodford testified that to her knowledge the last such comprehensive screening conducted at San Quentin took place in 2003 or 2004, during her tenure as Warden there. (*Id.* ¶ 25.)

Nor has San Quentin provided for consistent monitoring of condemned inmates by either custody or mental health staff, such as that prescribed by CDCR policy for inmates

in other segregated units. (*See id.* ¶¶ 28-29, 33-34 (discussing the importance of CDCR Form 114a custody logs and classification committees as opportunities to assess inmates' mental health needs, neither of which appear to be properly used for condemned inmates).) While mental health staff walk through the tiers periodically, there is no focused effort by custody or clinical staff to conduct regular one-on-one screening. (*Id.* ¶ 22.) In the absence of glaring signs of mental health crisis, it is therefore possible for a condemned inmate can go decades without significant contact with mental health staff. (*Id.* ¶ 62 (discussing 2010 suicide of condemned inmate whose files indicated no apparent contact with mental health staff between 1990 and his death).) The lack of a coherent screening model for long-term condemned inmates results not only in such tragic suicides, but in an overall pattern of systematic under-identification of condemned inmates' serious mental health needs. (*See id.* ¶ 26; Stewart Expert Decl. ¶ 453 (testifying that the percentage of condemned inmates at the EOP level of care is lower than would be expected given the nature of that population); (*see also* Woodford Expert Decl. ¶¶ 30, 31, 32, 55) (identifying particular individuals whom she would have referred for evaluation for a higher level of care).)

Defendants' policies also categorically deny access to higher levels of care to condemned prisoners. Defendants impose a blanket ban that prevents condemned inmates from being transferred to DSH intermediate care facilities (ICF). (*See* Woodford Expert Decl. ¶ 44.) There is no custodial justification for such a ban. (*Id.* ¶¶ 47-50.)

Defendants have long pointed to a vague and amorphous "Specialized Care for the Condemned" program at San Quentin as a remedy for this inexplicable and unsupportable blanket ban. The program "was implemented on November 8, 2010, and has been in existence ever since, with a census of 8 to 10 inmates at any given time." (Special Master's 25th Round Report at 177.) After years of "development," the Specialized Care program still lacks a written Local Operating Procedure governing its operation, a clearly-defined set of governing clinical criteria, or an organized and planned mental health or custodial staffing plan or package. (*See* Woodford Expert Decl. ¶¶ 45-46.) While

Defendants continue to delay in producing such necessary elements of any program, the individuals who are either participants or candidates for participation remain gravely ill and desperately in need of a higher level of mental health care. (*See* Stewart Expert Decl. ¶¶ 457-60; 466-71 (discussing individuals housed in both the CTC and the East Block and concluding that all of the individuals interviewed evidenced severe mental health problems and need for transfer to inpatient care).) Defendants have, in short, engaged in years of heel-dragging on the development of this program, all while maintaining their unjustified and unjustifiable ban preventing very ill class members from obtaining necessary psychiatric hospital-level care.

Finally, although population levels across CDCR have decreased in recent years, the death row population has only grown – and in fact, there remain only a few months before there is simply no more room to house condemned inmates at San Quentin. (Woodford Expert Decl. ¶ 37.) In 2011, the Governor cancelled a plan to build a new condemned housing facility that might have provided for appropriate housing, medical, and mental health space for this growing population; no replacement for this plan has been set forth. (*Id.* ¶¶ 36-38.) These housing units already lack space for mental health treatment. Filling them to capacity and beyond aggravates the problem. For example, the same finite number of walk-alone yard cages are used for non-mental health programs, such as basic out-of-cell time, and for mental health programs, such as therapeutic groups– a scheduling and logistical nightmare at best. (*See id.* ¶¶ 39-41.) The maximum-capacity operation of death row also limits staff's ability to safely operate the condemned units and to make rational judgments about housing locations, which appears to have contributed at least in part to the suicide of one man who was forced to remain housed in close proximity to others who were tormenting him. (*See id.* ¶ 64; *see also* First Half 2012 Suicide Report at 55 (concluding that this man's suicide was preventable "if mental health staff and custody staff had collaborated" regarding his situation).)

Inadequate staffing, an unsupportable ban on higher levels of care, and overcrowding combine to endanger the welfare of these prisoners constitute a violation of

the Eighth Amendment. Defendants' attitude is apparent from a telling line in a January 25, 2012 memorandum from Dr. Eric Monthei, the Chief of Mental Health at San Quentin, to Dr. J. Scaramozzino, the Deputy Director for DCHCS. (Bien Decl. Ex. 78.) After detailing the obstacles to implementation of the "Specialized Care of the Condemned" program within San Quentin's CTC, Dr. Monthei writes: "If the Death Penalty is repealed in November, the whole issue becomes moot." (*Id.* at 4.) A hope that the voters would make the "whole issue" go away is no substitute for adequate planning, programming and resources sufficient to provide necessary treatment given the serious mental health needs of some of California's most mentally ill inmates, and the refusal to provide a remedy constitutes deliberate indifference.

K. Defendants Have Not Addressed Dangerously Inadequate Reception Center and ASU Screenings

As Defendants acknowledge, "[b]ecause severely mentally ill inmates often cannot alert staff to their mental health needs, delivery of adequate mental health care to such inmates requires a system for screening and evaluating those who require mental health treatment." (Defs. Motion at 16:6-8.) Defendants claim to have implemented a comprehensive mental health system "for screening and evaluating inmates with mental health issues upon admission, readmission and transfer, using standardized mental health screening forms and protocols." (Belavich Decl. at 3:23-25, Docket No. 4277.) Defendants' experts also claim, without any analysis, that "CDCR has a well-established and clearly defined system for screening and evaluating inmates for serious mental illness, both at the time of reception and during incarceration." (Joint Report at 10.)

Defendants, in fact, are fully aware of serious deficiencies in their current screening instrument and procedures that they know put lives at risk. The problems concern both the reception center ("RC") and administrative segregation ("ASU") screening tools, but have been unaddressed despite their identification in the review of two suicides, one in 2010 and another in 2012.

In the Quality Improvement Plan prepared for the August 22, 2010 suicide that

occurred in the stand-alone ASU at CSP-LAC, the Suicide Prevention and Response Focused Improvement Team ("SPR FIT") discussed the "inadequacy of the 31-item questionnaire to highlight current mental health problems in inmates who are new arrivals to administrative segregation." (Kahn Under Seal Decl. Ex. 45.) In an email entitled "DRAFT of new ASU screener – comments requested," dated October 10, 2012, more than two years after the suicide, Dr. Canning, CDCR's suicide prevention coordinator, wrote that "[t]he 31-item screener has never been validated in the CDCR setting, takes too long to administer, and does not address what we believe are the most important psychological factors effecting an inmate's behavior soon after entry into ASU: distress, isolation, loneliness, fear, and possibly thoughts of suicide." (Bien Decl. Ex. 98.) The agenda from a January 28, 2013 SPR-FIT meeting shows that among the "ongoing items" is "Update on proposal for new ASU screening tool (to replace 31-item questionnaire)." (Bien Decl. Ex. 97.) Defendants have long known that their current screening tool is inadequate, yet they have failed to replace or revise this tool. This failure places prisoners at great risk of death, harm and suffering in the ASUs.

On May 16, 2012, a prisoner committed suicide in his general population cell at Pleasant Valley State Prison. (Kahn Decl. filed under seal ¶¶ 8-9, Docket No. 4340, Jan. 14, 2013.) During his reception center screening, he responded positively on three questions: (1) that he had a history of past psychiatric hospitalizations; (2) that he had history of taking psychotropic medications; and (3) that he had a suicide attempt history. (*Id.*) Despite these responses, under CDCR's scoring rules on their reception center 31-item questionnaire, these responses did not trigger a referral for further evaluation. (*Id.* at 9.) The Suicide Reviewer in this case, the same Dr. Canning, again identified the need to evaluate changes to the scoring rules for this screening questionnaire, noting that "the scoring rules for the questionnaire do not include several significant questions: history of psychiatric (and involuntary) hospitalizations, history of taking psychotropic medications, and *most surprising, a history of having made a suicide attempt*." (*Id.* at 9 (emphasis added).) The problem identified with the scoring rules was directed to the SPR-FIT of the

DCHCS to make recommendations for changing the scoring rules. (*Id.* at 10.) As of January 28, 2013, eight months after this suicide, and years after the 2010 suicide, this critical reception center screening deficiency remains an "ongoing item." (Bien Decl. Ex. 97.)

Defendants have identified serious and significant problems with their own screening tools, which they admit fail to identify and refer prisoners who have mental health concerns and are at risk. Despite this knowledge, the deaths of multiple human beings, and the passage of time, Defendants have still not remedied these failings. This is further evidence of *Coleman* deliberate indifference to the harm that may befall class members.

L. Defendants' Custodial Policies, Practices and Procedures Violate Constitutional Standards In Their Excessive and Unnecessary Use of Force, Unfair Disciplinary Procedures, and Overly Harsh, Rigid, and Intrusive Security and Housing Procedures That Exacerbate Mental Illness and Interfere with Mental Health Treatment.

This Court's 1995 decision found "substantial evidence in the record of seriously ill inmates being treated with punitive measures by the custody staff to control the inmates' behavior without regard to the cause of the behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illness," which the Court attributed in part to inadequate training. *Coleman*, 912 F. Supp. at 1320. The Court also found that Defendants' policies and practices that subjected mentally ill inmates to "the use of tasers and 37 mm guns, without regard to whether their behavior was caused by a psychiatric condition and without regard to the impact of such measures on such a condition," violated the Eight Amendment. *Id.* at 1321-23.

These abhorrent practices persist today. While CDCR custody officers no longer have access to tasers, officers still have a dangerous combination of serious weapons, poor oversight and guidance, and minimal accountability. (Vail Expert Decl. ¶¶ 37-50, 71-73.) The rules violation process still fails to meaningfully incorporate input from mental health clinicians, resulting in persistently high rates of punitive measures against mentally ill inmates. (*Id.* ¶ 79.)

Plaintiffs' expert, Eldon Vail, found significant deficiencies in many of CDCR's practices regarding the use of force and rules violations, both of which disproportionately affect prisoners with mental illness. He concluded that: (1) "CDCR, as a matter of practice and sometimes by policy, engages in unnecessary and excessive use of force with mentally ill inmate patients;" (2) the RVR process is "seriously compromised for mentally ill inmate patients, and does not systematically account for their mental illness when adjudicating prison rule violations;" and (3) CDCR "allows custody staff to dominate and interfere with mental health treatment." (*Id*. ¶ 34.) Mr. Vail's conclusions are buttressed by vivid and troubling accounts of unnecessary and excessive force against *Coleman* class members. Mr. Vail also details CDCR's failure to respond to the critical recommendations of *its own expert.*

Mr. Vail found that "CDCR uses physical force on mentally ill inmate patients at a rate that is dramatically higher than on the non-mental health population." (*Id.* ¶ 35.) Although CDCR requires medical staff to attempt to de-escalate the situation before force is used against a mentally ill patient, Mr. Vail observed that consultations with medical staff during controlled uses of force were "cursory at best, with only a minute or two spent by the practitioner with the inmate, before the intervention is deemed to be ineffective." (*Id.* ¶ 62-63.) Meanwhile, Mr. Vail noted the "disturbing frequency" with which batons are used in CDCR facilities, and the "lack of clear direction" to officers about the appropriate use of the baton. (*Id.* ¶¶ 40-41.) Mr. Vail observed a problematic prevalence of Oleoresin Capsicum (OC) crowd dispensers, OC grenades, and expandable batons – "weaponry [which] is a rarity inside living units in correctional programs around the country." (*Id.* ¶ 37.) He found that CDCR officers "overrel[y] on force" and "routinely use more pepper spray than is necessary to control a situation and routinely do not allow for sufficient intervals before dispensing additional rounds." (*Id.* ¶¶ 38, 44.)

Mr. Vail observed a number of incidents in which excessive amounts of pepper spray were used against disoriented mentally ill prisoners who were "not lucid or coherent enough to be able to follow the officer's orders." (*Id.* ¶¶ 52, 58.) In one instance, a

decompensating inmate-patient at Corcoran refused medications, and the officers sprayed so much OC at him that they all slipped in the pool of liquid when they subsequently entered the cell. (*Id.* ¶ 52.) In another incident at San Quentin, officers threw two OC grenades and "four lengthy bursts from a large OC dispenser" within a period of five to six minutes at a single mentally ill inmate "who presented no imminent threat." (*Id.* ¶ 58.) There, too, the "inmate appeared so disoriented that it was clear halfway through the event that he did not have the capacity to comply with the orders." (*Id.*)

In the face of these brutal practices, CDCR failed to respond even to the recommendations of its own expert, Steve Martin. Mr. Martin issued a series of recommendations to CDCR with respect to its use of force and RVR practices. Like Mr. Vail, Mr. Martin expressed concern about the lack of guidance for officers about appropriate use of the expandable baton. (Bien Decl. Ex. 110 (*Coleman* Audit Best Practice Recommendations for Use of Force) at DEXP105138.) Mr. Martin also "question[ed] the use of crowd control delivery systems into a cell of an unarmed or unbarricaded inmate" and suggested that OC canisters should be weighed before and after use to monitor the amount of gas deployed. (*Id.* at DEXP105139.) These concerns are consistent with concerns raised by the Office of the Inspector General in 2011, which CDCR specifically rejected. (Bien Decl. Ex. 114 (OIG Report on Use of Force within CDCR, Nov. 2011) at 13 of 19.)

Despite these recommendations, it appears that none of the necessary training or guidelines have been made available to CDCR custody staff. (Vail Expert Decl. ¶ 46.) While CDCR issued a memorandum on the subject of OC gas, it mentioned nothing about the use of crowd-control sized OC dispensers for cell extractions and did not incorporate Mr. Martin's recommendation that CDCR weigh the amounts of gas deployed by officers in use of force incidents. (*Id.* ¶¶ 47-50.) Mr. Vail also found that CDCR has not taken steps to implement Mr. Martin's "very important recommendation" that CDCR review and investigate incidents of force that include "unexplained injuries" or "impact strikes to lethal target areas." (*Id.* ¶¶ 73-75; Bien Decl. Ex 110 at DEXP105138.) To the contrary,

neither Mr. Vail nor Mr. Martin could find "even one example of an officer disciplined for excessive UOF." (Vail Expert Decl. ¶ 72; *see also* Bien Decl. Ex. 86 (Martin Dep. at 95:24-06:1 ("I was not able to document a fully realized imposition of a disciplinary sanction for an excessive use of force I looked at.")).) Mr. Vail found that "[t]he absence of a transparent and effective review and employee discipline system is, in and of itself, a message to line staff that they will likely suffer no consequences for the unnecessary and excessive use of force against inmate patients." (Vail Expert Decl. ¶ 72.)

Unfortunately, Defendants' record of ignoring essential recommendations of their own experts about egregious practices against mentally ill patients extends to the area of Rule Violation Report (RVR) practices as well. Mr. Vail observed that mental health professionals were consistently frustrated about "not knowing whether or how their input is actually used in the RVR hearing process." (Vail Expert Decl. ¶ 81.) Mr. Vail also noted with concern that "[n]o one, including prison wardens on my tours, kept any aggregate data on how often the mental health clinician's input changed the outcome of or sanction at the hearing." (*Id.*) In his written recommendations, Mr. Martin had called on CDCR to require RVR hearing officers to "affirmatively state whether they modified or mitigated the penalties based on the MH assessment." (Bien Decl. Ex 110 at DEXP105141.) This recommendation has also fallen on deaf ears. (Vail Expert Decl. ¶ 86.)

Mr. Vail also found that Mr. Martin's recommendation for greater communication between hearing officers and mental health clinicians about the RVR process had not been realized. (Bien Decl. Ex 110 at DEXP105141; Vail Expert Decl. ¶ 90.) Rather, mental health input into the RVR process continues to be "formulaic and ineffective." (Vail Expert Decl. ¶90) Ultimately, the RVR process for the mentally ill has "several fundamental flaws" and there is simply no evidence that the system for handling disciplinary proceedings for mentally ill prisoners is "actually working." (*Id.* ¶ 79.)

The parties' experts largely agree on a range of grave concerns regarding both the use of force and the rules violation process as they relate to *Coleman* class members. For

example, Martin acknowledged that there is a disparity in CDCR's use of force against the mentally ill and that they are subject to use of force at a higher rate than the general population. (Bien Decl. Ex. 86 (Martin Dep. at 62:14-63:7).) He further agreed that blanket custody procedures and protocols that fail to differentiate between a violent prisoner and one who needs protection from the general population are "not correctionally sound" and are unconstitutional "if there are onerous or punitive conditions, a de facto type of punishment when the offender hasn't done anything. Due Process implications, if nothing else. If not Eighth Amendment." (Bien Decl. Ex. 86 (Martin Dep. at 41:22-47:13); *see also* Vail Expert Decl. ¶ 120.) Indeed, the excessive force issues that Martin found were so serious and so obvious that he expressed anger that the *Coleman* Special Master and Plaintiffs' counsel had failed to identify and stop the practices themselves. (Bien Decl. Ex. 86 (Martin Dep. at 85:13-88:4).) All experts who have reviewed Defendants' practices agree that Defendants persist in using force and punishment against mentally ill prisoners while neglecting to account for and to address their clinical needs.

V. OVERCROWDING-RELATED DEFICIENCIES REMAIN MAJOR BARRIERS TO THE DELIVERY OF CONSTITUTIONAL MENTAL HEALTH CARE

The *Coleman* class has to date experienced little to no benefit from Realignment. The undisputed evidence shows that the numbers of prisoners with serious mental illness in the prison system—the *Coleman* class—has been reduced by only a small percentage compared to the overall reduction of the prison population. (Haney Expert Decl. ¶ 54; 2011 Suicide Report at 16.) In addition, many *Coleman* class members are being treated at a lower level of care than is clinically indicated. (Kaufman Expert Decl. ¶¶ 161-182; Stewart Expert Decl. ¶¶ 275, 305, 346-347, 362-363.) Ongoing constitutional violations in mental health care persist and resources are stretched thinner than ever.

The Defendants, including the Governor, have managed Realignment and California's financial crisis, without regard for, and with deliberate indifference to, the health and safety of the *Coleman* class. Even as the population reductions of Realignment began to kick in, Defendants prioritized, once again, budget savings over all else,

squandering the opportunity to take major steps forward in remedying the ongoing violations. (Bien Decl. Ex. 123 ("Blueprint," Executive Summary) ("A blueprint to save billions of dollars, end federal court oversight and improve the prison system").) The current dangerous levels of clinical and custodial staffing shortages in CDCR and DSH are a direct result of Defendants' intentional and conscious decisions to maximize cost-savings by imposing a hiring freeze on all state public employee positions and managing Realignment mission changes to maximize budget savings. These decisions were made in violation of existing orders of this Court to fully staff CDCR and DSH inpatient psychiatric programs and to maintain clinical vacancy rates under 10% through use of contract registries. (Docket Nos. 4199, 3761, 3613, 1800, 1774, 1772, 1667, 1654, 1383, 1198.)

Realignment was purportedly designed to address (at least in part) the overcrowded conditions that were the primary cause of the unconstitutional care for the *Coleman* class. (Bien Decl. Ex. 123 ("Blueprint," Executive Summary) at 1.) Yet Defendants have failed in their constitutional obligations and ignored the serious risks of harm that mentally ill prisoners are still made to endure. Even with the population reductions that have occurred, California remains an outlier, and is one of the most overcrowded prison systems in the United States. Some individual prisons are much *more* overcrowded than the overall systemwide figure indicates, and they have scarcely benefitted, if at all, from the overall population reductions that have occurred. (Haney Expert Decl. ¶ 31.) Many individual prisons are operating at extremely crowded levels, far above their abilities to provide appropriate housing and mental health treatment to the *Coleman* class members in those facilities. The female population at CCWF, for example – which has serious deficiencies in its delivery of mental health care (*see, e.g.*, Kaufman Expert Decl. ¶¶ 24-32, 48-56, 66-67) – faces a staggering level of extreme overcrowding (at nearly 180% capacity), while five (5) prisons have populations over 160% capacity (only two of which Plaintiffs' experts were able to visit in the abbreviated discovery period).

The three-judge court and the Supreme Court found that overcrowding was the

primary cause of the constitutional violations in this case. *Plata*, 131 S. Ct at 1937. Stunningly, Defendants' motion to terminate does not mention or reference overcrowding once, except to say that the three-judge court's order was "premised on outdated evidence" (Defs. Motion at 15, n.7), an assertion that was squarely rejected. *Id.* at 1938. Even more baffling, Defendants specifically directed their experts *not* to look at overcrowding in completing their review of whether California prisons provide constitutional care. (*See, e.g.*, Bien Decl. Ex. 83 (Dvoskin Dep. at 191:22-192:1 ("I was not asked to render an opinion" on overcrowding)); Ex. 86 (Martin Dep. at 10:12-21 ("I wasn't asked to render opinions on crowding.")); Ex. 88 (Moore Dep. at 32:13-22 ("We didn't look at overcrowding.").)

Defendants' willful blindness notwithstanding, the same overcrowding-caused deficiencies identified by the three-judge court and the Supreme Court are still major barriers to the delivery of a minimally adequate level of mental health care to the *Coleman* class. The current and ongoing constitutional violations do stem from Defendants' many knowing refusals to take sensible and necessary steps to remedy those violations. But the primary driver of the current and ongoing violations is the overcrowded conditions that still plague the California prison system.

The Receiver recently presented evidence of the direct relationship between existing levels of overcrowding and delivery of health care services at today's prisons. (Receiver's Resp. to Defs.' Objs. to Receiver's 22nd Report at 4-5, *Plata* Docket No. 2547, Feb. 22, 2013 (providing data showing that the most crowded prisons have poorest levels of compliance with basic health care standards).)

The photographs attached to Secretary Beard's declaration (Docket No. 4281) and Chris Meyer's declaration (Docket No. 4278) purport to demonstrate that the gyms and dayrooms have, by and large, been emptied of bunk beds,[6] and that at least some of the

[6] Whether, in fact, CDCR has truly emptied all of these overcrowded "bad beds" is far (footnote continued)

numerous promised health care construction and upgrade projects have finally been completed after years and years of cancellations and delays. But those photographs paint a very incomplete picture, one that omits a whole host of horrors.

Plaintiffs have introduced numerous photographs taken during their experts' inspections of CDCR prisons that occurred in January and February of 2013. They provide shocking and graphic current evidence that most *Coleman* class members, and most CDCR prisoners, have yet to realize any benefits in their housing or health care from Realignment or the Governor's "Blueprint," which is yet another plan to do things that this Court (and Judge Henderson in *Plata*) ordered many years ago. Conditions across the state are in too many ways unchanged from 2007 and 2008, when photographs of some of the exact same locations shocked the three-judge court, the Supreme Court and the public.

The evidence now before the Court demonstrates the ways in which overcrowding remains the primary barrier to Defendants' meeting their constitutional obligations. The system is filled with "bad beds," cages, non-confidential treatment spaces, crowded and cluttered medical units and offices, dangerous segregation units, unsafe cells, "alternative housing," and unlicensed, converted housing units used for mental health care. There are shortages of yard space in high security units. (Woodford Expert Decl. ¶ 41.) There is not enough staff or treatment space to provide adequate and meaningful treatment to prisoners with serious mental health needs. Clinical staff are spread thin and forced to improvise storage rooms and other converted areas into treatment and office space, while construction projects are trumpeted but remain promises on paper.

There is a correctional culture that is still stressed by dangerous levels of overcrowding and that continues to utilize excessive and unacceptable uses of force, predominantly impacting the mentally ill. (Vail Expert Decl. ¶¶35, 104, 107.) The cycle

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from clear. Plaintiffs' experts happened upon some extremely overcrowded housing units on their inspections that had all of the characteristics of the "bad beds" highlighted in the three-judge court trial. (*See, e.g.*, Haney Expert Decl. ¶ 161 & Photo Ex. W.)

of overcrowding-related violence, tensions, riots and homicides, resulting in harsher and increased security measures, continues unabated in CDCR. Modified programs and lockdowns, whether caused by violence or by custodial staffing shortages, continue to result in frequent cancellations of programs and activities, including mental health treatment. (*See* Vail Expert Decl. ¶¶ 104-108; Bien Decl. Ex. 79 (*Mitchell v. Felker*, No. 08-CV-01196 JAM EFB (E.D. Cal.), Decl. of Devin M. McDonell in Support of Pls.' Mot. for Class Certification and Mot. for Preliminary Injunction & Exs., Docket No. 160, Mar. 5, 2013 (providing data on security-based lockdowns in CDCR for 2010 and 2011).)

As Plaintiffs' expert Dr. Stewart describes, the alarming rate of suicide in CDCR's system is closely related to the effects of overcrowding. (Stewart Expert Decl. ¶¶ 170-177.) CDCR's still-crowded system is operating in ways that continue to place prisoners at high risk of suicide:

> First, overcrowded prisons are more frequently locked down and tend to offer far less programming to each prison than non-overcrowded ones. . . . [T]hese conditions create heightened risks for suicide prevention in a variety of ways, but one important way they create risks is because they impair the functioning and mental health of individuals who are mentally ill and or otherwise susceptible to suicidal ideation. Both the lack of purposeful activity and the social isolation experienced in locked-down, overcrowded prisons are damaging to mental health. Second, overcrowded prisons tend to have fewer mental health and custody staff for each prisoner, making surveillance more difficult among the population of at risk mentally ill individuals. Third, in my experience, overcrowded prisons are more violent and stressful for mentally ill prisoners than prisons that are not overcrowded. These factors greatly increase the risks of suicide among susceptible prisoners.

(*Id.* ¶¶ 174.)

The dysfunction in the system that chronic and severe overcrowding produced, and the norms, expectations, and culture that it has generated, have been entrenched for a very long time. Backlogs and other crowding-related stresses and deficiencies still predominate across the system. (Haney Expert Decl. ¶ 32.) Class members for their "own safety" are made to suffer non-therapeutic and damaging placements in harsh segregation units or under a "Lack of Bed" designation. (*See, e.g.*, Haney Expert Decl. ¶¶ 44-50, 141-162, 217-228, 243-268.) Inhumane units persist where suicidal men and women are made to sleep on the floor, receive treatment only in cages, and move from one place to another

only in cuffs and restraints, regardless of their actual clinical needs and security status. (*See* Stewart Expert Decl. ¶¶ 199-238; Vail Expert Decl. ¶¶ 104-107.)

Thousands of human beings – including those with serious mental illness – have been forced to live *with a cellmate* in cells that are too small to humanely house a *single* person under current national standards. Defendants are well aware of this shocking fact, but have not remedied it. Pulitzer/Bogard & Associates (P/B&A) was hired to complete a report on "Prison Capacity Planning" for CDCR. The final report, dated October 3, 2011, found that, under the American Correctional Association (ACA) standards, California's prisons should house no more than 94,691 prisoners. (Bien Decl. Ex. 8 (P/B & A California Department of Corrections and Rehabilitation Prison Capacity Planning Final Report) at 4.) Defendants then adjusted the ACA capacity figure upward, calculating a "Prison Operating Capacity" (POC) that yielded a maximum systemwide POC of 103,470 prisoners – almost exactly 130% of design capacity, and approximately 6,000 prisoners less than the three-judge court-ordered cap. (*Id*; *see also* Pls.' Suppl. Br. in Opp. to Defs.' Mot. to Vacate Population Reduction Order & in Support of Pls.' Mot. for Further Relief, Docket No. 4373, Mar. 11, 2013 (further analysis of P/B&A report in briefing to three-judge court).)

P/B&A further identified a serious problem with the way Defendants were housing prisoners in California's still terribly crowded system:

> The CDCR currently has more than 8,000 cells that are less than 55 square feet, including more than 2,800 cells that are less than 40 square feet. *In most cases, these cells hold two inmates, even though they would not be large enough (per ACA standards) for even one inmate.* The decision was made early on that while these cells would not be considered eligible for double bunking under the new methodology, at the same time they could not just be considered unusable and taken off line.

(Bien Decl. Ex. 8 at 10-11 (emphasis added).)

The fact that 8,000 CDCR cells do not meet the ACA standard for minimum cell size to house a single prisoner is shocking. That a substantial number of such undersized cells are filled with *two* prisoners is unconscionable. (Haney Expert Decl. ¶ 159.) Yet 15 months after CDCR received this report, Plaintiffs' experts observed such cells in use for

double-celling at CIM. Madrone Hall at CIM was overcrowded with prisoners on the day of the tour. The cells in that unit are 47.8 gross square feet each. (Bien Decl. Ex. 8 at 93.) Several inmates, including two EOP inmate-patients, were double-celled in that unit, a shocking sight, and a situation that places mentally ill and vulnerable prisoners at considerable risk of psychological and other harm. (Haney Expert Decl. ¶¶ 154-59 & Photo Ex. U.)

Figure 2 CIM Reception Center housing for 2 EOP patients, one of whom slept on floor, taken Feb. 13, 2013.

The Plaintiffs' experts provide extensive visceral evidence of the impact of overcrowding and space shortages in their declarations. Two more examples are provided below.

Figure 3 CIM A-Yard, Angeles Dorm, which houses EOP, CCCMS and general population, taken Feb. 12, 2013.

Figure 4 Treatment cages for group therapy in EOP administrative segregation unit, MCSP, taken Feb. 7, 2013.

To suggest that these are the pictures of a prison system that is not overcrowded, "provide[s] humane conditions of confinement," and "take[s] reasonable measures to guarantee the safety of the inmates," *Farmer*, 511 U.S. at 832, is deeply cynical, and it is entirely incorrect. Defendants have yet to demonstrate the commitment and action

necessary to meet their constitutional obligations.

CONCLUSION

Constitutional violations are current and ongoing and present needless risk of injury and death to California state prisoners with serious mental illness. For the reasons stated herein, Defendants' termination motion should be denied in its entirety.

DATED: March 15, 2013

Respectfully submitted,

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