Case Nos. 09-1424

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

EVERETT HADIX, et al.,

Plaintiffs-Appellants,

v.

PATRICIA CARUSO, et al.,

Defendant-Appellees.

BRIEF OF THE PLAINTIFFS-APPELLANTS

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UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit
Case Number: 09-1424 Case Name: Hadix v. Caruso

Name of counsel: Elizabeth Alexander, Patricia Streeter

Pursuant to 6th Cir. R. 26.1, Everette Hadix, et al., Plaintiffs-Appellants
Name of Party
makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

No.

CERTIFICATE OF SERVICE

I certify that on July 16, 2009 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

s/ Elizabeth Alexander

This statement is filed twice: when the appeal is initially opened and later, in the principal briefs, immediately preceding the table of contents. See 6th Cir. R. 26.1 on page 2 of this form.

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REQUEST FOR ORAL ARGUMENT

Plaintiffs-Appellants request that the Court permit oral argument on the grounds that this case involves a complex and extensive factual record and also involves application of complex constitutional principles to those facts, so that oral argument is likely to assist the Court.

JURISDICTIONAL STATEMENT

The district court has subject matter jurisdiction over this civil rights class action pursuant to 28 U.S.C. §§ 1331 and 1343. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1292(a)(1) as these consolidated appeals challenge orders that dissolved an injunctive order and refused to grant a requested injunctive order. This appeal is taken from an order issued on March 31, 2009. R. 2903. The Notice of Appeal was filed on April 1, 2009. R. 2905.

STATEMENT OF ISSUES PRESENTED

1. Whether the district court erred in determining that prison conditions did not violate the Eighth Amendment because Defendants[1] did not act with deliberate indifference, in light of the fact that Plaintiffs[2] sought only injunctive relief?

2. Whether the district court erred in failing to apply the standard set forth in *Farmer v. Brennan,* 511 U.S. 825 (1994), for determining that prison conditions violate the objective component of the Eighth Amendment?

3. Whether the district court erred in holding that, in order to obtain further relief from the court, Plaintiffs had to prove not only a violation of the Eighth Amendment but also a violation of the requirements of the original Consent

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[1] Defendants-Appellees (hereinafter "Defendants").

[2] Plaintiffs-Appellants (hereinafter "Plaintiffs").

Decree?

4. Whether the relief requested by Plaintiffs was within the scope of the mental health provisions of the Consent Decree?

5. Whether the district court violated Fed. R. Civ. P. 52(a) by failing to provide findings of fact explaining its decision?

6. Whether the district court's finding that Defendants had complied with the preliminary injunction was clearly erroneous?

STATEMENT OF THE CASE

A. The Early History of the Case

This class action challenging conditions of confinement at Michigan's oldest and largest prison was filed pursuant to 42 U.S.C. § 1983 in 1980. At that time, the prison was known as the State Prison of Southern Michigan ("SPSM"). The district court approved a Consent Decree addressing almost all of the issues raised in the complaint (E.D. R. 2),[3] other than certain access to court issues, on April 4, 1985. The Consent Decree was designed to "assure the constitutionality" of conditions of confinement within the prison. E.D. R. 199 at 1. Among other

[3] Some of the proceedings in this case took place in the Eastern District of Michigan, while others took place in the Western District following transfer of parts of the case. In this brief, the designation "E.D. R." refers to a docket number in the Eastern District of Michigan, while "R." refers to a docket number in the Western District.

issues, the Consent Decree addresses fire safety, medical care and mental health care issues. *Id*. at 7-23. The Consent Decree expressly extends to all areas physically located within the walls of what was at the time the Central Complex of the State Prison of Southern Michigan, including the Reception and Guidance Center ("RGC"). *Id*. at 1 ("This was an action brought pursuant to 42 USC 1983 and other applicable statutes. . . seeking declaratory and equitable relief with respect to the conditions of confinement at the Central Complex of the State Prison of Southern Michigan, including the Reception and Guidance Center (hereinafter referred to as SPSM-CC).").

A separate Order Accepting Consent Judgment also defines which facilities are within the scope of the Consent Decree. E.D. R. 213. That Order concludes that all prison facilities physically located within the walls of what was once the Central Complex of the State Prison of Southern Michigan are automatically *Hadix* facilities. *Id.* at 1-2. The cellblocks within those original walls included Cellblock 3, which is now part of RGC. *Hadix v. Johnson,* 367 F.3d 513, 518 (6th Cir. 2004). The Order Accepting Consent Judgment also defined as part of the *Hadix* facilities those facilities that supplied support services to one of the original *Hadix* facilities. E.D. R. 213 at 1-2; *see also* E.D. R. 656 (declaring Duane Waters Hospital, now called Duane Waters Health Center ("DWH"), a *Hadix* support

facility). Cellblocks 1 and 2 of the Egeler Correctional Facility also qualify as *Hadix* support facilities. *Hadix v. Caruso,* 297 Fed. Appx. 504, 507 (6th Cir. 2008).

For a variety of reasons, various issues in this case were transferred from the Eastern District to the Western District of Michigan at different times.[4] Injunctive relief related to all issues in the Eastern District has now been terminated.

B. Medical Orders

Since the enactment of the Prison Litigation Reform Act ("PLRA") in 1996, the Western District court has held a number of hearings pursuant to motions by Defendants seeking to terminate injunctive relief pursuant to the provisions of the Act.[5] The first hearings addressed the medical care sections of the Consent Decree, and resulted in a determination that certain provisions of the

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[4] *See, e.g., Knop v. Johnson*, 977 F.2d 996, 1014 (6th Cir. 1992) (affirming finding of constitutional violation regarding access to courts, but vacating district court order and remanding *Hadix* access to courts issue to the Western District for development of an appropriate remedy); E.D. R. 835 (transferring medical and mental health issues to the Western District); E.D. R. 1441 (transferring issues regarding SMT (Parnall Correctional Facility) to the Western District).

[5] The PLRA termination provisions currently require termination of injunctive relief in prison conditions of confinement cases, in the absence of a current and ongoing violation of federal law, if defendants file an appropriate motion. 18 U.S.C. § 3626. The language of this provision was slightly different at the time of the first hearing regarding termination. *See* note 6, *infra.*

medical section of the Consent Decree, as well as enforcement orders related to the treatment of the medically disabled, remained necessary in light of Eighth Amendment violations resulting from non-compliance with various requirements of the Consent Decree.[6] In 2005 and 2006 the district court issued additional injunctive relief regarding medical care.[7]

C. Mental Health Orders

On January 8, 2001, the district court granted Defendants' motion to terminate enforcement of the mental health provisions of the Consent Decree, effective ten days after Defendants accomplished some minor administrative tasks. R. 1436. On November 13, 2006, the court granted Plaintiffs' motion to reopen the mental health issues, on the ground that reopening of the decree was necessary to allow the court to address fully the constitutional violations involving medical care at the *Hadix* facilities. R. 2186 at 23-24. The court also issued a preliminary injunction that included requirements that Defendants develop various policies and plans. R. 2187.

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[6] Op., R. 822, Nov. 18, 1996; Order, R. 1373, Feb. 18, 2000; Findings of Fact & Conclusions of Law, R. 1372 at 24, 32, 36, 37, 44, 51, Feb. 18, 2000; Findings of Fact, R. 1658 at 263, Oct. 29, 2002.

[7] Op., R.1915, Oct. 19, 2005; Permanent Inj., R. 2234, Dec. 7, 2006 (Rec. 2234), *remanded, Hadix v. Caruso,* 248 Fed. Appx. 678, 679 (6th Cir. 2007) (*per curiam*).

Defendants filed various plans for compliance with the mental health order[8] and also appealed the order, along with a number of other orders, to this Court. On September 26, 2007, this Court remanded those orders, without vacating the district court's decisions:

> Because a recent opinion by the district court may moot some of these appeals,[9] because the state has agreed to comply with some of the orders underlying these appeals and because both the State's planned closing of one prison and the district court's recent decision narrow the scope of these disputes, we remand the orders to the district court to determine, which ones, if any, have become moot and to determine the scope of the dispute underlying the remaining orders.

Hadix v. Caruso, 248 Fed. Appx. 678, 679 (6th Cir. 2007) (*per curiam*).

In November 2007 Defendants filed a motion to terminate all injunctive relief related to mental health, and Plaintiffs subsequently filed a motion for

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[8] Defs.' Health Care Plan Regarding Mental Health Activities, R. 2256, Dec. 28, 2006 (rejected by the district court in Order, R. 2408, May 4, 2007); Defs.' Revised Health Care Plan Regarding Mental Health Activities, R. 2474, June 7, 2007; Defs.' Revised Mental Health Plan, R. 2601, Aug. 20, 2007. The district court did not rule on the acceptability of the last two plans.

[9] The reference is to Defendants' appeal from two orders by the district court that barred Defendants from transferring prisoners in order to close three *Hadix* cellblocks until Defendants produced and implemented a plan to close them safely. While the appeal was pending in this Court, the district court accepted Defendants' revised plan for closure. R. 2624. After the remand from this Court, the cellblocks closed, and the parties agree that the issues regarding the closure of those cellblocks are moot.

further relief regarding mental health care.[10] The district court heard three days of trial testimony in April 2008, with two additional days of trial in July 2008. The court issued its order denying relief to Plaintiffs and granting Defendants' motion to terminate injunctive relief regarding mental health care on March 31, 2009. R. 2904. Plaintiffs filed a Notice of Appeal from that Order on April 1, 2009. R. 2905.

STATEMENT OF FACTS

A. The Failure to Provide Meaningful Screening for Serious Mental Illness

The current mental health system in RGC routinely and predictably fails to identify persons with serious mental health needs, and it has never identified a percentage of prisoners in need of treatment that is consistent with national data on the prevalence of mental illness in correctional settings. Defendants' own experts testified that Defendants would have to justify their low rate of identifying and admitting to their caseload only 7-9% of prisoners, in contrast to national figures that indicate that approximately two to three times that percentage of prisoners are suffering from a significant mental condition.[11]

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[10] Defs.' Mot. to Terminate Inj. Relief, R. 2684, Nov. 20, 2007; Pls.' Mot. for Further Relief, R. 2757, Apr. 7, 2008.

[11] Hr'g T., vol. 1, 59, 65-66 (App. 845-847); Hrg.T., vol. 6, 988 (App. 997); *see also* R. 2609-02 at 2-4; Pls.' Ex. 7 at 1 (App. 1016); Hr'g T., vol.1, 226 (App.

The court-established Office of the Independent Medical Monitor ("OIMM")[12] issued a report finding that mental health care at the *Hadix* facilities reflected a "[s]ubstantial failure to identify mental illness on intake." R. 2773 at 3. The report also noted that the referring diagnoses from the Defendants' psychologists were downgraded by the RGC psychiatrists more than half the time; one such psychiatrist assigned an Axis I diagnosis other than substance abuse only 5% of the time. The intake diagnostic process at RGC functions so poorly that less than a quarter of the prisoners who end up being admitted to the mental health caseload at some point are actually admitted as a result of the screening process in RGC. Pls.' Ex. 45 at 39 (App. 1070). Unfortunately, most of the prison facilities to which prisoners are transferred after the RGC process do not have an out-patient mental health team ("OPT"), Defs.' Ex. AA (App. 1190-1193), so the process for identifying prisoners after they leave RGC is haphazard.

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877) (head of Psychological Services Unit testifies that Michigan has identified a lower number of seriously mentally ill prisoners than have other states); Hr'g T., vol. 5, 663-666 (App. 940-943) (previous Michigan study showed that 23% of state's prisoners had a major mood disorder and 4.6% had a psychotic disorder). A recent national survey of state prisoners indicated that 25.5% reported a diagnosed mental health condition. Andrew P. Wilper, et al., *The Health and Health Care of US Prisoners; Results of a National Survey*, 99 Amer. J. Pub. Health, 666, 669 (2009).

[12] *See* R. 2234 at 2.

Very shortly before trial, Defendants suddenly began to admit a markedly higher percentage of prisoners to the caseload. This jump in admissions appears to be simply an artifact, since it resulted from their decision to cease the frequent practice of discontinuing the current prescriptions for psychotropic medications of prisoners coming into RGC.[13] Under the eve-of-trial "bridge order policy", a prisoner who arrives with a verified prescription for a psychotropic not only automatically has his medication continued until he sees a psychiatrist, but also he is temporarily listed on the mental health caseload at RGC, which means that he will appear in its statistics as admitted to the RGC caseload. Defs.' Ex. A at 1 (App. 1130); Hr'g T., vol. 1, 129 (App. 868); Hr'g T., vol. 3, 577-579 (App. 930-932).

Once the prisoner is evaluated by a psychiatrist, the psychiatrist is free to decide that the patient does not need treatment, with the result that the patient will shortly thereafter exit the caseload. Defs.' Ex. A at 1 (App. 1130); Defs.' Ex. Q at 12 (App. 1181); Hr'g T., vol. 1, 208 (App. 871); Hr'g T., vol. 3, 577-579 (App. 930-932). As Defendants' mental health expert Jeffrey Metzner, M.D., testified,

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[13] In 2007, 12.5% of prisoners came in with a verified prescription for a psychotropic medication, but only 7.1% of all prisoners were accepted into the mental health caseload. Pls.' Ex. 45 at 37 (App. 1069); Hr'g T., vol. 1, 129 (App. 868).

the bridge order produces an "artificial elevation" in the statistics of those in treatment when they "initially get on the mental health caseload." Hr'g T., vol. 1, 36-37 (App. 842-843). In fact, Dr. Metzner disagreed with the bridge order concept as implemented by Defendants because using this mechanism to inflate admission rates was "not exercising great clinical judgment" and he expressed concern about "what is going to happen when you actually get to exercise clinical judgment." *Id.* at 36 (App. 842).

The use of the bridge order to avoid the use of clinical judgment relates to concerns, which Defendants have ignored for years, about discrepancies in the performance of their psychiatrists. During a six-months period, one of the three psychiatrists who evaluated patients for admission to the caseload at RGC did not refuse admission to the caseload ("TNR")[14] to any of those 108 patients screened for caseload admission[15] and she found that 30.6% suffered from a major mental disorder. Defs.' Ex. Y at 5 (App. 1183) (entries for Zara). Another psychiatrist evaluated 261 patients and TNRed 13% while finding that 17.6% of those he admitted to the caseload suffered from a major mental disorder. Strangely, he

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[14] This is RGC's acronym for "treatment not required."

[15] As discussed below, other mental health staff screen patients before the psychiatrists decides on admission to the caseload.

TNRed four of the patients he diagnosed with a major mental disorder; by policy patients diagnosed with a major mental disorder are to be admitted to the caseload automatically. *Compare id*. (entries for Khan) *to* Pls.' Ex. 104 at 94-95 (App. 1126-1127).

During the same time period, the third full-time psychiatrist saw 179 patients and TNRed almost 34.6% of them, while finding that only 6.7% of those admitted to the caseload suffered from a major mental disorder. Thus, this psychiatrist TNRed patients at a rate several times higher than did the other psychiatrists, and he also diagnosed major mental illness at a markedly lower rate than the other psychiatrists. Defs.' Ex. Y at 11 (App. 1184) (entries for Thai).

During another six-months period, the discrepancies are even starker. This third psychiatrist TNRed 50% of the 156 patients he saw and found that only 3.8% of those placed on the caseload suffered from a major mental disorder. Defs.' Ex. Z at 11 (entries for Thai) (App. 1189). In contrast, the other two full-time psychiatrists at the time TNRed at rates of 10.8% and 12.6%, and they diagnosed major mental disorders at rates of 39.4% and 41.1% respectively. *Id.* at 5, 6 (App. 1187-1188) (entries for Wilanowski and Khan). Significantly, the psychiatrists' supervisor confirmed that there were no differences in assignments of the psychiatrists that could explain these discrepancies. Hr'g T., vol. 1, 234 (App.

878).

The OIMM reported on a number of cases in which the decision to TNR a patient caused harm. MH2 was diagnosed by a psychiatrist at the Department of Corrections' ("MDOC") Huron Valley in-patient mental health unit as having severe Bipolar Disorder with psychotic symptoms. He was transferred to DWH where he was placed in restraints in an observation cell and repeatedly given anti-psychotic medications by injection. He was unresponsive, not eating or drinking, and was reported by the nurse to be engaging in psychotic behavior. Nonetheless, the RGC psychiatrist decided that he was simply a "malingerer". The patient almost died as a result of a forced feeding initiated at DWH and subsequently the MDOC had to start guardianship proceedings. R. 2773 at 14-17; *see also id.* at 19-20, 24-26 (describing MH-4 and MH-6). Plaintiffs' experts similarly provided many examples of harm from the psychiatrists' failure to diagnose mental illness.[16]

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[16] K19 had suffered from depression since childhood and had exhibited suicidal thoughts and behaviors. He arrived at RGC with a prescription for anti-psychotic and anti-depressant medications and reported hearing voices. He was not eating. The "third psychiatrist" discussed above saw him after he had been put on suicide precautions. That psychiatrist TNRed him and he did not receive his medications. This resulted in obvious mental suffering. Plaintiffs' psychiatric expert Dr. Kupers evaluated him the following month, and found "pathological slowness of thought and behavior," and "all the classic symptoms of depression." K19 was also considering self-harm. R. 2609-2 at 11-12. Dr. Kupers also found that prisoners at RGC frequently had their psychotropic medications discontinued on the ground that the prisoner agreed to stop the medication, when in reality the

All of the experts not identified with Defendants testified to a problem with the psychiatrists' inappropriate use of TNRs.[17] Even Defendants' psychiatric

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prisoners wanted to continue their medications, with resulting mental suffering. K20, for example, was placed in a psychiatric hospital when he was nine years old. He came to RGC with prescriptions for psychotropic medications and he had been suicidal in the past. It took more than five weeks to see a psychiatrist, who told him he would be better off without medications. He was still without medications after 45 days in RGC. When seen by Dr. Kupers, he was quite depressed, hopeless and lacking in a sense of the future. *Id.* at 7-8. Dr. Kupers concluded that, in RGC, "individuals who have documented past histories of Schizophrenia, Bipolar Disorder or Major Depressive Episode with suicide attempts, are diagnosed 'Adjustment Disorder,' 'No Axis I Disorder' or merely 'Substance Abuse Disorder,' then the treatment plan is 'TNR,' treatment not required, and the individual is dropped from or not enrolled in mental health treatment." R. 2609-03 at 6. This same "third psychiatrist" routinely dissuaded prisoners from continuing their medications, subjecting such mentally ill prisoners to great harm. Hr'g T., vol. 2, 275-276 (App. 889-890). *See also* R. 2609-02 at 28, 39-40; R. 2609-05 at 5, 8-9, 11-12, 16; Hr'g T., vol. 5, 675-677, 802 (App. 944-946. 974); R. 2773 at 17-19 (describing patient who came in to RGC after being placed on suicide watch in a country jail but was assessed as at low risk of suicide and not referred for treatment; his condition deteriorated until he had to be seen in the DWH emergency room because he was crying, withdrawn and depressed; he did not see a psychiatrist until he had been at the facility for seventeen days, and two days after the emergency room visit, while he deteriorated); *id.* at 19-22 (example of clearly wrongful TNR of prisoner who came from suicide watch at a county jail with prescriptions for anti-psychotic medications and with clear signs of paranoia and delusional thinking); *id.* at 26-28 (patient who had spent most of the previous year at psychiatric hospital not referred at entry for evaluation; fourteen days later sent to DWH for psychiatric observation; his psychotropic medications were disrupted for at least two weeks; his severe mental illness was obvious; he was allowed to deteriorate in the RGC segregation unit ("SMHU") without treatment).

[17] R. 2773 at 3, 8-11, 14-17, 19-22, 24-26; *cf. id.* at 14-17 (noting case in which RGC psychiatrist describes clearly psychotic patient as merely malingering) (Cohen); Hr'g T., vol. 5, 651-653, 675-676, 680-681, 684-686, 691-692, 696-698

expert Jeffrey Metzner, M.D., agreed that these discrepancies in diagnostic practices, and the low overall rate of admitting patients to treatment, required an explanation, which Defendants had never provided. Hr'g T., vol. 1, 88-91, 96 (App. 853-857); Hr'g T., vol. 6, 988-989 (App. 997-998). Despite the fact that Defendants had known about staff complaints about the TNR problem for years,[18] Defendants took no action until the bridge order, on the eve of trial – an action neither supported by their own expert nor one that attempted to address the underlying failure to exercise appropriate clinical judgment that their expert condemned.

B. Staff Disorganization and Division

Mental health staff's divided lines of authority frequently leave patients needing care in a deadly limbo. Services are fragmented among the private medical provider, at the time Correctional Medical Services, Inc. ("CMS"), which provides physician and mid-level provider services; the MDOC, which provides nursing services; the Department of Community Health, which provides the out-

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(App.937-939, 944-945, 947-948, 951-953, 954-955, 956-958) (Walsh); Hr'g T., vol. 6, 871-873, 1047-1048 (App. 979-981, 1012-1013) (Dlugacz and Walden), Hr'g T., vol. 2, 261-262, 275-276, 284 (App. 883-884, 889-890, 892) (Kupers).

[18] Hr'g T., vol. 1, 181, 186, 222 (App. 869, 870, 876); Pls.' Ex. 103 (App. 1088-1102).

patient team services ("OPT") for patients on the psychiatrists' caseload; and the MDOC psychologists in the Psychological Services Unit ("PSU"). Although Defendants in their August 2007 Mental Health Plan promised to integrate PSU and OPT,[19] at the time of trial that merger had not happened, and the other separate lines of authority remain.

While Defendants pointed to their case management meetings as performing the necessary coordinating functions between the disciplines, such as allowing review of cases in which a prisoner was erroneously TNRed, the minutes of those meetings do not show that the meetings performed those functions. Defs.' Ex. E (App. 1132-1178). *See also* Hr'g T., vol. 6, 880, 1010 (App. 983, 999). Only a handful of staff attend, and the meeting notes are so sparse that they would not be informative to someone who read only the notes. *See* Defs.' Ex. E (App. 1132-1178). In fact, Defendants' psychiatric expert testified that case management meetings are "not the avenue to do integration." Hr'g T., vol. 1, 54 (App. 844).

Defendants' own records indicate that, for the period January-February 2008, the time for an emergency referral from PSU to OPT, which employs all the psychiatrists, was as long as fourteen days. Defs.' Ex. H at 1 (App. 1179). For the same time period, the maximum elapsed time for an urgent referral was 73 days.

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[19] *See* Defs.' Revised Mental Health Plan, Aug. 20, 2007, *supra* note 8.

Id. Policy allows a 28-day delay between a referral from PSU to a psychiatrist. Hr'g T., vol. 2, 293 (App. 895). These delays expose prisoners to a substantial danger of serious harm. *Id.* at 294-296 (App. 896-898).[20]

Minutes of a 2008 PSU staff meeting refer to "poor identification of the MI" [from context, mentally ill], "people slipping through the cracks", and "OPT's inability to fulfill their mission due to poor staffing." Pls.' Ex. 102 at 328377 (App. 1086). Another set of minutes from the same month includes the following:

> Significant difficulties noted with psychiatric coverage. Examples presented of psychiatry failing to identify mental illness and suicidality. Numerous instances of a failure to see patients timely. Very long waiting list. Pressures to make "urgent" referrals into "routine" referrals. . . . Psychologists who feel that patients are getting better during the long wait and don't need psychiatrist intervention should make sure to release the hold[.]

Id. at 328378 (App. 1087). This dysfunctional system harms patients.[21]

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[20] Defendants admitted that their calculated average time for an OPT referral to be completed is wrong, with delays coded as eleven days actually taking 18 days. Defendants do not know the true average length of time for these referrals. Pls.' Ex. 104 at 17-20 (App. 1104-1107).

[21] Hr'g T., vol. 2, 340-343 (App. 912-915); Hr'g T., vol. 6, 880-881, 1047-1048 (App. 983–984, 1012-1013); Hr'g T., vol. 5, 682-684 (App. 949-951); R. 2610-02 at 19-20; Hr'g T., vol. 1, 107-109 (App. 863-865); R. 2773 at 3.

C. The Lack of Staff Supervision

Mental health staff are inadequately supervised. Both PSU and OPT employ limited-license psychologists, who are required by Michigan law to be directly supervised by a fully licensed psychologist. Hr'g T., vol. 3, 452 (App. 924). The unit chief for the OPT is a limited-license psychologist who does not have an on-site supervisor. Hr'g T., vol. 1, 85-87, 105 (App. 850-852, 862). There is only one licensed psychologist for the twelve limited-license psychologists assigned to PSU. Hr'g T., vol. 2, 303-304 (App. 899-900). Defendants' own expert disapproved of the use of limited-license psychologists and was unable to state an opinion as to whether the supervision of the limited-license staff was sufficient. Hr'g T., vol. 1, 84-86 (App. 849-851).

The need for supervision is particularly great because the limited-license staff are performing critical functions such as competency examinations and determinations of whether to remove a prisoner from suicide observation that require fully-licensed staff. Hr'g T., vol. 2, 304-306 (App. 900-902). Limited-license staff were also stopping inappropriately stopping referrals from somatic physicians to psychiatrists. *Id*. at 307 (App. 903). Appropriate supervision would require that the supervisor actually see some patients with the person being supervised, so that the supervisor could develop an informed opinion of the

quality of work done by the limited-license psychologist. *Id.* at 310-311 (App. 905-906); Hr'g T., vol. 6, 878 (App. 982).

There is also no clinical supervision for the psychiatrists; their administrative supervisor is a limited-license psychologist. Hr'g T., vol. 1, 88-89 (App. 853-854); Hr'g T., vol. 3, 554 (App. 962). It is this lack of clinical supervision that allows the several-fold discrepancies regarding the percentages of patients accepted onto the caseload by the various psychiatrists to persist. Hr'g T., vol. 5, 779-780 (App. 970-971). A psychiatrist should be supervising the psychiatrists. *Id.* at 782 (App. 972).

This lack of supervision also produces the chasm between what supervisors think is happening and actual practice. For example, although supervisors claimed that staff were requesting previous mental health records for patients, the head of the OPT could in fact find only one instance in which such records had ever been requested.[22] Similarly, although by policy patients who decline psychotropic medications are supposed to stay on the mental health caseload, such prisoners are routinely discharged from treatment. *Compare* Pls.' Ex. 45 at 54 (App. 1071) *to* Pls.' Ex. 48 at 63 (App. 1078); R. 2773 at 20; R. 2609-02 at 11-12.

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[22] *Compare* Hrg. T., vol. 1, 96-97 (App. 857-858); Pls.' Ex. 47 at 58-59, 63-64 (App. 1073-1074, 1075-1076) *to* Pls.' Ex. 104 at 47-52 (App. 1120-1125).

There is a substantial danger of serious harm from the effects of the lack of supervision and staff integration. Hr'g T., vol. 2, 308, 313, 316, 342 (App. 904, 907, 908, 914); R. 2773 at 3. Predictably the indirect effects of this lack of supervision, such as the failures to request previous records, also result in missed diagnoses and cause harm. Hr'g T., vol. 2, 271, 385-386 (App. 888, 916-917); Hr'g T., vol. 5, 684-686 (App. 951-953).

D. Lack of Staffing and Treatment Beds

After the Consent Decree mental health requirements were terminated, Defendants deliberately set about to reduce the quality and quantity of mental health services. In July 2006, the Department of Community Health announced its intentions to "downsize" and "streamline" mental health services by moving prisoners out of treatment through modifying the OPT referral process so that it was slower in making referrals to staff and by removing prisoners from the caseload. Pls.' Ex. 97 (App. 1085).

This downsizing was accompanied by a substantial reduction in access to treatment beds for *Hadix* class members. DWH eliminated a 22-bed mental health treatment unit after it lost its hospital accreditation, even though DWH is the only place in the system that was designed to care for a prisoner who needs both in-patient medical treatment and on-site psychiatric care. Hr'g T., vol. 2, 268-269

(App. 885-886); Ex. 34B at 41-42 (App. 1059-1060). HVM's in-patient mental health facility also lost its accreditation and the self-mutilators unit closed. Hr'g T., vol. 2, 269-270 (App. 886-887). While the MDOC once planned that 4.4% of its beds would be mental health beds, currently, about 1.4% of the beds are designated for mental health. *Id.* at 270, 393 (App. 887, 918); Pls.' Ex. 36A at 20 (App. 1067). No mental health beds have been added for years, despite increases in the prison population.

The MDOC provides too few in-patient mental health beds to meet the needs of the system. Based on the testimony and exhibits presented at trial, the following table shows the capacity and average census at HVM:[23]

HVM Capacity and Average Census

Unit	Authorized Beds	Average Census	Difference
Acute	40	35	+5
CSP	8	15	-7
RTS	120	120	0
RTP	260	235	+25
Discharged	0	15-20	-15-20
Total	428	420-425	+3-8

As a practical matter, there are fewer than ten available beds out of a total of 428 authorized beds. This means that the facility is routinely running above 98%

[23] Defs.' Ex. HH at unnumbered 20-22 (App. 1257-1259); Hr'g T., vol. 1, 210-213 (App. 872-875).

of capacity. In fact, the head of the OIMM testified that recent data showed HVM as running above capacity. Hr'g T., vol. 5, 801 (App. 973). As Defendants' psychiatric expert testified, prisons and hospital are designed to run at 90% capacity in order to avoid waiting lists, and delays in admission would be expected at this level of population. Hr'g T., vol. 1, 70 (App. 848). Of note, Defendants' claim that all referrals from RGC to the Crisis Stabilization Program Unit ("CSP") were accepted by the CSP, and arrived at the facility that same day, is belied by Defendants' own monthly reports, for the only periods in which Defendants supplied enough data to test the matter. *See* Defs.' Ex. DD (prisoners 665043, 637454) (App. 1213, 1222-1223); Defs.' Ex. EE (prisoner 632973) (App. 1254-1256). The PSU Monthly Meeting Notes contain directions on "last resort" measures if staff are told that all the CSP beds are full. Defs.' Ex. BB for 12/20/07 at unnumbered 2 (App. 1199). The OIMM not surprisingly concluded that HVM needed 80 additional beds to meet demand. Hr'g T., vol. 6, 895-896 (App. 987-988).

These four observation cells in DWH are the only mental health beds in the *Hadix* complex. When the observation cells at DWH are full, staff are instructed to use the SMHU segregation unit instead. Defs.' Ex. BB for 12/20/07 at unnumbered 2 (App. 1197)*; see also* Hr'g T., vol. 6, 895 (App. 987). Mentally ill

prisoners are frequently placed in the SMHU. R. 2800-2 (spreadsheet comments re Prisoners 6, 11, 15, 27); Hr'g T., vol. 5, 705-706 (App. 965-966); Pls.' Ex. 31 at 327001-327002 (App. 1023-1024). Many of these placements result because mentally ill prisoners have difficulty following the norms of prison staff and the prisoner culture; their illness leaves them vulnerable to predatory fellow prisoners. Hr'g T., vol. 2, 276-277, 317 (App. 890-891, 909); Hr'g T., vol. 6, 891-892 (App. 985-986). Segregation is toxic to mentally ill prisoners. Hr'g T., vol. 2, 319 (App. 911). PSU staff attempted to raise the issue of the placement of fearful mentally ill prisoners in the SMHU, but the warden brushed off the concerns. Defs.' Ex. BB for 1/23/08 at unnumbered 2 (App. 1195).

Staffing numbers are also insufficient. Defendants have admitted that OPT needs 1.5-2.0 additional psychiatrists and 3.5 additional qualified mental health professionals, based solely on planned changes in the evaluation process; this estimate does not include additional staffing for the RGC screening or assessment process. Defs.' Ex. SS at unnumbered 4 (App. 1278).

This estimate does not address the needs at DWH, where the lack of any on-site psychiatric coverage results in unacceptable delays in responding to referrals to psychiatrists. *See* Hr'g T., vol. 3, 567-568 (App. 927-928); Hr'g T., vol. 6, 940-941 (App. 992-993). While only psychiatrists prescribe and monitor psychotropic

medications for other prisoners, psychiatrists are typically not even involved in these functions for DWH patients. *See* R. 2773 at 24-26; Hr'g T., vol. 6, 1030 (App. 1005); *see also* discussion *infra* at 24-25. Further, patients can be too ill for in-patient treatment; the closing of the DWH mental health unit means that prisoners with both complex medical and mental health needs simply cannot get all those needs addressed. *See, e.g.,* Hr'g T., vol. 6, 1045-1046 (App. 1010-1011); Rec. 2773 at 3; *see also* discussion of Childers case *infra* at 27-29.

The lack of mental health services for patients in DWH is truly shocking. For example, the head of the OPT, Craig Crawford, discussed in his direct testimony a paraplegic patient who was non-compliant with his medical treatment as an example of the care provided by the system. Hr'g T., vol. 6, 906-907 (App. 989-990). Although Mr. Crawford knew that this patient was delusional during the summer of 2007, he did not record that information in the patient's medical records. *Id.* at 939-940 (App. 991-992); *see also* Pls.' Ex. 106 at 331216 (App. 1128). When the patient refused a CT scan necessary to diagnose a suspicious mass in his pelvis, a social worker asked Mr. Crawford to see the patient immediately. It took him six days to see the patient, and it took about two more weeks to get to a psychiatrist. Hr'g T., vol. 6, 940-941 (App. 940-941). Staff delayed about three months after the referral to Crawford to begin guardianship

proceedings, even though Mr. Crawford knew that the patient had an urgent need for the CT scan he was refusing. *Id.* at 940-943 (App. 992-995). Eight months after the social worker tried to involve Mr. Crawford, no guardianship hearing had taken place and the OIMM was urging them to consider the paneling process for involuntary medication to try to obtain patient consent to the CT scan. *Id*. at 940-944 (App. 992-996).

In another case, a limited-license PSU staff member at DWH found a patient suffering from multiple myeloma competent the same day that the patient was sent to a local hospital and found not to be competent. After the guardian was appointed, an RGC psychiatrist saw the patient at DWH and, despite the guardianship and a current prescription for psychotropic medication, TNRed the patient without any explanation. The psychiatrist's medical note indicated that the patient should contact the psychiatrist if he wanted treatment, but the patient was not capable of contacting the psychiatrist. *Id*. at 1027-1028 (App. 1003-1004); *see also* Hr'g T., vol. 5, 696-702 (App. 956-962).[24]

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[24] The district court assumes that this evidence was proffered to show that Defendants were deliberately indifferent because Defendants should have forced the prisoner to accept life-prolonging medical treatment, and the court disagreed with that assumed claim. R. 2903 at 20-21. In fact, Plaintiffs have never made such an assertion; rather, Plaintiffs' experts criticized the failure to provide clearly indicated *mental health* treatment. As Plaintiffs' psychological expert pointed out, if the mental health staff had provided necessary treatment, including contacting

Another patient with serious cardiac and psychiatric problems had his psychotropic medication changed by outside consultants because of the potential effects of his prescribed medication on his heart problems. After he returned to DWH, his mental status deteriorated on the new medication, but he was predictably not monitored by a psychiatrist at DWH. He then stopped taking his psychotropic medications. Following a transfer to a local hospital, he was found to be floridly psychotic. The medical record does not contain any communications between medical and mental health staff at DWH regarding this man's treatment needs. Hr'g T., vol. 6, 1024-1027 (App. 1000-1003).

Another patient at DWH with liver cancer, Hepatitis C, and diabetes, was experiencing confusion, which may have been due to his medical problems or a side effect of his heart medication. A physician's assistant prescribed haldol (a powerful antipsychotic) and ativan (an anti-anxiety drug). He needed a psychiatric consultation and coordinated treatment involving medical and mental health staff but did not get it. *Id*. at 1041-1042 (App. 1006-1007). Another patient may have died from this lack of coordinated care. He was supposed to be followed by psychiatry, but was not, even though he was taking psychotropic medication that

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the guardian to authorize psychotropic medications, the patient might have been spared his terrifying delusions that the medical staff was trying to kill him. Hr'g T., vol. 5, 696-702 (App. 956-962).

placed him at risk of falling. He experienced an episode of falling, but still did not receive a psychiatric review of his medication regime. He fell again, sustaining a cerebral hemorrhage, from which he apparently died very shortly thereafter. *Id.* at 1043-1044 (App. 1008-1009).[25]

A few months before trial began, all of RGC for a period of time had no on-site psychiatric coverage. Hr'g T., vol. 3, 568-569 (App. 928-929). For the last month in which statistics were available, the OPT caseload at RGC was 211% of recommended capacity (Defs.' Ex. RR at 1 (March 2008 statistics) (App. 1272); Hr'g T., vol. 5, 802 (App. 974); R. 2609-2 at 53-54 ; Hr'g T., vol. 1, 87-88 (App. 852-853) (Defendants' psychiatric expert testifies that if staff are appropriately identifying 15% of prisoners for admission to the caseload, more staff are needed)), so the system is at the breaking point.

E. Delays and Denials of Care

RGC prisoners going through the screening process experience significant disruptions in their prescriptions for psychotropic medications, the specific problem that the bridge order was supposed to fix. According to an OIMM

[25] The district court discounted the credibility of Plaintiffs' medical expert on the ground that he "selectively discuss[ed] fragments of patients' experiences without explaining the context." R. 2903 at 21. As the summary of his testimony above makes clear, this criticism is unpersuasive.

Report, approximately a third of the prisoners with verified prescriptions for psychotropic medications experienced a delay of two days or more in receiving their medications. R. 2797 at 3.[26] In addition, the Report documents a number of significant medication errors, delays in seeing a psychiatrist, and questionable mental health decisions. *Id*. at 4-14. As to prisoners who report such medications, but do not arrive with verification, same-day medications are ordered only in emergencies. Pls.' Ex. 48 at 73-76 (App. 1081-1084).

The case of Chad Childers presents a textbook case of this how this dysfunctional system harms vulnerable prisoners. Mr. Childers, age 26, had a history of mental illness from his late teens, with a diagnosis of schizophrenia, paranoid type. Pls.' Ex. 34B at 4-5 (App. 1033-1034). At the same time, he had the advantage of a loving family that did everything possible to make certain that MDOC was fully informed and prepared to deal with his illness, which had stabilized on a three-drug regimen. *Id*. at 6-7 (App. 1035-1036). His mother gave the probation officer extensive information about her son's history of mental

[26] Defendants claimed at trial that prisoners coming into RGC with verified prescriptions for psychotropic medications received those medications in less than a day. In fact, medical records showed that the summary upon which Defendants relief for that claim automatically treated the date that the medication was entered into the pharmacy computer as the date the prisoner entered the facility, even though medical records showed arrival dates of two weeks earlier. Pls.' Ex. 104 at 35-47 (App. 1108-1120).

illness to pass on to the prison system. *Id.* at 9-11 (App. 1037-1039); Pls.' Ex. 19 at 326925, 326938 (App. 1017-1018).

Mr. Childers arrived at RGC on March 28, 2007, but he received none of his medications until April 1, even though the records from the county jail documented his history of schizophrenia and current medications and dosages. Pls.' Ex. 33 at 327005-327007 (App. 1027-1029); Pls.' Ex. 32 (App. 1026). He did not receive one of his prescribed medications for over a month. Pls.' Ex. 31 at 327002 (App. 1024). Although Mr. Childers was admitted to the OPT caseload on March 29, he received no treatment from OPT (other than medications) as he began to deteriorate. T., vol. 5, 704-705 (App. 964-965); Pls.' Ex. 33 at 327017 (App. 1030). He was housed in a filthy cell on the fourth tier of the cellblock (five floors up from base) although a base cell had been ordered for him. Pls.' Ex. 33 at 327018 (App. 1031); Pls.' Ex. 20 at 326945-326947 (App. 1019-1021). For someone with Mr. Childers' mental problems, placement on the fourth tier is likely to be harmful because of the fear of falling or being pushed over the railing by other prisoners that such housing engenders. Hr'g T., vol. 5, 704 (App. 964).

By April 22, Mr. Childers was scheduled to transfer to the SMHU, a segregation unit, because of "agitated, bizarre, hostile behavior." Pls.' Ex. 31 at 327001 (App. 1023). He was diverted from the SMHU solely because of a medical

problem that required intravenous antibiotic therapy and placement in DWH. Upon arrival at DWH, staff characterized him as "delusional and paranoid." Mr. Childers repeatedly pulled out his intravenous lines, complicating his recovery. During his deterioration, Mr. Childers' mother tried desperately but unsuccessfully to get help for her son.[27] Because of his medical condition, Mr. Childers could not be transferred to the in-patient mental health unit at Huron Valley ("HVM"), where he needed to be. Pls.' Ex. 34B at 41-42 (App. 1059-1060).

Mr. Childers was eventually transferred to a different mental health unit and, one year later at the time of trial, was still recovering from his severe psychotic break. *Id.* at 57 (App. 1065). In short, mental health staff failed to maintain his established and effective medication regime and failed to monitor or treat Mr. Childers as he became increasingly paranoid and delusional. These failures represented profound failures of coordination and cooperation between medical and mental health services, causing him physical and mental suffering. Hr'g T., vol. 5, 702-707 (App. 962-967).

Many other patients were harmed by the failures to provide mental health care. One such patient, for example, had prostate cancer that Defendants had

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[27] Pls.' Ex. 34B at 18-23, 25-28, 30-33, 35-37, 41-46 (App. 1040-1045, 1047-1050, 1052-1055, 1056-1058, 1059-1064).

failed to treat for a year after it was strongly suspected. During the period that the patient's diagnosis was delayed, the physician made a referral to an OPT psychiatrist but PSU stopped the referral – a direct and inappropriate consequence of the dysfunctional relationships between physicians employed by the contractor, OPT, and PSU. R. 2609-02 at 14-15.

Another patient was given a referral to OPT after he was placed in the SMHU. The patient was crying and exhibiting symptoms of withdrawal and expressions of severe hopelessness and helplessness. The patient had previous suicide attempts and psychiatric hospitalizations. It took 17 days after the first referral to mental health for the patient to see a psychiatrist. R. 2773 at 17-19; *see also id.* at 26-28 (delay of fourteen days in obtaining a psychiatric evaluation of a patient who had spent most of the previous year in a psychiatric hospital and who was placed in an observation cell prior to his evaluation).

Defendants' efforts to reduce the quality and quantity of mental health treatment[28] have been extraordinarily successful. As discussed above, the lack of staffing and mental health beds, combined with the lack of staff supervision and coordination, presents a substantial dangerous of serious harm reflected in the delays and denials of care, and ultimately in the deterioration of the mental health

[28] *See* discussion *supra* at 19-20.

of numerous prisoners. Hr'g T., vol. 2, 308, 313, 316, 340, 342-343 (App. 904, 907, 908, 912, 914-915); R. 2773 at 3. In some cases, these failures have even resulted in death. Hr'g T., vol. 2, 342 (App. 914); Hr'g T., vol. 6, 1043-1044 (App. 1008-1009); *see also* R. 2773 at 14-17(describing another psychotic patient (called a malingerer by one of the psychiatrists) who was subjected to the use of restraints and forced feedings; he nearly died from dehydration in DWH after he developed a MRSA[29] (antibiotic-resistant) infection and sepsis but was not evaluated by a medical services provider).

SUMMARY OF ARGUMENT

The district court's decision that the evidence did not show a constitutional violation in the provision of mental health care was based on a profound misunderstanding of the Eighth Amendment standard as applied to a case seeking injunctive relief. The court below reasoned that, under *Farmer v. Brennan,* 511 U.S. 825 (1994), there are two components to proof of an Eighth Amendment violation regarding mental health care in the prison context: a showing of a serious mental health need (the objective component) and a showing that the defendants failed to protect the prisoners despite actual knowledge of that need, *i.e.*, with "deliberate indifference" (the subjective component). The court decided

[29] Methicillin-resistant *Staphylococcus aureus*.

that Plaintiffs had not shown "deliberate indifference", and never reached a conclusion on the objective component.

The problem with the district court's analysis is that this case involves a request for injunctive relief. As this Court has previously held in this very case, relying on guidance provided in *Farmer* itself, when an injunctive challenge to prison conditions of confinement actually goes to trial, Plaintiffs are not required to prove "deliberate indifference" as a separate element, "because the same information that would lead to the court's conclusion [of a violation of the objective component of an Eighth Amendment violation] was available to the prison officials." *Hadix v. Johnson,* 367 F.3d 513, 526 (6th Cir. 2004).

Presumably because of the court's mistaken application of the subjective component of an Eighth Amendment violation, the court never addressed directly whether the objective component was violated, that is, whether the failures to provide necessary mental health care created an excessive risk to prisoner health and safety for prisoners who had serious mental health needs. *See Farmer*, 511 U.S. at 837. In fact, Plaintiffs have established an overwhelming record demonstrating that excessive risk, so the court's ruling must be reversed.

The district court also committed legal error in assuming that the only relief that it was empowered to issue was relief embodied in the original Consent Decree

in this case. In fact, it has been clear ever since *United States v. Swift & Co.,* 286 U.S. 106 (1932), and *United States v. United Shoe Machinery Corp.,* 391 U.S. 244 (1968), that consent decrees may be modified if they fail to eliminate the violation of law that was the goal of the consent decree. In any event, Plaintiffs' requests were in fact within the scope of the mental health provisions of the Consent Decree.

In addition, the district court violated Fed. R. Civ. P. 52(a) by failing to make necessary factual findings to allow this Court to have a clear understanding of how the district court reached its decision. *See Zack v. Comm'r of Internal Revenue,* 291 F.3d 407, 412 (6th Cir. 2002). Finally, the district court's finding that Defendants had complied with the November 2006 preliminary injunction was clearly erroneous.

ARGUMENT

I. THE DISTRICT COURT ERRED IN FINDING THAT PLAINTIFFS WERE REQUIRED TO SHOW A VIOLATION OF THE SUBJECTIVE "DELIBERATE INDIFFERENCE" COMPONENT OF THE EIGHTH AMENDMENT.

The district court reasoned that Plaintiffs could not succeed without showing that Defendants had violated the subjective component of the Eighth Amendment as applied to conditions of confinement challenges. R. 2903 at 7

(noting the objective and subjective components of an Eighth Amendment violation and requirement that plaintiff in a conditions of confinement case demonstrate that the defendant prison official "subjectively perceived facts from which to infer substantial risk to the prisoner, that he did in fact draw the inference, and that he disregarded the risk.") (citing *Comstock v. McCrary,* 273 F.3d 693, 702 (6th Cir. 2001). The court concluded that Plaintiffs had not established deliberate indifference, and had not "recklessly and systematically disregarded mental health concerns of *Hadix* prisoners." R. 2903 at 16.[30]

In so doing, the court applied an incorrect legal standard, even though the correct legal standard had been articulated by this Court in an earlier stage of this very case.[31] This Court, noting that the *Hadix* class seeks only injunctive relief,

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[30] The court also viewed each individual piece of evidence introduced by the parties through the lens of whether it showed "deliberate indifference". *See, e.g., id.* at 19-20 (limited-license chief of OPT, even if he did not always "make exactly the best possible call" demonstrated "the opposite of deliberate indifference" because he exhibited "genuine warmth and concern" for the prisoners he treated); *id.* at 20 (no deliberate indifference in treatment of individual prisoner); *id.* at 21 (Dr. Kupers' testimony on behalf of Plaintiffs discounted and testimony of Dr. Walden on behalf of Plaintiffs not credited because they did not focus on question of deliberate indifference).

[31] The Court reviews Plaintiffs' challenges to the legal standard applied by the district court *de novo. Dow Chem. Co. v. U.S.,* 435 F.3d 594, 599 n.8 (6th Cir. 2006) (legal standards applied by district court are subject to *de novo* review). *See also Talal v. White,* 403 F.3d 423, 426 (6th Cir. 2003) (generally a conditions of confinement claim of deliberate indifference involves a mixed question of law and

held the following:

> In this case, we are concerned with future conduct to correct prison conditions. If those conditions are found to be objectively unconstitutional, then that finding would also satisfy the subjective prong [of an Eighth Amendment violation] because the same information that would lead to the court's conclusion was available to the prison officials.

Hadix v. Johnson, 367 F.3d 513, 526 (6th Cir. 2004).

This Court's 2004 decision is based on the Supreme Court's leading case regarding the standard for determining whether prison conditions of confinement violate the Eighth Amendment, *Farmer v. Brennan,* 511 U.S. 825 (1994). *Farmer*, as noted by the district court, articulates an Eighth Amendment standard with both an objective and subjective component – a prison official must know of and disregard (the subjective state-of-mind component) an excessive risk to prisoner health and safety (the objective component). *Id*. at 837.

The district court failed to consider, however, that in *Farmer* the Supreme Court distinguished the analysis that courts are to use in applying this standard when prisoners seek injunctive relief rather than relief in damages. The Supreme Court noted that, at points prior to trial, such as at the summary judgment stage, a prisoner seeking an injunction would be required to show that the defendants

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fact, which is reviewed de novo).

knew of and disregarded an objectively intolerable risk. At the same time, the Court pointed out that, for purposes of injunctive relief, once a case proceeds to trial, the prison officials are charged with knowledge of the risks that the plaintiffs then proved:

> If, for example, the evidence before a district court establishes that an inmate faces an objectively intolerable risk of serious injury, the defendants could not plausibly persist in claiming lack of awareness, any more than prison officials who state during the litigation that they will not take reasonable measures to abate an intolerable risk of which they are aware could claim to be subjectively blameless for purposes of the Eighth Amendment[.]

Id. at 846 n.9. Accordingly, the district court erred by relying on its finding that Defendants are not "deliberately indifferent" in violation of the subjective component of an Eighth Amendment violation.[32]

II. THE DISTRICT COURT ERRED IN FAILING TO FIND AN OBJECTIVELY UNREASONABLE RISK OF HARM UNDER THE EIGHTH AMENDMENT.

The district court barely touched on the objective component of an Eighth Amendment violation. While the court correctly noted that the "objective

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[32] Of note, the case from this Court that the district court relied upon for imposing a subjective state-of-mind requirement was a wrongful death case seeking only damages relief. *Comstock,* 273 F.3d at 697-98 (cited in R. 2903 at 7).

component requires the plaintiff to show that the medical need at issue is sufficiently serious," R. 2903 at 7, it did not state a conclusion regarding the objective component of an Eighth Amendment violation or otherwise address that component. The district court thus, by failing to even consider the objective component of an Eighth Amendment violation, and applying the subjective component in a case where it was inapplicable, committed manifest legal error.[33]

The Supreme Court in *Farmer* describes in some detail the objective component of an Eighth Amendment violation with regard to conditions of confinement. The Court expresses the objective standard in several slightly different formulations, variously referring to an "excessive risk",[34] "significant risk of harm",[35] "substantial risk of harm",[36] "substantial risk of serious harm."[37] and "objectively intolerable risk of harm".[38] These multiple formulations by the Court make clear that it was not requiring any talismanic level of probability that a risk

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[33] This Court reviews de novo challenges to the legal standard used by the district court. *See* note 31, *supra.*

[34] 5ll U.S. at 837.

[35] *Id.*

[36] *Id.* at 842.

[37] *Id.* at 843.

[38] *Id.* at 846.

would occur; rather the reference to an "excessive risk" indicates that a court weighs the likelihood of harm along with the severity of a particular harm, should it materialize, to determine whether that risk satisfies the objective component.

Significantly, the Eighth Amendment "does not mandate comfortable prisons but neither does it permit inhumane ones[.]" 511 U.S. at 832 (internal quotation marks and citations removed):

> The [Eighth] Amendment also imposes duties on these officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must take reasonable measures to guarantee the safety of the inmates.

Id. (internal quotation marks and citations omitted); *see also Helling v. McKinney,* 509 U.S. 25, 33 (1993) (Eighth Amendment protects prisoners against future harm). Thus prison staff have an affirmative obligation to remove unreasonable risks to prisoners. *Farmer,* 511 U.S. at 833 ("having stripped [prisoners] of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course.") (citations omitted).

Among the claims of exposure to risks that this Court has held "sufficiently serious" to potentially violate the Eighth Amendment is a claim that prison

officials allowed prisoners to smoke in non-smoking areas, exposing the prisoner plaintiff to excessive levels of second-hand tobacco smoke despite his allergy to the smoke, resulting in his development of sinus problems and dizziness. *Talal v. White,* 403 F.3d 423, 425, 427 (6th Cir. 2005). Other medical conditions that fall far short of life-threatening can also constitute "serious medical needs." *Boretti v. Wiscomb,* 930 F.2d 1150, 1154 (6th Cir. 1991) (denial of dressing and pain medication for wound); *Greeno v. Daley,* 414 F.3d 645, 653 (7th Cir. 2005) (severe heartburn with frequent vomiting); *Brock v. Wright,* 315 F.3d 158, 163-64 (2d Cir. 2003) (painful keloids[39]); *Clement v. Gomez,* 298 F.3d 898, 904 (9th Cir. 2002) (effects of pepper spray on prisoners not involved in use of force incident); *see also Vaughn v. Gray,* 557 F.3d 904, 909 (8th Cir. 2009) (holding that jail officials who knew that a mentally ill man was behaving strangely and had been vomiting for seven hours had a serious medical need that required treatment and could be found to be deliberately indifferent; denying qualified immunity).

This Court has made clear that a failure to address serious mental health needs is just as constitutionally unacceptable as a failure to address serious physical health needs. *Perez v. Oakland County,* 466 F.3d 416, 423, 428 (6th Cir.

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[39] Keloids result from the excessive growth of scar tissue at the site of a skin injury.

2006) (Eighth Amendment right to medical care for serious medical needs encompasses psychological needs, including right to psychological counseling and medication); *see also Clark-Murphy v. Foreback,* 439 F.3d 280, 287-88 (6th Cir. 2006) (noting that "little room for debate exists" as to whether the deprivation of medical care, including psychological services, would be "sufficiently serious" to satisfy the objective component of an Eighth Amendment violation) (citation removed); *Comstock,* 273 F.3d at 703 (psychological needs may constitute serious medical needs sufficient to satisfy objective component of Eighth Amendment violation). As set forth above in the Statement of Facts, Plaintiffs here established a substantial risk of serious harm for prisoners with serious mental health needs; indeed, Plaintiffs established that the risk of harm had often caused actual injury and even death.

A. Intake Screening for Serious Mental Health Needs

In every major area, systemic deficiencies in mental health care placed prisoners at unreasonable and excessive risk of harm. As noted above, the two most important determining factors regarding whether an incoming prisoner is placed on the treatment caseload are the identity of the psychiatrist who is randomly assigned to evaluate the prisoner, and whether the prisoner arrives with an existing prescription for psychotropic medications. Most prisoners are, after

completion of the RGC process, assigned to prisons that lack a psychiatrist, and mental health screening has been little better than a matter a chance. As also noted in the Statement of Facts, prisoners who are wrongfully not identified as in need of placement on the caseload suffer as a result of their untreated mental illness. *See supra* at note 16 and accompanying text.

As Plaintiffs' psychiatric expert testified, the risk of harm from the failure to identify the seriously mentally ill takes many forms. Prisoners with serious mental illness have a high risk of assault by other prisoners because of special vulnerabilities. Such prisoners are also likely to incur disciplinary infractions and end up in segregation because of their illness. For the seriously mentally ill, who come into the system with their illness relatively controlled, their treatment is discontinued, and they go out of remission, their condition worsens in the short run causing severe mental suffering, and their long-range prospects for continued remission decrease. Hr'g T., vol. 2, 291-292 (App. 893-894). Similarly, Plaintiffs' expert psychologist found a substantial danger of serious harm from the failure to identify prisoners with serious mental health needs. Hr'g T., vol. 5, 675-676 (App. 944-945) (citing Patients RW-01, 02, 04, 05, 07, 09, 10, 11, 19, 21-24, 26-29, and Patients 33-35 from R. 2609-05).

This system, which misses three-quarters of the prisoners eventually

identified for treatment, and which currently operates by essentially eliminating the clinical judgment of the RGC psychiatrists, poses a substantial risk of serious harm to seriously mentally ill prisoners. Mental health screening practices and policies that pose a substantial risk of serious harm, like all conditions that impose such a risk, violate the Eighth Amendment. *See, e.g., Woodward v. Corr. Med. Servs. of Ill., Inc.,* 368 F.3d 917, 926 (7th Cir. 2004); *Gibson v. County of Washoe,* 290 F.3d 1175, 1188-89 (9th Cir. 2002).

B. Staff Disorganization, Lack of Supervision Resulting in Treatment Delays, and Failures to Provide Follow-up Care

As noted above, emergency referrals to the psychiatrists took as long as fourteen days. *See supra* at 15, 30. When a social worker tried to make an immediate referral to a psychiatrist for a delusional patient in DWH who was refusing a CT Scan for a suspicious mass in his pelvis, it took five days before a psychologist saw him and sixteen days before the patient was seen by a psychiatrist. Hr'g T., vol. 6, 939-941 (App. 991-993); Pls.' Ex. 106 at 331216-331217 (App. 1128-1129). Although the limited-license psychologist, who was also the OPT chief, knew that the matter was urgent, the first steps toward seeking a guardianship for the patient did not take place for months. Hr'g T., vol. 6, 941-943 (App. 993-995). Defendants' staff admitted that there were numerous failures

to see patients in a timely manner and a very long waiting list. *See supra* at 16. At the same time, limited-license staff were stopping referrals to psychiatrists. *See supra* at 17. These failures to provide treatment, and treatment delays, pose a substantial danger of serious harm to prisoners with serious mental health needs. *See* Hr'g T., vol. 2, 296 (App. 898).

Once a prisoner's serious mental health needs have been identified, prison officials are obligated to provide mental health care addressing those needs. *Comstock,* 273 F.3d at 702; *see also Woodward,* 368 F.3d at 927(failure to take steps to prevent suicide despite knowing of suicide risk violated Eighth Amendment; affirming jury verdict that actual practice of medical contractor was so deficient regarding the treatment of the mentally ill that mentally ill detainees were at substantial risk of serious harm); *Olson v. Bloomberg,* 339 F.3d 730, 738 (8th Cir. 2003) (delay in providing medical care when staff knew of a substantial risk of serious harm from need for care violates Eighth Amendment); *De'Lonta v. Angelone,* 330 F.3d 630, 634-35 (4th Cir. 2003) (finding that complaint stated Eighth Amendment claim by alleging failure to provide any treatment for gender identity disorder beyond placing prisoner in a facility for prisoners with mental health issues and providing counseling and anti-anxiety medications when prisoner alleged that lack of hormone treatment, or other treatment specific to

addressing the mental health problem, caused medical and psychiatric issues, including a compulsion to self-mutilate).

Similarly, the failure of officials to provide access to health care staff qualified to address the medical problems of prisoners, thereby creating a substantial risk of serious harm, violates the Eighth Amendment, as courts have frequently found. *See LeMarbe v. Wisneski,* 266 F.3d 429, 438 (6th Cir. 2001) (failure of surgeon to refer to a specialist who could address the patient's needs). *See also Brown v. District of Columbia,* 514 F.3d 1279, 1284 (D.C. Cir. 2008) (failure to transfer prisoner to a hospital); *Mandel v. Doe,* 888 F.2d 783, 789-90 (11th Cir. 1989) (preventing prisoner from seeing a doctor); *Toussaint v. McCarthy,* 801 F.2d 1080, 1112 (9th Cir. 1986) (use of unqualified personnel to provide medical services). Defendants' practice of allowing limited-license psychologists to stop referrals to psychiatrists violates this standard.

III. THE CONSENT DECREE WAS SUBJECT TO MODIFICATION AS NECESSARY TO CURE THE CONSTITUTIONAL VIOLATION.

The district court reasoned that only if the Defendants' conduct violated both the Consent Decree and the Constitution could it issue relief. Rec. 2903 at 14.[40] In fact, the Supreme Court has long recognized "the power of a court of

[40] The Court reviews de novo this legal conclusion by the district court. *See* note 31, *supra.*

equity to modify an injunction in adaption to changed conditions, though it was entered by consent." *United States v. Swift & Co.,* 286 U.S. 106, 114 (1932) (Cardozo, J.) "A continuing decree of injunction directed to events to come is subject always to adaptation as events may shape the need," and "consent" to an injunction entered by the court is "not an abandonment of the right to exact revision in the future, if revision should become necessary in adaptation to events to be." *Id.* at 114-15; *see also United States v. United Shoe Mach. Corp.,* 391 U.S. 244, 250, 252 (1968) (holding that, because an injunction had failed to eliminate an illegal monopoly, "the time has come to prescribe other, and if necessary more definitive, means to achieve the result," *i.e.,* to modify the injunction by ordering additional relief; district court has a duty to issue relief in such circumstances).

In the years since *Swift,* the Supreme Court has liberalized the standard for modifying a consent decree, particularly in institutional litigation. *See Rufo v. Inmates of Suffolk Co. Jail,* 502 U.S. 367, 381-82 (1992) (adopting "flexible approach" to modifying consent decrees in institutional reform litigation). This Court anticipated *Rufo*'s more flexible standard. *Heath v. De Courcy,* 888 F.2d 1105, 1110 (6th Cir. 1989) (stating that consent decrees in institutional reform cases are "subject to a lesser standard of modification than that dictated by *Swift*," and that "[t]o modify such consent decrees, the court need only identify a defect or

deficiency in its original decree which impedes achieving its goal, either because experience has proven it less effective, disadvantageous, or because circumstances and conditions have changed which warrant fine-tuning the decree").

Since *Rufo,* moreover, this Court has flatly rejected the position of the district court. *Waste Mgmt. of Ohio, Inc. v. City of Dayton,* 132 F.3d 1142, 1146 (6th Cir. 1997) (reversing district court that had held that it had no jurisdiction to modify, at the request of the non-governmental party, a consent decree embodying injunctive relief; courts have a duty to modify consent decrees as required by circumstances). Accordingly, there is no arguable merit to the district court's assumption that it could not modify the Consent Decree to cure the constitutional violation shown by Plaintiffs.

Finally, the district court did not actually analyze the Consent Decree provisions in purporting to determine that the relief sought by Plaintiffs was not within its scope. The Plaintiffs' motion for further relief sought eleven items. R. 2757. One item was appropriate staff training to follow policy. *Id.* at 3. That requested order is covered by Consent Decree § II.A.8.a (requiring appropriate staff training) in conjunction with § II.B.1.c (applying § II.A.8.a to mental health care). E.D. R. at 12, 15. Similarly, Plaintiffs' request for quality assurance programs, R. 2757 at 3, is covered by § II.A.12 (requiring quality assurance

programs) coupled with § II.B.1.c (applying § II.A.12 to mental health care). E.D. R. at 13, 15.

Plaintiffs' request that prisoners with serious mental health needs not be confined in the SMHU, R.2757 at 2, falls within the scope of Consent Decree § II.B.4.b, which provides that the MDOC shall provide suitable separate housing within the facility for every prisoner who exhibits a serious threat of suicide or otherwise requires a protective environment, allowing continuous observation. E.D. R. at 17. Plaintiffs' request for monitoring of the availability of beds for Hadix prisoners in HVM, R. 2757 at 3, is covered by § II.B.3.c., which requires the MDOC to have a plan to assure that *Hadix* prisoners have "adequate access to the Riverside Psychiatric Center or to other similar facilities fully licensed or operated by the Michigan Department of Mental Health." E.D. R. 199 at 15.

Plaintiffs' request that Defendants be required to revise their mental health screening instruments to provide for in-person interviews with a psychologist for prisoners with a history of significant mental health needs, as well as their request for appropriate screening for developmental and other organic brain disorders, R. 2757 at 2, are within the scope of the requirement of the Consent Decree in § II.B.5 that each prisoner receive a psychological evaluation utilizing professionally designed and approved tests and procedures, including a personal

interview for prisoners whose offense, test results or behavioral history indicate a need for further testing. E.D. R. 199 at 18; *see also id.* at 15 (§ II.B.3.b, requiring that "contemporary professional standards of care must be followed).

Plaintiffs' proposed requirement that no prisoner be discharged from the mental health caseload simply because the prisoner refuses psychotropic medications, R. 2757 at 2, is within the scope of II.B.3.c., which requires that Defendants' mental health plan provide for systematic outpatient care, follow-up care, and continuity of care for prisoners with serious mental illness. E.D. R. 199 at 15. Plaintiffs' proposed requirement that Defendants implement policy that, when health care or mental health care staff identify a prisoner who needs psychiatric evaluation, that evaluation take place within appropriate time lines, R. 2757 at 1-2, falls within the scope of Consent Decree § II.A.4.a, which requires access to medical staff within a reasonable time given the particular medical complaint, in conjunction with II.B.1.c., which applies the medical provision to mental health care. E.D. R. 199 at 9, 15.

Finally, Plaintiffs' requests for orders for a deadline for full integration of PSU and OPT, for meaningful supervision of mental health care staff, and for implementation of policy requiring staff to make reasonable attempts to obtain previous mental health records, R. 2757 at 1-2, are all within the scope of Consent

Decree §§ II.B.3.a & b, which together require that professional staff be responsible for provision of adequate mental health care to meet the serious mental health needs of each prisoner, in conformity with contemporary professional standards of care. E.D. R. 199 at 15. Accordingly, the district court's conclusion that it had no power to act under the Consent Decree was erroneous.

IV. THE DISTRICT COURT'S FAILURES TO MAKE NECESSARY FINDINGS OF FACT VIOLATED FED. R. CIV. P. 52(a).

The district court violated Fed. R. Civ. P. 52 by failing to make findings of fact sufficient to resolve the issues before it. Rule 52(a) requires the district court to make findings in all cases tried without a jury, or with an advisory jury, and in cases in which granting or refusing an interlocutory injunction is at issue. The failure of the district court to prepare the required findings makes appellate review of the merits impossible:

> [T]he trial court's findings must support the ultimate legal conclusions reached. The findings are necessary not only to reveal the logic behind the trial court's decision, but also to enable an appellate court to conduct a meaningful review of the trial court's order. The findings should be explicit so as to give the appellate court a clear understanding of the basis of the trial court's decision, and to enable it to determine the grounds on which the trial court reached its decision.

Zack v. Comm'r of Internal Revenue, 291 F.3d 407, 412 (6th Cir. 2002) (internal

quotation marks and citation removed). *See also Supermercados Econo, Inc., v. Integrand Assurance Co.,* 375 F.3d 1 (1st Cir. 2004) ("appellate review is utterly impractical when neither the conclusions of law which guided the district court ruling, nor the findings of fact essential to a principled decision under the applicable law, are discernible from its decision) (internal quotation marks and citation omitted); *Atl. Thermoplastics Co., Inc., v. Faytex Corp.,* 5 F.3d 1477, 1479 (Fed. Cir. 1993) (reversing district court where its opinion was too conclusory and sparse to provide a factual basis for determining the issue on appeal); Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* vol. 9C § 2571(3d ed. 2008) (the purposes of Rule 52 include affording the appellate court a clear understanding of the trial court's grounds for decision and assuring care on the part of trial courts in ascertaining and applying the facts).

This case represents a particularly clear violation of Rule 52(a) because, as argued above, the district court erred in its application of the basic constitutional standard, so that there are not even any ultimate findings of fact on the critical issue of the existence of a substantial risk of serious harm. Beyond that failure, the district court also failed to make almost any subsidiary findings.

While the district court provided a few words of evaluation about lay and expert witnesses, these brief comments are virtually useless in resolving the

questions before this Court. For example, the district court makes a finding that certain of Defendants' lay witnesses cared for their patients and therefore did not act with deliberate indifference. *See* R. 2903 at 19-20 (witnesses Baker and Crawford). Such findings, however, tell us nothing about whether a substantial risk of serious harm existed regarding the mental health care afforded patients.[41] Similarly, the district court found Plaintiffs' experts unhelpful, "not especially germane" or not credible because they did not testify about the non-issue of deliberate indifference. *Id.* at 21-22 (Kupers, Walden, and Walsh).[42]

The district court's major finding that could appear to relate to the objective component of an Eighth Amendment violation is its summary finding that it found credible the report and testimony of Defendants' psychiatric expect, Jeffrey Metzner, M.D. *Id*. at 16-17. The problem with this finding is that Dr. Metzner's testimony and report provide no support for a claim that the system provides a constitutional level of mental health care; Dr. Metzner explicitly disclaimed any

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[41] Further, neither Baker nor Crawford testified about the risk of harm to patients.

[42] The district court also believed that Dr. Walden focused on fragments of patients' records and his conclusions were generally limited to finding a bad outcome or stating that the care did not demonstrate best practices. *Id*. at 21. As set forth *supra* at 22-26, the claim that Dr. Walden's testimony was based on fragments is odd because he focused almost exclusively on failures of care that he found to have caused injury to the patient, or put the patient at risk of harm.

attempt to testify as to the actually functioning of the system.

When Dr. Metzner was asked on direct to state an opinion about the effectiveness of the RGC process for identifying mentally ill prisoners, he said the following:

> I think there's a process in place that, *if implemented,* is adequate to do the screening mechanism of a reception center. What I also have said is that the department is going to have to come up with their answers around why until recently this figure was 7 to 9 percent of the total population.

Hr'g T., vol. 1, 59 (App. 845) (emphasis added); *see also id.* at 30-31 (App. 840-841) (showing that in general he did not attempt to assess implementation of Defendants' plan to satisfy the requirements of the 2006 mental health injunction); *id.* at 59 (App. 845) (he did not do an assessment to determine whether the psychiatrists were adequately diagnosing mental illness). Dr. Metzner readily conceded the limited scope of his review of mental health care:

> Q. The only issu[e] that your report appears to cover is whether the policy addresses the court's order. There's no real attempt in your report to assess overall on-the-ground performance of the system?
> A. As – in general, that's accurate.
> Q. Okay. For example, as you said, it doesn't assess the claims of underdiagnosis or delays in mental treatment that are in the reports of the experts?
> A. Correct.

Id. at 65 (App. 846).

Dr. Metzner also stated that it is a "bad practice" for a system to discontinue the psychotropic medications of a quarter of prisoners going through Reception, *id.* at 99-100 (App. 859-860),[43] and that if the percentage of prisoners on the caseload did *not* fall back to the previous 9% once prisoners left RGC, it would support Plaintiffs' position that psychiatrists at RGC were failing to diagnose mental illness appropriately, because the bridge order system should not affect that percentage. *Id.* at 102 (App. 861).[44] He expressed his disagreement with Defendants' abandonment of clinical judgment in the admission process. *See supra* at 9-10. In short, Dr. Metzner never testified that the RGC screening process was actually working in a reasonable manner to identify prisoners with serious mental health needs.[45] Nor did he investigate, or testify about, whether there was sufficient staffing, or mental health beds, or provision of necessary

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[43] He noted that he was assuming that the prisoners on such medications had a clinical need for them. *Id.* at 100 (App. 860).

[44] Significantly, Dr. Metzner also stated that the low percentage of persons identified as in need of treatment was an issue; "[W]hether it's the 7, 8, or 9 percent figure, [it] has always been a concern." *Id.* at 66 (App. 847).

[45] In fact, Dr. Metzner's "essential mission" was assessing whether Defendants' first mental health plan was consistent with the court's initial order. *Id.* at 66 (App. 847).

mental health services. *See supra* at 52. Accordingly, there is literally nothing from the district court that sheds light on its evaluation of the determinative issue here – the existence or non-existence of a substantial risk of serious harm.

V. THE DISTRICT COURT'S FINDING THAT DEFENDANTS HAD CURED THE VIOLATIONS OF THE NOVEMBER 2006 PRELIMINARY INJUNCTION AND SUPPLEMENTAL ORDERS IS CLEARLY ERRONEOUS.

The district court found that Defendants had substantially complied with all the provisions of the preliminary injunction. R. 2903 at 9-13. One of the requirements of the preliminary injunction was that Defendants develop a plan for "adequate psychiatric and psychological staffing at *Hadix* facilities to ensure that routine and emergent psychiatric and psychological services are provided in a timely way[.]" R. 2187 at 1. The district court found that Defendants had satisfied this requirement because they had added three psychologist positions at RGC, there was a working on-call system for psychiatrists, and because fewer facilities were part of the *Hadix* class. R. 2903 at 10-11.

It is true that some *Hadix* facilities closed during the pendency of the proceedings, but the only change in RGC was the closure of Cellblock 7. That closure, however, had no effect on the psychiatrists' workload for screening prisoners. Cellblock 7 held only prisoners who had completed the reception

process, pending their transfer to other facilities. After Cellblock 7 closed, RGC continued to screen all incoming prisoners from Michigan's lower peninsula; the change was accomplished by completing the screening process in a much shorter period of time. R. 2338 at 2. Thus, the closure did not affect the number of prisoners that the psychiatrists must evaluate each month.[46] Further, the court's conclusion of sufficient psychological staff does not support its conclusion that the separate requirement of sufficient psychiatric staff was met. Finally, a finding that on-call psychiatric services for emergency needs were reasonably available cannot demonstrate compliance with the preliminary injunction requirement that adequate psychiatric staffing for routine and emergency services be provided.

In fact, the evidence at trial showed that, for the last month in which data were available, the OPT caseload for RGC was at 211% of capacity, and it had been rising for months. Defs.' Ex. RR (App. 1272-1274). Plaintiffs' and Defendants' psychiatric experts, as well as the head of the OIMM, agreed that

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[46] Defendants claimed that, for the first three months of 2008, the number of prisoners going through RGC declined about 8%. R. 2824 at 8 (assuming decline of 939 in 2008 from population of 12,273 in 2007). Such a decline, unrelated to closing Cellblock 7, does not remove the need for additional psychiatric staff, in view of the complete lack of on-site psychiatric coverage for DWH, *see supra* at 22-23, and the extraordinarily heavy psychiatric caseloads at the same time (211% of the MDOC's recommended caseload capacity for RGC as of March 2008). *See supra* at 26.

RGC needed additional psychiatrists. Hr'g T., vol. 5, 802 (App. 974); R. 2609-02 at 53-54; Hr'g T., vol. 1, 87-88 (App. 852-853) (Metzner indicating that if 15% of incoming prisoners continue to be admitted to the OPT caseload, he would be inclined to accept the estimate of a need for 1.5-2.0 additional psychiatrists and three other mental health staff); *see also supra* at 16 (describing other evidence of staff shortages). There is literally no evidence in the record supporting the district court's reasoning that Defendants have provided sufficient psychiatric staff to meet the need, and the district court's finding to the contrary is based on an unwarranted assumption regarding the effect of closing Cellblock 7, an assertion that Defendants correctly never proposed.

Further, in finding compliance with the November 2006 order,[47] the court simply failed to consider the further order of May 2007 rejecting Defendants' plan for compliance with the injunction. R. 2408. That order required Defendants to submit a plan that would provide, among other things, for an emergency mental health unit in RGC and would account for the usage of in-patient mental health beds at HVM, with measures as necessary to assure delivery of necessary mental health care to *Hadix* prisoners, *i.e.,* if the HVM beds were at capacity. *See* R. 2408 at 1-2.

[47] R. 2187.

Defendants have never done either of these things. There has never been the suggestion of a plan to provide an emergency mental health unit at RGC to replace the use of the SMHU. Defendants' own mental health expert stated that he would be concerned if any prisoners were assigned to the SMHU because of their mental illness. Hr'g T., vol. 1, 112-113 (App. 866-867). In fact, SMHU is used for psychological observation. Defs.' Ex. NN (SMHU Log for 2/6/08 (App. 1261) & 2/14/08 (App. 1263) (prisoner 281804)); Defs.' Ex. OO (SMHU Log for 3/13/08 & 3/25/08 (prisoner 679162)) (App. 1267, 1268); *see also* R. 2800-2 (SMHU spreadsheet comments re Prisoners 6, 11, 25). Similarly, Defendants told Dr. Metzner that prisoners prescribed psychotropic medications are not housed in SMHU beyond "a couple of days." Hr'g T., vol. 1, 112 (App. 866). The psychologist who made rounds in SMHU apparently was not aware of this claimed policy, since he testified on direct about a prisoner on psychotropic medications who spent ten days in the SMHU. *See* Hr'g T., vol. 3, 459 (App. 925) (re prisoner 678759); Defs.' Ex. PP (SMHU Log for prisoner with entry date of 3/31/08; *see also* entry for 4/9/08 (prisoner 678759)) (App. 1270-1271). This chasm between policy and actual practice demonstrates the need for a mental health unit at RGC.

Plaintiffs' mental health expert, Dr. Kupers, described SMHU as "a holding tank for people with serious mental illness." Hr'g T., vol. 2, 316 (App. 908). He

also noted that SMHU held prisoners awaiting transfer to in-patient mental health treatment, and he condemned the housing of seriously mentally ill prisoners there because segregation is toxic for the mentally ill. *Id.* at 317-319 (App. 909-911); *see also id.* at 408 (App. 919). The head of the OIMM, Robert Cohen, M.D., testified that both medical and mental health problems tend to worsen in segregation units. He also testified that he had recommended this mental health unit for RGC to serve prisoners who are at risk of decompensating in general population. Hr'g T., vol. 5, 768-769 (App. 968-969). The district court simply ignored this issue, and provided no rationale for ignoring this part of the court's previous orders.

In August 2007, Defendants submitted a statement that the system had a sufficient number of mental health beds to meet the demand from the *Hadix* facilities, but the evidence at trial overwhelmingly demonstrated the opposite. As noted *supra,* Plaintiffs' evidence demonstrated that HVM was running at 98% of capacity, and the OIMM testified that the most recent data showed HVM running above capacity. Defendants' own expert testified that delays in admission would be expected at this level of population. *See supra* at 21.

This Court will not reverse a district court's findings of fact unless they are "clearly erroneous." *Andrews v. Columbia Gas Transmission Corp.,* 544 F.3d

618, 624 (6th Cir. 2008). At the same time, the "clearly erroneous" standard is not toothless:

> Yet, while our review is deferential, it is not nugatory. [A]n appellate court may reverse a lower forum's factual finding for clear error when, even though the record contains some evidence in support of the finding, consideration of the overall evidence leaves the reviewing court with the definite and firm conviction that a mistake has been committed.

Indmar Prods. Co., v. Comm'r of Internal Revenue, 444 F.3d 771, 777-78 (6th Cir. 2006) (internal quotation marks and citations omitted). This is such a case; the district court's findings on this issue are "clearly erroneous."

CONCLUSION

For the above reasons, Plaintiffs request that this Court reverse the district court and remand with directions to grant Plaintiffs' requested relief.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C) and circuit Rule 32-1 for Case Number 09-1424, I certify that Plaintiffs-Appellants' Brief is proportionately spaced, has a typeface of 14 points and contains 13, 961 words.

Dated: July 16, 2009 s/Alicia Gathers

CERTIFICATE OF SERVICE

I certify that on this 16th day of July, 2009, Plaintiffs-Appellants' Brief was sent by the CM/ECF system to:

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Addendum

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