REPORT ON MENTAL HEALTH ISSUES AT *HADIX* FACILITIES

by TERRY A. KUPERS, M.D., M.S.P.

I. INTRODUCTION

I incorporate by reference into this report my declaration of August 10, 2007 (Exhibit A). My biographical information and qualifications are outlined in my curriculum vitae (Exhibit B). This report is preliminary in the sense that I expect to review depositions of defendants' staff and other documents that are produced. Since writing my declaration, I have reviewed the SERAPIS charts for most of the 37 prisoners I interviewed. In the interest of confidentiality, I have assigned each prisoner mentioned in this report a number, K.1, K.2, K.3, etc., where the K signifies that the prisoner is one I interviewed or mention in this report. Exhibit C contains the list of prisoner names and assigned K-numbers that will be separately provided.

In the period prior to my tour in July 2007, a large number of prisoners were transferred out of *Hadix* facilities to non-*Hadix* facilities, including Huron Valley and other sites containing mental health treatment programs and segregation units. Obviously this took a certain amount of pressure off of programs within *Hadix* facilities. For example, on my tour I visited the temporary segregation unit at RGC and the segregation unit (SMHU) at JMF and found many cells empty and the census of the units far under capacity. This exodus temporarily lessens the problem of confining prisoners with un-diagnosed mental illness in segregation (diagnosed prisoners on the mental health caseload are excluded) and temporarily diminishes in severity the pattern of recycling between segregation and observation or other mental health treatment programs. In fact, it was my impression that many of the most severely disturbed (from a

psychiatric perspective) prisoners had been removed from the *Hadix* facilities very recently. Still, it was possible for me to detect problems in the provision of mental health treatment within the *Hadix* facilities because, even with a diminished sub-population of prisoners suffering from serious mental illness, the unfortunate patterns of systemic neglect that I reported in my 2003 Cain Report are still operable and detectable, and prisoners currently housed in *Hadix* facilities were able to tell me about their experiences within *Hadix* facilities prior to the exodus of prisoners as well as their experiences in other facilities. I am assuming that the problems I detected and will report on below will only become worse if the *Hadix* facilities are once again filled to capacity.

II. A VERY LARGE AND GROWING NUMBER OF PRISONERS SUFFER FROM MENTAL ILLNESS

A large number of prisoners in the Michigan DOC suffer from serious mental illness. National epidemiological studies until recently had placed the prevalence of serious mental illness in state prisons between approximately 15% and 30%. Thus, Dr. Jeffrey Metzner wrote in 2002: "Studies and clinical experience have consistently indicated that 8 to 19 percent of prison inmates have psychiatric disorders that result in significant functional disabilities and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration.[1] Since Dr. Metzner wrote that, the population in corrections has risen appreciably, and according to most experts and statisticians examining correctional systems, the percentage of prisoners with serious mental illness has also risen. Thus, the recent Special Report from the Federal Bureau of Prison Statistics, "Mental Health Problems of Prison and Jail Inmates" confirms that there are a huge and unprecedented number of individuals suffering from serious mental illness (SMI)

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[1] Metzner, J. L. (2002) "Class Action Litigation in Correctional Psychiatry, Journal of the American Academy of Psychiatry and Law, Vol. 30, No. 1,19-29, at pp.19-20.

behind bars today, concluding that 56% of State prisoners suffer from a mental health problem, as measured by a structured interview (not necessarily a clinician's diagnosis); and notes that the proportion of prisoners suffering from serious mental illness has actually been rising even as the incarcerated population multiplies. The Bureau of Justice Statistics had placed the percentage of state prison inmates suffering from a significant mental condition at 16% in its comparable 1999 study.[2] The 2006 Bureau of Justice Statistics Report continues that prisoners with mental health problems are twice as likely as other prisoners to have been homeless prior to incarceration, . . . and state prisoners with a mental health problem are twice as likely as those without to have been injured in a fight since being incarcerated.[3] And recent epidemiological studies are consistent with the Bureau of Justice Statistics' findings. For example, Traolach Brugha and colleagues found, in a national British study (the statistics are comparable in the USA, and the Brugha study was published in the American Journal of Psychiatry) that the prevalence of psychotic disorders is ten times as high in prison as it is in the community at large.[4] There is no evidence suggesting that Michigan's statistics vary from national trends.

In the same 2002 article, Dr. Metzner compares the percentage of prisoners on the mental health caseload in several states. In the Vermont DOC, 24% of prisoners are on the mental health caseload, in the Massachusetts DOC 18% are on the mental health caseload, in the Ohio DOC 13.5% are on the mental health caseload, and in the Georgia DOC 12.5% of prisoners are on the mental health caseload. He cites the comparable figure for the Michigan DOC: 6.1% of

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[2] Ditton, P. (1999) "Mental Health and Treatment of Inmates and Probationers," U.S. Dept. of Justice, Bureau of Justice Statistics Special Report.
[3] "Mental Health Problems of Prison and Jail Inmates," U.S. Dept. of Justice, Bureau of Justice Statistics Special Report, can be found at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>, September, 2006.
[4] Brugha, T., Singleton, N., et al. (2005). "Psychosis in the Community and in Prisons: A Report from the British National Survey of Psychiatric Morbidity," American Journal of Psychiatry, 162, 4, pp. 774-780.

prisoners were on the mental health caseload in 2001. In my experience investigating mental health services in many states, the mental health caseload tends to include between 13% and 18% of the prison population, and still there are many prisoners in need of mental health services who are not in treatment. There is no evidence that in the Michigan DOC the mental health caseload has been expanded since 2001. In fact, on the Michigan DOC website today there is this statement: "As of Spring 2002, the total number of prisoners on active treatment status in the CMHP was approximately 2,880 or 5.9% of the total population of 48,920 prisoners in DOC prisons and camps."[5] We also know that the prison population has grown in that period from 47,563 in 2001 (MDOC statistics) to 51,499 in July, 2007 (Mr. Govorchin supplied that figure during my tour). Considering the fact that the proportion of prisoners suffering from serious mental illness has also grown in the intervening years, the Michigan DOC is not providing mental health care to a large number of prisoners in need of treatment.

These statewide figures are significant to the functioning of the Charles Egeler Reception Center (RGC), the primary intake for male prisoners for the state. In order to appropriately designate facilities around the state to which incoming prisoners will be transferred, it is critical that prisoners with serious mental illness be properly identified. If mental health staff (PSU & OPMH) designate too few prisoners as mentally ill and needing treatment, then the statewide caseload is inappropriately downsized.

III. MENTAL HEALTH SERVICES ARE INADEQUATE RELATIVE TO THE NEED

Considering the large proportion of prisoners with significant and serious mental illness, relatively few prisoners in the Michigan DOC are receiving mental health treatment. It is my

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[5] <http://www.michigan.gov/corrections/0,1607,7-119-9741_9744---,00.html>.

understanding that, excluding groups for assaultive offenders and sex offenders, only approximately 6% of prisoners in the Michigan DOC are on the mental health (CMHP) caseload. Other prisoners have some contact with PSU clinicians, but with their duties, including assessments and rounds in segregation, and with the assignment to act as first responders only, this does not appreciably correct for the shortfall in mental health treatment. As I explained in my Declaration, there have been no new treatment beds (inpatient, Residential Treatment Program or RTP, and other programs that are more intensive than outpatient treatment) added to the mental health system within the Michigan DOC, and quite a few programs have closed (for example, the psychiatric inpatient unit at DWH and the SMPU [Self-Mutilators Prevention Unit]) or lost JCAHO accreditation (DWH and Huron Valley). One would hope that outpatient services would expand to fill the need, but with only approximately 6% of prisoners on the caseload, this is by no means the reality.

In my tours and interviews, I found much evidence of insufficient provision of needed mental health services everywhere within the *Hadix* facilities. Supplementing the opinions expressed in my Declaration, I will organize a discussion of these insufficiencies into topics: (a.) Under-diagnosis; (b.) Long Waits for Mental Health Care; (c.) Discontinuities and Discontinuation of Treatment; (d.) Problems with Suicide Prevention and Crisis Intervention; (e.) Cell-front Interviews and Lack of Confidentiality; (f.) Problems with Medication Management; (g.) Prisoners with Serious Mental Illness are left to Shift for Themselves; (h.) Tragedies Result from Inadequate Mental Health Treatment.

(a.) UNDER-DIAGNOSIS IS A VERY LARGE PROBLEM

When there are insufficient mental health services to treat a large number of prisoners with mental illness, there is a tendency for staff to respond by minimizing the emotional

complaints and psychiatric histories of prisoners they assess and to downgrade their diagnoses from a condition that requires relatively intensive treatment to one that does not require as intensive treatment or requires no treatment at all. Mental Illness very obviously goes under-diagnosed in the *Hadix* facilities. As I outlined in my Declaration, in Reception there are too few complete face-to-face assessment interviews, past psychiatric records and history are not adequately sought nor considered, too many prisoners with mental illness are persuaded not to seek mental health treatment, there is too little neuropsychological testing to discover cases of symptomatic 'closed head injuries' (very prevalent in the male prison population) and other forms of organic braid disorder, there is an overemphasis on manipulation and malingering at the expense of diagnosing serious mental illness that co-exists with the manipulations, and in these and various other ways diagnoses are inappropriately downgraded and prisoners are not provided the mental health treatment their condition requires. After the prisoner leaves Reception, mental health assessments are done periodically, for example by request or upon referral from custody or medical staff or when a prisoner is transferred to segregation, but the same tendency to under-diagnosis mental illness and disregard psychiatric disability is evidenced.

Of course, if sufficient services for prisoners suffering from significant or serious mental illness are not available, one way for clinical staff to feel more comfortable with the shortfall is by not diagnosing mental illness that would require treatment. That way the shortfall in services is not as apparent, or does not weigh as heavily on the conscience of over-extended providers of mental health services. Why diagnose what one cannot treat? Thus, one of the PSU clinicians told me during a joint meeting with PSU and OPMH staff that she tries not to refer "too many cases" to OPMH because they are so overloaded with cases. In that straightforward comment lies the crux of the problem: the only way to decrease the volume of referrals to OPMH is to

raise the bar in terms of who is to be referred.

This is contrary to contemporary practice in the community. There, psychiatrists and psychologists look very carefully for symptoms and signs that might reflect serious mental illness. Consider just one timely example: in recent years the reported prevalence of Bipolar Disorders in the community has literally doubled, and psychiatrists and psychologists are on the alert to find cases that would previously have escaped diagnosis. Current thinking in the mental health professions is that early diagnosis and aggressive treatment are likely to decrease morbidity and improve prognoses, one hopes preventing the individual with an emerging serious mental illness from entering the criminal justice system. Some prior stringent criteria for assigning the diagnosis Bipolar Disorder have been relaxed, and now an individual who experiences upward swings of mood alternating with periods of sadness, even if the upswings are not truly manic and the downswings do not meet official criteria for Major Depressive Disorder, is more likely to be diagnosed as suffering from a condition that falls within the expanded "Bipolar Spectrum" of psychiatric disorders. And patients whose diagnosis falls within the Bipolar Spectrum are more likely than ever before to be prescribed mood stabilizing, antidepressant and anti-psychotic medications. But in the Michigan DOC, that same individual is very unlikely to be diagnosed at all. Thus, I discovered quite a few cases of prisoners who had been diagnosed in the community or at the sending county jail with a bona fide significant mental illness who, when they arrived at Reception, were given a less serious diagnosis and would no longer be prescribed the mood stabilizing, anti-psychotic and antidepressant medications that had been prescribed prior to their admission to prison.

> Prisoner # K.20., a 27 year old African American man, has been in Reception for 45 days this term. He was a psychiatric inpatient at age 9 for 4 months, and was prescribed anti-psychotic medications, including Thorazine. He has taken medications for Unipolar Mood Disorder/Depression since then, plus

> Seroquel (a strong anti-psychotic medication) and Lexapro (an antidepressant), with positive effect, but there have been no subsequent psychiatric hospitalizations. He has been suicidal in the past. He has an aunt who suffers from Bipolar Disorder and wants to die. He tells me he cries quite a lot, has very low energy, does not enjoy anything, has no appetite and has lost weight, a few pounds, and isolated himself. He does not sleep well and has nightmares. During a previous prison term he was in segregation for a long stretch. He does not like the harsh conditions of segregation, but his depression makes him want to withdraw and be alone – and that stint in segregation permitted him to do that. He is in prison again because of a parole violation. He has a daughter who he misses dearly. He cries as he tells me he does not think about the future and he has very negative thoughts about himself. His daily routine mostly involves sitting in his cell by himself. He is not currently suicidal. His medications, including Seroquel and Abilify (two very strong newer generation anti-psychotic medications), and Lexapro (an antidepressant), kept him from thinking bad thoughts. He came to Reception on psychiatric medications, and told the nurse who did a screening that he needs them. He waited a week to be seen by PSU staff, and did not see a psychiatrist until a week prior to our interview. He tells me the doctor in Reception told him he would do much better in prison with no psychiatric medications. He has written a kite seeking mental health services but has not been seen. Meanwhile, he has not had any psychiatric medications in the 45 days he has been in the RGC, and he feels that is why he is so depressed. On mental status he is quite depressed with marked psychomotor retardation (slowing of thoughts and behavior, typical of depression), low self-regard, anhedonia (finding no pleasure in anything), hopelessness and lack of a sense of future. Notes in his chart mention previous prescription of psychiatric medications but assign a diagnosis of Adjustment Disorder (less serious than Major Depressive Disorder or Bipolar Disorder). Notes contradict each other, for example mentioning prior psychiatric medications but then saying there is no past psychiatric history, or describing sadness, anhedonia and problems eating and sleeping, but then stating the mental status is unremarkable. A 6/26/07 note claims the prisoner has no interest in treatment, in contrast to what he told me. But a 7/31/07 progress note by Paul Schneerman, MA, mentions "Patient stated that he believes he still needs a medication, due to some of the symptoms he has been having the past couple of weeks."

Another method for reducing the number of candidates for mental health treatment in a system that does not have enough treatment slots for all the prisoners-in-need is to raise the bar for entry into mental health treatment. The Michigan DOC employs the GAF (Global

Assessment of Functioning, a component of the DSM IV multi-axial diagnostic formulation[6]) as a major criterion for including prisoners among the mental health caseload. According to the DSM IV, a GAF of 80 to 100 out of a possible 100 is assigned on "Axis V" to highly functioning individuals, a GAF of 60 to 80 is assigned to individuals who have mild or transient symptoms that do not interfere in a serious way with their social, occupational or psychological functioning, a GAF of 50 to 60 is assigned to individuals with moderate symptoms or moderate difficulty in social, occupational or school functioning, a GAF of 41 to 50 is assigned to individuals with serious symptoms or impairment in those realms, a GAF of 31 to 40 is assigned to individuals with impairment in reality testing or communication or major impairment in several areas, a GAF of 21 to 30 is assigned to individuals whose behavior is considerably influenced by delusions or hallucinations or have serious impairment in communication or judgment or inability to function in all areas, a GAF of 11 to 20 is assigned to individuals who are some danger of hurting self or others or occasionally fail to maintain minimal personal hygiene or suffer major impairment in communication, and a GAF of 0 to 10 is assigned to individuals who are a persistent danger to self or others or are persistently unable to maintain minimal personal hygiene.

According to MDOC policy, to qualify for acute psychiatric hospital care a prisoner must have a GAF in the 1-20 range, to qualify for crisis stabilization his GAF must be between 21 and 35, to qualify for RTP it must be between 36 and 50, and to qualify for outpatient mental health services it must be below 60. Of course, assignment of a GAF is an imprecise, some would say subjective phenomenon. Some people who are very suicidal function very well in other ways, and would earn a GAF of 70 or 80 were it not for their chronic lethality. Others who are

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[6] American Psychiatric Association, Diagnostic and Statistical Manual of Psychiatric Disorders, 4th Edition, published by the APA, 1994.

functioning relatively well in most regards might be plagued by hallucinations and suicidal ideation much of their waking life – should they be given a GAF of 25 (behavior is considerably influenced by hallucinations or serious impairment of judgment) or 55 (moderate difficulty in social, occupational or school functioning)? An individual suffering from chronic Schizophrenia or Bipolar Disorder who is in remission might earn a GAF significantly higher than 60 because he is not currently symptomatic and is functioning relatively well – but he should be in outpatient mental health treatment. According to MDOC policy and practice, he would not be eligible for outpatient mental health treatment.

There is debate among mental health professionals about the relevance of the GAF in correctional settings. After all, if a prisoner has no job and is provided with three square meals a day, especially if he spends nearly 24 hours in a segregation cell, how appropriate is it to gauge his "difficulty in social, occupational or school functioning." Also, the GAF score that meets criteria for serious mental illness is not the same in all departments of correction. For example, I participated in settlement negotiations in the *Ayres v. New Mexico DOC* litigation, where it was agreed that any prisoner whose GAF was beneath 60 would be assumed to be suffering from a serious mental illness that would preclude his confinement in the supermaximum segregation unit. Thus a GAF of 60 would earn the designation serious mental illness and cause one to be excluded from isolated confinement in New Mexico, whereas the same GAF might not qualify one for receiving outpatient mental health services in the Michigan DOC. In other words, where one sets the bar for acceptance into outpatient mental health treatment determines how many prisoners will be deemed eligible and how many will be tagged TNR (treatment not required). In spite of PSU and OPMH staff's assurance when I met with them that malingering (the exaggeration or feigning of symptoms for secondary gain) is not used to preclude proper

diagnosis of possibly co-existing bona fide psychiatric disorder, the following case illustrates both the un-diagnosing and the implicit allegation of malingering.

> Prisoner # K.19., a 19 year old African American man, began his first prison term on 6/14/07. Since childhood he has suffered from depression, interspersed with racing thoughts. He has a history of suicide ideation and some suicidal behaviors. A favorite grandmother died in 2004, and two friends died in 2005 and 2006. He became even more depressed and started getting into trouble. In October, 2006, he was shot by police. He was prescribed psychiatric medications in jail and arrived at Reception on medications. He avers a long history of depression, "I've always had low moods," and nightmares. He was taking the anti-psychotic medication Seroquel and an antidepressant because he had been hearing voices since being shot. He is not currently suicidal. He was not eating when he arrived at Reception because he had no appetite, and he was hearing voices. He writes music, sings, and was in choirs and choruses in the community, but he has been feeling no pleasure in music or anything else lately (anhedonia), so he quit doing his music. The medications he took helped him feel better, and he was able to relate to others and play cards. He was in the mental health unit in the jail because of his depression. Now, without medications in Reception, he stays to himself. Because of what he calls "staff mistakes," he spent a week in the Special Management Housing Unit (segregation). There was no ticket. In segregation he felt very closed in. On mental status exam this young man is very depressed with marked psychomotor retardation (pathological slowness of thought and behavior), low self-esteem, anhedonia, hopelessness and worthlessness (all the classic symptoms of depression). He is not currently suicidal but thinks about self-harm. His clinical chart contains a nurse's intake screening note reflecting he was prescribed Sinequan 200 mg. per day, Seroquel 100 mg. per day and Desyrel 100 mg. per day – all taken the day of admission, and verified (with the jail). But a 7/23/07 Medical Transfer by a nurse notes psychotropic medications not applicable, and no abnormal psychiatric history. A Comprehensive Psychiatric Assessment diagnoses Depressive Disorder NOS as primary, GAF 60, and a Suicide Screening is checked yes for Sheriff/C.O. indicates prisoner is/was suicidal and/or may currently be a suicide risk. He was put on suicide precautions and referred to OPMH. On 6/21/07 psychological tests by Laura Hogan, M.A., reflect "someone who might over-report symptoms as a means to appear more disturbed than he really is." He was not eating around 7/22, but nobody connects failure to eat with depression. Dr. Tai saw him on 6/20 and found no major mental disorder, a GAF of 64, and recommended TNR (treatment not required. On 7/22, during rounds in segregation, he tells Allan Small he wants his medication back (Dr. Tai wrote he does not want medications). A 7/25/07 QMHP/Comprehensive Psychiatric Assessment by Dr. Tai finds an unremarkable mental status exam, notes no depression, and concludes "All in all, Mr. ___ was involved in a situation where he was used while he probably

> tried to use other people for personal gain…. He has displayed no evidence of a major mental illness."

The last is an interesting note in that it occurs in the same time period as my exam, finds no signs nor even symptoms of mental illness, and the clinician (Dr. Tai) essentially sets himself up as judge and finds this prisoner guilty of alleged crimes with which, evidently, he was never even charged. Rationalized by under-diagnosing, prisoners in need of mental health treatment are not provided treatment, but instead are denied access or discontinued from the mental health caseload (TNR, treatment not required, is written in their charts).

> Prisoner # K.22., a 30 year old Caucasian man with red hair and blue eyes was interviewed in Reception/RGC. He was told by the psychologist that if he seeks mental health treatment it will hold him back from parole and negatively affect which institution he is assigned. In 2004, when he was in prison for 21 days, he was told the same thing. He had been taking the antidepressant Zoloft, he knew that he suffered serious mood swings, and thought his diagnosis was Bipolar Disorder. By now he has been in treatment for 4 years for Bipolar Disorder, and is aware that he cannot focus nor concentrate when he is experiencing mood swings. Now, being off of all psychiatric medications, his mind is "cloudy," he suffers from anxiety and his moods are up and down. When he is in prison and is not treated he has trouble coping. The medications help a lot by slowing his racing mind and permitting him to concentrate better on tasks. There is family history of Bipolar Disorder. My mental status examination reflected clear clinical depression, but he denies suicide ideation. When he arrived at Reception he saw the psychiatrist, Dr. Tai, who dissuaded him from being prescribed psychiatric medications. His clinical chart contains a 7/17/07 nurse's screening exam with a diagnosis Bipolar Disorder, verified medications at admission are Geodon, 40 mg. per day, Remeron, 60 mg. per day, Celexa, 40 mg. per day, Tegretol 200 mg. three times per day and an urgent referral to psychological services was made, but Dr. Tai's mental status exam uncovered no abnormal findings.

I discovered that many prisoners newly admitted to Reception who had been receiving mental health treatment were persuaded to forego mental health services, in many cases the rationale being that they will not do as well with the parole board or in their assignment to institutions and programs if they are on the mental health caseload (Prisoners # K.19, K.20, K.21, K.22, K.28, K.29 & K.31). I did not have an opportunity to fully explore the structural

reasons for staff to tell prisoners that if they are in mental health treatment they will not do well at their parole hearings or that they will not be able to transfer to the facility or program they would prefer. There are both idiosyncratic and structural problems here. The idiosyncratic problem is that a clinician is advising a prisoner against treatment that might be needed for reasons that are outside the area of mental health concerns, and then, in many of the cases I examined, that clinician is at the same time down-grading the prisoner's diagnosis or under-diagnosing him. This is not appropriate and the care falls below the standard of care in the community. But structurally, it may be true that the fact that a prisoner is undergoing mental health treatment may prejudice the parole board or may mean that he cannot go to certain institutions and programs. This gets us into another area which I will merely mention and not explore fully here: in many cases the location of programs at certain facilities, each with a certain security level, puts prisoners with mental illness and psychiatric disability at great disadvantage. If a prisoner is classified at one security level, for example Level I, but there are no mental health services at that level, then when he suffers a psychiatric crisis he will be sent to a higher level facility – for example JMF, which is Level II/IV – and this through no misbehavior or fault on his part, but merely because he suffers from a mental illness. I also encountered prisoners whose security level was raised because they suffer from a medical condition – for example, prisoner # K.5. Dissuading prisoners with mental illness from seeking mental health treatment and then downgrading their diagnoses so that it appears they do not need the treatment constitutes unacceptable clinical/professional conduct; and at the same time there are structural problems in the Michigan DOC (the biases of parole boards and the need to send prisoners with mental health and medical problems to higher security institutions for treatment) that must be addressed if a

significant number of prisoners in need of adequate mental health services are to benefit from them.

(b.) THERE ARE LONG DELAYS IN SEEING MENTAL HEALTH CLINICIANS

Prisoners in all the *Hadix* facilities and programs I visited complained about long delays seeing mental health staff. In the days just prior to my tour, a large number of prisoners in Reception were evaluated in timely fashion. I do not know what to make of that. Elsewhere prisoners told me they had waited a long time before being evaluated by a mental health clinician in Reception as recently as months earlier. And many told me that the psychiatric medications they had been taking prior to admission to MDOC were discontinued precisely because they were not seen by a psychiatrist for weeks after arriving in RGC. Many of the prisoners I interviewed told me there are long delays before prisoners are seen by a psychiatrist in Reception, or in other *Hadix* facilities when they request mental health care or when their medical providers request mental health assessment and treatment for them. I will provide one illustrative case.

> Prisoner # K.9, a 56 year old Caucasian bearded man in a wheelchair, was seen in the visiting area of JMF on 7/25/07. He reports he has been in several prisons, but JMF is the only one where he gets disciplinary tickets. He reports "deep depression" since 1982, when he lost an important job and had a bad injury. He is in a wheelchair because of surgery on his prostate and back. He would like to see mental health for treatment, but feels they keep canceling his appointments. He thinks he has been seen 3 or 4 times in the last four months. He has been seen by a psychiatrist, and prescribed Neurontin, 800 mg. per day, and Zoloft, 100 mg. per day. The chart contains a diagnosis of Mood Disorder NOS and polysubstance abuse. A 7/6/07 Memorandum from Robert Cohen, Assoc. Independent Medical Monitor, Hadix v. Caruso, to Barb Hladki, Hadix Consent Decree Administrator regarding this prisoner notes prostate cancer, "which has gone untreated for over a year…. Mr. ___ had to wait nine months, until March 19, 2007, before the required prostate biopsy was performed." Dr. Cohen also noted a failure of medical staff to adequately treat his pain. Regarding Depression, Dr. Cohen writes: "Mr. ____ has multiple serious medical problems. He sought psychiatric care because of

depression and hallucinations. The following series of SERAPIS entries dated 11/14/06, 11/17/06 (2 entries) and 11/17/06, vividly demonstrate how (Prisoner # K.9) and his physician were both obstructed from obtaining psychiatric consultation. Dr. Everette's desperate note written 11/17/06 describes her inability to obtain psychiatric care for her patient. On that day Dr. Everette made a direct referral to Dr. Weller, the JMF psychiatrist, but her consultation was thwarted by PSU staff. Although physician staff at JMF have consistently said that they could not directly contact a psychiatrist, MDOC staff have assured me that direct consultations are possible. This case clearly demonstrates that PSU staff have the ability to block psychiatric consultation even when requested by a physician." An 11/14/2006 Progress Note by Kevin Tolsma, MS, LLP, reflects this prisoner has "given up" on medical,… feeling "down,…. If he can not see the psychiatrist now, he no longer wishes to come up to the clinic to see me." I reviewed the SERAPIS chart for this patient dating back to 6/17/06, and I concur with the medical monitor's interpretations and concerns. He was referred by PSU for OPMH assessment on 12/19/06, and seen by Dr. Weller on 1/5/07. She noted mood disorder and prescribed Zoloft. Only on 1/18/07, after the OIMM complained about the delay, was he placed on the mental health outpatient caseload and seen by a nurse, therapist, case manager and psychiatrist. A 3/20/07 Medication Review by Dr. Weller, subsequent to the period that the Independent Medical Monitor was concerned about, found him to suffer with a Mood Disorder Due to a medical condition, and Zoloft 100 mg. per day was still being prescribed.

The delays I heard about from many prisoners are excessive. Prior to assessing an individual, a mental health provider cannot know how urgent the need is for psychiatric treatment. The story of the tragic demise of Prisoner # K.36 involves, among many other problems, a failure on the part of the psychiatrist to examine the patient as his condition deteriorated over a period of several days or longer (see below, section h.) I found that generally, when a prisoner in *Hadix* facilities expresses self-harm inclinations, he is quickly transferred to an Observation cell, and that is to the credit of custody and mental health staff. But for almost all other psychiatric needs, I repeatedly heard from prisoners about long delays and saw chart evidence of long delays (weeks, in many cases) between request or referral and assessment by a mental health clinician (usually PSU staff are quicker to respond than OPMH staff). The Independent Medical Monitor has repeatedly reported entirely unacceptable delays

and obstructions between the time a medical practitioner requests psychiatric consultation and the time the patient is actually seen, and my investigation results in the same concern.

As I discussed in my Declaration, there does seem to be a serious failure of collaboration between medical and mental health clinicians, as evidenced by delays in psychiatric assessments requested by medical practitioners. There also seems to be a continuing problem with collaboration between PSU clinicians and OPMH clinicians, as evidenced by the fact that in a majority of cases I reviewed where PSU clinicians diagnosed mental illness warranting mental health treatment and referred prisoners to OPMH, OPMH changed the diagnoses and decided that no treatment was required. If this were merely a case of PSU staff continually erring in their diagnoses, then OPMH staff would be correct in changing the diagnosis and discontinuing treatment. But as I discussed in section (a.), above, in many of the cases with which I am familiar, my own clinical impression was in agreement with the PSU staff who had made the original referral to OPMH, and I felt that the OPMH staff were inappropriately downgrading the diagnoses (i.e., under-diagnosing) and denying needed mental health treatment. I know that other experts have questioned the wisdom of the division of functions between PSU and OPMH. I add my voice to those who are concerned about failures of collaboration when functions are thus divided.

(c.) DISCONTINUITIES AND DISCONTINUATION OF MENTAL HEALTH TREATMENT

I found much evidence of inappropriate discontinuity and discontinuation of mental health treatment. The Independent Medical Monitor has repeatedly expressed concerns about discontinuities in medication delivery due to inefficient pharmacy practices and other staff errors. I discussed the problem in my Declaration, as well as the potentially dangerous effects of discontinuations and discontinuities, and I will simply present a couple of illustrative cases here.

Prisoner # K.17, a 60 year old man with long hair, a beard and ruddy complexion, entered prison for the first time on Feb. 1, 2007, after being in jail for a year. He was in RGC, then 7 Block and finally arrived at STP on 3/21/07. He is prescribed Risperdal, Celexa, and Depakene, and says his diagnosis is Bipolar Disorder. He was taking Seroquel, Effexor and Lexapro when he entered prison. He mostly stayed to himself at home prior to his incarceration. At Reception a mood stabilizer was added to his medications. His medications were discontinued for three weeks when he entered Reception, and he does not remember undergoing psychological tests. His medications had also been discontinued for a month during his jail tenure. For the three weeks following admission to Reception when his medications were discontinued, he wrote kites stating he needed the medications, and he did not eat for four days. As soon as he was eventually seen by the psychiatrist and his medications were restored, he felt much better. On mental status this man is flat and concrete with no obvious thought disorder nor hallucinations or delusions. His SERAPIS chart indicates screening by N. Raley, RN, on 2/1/07 – reflects he was Bipolar and taking psychiatric medications. Medications included Lexapro 40 mg. on day of admission, Effexor 75 mg the night before, and Seroquel 800 mg. the day of admission. He was seen by OPMH the next day, given a diagnosis of Bipolar I Disorder, polysubstance abuse and personality disorder, and a GAF of 56. On 2/22/07, a psychiatrist, Dr. Wilanowski, ordered a bottom bunk related to risk of heat-related illness, and prescribed Celexa , Risperdal and Depakene. That means there was a gap in medications between admission on 2/1 and prescription on 2/22 – three weeks, as the prisoner reported.

Prisoner # K.18, an obese, tattooed, graying 66 year old man, has been in prison since February on his fourth term (total 15 years in prison). He thinks he is being medicated for his bad temper. He takes Wellbutrin, Elavil, Lamictal and Risperdal. He did home improvements in the community and has never been in a psychiatric hospital. When he arrived at Reception he was given psychological tests and talked to the psychologist for an hour. He had been taking psychiatric medications when he was admitted, but did not receive any medications in Reception for three weeks. He told the nurse he needed medications, and his medications were on file from a previous term. When his medications were abruptly discontinued he became “jumpy and frustrated” and received a disciplinary ticket for sleeping at the wrong time. He was transferred to STP in January, 2007, and again his medications were discontinued for two weeks and he had a hard time – he thinks the medications are discontinued because the staff are inefficient. He has not been in segregation nor Observation. He had been in RTP during prior terms, but not during this term. His SERAPIS chart contains brief mental health notes, and quite a few medical entries, including cardiology clinic reports. The chart corroborates the history he reported.

(d.) PROBLEMS WITH SUICIDE PREVENTION AND CRISIS INTERVENTION

Nationwide statistics reflect that the prevalence of suicide in prison is approximately twice that in the community at large,[7] and, stunningly, approximately 50% of successful prison suicides occur among the 6% to 8% of prisoners confined in segregation settings at any given time.[8] The rate of suicide in prison has diminished a little in the last decade, in large part because of research showing it to be a huge problem and litigation requiring states and the federal government to implement improved suicide prevention programs in their prisons.

There are well-established clinical guidelines for the assessment and treatment of individuals who have attempted suicide or seem intent upon taking their own life.[9] First, a thorough assessment is indicated. If there are indicators of very serious suicide risk, for example severe depression, a past history of suicide attempts, a note indicating sincere intent to commit suicide or command hallucinations (voices) ordering the individual to take his own life, then the individual who seems to be at risk of suicide needs to be placed in a safe setting. In the community this usually means a psychiatric hospital, but in a prison an observation room might be adequate for a prisoner who does not pose a very serious risk – under specific conditions. A critical condition is that the stay in an observation cell be very brief (less than 24 hours or, depending on staffing considerations, 48 hours over a weekend).

In order to properly treat patients in observation, and not turn observation into another form of punitive isolated confinement, staff's approach must be therapeutic rather than punitive, the prisoner's dignity and privacy must be respected, and the mental health staff must take the

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[7] Hayes, L. (1995). Prison Suicide: An Overview and Guide to Prevention. Washington, D.C., U.S. Department of Justice.
[8] "Prison Suicide Increase: Isolation the Culprit," Correctional Mental Health Report, No. 8, Vol. 6, 2007, p. 87.
[9] Kupers, T. "Prison Suicide," in Kupers, T., Prison Madness: The Mental Health Crisis Behind Bars and What we Must Do About it. San Francisco: Jossey Bass/Wiley, 1999, pp. 175-192.

time to gain the suicidal prisoner's trust and offer the intensity of treatment that is required in such an emergency. The main component of treatment with a suicidal individual is one-on-one personal, confidential therapeutic contact in a private, confidential setting. A trusting relationship must be established in order to foster disclosure on the suicidal individual's part about the inner sense of despair and hopelessness that is driving the prisoner to seriously consider taking his own life.

Psychotropic medications might also play an important part in the treatment of a suicidal individual, especially where there is severe depression or psychosis that includes hallucinated voices commanding the individual to harm himself or herself, but there are many problems and complexities in their prescription. For example, the most often prescribed type of medication in suicidal crises – i.e. antidepressants – can take between two and four weeks to reach full effect, so they are not very useful in the acute situation. But the prisoner experiencing command hallucinations ordering him to take his own life, the prescription of anti-psychotic medications can have an immediate and life-saving effect. Another crucial part of the treatment of individuals intent on taking their own life is for the clinician to figure out what stressors are driving him or her to this level of despair, and then attempt to help him or her change that situation so that those stressors will not drive him or her to another suicide attempt after the immediate treatment for the current suicide crisis has ended. In a significant proportion of cases the individual must be referred to a hospital or crisis unit setting. Examples of this are when the suicide crisis is driven by serious mental illness and hallucinated voices are commanding the individual to kill himself, when the crisis cannot be quickly alleviated, or there is a high risk of self-harm.

According to Andre Ivanoff and Lindsay M. Hayes,[10] national experts on suicide prevention in correctional settings:

> In determining the most appropriate housing location for a suicidal inmate, correctional officials (with concurrence from medical or mental health staff) often tend to physically isolate and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate because the use of isolation escalates the inmate's sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints … should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Handcuffs should never be used to restrain a suicidal inmate. Housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration.

These are principles that reflect a consensus in the mental health field. They are not being followed in the *Hadix* facilities. Observation cells are very problematic. In RGC and JMF the observation cells are placed within segregation or detention units. The doors to the cells are constructed partially or entirely of solid metal, so direct observation is not possible. But then, there are often no staff within sight. The observation cells have video cameras in place, but the cameras are monitored from a screen in the control center, and I passed the control center in the RGC segregation/observation area several times during my tour and saw no staff members observing the prisoners inside the observation cells. Some prisoners in observation are placed on "one-to-one", meaning a staff member sits outside their cell at all times. I am told by clinical staff that prisoners in the new observation cells, or "hard cells", at DWH will have constant one-to-one monitoring. But the monitoring staff member is a custody officer, and usually faces away from the prisoner being observed and does not interact very often with the prisoner. Prisoners in

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[10] Andre Ivanoff and Lindsay M. Hayes, "Preventing, Managing, and Treating Suicidal Actions in High-Risk Offenders," Jail Suicide/Mental Health Update, Vol. 11, No. 2, Summer, 2002, pp. 4-5.

observation cells are on an even more restrictive regimen than they would be in a punitive detention status in segregation. Thus, in most cases, they are naked except for a suicide-resistant gown (prisoners call them “bam bam suits”) and blanket, they are not permitted out of their cell to shower or go to recreation, and they are permitted very little in the way of amenities, visits, etc. It is as if they are being punished for expressing suicidal or psychotic ideation. The clinical staff talk to them very little, and then mostly at cell-front, where confidential conversation is not possible because prisoners in neighboring cells and staff passing by can overhear the conversation.

Too often, circumstances like these, the distraught prisoner will merely aver that he is no longer suicidal so he can avoid exposing his emotional distress in a non-confidential setting and he can gain exit from the very restrictive observation cell. This is not a therapeutic arrangement at all. Individuals in the midst of a suicidal or psychotic crisis need supervised social interaction and private, confidential contact with clinicians, where it is possible to explore the reasons for the despair that has led them to become suicidal or psychotic. I saw very little opportunity for this kind of therapeutic intervention in the *Hadix* facilities in observation cells situated within punitive segregation units. And, as I mentioned in my Declaration, there is no two-way communication system for prisoners to beckon staff when they need them.

PSU and OPMH staff told me that observation within segregation is used for the shortest period possible, usually a matter of a day or two. This would be a fine usage pattern, since observation cells should only be used as an interim suicide prevention method. If, within a matter of 24 or 48 hours, a patient remained suicidal or psychotic, the appropriate plan would be an emergency transfer to a crisis unit or inpatient psychiatric hospital, which, in the Michigan DOC today, would mean a transfer to Huron Valley Facility. I reviewed the document provided

by MDOC, "Suicide Observation Prisoners Placed in SMHU, 11/13/06 – March, 2007." On this document the dates of placement and removal from observation cells within *Hadix* facilities are listed. There were 65 occasions when prisoners were placed in observation cells during the time period. I averaged the lengths of stay in observation, and arrived at an average of 4.43 days per observation placement. This is higher than I would expect from the staff's explanation that observation cells were utilized only for a day or two, and of course if the average stay is almost 5 days, approximately half the observation periods are more than 5 days. In fact, there was one prisoner who was in an observation cell for a total of 12 days in December, 2006 (two separate placements), there was another who was in observation for a total of 26 days from January to February, 2007, and there was a third prisoner in observation for 20 days from January 2 through January 22, 2007. The prisoner I discovered in observation in Unit 1 of RGC had been there for a week and a half or two weeks, though he told me that only a week was for the purpose of suicide observation (the remainder of his time was for protection purposes). He had been transferred immediately to observation when he reported thoughts of self-harm to custody staff, he was evaluated in timely fashion, and he received daily visits from his therapist. However, while in observation he was stripped except for a "bam bam suit" and was not permitted out of his cell for recreation nor for showers – in other words, the regimen is even more restrictive than that in punitive or administrative segregation. All visits with his therapist except the one on his last day in observation occurred at cell-front, and he was retained in observation for a longer-than-acceptable time period. There were no other prisoners on observation status during the days of my tour, but I did review a relevant document from the Office of the Independent Medical Monitor.

> Prisoner # K.35 made a suicide attempt by hanging at JMF, while confined in an administrative segregation cell, on 4/29/07. Dr. Robert Cohen, OIMM,

> 5/21/07, reviewed the record, PSU had evaluated the patient a few hours earlier and he had stated "I am not suicidal." There is one prior suicide attempt. A 3/12/07 mental health evaluation notes the patient's "major problems can be summarized by his efforts to control things that he cannot and, consequently, he becomes frustrated." Dr. Cohen noted that nursing was concerned about the patient's odd behavior and failure to make eye contact hours prior to the serious suicide attempt and asked for an assessment, but the physician in charge recommended observation and mental health assessment the following morning. While PSU saw him, no psychiatrist saw him before or after the suicide attempt. Dr. Cohen noted that the segregation cells in JMF were not appropriate for suicide observation, and implied this man should have been sent on an emergency basis to DWH hours prior to the suicide attempt (at a time when that facility contained a psychiatric inpatient unit, which is no longer the case, so a transfer to Huron Valley would be appropriate today).

The mental health staff's general approach to suicide underscores many of the inadequacies of the mental health treatment program in the *Hadix* facilities. From my interviews with prisoners who have attempted suicide (Prisoners 2, 3, 4, 6, 7, 21 and 22) and a review of their clinical and social service charts, it is clear that the staff's usual response to a suicide attempt is to remove the prisoner from his cell, sometimes by a use of force, and to move him to an observation room within a segregation unit where there are few if any amenities, the prisoner is left, usually with no clothes, with a "bam bam suit" (a "suicide-proof gown" and a blanket made of the same material). Then, the prisoner is observed on a one-to-one basis or every fifteen minutes or by video monitor, the mental health staff visit the prisoner at least once per day, but from the prisoners' reports as well as notes in their charts, most of these visits are at cell-front. Judging from notes in the charts and the prisoners' reports, in most cases the discussion is very limited.

The problem with a punitive/deprivation approach to suicide risk is that deprivation measures do not get to the prisoner's despair, and as soon as he is released from confinement or restraint, he is likely to plan an even more lethal attempt. Meanwhile, the already suicidal

prisoner is very likely to turn on himself the anger he feels on account of what he considers unfair and brutal treatment, for example the humiliation of being stripped and deprived of all his possessions, even his time on the yard. One cannot punish a person into transcending their despair. In fact, the prisoner knows that in order to get out of observation he needs to convince the mental health staff that he is no longer suicidal, so when the mental health staff member makes rounds and asks him at cell front if he still wants to take his own life, he is inclined to answer that he is no longer planning or desiring to kill himself. Then, back in his cell, he can make another attempt.

(e.) CELL-FRONT INTERVIEWS AND LACK OF CONFIDENTIALITY

The prisoner has a right to privacy during a clinical interview, and confidentiality to the extent that is practical in a prison setting. The 1990 Code of Ethics of the American Correctional Health Services Association (ACHSA) state that the correctional health professional must "provide sound privacy during health services in all cases and sight privacy whenever possible" (cited in Psychiatric Services in Jails and Prisons, a publication of the American Psychiatric Association, 2000). The problem with cell front interviews is that a prisoner is unlikely to be candid about psychiatric symptoms in such a setting. Besides, talking through the port hole in the metal boxcar doors does not provide a context in which sufficient trust can be engendered for the clinician to find out what the prisoner is feeling and whether he is planning self-harm. I have known too many cases where a prisoner refused to discuss anything important with a clinician who saw him exclusively at cell-front, only to suffer from untreated psychosis or to attempt self-harm or suicide after refusing to say very much at cell-front.

Cell-front interviews are a problem mainly in segregation settings. Of course, with the exodus of a significant proportion of the prisoners from *Hadix* facilities, and the under-utilization

of segregation units, cell-front interviews are not as much of a problem as they would be were the facilities and segregation units filled to capacity. Rounds in segregation units are an acceptable way for mental health clinicians to quickly spot problems as they arise and to arrange longer, confidential interviews with prisoners who need them. Prisoner # K.4., who had been in temporary segregation/Observation for almost two weeks when I interviewed him, had been seen only at cell-front during the week or longer that his tenure in segregation was for the purpose of suicide observation (he spent part of the time in segregation for protection). He made the point that he had to ask the clinician who was following him if they could meet in a private, confidential setting, and then on his last day in observation he was afforded an interview in an office on the cellblock. The problem with cell-front interviews is related to the problem of locating observation within segregation units, as is done in *Hadix* facilities, and I have already commented about the inappropriateness of that location in section (d.)

(f.) PROBLEMS WITH MEDICATION MANAGEMENT

As I wrote in my Declaration, discontinuation and lack of continuity in the provision of psychiatric medications can have grave effects, ranging from discomfort and insomnia in patients taking mood-stabilizing medications to outright manic episodes in individuals who depend on mood stabilizers to avoid dramatic mood swings. When antidepressant medications are discontinued abruptly or there is a gap in their use for any reason, a depressive episode is likely to evolve, and it may be complicated by suicidal ideation or actions. When anti-psychotic medications are discontinued abruptly, or there are discontinuities in their delivery, the patients are prone to acute exacerbations of psychosis. In other words, discontinuation and discontinuities in medication delivery can have very dire clinical consequences – *see* section (c.), above.

As I reported in my Declaration, there are serious problems with regard to the monitoring of psychiatric medications. I discovered long delays before prisoners entering the system at Reception are seen by the psychiatrist and have their medications renewed. In many cases, prisoners' medications are abruptly discontinued upon admission to DOC and then not prescribed for many days or weeks, if at all. There are unacceptably long delays before a prisoner can see a psychiatrist in other settings, for example SMT or JMF. When a patient suffering from a serious mental illness such as Schizophrenia decides not to continue taking medications, prevailing standards of care require that he be continued on the caseload and seen periodically to assess his psychiatric condition, and also so the psychiatrist can offer him an opportunity to learn more about his illness and treatment and to form a therapeutic relationship with clinical staff. With this ongoing clinical relationship in place, the patient is likely to re-initiate his medication regimen at some point, or at least the clinician can help him cope and the ongoing relationship will help him remain stable. The way PSU and OPMHS discharge patients from the mental health outpatient caseload when they decide not to take medications is an entirely unacceptable practice. I saw at least one severely disturbed prisoner in segregation who was not prescribed medications and was not being seen by OPMH at all (Prisoner # K.6).

The main problem with medication management in *Hadix* facilities where there is no day treatment program, no residential treatment program, no crisis intervention unit and no longer a psychiatric hospital (since the psychiatric unit at DWH was closed), is that medications become the sole clinical modality available to prisoners with serious mental illness. There are clinicians and psychologists who visit prisoners, usually monthly or quarterly, and there are case managers. But adequate provision of mental health treatment requires a full range of mental health modalities. While some prisoners with serious mental illness are transferred to other institutions

where a broader range of treatment modalities are available, it remains the case, as I reported in my 2003 Cain Declaration, that many prisoners with serious mental illness on the OPMH caseload are treated almost exclusively with psychiatric medications, with or without large gaps in the continuity of medication provision, and are left to shift for themselves in the general population or in segregation. There are no group therapies for mental health treatment purposes (I do not include assaultive offender program or sex offender program groups as treatment). Then, when psychotropic medications are the only mental health treatment prisoners receive other than brief or infrequent visits with their PSU or OPMH case manager, the cancellation of an appointment with the psychiatrist or the long delay before an appointment can be arranged become all the more stressful delays for the prisoner.

(g.) MANY PRISONERS WITH SERIOUS MENTAL ILLNESS ARE LEFT TO SHIFT FOR THEMSELVES

Of course, if a prisoner with serious mental illness is inadequately assessed and discontinued from the mental health caseload, he is left to his own devices to survive or be victimized in the general population, or to run afoul of the disciplinary system and be consigned to punitive segregation. Prisoners with mental illness are not known for their ability to follow rules, neither the formal rules of the DOC nor the unwritten laws of the male "prison code." They tend to get into trouble in both regards. Either they are caught by security staff breaking rules and are sent to segregation as punishment, where their psychiatric condition is likely to deteriorate, or they are victimized by other prisoners. I will not discuss victimization in great detail, except to say that having allies is very important in prison. If a prisoner wishes to rob someone else, or even beat and rape someone, he has to make sure that his victim does not have friends who will retaliate. Individuals with mental illness tend, on average, to lack the capacity to maintain close social ties, and thus they tend to be loners. It is well known in prison that if

you want to rob someone, assault someone, or even inform on (snitch) someone, the best person to direct the malevolent act toward is a prisoner with mental illness.

> Prisoner # K.24, a slim, balding 50 year old disheveled and foul-smelling Iraqi-American man with long hair cannot tell us how old he is. He was interviewed in an office at JMF by myself, Dr. Walsh and Ms. Streeter. He speaks almost no English so we invited another prisoner from the Middle East to translate. He reeks of tobacco and bad smells emanate from his unkempt body. The day before we interviewed this man he was seen by Dr. Small with a translator. He isolates himself quite a lot. According to our translator as well as other prisoners we spoke to on the unit, all the prisoners know he has mental problems and is very disabled, and that he smells bad and talks to himself all day while wandering aimlessly. The other prisoners either avoid him or try to look out for him. According to the translator, prison is no place for this very disturbed man. To the extent I could do a mental status, with the language barrier, this man seems depressed, probably psychotic, and at least not entirely coherent. His personal hygiene and internal preoccupations are consistent with active, chronic psychosis. The SERAPIS file contains a JCF mental health evaluation on 9/30/04 with little information except that he cannot speak English, and is therefore being taken off the list for group therapy (presumably AOP, anger management). There is no mental health treatment, nor attention. But a 10/4/05 progress note at RCF by a nurse states: "Received call from housing unit officer this evening regarding his hygiene. Officer stated that he had left a diaper full of BM on the back of the toilet. Apparently these kind of things happen on a regular basis and custody did not know how to address." He is given diapers, but no mental health treatment. A 11/18/05 psychologist's mental health evaluation at RCF diagnosed Delusional Disorder, a GAF of 55, and states: "He jumped from a 3-story building, but he explained that he was not trying to harm himself; he was 'trying to fly to God.'" "Recommend OPT." The next note, on 12/07/05, changes the diagnosis to Adjustment Disorder, Unspecified, and recommends TNR. He is noted to speak to himself, but explains he is speaking to God in a form of prayer. No mental health treatment is given. At one point he asks a translator if she is a queen. He was transferred to JMF approximately 1/26/07, still not receiving mental health treatment. He continued to be seen infrequently by medical, with a "Late Effect, Spinal/trunk Fracture." A 7/17/07 progress note by Gale Sandoval states: "Asked by custody to write accommodation for single cell room as inmate is defecating in his cell, custody will do a mental health referral." A mental health nurse writes on 7/18/07 "Custody reporting very poor hygiene. Review of medical record indicates this has occurred before." A 7/20/07 MH Progress Note at JMF by Allan Small, MA, states language precludes exam but "it is not clear whether this inmate is suffering from mental illness. Mr. Small concludes there is no current mental illness. He recommends staff (custody?) monitor for speaking

> to self and unusual behavior, to be seen by PSU as needed. In other words, no treatment required (but that is not written on the chart note).

Prisoner # K.24 is clearly very disturbed, almost certainly psychotic, and is totally dysfunctional to the point of continually soiling himself and walking around aimlessly talking to himself or to God. Yet he receives no mental health treatment. Prisoner # K.25 has a history of depression and was treated for quite some time in an RTP, but at JMF he is not receiving mental health treatment and had to be placed in protection (in segregation) after being assaulted a few days following our interview.

(h.) TRAGEDIES RESULT WHEN THERE IS INADEQUATE MENTAL HEALTH TREATMENT

The dangers of segregating a prisoner suffering from serious mental illness were tragically illustrated by the death of Prisoner # K.36, a 21 year old prisoner who was in restraints within a segregation cell when he expired on August 6, 2006. I derive his story from a review of Dr. Jerry Walden's Declaration of 9/2/06.

> The diagnoses in the clinical chart for Prisoner # K.36 included Bipolar Disorder, substance abuse, and depression, with a record of multiple prior suicide attempts and psychiatric hospitalizations. He was prescribed Remeron (an antidepressant) and Geodon (anti-psychotic), and later Seroquel (anti-psychotic) and Lithium (a mood-stabilizer), for his psychiatric problems. During August, 2006, he was in a segregation cell, but Dr. Walden was informed that was for observation, not punishment. Dr. Walden questions this status, since he was placed in restraints and his water was cut off on August 2, 2006, interventions that suggest punishment, not observation. The temperature was around 100 degrees, and because of medications and medical conditions the man was at great risk of heat-related morbidity, but no precautions were instituted. He was described by Mr. Duffy, a social worker, as "floridly psychotic," and later as having loose associations, not oriented, and labile. He was kept in restraints, at first soft restraints and then hard restraints when he slipped one hand out of the soft restraints, for three days. He was repeatedly noted to be yelling. Dr. Walden notes that he had numerous risk factors for cardiac disease, but staff did not monitor his fluid intake during those three day in restraints. At one point it is noted that his medications are not working but cannot be altered because no psychiatrist is available. On August 4 he was not seen by a psychiatrist and his vital signs

> were not monitored appropriately. He refused water and was yelling and incoherent on August 4. He suffered burns to his skin because of urinating on himself while in restraints. On August 6 his restraints were replaced by a belly chain. There were no contacts with a psychiatrist. The psychologist saw him in his cell, but instituted no treatment. On August 6 he was found to be not breathing, and died soon thereafter. Likely causes of death include dehydration with cardiac complications, aggravated by the psychiatric medications he was prescribed – and there was, according to Dr. Walden, inadequate monitoring of blood levels related to the psychiatric medications.

The tragic demise of Prisoner # K.36 illustrates many problems in the delivery of mental health care, including the failure to monitor a patient's blood levels when he is taking potentially toxic psychiatric medications, a failure to institute proper precautions during a heat wave when his medications and cardiac condition make him doubly vulnerable to heat effects, placement in a stark segregation cell when he needed to be observed closely for both medical and psychiatric reasons, failure of medical and psychiatric staff to collaborate closely on urgent critical care for this man, etc. I will focus on the issue of restraints. I am very aware that subsequent to the tragic demise of this young man, prisoners with serious mental illness have been excluded from segregation units within *Hadix* facilities, and restraints are not to be used within segregation cells. But there is more to the issue of restraints. Current psychiatric practice and standards require that when restraints are used in a psychiatric setting, a number of steps must first be traversed. All less constrictive options must be attempted and exhausted. The restraints must be used in a very measured way, and only to the extend absolutely required by the clinical situation, to be discontinued at the earliest possible time, and most importantly, because restraints are only used when the situation is very critical and urgent, there must be increased monitoring by medical and psychiatric staff. In the community, when restraints are utilized in a psychiatric or medical facility (for psychiatric reasons) the psychiatrist must actually come in and see the patient and write the order, and then must repeat the examination and re-write the

order at very brief intervals – typically every four hours. The reason for the requirement that a psychiatrist examine and re-write orders at frequent intervals is that the condition requiring the extremity of intervention restraints constitute, and the restraint process itself are potentially very harmful, and by requiring close monitoring by a psychiatrist the accrediting and auditing agencies are hoping to attain adequate levels of expert clinical supervision in the process. In the case of Prisoner #K.36, the psychiatrist never even saw the prisoner during the several days he was in a psychotic state and restrained before he died. And the psychiatrist ordered no blood tests or precautions to avoid potentially lethal effects of the heat with someone on this kind of psychiatric medications. It is a good thing that subsequent court orders and practice revisions require that prisoners on the mental health caseload not be placed in segregation and that restraints not be used in segregation. But if the same level of inattention and poor practice by mental health exists in any other context, there is a very great danger that a similar or equivalent tragedy will occur again.

> Prisoner #K. 39, who I am familiar with only because of a chart review by the Office of the Independent Medical Monitor, had a seizure disorder and was transferred to JMF in Dec 07, 2006. His transfer sheet stated that he needed to be seen by the outpatient mental health team. PSU stated he could go to any institution, he had "no mental health history noted." On 12/4/05 he had been noted to be combative and assaultive and unsuitable for general population. On 12/5/05 he was in temporary administrative segregation on 12/5/05 and was noted to be alert and oriented. But he did not remember why he was there in ad seg. By 12/18/05 he had not eaten for a day. He attempted to talk but made no sound. An assessment wondered if he was post-ictal (i.e. maybe he had a seizure). On 12/19 he was at Foote Hospital, was felt to be post-ictal but also thought to be catatonic. A neurologist opined that his diminished state of consciousness might be due to the Haldol he was taking (an older anti-psychotic medication with risk of neurological side effects) for a psychotic disorder. A psychiatrist saw him and continued the Haldol, planning to request his records to help with his diagnosis. On 12/22/05 he was transferred to JMF. Monthly notes from 8/06 in DWH list seizure disorder and schizophrenia with a high fall risk. Dr, Howse. According to his nursing file he was in a posey from at least Aug. 06 to the end of February, 2007. During this time he was also in observation and restraints were applied. There are

> minimal details from the log sheets, for instance noting he was awake or asleep. There were no notes by a psychiatrist in the DWH. There was also no good assessment of the patient as to why he was in a posey, except to say he was a fall risk. The OIMM staff found this very unusual in the modern day of using restraints only when medically necessary, and constantly renewing the restraining order with documentation as to need. He was found to be hypoxic on 3/16/07 and transferred again to Foote Hospital. By 3/16/07 he was in acute respiratory distress with likely bacterial pneumonia at Foote Hospital. He was also felt to be floridly psychotic. And Dr. Patten notes that he has a history of being catatonic due to Paranoid Schizophrenia. He likely died soon after.

What is impressive about this tragic case study is, again, that this man suffered from a very serious mental illness, Paranoid Schizophrenia with Catatonia, but as his medical condition deteriorated and he became unresponsive verbally there was little if any psychiatric care and very poor collaboration between the medical practitioners and the psychiatrist.

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In summary, there are many areas of inadequacy of mental health treatment in *Hadix* facilities. Changes have recently been put in place. For example, there are to be no restraints utilized within segregation cells and no prisoners on the mental health caseload are to be in segregation. But the changes only affect the *Hadix* facilities, so a *Hadix* class member who is transferred to a non-*Hadix* facility remains in jeopardy of practices that have been banned at *Hadix* facilities, and this limits the choices of mental health staff within *Hadix* facilities who are considering treatment options for their patients. Among 37 prisoners I interviewed, I found two who had been told by their clinician that a transfer would be arranged for them to an RTP (residential treatment program, a "stepdown" mental health treatment unit that is not at a hospital level of care, but involves more intensive treatment than outpatient care), but they were not subsequently transferred to an RTP. As of the writing of this report, one, Prisoner # K.4, was transferred to general population and outpatient mental health care at another facility, and the

other, Prisoner #K12, remains at JMF general population and outpatient level of care. The point here is that clinicians are on record recommending RTP level of care but the prisoner is not transferred to RTP. In addition, the cases I described I have presented illustrate other unfortunate insufficiencies in mental health treatment at *Hadix* facilities.

Ultimately, all the problems I have discussed concerning inadequate mental health care, even the under-diagnosing, are related to the reality that the mental health staffing and the mental health programs are not adequate to the task of treating the large number of prisoners suffering from significant and serious mental illness. In many cases where I detected inappropriate under-diagnosing, the clinician responsible did not see the prisoner in a timely manner and then did not spend enough time with him to permit full discussion of the prisoner's emotional experiences and disability. Similarly, the reason for cell-front interviews is that they require less staff time. If security and mental health staff had sufficient time to move the prisoner from segregation or observation into an office, and then to conduct an interview of the length of time necessary, the prisoner would be more forthcoming about symptoms and self-destructive impulses. If there were more clinical staff, there would be fewer and shorter delays arranging assessments and treatments at all levels. The tragic demise of Prisoner # K.36 occurred in the context of a psychiatrist not being available to properly monitor heat dangers, the use of restraints, etc. It is a shortage of staff and programs that underlies the serious deficiencies in the provision of mental health care at the *Hadix* facilities. With upwards of 20% of prisoners suffering from significant mental illness, a mental health caseload of approximately 6% is grossly inadequate. The shortfall in terms of diagnosis and treatment puts prisoners at great risk, as I will discuss in the next section.

V. PRISONERS WITH MENTAL ILLNESS ARE RELEGATED TO SEGREGATION

Many prisoners with serious mental illness who do not receive adequate treatment are eventually consigned to terms in segregation. Prisoners with serious mental illness are overrepresented among prisoners in segregation, as I explained in my 2003 Cain Report. It has been known for as long as segregated housing has been practiced in prison that human beings, especially those prone to mental illness, suffer a great deal of pain and mental deterioration when they remain in segregation for a significant length of time. This is especially the case for prisoners who suffer from mental illness. Thus, in 1890, the U.S. Supreme Court found that "[a] considerable number of prisoners fell, after even a short confinement [in isolated confinement], into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."[11]

Human beings require some degree of social interaction and productive activity to establish and sustain a sense of identity and to maintain a grasp on reality. In the absence of social interactions, unrealistic ruminations and beliefs cannot be tested in conversation with others, so they build up inside one's mind and are transformed into unfocused and irrational thoughts. Without social interactions, individuals have no way to test the reality of their fantasies, and thus there is a tendency toward paranoia and an inability to control the rage that mounts with each perceived insult. An example from everyday life in the community: I walk into a room, two people are talking and lower their voices as I enter. I have the momentary fantasy they were talking about me and that's why they lowered their voices when I walked in; I

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[11] *In re Medley*, 134 U.S. 160, 168 [1890].

approach them and their friendly greetings disabuse me of what I now can judge to be an erroneous and paranoid fantasy on my part. This kind of reality testing goes on in everyone's daily life. We have suspicions, negative thoughts and fears, and our subsequent interactions with others permit us to test their reality. Prisoners in isolated confinement have no opportunity to "check out" their possibly paranoid projections with a sympathetic friend, and they multiply and go untested. This is merely one example of the debilitating effects of such confinement.

Productive activities serve as a basis for testing the reality of imagined thoughts, for maintaining a sense of one's worth or self-esteem, and for testing the wisdom of acting out inner impulses, and they provide a necessary outlet for physical and psychological energy. Where productive activities are severely restricted, the resulting idleness multiplies the effects of social isolation.

Prisoners in segregation do what they can to cope. Many pace relentlessly. Those who can read books and write letters. But many prisoners are illiterate. Nationwide, at least 40% of prisoners are functionally illiterate,[12] and evidence is accruing that illiterate prisoners fare less well than others in isolated confinement. This makes sense; if one is alone in a cell nearly 24 hours per day and cannot even read the newspaper or write a letter, the sense of unreality and isolation is likely to grow. Prisoners prone to or suffering from mental illness have even more difficulty concentrating than do others, and many, on account of anxiety or hallucinations or obsessions or despair, find it impossible to read or write while restricted to a cell.

In the context of near-total isolation and idleness, psychiatric symptoms emerge in previously healthy prisoners. For example, a prisoner may feel overwhelmed by a strange sense

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[12] The Center on Crime, Communities, and Culture, "Education as Crime Prevention." Research Brief, Occasional Paper Series, Sept., 1997, Vol. 2, New York: Center on Crime, Communities, and Culture.

of anxiety. The walls may seem to be moving in on him (it is stunning how many prisoners in isolated confinement independently report this experience). He may begin to suffer from panic attacks wherein he cannot breathe and he thinks his heart is beating so fast he is going to die. Almost all prisoners in long-term segregation, in Michigan DOC and elsewhere, tell me that they have trouble focusing on any task, their memory is poor, they have trouble sleeping, they get very anxious, and they fear they will not be able to control their rage. Other researchers report these symptoms in a large majority of prisoners in isolated confinement.[13] The prisoner may find himself disobeying an order or inexplicably screaming at an officer, when really all he wants is for the officer to stop and interact with him a little longer than it takes for a food tray to be slid through the slot in his cell door. Many prisoners in isolated confinement tell me it is extremely difficult for them to contain their mounting rage, and they fear losing their temper with an officer and being given a ticket that will result in a longer seg term.

Hans Toch summarizes the hundreds of interviews he did with prisoners, many in long-term isolated confinement in New York State DOCS correctional facilities.[14] He coined the term "isolation panic" for the symptoms he regularly discovered in the men, including panic, rage, a sense of total loss of control, an experience of emotional breakdown; many exhibited very regressed behavior and many resorted to self-mutilation.[15] Toch distinguished between incarceration, which is difficult but tolerable, and isolated confinement, which is not tolerable for many.

Social psychologist Craig Haney has conducted research with a large number of prisoners in isolated confinement. He randomly selected prisoners and found very high prevalence rates

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[13] *See* B., below.
[14] Toch, Hans, Men in Crisis: Human Breakdown in Prisons, Chicago: Aldine, 1975, pp. 20.
[15] *Ibid.*, pp. 38-43.

for a large list of emotional symptoms. Over 80% of the prisoners reported massive anxiety. Likewise, over 80% of the prisoners complained of headaches, troubled sleep, and lethargy. Over half complained of nightmares, heart palpitations, violent fantasies, depression or despair, and fear of impending nervous breakdown. Complaints of obsessive ruminations, confused thought processes, oversensitivity to stimuli (a strong startle reaction), irrational anger and social withdrawal were widespread.[16]

Psychiatrist Stuart Grassian examined a large number of prisoners during their stay in segregated, near-solitary confinement units and concluded that these units, like the sensory deprivation environments that were studied by psychologists in the 1960s, often induce psychosis, especially in prisoners who have histories of mental illness or a predisposition to psychiatric breakdown.[17]

I will not review all of the research literature here, but there has been a substantial amount of research into the harmful effects of isolated confinement, especially if the prisoner thus confined suffers from a serious mental illness or is vulnerable to mental illness. In their *amicus* brief in *Wilkinson v. Austin*, leading mental health experts summarize the clinical and research literature about the effects of prolonged isolated confinement and conclude: “No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects” (p. 4).

It has been my experience, from tours and well over a thousand clinical interviews with prisoners in isolated confinement units in ten states, that the conditions that cause emotional distress in relatively healthy prisoners cause psychotic breakdowns, severe affective disorders

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[16] Haney, Craig, “Mental Health Issues in Long-Term Solitary and ‘Supermax’ Confinement,” Crime & Delinquency, 49,124,127, 2003.

[17] Grassian, Stuart, "Psychopathological Effects of Solitary Confinement," American Journal of Psychiatry, 140, 11, 1450-1454, 1983.

and suicide crises in prisoners who have histories of serious mental illness, as well as in a certain number of prisoners who never suffered a breakdown in the past but are prone to break down when the stress and trauma become exceptionally severe. When an average individual who is placed in an environment develops massive free-floating anxiety, hyper-responsiveness, paranoid ideas, confusion, perceptual distortions, motor excitement and so forth, and becomes frightened he will not be able to control his aggressive fantasies, just imagine how difficult it would be for someone who is prone to paranoid psychosis or suicidal despair to remain balanced. Dr. Grassian's last reported psychiatric symptom, the rapid reduction of symptoms upon termination of isolation, may or may not occur – in my clinical experience, once an individual crosses a line into psychosis or depressive despair, it is very possible that removal from the harsh conditions of isolated confinement will not be sufficient to bring him back to a normal mental state.

As I mentioned above, suicide is a huge problem in isolated confinement. Despair is bred by conditions of long-term isolated confinement. When prisoners sense that staff do not take their pain and despair seriously, but rather view them as "malingerers" or problem prisoners whose only mental illness is Antisocial Personality Disorder, they experience even more despair. It is no accident that approximately half of suicides that occur in prison take place in isolated confinement, or involve prisoners who are serving a term in isolated confinement. Of course, the ultimate tragedy occurs when the despair becomes overwhelming for the prisoner, but over-concern about malingering or manipulations leads mental health staff to miss what would otherwise be clear signs of an impending suicide.

At *Hadix* facilities, there is a recent ban on confining prisoners on the OPMH caseload in segregation. It is my understanding that this does not preclude sending prisoners with serious mental illness who run afoul of the disciplinary process to other, non-*Hadix* facilities where they

will spend time in segregation. In fact, many prisoners have recently been removed from the segregation units at the *Hadix* facilities, and the temporary segregation unit at the RGC and the SMHU at JMF are running very much below capacity. Thus, during my tour, I found relatively few prisoners with serious mental illness in segregation (I did find some, and this is because they had been discharged from the mental health caseload in spite of continuing psychiatric problems – *e.g.*, Prisoner # K.12, or they are in Observation, which at RGC and JMF is inside the segregation units – *e.g.*, Prisoner # K.4). But I did find quite a few prisoners who have served significant amounts of time in segregation previously at *Hadix* facilities or in other facilities.

> Prisoner # K.6, a 55 year old, graying, very thin African American man wearing glasses with his hair in dreads reports that he hit his father with an axe and has been in prison since 1990. I interviewed him in an office while he was in segregation, and he reports he has been in segregation for over a year. He believes officers are "messing with me," that they put things in his food. He was found Guilty but Mentally Ill. He has been mentally ill all of his life, hearing voices much of the time, usually diagnosed Paranoid Schizophrenia. He likes some medications, the best was Mellaril. Haldol caused neurologic (EPS) symptoms. He is not on any medications at present except for treatment for his prostate cancer, and he is not on the OPMH caseload. In segregation he talks to himself – he never did that prior to placement in segregation - and he hears voices. He has television and reads books, but he has significant concentration and memory problems since being in segregation. He has a history of substance abuse, drugs and alcohol. He tells me that the hearing officer who sentenced him to segregation did not hear from OPMH, but had his 1994 forensic examination when he sentenced him to segregation. He has been in psychiatric hospitals many times, in and out of prison. He says the best adjustment he ever made to prison was in the period 1995 to 1999 when he was at Huron Valley Center, the psychiatric inpatient and the RTP unit. On mental status this man is slightly bizarre, he is coherent but there is some internal preoccupation. He is somewhat concrete, but very idiosyncratic in his responses to proverbs. He is quite positive for first rank symptoms, including the conviction someone is listening to his thoughts all the time. He complains of great difficulty sleeping in segregation, he has flashbacks, he perceives the walls melting, and he tries his best to "mellow out." He says that PSU staff make rounds and come to his cell-front, but the visits are brief and cursory. His chart includes a diagnosis of Paranoid Schizophrenia in 1990 with a GAF of 50. He was prescribed medications at that time. Epilepsy is also noted. The SERAPIS Chart contains a 5/31/07 90 day seg mental health screening that reflects this prisoner was placed in

> segregation on 6/14/06, and lists diagnoses. Currently there is no diagnosis on Axis I, with a primary Axis II diagnosis of Antisocial Personality Disorder and an unremarkable mental status examination. A 7/9/04 note by Marilyn Harris, RN, reflects a history of psychiatric inpatient treatment for six months in 1977, psychiatric inpatient stays in a Forensic center (possibly related to court proceedings), then at DWH (9/94 for 8 days), and two admissions to Huron Valley RTP in 1995 and 1999. This note reflects "flight of ideas, … positive hallucinations, auditory, they are whispers and not bothersome, he refuses medication for this, very talkative, moderate anxiety, hyperactive, animated, overactive, hostile, has history of suicide attempts, 2 attempts by ingesting Purex in 1969, and hanging, and a primary diagnosis of Schizophrenia, Paranoid Type, and polysubstance abuse with a GAF of 59. Then there is a 12/3/04 QMHP Report by Frank VanGoethem stating that the patient requests removal from the OPMH caseload. There is a case summary, noting 5 volumes of charting, noting Zyprexa (a strong anti-psychotic medication) was discontinued on 11/5/01, and opining that this prisoner never suffered from serious mental illness, but manipulated (i.e., malingered, though that word is not employed) to get out of segregation. The prisoner is discharged from the OPMH caseload to be followed by PSU. Notes in July, 2007, reflect medical work-up for prostate cancer. An 8/4/07 note reflects that he had to be moved "Pt states he is having difficulty breathing and has dx of COPD (emphysema) – was in environment where another patient was gassed."

Contrary to Mr. Van Goethem's opinion, Prisoner # K.6 suffers from Paranoid Schizophrenia, chronic with active thought disorder and hallucinations. Schizophrenia is a lifetime illness that pursues a waxing and waning course. At one point in time he may be floridly psychotic, at another time he may be quietly listening to hallucinated voices, and at still another time he might be delusional and incoherent. The fact that he does not want to continue the anti-psychotic medications he has been taking over a lifetime does not mean he can be discharged from the outpatient mental health caseload. He is severely disabled with a GAF below 40. He is deteriorating in segregation. He is receiving neither appropriate monitoring nor treatment. There is a question of his competence to decide about taking medications, but even if he is permitted to refuse, given the seriousness of his mental illness he should not be in

segregation and he should be on the mental health caseload. Transfer to a therapeutic setting such as a long-term RTP is indicated

I was told by PSU and OPMH staff that when a prisoner/patient on their caseload receives a ticket for a disciplinary infraction, he is usually transferred to Huron Valley for more intensive psychiatric treatment, and the hearing officer usually dismisses the ticket. If this were the case, it would be a very good practice. But the staff's presentation of the disciplinary system for prisoners with mental illness sharply contrasts with what many of the prisoners I interviewed reported. Many told of receiving disciplinary tickets and serving time in detention/segregation. Some told of going to the intensive treatment units at Huron Valley only to be faced with a term in segregation for tickets after they were released from the treatment program.

Another very serious problem is the mixing of various populations in segregation units.. Prisoners on the OPMH caseload are not supposed to be housed in segregation in *Hadix* facilities. But the reality is that prisoners who have been inappropriately under-diagnosed and consigned to "TNR" are placed in segregation, and I interviewed several individuals in this category during my tour, including Prisoner # K.6. Other prisoners with serious mental illness are sent to non-*Hadix* institutions and placed in segregation, often for rule violations that occurred in Hadix facilities. There are likely to be very destructive effects when prisoners prone to mental illness are placed in segregation. There are also negative consequences when prisoners in need of protective custody are placed in segregation units that are meant for punitive detention, a scenario that was reported to me by several prisoners in 2007 in the *Hadix* facilities. (Prisoner # K.4, was placed in segregation for protective custody. Another example is Prisoner # K.38 - I did not see him, but I reviewed his clinical chart, where a 7/19/07 MH Progress Note from RGC states: "Inmate is housed in SHMU because of a need to protect him from another

inmate that he testified against. Also Prisoner #K.25 was involved in an altercation, hurt, and then placed in segregation for protection, and Prisoner # K.5. was in segregation because of a need for protection.) Protective custody should involve separation of vulnerable prisoners from general population, but should not involve deprivation of activities and amenities. When segregation is utilized as a site for protective custody, prisoners are disinclined to ask for protection, and those who do find their way into protective custody in segregation units at the *Hadix* facilities are then mixed among punitive segregation prisoners, prisoners with serious mental illness who have been under-diagnosed and discharged from the OPMH caseload, and prisoners on administrative segregation.

Since many prisoners with serious mental illness, whether or not their illness is diagnosed and treated by mental health staff, are more likely than other subpopulations to seek protective custody, the placement of protective custody within segregation units has very detrimental effects on them. I have already discussed the problems that arise when observation cells are placed within segregation units. I will mention here the problem that, in a unit with detention, protection, administrative segregation and mentally ill prisoners all mixed in, there is a lot of screaming, especially at night, and there are periodic “gassings” – i.e., the prisoner seeking protection is confined next to a prisoner who is assaultive, and staff proceed to spray the assaultive prisoner with mace or pepper-spray in the process of cell extraction. The “gas” permeates the area, and the prisoner in protection not only has to suffer the shouting and screaming at night of the mentally ill and misbehaving prisoners, but also is exposed to the mace or pepper-spray used in the neighboring cell. Thus, Prisoner # K.6, who is suffering from an un-diagnosed serious mental illness, subsequent to our interview, has this note in his SERAPIS chart: “8/4/07 Pt states he is having difficulty breathing and has dx of copd (emphysema) – was

in environment where another pt was gassed." He was in the segregation unit because he needed protection following an altercation. He had to be moved to another cell. The point is that prisoners needing protection should, according to American Correctional Association standards, be transferred to a unit where their privileges will remain commensurate with their security classification – they should not suffer the deprivations of segregation merely because they need to be protected.

> Prisoner # K.5, a short, goateed Caucasian man, was interviewed at JMF on July 25, 2007. He was in a segregation cell and was brought to an office for our interview. He explained he was in segregation for protection. As far as he knows, there is no protection unit where amenities and programs are equivalent to those in general population, so protection means segregation, and protection prisoners are mixed in segregation with detention and administrative segregation prisoners. He had been on a minimum security farm, but had kidney stones and needed to be sent to JMF, a level 2/4 facility, in order to receive proper medical care. He thinks he has diabetes as well. Since arriving at the higher security level JMF, he has had his property smashed and feels unsafe. He has been in prison since late 2006, and at JMF for 7 months. He has suffered from Attention Deficit Disorder with Hyperactivity (ADHD) since childhood, and had been on stimulant medication treatment (Adderal, 60 mg. per day) in the community with very good results, but that medication was discontinued as soon as he entered Reception. He saw a psychiatrist in the community from age 12 to 26, who prescribed Adderal. He also reports compulsive symptoms, including counting, walking on lines and compulsive gambling – all of which he attributes to his Obsessive Compulsive Disorder (OCD - undiagnosed and untreated in MDOC). In Reception he was told by mental health staff that he suffers from Bipolar Disorder, and they prescribed Depakote and Seroquel. He does not believe he suffers from Bipolar Disorder, and the medications "made me into a zombie." He reports that when he did not take the medications that were prescribed, he was written a ticket for substance abuse – i.e., staff suspected he was selling the unused pills – but that was eventually dismissed. He now is prescribed Neurontin three times per day. He says that PSU staff conduct rounds in segregation. He reports there is a lot of shouting in the segregation unit, he thinks because of the mix of detention and protection prisoners. He gets one hour of "recreation" per day, alone in a small fenced area with a telephone. In his clinical chart this man is described as having no insight. I actually found him very insightful. He has no history of mania, nor of significant depression, but his history is very consistent with ADHD, and he had a very good outcome with prescribed stimulants. His chart contains a diagnosis of Bipolar Disorder (3/6/07), but he was

discontinued from OPMH. He is being treated with Tegretol while in Administrative Segregation.

VI. THERE IS RECYCLING BETWEEN SEGREGATION, OBSERVATION AND OTHER TREATMENT PROGRAMS

Because the pattern described is unchanged, and because the case illustration is a prisoner confined at JMF, I am going to quote at length from my 2003 Cain Report about the problem of recycling between Segregation and Observation: "When the diagnosis of serious mental illness is missed, or when a prisoner with serious mental illness is erroneously deemed to have 'No Axis I diagnosis' or to be 'merely malingering,' and that prisoner breaks rules or becomes assaultive, then he is given a disciplinary ticket and is likely punished with time in isolated confinement, i.e., Segregation. Then, in too many cases the stress of isolated confinement causes deterioration in his mental status and eventually he suffers an obvious acute psychotic breakdown (decompensation) or makes a serious suicide attempt. He is placed in Observation and eventually he is either returned to his segregation cell (here is the first loop of the recycling, from segregation to Observation and back to Segregation) or, if his condition is deemed serious enough (i.e., if he meets criteria) he is transferred to the crisis unit for further evaluation and then returned to segregation (the second loop of recycling, from segregation to crisis unit and back to segregation), or he is advanced to a therapeutic program such as an RTP or the acute psychiatric unit at HVC or the Waters facility, or the self-mutilation program at HVC (the last two have been closed since I wrote this).

CASE EXAMPLE: Prisoner 12 (a different numbering system, not someone on my current list of prisoners' names and numbers for the Hadix facilities). This 37 year old white male was interviewed by Dr. Walsh on 5/29/02 in the law library room of JMF, a level IV prison. Present and participating in the interview was PLSM attorney Maia Storm. He stated that he is a 3 time offender with a long history of depression and suicidal preoccupation, and has been in detention segregation confinement since 1/01. In addition, he reported that he has several medical problems…. He first entered the Michigan prison

system in 1984, but few of his old records were provided by the MDOC. A psychological report dated 1/19/01 by B. Wright, Ed.D, noted a history of treatment for paranoid thinking and alleged command auditory hallucinations, but found him responsible, giving him a diagnosis of R/O Delusional Disorder, persecutory type, and Schizotypal Personality Disorder. There is an undated psychiatric evaluation showing his age as 26 (1991) with a history of his cutting his arms and legs, and being prescribed Sinequan. Dr. Orlowski diagnosed him as Bipolar Disorder, Chronic, Moderate Severity. Another psychiatric evaluation by K. Mehra, M.D., dated 2/22/94, noted this man had been treated in the past with Mellaril, Prozac, Sinequan and Elavil, but reported at the time he said they did not help him much with his symptoms. Dr. Mehra diagnosed him as Depressive Disorder, NOS, and ASPD, by history, and recommended he be followed by the OPMHT.

On 4/22/97, he was admitted to HVC, with depression, insomnia, a wish he were dead, and hallucinated voices. The admission diagnosis, by psychiatrist F Safi, M.D., was Major Depression with Psychotic Features (provisional), R/O Malingering, R/O Dysthymia, and Mixed Personality Disorder. Dr. Safi's discharge diagnosis was Adjustment Disorder, Chronic, and Mixed Personality Disorder (Narcissistic, Antisocial, Borderline and Dependent). He was re-admitted to HVC on two more occasions. A note on 8/29/97 repeats the report of hallucinated voices and reflects that this prisoner attributed his assaultive misconduct in Ad Seg to these voices, but that "he had not been observed to be responding to internal stimulation." He was diagnosed Adjustment Disorder, Chronic with disturbance of conduct, and Borderline Character Disorder. He was discharged with a final diagnosis of Malingering and Personality Disorder NOS, in a brief report by Dr. Safi, with a recommendation for follow-up by the OPMHT.

Examination of the cell use printout reveals that his man has been confined in segregation status housing a total of approximately 2 years 1 month cumulatively. There is a definite pattern in this record of this man cycling back and forth between population, Ad Seg, Detention, and mental health placement in either AC or hospital settings. Throughout much of this time he was treated with a variety of psychiatric medications, including anti-psychotics and antidepressants. Although MDOC MH staff had long diagnosed him with recurrent major depression for almost 6 years continuously, in 1997 he was un-diagnosed, labeled a malingerer, and his medications were discontinued, except for Elavil, which he stated he was taking for his migraine headaches at the time of interview. The printout of his major misconduct record, covering 1/27/89 - 11/13/01, contained 77 tickets, including 3 for assault and battery against staff, 6 for threatening behavior, and 1 for possession of a weapon. The 3 staff assaults occurred after 3/99, as did 4 of the 6 threatening behavior tickets and the weapon charge.

When interviewed by Dr. Walsh, this man presented as disheveled in appearance, speaking rapidly with pressure of thoughts and appeared extremely anxious. He frequently tapped his left foot almost uncontrollably, and motor behavior appeared agitated. This tic recurred repeatedly throughout the interview and appeared to be involuntary. He admits to many instances of SIB, including repeated cutting of his arms and legs, which he says sometimes are in response to voices he hears telling him to do it. This intensifies when he is in the isolation and loneliness of his Ad Seg cell, and he says he gets very "uptight" and confused, and "I end up spilling blood--blood quiets them down." Sometimes its "the voice of my dead brother, Billy, he's powerful, persuasive." Other times he says there are 3 different voices at the same time, "chantings of being commanded to kill people, but never identifies who. Kill him, kill him, kill him. It's very confusing." Occasionally, during the interview he would ramble on and become quite tangential, then suddenly would drift and shift subjects. He readily admitted to being quite suspicious about officers tampering with his food. He also said the officers "set me up", that they put a large plastic bag full of "legal envelopes and shake down slips" in his cell, and then found him guilty of major misconduct. Another time he says the guards deliberately "killed my pet mice. They knew they were my pets. I used to feed them and make little toys for them. I caught them and domesticated them, and they killed them." He reports long term depression, varying in intensity from mild to severe when he is in AS for long periods. He admits to repeated suicide attempts, some to get attention, some out of frustration, and some when he really wanted to die. This man says he fears telling the MH staff he is feeling suicidal because of the brutal way he is treated if he does disclose it. He said "they strip a guy naked, put him in the (observation) cell, bam-bam suit, and he becomes an animal. So I don't tell them. It pushes people over the edge." He then showed Dr. Walsh a long cut on his right forearm that he says he let heal by itself, saying he wrapped it in an ace bandage and avoided getting it treated because he feared placement in the observation cell.

MDOC records reveal that this prisoner had a non-violent history both in the community and while incarcerated, until he was placed in segregation for repeated misconducts. In addition, he appears to have many characteristics of Schizoaffective Disorder, Depressive Type, and has exhibited active psychotic-like behavior at least several times during his confinement, usually after placement in Ad Seg. He also has exaggerated his symptoms to escape the trauma and terror he reports experiencing locked up in these cells. Some MDOC MH staff believe that his psychotic-like behavior may be associated with a severe personality disorder, possibly Schizotypal or Borderline PD. The fact is, however, that regardless of what the most accurate diagnosis is, his mental disorder becomes so severe without treatment that he becomes a danger to both himself and others, especially staff, and especially when confined under the destabilizing and extremely punishing conditions of being locked up in segregation.

Once a prisoner has demonstrated an incapacity to tolerate the stress of segregation status, one would think that after completing the therapeutic program (HVC, RTP, SMTP, etc.), he would be transferred to a more tolerable setting so that his condition would not deteriorate anew. But in the Michigan DOC this is usually not the case. Thus, prisoners with serious mental illness are recycled between segregation and Observation (loop one), segregation and crisis unit (loop two), or segregation and treatment unit (loop three). It is not unusual for a prisoner to recycle repeatedly in all three loops during his career as a prisoner with serious mental illness. Either the individual who has already proven to be emotionally unstable and prone to psychosis or suicide is "un-diagnosed" – for example, I reviewed many cases where the clinicians at HVC concluded there was "no Axis I diagnosis" – OR, the individual is transferred back to the same segregation setting where he had suffered the breakdown and from which he had been transferred to the treatment facility (here is the third loop of the recycling process). In many instances, policy actually dictates this kind of recycling – *i.e.*, policy requires that the prisoner be returned to the sending institution upon discharge from the treating institution.

I did not discover much evidence of current recycling at *Hadix* facilities, probably because many prisoners with serious mental illness have been disallowed in segregation, and many of those who would predictably be meted a segregation term for unacceptable behaviors have been transferred to other facilities (where there is no ban on placing prisoners with serious mental illness in segregation). But there was definitely evidence that the recycling pattern continues within the Michigan DOC, and it is my prediction that if *Hadix* facilities are once more filled to capacity, the recycling will be obvious. I will present a case that reflects the pattern, involving a prisoner currently confined at JMF.

Prisoner # K.12, a 31 year old Caucasian man with closely cropped hair and a short beard, has been in prison 5 years this term, and 12 years all together. He was moved to JMF in January, 2007. He thinks he suffers from mental illness. He hears voices, cannot control his temper, and is commanded by voices to assault others. He used illicit substances in the community, in large part to control the mental illness. He was in segregation from April through October, 2006. He spends a lot of time in segregation. He was in observation a few weeks go. He has not gone from segregation to observation, but he has gone from observation to segregation on more than one occasion. In segregation his voices get worse. When the officers strip him down he feels humiliated and gets more paranoid. He was at Huron Valley in the Residential Treatment Program (RTP). In RTP, if you get into a fight, they put you in Observation, not segregation. He believes that had he stayed at the RTP he would have stayed out of trouble and done better in prison. But 3 days after being sent from the RTP to Bellamy Creek, he was "in the hole." He spent 7 months in segregation at Bellamy Creek. When "in the hole" he shuts down, cries a lot, and feels people are laughing at him. While in segregation he only sees mental health staff (PSU?) at cell-front, never in a private, confidential setting. He states poignantly and with sadness that he is a "paranoid person" and gets angry in segregation or observation – that is why he spends so much time in segregation. He sees Dr. Weller frequently at this time, and refuses to see Frank Van Goethem, who he feels betrayed confidentiality and told about his mental illness (possibly in relation to a disciplinary hearing? – I have no further information). When he is in observation he feels that nobody talks to him, and his mind races even more than usual. He had been in psychiatric hospitals twice while in the community. He thinks OPMH staff are trying to get him to sign off, i.e. that he needs no mental health treatment. He is slated to go to RTP. Mental status reflects depressed affect, with flatness and psychomotor retardation. There is a certain amount of obsessionality, and he has trouble abstracting. He gives credible reports of manic symptoms at other times, and hallucinated voices when he is manic. When he is manic he experiences flight of ideas, severe insomnia, great energy, and the ability to stay up for 5 or 6 days and then "crash".

In this prisoner's chart there are notes dating back to March, 2003, diagnosing Bipolar Disorder with substance abuse and a personality disorder. An 8/4/04 progress note diagnoses Bipolar Disorder and reflects referral to RTP. An 8/10/04 note also diagnoses Bipolar Disorder, notes he is in Administrative Segregation, and an 8/13/04 note documents transfer to the RTP at Huron Valley. On 1/16/07 the patient is in segregation and tells the PSU clinician doing rounds that he wants to explore mental health treatment again. On 1/29/07 he is referred, presumably by PSU, to OPMH, with a diagnosis of Bipolar Disorder, Substance Abuse and Antisocial Personality, and a recommendation for outpatient mental health treatment. A note by Frank Van Goethem on the same date expresses doubt about a Bipolar diagnosis and

accuses the patient of seeking secondary gain. Dr. Weller, the psychiatrist at JMF OPMH, sees the patient on 2/1/07, notes severe paranoia and depression with anxiety, reviews the long history of depression since a first significant suicide attempt at age 15, notes more recent suicide attempts by overdose two years ago with need for hospitalization, notes long history of psychiatric medications including anti-psychotic, mood stabilizing and antidepressant medications, notes this is at least the third major depressive episode, that he also has seizures by history, and Diagnoses Mood Disorder NOS with polysubstance abuse and antisocial personality. She admits the patient to OPMH and prescribes Prozac, a mood stabilizer and a seizure medication. By 6/4/07 Dr. Weller notes he is not doing well, and changes some of his medications. There are a series of alternating notes by Dr. Weller and Frank Van Goethem, she diagnosing and treating a serious mental illness, he doubting that the patient is suffering from an Axis I diagnosis (see note of 6/7/04). On 6/29/07 the patient is sent to Observation because he appears "paranoid." He is evidently released from Observation later that day. On 7/3/07 Dr. Weller reports he is hearing voices. On the same day, Mr. Van Goethem again doubts there is a mental illness and says the medications are not working because they are not indicated. After a few more notes by Dr. Weller and Mr. Van Goethem, on 7/24/07 Mr. Van Goethem notes that the patient does not want to see mental health because "You all have been spreading my business out on the yard." On 7/25/07 he is in the ER at DWH with racing thoughts and insomnia. In other words, the excessive skepticism by Mr. Van Goethem is out of line with the reality of this man's serious mental illness, as evidenced by multiple valid past diagnoses and hospitalizations as well as repeated effective prescriptions of anti-psychotic and mood stabilizing medications. The psychiatrist accurately diagnoses and attempts to treat the disorder, but probably because of unfortunate meetings with Mr. Van Goethem, the patient refuses to comply with Dr. Weller's treatment and continues to experience exacerbations of his serious mental illness. As of August 20, 2007, he is listed on the Michigan DOC website as confined at Southern Michigan Correctional, so as of three weeks after I interviewed him he has not been transferred to a Residential Treatment Program, as he was told he would be.

VIII. INADEQUATE TREATMENT RESULTS IN MORE SEVERE PSYCHIATRIC MORBIDITY AND DISABILITY AND WORSE PROGNOSES

Serious mental illnesses such as Schizophrenia or Bipolar Disorder typically exhibit a waxing and waning course over a lifetime that includes periodic acute episodes alternating with periods of relative stability when the individuals comply with treatment, including the proper medication regimen. Research shows that the longer an individual's acute psychotic or

depressive episode is left untreated, the worse his prognosis. Research also shows that early detection of serious mental illness, removal of the individual suffering from mental illness from the noxious and traumatizing environment, and intensive comprehensive treatment greatly improve prognoses. Mental health clinicians in the community work hard to detect serious mental illness early and provide people vulnerable to serious mental illness a sheltered and therapeutic environment, and the standards in correctional mental health require the same commitment. Clinicians are required to try their best to provide intensive treatment, including but not limited to medications, and to protect the individual from repeated traumas – all this in the hope of improving his or her condition and prognosis. Conversely, and tragically, if the individual is left untreated or inadequately treated in a situation that is extremely stressful and traumatic, the psychosis or depression worsens and the prognosis becomes more grave. (This is an underlying reason for the exclusion from isolated confinement of prisoners who suffer from serious mental illness in many correctional systems.)

If a prisoner suffering from psychosis is left to hallucinate and evolve a fixed delusion in his cell as he suffers harsh prison conditions such as obtain in segregation, and is denied adequate mental health treatment, then his condition is likely to deteriorate further until he reaches the point where he is laughing inappropriately, smearing feces, experiencing bizarre and fixed delusions, and exhibiting other signs of decompensation. Sadly, this is the plight of many prisoners I have met in Michigan DOC facilities.

IX. RECOMMENDATIONS AND DEFENDANTS' REVISED *HADIX* MENTAL HEALTH CARE PLAN

I have reviewed defendants' August 20, 2007 Revised *Hadix* Mental Health Care Plan Submitted Pursuant to the Court's November 13, 2006 and May 4, 2007 Orders. It addresses only RGC and JMF, and not SMT. For the facilities it covers, it discusses PSU rounds in

segregation being assigned to the same psychologist, weekly multidisciplinary case management meetings, the addition of a full licensed supervising psychologist who will supervise mental health staff as well as facilitating collaboration between mental health and medical staff, the addition of two additional psychologists, improvements in on-call psychiatrist coverage, improved rounds in segregation, including non cell-front sessions, placing observation cells outside of segregation units, instituting a policy whereby mental health staff must write orders to initiate observation and a QMHP must do a timely assessment, the QMHP conferring with a psychiatrist and the psychiatrist seeing the patient if he is in observation for over 24 hours, and then every 24 hours, constant one-on-one observation with video cameras being only supplemental, improvements in the timeliness of medication follow-up appointments, and attempts to integrate the functions of PSU and OPMH staff to some extent. An argument is put forth that crisis beds at Huron Valley are adequate for the needs of mental health treatment at *Hadix* facilities, so there is no need for inpatient beds at DWH, and there is discussion of an external Quality Improvement process.

I like most of the changes included in this document. Certainly additional supervisory and clinical staff, better collaboration between mental health and medical staff as well as between PSU and OPMH staff, more non-cell-front interventions, removing observation cells from segregation units, requiring higher level professionals including psychiatrists to follow patients in observation, more one-on-one observation and discontinuing primary reliance on video monitoring during observation, and improving medication management are all very positive steps toward improving the deficiencies I pointed out in my 2003 Cain Declaration, my July 10, 2007 Declaration in *Hadix*, and in this Report. I vehemently disagree with the proposition that the crisis unit at Huron Valley is adequate for mental health treatment purposes

at the *Hadix* facilities. As I have pointed out above, current lengths of stay in observation are excessive, and if there was a crisis intervention unit or psychiatric hospital on-site it would be possible to institute a policy that stays in observation be limited to 24 or 48 hours and then the patient must be transferred to the crisis unit or hospital if he requires further observation or intensive treatment. Obviously the lengths of stays of recent months occurred while the data on occupancy of the CSP at Huron Valley was accruing, so changes at Huron Valley are not remedying the problem of prolonged observation stays at *Hadix* facilities. I cannot comment about the Quality Improvement process until I see more data about its actual operation and effectiveness.

While the changes in defendants' Revised Mental Health Plan are mostly very encouraging, they definitely do not go far enough. They do not touch on the level of under-diagnosing I have described in this report, they don't mention the problem with criteria for admission to the outpatient mental health caseload being set too high, they do not put an end to the practice of cell-front interviews aside from rounds, they do not require that mental health clinicians provide effective psychotherapeutic interventions with prisoners in observation and otherwise in need of mental health treatment, they do not address the problem of insufficient treatment slots for the large number of prisoners with significant mental illness (though the addition of FTE psychologists is a start in that direction), they do not remedy the counter-therapeutic deprivations of the observation cells, they do not touch on the problem of mixing detention, protection and mentally ill prisoners in segregation, and they do not address the problem of *Hadix* facility prisoners being transferred to other institutions and either not receiving the level of care recommended by *Hadix* facility mental health staff or being sent to segregation and recycling between segregation and treatment settings at the other facilities.

While I feel that the changes included in Defendants' Revised Mental Health Plan are definitely positive, they do not go far enough. I will conclude with a list of additional remedies that I believe are minimal requirements if adequate mental health services are to be delivered to prisoners in need in the Michigan DOC:

1. The mental health assessments in Reception must be upgraded. At a minimum, past psychiatric records must be sought for prisoners with known psychiatric histories, an entire lifetime of psychiatric morbidity and disability must be examined rather than limiting assessment to current symptoms, more neuropsychological assessments must be performed for 'closed head injuries' and other conditions known to be pervasive among prisoners, face-to-face assessment interviews must be conducted with a greater proportion of entering prisoners, there must be no delays or discontinuities in the prescribing of psychiatric medications that were taken by the entering prisoner prior to incarceration, prisoners must not be dissuaded from seeking mental health treatment because of stigma related to parole hearings or placement in institutions, and sufficient time must be spent by the assessing clinician with each entering prisoner to establish rapport and determine the prisoner's actual mental health status. Of course, these changes will require more staff time, and therefore additional staff will be required.

2. The pervasive under-diagnosis that I discussed in this and previous reports must be addressed and corrected. This is an issue of clinical supervision and peer review. It is simply not permissible to down-grade diagnoses so that mental health services are unnecessary. There are many ways to effect better policies, better clinical supervision, adequate peer review, utilization review and other measures to insure that proper diagnostic procedures will be in place.

3. While it is encouraging that a Psychologist Supervisor and two other Psychologist positions are proposed in the Revised Mental Health Plan, many additional staff will be needed

to enhance mental health assessment and treatment programs within the Hadix facilities. The new positions must be new – *i.e.*, the proposed staff must not be transferred from existing positions without filling those other positions – otherwise there would be no net gain. And other staff positions must be created, budgeted and filled, so that the under-diagnosing and lack of adequate mental health treatment can be ameliorated.

4. A greater percentage of the MDOC prisoner population must be delivered mental health treatment. The current percent on the mental health caseload is approximately 6%. According to all statistical analyses I am aware of, that percentage will have be increased by at least double if the prisoners in need of mental health treatment are to be served. That means many more staff will be needed. Also, the new staff must be qualified – there must be sufficient numbers of licensed psychologists and psychiatrists among them to provide competent professional services.

5. Treatment modalities offered at the *Hadix* facilities must be expanded. The Revised Mental Health Plan mentions group psychotherapy. That would be an important addition. Also, more intensive (*i.e.*, more frequent sessions, longer sessions, etc.) individual psychotherapy must be available when indicated. Again, this will require additional staff.

6. There needs to be serious upgrading of suicide observation and crisis intervention. I believe that a crisis unit or psychiatric hospital is needed on site, because there is simply too much delay in transferring suicidal and psychotic prisoners from observation to Huron Valley. When a prisoner is in a suicidal or psychotic crisis, he needs intensive treatment, and should not be severely deprived in a bare observation cell. It is a very important advance that the observation cells in segregation units will no longer be utilized for that purpose, and that the new "hard cells" at DWH will be utilized. But there are very few observation cells located in non-

segregation settings, and there are not sufficient cells at DWH for crisis treatment at all *Hadix* facilities. Further, my concern about the cells at DWH is that there is no longer a psychiatric inpatient unit at DWH. That means that the prisoners in observation will have no psychiatric treatment program they can join. A suicidal crisis needs to be managed by staff who spend a lot of time encouraging the suicidal prisoner to talk about what drove him to despair, and there need to be group and milieu therapies for the prisoner-in-crisis. These are simply not available at DWH, and this is part of the reason I believe a crisis unit or psychiatric inpatient unit is needed inside the *Hadix* facilities.

7. There need to be rigorous peer review and utilization review systems, where discontinuities in medication prescribing, under-diagnosing of mental illness, unacceptable delays in seeing a mental health provider, lack of on call psychiatrists and so forth can be addressed.

8. The "bar must be lowered" in terms of which prisoners are eligible for outpatient mental health treatment. A GAF of 60 is the wrong criterion. The aim needs to be to make treatment available to prisoners in need. Sometimes a prisoner with Posttraumatic stress disorder should see a clinician on an urgent basis, but if criteria for acceptance into the outpatient guideline are too stringent or too rigid, for example if his GAF is not low enough, he will not receive needed care. This problem must be addressed with new criteria and more available services.

9. There need to be clear policies regarding mental health staff involvement in the disciplinary process aimed at avoiding the confinement of prisoners with significant mental illness in segregation.

10. All the provisions of defendants' Revised Mental Health Plan and my Recommendations in this Report need to be applied at SMT.

11. I should mention one other point that came up during my July tour of *Hadix* facilities. If the MDOC is considering a contract with a private agency to supply mental health services, as Mr. Govorchin indicated during my tour, I should note that there have been experiences with CMS, the private contractor for medical services, and PharmaCorr, the private contractor for pharmacy services, that ran into serious problems, as pointed out repeatedly by the Office of the Independent Medical Monitor. In Plaintiff's Brief in Opposition to Defendants' Motion to Approve Transfer Plans, pp. 20-30, there is a summary of events in the contract relationship between MDOC and CMS, and MDOC and PharmaCorr, and this rather troubling history causes me to have concerns about any future contract with a private agency to supply mental health services within the MDOC. Supervision is key, no contract can be effective and provide adequate services in the absence of very expert and rigorous supervision of the contracts, and this is an area where MDOC's track record is very poor. My concern is that since there were big problems in the contract arrangements with CMS (medical services) and PharmaCorr (pharmacy services), these problems must be addressed carefully, and with monitoring, if a contract arrangement is launched for mental health services. Key issues are transition – there need to be no disruptions in services during the transition to a contract arrangement – and supervision – there needs to be adequate quality assurance and utilization review so that the contract agency is held accountable on an ongoing basis by the MDOC.

Respectfully submitted,

Dated: August 23, 2007

Terry A. Kupers, M.D., M.S.P.

Exhibit A

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN

EVERETT HADIX, *et al.*,)
)
Plaintiffs,)
) Case No. 4:92-CV-110
v.)
) Honorable Robert J. Jonker
PATRICIA CARUSO, *et al.*,)
)
Defendants.)
_______________________________)

DECLARATION OF TERRY A. KUPERS, M.D.

Terry A. Kupers, M.D., M.S.P., pursuant to 28 U.S.C. § 1746, hereby makes the following declaration under penalty of perjury:

1. I am Institute Professor in the Graduate School of Psychology of the Wright Institute in Berkeley and maintain a clinical practice in Oakland, California. I am a Diplomate of the American Board of Psychiatry & Neurology (Psychiatry, 1974, for life). My *curriculum vitae* is in Attachment A.

2. My experience evaluating prisoner mental health in Michigan prisons began in February 1982, when I spent five days touring the three largest Michigan prisons, the State Prison of Southern Michigan (SPSM) in Jackson, the Michigan Reformatory (MR) in Ionia, and the Marquette Branch Prison (MBP) in Marquette, as an expert in psychiatry for the United States Department of Justice investigation into Michigan prisons that led to the filing of *USA v Michigan*.[1]

3. Since then, I have periodically conducted other inquiries and reported findings related to prisoner mental health care in Michigan in various litigation listed in my

[1] Case No. G84-63CA, Judge Richard Alan Enslen in the U.S. District Court for the Western District of Michigan.

curriculum vitae, Attachment A: For example, in 1997 I conducted research, including an analysis of questionnaires I designed that were filled out by 461 male Michigan prisoners.[2] From 1998 through 2002 I toured several additional Michigan prisons, including Scott Correctional Institution (including its Residential Treatment Program) and Western Wayne Correctional Facility.[3] In May 2002, I toured Standish Correctional Facility and Ionia Maximum Correctional Facility.[4] On each site visit, I interviewed numerous prisoners and staff members.

4. In 2003 I again toured several Michigan prisons and reported[5] the following findings:

a. There is a marked tendency to under-diagnose mental illness in the Michigan DOC and to dismiss prisoners' symptoms and concerns as "manipulation" or "malingering."[6]

b. Even treatment that is ordered by the court or recommended during the intake process at RGC, such as sexual offender group therapy and assaultive offender group therapy, is denied to a significant proportion of prisoners or denied until he nears completion of his term, and these mandated treatments are not available in segregation.

c. There is a failure to adequately consider mental health issues in the disciplinary process.

d. There is a failure to develop an adequate treatment plan for prisoners who are both disturbed *(i.e.*, suffer from mental illness) and disruptive (*i.e.*, break rules and assault others), these are the prisoners most likely to be un-diagnosed (declared to suffer from no mental illness) and/or classified to segregation.

e. There is a pattern of repeated recycling from isolated confinement to treatment setting and back to isolated confinement.

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[2] In *Cain et al. v. Michigan Department of Corrections*), Court of Claims Nos. 88-699-AC, 93-14975-CM, 96-16341-CM Ingham County Circuit Court.

[3] In *Nunn v. MDOC,* No. 96-cv-71416-DT, E.D. Mich, *Bazzetta v. MDOC*, No. 95-cv-73540-DT, E.D. Mich, *Everson v. MDOC,* No. 00 cv-73133-DT, E.D. Mich, and *Neal v. MDOC, No. 96-6986-CZ,* 22nd Judicial Circuit (Washtenaw County).

[4] *Cain v. MDOC*.

[5] In *Cain v. MDOC*. My 2003 report also referred to herein as my 2003 *Cain* Report.

[6] Malingering is the exaggeration or feigning of symptoms for secondary gain, for example placement in a less harsh environment or gaining advantage in court.

f. There is a punitive and counter-therapeutic approach to suicide prevention.

g. There is no safe and therapeutic setting for long-term maintenance of prisoners with serious mental illness who do not need acute psychiatric care, but cannot cope in general population and are prone to breakdown in segregation.

h. Many prisoners suffering from serious mental illness are consigned to isolated confinement, including Detention and Administrative Segregation, where they do not receive adequate mental health care and their condition deteriorates.

i. Cell-front interviews are very problematic, and thus screening for mental illness and monitoring and treatment of prisoners with mental illness in isolated confinement are inadequate.

j. Prisoners with mental illness, mental retardation or brain disorders are not able to achieve a reduction of their classification level because they are at a huge disadvantage in trying to accomplish the requirements for a downward shift of level.

k. There are not adequate treatment and rehabilitation programs for prisoners with mental retardation, organic brain disorders or developmental disabilities, especially if they also suffer co-morbidly from another serious mental illness.

l. Prisoners are not adequately evaluated for substance abuse and “dual diagnosis,” and do not receive adequate substance abuse treatment.

m. There are insufficient slots in mental health treatment programs at all levels of classification and treatment needs to handle the large number of prisoners with serious mental illness.

n. There are insufficient staff and programs to meet the needs of prisoners with serious mental illness, mental retardation and brain disorders.

5. In July 2007, I toured the *Hadix* facilities: the Charles Egeler Reception and Guidance Center (RGC) (including Reception, the Duane Waters Health Center (DWH) and C-Unit), the Southern Michigan Correctional Facility (JMF), and the Parnall Facility (SMT). At each facility I spoke with staff from Psychological Services (PSU) and Outpatient Mental Health (OPMH), plus other staff as I toured the facilities. I interviewed 37 prisoners in private settings and reviewed most of their clinical charts. In addition, I have reviewed many of the recent discovery items in *Hadix*, policies for

medical and mental health services, responses to interrogatories, reports from the Office of the Independent Medical Monitor, and other relevant documents.

6. Based upon my experience with the Michigan system, I have made the findings in the paragraphs that follow regarding the mental health care of the prisoners in *Hadix* facilities, as well as *Hadix* prisoners who are transferred to non-*Hadix* facilities.

a. Psychological Assessment in Reception is quite problematic. Some positive developments have accrued since my 2003 findings. For example, the non-private cubicles where psychological assessments were previously conducted have been replaced by actual offices where confidentiality is possible. Also, prisoners entering the system on psychiatric medications are not assessed by PSU staff prior to their referral to OPMH staff. Now they are referred directly to the psychiatrist for medication evaluation. It seems that in the days prior to our tour, the waiting time to see the psychiatrist was quite short in these cases. But then when I interviewed prisoners in other *Hadix* facilities (including JMF and SMT) who had passed through Reception as recently as months earlier, they told me that there were long delays before they saw a psychiatrist in Reception. According to the Chief Psychologist, past psychiatric records are typically not sought. The standard in this regard does not require the DOC or OPMH to seek records for all entering prisoners. Rather, when a prisoner is known to suffer from a serious mental illness by history, or is known to have attempted self-harm in the past, then a reasonable effort must be made to acquire his past psychiatric records. Lacking such records, the psychological staff in Reception administer psychological tests for all prisoners, but conduct complete face-to-face examinations with only approximately one-third of entering prisoners. The Chief Psychologist avers that the clinicians are only

looking for present symptomatology. The problem with this approach is that most serious mental illnesses, including Schizophrenia, Bipolar Disorder and Major Depressive Disorder, pursue a waxing and waning course over a lifetime. They may be in remission at the time a prisoner is received at RGC. But subsequently, due to the waxing and waning course of the mental illness and/or due to the expectable stresses and traumas of daily life in prison, these prisoners are likely to experience exacerbations of their serious mental disorder. But once the PSU assessment is done and the prisoner is deemed not to require mental health treatment ("TNR", treatment not required, is written on their charts), that prisoner is left to his own devices and is at high risk of victimization by other prisoners, consignment to punitive segregation or severe deterioration of his condition.

b. There is a consistent pattern of "under-diagnosing." By that I mean that prisoners suffering from serious mental illness have their diagnoses downgraded inappropriately to a less severe illness or no mental illness at all, and on many occasions have their treatment discontinued.[7] National statistics reflect that a very large proportion of prisoners suffer from mental illness that requires treatment, but in stark contrast to those statistics, far too few prisoners in *Hadix* facilities are on the mental health caseload.

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[7] There are many forms of under-diagnosing. For example, admission to the OPMH caseload requires an Axis I diagnosis (a format in the Diagnostic and Statistical Manual, 4th Edition, of the American Psychiatric Association) that reflects serious mental illness. If a clinician decides that a prisoner who had previously been diagnosed with Schizophrenia or Bipolar Disorder, both of which are serious mental illnesses that pursue a waxing and waning course over a lifetime, is now merely suffering from an "Adjustment Disorder," or suffers from no Axis I condition, but rather has Antisocial Personality Disorder (which is recorded on Axis II), then that prisoner is not going to meet the criteria for enrollment in the mental health caseload.

I have found during my tours of the *Hadix* facilities the following widespread patterns of under-diagnosing:

(1). In Reception, individuals who have documented past history of Schizophrenia, Bipolar Disorder or Major Depressive Disorder 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.

(2). Prisoners who report during their Reception evaluation that they have a history of mental illness, and prisoners who have been taking psychiatric medications, verified on their jail transfer documents, are advised by mental health staff not to seek mental health treatment because such treatment might adversely affect parole proceedings or adversely affect their institutional assignment. Then, mental health staff report on the chart that the prisoner suffers from a minor emotional condition and does not wish to participate in mental health treatment.

(3). Very little in the way of neuropsychological assessment and neurological examination is done. This is problematic because problems related to "closed head injuries" and other causes of organic brain disorders, which are very prevalent among a population of prisoners, are consequently under-diagnosed. Prisoners with organic brain disorders are prone to inappropriate behavior, but because no testing was done they are usually left to shift for themselves with no mental health intervention, and then they run afoul of the disciplinary system and frequently end up in some form of punitive segregation.

(4). Outside of Reception, many prisoners I encountered are diagnosed with a primary condition such as "substance abuse disorder" or "adjustment disorder" – relatively minor mental illnesses – even though they have a history of repeated psychiatric hospitalizations, past diagnoses of Schizophrenia or equivalent serious mental illnesses, and are prescribed strong psychiatric medications with anti-psychotic, mood stabilizing and antidepressant effects. This makes no sense. Either they suffer from a mental illness that justifies their being prescribed strong and potentially toxic psychiatric medications, or they do not and should not have to undergo the risk of side effects. In many cases, when I noted this discrepancy between diagnoses and medications, the prisoner reported that he had been diagnosed and hospitalized in the past for serious mental illness and suicide attempts, and had been taking the strong psychiatric medications with good effects over many years. In general, when a patient has a positive response to a psychiatric medication that is anti-psychotic or mood stabilizing, this is evidence he suffers from the mental illness that warrants such medications, *i.e.*, a psychotic condition such as Schizophrenia or an affect disorder such as Bipolar Disorder.

(5). In these and other ways, prisoners with a long history of serious mental illness that is known to follow a waxing and waning course over a lifetime are somehow viewed as no longer suffering from the disorder. Then, their medications might be discontinued and they are consigned to "TNR" (treatment not required) or they continue to be prescribed medications that would be effective for a serious mental illness but not a lesser condition such as a personality disorder or substance abuse.

7. It was clear at the time of my 2007 tour that many prisoners had been recently transferred out of *Hadix* facilities, and that the segregation and observation cells were

very much under capacity, and in many cases practically empty. In my 2003 *Cain* Report I discussed the tendency for prisoners suffering from serious mental illness, who are inadequately treated, to find their way into segregation units. There the stresses of isolated confinement worsen their psychiatric disorder or increase the likelihood of their attempting suicide. An astonishing and disproportionate number of successful suicides in prison occur within segregation/detention settings. Nationwide statistics reflect that approximately 50% of successful prison suicides occur among the 6% to 8% of prisoners confined in segregation settings at any given time. Then, in too many cases, when they are noticed to be a danger to themselves, they are transferred to an observation cell until the acute exacerbation of their condition or their suicide risk subsides, and then they are returned to segregation where the stress of isolation once again exacerbates their psychiatric difficulties to the point they are again sent to observation or the hospital. This is the process of "recycling" between segregation and observation (or hospital) and back to segregation. But it is clear that the very individuals with serious mental illness who are prone to this kind of recycling were transferred from the *Hadix* facilities prior to our July tour. When asked about their fate, I was advised by the attorney for the Michigan Department of Corrections that because they had been transferred from the *Hadix* facilities, they are no longer a part of the *Hadix* class. I am concerned lest prisoners with serious mental illness who were part of the *Hadix* class and were under-diagnosed and removed from the mental health caseload in *Hadix* facilities will subsequently be consigned to facilities where their care will fall below the minimal level of care required under the *Hadix* consent decree, and many of them will repeatedly cycle between segregation and observation – *i.e.*, the unacceptable conditions and lack of care I reported

in 2003 and Dr. Robert Walsh reported in 2005 will befall prisoners exiting *Hadix* facilities. In fact, psychological services and outpatient mental health staff were unable to assure me that statewide mental health programming had changed in the interval between my 2003 Report and my 2007 tour. Adding to the cause for concern, I interviewed prisoners currently confined in *Hadix* facilities who have a record of being sent to segregation, then to observation or a mental health treatment unit, and then returned to segregation. Thus it appears that the recycling between segregation and observation status that I reported in 2003 continues and involves prisoners in *Hadix* facilities.

8. During my 2007 visit, staff of the Michigan Department of Corrections Psychological Services Unit (PSU) and Community Health Outpatient Mental Health Services (OPMH) confirmed that there have been no increases in statewide mental health beds since my 2002 visit, which presently total 703 for male prisoners (inpatient, crisis and residential treatment program beds). This is in spite of the fact that the prison population has grown from 48,929 in 2003 to 51,499 at the time of my 2007 tour. The following reduction in available services were also noted:

a. Twenty-two psychiatric inpatient treatment beds have been removed from Duane Waters Hospital (DWH), now the Duane Waters Health Center, at RGC. I agree with Dr. Cohen, the Independent Medical Monitor, that a facility as large as the Jackson Complex needs a psychiatric inpatient unit, as he noted in his letter to the Court on April, 25, 2007 (Dkt. No. 2401).

b. The self-mutilation unit (SMTP) in a non-*Hadix* facility has been closed.

c. There is no longer JCAHO accreditation for either DWH or the facilities at Huron Valley in Ypsilanti, whereas both were accredited as inpatient psychiatric facilities in the past.

d. Huron Valley Center (HVC) has closed as a psychiatric hospital, but there is an approximately equivalent number of inpatient psychiatric beds, lacking JCAHO accreditation, in the male and female facilities at Huron Valley.

9. The fact that statewide acute and subacute psychiatric beds have not increased in number in recent years means that the problems I found when I toured non-*Hadix* facilities in 2002 almost certainly still exist. The loss of JCAHO accreditation for the system's inpatient psychiatric facility (formerly HVC) and the closing of the DWH psychiatric unit reflect a significant downgrading of acute inpatient psychiatric care. Thus, it is my understanding that no significant system-wide changes have been put in place to improve the quality of mental health care I described in my 2003 *Cain* Report, nor to improve on the "recycling" from segregation to observation and back that I discussed in that report. My interviews with prisoners during this tour corroborate that reality. Meanwhile, the statewide prison population has increased by approximately 2,500 prisoners.

10. I discovered many inappropriate discontinuations of psychiatric medications for prisoners with serious mental illness. I discovered cases where psychiatric medications were discontinued abruptly when prisoners entered the system. I discovered cases where prescribed medications were not delivered to the patient for days or weeks at a time, and I discovered cases where prisoners in need of psychiatric medications were persuaded by clinical staff to forego medications and influenced not to seek mental health

treatment. Discontinuation and lack of continuity in the provision of psychiatric medications can have grave effects, ranging from discomfort and insomnia in patients taking mood-stabilizing medications to outright manic episodes in individuals who depend on mood stabilizers to avoid dramatic mood swings. When antidepressant medications are discontinued abruptly or there is a gap in their use for any reason, a depressive episode is likely to evolve, and it may be complicated by suicidal ideation or actions. When anti-psychotic medications are discontinued abruptly, or there are discontinuities in their delivery, the patients are prone to acute exacerbations of psychosis. In other words, discontinuation and discontinuities in medication delivery can have very dire clinical consequences. I discovered numerous cases of discontinuation and discontinuity among the prisoners I interviewed and the charts I reviewed.

11. There are serious problems with regard to the monitoring of psychiatric medications. I discovered long delays before prisoners entering the system at Reception are seen by the psychiatrist and have their medications renewed. In many cases, this means their medications are abruptly discontinued upon admission to DOC and then not prescribed for many days or weeks, if at all. There are unacceptably long delays before a prisoner can see a psychiatrist in other settings, for example SMT or JMF. When a patient suffering from a serious mental illness such as Schizophrenia decides not to continue taking medications, prevailing standards of care require that he be continued on the caseload and seen periodically to assess his psychiatric condition, and also so the psychiatrist can offer him an opportunity to learn more about his illness and treatment and to form a therapeutic relationship with clinical staff. With this ongoing clinical relationship in place, the patient is likely to re-initiate his medication regimen at some

point, or at least the clinician can help him cope and the ongoing relationship will help him remain stable. The way PSU and OPMHS discharge patients from the mental health outpatient caseload when they decide not to take medications is an entirely unacceptable practice. I saw at least one severely disturbed prisoner in segregation who was not prescribed medications and was not being seen by OPMH at all.

12. Observation cells are very problematic. In the RGC and JMF the observation cells are placed within segregation or detention units. The doors to the cells are constructed partially or entirely of solid metal, so direct observation is not possible. But then, there are no staff within sight. The observation cells have video cameras in place, but the cameras are monitored from a screen in the control center, and I passed those control centers several times during my tour and saw no staff members observing the prisoners inside the observation cells. Some prisoners in observation are placed on "one-to-one," meaning a staff member sits outside their cell at all times. I am told by clinical staff that prisoners in the two new observation cells, or "hard cells", at DWH will have constant one-to-one monitoring. But the monitoring staff member is a custody officer, and usually faces away from the prisoner being observed and does not interact very often with the prisoner. Prisoners in observation cells are on an even more restrictive regimen than they would be in a punitive detention cell in segregation. Thus, in most cases, they are naked except for a suicide-resistant gown and blanket, they are not permitted out of their cell to shower or go to recreation, and they are permitted very little in the way of amenities, visits, etc. It is as if they are being punished for expressing suicidal or psychotic ideation. The clinical staff talk to them very little, and then mostly at cell-front, where confidential conversation is not possible because prisoners in neighboring

cells and staff passing by can overhear the conversation. Too often, the distraught prisoner will merely aver that he is no longer suicidal so he can avoid exposing his emotional distress in a non-confidential setting and he can gain exit from the very restrictive observation cell. This is not a therapeutic arrangement at all. Individuals in the midst of a suicidal or psychotic crisis need supervised social interaction and private, confidential contact with clinicians, where it is possible to explore the reasons for the despair that has led them to become suicidal or psychotic. I saw very little opportunity for this kind of therapeutic intervention in observation cells situated within punitive segregation units. Staff tell me that prisoners remain in observation cells only a day or two, and if their crisis is not resolved they are moved to Huron Valley for more intensive treatment. But the one individual who was in an observation cell at RGC during my tour had been there for well over a week; and other prisoners I interviewed told me that they had spent weeks or longer in observation cells at *Hadix* facilities and elsewhere. Finally, in the segregation units where the observation cells are located, there is no communication system between the cells and the control center. For example, in Cell Block 1 at RGC, there is a public address system that permits staff to give orders to prisoners, but there are no buzzers nor speaker boxes in cells that might permit prisoners to beckon staff. This is a concern for all prisoners in segregation cells, but it is especially worrisome for prisoners in observation cells, since they have no way to beckon staff when they believe they are in trouble.

13. I was told by PSU and OPMH staff that when a prisoner/patient on their caseload receives a ticket for a disciplinary infraction, he is usually transferred to Huron Valley for more intensive psychiatric treatment, and the hearing officer usually dismisses

the ticket. If this were the case, it would be a very good practice. But the staff's presentation of the disciplinary system for prisoners with mental illness sharply contrasts with what many of the prisoners I interviewed reported. Many told of receiving disciplinary tickets and serving time in detention/segregation. Some told of going to the intensive treatment units at Huron Valley only to be faced with a term in segregation for tickets after they were released from the treatment program.

14. Prisoners in treatment for medical illnesses tend not to receive timely nor adequate psychiatric consultation and treatment. There seems to be a serious problem of collaboration between medical providers and psychiatric providers. The Independent Medical Monitor has discussed this problem at length, for example in his April 25, 2007 letter to District Judge Richard Enslen. I will not discuss it further here except to say that from a psychiatric perspective, this situation results in serious problems.

15. There are often long delays for appointments to see mental health staff. This is the case in Reception, where prisoners often wait for days or weeks to be evaluated, often having their psychiatric medications discontinued in the meanwhile; it is also the case that prisoners in other units can wait for days or many weeks to see mental health staff after they submit a "kite" requesting mental health care.

16. The division of labor between the PSU and OPMH staff creates many complex deficiencies in the provision of mental health treatment in the *Hadix* facilities. PSU staff do psychological assessments in Reception and are the first responders in psychiatric crises. They also make rounds in segregation units and provide some ongoing mental health treatment. OPMH staff include a psychiatrist. They provide outpatient treatment, including medication management and consultation to medical practitioners.

This dual agency arrangement causes problems. For example, in many cases PSU clinical staff diagnose serious mental illness in a prisoner at Reception, but OPMH staff disagree and adjust the diagnosis downward while recommending TNR (treatment not required). Or, PSU staff see a patient needing an urgent evaluation by a psychiatrist, but the psychiatrist does not see the patient for days or longer. The Independent Medical Monitor has discussed many problems flowing from the dual agency arrangement, including the fact that PSU staff conduct rounds in segregation units but OPMH do not.

17. The mixing of various populations in segregation units is a continuing problem. Prisoners on the OPMH caseload are not supposed to be housed in segregation in *Hadix* facilities. But the reality is that prisoners who have been inappropriately under-diagnosed and consigned to "TNR" are placed in segregation, and I interviewed individuals in this category during my tour. Other prisoners with serious mental illness are sent to other institutions and placed in segregation, often for rule violations that occurred in *Hadix* facilities. There are likely to be very destructive effects when prisoners prone to mental illness are placed in segregation. There are also negative consequences when prisoners in need of protective custody are placed in segregation units that are meant for punitive detention, a scenario that was reported to me by several prisoners in 2007 in the *Hadix* facilities. Protective custody should involve separation of vulnerable prisoners from general population, but should not involve deprivation of activities and amenities. When segregation is utilized as a site for protective custody, prisoners are disinclined to ask for protection. Since many prisoners with serious mental illness, whether or not their illness is diagnosed and treated by mental health staff, are more likely than other subpopulations to seek protective custody, the placement of

protective custody within segregation units has very detrimental effects on them. I have already discussed the problems that arise when observation cells are placed within segregation units.

18. In conclusion, based upon my knowledge and experience, it is my opinion that the mental health care received by seriously mentally ill prisoners at the *Hadix* facilities is inadequate. As pointed out in my findings above, Michigan's prison health care system fails to provide adequate mental health care because of a marked failure of intake staff to properly identify and diagnose mentally ill prisoners, the repeated "recycling" of disturbed and disruptive prisoners between isolated confinement and treatment settings, and the shortage of staff, programs and slots in mental health treatment programs to handle the large mentally ill prisoner population. Furthermore, with respect to mentally ill *Hadix* prisoners who are transferred elsewhere in the state system, it is my opinion that Michigan's prison mental health system is similarly not equipped to treat the needs of these prisoners.

I declare under penalty of perjury that the foregoing is true and correct.

Terry A. Kupers, M.D., M.S.P.

Executed on August 10, 2007