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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Fred Graves, et al., Plaintiffs, v. Joseph Arpaio, et al., Defendants.	No. CV 77-479-PHX-NVW **PLAINTIFFS' MOTION TO ENFORCE FOURTH AMENDED JUDGMENT AND FOR ADDITIONAL RELIEF**

The most seriously mentally ill detainees unnecessarily suffer at the Maricopa County Jail (the "Jail"). These are men and women who need to be transferred to a psychiatric hospital to receive adequate care. Instead, they remain warehoused at the Jail, often confined in the most punitive housing units. Locked down for up to 24 hours a day, they deteriorate, refusing medication and treatment, living in their own squalor, and growing more symptomatic by the day.

Many of these detainees languish in the Maricopa County Jail because their criminal cases are at a standstill, their severe mental health problems having forced the courts to deem them incompetent to stand trial. Unlike Maricopa, most counties in the

country send detainees who have been deemed incompetent to a hospital to be restored to competency. Defendants have chosen to keep their restoration program at the Jail, thus denying the most seriously mentally ill detainees the hospital-level care they need.

The Court sought to remedy this problem in the Fourth Amended Judgment, mandating in Paragraph 3 that Defendants provide "ready access to care to meet [prisoners'] serious medical and mental health needs," and "[w]hen necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided." Doc. 2299 at 2. Defendants have failed to comply with this provision. Rather, the same problems that prompted the Court to order this remedy in 2008, and retain it in 2014, remain. The Court should now enforce that relief against Defendants to bring them into compliance with the Revised Fourth Amended Judgment. Pursuant to Local Civil Rule 7.2, Plaintiffs therefore respectfully file their Motion to Enforce the Revised Fourth Amended Judgment on behalf of pretrial detainees in need of psychiatric hospitalization who remain housed at the Maricopa County Jail.

I. Background

On September 30, 2014, the Court denied Defendants' Motion to Terminate (Doc. 2142). The Court found that Defendants were providing constitutionally inadequate medical and mental health care to prisoners in its facilities. The Court ordered that the existing relief of the Third Amended Judgment (Doc. 2094) continue and granted new relief to remedy specific ongoing problems it identified. Doc. 2283 at 4, 57-58.

The three general remedies the Court retained require Defendants to (1) provide adequate intake receiving screenings, (2) ensure that prisoners have ready access to care, either at the Jail or an appropriate outside facility, and (3) ensure prisoners' timely access to prescription medications. Doc. 2284 at 1-2. The thirty-one implementing remedies were entered "[t]o show compliance with" the three general provisions. *Id.* at 2.

II. Defendants Have Failed to Comply with Paragraph 3 of the Revised Fourth Amended Judgment.

Plaintiffs respectfully request that the Court enforce Paragraph 3 of the Revised Fourth Amended Judgment (Doc. 2299), requiring that "[a]ll pretrial detainees confined in the jails shall have ready access to care to meet their serious medical and mental health needs," and "[w]hen necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided." Doc. 2299 at 2.

When this Court entered the Fourth Amended Judgment, it provided a remedy to cure the constitutional violations that, as it found, continued at Defendants' facilities. The general provisions are not, as Defendants suggest, a mere "summary of the Court's orders." *See* Doc. 2333 at 2. Rather, these three provisions are the Court's *primary* orders. The additional implementing remedies are designed "[t]o show compliance with" the general remedies. Doc. 2284 at 2. As shown below, Defendants have failed to comply with Paragraph 3 of the Revised Fourth Amended Judgment. As a result, the most seriously mentally ill men and women confined to the Maricopa County Jail suffer needlessly and are placed at an unreasonable risk of harm.

A. Defendants Have Failed to Ensure that Prisoners Have Ready Access to Hospitalization to Meet Their Serious Mental Health Needs

A significant population of prisoners at the Jail is seriously mentally ill and requires an inpatient or hospital level of care that Defendants fail to provide. This includes prisoners in need of acute stabilization and those in need of longer-term inpatient care. As a result of inadequate care at the Jail and denial of timely access to hospitalization, these prisoners suffer needlessly, decompensate, and are at risk of becoming a danger to themselves or others.

The problem of lack of access to inpatient care for the most seriously mentally ill prisoners is systemic and longstanding. In 2008, the Court found that, as a result of scarce community-based mental health services and the lack of beds at the state

psychiatric hospital, "the Maricopa County Jails often must house and provide treatment for those who should receive in-hospital psychiatric care." *Graves v. Arpaio*, 2008 WL 4699770, at *25 (D. Ariz. Oct. 22, 2008). The Court concluded that the Jail failed to provide hospital-level treatment, and it entered the remedy at issue here. *Id.* at 31.

Five years later, the Court again found that the Jail did not provide hospital-level treatment, and that Defendants remained obligated to identify detainees in need of psychiatric hospitalization and to make all reasonable efforts to transfer those detainees to an appropriate psychiatric facility. Doc. 2283 at 46. The Court's findings echoed those of its mental health expert, Kathryn Burns, MD, MPH, who documented Defendants' ongoing failure to hospitalize the most seriously mentally ill detainees from 2008-2014. *See, e.g.*, Tenth Report of Kathryn A. Burns, MD, MPH on Correctional Health Services Compliance with Second Amended Judgment at 5-6.

Jail systems around the country have developed systems to timely hospitalize mentally ill prisoners who require inpatient care. Rikers Island in New York, for example, has a jail unit at Bellevue Hospital for prisoners in need of a hospital level of care. Declaration of Pablo Stewart, M.D. (Doc. 2372-3), ¶ 337; Mar. 5, 2014 TT at 34:8-11 (Burns). The jail in Franklin County, Ohio, transfers such patients into a forensic unit at the state psychiatric hospital. *Id.* ¶ 339; Mar. 5, 2014 TT at 34:11-16 (Burns). The prisoners remain in the custody of the sheriff while they are hospitalized. *Id.* ¶ 339; Mar. 5, 2014 TT at 65:14-16 (Burns). In San Francisco, county officials likewise created a jail unit at the county hospital for seriously mentally ill prisoners, one that was staffed by sheriff's deputies to ensure security. *Id.* ¶ 338; (Mar. 6, 2014 TT at 53:2-13 (Stewart)). Many systems utilize the local hospital or state psychiatric hospital to provide care. *Id.* ¶¶ 337, 339; Mar. 5, 2014 TT at 34:11-12 (Burns). Corrections systems have alternately developed their own units, operated jail units at outside hospitals, or executed contracts with hospitals to accept prisoners. *See id.* ¶ 337; at Mar. 5, 2014 TT at 34:14-16(Burns).

Maricopa County, on the other hand, has not implemented a system that timely hospitalizes prisoners needing inpatient care. The county operates the Desert Vista psychiatric facility, which provides inpatient treatment. *Id.* ¶ 346; Mar. 5, 2014 TT at 38:13-18 (Burns). Desert Vista is equipped to handle seriously mentally ill prisoners, but Defendants do not utilize it effectively. *Id.* ¶ 346. Additionally, the Arizona State Hospital (ASH) has forensic units and manages high security seriously mentally ill people. *Id.* ¶ 346; Mar. 5, 2014 TT at 37:20-24 (Burns). Defendants have a memorandum of understanding (MOU) with ASH that allows them to send prisoners in need of inpatient care to the hospital for treatment at the County's expense. Mar. 5, 2014 TT at 39:19-23 (Burns). Defendants have not utilized the MOU, though. Dr. Burns testified in March 2014 that, over the life of the agreement, Defendants had yet to identify a single prisoner as in need of inpatient care and transfer the prisoner to the hospital. *Id.* at 39:23-40:1, 45:21-47:15; *see also* Eleventh Report of Kathryn A. Burns, MD, MPH on Correctional Health Services Compliance with Third Amended Judgment ["Burns Eleventh Report"] at 3. The patients described below and in Dr. Pablo Stewart's appended expert declaration show that Defendants still fail to timely hospitalize seriously mentally ill detainees, who unnecessarily suffer as a result.

1. Prisoners Warehoused Without Access to Inpatient Services

Instead of providing prisoners with timely access to hospitalization, Defendants allow them to remain noncompliant with their treatment and medication. As a result, these particularly vulnerable prisoners become increasingly symptomatic and decompensate. Their clinical deterioration manifests itself in many ways: they suffer worsening hallucinations and delusions, they attempt suicide or otherwise harm themselves, they refuse medications and treatment, they isolate themselves, they refuse to eat or bathe, they live in their own squalor, and they become assaultive. Furthermore, these seriously mentally ill prisoners frequently spend much of their incarceration locked down in their cells up to 24 hours a day, in either the MHU's acute units, which operate as lockdown units, or in the Jail's other lockdown units. While warehoused,

they suffer from extreme isolation. They are also denied access to any psychosocial rehabilitation services. These programs are critically important to adequately treat seriously mentally ill prisoners. As the Court found in 2014, "[t]he longer a pretrial detainee with mental illness is in isolation, the greater the risk the pretrial detainee's mental condition will deteriorate." Doc. 2283 at 48.

Dr. Stewart found dozens of examples of prisoners who deteriorated without appropriate care in lockdown. The records display a disturbing pattern of noncompliant, increasingly symptomatic patients warehoused without access to adequate treatment and denied hospitalization. Stewart Dec. *passim.* Some summaries follow:

Patient DC, from his March 27, 2015 booking, remained psychiatrically impaired and required a higher level of care than that which could be provided at the Jail. During his incarceration, he remained in the MHU, primarily in lockdown in one of its acute units, P-3. During assessments over the next several months, the patient's psychotic presentation was apparent. He frequently had food smeared over his cell-front window and his living space was littered in trash. He was placed on suicide watch (once for several weeks) multiple times due to his volatile and unpredictable behavior. His thoughts were delusional, illogical, and disorganized, and he spoke in "word salad."[1] On multiple occasions, the patient spread feces on his body. On September 8, 2015, the patient was deemed incompetent and unrestorable and was civilly committed. Stewart Dec. ¶¶ 353-54.

Patient TS was being treated by a county community provider for psychosis and organic delusional syndrome before his May 14, 2015 booking. He was moved to the MHU from intake, where he remained non-compliant and psychotic. Mr. TS was reported as making nonsensical, rambling, and delusional statements. He became aggressive and unpredictable, and he made danger-to-others (DTO) statements on at

[1] Psychiatrists use the term "word salad" as short-hand for speech marked by an incoherent, confused stream of words and phrases.

least one occasion. He refused his medications through July. Staff did little to actually engage the patient in treatment through August. *Id.* ¶¶ 402-03.

Patient TW, booked on May 9, 2014, remained symptomatic and uncooperative with staff as he remained in segregation through to his September 2015 release. On March 19, 2015, his Abilify prescription was discontinued following his consistent refusals. Assessments from May through August 2015 noted that the patient's room was full of trash and food containers. The patient was also observed talking to himself. He consistently refused to engage, declining to go to a confidential treatment space, not responding to staff and providers, refusing his medications, and refusing his labs. On August 19, 2015, he was deemed incompetent and unrestorable in RTC and he was release a month later. *Id.* ¶ 181.

Patient RG has been housed in the Jail's Special Management Unit (SMU)—the most isolated and punitive unit in the system—since December 9, 2014. During this time, he has been extremely psychotic and agitated, living in extremely unsanitary conditions in his cell, not eating adequately, and suffering needlessly. He has refused medications. In assessments, the patient reportedly yelled profanities, kicked his cell door, and made bizarre or delusional statements. He has been seen by providers every three months despite his acuity. During one assessment, he reportedly stated, "I don't work or play with others I don't care n**ger. The light in my room is my clock and my knee is the year. I've been here for over 90 days and that is kidnapping no control over 90 days. I need a psych eval. Don't turn nothing off n**ger." Mr. RG presents with a tremendously unstable mood and presents a serious risk of harm to others; he requires an inpatient level of care. *Id.* ¶ 266.

From her April 4, 2015 booking, Patient LL was transferred between the MHU and outpatient segregation; given her severe symptoms, she required an inpatient level of care. On one occasion, the patient let her menstrual blood drip on the floor of her cell and put her soiled clothing in the toilet. On another occasion, she was found smearing menstrual blood on her hands, face, and hair; her bunk was changed out

several times that morning, and the bunk of the prisoner living below her was also contaminated. Even in the MHU, the patient displayed psychotic behavior, including uncontrollable laughter, random crying fits, and incoherent rambling. During one assessment, she reportedly stated, "There are people out there jumping on my mom I can hear her crying for me." She was also observed pulling out her hair and eating it. She was described as disoriented, confused, and agitated. Her cell was messy and littered with trash. The patient was not offered any medications until July 1. *Id.* ¶ 291.

Patient JA was booked on January 16, 2015 and moved from intake to the MHU, where he remained until his release. While in the MHU, the patient remained very symptomatic. He repeatedly smeared feces over his cell. He was reportedly oblivious to his surroundings and experienced ongoing auditory hallucinations. On one occasion, he was observed kneeling with his head dunked into the toilet bowl. Dr. Jaffe described him as "globally impaired," suffering from "chronic psychosis." He was not seen by a provider for close to three months of his jail stay. He was deemed incompetent and unrestorable and his criminal charges dismissed in July 2015. Mr. JA suffered needlessly for the nine months he was incarcerated. Standard of care dictates that he should have been referred to a psychiatric hospital early in his incarceration; this was not done. *Id.* ¶ 315.

Patient JB, from his June 8, 2015 booking, was moved to the MHU for his psychotic behavior and potential danger to others, and he remained there. While in the MHU, Mr. JB regularly refused to eat; repeatedly refused medical tests, including alcohol withdrawal monitoring, weight checks, and vital signs; and threatened staff. His cell became littered with large piles of trash. No medications were ever offered to the patient. He remained symptomatic. He spoke in word salad, rambled, and could not be re-directed. On one occasion, he reportedly stated that his "dad is president and grandfather George Washington, so I am immune. They are trying to feed me food made of fingernail filing and body parts." He stated that he believed his food was made of body parts and made other references to his food being poisoned. He responded to

internal stimuli. Staff never sought to medicate or hospitalize this very ill patient. *Id.* ¶¶ 389-90.

Patient JF was being treated for schizoaffective disorder by the county's community provider before his April 20, 2015 arrest. He was moved into the MHU from booking after he smeared feces on his cell wall. While in the MHU, he primarily remained in one of the acute units, P-3, because he was unable to function elsewhere. He was observed pouring toilet water on his body and possibly drinking it, as well as attempting to flood his cell. He ripped up multiple mattresses. Mr. JF was preoccupied with delusional thoughts. On one occasion, he stated "I am Jesus I opened the skies. I sit on the right side of the father." He was noted as difficult to redirect, hypomanic, and hyperverbal. The patient periodically refused his medications. On July 30, Mr. JF was released to the streets. *Id.* ¶¶ 391-92.

Patient RO displayed extremely psychotic behavior throughout her incarceration, during which she was transferred between the MHU and outpatient segregation. The patient repeatedly smeared feces and blood in her cell and on her face. She pulled her hair out until she developed a bald spot; after her head was shaved, at her request, she was observed pulling out her pubic hair. She told a provider she eats her feces and drinks her urine. She was placed on closed custody status due to her unpredictable and violent behavior. She refused to engage with mental health providers and staff. She often refused medications, although she was reportedly on court-ordered treatment for Risperdal. Ms. RO was found incompetent and unrestorable on April 7, 2015, and she was released on or about April 17, 2015. *Id.* ¶¶ 399-401.

2. RTC Prisoners

Of particular concern is Defendants' handling of prisoners in the Jail's Restoration to Competency (RTC) Program. These are among the most seriously mentally ill prisoners in the Jail's population, and they comprise a substantial proportion of those in need of psychiatric hospitalization. During the six-month compliance

reporting period set by the Court (March-August 2015), 235 detainees were enrolled in the program.

Unlike many other jail systems around the country, which transfer prisoners deemed incompetent to proceed in their criminal cases to outside psychiatric facilities for treatment to restore them to competency, Maricopa County's RTC Program is based at the Jail itself. The resources to treat RTC prisoners are thus limited to those provided at the Jail. Without adequate care at the Jail, these prisoners—many of whom are refusing treatment—end up warehoused in the Jail's lockdown units. They are denied access to hospital-level care.

Dr. Burns has long criticized the operation of the RTC Program and its role in denying patients timely access to inpatient care. In her April 2012 report, Dr. Burns wrote that RTC patients' access to hospitalization and involuntary treatment was delayed, resulting in "needless suffering." Ninth Report of Kathryn A. Burns, MD, MPH on Correctional Health Services Compliance with Second Amended Judgment at 13. She further noted that "studies have demonstrated that delays in providing treatment result in slower and less complete or robust responses to treatment when it is eventually provided." *Id.* In her most recent report, Dr. Burns noted that Defendants reported improved access for RTC prisoners in need of inpatient care. Burns Eleventh Report at 3. However, Dr. Burns concluded, "[o]bservations during site visits to the MHU and actual chart reviews directly contradict the anecdotal reports of improvement." *Id.* She found that seriously mentally ill prisoners in need of hospitalization continue to linger "in the MHU for weeks or months, virtually without treatment, while the intricacies of the RTC and COT processes are weighed or worked through." *Id.*

Dr. Stewart identified dozens of cases showing the problems identified by Dr. Burns remain: Defendants' decision to keep RTC prisoners at the Jail leads to inadequate care, long-delayed treatment, and needless suffering. *See* Stewart Dec. ¶¶ 343-44, 350-62, 374-81, 387-88, 399-401, 410-11, 415-17, 420, and 422-24.

3. Non-Compliant Prisoners and COT Petitions

Defendants have transferred an extremely small number of prisoners to outside facilities for a court-ordered evaluation to determine if they should be subject to involuntary court-ordered treatment (COT). However, importantly, the COT process is not a valid substitute for access to hospitalization and inpatient care. The COT process is designed to determine if a patient should receive involuntary treatment; it is not designed to provide inpatient care. When those few patients have been sent to a facility for a court-ordered evaluation, their hospital stays were short and generally ended once the COT Order was secured. The patients were then transferred back to the Jail. Any short-term mental health gains from the brief period of inpatient care dissipate once the patient is returned to the Jail because of the harsh conditions and inadequate treatment they receive there.

There are many other prisoners for whom COT orders are not even sought or secured. Notably, Defendants generally do not seek COT Orders for prisoners in the RTC program. Dr. Stewart identified prisoner after prisoner whose treatment refusals were not addressed, and who remained jailed despite needing psychiatric hospitalization. Stewart Dec. ¶ 348 and *passim***.** Some examples follow.

Patient JW had been treated for schizophrenia by the county's community providers before his January 26, 2015 admission. He began refusing medications right after booking. Following his repeated refusals, the patient's Risperdal prescription ended without being renewed on February 17. He was not seen by mental health staff for a month while refusing medications. While off his psychotropic medications, the patient deteriorated. He was noted to have been diagnosed with HIV, but he refused medications, labs, or monitoring. He was observed responding to internal stimuli, was disheveled, refused to come out of his cell on multiple occasions, and displayed threatening behaviors at staff—including spitting at officers who attempted, on one occasion, to get him into a confidential room. He was force medicated once due to severe agitation and DTO behavior. He responded well to the medication, but then

refused voluntary medications. There are multiple entries from staff stating that the patient needed to be petitioned. Apparently a COT petition was filed, but was denied "due to pending court case." By August 15, a provider wrote that patient JW's treatment plan was to continue to offer him medications and "await outcome of RTC." He was found incompetent and unrestorable, and he was civilly committed by his criminal court on September 4, 2015. *Id.* ¶¶ 359-62.

Patient CB, booked on August 19, 2014, deteriorated in outpatient segregation over a period of several months as he refused treatment. A note from an early February 2015 assessment by Dr. Fangohr reported that the patient was refusing his medications; his Haldol prescription had been discontinued after his repeated refusals. During assessments over the next several months, the patient was often reported as agitated, uncooperative, and verbally abusive, yelling obscenities. He continued to refuse his psych medication and continued to be uncooperative through April and May 2015. His record includes multiple notes suggesting an involuntary treatment petition should be considered; the patient had previously been on court-ordered treatment in 2010. None was ever sought. In March, mental health staff wrote the petition would be considered "when Rule 11 [competency restoration] is completed." The patient was found incompetent and unrestorable and was ordered civilly committed on May 28, 2015. He was released on June 4 to Desert Vista Hospital after his criminal charges were dismissed. *Id.* ¶ 21.

Patient JP, from his booking on February 21, 2015, consistently refused medication, treatment, and meals. He decompensated throughout his incarceration, often housed in lockdown units. A March 13 note from a provider described his poor state: he was unable or unwilling to meet his own basic needs and was not showering, eating, or taking his prescribed medications, including anti-psychotic medications as well as medication for his high blood pressure. That day, emergency transport was ordered for this patient due to his having lost 20 lbs. since booking, and being dangerously hypertensive. Mr. JP continued to be symptomatic through July. He

reported hearing voices that were trying to speak through him. His hallucinations continued, and his behavior was described as grandiose and psychotic. A treatment petition was never secured by staff. *Id.* ¶¶ 119-121.

From his January 29, 2015 booking, Patient DY presented a danger to others as he refused his medication. He twice assaulted a cell-mate, once on January 31 and again on March 8. He was described as internally preoccupied, laughing for no reason and talking to himself. He used nonsensical speech and was not appropriately processing information. He was kept in lockdown units. Despite this patient's two unprovoked assaults, no emergency involuntary medication or hospitalization order was initiated. The patient was involved in another assault on May 11, but not petition was sought. Mr. DY was deemed incompetent and unrestorable, and civilly committed to Desert Vista by his criminal court on July 21, 2015. He was re-booked on August 11. While there is a COT order in his record for inpatient treatment for a period of 180 days from August 11, 2015, the patient cannot receive involuntary medications in the Jail because it is not licensed as an inpatient facility. He has been kept on lockdown units, and has continued to refuse medications and treatment. There was no documented effort to amend this order in the medical record. *Id.* ¶¶ 123-26.

Patient RB began refusing his medications in November 2014. He remained episodically non-compliant with his medications throughout his entire course of treatment. He complained of hearing voices through the vents. He was occasionally unresponsive to mental health staff attempts to assess him. When Dr. Stewart evaluated Mr. RB, the patient said he saw people on the ceiling and saw Bigfoot. He was extremely psychotic, standing in the middle of his cell and staring into space. He appeared to be in a great amount of distress. As of October 2015, this patient had not received psychotropic medication for almost six months and remained in segregation housing. *Id.* ¶¶ 131-33.

Ultimately, patients languish at the Jail instead of being timely hospitalized. Some patients eventually do receive inpatient care; however, by the time they do,

treatment has been so long delayed that their long-term prognosis dims. Dr. Burns testified that "the longer the person is ill, the longer it takes to help them get better." Mar. 5, 2014 TT at 40:18-19 (Burns). She went on, "[O]nce [the medication] does start to work, they don't get as well as they would have had treatment not been delayed." *Id.* at 40:20-21.

B. The Hospitalization Remedy Remains Necessary to Cure Constitutional Violations

Following Defendants' Motion to Terminate Third Amended Judgment, pursuant to the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626, the Court found that its hospitalization remedy remains necessary to cure existing constitutional violations. .

In weighing Defendants' termination motion, the Court was required either to modify the remedies or terminate them altogether, if it concluded that they were either too broad or no longer remained necessary to cure constitutional violations. The Court did neither, finding that the three general remedies of the Third Amended Judgment remained necessary and were narrowly drawn. *See* Doc. 2283 at 36 ¶ 85, 53 ¶ 216, 55 ¶ 230. As the Court noted, "Even if the existing relief qualifies for termination under § 3626(b)(2), if there is a current and ongoing violation, the district court must modify the relief to meet the PLRA standards." Doc. 2283 at 14 (citing *Gilmore v. California*, 220 F.3d 987, 1008 (9th Cir. 2000)). "If prospective relief remains necessary to correct a current and ongoing violation, the district court's authority to modify the existing prospective relief includes authority to expand or diminish the existing relief." *Id.* (citing *Pierce v. Orange County*, 526 F.3d 1190, 1204 n.13 (9th Cir. 2008)). It would be inconsistent with the Court's own findings and the PLRA to now hold that the hospitalization remedy lacks any legal effect and cannot be enforced.

C. Defendants Must Comply With the Existing Injunctive Relief

Defendants' non-compliance with the hospitalization remedy cannot be disregarded under general equitable principles. As the Supreme Court stated in *Hutto v. Finney*, "Once issued, an injunction must be enforced." 437 U.S. 678, 690 (1979).

After a final judgment, order, or decree has been entered, a party "cannot simply ignore" it. *Hook v. Ariz. Dep't of Corr.*, 972 F.2d 1012, 1016 (9th Cir. 1992). Instead, where a party seeks modification or vacatur, it must "follow the proper procedure under Rule 60(b)." *Id.* at 1017.

Rule 60(b) of the Federal Rules of Civil Procedure governs relief from a final judgment or order. It provides that a court may relieve a given party from a final judgment or order where "the judgment has been satisfied, released or discharged; it is based on an earlier judgment that has been reversed or vacated; or applying it prospectively is no longer equitable." Fed. R. Civ. P. 60(b)(5). The Supreme Court in *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367 (1992), set out a two-part test for assessing Rule 60(b)(5) claims. First, the party seeking modification or termination of relief under Rule 60 bears the burden of proving that the requirements of Rule 60 are satisfied and that the facts warrant dissolution of the injunction. *Horne v. Flores*, 557 U.S. 433, 447 (2009) (citing *Rufo*, 502 U.S. at 384); *see also Jeff D. v. Otter*, 643 F.3d 278, 283 (9th Cir. 2011) (applying *Rufo* test to a vacatur order and holding defendants bear the burden of proof for Rule 60 vacatur). Second, "a party seeking modification of a consent decree must establish that a significant change in facts or law warrants revision of the decree and that the proposed modification is suitably tailored to the changed circumstance." *Rufo*, 502 U.S. at 393. When evaluating a proposed modification, the court "must not create or perpetuate a constitutional violation." *Id.* The Court must also consider not only Defendants' compliance with the specific terms of the Judgment, but also their compliance with "the goals of the decree[] . . ., and whether those goals have been adequately served." *Jeff D.*, 643 F3d at 290.

Defendants are bound by an order granting injunctive relief "until the district court issues an order otherwise under Rule 60(b)." *Hook*, 972 F.2d at 1017. Relief from a court order is available only when the two-pronged Rule 60(b)(5) inquiry is met, not simply "when it is no longer convenient to live with the terms" of the decree. *Rufo*, 502 U.S. at 383. Indeed, "Defendants' desire to put a consent decree behind them does

not justify" relief from their obligations under a judgment. *Clark v. California*, 739 F. Supp. 2d 1168, 1176 (N.D. Cal. 2010). Where current and ongoing constitutional violations persist, "ongoing [c]ourt supervision, not a dismissal of relief," is warranted. *Id.* at 1233. Although a district court may, in "the exercise of its sound discretion," amend an existing order or decree, *Brown v. Plata*, 131 S. Ct. 1910, 1946 (2011), its power to do so is tied to Rule 60(b). *See Carey*, 706 F.2d at 967 (noting that a court may exercise its "long-established, broad, and flexible" power to modify relief where a party moves for such relief under Rule 60(b)(5)").

In answering a "critical question" of the Rule 60(b) inquiry—"whether the objective" of the injunction "has been achieved"—the Court's findings under the PLRA are instructive. *Horne*, 557 U.S. at 450. By retaining the remedial provisions of the Third Amended Judgment, the Court held under the PLRA that they were necessary to cure current and ongoing constitutional violations. As Dr. Stewart's findings make clear, the objective of the Court's remedy to ensure timely hospitalization and adequate treatment for the most seriously mentally ill detainees has not been achieved, and continuing relief remains necessary.

III. Additional Specific Relief is Required

"[C]onstitutional violations in conditions of confinement are rarely susceptible of simple or straightforward solutions." *Brown v. Plata*, __ U.S. __, 131 S. Ct 1910, 1936 (2011). "Courts may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration." *Id.* at 1928-29. Further, "[a] history of noncompliance with prior orders can justify greater court involvement than is ordinarily permitted." *Graves v. Arpaio*, 48 F. Supp. 2d 1318, 1337 (D. Ariz. 2014) (quoting *Sharp v. Weston*, 233 F.3d 1166, 1173 (9th Cir. 2000)). "Once a constitutional violation has been found, a district court has broad powers to fashion a remedy. A court may order relief that the Constitution would not of its own force initially require if such relief is necessary to remedy a constitutional violation." *Sharp*, 233 F.3d at 1173 (after failure to comply with prior injunction, district court did not

abuse discretion by issuing more specific directions that were not, in and of themselves, constitutionally required); *see also Graves v. Arpaio*, 623 F.3d 1043, 1050 (9th Cir. 2010) (PLRA authorizes prospective relief that does not "exactly map" onto constitutional requirements). A remedy is not barred by the PLRA's mandate that prospective relief be narrowly drawn and the least intrusive means to correct the violation simply because it has positive collateral effects. *Plata*, 131 S. Ct. at 1940.

Plaintiffs ask the Court to enter additional specific relief to ensure compliance with Paragraph 3 of the Revised Fourth Amended Judgment. Defendants already have in place a memorandum of understanding with ASH that allows them to transfer RTC patients in need of an inpatient level of care; however, they do not utilize it. Defendants should employ appropriate inpatient admission criteria to give meaningful effect to the memorandum of understanding and ensure that patients are timely transferred to ASH. Alternately, Defendants should better utilize the county-operated Desert Vista psychiatric facility, or form contracts with other psychiatric facilities that can provide appropriate care. Beyond sending patients to Desert Vista or other hospitals on a limited basis for court-ordered evaluations, Defendants, employing appropriate admission criteria, should identify and transfer patients in need of inpatient care to Desert Vista or other facilities for longer periods of treatment.

CONCLUSION

Defendants are violating Paragraph 3 of the Revised Fourth Amended Judgment, obligating them to transfer prisoners from the Jail to another facility when the Jail lacks the health care services required to treat them. This existing relief remains necessary to remedy the ongoing deficiencies in Defendants' provision of mental health care to seriously mentally ill prisoners who need inpatient care. Plaintiffs request that the Court order additional specific relief to ensure that Defendants comply with Paragraph 3.

DATED this 1st day of April, 2016.

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CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2016 I electronically transmitted the attached document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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