STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT

C/A No.: 2005-CP-40-2925

T.R., P.R., and K.W., on behalf of themselves and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc.,

Plaintiffs,

v.

South Carolina Department of Corrections and William R. Byars, Jr., as Agency Director of the South Carolina Department of Corrections

Defendants.

**ORDER GRANTING JUDGMENT IN FAVOR OF PLAINTIFFS**

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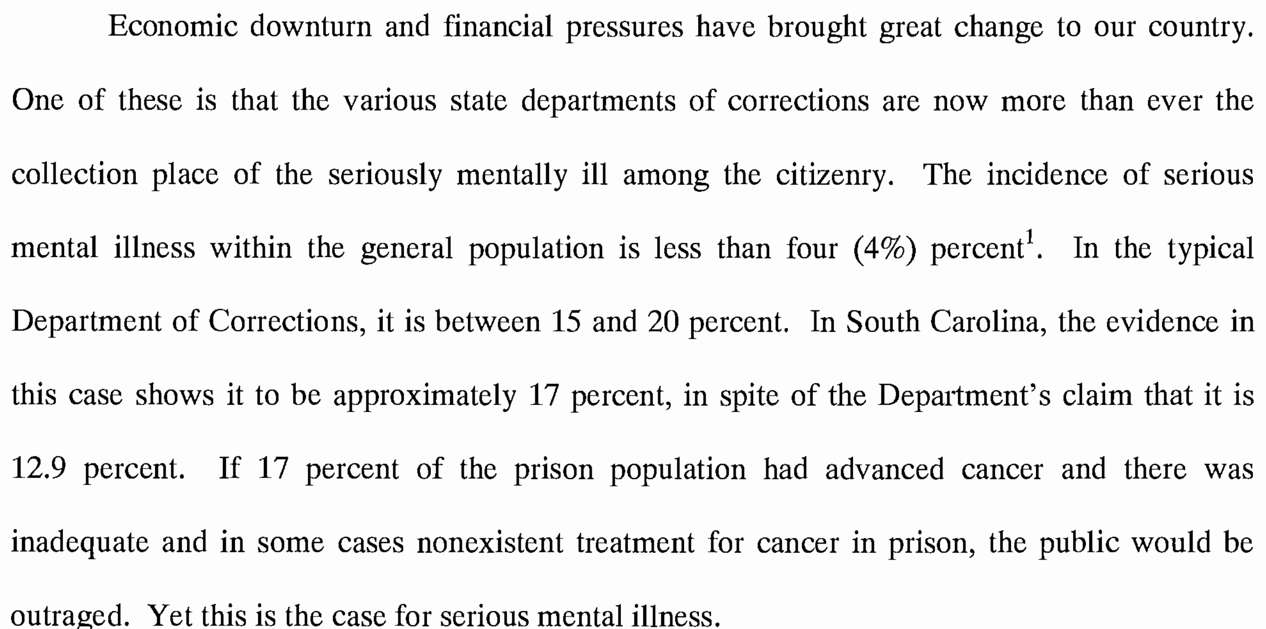
C.C.P. & G.S.

It has been the privilege of this writer to serve the State of South Carolina as a general jurisdiction judge for fourteen years. At the time this case was heard, Court Administration reported there were more than 5,000 new case filings per year for each of our state's circuit court judges. Thus, over 70,000 cases of every imaginable sort have come to this Court over the years. This case, far above all others, is the most troubling.

This case is a class action brought on behalf of approximately 3.500 state inmates who meet the definition of being seriously mentally ill. For purposes of this suit, the term "serious mental illness" was specifically defined in the Class Certification order dated November 1, 2007, and may be succinctly stated as all SCDC inmates from the date of the filing of the complaint who have been hospitalized for psychiatric services, referred to an Intermediate Mental Health Care Services Unit, or diagnosed by a psychiatrist with the following mental illness: Schizophrenia, Schizoaffective Disorder, Cognitive Disorder, Paranoia, Major Depression, Bipolar Disorder, Psychotic Disorder, or any other mental condition that results in significant

functional impairment including inability to perform activities of daily living, extreme impairment of coping skills, or behaviors that are bizarre and/or dangerous to self or others. Plaintiffs claim that their treatment within SCDC, or lack of treatment, constitutes a violation of the state constitution.

The evidence in this case has proved that inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness. As a society, and as citizen jurors and judges make decisions that send people to prison, we have the reasonable expectation that those in prison – even though it is prison – will have their basic health needs met by the state that imprisons them. And this includes mental health. The evidence in this case has shown that expectation to be misplaced in many instances.



Economic downturn and financial pressures have brought great change to our country. One of these is that the various state departments of corrections are now more than ever the collection place of the seriously mentally ill among the citizenry. The incidence of serious mental illness within the general population is less than four (4%) percent[1]. In the typical Department of Corrections, it is between 15 and 20 percent. In South Carolina, the evidence in this case shows it to be approximately 17 percent, in spite of the Department's claim that it is 12.9 percent. If 17 percent of the prison population had advanced cancer and there was inadequate and in some cases nonexistent treatment for cancer in prison, the public would be outraged. Yet this is the case for serious mental illness.

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[1] Figures vary depending upon the source, demographics, and differences in various definitions of "serious mental illness." The Court takes judicial notice of the statistical findings of the National Institute of Mental Health, which places the general population figure at 3.9%. Further statistical information may be obtained from the NIH at www.nimh.nih.gov/statistics/SMI_AASR.shtml.

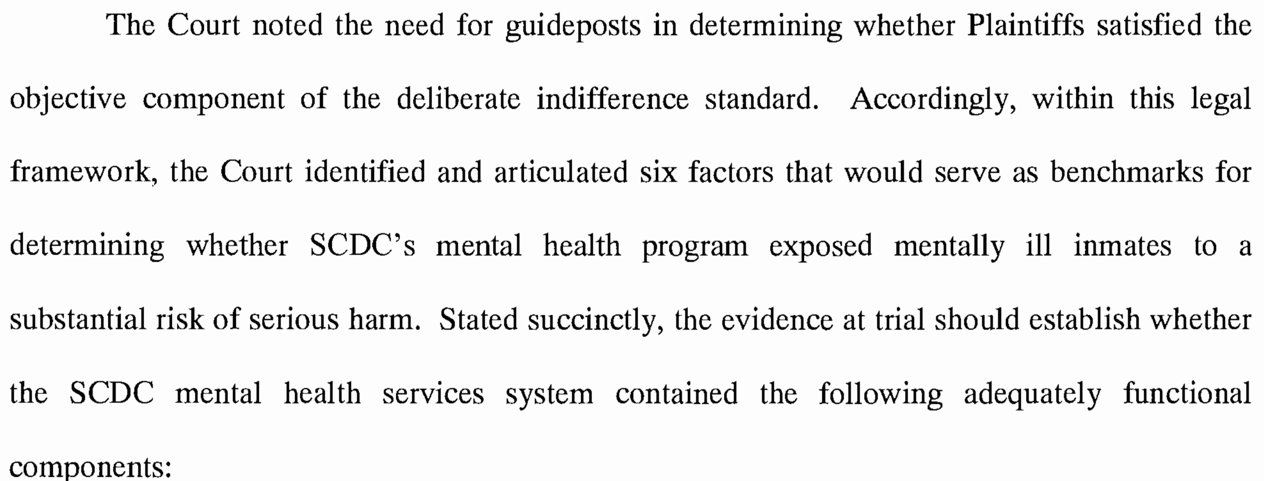
This litigation does not occur in a vacuum. What happens at the Department of Corrections impacts all of us, whether it is from the discharge of untreated seriously mentally ill individuals from prison into the general population, or tremendously increased costs for treatment and care that might have been prevented, or the needless increase in human suffering when use of force replaces medical care. The decisions of our Courts reflect the values of our society. To that end, our state can no longer tolerate a mental health system at the South Carolina Department of Corrections that has broken down due to lack of finances and focus.

While the Court finds the inadequacy of the mental health system at SCDC has not occurred by design, but instead by default, the Court further finds this decision in favor of Plaintiffs should not come as a shock to SCDC. Previous internal and external reviews of the SCDC mental health system have found multiple inadequacies and failures. Despite its knowledge of the grave risks these deficiencies pose to mentally ill inmates, SCDC has failed through the years to take reasonable steps to abate those risks. The Court recognizes that the Department is underfunded and understaffed in many particulars, not just mental health services delivery. The operation of any state agency is a matter of competing priorities, and the General Assembly, as keeper of the public purse, is not in a position to excessively fund any entity. Thus, this decision will ultimately require an increase in priority for mental health services commensurate with the level of serious mental illness within the prison population.

**DECISION**

In its prior Order Setting Forth Applicable Constitutional Standards ("Standards Order"), the Court delineated the standard of liability and burden of proof applicable to Plaintiffs' constitutional claim under Article I, § 15 of the South Carolina Constitution, which prohibits "cruel and unusual punishment." To prevail on a claim under Article I, § 15, the Court stated

that Plaintiffs must prove that Defendants acted with "deliberate indifference to serious medical needs of prisoners." Standards Order at 3 (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). This deliberate indifference standard contains both an objective and subjective component. *See Farmer v. Brennan*, 511 U.S. 825, 834-37 (1994). To satisfy the objective component, Plaintiffs must demonstrate that they are subjected to a substantial risk of harm that is sufficiently serious. *Id.* The objective component is not limited to past harm, but also protects inmates from an unreasonable risk of future harm. *Helling v McKinney*, 509 U.S. 25, 35 (1993). Plaintiffs may satisfy the objective component by showing that systemic deficiencies in a prison mental health system expose inmates with serious mental illness to a substantial risk of serious future harm. Standards Order at 7-8, *citing Helling*; 509 U.S. at 35; *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Flynn v. Doyle*, 2009 WL 4262746 at *19 (E.D. Wis. 2009); *Madrid v. Gomez*, 889 F. Supp. 1146, 1256 (N.D. Cal. 1995); *Neiberger v. Hawkins*, 208 F.R.D. 301, 317 (D. Colo. 2002).



The Court noted the need for guideposts in determining whether Plaintiffs satisfied the objective component of the deliberate indifference standard. Accordingly, within this legal framework, the Court identified and articulated six factors that would serve as benchmarks for determining whether SCDC's mental health program exposed mentally ill inmates to a substantial risk of serious harm. Stated succinctly, the evidence at trial should establish whether the SCDC mental health services system contained the following adequately functional components:

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.

Standards Order at 8-10, *citing Ruiz v. Estelle,* 503 F. Supp. 1265, 1339 (S.C. Tex. 1980) *aff'd in part, rev'd in part,* 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part,* 688 F.2d 266 (5th Cir. 1982), *cert. denied,* 460 U.S. 1042 (1983).

Employing these factors in the context of the objective component of the deliberate indifference standard, the Court finds by a preponderance of the evidence that the Plaintiffs have met the burden of proof and makes the following threshold findings.

First, the mental health program at SCDC is severely understaffed, particularly with respect to mental health professionals, to such a degree as to impede the proper administration of mental health services. This deficiency has a substantial impact on every aspect of the mental health program, beginning at Reception and Evaluation ("R&E"), where inmates are screened and evaluated for mental health needs, continuing into the treatment programs for seriously mentally ill inmates, and ending with deficient discharge planning for seriously mentally ill inmates being returned to the general public.

Second, seriously mentally ill inmates are exposed to a disproportionate use of force and segregation (solitary confinement) when compared with non-mentally ill inmates. Segregation and use of force are often used in lieu of treatment, with severe consequences for inmates with

serious mental illness. The inappropriate and extended reliance on segregation to manage inmates with serious mental illness, particularly those in crisis, exposes them to a substantial risk of serious harm by limiting their access to mental health counselors and psychiatrists, disturbing their eating and sleeping cycles, disrupting the administration of medications, and deepening their mental illnesses. These conditions have contributed to the deaths of multiple inmates in segregation, while placing other inmates and staff at risk. They have also led to the stigmatization of mental illness within SCDC that discourages inmates from seeking the limited mental health care the agency does provide.

Third, mental health services at SCDC lack a sufficiently systematic program that maintains accurate and complete treatment records to chart overall treatment, progress, or regression of inmates with serious mental illness.

Fourth, SCDC's screening and evaluation process is ineffective in identifying inmates with serious mental illness and in providing those it does identify with timely treatment.

Fifth, SCDC's administration of psychotropic medications is inadequately supervised and evaluated.

Sixth, SCDC's current policies and practices concerning suicide prevention and crisis intervention[2] are inadequate and have resulted in the unnecessary loss of life among seriously mentally ill inmates.

As a result of the above findings, the Court further finds that SCDC's mental health system exposes seriously mentally ill inmates to a substantial risk of serious harm and Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

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[2] "Crisis intervention" refers to SCDC's response to an actively mentally ill inmate who poses an immediate danger and must be sequestered for his own protection or the protection of other inmates and correctional officers.

The subjective component is met by proof that a defendant "knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer*, 511 U.S. at 834-837. At trial, the Plaintiffs presented overwhelming evidence that SCDC has known for years that its policies and practices expose seriously mentally ill inmates to a substantial risk of serious harm but has failed to take reasonable measures to abate that risk. The Court finds, therefore, that the Plaintiffs have satisfied the subjective component of the deliberate indifference standard.

As a result of the above findings, the Court grants judgment in favor of the Plaintiffs.

Below, the Court has separated the remainder of this Final Order into two sections. The first section articulates the factual findings and conclusions underlying the Court's decision with respect to the objective component by examining each of the six *Ruiz* factors listed above. The first section then articulates the factual findings and conclusions related to the subjective component. The findings made therein are by a preponderance of the evidence. Section Two then addresses the remedy the Court will grant in this case and the mechanism used to achieve it.

With regard to the factual findings and conclusions mentioned below in Section One, there are several references to individual circumstances involving specific inmates. The Department argued at trial that reference to an individual inmate and his/her particular situation was anecdotal and not indicative of the general administration of mental health services. Moreover, counsel for SCDC essentially argued that some of the specific inmate situations were "outliers" in that such was a constellation of unique events and circumstances that brought about an unfortunate result. The Court specifically rejects that argument. While no system involving thousands of inmates is expected to be perfect, the Court finds that the individual circumstances

referred to below are the result of a system that is inherently flawed in many respects, understaffed, underfunded, and inadequate.

# I. FACTUAL FINDINGS/DISCUSSION

## A. Objective Component

### 1. A systematic program for screening and evaluating inmates to identify those in need of medical care

As of 2011, 12-13 percent of the SCDC inmate population had been diagnosed by SCDC with a mental illness and was on the Department's mental health caseload. From that data, with a total inmate population at the time of trial of 23,306, a 12.9 percent fraction yields an approximate figure of 3,006 inmates that have been diagnosed as mentally ill.[3] Based on universally accepted national statistics, evidence presented to the Court at trial strongly indicates this percentage should be much higher. Multiple studies conducted nationwide suggest that a more accurate percentage of inmates with a serious mental illness should be somewhere in the range of 15 to 20 percent. SCDC's expert, Dr. Scott Haas, testified that seriously mentally ill inmates ordinarily comprise 18 percent of a prison population. Plaintiffs' expert, Dr. Raymond F. Patterson, testified that after detailed analysis, 17 percent was a conservative estimate of SCDC's seriously mentally ill population, and the Court finds the basis of his analysis to be credible.

The Court further finds this low, acknowledged percentage of mentally ill inmates at SCDC troubling because it indicates a high likelihood that there are hundreds of inmates with a serious mental illness at SCDC who are not receiving any treatment due to deficiencies in the screening and evaluation process used to identify and classify those with a serious mental illness.

[3] Exact numbers fluctuate due to the constant intake and release of inmates.

This low identification of mentally ill inmates has a synergistic impact on the mentally ill population, as it leads to a reduction in mental health professionals, the further disproportionate cutting of costs in difficult economic times within the mental health system because of a perceived lack of need for services, and a skewed analysis as to the efficacy of the existing mental health system. R&E serves as the intake facility for inmates entering into SCDC. If inmates with mental illnesses are not identified and appropriately classified at R&E, the Court finds that these inmates face a substantial risk of serious harm.

In addition to the concerns mentioned above, there was also evidence presented to the Court of regular violations of the SCDC mental health policy, two of which are particularly relevant to the Court as they relate to the screening and evaluation process at R&E. First, SCDC policy requires that a mental health counselor must meet with an inmate within 48 hours of the inmate being assigned to that counselor's caseload. At trial, there was evidence submitted to the Court of regular and persistent violations of this policy. Second, inmates are not being seen by a psychiatrist within thirty days of the counselor's initial assessment when a need for psychiatric treatment is indicated, also a violation of SCDC policy. Consequently, this results in inmates who are referred to a psychiatrist at R&E, but are then transferred into SCDC general population prior to assessment by that psychiatrist, creating a risk of harm for all inmates.

The Court finds, due to the concerns listed above, that the program used by SCDC for screening and evaluation fails to adequately identify and classify those inmates suffering from serious mental illness, thereby exposing them to a substantial risk of serious harm.

### 2. A treatment program that involves more than segregation and close supervision of mentally ill inmates

#### a. Segregation

The treatment program at SCDC places heavy reliance on segregation and use of physical force against seriously mentally ill inmates, as opposed to treatment.

Mentally ill inmates are substantially overrepresented in segregation units, known as Special Management Units ("SMU"), within SCDC. Inmates in segregation stay in solitary confinement in their cells 23-24 hours a day. Visitation, telephone, and other privileges are significantly restricted. As of September 2011, the percentage of mentally ill inmates in SMUs at the three SCDC institutions where the majority of men with serious mental illness are assigned ("Area Mental Health Institutions") demonstrates the disproportionate use of segregation to which members of the Plaintiff class are subjected. At Lee Correctional Institution ("Lee"), 16 percent of the total inmate population was mentally ill, yet 27 percent of its inmates in SMU were mentally ill.[4] The corresponding numbers at Perry Correctional Institution ("Perry") were 24 percent and 40 percent. At Lieber Correctional Institution ("Lieber"), the differential was even greater, where mentally ill inmates comprised 20 percent of all inmates, yet 42 percent of the inmates that were in segregation. During this same period, the percentage of mentally ill inmates in SMUs in all SCDC institutions was 23 percent, even though they represented less than 13 percent of the total inmate population.

Taking the entire population into consideration, a mentally ill inmate is twice as likely to be placed in segregation as a non-mentally ill inmate. As of September 2011, 16 percent of inmates on the mental health caseload were in SMUs in contrast with 8 percent of non-mentally ill inmates. For security detention, the most restrictive form of segregation, where inmates are placed in solitary confinement for indefinite periods, mentally ill inmates are more than three

[4] These percentages are based on the SCDC mental health caseload.

times more likely to be assigned this status than other inmates, at a rate of 8.7 percent compared with 2.8 percent.[5]

Not only are mentally ill inmates overrepresented in SMUs, they also spend disproportionately longer periods of time in the SMUs. For many mentally ill inmates, this period of isolation in SMU has lasted for several years. For example, the average cumulative disciplinary detention sentence for inmates with mental illness as of January 13, 2012 was 647 days, compared to 383 days for non-mentally ill inmates. These averages include extremely long periods of segregation for inmates whose disciplinary detention sentences exceeded their projected release date from SCDC. Again, these extended sentences were meted out against mentally ill inmates at over twice the rate of other inmates. The lengths of these sentences in segregation were also far greater for members of the Plaintiff class, exceeding their projected release date on average by 1,968 days or 5.39 years, compared with 1,065 days or 2.92 years for other inmates. Of the ten longest periods of disciplinary detention sentences beyond projected release dates, nine of the inmates were mentally ill. Their cumulative sentences for solitary confinement ranged from 20-36 years.

The evidence showed that these extended periods of segregation too often reflect the accumulation of disciplinary detention sentences for non-assaultive behavior of mentally ill inmates. For example, one 51-year-old mentally ill inmate who had been hospitalized at SCDC's psychiatric facility accumulated 19 years of disciplinary detention sentences from 2005-2008. For one non-assaultive offense in which he threatened harm, he received 999 days of disciplinary detention and lost visitation for three years. In interviews with Plaintiffs' experts, he was

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[5] The two principal forms of punitive segregation are security detention and disciplinary detention. Disciplinary detention consists of sentences served in segregation for a specific period of time for violation of SCDC administrative rules. Security detention is a classification assigned to inmates determined to present a particular risk to other inmates or staff that often remains in effect for periods lasting several years.

distressed that he was being denied "400 million dollars in his bank" and was set to appear on the television program "The Rich and Famous."

A 27-year-old female mentally ill inmate accumulated six and a half years of disciplinary detention segregation and lost access to the telephone and visitation for eight years for non-assaultive offenses, most of which were verbal or profane threats to staff or other inmates. One of the charges was prompted when she threatened two inmates who were making derogatory remarks about a medical condition that required her to wear diapers.

The evidence revealed that the great majority of the extreme periods in segregation are in fact served. For example, Leslie Cox, a member of the Plaintiff class, was confined in SMU for at least 2,565 consecutive days, from February 2001 - February 2008. James Wilson, another mentally ill inmate, was confined in SMU for at least 2,491 consecutive days.[6] SCDC records provide conflicting information about mentally ill inmate Rowland Dowling, who spent either 1,777 or 2,200 consecutive days in solitary. Other mentally ill inmates were confined in solitary for similarly lengthy periods.

SCDC's Guilty But Not Accountable ("GBNA") policy should theoretically reduce the number of mentally ill inmates in segregation but, in fact, has had a negligible effect. SCDC counselors are responsible for recommending findings of GBNA but this Court finds that, as Dr. Patterson testified, many SCDC counselors are not qualified to analyze accountability. Only 2 percent of mentally ill inmates receiving segregation sentences are determined to meet GBNA criteria.[7] Moreover, of those found to be GBNA, the finding has had no effect on their

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[6] SCDC records indicate that inmates Cox and Wilson were still in segregation as of February 25, 2008. It is unknown how much longer they remained in segregation after that date.

[7] Evidence introduced by Plaintiffs also showed that a small percentage of the disciplinary detention sentences for male mentally ill inmates at Area Mental Health Institutions were reduced or waived during a 21-month review period between 2010 and 2011.

sentences. Of all inmates in SCDC custody on September 1, 2011 who had been found GBNA, 25 were mentally ill. Despite being found "not accountable," all 25 had been sentenced to segregation.

The American Correctional Association ("ACA") defines disciplinary detention or punitive segregation as follows:

> A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined by the disciplinary committee or other authorized group for ***short periods of time*** to individual cells separated from the general population.

ACA *Standards for Adult Correctional Institutions Supplement*, p. 306 (2008) (emphasis added).

The ACA standards also recognize the potentially harmful effects of punitive segregation on the mental health of any inmate:

> Inmates whose movements are restricted in segregation units may develop symptoms of acute anxiety or other mental health problems; regular psychological assessment is necessary to ensure the mental health of any inmate confined in such a unit beyond 30 days.

ACA *Standards for Adult Correctional Institutions*, 3rd Edition, Standard 3-4244 (2008).

The evidence presented by Plaintiffs demonstrates that SCDC consistently showed little to no regard for the mental health of inmates in imposing periods of disciplinary or security detention, in the lengths of the segregation imposed, or in the effects on mentally ill inmates. The Department's practice consistently violates the ACA standards. Neither the disciplinary detention sentences nor classifications in security detention are for short periods of time. Once in segregation, the level of therapeutic care or intervention to address the needs of mentally ill inmates is grossly inadequate.

Dr. Janet Woolery, the principal psychiatrist at Lee, estimated that approximately 40-50 percent of the Lee SMU inmates she saw were demonstrating active psychotic symptoms.

Rather than placing mentally ill inmates into treatment programs, it appears that they are merely placed in SMUs. SMU patients receive no group therapy and sessions with both psychiatrists and mental health counselors are seldom held in a confidential setting. Sixty-three percent of the counselor audits produced by SCDC noted deficiencies for untimely psychiatric sessions and 77 percent noted deficiencies for untimely counselor assessments. Patient medical records provide further evidence that SMU patients often do not see psychiatrists or counselors on a timely basis. For example, SCDC policy requires that Edward Barton, diagnosed with schizophrenia and classified as an Area Mental Health patient, be seen by a mental health counselor at least once every 30 days, as well as by a psychiatrist at least once every 90 days. Yet, from July 2008 – November 2010, while confined in an SMU, Barton on six occasions went over 30 days without seeing a counselor; on four of those occasions he went over 60 days without seeing a counselor; and once he went 9 months without seeing a counselor. From September 2010 – August 2011, Barton twice went over 120 days without seeing a psychiatrist and once went over 6 months.

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SCDC's heavy reliance on segregation of mentally ill inmates raises serious concerns for the Court. As acknowledged by SCDC Mental Health Regional Coordinator Jacqueline Strong, risk factors for psychosis and suicide increase while an inmate is in SMU. It is not uncommon for an inmate in SMU to develop depression and experience a disturbance in eating and sleeping cycles.[8]

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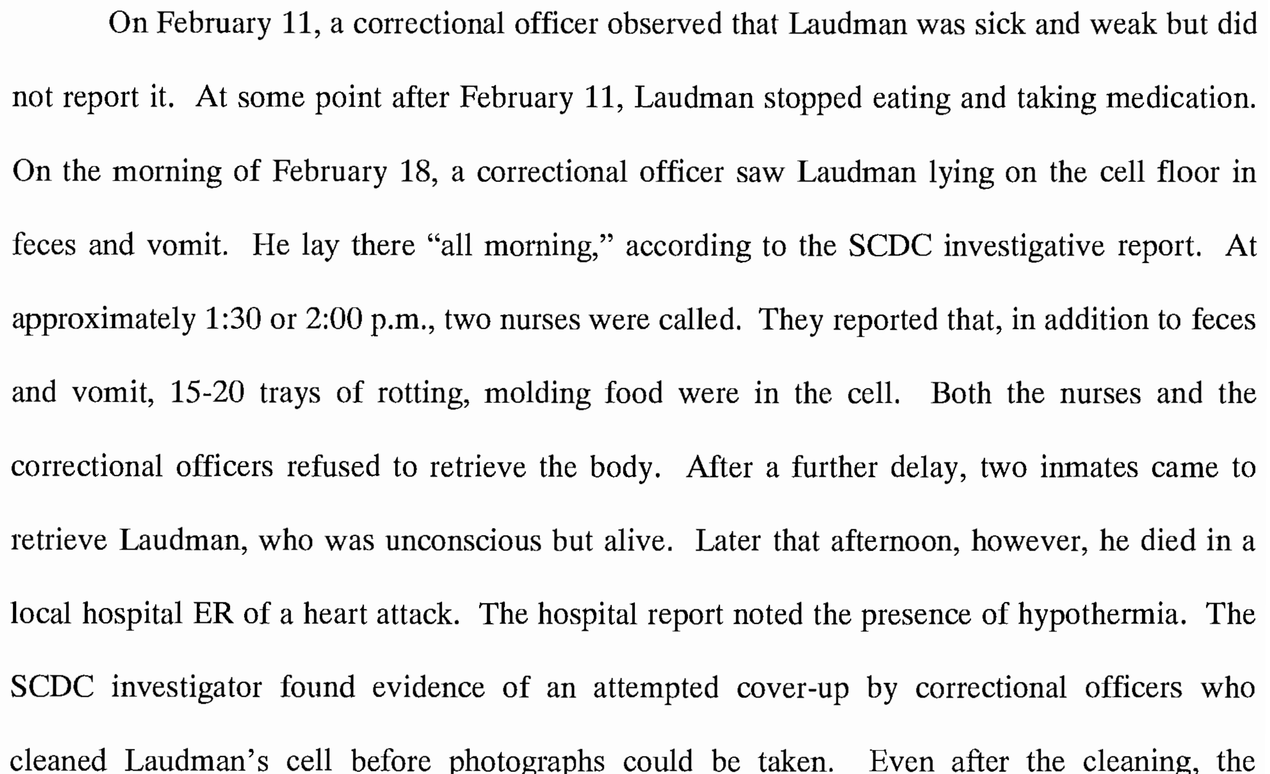
[8] Defendants relied upon a Colorado Department of Corrections study to assert that long-term segregation has no significant detrimental effect on mental health. However, the Court finds that the Colorado study is distinguishable from the situation at SCDC for two reasons. First, the Colorado study was limited to inmates who had spent no more than twelve consecutive months in segregation. Many SCDC mentally ill inmates stay in segregation for much longer periods of time. Second, the Colorado study was expressly limited to SMUs with substantially similar conditions to the Colorado State Penitentiary. Plaintiffs' two psychiatric experts, Dr. Metzner and Dr. Patterson, each testified they were familiar with the Colorado State Penitentiary and that conditions in SCDC segregation units were much harsher. As Dr. Patterson testified, the difference was like "night and day."

Moreover, evidence in the case shows conditions in SMUs fall below what is acceptable for a 21st century correctional institution. SMU cells are both extremely cold and inordinately filthy, often with the blood and feces of previous occupants smeared on the floor and walls.

Within the SMU of Lee Correctional Institution is a special 8-cell unit known as "Lee Supermax." On February 7, 2008, inmate Jerome Laudman was transferred to a cell in Lee Supermax. Laudman was schizophrenic, intellectually disabled, and had a speech impediment. According to his mental health counselor, he was neither aggressive nor threatening. No one notified the counselor of Laudman's transfer to Lee Supermax. According to an internal SCDC investigative report, Laudman was sprayed with chemical munitions and physically abused by a correctional officer during the transfer to Lee Supermax. The move was videotaped pursuant to policy, but when viewed by the SCDC investigator, the tape was, inexplicably, mostly blank. Laudman was stripped naked and left in a completely empty Supermax cell.



On February 11, a correctional officer observed that Laudman was sick and weak but did not report it. At some point after February 11, Laudman stopped eating and taking medication. On the morning of February 18, a correctional officer saw Laudman lying on the cell floor in feces and vomit. He lay there "all morning," according to the SCDC investigative report. At approximately 1:30 or 2:00 p.m., two nurses were called. They reported that, in addition to feces and vomit, 15-20 trays of rotting, molding food were in the cell. Both the nurses and the correctional officers refused to retrieve the body. After a further delay, two inmates came to retrieve Laudman, who was unconscious but alive. Later that afternoon, however, he died in a local hospital ER of a heart attack. The hospital report noted the presence of hypothermia. The SCDC investigator found evidence of an attempted cover-up by correctional officers who cleaned Laudman's cell before photographs could be taken. Even after the cleaning, the

photographs taken by the investigator show the cell in a deplorably dirty state. After Laudman's death, SCDC did no quality improvement reviews of Lee Supermax procedures and practices. In September 2008, seven months after Laudman's death, Dr. Metzner and Dr. Patterson inspected Lee Supermax and described it as "filthy."

**b. <u>Use of force</u>**

Mentally ill inmates also suffer from disproportionate, unnecessary, and excessive uses of force.

i. <u>Disproportionate Use of Force</u>. Between January 2008 and September 2011, mentally ill inmates were subjected to uses of force at a rate two and half times greater than non-mentally ill inmates. During this period, 27 percent of the Plaintiff class was subjected to the use of force in contrast to only 11 percent of other inmates. At the Area Mental Health Institutions for men, the reliance on use of force was even greater. At Lee, Lieber, and Perry, 40 percent, 43 percent, and 44 percent of mentally ill inmates were subjected to force, respectively, while the corresponding numbers of non-mentally ill inmates subjected to force at these institutions were 23 percent, 21 percent, and 16 percent, respectively. Although force was applied far less frequently at Camille G. Graham Correctional Institution ("Graham"), the Area Mental Health Institution for women, the same pattern was present. During the relevant review period, only fourteen use-of-force incidents were reported; however, ten of these incidents were directed toward mentally ill women, even though members of the Plaintiff class constituted less than half of the total inmates at Graham.

The evidence was clear and compelling that SCDC resorts to use of force in the agency's attempt to manage the conduct of mentally ill inmates. Of the inmates who were subjected to use of force, each mentally ill inmate who had been the object of a reported use of force during this

period was subjected on average to 3.35 separate incidents, while the use-of-force rate for other inmates was almost half that, at 1.72 incidents per inmate.

Of the thirty inmates most frequently subjected to the use of force, twenty-six were on the mental health caseload. The mental health conditions were so serious for many of these individuals that fifteen of the twenty-six required hospitalization during the same period at Gilliam Psychiatric Hospital ("Gilliam" or "GPH"). Ten of these fifteen inmates were hospitalized on multiple occasions. James Howard was subjected to 81 separate use-of-force incidents. Mr. Howard was hospitalized for psychiatric treatment on five separate occasions during this same period between January 2008 and September 2011.

SCDC's overreliance on the use of force in attempting to manage mentally ill inmates is, in part, a direct effect of the lack of training correctional officers receive. SCDC training coordinator Yolanda Delgado testified in deposition only twelve days before trial that "less than a handful" of correctional officers attended training sessions intended to improve the staff's knowledge and skills in dealing with mentally ill inmates.

ii. Unnecessary and Excessive Use of Force. Plaintiffs' corrections expert, Steve J. Martin, testified that while SCDC's use-of-force policy was consistent with national correctional standards, its use-of-force practices were not. Based on his review of over 1,000 incident reports at SCDC involving OC spray (pepper spray), Mr. Martin testified a pattern and practice existed that violated national standards and SCDC's own use-of-force policy. First, Mr. Martin testified in detail about eighteen case examples at SCDC of the unnecessary use of force where no threat of harm or other urgent circumstances were present and, in some cases, where OC spray was used simply as punishment. Mr. Martin testified, and the Court finds, that these cases were representative of the more than 1,000 incidents he

reviewed. Second, Mr. Martin found it common for SCDC correctional officers to use excessive force. For example, contrary to SCDC policy, SCDC officers routinely gas inmates with OC spray in amounts that exceed manufacturer instructions and at closer distances than the manufacturer directs. Mr. Martin identified nine case examples, documented in SCDC reports, where SCDC officers had used MK-9 crowd control fogger devices in large disbursements in individual closed cells, again contrary to manufacturer instructions and SCDC policy. In fact, Mr. Martin testified that having reviewed thousands of uses of OC spray in prisons and jails throughout the country, he had "never seen MK-9, a crowd control contaminant, so frequently used by a correctional force inappropriately." The use of such force is without penalogical justification.

SCDC's unnecessary and excessive use of OC spray on mentally ill inmates is consistent with its unnecessary and excessive use of physical restraints. Contrary to its policy and national correctional standards, SCDC places inmates in restraint chairs for predetermined blocks of time in set, four-hour increments.[9] For example, on December 12, 2007, inmate Steven Patterson was transferred to Perry from Gilliam but, by SCDC's mistake, with only five days' worth of psychotropic medications. On January 2, 2008, Patterson's medical record noted that he had not received medication since December 17, 2007 "and he's not doing well." That same day, he cut himself with a plastic spoon and was placed naked in a restraint chair for twelve hours, even though the videotape of his time in the chair shows him calm and cooperative. On January 3, he was returned to Gilliam.

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[9] SCDC witnesses testified this practice was changed shortly before the start of this trial so that inmates no longer will be placed in restraint chairs for predetermined blocks of time. The timing of this change concerns the Court, however, for "practices may be reinstated as swiftly as they were suspended." *Thomas v. Bryant*, 614 F.3d 1288, 1320 (11th Cir. 2010).

Mr. Patterson's experience was only one example of how SCDC uses restraint chairs as a substitute for medical treatment. Plaintiffs entered into evidence two gruesome SCDC videotapes of inmates with self-inflicted wounds who were kept in the restraint chair for extended periods of time before receiving adequate medical treatment. Inmate Jerod Cook cut himself on his arm. Approximately 90 minutes after being discovered, he was placed in a restraint chair where he remained for four hours. The videotape shows a pool of blood on the floor of Mr. Cook's cell. He is hardly able to stand before being placed in the restraint chair. He continues to bleed while in the restraint chair and pleads with correctional officers for medical help. As Dr. Patterson testified, the decision by security staff – rather than by medical staff – to keep Mr. Cook in a restraint chair for four hours under those conditions was an "outrageous, horrific response."

Inmate Baxter Vinson underwent a similar experience, cutting himself in the abdomen while in his cell. Approximately three hours and twenty minutes after his wound was discovered, security staff placed him in a restraint chair where he remained for approximately two hours before being transported to a hospital. The videotape shows that while in the restraint chair, Mr. Vinson is eviscerating, with his intestine coming out of the abdominal wall. The tape shows correctional officers tightening the restraints, thereby putting additional pressure on his abdomen. As Dr. Patterson testified, this was a medical emergency that required a sterile environment. The videotape gives further evidence of what Dr. Patterson characterized as "a broken system."

Inmates are often placed naked in restraint chairs. Bathroom breaks are infrequent, so that at times they are forced to urinate in the chair. A common practice at Perry when placing inmates in a restraint chair is to secure them in a painful, "crucifix" position, demonstrated to

Mr. Martin both by Perry correctional officers and inmates. Inmates Richard Patterson and Jonathan Roe both testified about spending hours in what they characterized as the "Jesus" position.

OC spray and restraint chairs are not the only methods of physical force employed by SCDC against mentally ill inmates. Shawn Wiles, a mentally ill inmate in SCDC's Maximum Security Unit, testified that correctional officers restrained his arms in a twisted position, soaked him with water, and left him outside for approximately an hour on a cold December night.

While SCDC contends these are isolated examples of inappropriate conduct by correctional officers, it offered little or no evidence of effective supervisory oversight of the use of force. Mr. Martin testified that one of the standard protections prison systems use to guard against excessive use of force is review of use-of-force incidents. The first element of an effective review process is an examination of the cases that are referred to senior management for review of questionable uses of force. The second element consists of an assessment of the findings concerning allegations of inappropriate force and corrective actions taken. Of the more than one thousand cases Mr. Martin reviewed, very few were referred to senior SCDC officials to assess an alleged inappropriate use of force. Mr. Martin found that of the few cases that were referred, SCDC officials made virtually no findings of excessive or unnecessary force.

In a prison system of more than 23,000 inmates, Mr. Martin testified that the almost complete absence of the identification by managers of inappropriate uses of force is a "huge red flag" that raises serious questions about the existence of an effective system to manage the use of force by correctional officers. Mr. Martin testified that the risk of harm to mentally ill inmates from the unnecessary and excessive use of force, if left unattended and not corrected, is ongoing

and substantial. The Court finds Mr. Martin's testimony, and the bases for his opinions, to be credible.

The Court is concerned by the absence of referrals for investigation of the cases presented by Mr. Martin, and the absence of findings by senior SCDC managers that those cases raise serious questions about the application of force against mentally ill inmates. The Court finds that such excessive uses of force have been largely unreported, uninvestigated, and unmanaged. The Court further finds that Plaintiffs have proven a pattern and practice of the use of unnecessary and excessive force.

### c. Limited involvement of psychiatrists

A substantial contributing factor to the lack of an effective treatment program is the limited involvement of psychiatrists in creating and administering treatment plans for mentally ill inmates. Psychiatrists at SCDC have no administrative or policy-making duties, and there is evidence that they do not attend meetings to create and develop treatment plans for inmates. The Court finds that psychiatrists, as the lead mental health professionals in the mental health program, must be more directly involved in creating and developing treatment plans. Furthermore, deposition testimony of some psychiatrists reveals an alarming lack of knowledge of policies and procedures at SCDC, the levels of care and criteria for referral to a particular level of care, and the role of the counselor in the mental illness treatment process. For example, SCDC psychiatrist Dr. Poiletman did not know what the terms SMU and CI stood for – meaning Special Management Unit and Crisis Intervention – terms inextricably tied to mentally ill inmates at SCDC. He did not know the difference between Area Mental Health patients and outpatients, did not know what mental health counselors do, and had "no idea" who drafted treatment plans. Likewise, Dr. Crawford, the principal psychiatrist at Graham, could not

describe the distinction between an Intermediate Care Services patient and an Area Mental Health Patient. She did not review treatment plans and did not start attending treatment team meetings until after her deposition. Dr. Woolery, the principal psychiatrist at Lee, was unfamiliar with treatment plans, did not know whether any of her patients were in Lee Supermax, and had never seen Lee Supermax herself. The Court finds these examples both illuminating and disturbing. For psychiatrists and other mental health staff at SCDC to provide effective services, they must have a more intimate knowledge of the processes and procedures vital to the mental health services system they are expected to direct.

**d. Limited access to higher levels of care**

Finally, SCDC's treatment program fails to provide mentally ill inmates with sufficient access to higher levels of care. All correctional mental health systems are organized by levels of care, and SCDC's system comprises four levels. From lowest to highest, these are outpatient, area, intermediate (ICS), and inpatient. The higher the level, the more services and staffing are required.

SCDC's Mental Health Director, Pamela Whitley, estimated that in 2008 the combined ICS and Area Mental Health caseload at SCDC was 515. In 2012, however, the combined ICS and area caseload was only 310, a 40 percent reduction. In February 2008, at Lee and Lieber combined there were 212 area and 211 outpatient mental health inmates, a 50/50 split. By September 2011, however, there were only 83 area inmates at Lee and Lieber (14.8 percent), while the outpatients numbered 478 (85.2 percent). From 2003 to 2011, male ICS inmates decreased from 315 to 135. The women's ICS program was discontinued, then revived, but at the time of trial consisted of only five inmates. In the 1990s Gilliam, the 88-bed inpatient psychiatric facility for male inmates, operated at full capacity, but at the time of trial only 47

beds were filled. It is undisputed that women inmates have a higher rate of mental illness than male inmates, but from 2007-2009 SCDC referred only 13 women to Geo Care (formerly "Just Care"), a private company with which SCDC contracts for inpatient psychiatric services for female inmates. SCDC offered no persuasive explanation for the decline in the number of inmates receiving higher levels of services during a period when the overall inmate population and mental health case load remained flat.

#### e. Conclusion

This Court finds that SCDC's use of force and segregation, as opposed to treatment, in a mental health system where psychiatrists have limited roles and where inmates face systemic obstacles in accessing higher levels of care, creates a substantial risk of serious harm for inmates with serious mental illness.

### 3. Employment of a sufficient number of trained mental health professionals

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The Court finds that the mental health program at SCDC is substantially understaffed. This has a causal effect for many insufficient aspects of the mental health program and greatly inhibits SCDC's ability to provide effective services to its mentally ill inmate population.

From 2008-2011, psychiatric staff at SCDC (psychiatrists and psychiatric nurse practitioners) ranged from 4.5 to 5.5 full-time equivalents (FTEs). At the time of this trial, SCDC had 5.5 FTE psychiatric staff serving an estimated 2,409 inmates on psychotropic medication, for a ratio of 1:437. If 17 percent of SCDC's population is mentally ill, rather than the 12.9 percent diagnosed by SCDC, the estimated number of inmates on psychotropic medication should be 3,170 and the ratio then is 1:575. Based on the testimony of Dr. Metzner and Dr. Patterson, the Court finds an appropriate ratio would be one FTE psychiatrist/psychiatric

nurse practitioner to every 150-200 inmates on psychotropic medication. At Gilliam, there are 1.2 FTE psychiatrists and psychiatric nurse practitioners for 62 patients, a 1:52 ratio. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for an inpatient setting would be 1:20. For the ICS program, there is currently .7 FTE psychiatric staff for 135 patients, a ratio of 1:193. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for intermediate care would be 1:150.

The Court also finds that SCDC is understaffed in clinical psychologists. In 2003, SCDC employed or retained four FTE clinical psychologists but needed, by its own admission, seven. From 2007-2011, however, SCDC averaged only .3 FTE psychologists.[10] To add some context, SCDC's expert, Dr. Haas, testified that the Kentucky Department of Corrections, his former employer, had 15-16 FTE psychologists to serve a total population of 12,000 – 13,000 inmates, a ratio of approximately 1:800. By contrast, SCDC's .3 FTE psychologists serve a total population of approximately 23,000 inmates, a ratio of 1:69,697.

Likewise, the ratio for counselors at Area Mental Health Institutions as of January 2012 is also problematic: 1:72 at Lee; 1:84 at Perry, and 1:100 at Lieber. In response to this information, Dr. Patterson and Ms. Whitley, SCDC's Mental Health Director, agreed that a more appropriate ratio for counselors at the Area Mental Health Institutions is 1:40. Counselor staffing at outpatient prisons is also insufficient. Ms. Whitley testified she became "very concerned" when counselor-patient ratios at outpatient prisons exceeded 1:65, and Dr. Patterson agreed. SCDC data, however, shows that counselor ratios at most of its outpatient prisons exceed 1:65. At the time of trial, the counselor-patient ratio at McCormick Correctional Institution was 1:157 and at Turbeville Correctional Institution 1:183.

[10] Shortly before trial, SCDC increased its psychologists to .7 FTE.

In total, Dr. Patterson recommended that SCDC employ at least an additional 20 FTE counselors, 14.5 FTE psychiatrists, and 17 FTE other types of mental health professionals. The Court accords great weight to Dr. Patterson's recommendations for staffing.

While it is clear that SCDC does not have enough counselors, it is equally clear that many of the counselors they do employ are unqualified. Hiring unqualified counselors can lead to the kind of deterioration in the delivery of mental health services that Perry experienced in 2009-2010. Within a period of a few months, all five of Perry's counselors were fired or resigned under investigation or following a serious reprimand. As Dr. Patterson testified, those counselor departures had a significant effect on mental health services provided at Perry, resulting in the cancellation of many psychiatric clinics and group therapy sessions. Disciplinary reprimands in counselor personnel files give further evidence of the overall poor quality of SCDC counselor services.

In 2009, SCDC began conducting internal audits of its mental health counselors. As Dr. Patterson and Dr. Metzner testified, the audits document a wide range of serious counselor deficiencies. Scores were particularly poor for Lee, Lieber, and Perry, the male Area Mental Health Institutions, where 55 percent of the audits were either "unsatisfactory" or "satisfactory, but with major concerns." Some of the deficiencies listed are disturbing. They include numerous instances of mentally ill inmates going for many months without seeing a counselor or psychiatrist, in violation of SCDC policy; treatment plans that were out of date and incomplete; and inadequate documentation of medication administration and group therapy sessions. Some counselors repeatedly failed their audits.

The Court finds that inadequate mental health staffing at all levels within SCDC represents a substantial risk of serious harm to inmates with serious mental illness.

### 4. **Maintenance of accurate, complete, and confidential mental health treatment records**

A treatment plan is intended to be a dynamic and fluid process that continues on a regularly scheduled basis, supplemented by constant updates and revisions. In order to be effective, treatment plans must be accurate, complete, readily accessible to professional staff, and confidential. During trial, evidence was presented to the Court indicating that documentation and maintenance of these records is poor. The treatment plans and automated medical records ("AMR") do not clearly state problems, objectives, goals, or even identify plan-responsible staff.

The importance of maintaining accurate and complete treatment records is vital to any medical services delivery system. For mentally ill inmates in particular, treatment plans and AMRs are critical for assessing progress as well as the effect of medication and therapy.

In addition, Dr. Metzner offered several examples of basic information about its mental health program that SCDC's aged computer system is unable to provide. For example, SCDC's computer system cannot retrieve the names or numbers of all inmates referred to the ICS program; the number of women inmates referred to Geo Care for inpatient psychiatric services; the number of inmates who have made serious suicide attempts; or the number of inmates whose psychotropic medications have expired without being timely renewed.

In summary, the evidence in this case shows that the recordkeeping system for SCDC is outmoded, poorly maintained, and not readily accessible to all staff. The Court finds that SCDC's failure to maintain accurate and complete mental health treatment records represents a substantial risk of serious harm to mentally ill inmates.

**5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation**

In evaluating this factor, some of the same concerns overlap with those of the previous factor – maintenance of accurate, complete, and confidential mental health treatment plans. The Court, however, will note three specific issues that raise further concerns. First, Medication Administration Records ("MAR") of mentally ill inmates provide crucial information upon which psychiatrists rely. SCDC uses standard MAR forms where nurses are required to sign their initials to confirm that medication was provided and administered. At trial, various MARs were introduced indicating the absence of initials and absence of any record that medications were provided at all. This indicates either the medication was not provided or the nurses failed to maintain accurate records. For example, in October and November 2008, inmate Jonathan Mathis was prescribed one medication to be taken twice a day and two other medications to be taken once a day. From his MAR, however, it appears he received no medications either month, without explanation.

Although counselors monitor MARs, the Court agrees with Dr. Patterson that SCDC counselors are not qualified to do so, as evidenced by counselor audits showing deficient MARs. Ms. Delgado acknowledged that a failure to adequately monitor MARs has no effect on a counselor's audit score. For example, the only audit that one Lieber counselor has ever passed was an audit in which 14 of the 15 MARs reviewed for which she was responsible were found incomplete or outdated.

The second issue of concern involves the suicide of Robert Hamberg. SCDC records show that Mr. Hamberg's morning medications had expired – specifically his anti-psychotic medicine Geodon – which he was supposed to receive twice a day. Nevertheless, his counselor

was still recording that he was compliant with his medication – that he was receiving it in the mornings and evenings. Thus, Mr. Hamberg was only receiving half of his prescribed dosage of anti-psychotic medication. Mr. Hamberg committed suicide on June 9, 2010 at Perry Correctional Institution.

The third issue of major concern in the area of medication administration involves pill lines. As Dr. Patterson testified, medication compliance is especially difficult for many mentally ill inmates, due to medication side effects and the nature of their illness. At many institutions, pill lines occur between 3:00 - 4:00 a.m., and mentally ill inmates are often left to their own devices to timely awake, stand in line, and then take their medication. The timing, press of business, and lack of individual attention at the pill line lends itself to inmates failing to take psychotropic medications.

This Court finds that the failure to appropriately supervise, evaluate, and dispense psychotropic medications creates a substantial risk of serious harm to inmates with serious mental illness.

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### 6. A basic program to identify, treat, and supervise inmates at risk for suicide

#### a. The setting of Crisis Intervention ("CI") cells

At trial, Dr. Patterson identified seven mentally ill inmates at SCDC, in addition to Jerome Laudman, whose deaths from 2008-2011 were both foreseeable and preventable.[11] In his opinion, two common factors contributed to these deaths. First, crisis intervention cells are located in segregation units, not in a medical setting, and thus lack sufficient medical interaction

[11] Six of these were suicides. The seventh, Stephen Jeter, was not ruled a suicide, but his death was related to a failed suicide attempt. Moreover, the Court is aware that two more SCDC inmate suicides occurred while this trial was actually in progress, one at Lee and one at Lieber, with both decedents either on or should have been on the mental health caseload.

and treatment. For example, CI inmates are not being assessed daily for mental health purposes. As of the date of trial, SCDC policy only required that inmates in CI be seen Monday through Friday, excluding holidays, and this policy is often violated. Inmates in CI cells spend the entire day in those cells, and are held for long periods of time – typically one to two weeks – but sometimes longer. CI cells, like other SMU cells, are cold and filthy, with trash, blood, and feces scattered or smeared about. Inmates are placed naked in CI cells. They often are not provided a blanket, and when one is provided it often is not clean. CI cells do not have mattresses. Inmates sleep directly on a cold steel or concrete slab. Inmate Richard Patterson testified how he tore up his Styrofoam food trays, then spread the pieces on his concrete slab to serve as a form of mattress. In addition, most inmates in CI do not see a psychiatrist and are not allowed group therapy. Interaction with counselors is brief, limited, and not confidential.

For at least a three-year period, from 2008-2010, correctional officers at Lieber, at times with the acquiescence of mental health staff and at other times without their knowledge, routinely placed CI inmates naked in shower stalls, "rec cages," interview booths, and holding cells for hours and even days at a time. Most of these alternative CI spaces did not have toilets and none were suicide resistant. Details of these placements are contained in Dr. Metzner and Patterson's inspection report, entered into evidence, as well as in their testimony and the testimony of various inmates. SCDC's own logs document over 100 of these alternative placements during the 27 months for which logs were provided.[12] The Court finds that the vast majority, if not all, of these placements were for inmates on crisis intervention. SCDC logs show that 55 of these placements at Lieber were for twelve hours or longer and 29 exceeded 24 hours. Inmate Isaac Anderson was confined over 86 consecutive hours in a Lieber rec cage from April

[12] SCDC could not locate Lieber SMU logs for several of the months requested.

2-6, 2009, with his first documented bathroom break coming after 42 hours in the cage. The interview booths and showers used for CI were often filthy and too small a space in which to lie down. Correctional officers brought CI inmates "finger food" meals to these spaces. Since inmates were not always provided bathroom breaks, some were forced to urinate and defecate in the same spaces where they were fed. Moreover, the Court finds that the use of such inappropriate spaces for CI has not been limited to Lieber. Plaintiffs presented inmate testimony and other evidence that SCDC has placed CI inmates in such spaces at other institutions prior to 2008 and after 2010. For the reasons discussed, the Court finds that SCDC's normal CI placements expose inmates with serious mental illness to a substantial risk of serious harm. The dehumanizing conditions of SCDC's alternative CI placements expose inmates to even greater risk.

**b. <u>Lack of constant observation</u>**

Second, SCDC's policy does not require constant observation; rather, inmates in CI cells are checked on 15-minute intervals, documented in cell-check logs. The evidence before the Court contains proven instances of fabricated cell check logs. For example, the cell check log of inmate Edward Broxton noted that at 6:30 a.m. on February 2, 2010, he was eating breakfast, even though an hour earlier, at 5:30 a.m., Broxton had hanged himself in his CI cell at Lee. Many of the cell check logs for Jerome Laudman were initialed "GM," although the only Lee Supermax correctional officer with those initials denied making the entries or authorizing anyone to use his signature. The SCDC Inspector General report on the drug overdose suicide at Perry of inmate James Bell documented evidence that his cell check logs had also been falsified. To make matters worse, on the Saturday before Bell's suicide his aunt, in an upset state, phoned SCDC to warn them of a "goodbye letter," suicidal in nature, she had received from her nephew.

SCDC mental health staff did not check on Bell until two days later, on Monday afternoon, when a counselor found him dead in his cell.

SCDC's expert, Dr. Haas, agreed with Dr. Patterson and Dr. Metzner that inmates on suicide watch require continuous observation. In 2008, inmate Brian Schriefer committed suicide while on CI at Gilliam by stuffing either toilet paper or a paper gown down his throat. As a result of Schriefer's death, SCDC stopped distributing gowns to CI inmates, instead requiring them to remain naked while in CI. SCDC did not change its policy, however, on continuous observation of suicidal inmates. Continuous observation would have prevented Schriefer's death.

The Court finds that SCDC's suicide prevention and crisis intervention practices create a substantial risk of serious harm to seriously mentally ill inmates.

### 7. **Summary of objective component**

As detailed above, this Court finds that the evidence in this case has proved SCDC's mental health program is inherently flawed and systemically deficient in all major areas. The Court further finds that a major contributing factor to the deficiencies in the SCDC program is the lack of a formal, comprehensive quality management program.

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Finally, having observed the testimony of the psychiatric and correctional experts for both Plaintiffs and Defendants, this Court finds Plaintiffs' experts more credible. In part, this finding is due to a comparison of their credentials and experience; in part, due to their relative persuasiveness on the witness stand; and in part, due to the wide disparity between Plaintiffs' and Defendants' experts in case preparation and particular knowledge of the SCDC system.

Based on the testimony of these experts and the other evidence presented at trial, the Court finds that SCDC's mental health program exposes inmates with serious mental illness to a

substantial risk of serious harm. Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

### B. Subjective Component

The subjective component of the deliberate indifference standard requires proof that SCDC knew that Plaintiffs were exposed to a substantial risk of serious harm, but failed to take reasonable measures to abate the risk. *Farmer*, 511 U.S. at 847. The subjective component should be determined in light of the prison authorities' "attitudes and conduct at the time suit is brought and persisting thereafter." *Id.* at 845-846.

The evidence is overwhelming that SCDC has known for over a decade that its system exposes seriously mentally ill inmates to a substantial risk of serious harm. In 1999, SCDC retained Dr. Patterson (Plaintiffs' expert), through a grant, to inspect its mental health program. His report, issued in 2000, characterized the program as being in a state of "profound crisis." In October 2000, a Joint Legislative Proviso Committee report concluded that "inmates with mental illness are not receiving adequate treatment . . . and oftentimes leave prisons worse off than when they entered." In April 2003, a South Carolina Task Force whose members included three former SCDC Directors issued a report that concluded Gilliam was "clearly inadequate." In May 2003, the South Carolina Department of Mental Health issued a report on SCDC's mental health program, noting "[t]he lack of psychiatric coverage has resulted in a critical situation, with extremes of poor care, inhumane treatment, and dangerousness . . . ." In September 2003, SCDC Director Jon Ozmint, in an application for technical assistance, stated that "[t]he current plight of persons with mental illness at SCDC is at a crisis level." In June 2005, the Plaintiffs filed their Complaint in this case, alleging constitutional deficiencies in SCDC's program. From 2006-2010 Plaintiffs' experts issued eight site inspection reports criticizing conditions in SCDC

facilities. In October 2007, SCDC psychiatrist Dr. Michael Kirby wrote a letter to his supervisor noting several serious problems with SCDC's mental health system. In June 2008, SCDC investigator Lloyd Greer issued his report on the death at Lee Supermax of Jerome Laudman. From 2008-2010, Lieber SMU logs documented the use of shower stalls and other inappropriate spaces for CI placements. In 2009-2010, SCDC was aware that the counselor shortage at Perry created serious deficiencies in the delivery of mental health services. In January 2010, a United States Department of Justice report was highly critical of SCDC's medication management and administration practices. SCDC's own counselor audits from 2010-2011 revealed numerous unsatisfactory practices and major deficiencies. January 2012 internal data showed counselor-to-patient ratios at many SCDC facilities that were excessively high. Finally, through the discovery process in the litigation of this case from 2005-2012, SCDC was made aware of the serious allegations raised by Plaintiffs and their experts, many of which are supported by SCDC's own records.

The Court finds from this evidence that SCDC knows and has known, since before this lawsuit was filed, and persisting thereafter until the time of trial and even to present date, that its mental health program is systemically deficient and exposes seriously mentally ill inmates to a substantial risk of serious harm.

That, however, does not end the analysis. The second element of the subjective component focuses on action: has SCDC taken reasonable measures to abate the risks of which it is aware? The evidence shows that from 1999 until the filing of this action in 2005, SCDC did virtually nothing to address, much less eliminate, the substantial risks of serious harm to which class members were exposed. What limited action SCDC has taken since the filing of this lawsuit has had little to no effect in abating the unconstitutional deficiencies this Court has

found. "[T]o rely on intervening events occurring after suit has been filed the defendants must satisfy the heavy burden of establishing that these such events 'have completely and irrevocably eradicated the effects of the alleged violations.'" *Thomas v. Bryant*, 614 F.3d 1288, 1320-21 (11th Cir. 2010).

SCDC has failed to meet this "heavy burden." At trial SCDC identified the measures it has taken since 2005 to improve its mental health program. These include the hiring of two administrators and some administrative support staff, an increase in psychiatric staff FTEs, a re-organization of group therapy, a new protocol for addressing self-injuring behavior ("SIB"), mental health dorms, increased use of tele-psychiatry, new training programs for clinical and security staff, and counselor audits.

The Court finds that these are small steps that have had little impact on the systemic deficiencies in SCDC's mental health program. The mere hire of administrators to replace other administrators is not necessarily an improvement. Additional administrative support staff does not address the dire need for more clinical staff. Since 2008, SCDC's psychiatric staff has remained relatively flat and currently consists of 5.5 FTEs, although this Court has found that at least 14.5 FTEs are needed. As discussed, counselor and psychologist FTEs are far too low. Reorganized or not, group therapy sessions are frequently cancelled and unavailable for most inmates in segregation and crisis intervention. SCDC introduced no persuasive evidence that its new, decentralized SIB protocol has improved SIB-related issues. SCDC's concentration of some mentally ill inmates in designated dorms is no substitute for an adequately staffed mental health program. At the time of trial, SCDC had not implemented expanded tele-psychiatry services, but had merely requested a feasibility study. SCDC's training programs are limited in scope and poorly attended. Counselors are the only mental health clinicians subject to formal

audits, and those audits, though limited in scope, reveal alarming deficiencies. Despite a low bar for passing, many counselors fail their audits, some repeatedly.

Half-hearted measures will not foreclose a finding of deliberate indifference. "Patently ineffective gestures purportedly directed towards remedying objectively unconstitutional conditions do not prove a lack of deliberate indifference, they demonstrate it." Standards Order at 13, (quoting *Coleman v. Wilson,* 912 F. Supp. 1282, 1319) (E.D. Cal. 1995)). *See also Thomas*, 614 F.3d at 1320 (11th Cir. 2010) ("practices may be reinstated as swiftly as they were suspended"). The steps SCDC has taken have been small ones, characterized by SCDC itself as "band aids,"[13] many of which were instituted shortly before and even during trial, that have failed to adequately address the known systemic deficiencies in its mental health program. The SCDC mental health program needs far more than band aids, and the Court finds that the measures taken by SCDC to correct its systemic deficiencies are neither reasonable, timely, nor effective. Plaintiffs have therefore satisfied the subjective component of the deliberate indifference standard.

## II. REMEDY TO ADDRESS CONSTITUTIONAL VIOLATIONS

### A. Overview

In devising a remedy for the constitutional deficiencies at SCDC, the Court is required to balance two competing interests. First, it is not the role of this Court to micromanage the daily administration of the mental health program at SCDC. Moreover, this decision comes in a time of economic recession and heavy scrutiny of governmental expenses. However, "[c]ourts may not allow constitutional violations to continue simply because a remedy could involve intrusion into the realm of prison administration." *Brown v. Plata,* 131 S.Ct. 1910, 1928-29 (2011).

[13] SCDC's June 8, 2009 Memorandum on Applicable Standards contended that SCDC had a "well-developed mental health system . . . in place for decades," that needed nothing more than "band aids or other minor remedies."

Additionally, the economic "cost of protecting a constitutional right cannot justify its total denial." *Bounds v. Smith,* 430 U.S. 817, 825 (1977). "A plea of lack of funds is an insufficient justification for the failure of the executive department" to provide constitutionally mandated treatment programs. *Crain v. Bordenkircher,* 176 W.Va. 338, 364, 342 S.E.2d 422, 449 (1986), (quoting *Moore v Starcher,* 167 W.Va. 848 - 853, 280 S.E.2d 693, 696 (1981)).

Second, under the separation of powers doctrine, this Court may not usurp the authority of other branches of government. The separation of powers doctrine, however, "is not fixed and immutable." *State v. Langford*, 400 S.C. 421, 434, 735 S.E.2d 471, 478 (2012). On the contrary, the doctrine contains "grey areas" and an "overlap of authority" among governmental branches. *Id.*

> "Separation of powers does not require that the branches of government be hermetically sealed; the doctrine of separation requires a cooperative accommodation among the three branches of government; a rigid and inflexible classification of powers would render government unworkable." At its core the doctrine therefore "is directed only to those powers which belong exclusively to a single branch of government."

*Id.* (quoting 16A Am.Jur.2d, *Constitutional Law* § 244, 246).

In *Blaney v. Cmmr. of Corrections*, 374 Mass. 337, 372 N.E.2d 770 (1978), following defendants' submission of deficient plans to remedy prison conditions, the court entered a remedial order giving explicit directions for defendants to follow. The court rejected defendants' argument that the order violated separation of powers, noting that courts have power to direct public officials to carry out their lawful obligations. 374 Mass at 339-42, 372 N.E.2d at 773-74. "As to judges' authority to fashion detailed orders to correct established violations of constitutional rights . . . [s]uch functions are judicial, and in no way usurp the power of the executive." 374 Mass. at 342-43, 372 N.E.2d at 774, *citing Swann v. Charlotte-Mecklenburg*

*County Bd. of Educ.*, 402 U.S. 1, 15 (1971); *U.S. v. Montgomery County Bd. of Educ.*, 395 U.S. 225, 234-36 (1969). *See also In re K.C.,* 325 Ill. App. 3d 771, 779-80, 759 N.E.2d 15, 23 (2001) ("When the legislature creates a statute that contemplates an interplay between the courts and the executive branch, court orders directing the actions of the executive agencies do not violate the doctrine of the separation of powers."); *Crain,* 176 W.Va. at 364, 342 S.E.2d at 449 (where a court ordered the West Virginia Department of Corrections to implement an extensive remedial plan addressing constitutionally deficient prison conditions.); *Haley v Barbour Cnty.,* 885 So. 2d 783, 790 (Miss. 2004) (noting court regulation of the number of inmates a county may deliver to a prison does not violate separation of powers.); *Massameno v. Statewide Grievance Comm.*, 234 Conn. 539, 567, 663 A.2d 317, 333 (1995) (stating a court does not violate separation of powers doctrine by supervising and disciplining executive branch prosecutors.)

Finally, this Court is bound to uphold the South Carolina Constitution and protect the rights of the mentally ill inmates at SCDC. Moreover, it is the action of a circuit court that triggers the placement of an inmate into the custody of SCDC, under Court authority, and thus this Court has the inherent power - and responsibility – to see that the imprisonment of that inmate complies with constitutional mandates. The Court is convinced that to view the evidence put forth in this case and then do nothing could be a great miscarriage of justice.

To address the constitutional deficiencies in the mental health system at SCDC, Plaintiffs have proposed a remedial plan comprised of three components. First, SCDC would be required to submit a written plan for remedying the systemic deficiencies identified by the Court. Second, SCDC must rely upon factors and guidelines identified by the Court in creating this plan, which the Court will then review and either approve or disapprove. Third, the Court will retain jurisdiction of this case and appoint expert monitors and/or a special master who will report

periodically to the Court. SCDC has raised objections to this plan, arguing that it constitutes an impermissible burden shift and is violative of the separation of powers doctrine.

The Court denies SCDC's objections. It would be highly impractical for Plaintiffs to identify and create a plan to implement changes to the mental health system at SCDC. Rather, once the Court has ruled, SCDC is in the best position to propose steps and changes to its existing system. *See Alexander S. v. Boyd*, 876 F. Supp. 773, 804-04 (D.S.C. 1995) (where a court ordered the South Carolina Department of Juvenile Justice to submit remedial plan within 120 days of order); *Crain*, 176 W.Va. at 341, 342 S.E.2d at 426 (where a court ordered the West Virginia Department of Corrections to submit remedial plan within 180 days of order). As a result, the Court adopts Plaintiffs' proposals and requires SCDC to submit a written plan to the Court within 180 days of the date of the Final Order in this case. In executing the remedial plan to be submitted by SCDC, the Court will retain jurisdiction but also intends to appoint a monitor who will report periodically to the Court. The Court will provide the parties, through motions, an opportunity to suggest the appropriate appointee(s) to oversee this process.

**B. <u>Remedial Factors and Guidelines</u>**

In formulating specific factors and guidelines for SCDC's remedial plan, the Court will again utilize the *Ruiz* factors above, along with additional sub-factors and components listed thereunder. In devising a plan to remedy the constitutional deficiencies identified by the Court, SCDC shall be directed in the Order to prepare a written plan that includes, at a minimum, the following:

1. **<u>The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care</u>**

   i. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of increasing the number of inmates recognized as mentally ill and being admitted to the mental health program by a minimum of two percentage points (14.9 percent of the inmate population);

   ii. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;

   iii. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and

   iv. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

2. **<u>The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC</u>**

   **a. Access to Higher Levels of Care**

   i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefor;

   ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefor;

   iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam

Psychiatric Hospital, or its demolition for construction of a new facility;

iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and

v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

**b. Segregation**

i. Provide access for segregated inmates to group and individual therapy services;

ii. Provide more out-of-cell time for segregated mentally ill inmates;

iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

iv. Provide access for segregated inmates to higher levels of mental health services when needed;

v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

c. **Use of Force**

i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

ii. The plan will further require that all instruments of force, (e.g, chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;

iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;

vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;

vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and

xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

3. **Employment of a sufficient number of trained mental health professionals**

i. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

ii. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;

iii. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

iv. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;

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v. Require appropriate credentialing of mental health counselors;

vi. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

vii. Implement a formal quality management program under which clinical staff is reviewed.

4. **Maintenance of accurate, complete, and confidential mental health treatment records**

i. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:

- Names and numbers of FTE clinicians who provide mental health services;

- Inmates transferred for ICS and inpatient services;
- Segregation and crisis intervention logs;
- Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);
- Use of force documentation and videotapes;
- Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;
- Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;
- Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;
- Quality management documents; and
- Medical, medication administration, and disciplinary records.

ii. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

5. **<u>Administration of psychotropic medication only with appropriate supervision and periodic evaluation</u>**

i. Improve the quality of MAR documentation;

ii. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

iii. Review the reasonableness of times scheduled for pill lines; and

iv. Develop a formal quality management program under which medication administration records are reviewed.

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6. **A basic program to identify, treat, and supervise inmates at risk for suicide**

i. Locate all CI cells in a healthcare setting;

ii. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

iii. Implement the practice of continuous observation of suicidal inmates;

iv. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

v. Increase access to showers for CI inmates;

vi. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

vii. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and

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viii. Implement a formal quality management program under which crisis intervention practices are reviewed.

## CONCLUSION

Even the most brief and facile view of the evidence put forth by Plaintiffs in this case reveals obvious, significant, and longstanding problems with mental health services delivery at SCDC. Prior to trial, this Court tried its very best to bring the parties together for settlement purposes, even requiring the Director of SCDC and the guardian for the Plaintiffs, attorneys for both sides, and other interested parties to meet in an effort to resolve the case. The Court was not present for these discussions and thus cannot determine why they were unsuccessful.

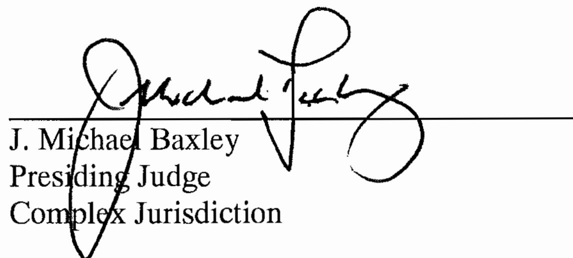
We are now eight years into this litigation. Rather than accept the obvious at some point and come forward in a meaningful way to try and improve its mental health system, Defendants

have fought this case tooth and nail—on the facts, on the law, on the constitutional issues, portraying itself as beleaguered by the burdensomeness of Plaintiffs' discovery, and generally harrumphed by the invasive nature of Plaintiffs' counsels' tactics and strategies. This Court has spent dozens of hours in hearings and conferences in an effort to resolve discovery disputes, most of which involved delay, missed deadlines, and recalcitrance on the part of the Defendants.

This Court can never criticize any party for a vigorous exercise of offense or defense in civil litigation, for such is the foundation of our adversarial system of justice. But justice in this case is not really about who wins or loses this lawsuit. The hundreds of thousands of tax dollars spent defending this lawsuit, at trial and most likely now on appeal, would be better expended to improve mental health services delivery at SCDC.

For the reasons set forth above, the Court grants judgment in favor of the Plaintiffs and orders SCDC to submit a proposed written remedial plan consistent with this Order.

**IT IS SO ORDERED.**



J. Michael Baxley
Presiding Judge
Complex Jurisdiction

Hartsville, South Carolina

January 8, 2014