REPORT ON MENTAL HEALTH ISSUES AT *HADIX* FACILITIES

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I. BACKGROUND

I am a Michigan fully Licensed psychologist, retired from the Michigan Department of Corrections (MDOC) in 1999, 22 years of which I served as Administrator/Director of Psychological Services for the Jackson area prisons and its then-JCAHO accredited hospital. In that capacity, I was responsible for overseeing the provision of all psychological services at the *Hadix* and other area prisons. During that time I had overall responsibility for all psychological services at those facilities, including the development, drafting and critical review of related Operating Procedures and Policy Directives. From 1981 through 1999 I consulted with the MDOC's litigation coordinators and assistants on psychological and mental health services relative to the prisoner litigation in *USA v. State of Michigan*[1] and *Hadix, et al. v. Johnson, et al.* My *curriculum vitae* is contained in Attachment A.

In 2002 in connection with another case, *Cain, et al. v. Michigan Department of Corrections,*[2] I toured ten Michigan prisons, including the Southern Michigan Correctional Facility (JMF), and performed psychological evaluations on segregation prisoners who had histories of mental illness but who the MDOC mental health staff had claimed were not mentally ill. I performed follow-up psychological evaluations in 2005 on similarly-situated prisoners in four Northern Michigan prisons following assurances by the MDOC that conditions were

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[1] *USA v. State of Michigan,* Civil Case No. G84-63CA, U.S. District Court, Western District of Michigan.

[2] *Cain v. Michigan Dep't of Corrections*, Court of Claims Nos. 88-699-AC, 93-14975-CM, 96-16341-CM, Ingham County Circuit Court.

significantly improved. The report of my findings on mentally ill prisoners in MDOC segregation units is in Attachment B. I also toured and interviewed staff at the Reception and Guidance Center (RGC) in 2001 and 2003, and evaluated the quality and effectiveness of its intake screening and evaluation programs. Findings from these tours and prisoner evaluations have direct bearing on what can be expected to face *Hadix* prisoners when they are transferred from the class covered Jackson facilities to non-*Hadix* facilities. My report on RGC psychological services is contained in Attachment C.

In preparation for my report in this case, I toured the following *Hadix* facilities July 19 - 20, 23 - 27, 2007: the Charles Egeler Reception Center (RGC), including the "hard observation" rooms in the Duane Waters health center (DWH) and the Chronic Care Building (C-Unit), Southern Michigan Correctional Facility (JMF), and the Parnall Correctional Facility (SMT), specifically A-Unit and the observation cell in 10 Block. I interviewed various staff and prisoners at these units, and reviewed prisoner health record information. I also reviewed an extensive array of mental health care related documents provided by the MDOC in discovery responses, including MDOC and Michigan Department of Community Health (MDCH) Policy Directives, Operating Procedures, Program Statements, Program Admission Criteria, Criteria for Test Battery Screening, Criteria for Referral to the Psychologist, computer lists and printouts, case management meeting minutes, submitted SERAPIS mental health records on 167 prisoners, and other documents.[3] I also personally interviewed and reviewed mental health records on 36

[3] Including those contained in defendants' discovery responses of April 30, 2007 and attachments provided in partial response to plaintiffs' discovery request of June 14, 2007: Attachments 1, 2, 5, 8, 11, 13-17, 22, 23, 25 & 26. As of this date, defendants' have not provided answers to the questions in the plaintiffs' interrogatories sent in June 2007.

Hadix prisoners, and reviewed records on one deceased prisoner.

II. OVERVIEW OF THE MDOC MENTAL HEALTH SERVICES PROGRAM

The MDOC operates a bifurcated system wherein responsibility for mental health services is arbitrarily divided between the MDOC's Psychological Services Units (PSUs) and the MDCH's Corrections Mental Health Program (CMHP). Presented as providing a "continuum of mental health services", these programs in fact allow large numbers of prisoners with serious mental illness (SMI) and major mental disorders (MMD's)[4] to fall between the gaps in this continuum, resulting in their receiving little mental health care beyond being placed in administrative segregation units, very briefly "rounded" twice monthly, and evaluated psychologically with "check-list" reviews at 30 and 90 day intervals. There is little meaningful coordination between the PSU and CMHP staff, and neither appear to significantly coordinate their services with the physicians providing primary medical care. The PSUs are responsible for providing initial psychological evaluations and program recommendations for newly committed male prisoners to the department's RGC, emergency crisis intervention, identification and referral of prisoners with SMIs or MMDs to CMHP staff, group psychotherapy for sex offenders (SOP) and assaultive offenders (AOP), segregation rounds, 30 and 90 day evaluations of segregation prisoners not on CMHP caseloads, parole board pre-release screening evaluations, reduced custody screening evaluations, and have responsibility for evaluations for prisoners charged with major misconducts (disciplinary infractions) suspected of having SMIs or MMDs.

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[4] While definitions have varied, SMI essentially refers to diagnostic categories of disorders more traditionally thought of as mental illness, such as psychoses, severe mood disorders, etc., while MMD is broader and includes some conditions, based on functional level of impairment, that might not traditionally be regarded as mentally ill. SMI is essentially more of a legal concept, while MMR is more clinical and I will use them interchangeably in this report.

These staff, programs and services are managed directly by the MDOC. The CMHP, on the other hand, is charged with the responsibility of evaluating and treating prisoners with SMIs or MMDs on a level of service need continuum beginning with the most intensive level of crisis care in the Crisis Stabilization Program (CSP), then progressing through acute care (AC), or inpatient psychiatric hospital care, rehabilitative treatment in Comprehensive Care Units (CCUs), Residential Treatment Programs (RTPs) and Outpatient Treatment (OTP). These staff, programs and services are operated by the MDCH under a contractual agreement that came about as part of the MDOC's resolution of the mental health portions of the *USA v. Michigan* litigation and was later incorporated into the resolution of the mental health provisions in *Hadix v. Johnson* Consent Decree (a brief history of this division of services and its role in creating the current problems MDOC faces in treating the mentally ill, is presented in the paper contained in Attachment D, pp. 3-5).

III. INTAKE SCREENING: RECEPTION CENTER PROBLEMS

The RGC is responsible for medically and psychologically screening virtually all newly committed male prisoners committed to the MDOC, with the exceptions of prisoners convicted in Michigan's Upper Peninsula, who are intake processed at Marquette Branch Prison (MBP), and some parole violators, who are processed at the Robert Scott Correctional Facility (SCF). I toured and evaluated the program at RGC in 2001, 2003 and most recently in July, 2007. During this most recent visit I, along with plaintiffs' psychiatric expert Terry Kupers, M.D., plaintiffs' attorney Patricia Streeter, and OIMM expert Henry Dlugacz, Ph.D., met with defendants' attorney, A. Peter Govorchin, and the following RGC and MDOC/MDCH managerial staff: PSU's Diane Gartland, Psy.D., CMHP's Jean Simon, RN (for supervisor Craig Crawford, M.A.),

Aleksandra Wilanowski, M.D., and CMHP's Roy Calley, M.A. and Joan Roggenbuck, M.A. (for John Rushbrook, Ph.D.).

During the tour, I was informed by RGC staff that there is close cooperation between PSU and CMHP staff and that the relatively few referrals PSU makes to CMPH that are not accepted for admission are followed by PSU while at the facility. However, these prisoners are typically designated as either "no major mental disorder" (MMD) and/or "treatment not required" (TNR), and it was both unclear as to what being "followed" consisted of, and I could obtain no indication that any further follow-up or treatment would be available once they left RGC. Further, in looking at defendants' own data in its summary of mental health referrals (report no. X78033-01 for November 2006, December 2006, January 2007, February 2007 (Bates pages No. 200957, 200960, 200962, and 200964))[5] (Exhibit E), PSU staff for each of the above months referred between 14.8% - 18% of the RGC intake to CMHP staff for consideration of admission to their outpatient treatment program (OPT), yet CMHP staff only accepted for admission between 15.3% - 21.8% of the PSU referrals, or between 2.2% - 3.2% of the prisoners entering the system. Similar figures hold for state-wide intake if the much smaller intake figures from MBP and SCF figures are included. These figures are far below regional and national figures concerning the prevalence of mental illness in correctional populations[6] and they

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[5] The Bates page numbers referenced in this report come from discovery documents received by plaintiffs from defendants. These referenced pages are included as Attachment E.

[6] U.S. D.O.J. Bureau of Justice Statistics, 1999 Report *Mental Health and Treatment of Inmates and Probationers,* found the rate of prisoner reported treatment for a mental disorder to be 16% nationally; a 2006 BJS study, *Mental Health problems of Prison and Jail inmates* found 55% of male state prisoners report major mental problems, and a 2001 study, *Mental Health Treatment in State Prisoners, 2000,* found 10% of state prisoners receiving psychotropic medications.

overwhelming represent referrals for OPT care, not for inpatient, CSP or RTP placement. Thus, in RGC, there appear to be two aspects of this problem identified here: PSU is picking up a significant number of prisoners exhibiting active indications of MMD (although even these figures are lower than regional and national data, and do not appear to reflect prisoners who are in prodromal, residual or in states of remission at the time of entry into the system), and the CMHP staff, however, are denying admission to the overwhelming majority of these referrals. Failure of the two programs to effectively communicate with each other and to coordinate services results in a pattern of prisoners with significant MMD not being identified nor treated in RGC.

A second problem I found in RGC that contributes to above failure to identify and treat prisoners with MMDs concerns the PSU's failure and refusal to obtain copies of prior community mental health treatment records on prisoners reporting such histories. The practice of routinely requesting such records was in effect at least between 12/74 - 6/99 (when I retired), was very effective in documenting prior diagnoses and treatment, and almost all prisoners asked during their interview readily signed release authorization forms. Once the records were received, the RGC psychologist requesting them would review them and forward them to the facility to which the prisoner had transferred. If there was any indication in these records of emergent or urgent attention being needed, the psychologist would immediate telephone mental health staff at the receiving facility and FAX the information. Without these records there is no verification of the prisoners prior MMD, and if he was asymptomatic at intake, then there is a high probability that his condition will be missed by RGC screening staff. The outcome of this failure, as I found in my 2002 and 2005 statewide evaluations of segregation prisoners, is that the stresses of

incarceration will eventually cause the person's condition to exacerbate and he will have increasing trouble following rules and coping with the prison environment. He more than likely will be viewed as a antisocial personality and his behavior as wilful disobedience, and he will end up in segregation as a "management problem." Requests for mental health treatment by such prisoners is often viewed as malingering and manipulation aimed at getting out of segregation. Some of the adverse consequences of such failure to obtain past treatment records are illustrated by the following prisoners I interviewed: Cases W02, W21, W23, W24, W26, W27, W28, and W29 .

During the tour and interviews I found repeated reference to RGC "fast-tracking" prisoners through the RGC screening and evaluation process, and I was told that the goal is to reduce it from an average of approximately 21 days down to 5 days so that they are "pushed" through the process as fast as possible. As a consequence of this emphasis, many special needs prisoners actually by-pass the standard RGC psychological test battery used for mental health screening. Specifically, I was told that RGC prisoners with serious medical problems that are sent to DWH for treatment as well as those with apparent behavioral problems that go to the RGC Special Management Housing Unit or SMHU (basically, administrative segregation), typically bypass this testing and are often classified directly to receiving facilities, yet these are some of the very people for whom the system potentially needs to have screening and baseline data. My belief that the RGC screening process is failing to identify a large number of prisoners with MMDs is supported by my findings in my *Cain* case evaluations, where as many as 60% of the men in segregation I found to have MMDs were not identified in RGC, and the majority of these had, at some point after leaving RGC, been later diagnosed by receiving facility staff

(only to later be undiagnosed) as mentally ill/MMD. Most, if not all such prisoners were transferred out of JMF's segregation prior our arrival.

To be clear, I am referring to undiagnosing as the practice of eliminating a previously well established diagnosis of a mental illness or an MMD and changing it to either no diagnosis on that Axis[7] or attributing all the patient's signs and symptoms to a "lesser," co-morbid condition such as drug abuse/dependence, antisocial behavior, or a personality disorder. Underdiagnosis on the other hand, occurs when signs and symptoms of a MMD are either initially missed entirely or ignored and instead of diagnosing an MMD, another, less serious condition is diagnosed. When there is comorbidity the secondary condition is typically chosen. When there is either no co-morbidity, and an alternative, lesser diagnosis is made without adequate documentation, underdiagnosis becomes mis-diagnosis.

Typically, I have found cases of underdiagnosis and mis-diagnosis to be more common in RGC than undiagnosing, which I have found to be more prevalent in JMF and other receiving facilities. The problem seems associated with failure to recognize that most SMIs/ MMDs, such as many of the psychoses, major mood disorders and some major anxiety disorders, are life-long conditions that are rarely ever "cured," but which, with adequate treatment, can go into periods of significant remission. However, the experience of major life changes, sudden emotional trauma or significant prolonged stress such as occurs in prison, can and often does exacerbate the

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[7] DSM-IV, *the Diagnostic and Statistical Manual of Mental Disorders, fourth edition,* classifies mental disorders on 5 Axes, or information domains. Axis I is for Clinical disorders other than Personality disorders or Mental Retardation, which are recorded on Axis II. Axis III is for Medical conditions, Axis IV is for Psychosocial/Environmental problems affecting the person/disorder, and Axis V is a scale for the Clinician's judgment of the persons level of functioning.

condition sufficiently that it re-emerges from its dormancy. Improper diagnostic behavior also appears to occur frequently in prisoners who have co-existing personality disorders, which unfortunately is very common in prison populations. When such prisoners are not responsive to current treatment interventions, and their behavior is disruptive or even assaultive, prison mental health staff too often attribute the behavior to the personality disorder, undiagnose the mental illness, label the prisoner a malingerer, and relegate responsibility to custody staff and administrative segregation (AS). The fact is that it is virtually impossible and a psychological fallacy to attribute the behavior exclusively to either condition alone, when in reality it is probably related to both conditions and is treatable. Examples of undiagnosing and/or underdiagnosing in the *Hadix* facilities were found in the following interviewed prisoners: Case Numbers: W01, W04, W07, W19, W27, and W28.

This emphasis on "fast-tracking" in RGC is also related to the loosening-up of the psychological test screening portion of the criteria used for referral of prisoners to a psychologist for evaluation. I originally developed these criteria for RGC in 1983, and revised it 11/18/92 to help reduce what was then believed to be too high a rate of over-referral (i.e., false positives) assumed to be occurring by an outside consultant. This was done to shift resources to provide more staff to treat identified mentally ill prisoners at a time the MDOC did not want to budget and recruit additional mental health staff. The original screening criteria identified 25-35% of the intake population as reasonably "safe" to bypass psychological evaluations in the sense that the false negative rates were low enough as to minimize the probability of missing people with MMDs, The 1992 revised criteria pushed this further and while reducing the false positive rate, increased the false negatives, who, if later suspected of MMD, were referred for psychological

evaluation before leaving RGC.[8] The current "criteria for referral to the psychologist" (*see* Bates pages 200192-200198) (Exhibit E) has further adjusted the testing scores/findings cutoff to exclude more people from undergoing full psychological evaluation, and this appears to be contributing to an even higher false negative rate, resulting in more prisoners with MMD not being identified or referred for treatment.

I had previously reported that we found that providing 2/3's of the prisoner intake with full psychological evaluations seemed the optimal level for minimizing the number of prisoners incorrectly identified as non-MMD. I believe the current criteria and application of them, which according to the defendants (Bates page 200186) (Attachment E) results in only 1/3 being referred for full psychological evaluation, is partly responsible for too many prisoners either in a state of remission, a prodromal or a residual phase of a MMD being missed in RGC altogether, and ending up in long term segregation as I found happening in my 2002 and 2005 evaluations in the *Cain* case. State statute (P.A. 1953, No. 232, Sec. 67, amended as P.A. 1960, No. 103, Sec. 1) and Administrative Rule 791.267 require "physical and psychiatric examinations" on all prisoners arriving at reception centers. The consent decree entered into in this case (*Hadix, et al. v Johnson, et al.*) gives some leeway in the screening by stating "this includes, in addition to testing, a personal interview by a licensed professional staff with those inmates whose offense, test results or behavioral history indicates a need for further screening." However, the current RGC practice amounts to substituting the testing in place of an actual full psychological evaluation on approximately 2/3's of incoming RGC prisoners, which is a very long way from

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[8] Described in Walsh, R.R. (1992) *Revised Criteria for Screening Psychological Test files of Incoming Prisoners in the Reception and Guidance Center,* Michigan Department of Corrections, Reception and Guidance Center.

my understanding of the intent of this screening requirement the MDOC agreed to when I worked for them.

It also is not appropriate to substitute psychological tests, no matter how well designed, for the face-to-face psychological evaluation. It is interesting to note that these changes in screening criteria for psychological evaluations took place not too long after the mental health provisions of the Consent Decree were terminated.[9] The state statute and administrative rule governing the creation of the reception centers recognized the importance of allowing for a comprehensive study of new prisoners by allowing up to 60 days to complete such evaluations, that has been systematically diluted to a Level I believe that actually jeopardizes the health and safety of prisoners. Quite often for many prisoners with MMD who were unable to get mental health care in the community, the RGC testing and psychological evaluation are the only baseline mental health data we will have to compare changes in functioning later that may occur as a consequence of the stresses of incarceration.

A disturbingly large proportion of prisoners I interviewed in July 2007 reported to me that they had been actively discouraged from accepting psychotropic drugs and even admission to the mental health caseload, primarily by CMHP staff who told them if they did so it would negatively effect their placement and probably even their chances for parole because the parole board would think them unsafe for release. Most of these men also told me that based on this information, they declined medication and OPT admission. Some of these men also reported that opinion was substantiated by other prisoners and non-mental health staff they spoke to, indicating a pervasive, anti-therapeutic belief in RGC shared by many. I was informed that

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5 *Hadix v. Johnson,* Order, 01/08/01 (Dkt. No. 1436).

being on psychotropic medication did restrict some placement of prisoners, primarily with regard to community program eligibility. the point is that whether or not true, it is improper to discourage prisoners in need of mental health services from accepting these services, and if true, then MDOC and MDCH need to correct this practice. I found examples of this in the following prisoners: Case Numbers W33, W34, and W35.

There are very limited program options in the MDOC for prisoners with serious social skills deficits to receive treatment unless they are developmentally disabled and have non-violent histories. The Social Skills Development Unit (SSDU), located at a non-Hadix facility, will not accept prisoners with such deficits if they have come about as a consequence of cerebral disease, closed head injury (CHI) or other form of traumatic brain injury (TBI). These prisoners often suffer some form of frontal lobe impairment and are often quite responsive to brain injury rehabilitation programs. Without such programming, such prisoners have an increased risk of experiencing serious adjustment problems during incarceration, including impaired ability to cope with rules and regulations, and they have an increased likelihood of ending up in segregation. During my *Cain* case evaluation of prisoners in segregation units around the state, I found very high reported rates of CHIs among these prisoners, reaching as high as 50% in my 2005 follow-up sample. I found examples of this among the following prisoners I interviewed in the *Hadix* facilities: Case Numbers W01, W21, W22 and W29.

Related to the above is the disturbing finding that RGC does little, if any, specialty testing or screening for the presence of deficits associated with brain impairment, so it is difficult to ascertain the actual magnitude of the problem. At the time I retired in 1999, RGC was still doing limited neuropsychological testing on prisoners with histories of TBI, utilizing instruments

specific to the suspected deficits, rather than full batteries, although that too was possible if clinically warranted. RGC does include a good general indicator of possible brain impairment in its intake battery, the written portion of the Symbol Digits Modalities Test (SDMT), which is group administered, but still appears to fail to follow-up with the individually administered oral version of that test when the results suggest impairment. This is necessary to validate the written version results and it was still being routinely done in 1999, but had stopped being done when I evaluated RGC screening in 2001 and 2003. This appears to be another unfortunate consequence of "fast-tracking," even though the oral version takes less than several minutes to administer and can yield valuable information about cognitive impairment in multiple modalities. This change seems to have occurred after the mental health portion of the *Hadix* Consent Decree was terminated in early 2001. The result is that many prisoners with impaired brain function will not be identified or provided treatment, and as a consequence will have increased risk of rule violations and placement in long term segregation.

Speciality testing for learning disability, attention deficit disorder, language impairment, mental retardation, impaired adaptive behavior, etc., does not appear to be done with any significant frequency. While the RGC PSU staff interviewed indicated that some such testing was done when needed, they were not able to cite any figures nor criteria for determining which prisoner variables determined who received such testing. In the 2003 review I was told such testing was "optional" on the part of the psychologists, but found that few if any were actually employing that option. During my recent evaluations, I found learning disabled prisoners who had no evidence of having undergone any speciality testing, including case Numbers W05, W10, W11 and W22.

The observation cell in 1 Block South is situated to the East of the officer station and the block showers, so it is not directly observable from the officer's desk area. There is an in-cell, encased camera hooked up to a monitor at the officer's station. When we toured the block I noticed that there was a prisoner in this cell under suicide watch, but when we got down to the officers station, there was no one watching the monitors. We were informed that most prisoners that are placed in these cells are not kept in them very long, that they are seen by OPT psychiatry very soon after placement, and, if needed, they are referred off-site to the CSP or RTP. We were also informed that generally these transfers happen quickly, and it is unusual to have long delays. These prisoners are kept in the observation cell while awaiting transfer, and according to staff, these transfers typically happen quickly, without much delay. I have a problem with this answer because there used to be a 22 bed acute care psychiatric unit in DWH that frequently served this purpose and was often full with prisoners awaiting transfer to the MDOC's licensed inpatient psychiatric hospital (the Huron Valley Center, or HVC, now closed), and recently publicized tragedies involving the deaths of prisoners either in or recently released from observation cells in *Hadix* facilities suggest the opposite.

We toured the new "hardened observation cells" being created to provide a non-segregation alternative to managing disruptive prisoners who previous to this court's order would have been placed in 4-point top-of-bed (TOB) restraints. It was clearly stated to me that these cells were for non-mentally ill prisoners with serious behavior problems who would normally have been placed in TOB restraints, so it is doubtful that this will address the problem of placing mentally ill prisoners in segregation unit observation cells, which is also a state-wide problem. The specific cell shown to me that had its renovations completed actually had an uncaged ceiling

sprinkler head exposed that could easily be used by someone trying to hang himself, which I pointed out to the staff escorting us on the tour. Non-segregation observation cells designed to house mental ill and suicidal prisoners briefly, while awaiting tranfer to CMHP units, still need to be created at these facilities.

IV. PROBLEMS WITH MENTAL HEALTH SERVICES AT THE SOUTHERN MICHIGAN CORRECTIONAL FACILITY (JMF)

I toured JMF and interviewed prisoners at that facility on July 19, 20, 25, and 27, 2007, and along with plaintiffs' psychiatry expert Terry Kupers, M.D. and plaintiffs' attorney, Patricia Streeter, interviewed selected staff on July 25. Also present at the staff interview were defendants' psychiatry expert Lee Rome, M.D., defendants' attorney A. Peter Govorchin, PSU managerial and clinical staff Hampton Walker, Ph.D. and Kevin Tolsma, M.A.; CMHP clinical staff Michaela Weller, M.D. and Frank VanGoethem, M.A. Staff confirmed that all prisoners in segregation that had been receiving psychotropic medication had been earlier transferred out of JMF per order of MDOC Deputy Director Dennis Straub, and that any prisoners in JMF general population on such medications are prohibited from being placed in JMF segregation. There currently are no OPT prisoners in segregation at JMF. The administrative segregation census at the time of these interviews was reported to be 21 men, with 5 of them in the process of transferring out to other facilities, down from a previous count of 94. When we inquired as to where these men were transferred and what services were provided to them, we were informed that since they had been transferred out of the *Hadix* facilities they were no longer part of the *Hadix* class and thus beyond our purview. The prisoner population we were thus left to examine individual cases from, was in fact, whether by design or coincidence, a biased, non-representative sample devoid of the most serious and mentally ill people who had been housed in

JMF prior to our arrival. Thus, it would be expected that most, if not all of this population would have little, if any, indication of MMD or mental illness.

Even with this strongly "sanitized" JMF population to sample from, I still found indications that undiagnosis of previously diagnosed SMI/MMD remains prevalent. Prisoners with well established and documented histories of SMI/MMD appear to be under constant review by some PSU and OPT staff to find them to have been misdiagnosed, instead of concentrating on their treatment needs. For example, Prisoner No. W-01 has a extensively documented history of Schizoaffective disorder, Major Depressive Disorder, Severe, Recurrent, with Psychotic Features and has been treated at most levels of CMHP care, and has been prescribed many different psychotropic drugs in the past. He also has had numerous suicide attempts and many reported incidents of CHI's. When at HVC (now closed) in 1997 some neuropsychological testing was performed and strong indication of cerebral impairment was reported. His OPT considers his current diagnosis of Bipolar Disorder, NOS incorrect, and it has been "under review" for months since his return to prison, as reflected repeatedly in his records, which openly doubt that he ever had an Axis I diagnosis other than Polysubstance Abuse. He is also co-morbid for personality disorder and it appears that the OPT wants to eliminate his Axis I diagnosis so that he can be removed from the treatment caseload.

There are no acute care psychiatric beds available in the Jackson area for temporary placement of actively mentally ill prisoners, who, instead must remain in the punishing and anti-therapeutic environment of segregation observation cells until they can be finally accepted and transported to a treatment facility. These current observation cells are actually harsher and more restrictive than regular segregation cells, and have almost universally been described to me by

prisoners who have been in them as extremely punishing, distressful and like being tortured. Contrary to what staff indicated, many prisoners I interviewed here and around the state have told me that they have been left in these cells for very long periods of time, up to as much as three weeks or more. Whether intentional or not, the effect of placing mentally ill men in these cells is that of punishing them for their mental disorder, not treating it. Examples of men I found who have experienced long periods of observation cell confinement include Case Numbers W01, W07, W08, and W09.

I have observed a severe shortcoming in the care provided to people with SMI/MMD in that there appears to be a deficit in treatment access for prisoners who respond fairly well to OPT care. Instead of recognizing the need to continue following these people in maybe reduced contact but active status, they are instead often discharged from the caseload as no longer MI and no longer needing mental health services. There seems to be an almost total blindness to the fact that these typically are lifelong conditions and are not "cured," but rather subject to periods of remission and, when subjected to significant stress, exacerbation of their symptoms.

I was not able to get a clear answer on how self-injurious (SIB) and self-mutilative (SMB) behavior is treated now that the Self-Mutilation Prevention Unit (SMPU) has been closed, other than in RGC where I was told such cases are now treated by their OPT staff. It has been a long standing practice that I have observed in the MDOC for over 30 years for mental health staff to almost universally regard such behavior as volitional and basically defer management responsibility to custody staff with limited assistance from PSU. This is inappropriate and a serious shortcoming that causes harm to people with a MMD that need treatment. There is a considerable body of research indicating that much SIB has specific

neurochemical components and is maintained by the release and binding of dopamine and endogenous opiates to receptors in specific areas of the brain.[10] People kept in highly stressful situations for prolonged periods naturally release large amounts of dopamine triggering a cycle of excessive arousal, release upon SIB, and re-arousal, a pattern I have observed frequently in many prisoners locked up in long term segregation who repeatedly engage in this type of behavior. This cycle can be broken by a combination of selective antidepressant drugs in conjunction with individual psychotherapy, but I have yet to see a PSU or a CMHP protocol reflecting this. The only document I could find among the voluminous pages of discovery documents defendants submitted was an outdate Policy Directive on the now closed SMPU that contained the old, traditional punitive approach couched in pseudo-behavioral psychology language. Even though this type of prisoner would have been moved out of segregation when MDOC started emptying that unit of prisoners, I still was able to find one case of a man who had lived through that repeated cycle, Case Number W10. confining these prisoners in observation cells for long period actually serves to help re-precipitate the SIB rather than help control it.

V. MDOC FACILITY-WIDE MENTAL HEALTH SERVICE PROBLEMS

Most of the more positive changes I have seen in the *Hadix* facilities appear to clearly be related to this court's recent intervention following the tragic deaths of T.S., P.H., and others, as well as the many other findings reported by the OIMM's Robert Cohen, M.D. and by plaintiffs' medical expert, Jerry Walden, M.D. indicating that the very poor quality of mental health

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[10]*See* Schroeder. S.R., Oster-Granite, M.L. & Thompson, T., eds. (2002) *Self-Injurious Behavior: Gene-Brain-Behavior Relationships.* Washington, D.C., American Psychological association, for more detail and references to over 900 studies supporting these findings of the role of physiological and neurochemical mechanisms in this behavior.

services and lack of meaning full cooperation, coordination and consultation between PSU, CMHP and medical staff is having harmful systemic effects. Similar tragic and avoidable deaths of mentally ill prisoners have also occurred in other correctional facilities around the state, including prisons in Ionia and the Upper Peninsula. Specifically at the *Hadix* facilities, there have been cases reported of PSU staff blocking physician access to CMHP psychiatrists, CMHP staff not promptly evaluating and removing very decompensated mentally ill prisoners from segregation observation cells, on-call psychiatrists not answering pages from the ER and excessively delayed transfers of these prisoners out of these punishing observation cells to critically needed inpatient treatment beds. Based on my findings at the *Hadix* facilities and the many non-*Hadix* facilities I have visited, it is clear that these substandard observation cells are actually being used inappropriately as *de facto* mental health beds, and this is extremely harmful to prisoners in suicidal crisis.

The mental health components of dealing with people trying to come to terms with debilitating chronic physical illness and terminal illness is often overlooked by many health care staff, and needs to be addressed because of its extremely harmful effects. It is especially attenuated in prison where the often critical support structure of family and close friends is sharply limited if not outright precluded. The consequences can and do sometimes prove fatal to non-terminal, chronically ill prisoners, and contribute to unnecessary suffering and agony for those who are terminally ill. Through my consultation with Prison Legal Services of Michigan (PLSM) and the American Friends Service Committee (AFSC) in Ann Arbor, I have reviewed records of cases where physically ill prisoners have become so paranoid that they refused life saving medication because they believed staff were trying to poison them with it, while mental

health staff checking on the prisoner failed to see the behavior as being associated with their cognitive deterioration and an emerging MMR needing intervention. This has occurred at several facilities around the state, and at JMF, where at least one such prisoner, P.H., died as a consequence last year. In other cases I have reviewed for PLSM and AFSC, several prisoners died from the consequences of starvation, and the records I reviewed indicated that they were refusing food and water because they believed the guards were poisoning them, yet mental health staff failed to intervene. This is the result of a number of factors converging at once, but it is especially prone to happening in a fragmented, bifurcated mental health care system that needs to be merged into a single entity with clear lines of clinical and administrative authority.

It is also very clear to me that as bad as mental health services have become at the *Hadix* facilities, they are even worse in the prisons I toured and evaluated prisoners at around the state. Clinical supervision of mental health staff in many of these prisons is severely lacking, and department-wide policy directives designed to improve services are not uniformly or fully implemented. The fact that the MDOC has limited many of this necessary litigation-influenced changes in practices harmful to the mental health of *Hadix*-class prisoners to only the *Hadix* facilities, demonstrates its lack of commitment to eliminating harmful practices beyond where it is forced to. This is a particularly ominous change because when I was involved as an employee assisting the department in determining what was necessary and reasonable to agree to in negotiating the mental health provisions of this Consent Decree, there was a willingness to implement such changes system-wide.

VI. DEFENDANTS' REVISED MENTAL HEALTH PLAN

I have reviewed the Mental Health Plan submitted in December 2006 by the defendants in response to this Court's previous findings and orders. I find some important, significant proposed changes that would significantly improve mental health services if they are fully implemented and monitored, as well as some that need further modification.

The defendants' new instructions for PSU staff segregation rounds are a major improvement (Exhibit C to defendants' revised MH plan), and if properly implemented, supervised and Q/A audited, will help reduce the very harmful effects experienced by prisoners confined for long periods in these units. For this to work, however, there will need to be good coordination between PSU, custody and CMHP staff, prisoners significantly decompensating must be moved promptly to secure treatment settings, and transfers to treatment settings must not be blocked or excessively delayed by MDOC administrators. The instructions on what to look for on rounds appear adequate, and if done properly, will take more than the 60 second rounds I found common around the state, not just in the records submitted as Exhibits D and E with the plan. The extremely high risk conditions for people confined in those units does require vigilant daily rounds to insure prisoner harm is minimized. The employment of management plans for prisoners showing early signs of coping problems who are not immediately being transferred from the unit is likewise an important improvement, but these must be individualized and relevant to the findings. I have seen far to many management plans consisting of predominantly or standard,"boiler-plate" type general language that is not very meaningful to specific problems.

The requirement that individual psychological evaluations, when warranted,. be done in a room with auditory privacy, and no longer at the cell door, is a much needed and long overdue

improvement that should help. This should include the required 30 and 90 day evaluations.

With regard to the placement of prisoners needing transfer to CSP or AC units, the placement of these men in observation cells as presently done, remains very troubling. The bureaucratic hurdles and delays awaiting approval can be deadly, as demonstrated clearly by the avoidable and preventable death of prisoner T.S. This is what has to be "fast-tracked," (not RGC processing) with custody administration ability to block it severely curtailed, and the ability of CMHP receiving facility staff to refuse acceptance of the prisoner into the program, totally eliminated. If there is a training issue here, then it to needs to be addressed. If one Qualified Mental Health Professional (QMHP) makes an informed clinical determination that the prisoner needs CSP or AC services, then another QMHP should not be able to override or delay it. This service blocking and delay in service provision is yet another example of the lack of coordination and cooperation that is an inevitable byproduct of a poorly conceived, bifurcated mental health services system that results in harm for too many of its recipients.

Defendants' Mental Health Plan 's proposed weekly case management meetings (their MH plan Attachment A) and the proposed tracking system for following special needs and "at risk" prisoners, also are necessary and important improvement. The early reports/minutes of these meetings looked promising, but later ones appeared censored and devoid of significant content. For this process to work and be effective, the minutes should contain appropriate detail so the effectiveness can be evaluated, mistakes learned from, practices adjusted, and the process improved as needed. I strongly believe that prisoners with prior histories of MMD that may be asymptomatic when they arrive in RGC should be properly identified and included in the list of special needs/at-risk people, because they are precisely a category of prisoner especially

vulnerable to the stresses of AS placement. Properly identified, if and when placed in segregation, it would then be less likely for mental health staff to confuse an exacerbation of their MMD with symptom faking and malingering.

I have concerns about some of the staffing proposals in the defendants' Mental Health Plan, and the on-call psychiatrist coverage needs to have built in supervisory monitoring, as I found at least one case (W06) during my prisoner interviews where the records reveal the on-call psychiatrist failed to answer a page from the ER physician. Further, shuffling psychiatrists across facilities and assigning extra work hours will not solve the work load problems; more psychiatrists need to be hired to cover the actual service needs. Replacing the JCF psychiatrist coverage with a non-psychiatrist detracts from services at that facility, and seems like trying to stop a hemorrhage by applying a band aid. I believe that the MDOC needs to honestly address the true prevalence of people with SMI/MMR in the corrections system, and hire enough QMHPs to properly treat those in need, instead of continuing to rely on its segregation units for auxiliary mental health treatment resources.

VII. SUMMARY AND CONCLUSIONS

Once the MDOC was relieved from court supervision under the mental health portions of the *Hadix* Consent Decree, it appears to have begun a slow but progressive process of cutting back, diluting, modifying and eliminating the mental health services it had previously put in place to eliminate acknowledged constitutional violations, resulting in a significant deterioration of these services to the extent that conditions have once again become harmful to these prisoners.

Specifically, licensed psychiatric beds at DWH were totally eliminated, removing any safety net mentally ill prisoners have while awaiting psychiatric evaluation, resulting in them

having to endure the punitive and anti-therapeutic isolation of segregation observation cells. Even the so-called observation "hard cells" recently created on the 4th floor of DWH will not alleviate this problem, as we were told by staff they are to be used for serious behavioral problems that previously would have been held in 4-point top-of-bed restraints.

RGC intake screening is being further streamlined and "fast-tracked" to move prisoners through the center quicker, and as a result, referral criteria for psychological evaluations have become increasingly restrictive and far fewer prisoners are being referred for full psychological evaluations. This has resulted in more mentally ill prisoners asymptomatic at intake, who are at high risk of deteriorating psychologically under the stresses of the prison environment, being missed and denied access to treatment.

Even under court scrutiny the MDOC still cannot provide proper and adequate mental health care of many prisoners in the *Hadix* facilities, as evidenced by the findings previously discussed.

Most of the conditions and programs in place at the time the mental health portions of the *Hadix* Consent Decree were terminated represented a minimally adequate level of mental health care. This unfortunately was only achievable because of the court supervision, as conditions in the prisons I visited around the state were far worse. While the MDOC did make many of its policy directives, operational procedures and program statements that grew out of this court's involvement in the Consent Decree applicable department-wide, in actual fact their was little or no evidence of meaningful implementation in the non-*Hadix* prisons I visited.

Many of the findings reported in my 2001, 2002, 2003 and 2005 evaluations and reports are still valid today. Conditions in the *Hadix* facilities regarding mental health services are

substandard and in need of improvement, but conditions in non-*Hadix* facilities are even worse. Subsequently, moving *Hadix* prisoners to non-*Hadix* facilities would in all likelihood cause these prisoners greater harm.

It is clear to me that the CMHP psychiatrist is the "gate keeper" with regard to admission to mental health treatment programs, as both MDOC and MDCH intended. The problem is that it is a one-way gate keeper function, designed to control who gets admitted to these programs, with no similar role in evaluating the correctness of decisions by non-psychiatric staff that individual prisoners do not meet program admission criteria. Obviously, the way this is set up, there is far more concern directed towards preventing an occasional non-mentally ill prisoner from gaining program admission, than there is for preventing mentally ill prisoners from being arbitrarily denied admission and left to often end up in segregation. Further, it appears that the OPT psychiatrists have no significant clinical supervision available to them, and thus their admission and non-admission practices vary quite widely, as evidenced in strikingly disparate admission/rejection rates of referrals in RGC and JMF to CMHP services (Bates pages 201089-201193, 207814-207825) (Exhibit E). Related to this is the fact that CMHP psychiatrists do not typically make rounds of prisoners confined to segregation status, nor do they typically enter these units to perform periodic evaluations, such as the 30 day and 90 day ones PSU makes. To be the gatekeeper requires responsibility and oversight at both ends of the admission decision making.

VIII. FINAL RECOMMENDATIONS FOR REDUCING PRISONER HARM ASSOCIATED WITH MENTAL HEALTH SERVICES AT *HADIX* FACILITIES

My final recommendations for reducing prisoner harm associated with mental health

services at *Hadix* facilities are as follows:

1. End the harmful practice by QMHPs of heavily undiagnosing, under-diagnosing and misdiagnosing prisoner mental disorders. It too frequently results in segregation placement and punishment of these men for their illness. This will require closer clinical supervision of all QMHP's specific diagnostic skills training, regular and meaningful Q/A reviews, and significant attitude changes.

2. Totally change the way in which administrative segregation is overused to control and extend punishment to unruly prisoners. Sharply limit the amount of time a person can be kept in AS without mental health evaluation, and implement serious efforts to help prisoners with problem behavior by anger management training and short term psychotherapy. Current practices exacerbate pre-existing mental problems, breakdown non-MMR prisoners, and actually serve to increase rather than diminish misconduct and assaultive behavior.

3. Eliminate the widespread practice of denying treatment to prisoners in mental health crisis by labeling them as malingering or manipulating, and deal with the actual underlying disorders. Recognize that people with SMI/MMRs can and do actually exaggerate their symptoms and manipulate if they feel they are being ignored or dismissed by QMHPs. This too will require better supervisory monitoring, training and attitude change.

4. Stop denying CMHP treatment admissions to prisoners who are severely decompensated on the basis that their condition may be primarily due to a personality disorder. Their condition also is a valid MMD, and can and should be treated, as they are at equal risk of suffering from serious harm by being neglected and excluded from CMHP caseloads. Instead, staff should truly base the decision on the prisoners' actual Global Assessment of Functioning

(GAF) score, recognizing that having to be managed in AS units is an impaired level of functioning. This too, is a significant training issue, because this assessment still has a subjective component to it that can make a critical difference as to whether a very mentally disturbed prisoner is allowed into treatment.

5. End the practice of cell door QMHP interviews and require all mental health evaluations to be done in a room with auditory privacy. If a prisoner appears to be deteriorated and dangerous to move to an interview room with auditory privacy, then he should in all likelihood be admitted to a CSP and transferred out of AS.

6. QMHPs making mental health screening rounds can rely on cell side contact if they spend an adequate amount of time interacting with the prisoners (significantly more than 60 seconds) and have any prisoner showing indication of SMI/MMR moved to a private room for a full psychological evaluation.

7. The MDOC's Suicide Prevention Policy needs to be critically re-examined and updated. Observation Cell use should be sharply limited and people having that degree of risk should be managed by direct, face-to-face observation. As we observed in our tours, the in-cell cameras do not meet this need. A significant number of these cells should also be located outside of segregation and they should not be used as overflow AC beds as they currently are. They also should not be used for prolonged periods while the QMHP tries to decide what to do with these prisoners, as the effects typically are experienced by prisoners kept in them as extremely punishing. In my experience in this system a significant number of AC beds needs to be available in the Jackson complex, and I strongly recommend reinstatement of the 22 inpatient beds in DWH.

8. Prisoners engaging in SIB/SMB should not be kept in observation cells but rather need to be promptly evaluated and admitted to CSP services and properly treated for MMD by psychiatric and psychological treatment intervention.

9. The overuse and reliance by QMHPs on a variety of screening checklists needs to be critically evaluated. I have found many serious abuses of it around the state, suggesting that "streamlining" has gone to far and actual can result in injury to prisoners when their MMD symptoms are missed. At minimum, an individualized, significant narrative should be added and closely monitored by supervisors for quality, with particular emphasis on monitoring the segregation screening forms.

10. All segregation assigned staff (custody and mental health) should be placed on mandatory rotation schedules to help reduce the desensitization to human suffering that occurs in these settings. There is extensive documentation of the dehumanizing effects of incarceration, going back at least to the Stanford Prison Experiments of the 1960s, as well as post-WW II studies of POWs. Anyone who can walk away from the pain and suffering exhibited in the video tape recording of the death of T.S. in a JMF observation cell, and not intervene, clearly, at a minimum, has been working in that setting too long.

11. The Mental Health Services delivery system in the MDOC is badly fragmented and dysfunctional and it adversely affects the health and safety of *Hadix* facility prisoners, as well as non-*Hadix* facility prisoners. In my work with PLSM and AFSC, I have also seem considerable evidence of that happening in the medical care of prisoners as well, further reinforced by what I have reviewed in the reports of the IMM, Dr. Robert Cohen. There is little or no coordination between medical, CMHP and PSU services, with at least three different management and

reporting structures, MDOC, MDCH and CMS (Corrections Medical Services, the private medical contractor). The result is that prisoners suffer and sometimes die unnecessarily. Recruiting and retaining competent, dedicated health care staff has been a unsolved problem throughout my 30+ years of contact and involvement with the MDOC, and it must be addressed. Corrections' almost universal reputation as a punitive, anti-therapeutic force has been a factor frequently reported to me over my 22 years of trying to recruit psychologists and assisting with efforts to recruit psychiatrists, and that will have to change if these problems are to be brought under control. Having seen management by MDOC and privatization fail abysmally, I believe the entire health care delivery needs to be under the independent management of the agency best suited to handling these problems, the MDCH. All services should be under one organizational structure, affording close cooperation and information flow. To soften MDOC's punitive reputation, solve the recruitment problem, and improve the quality of services, formal, accredited internship and residency programs should be established at all major Michigan Universities with medical, psychiatric and clinical psychology doctoral degree programs. DWH and HVC should be reopened as accredited and licenced hospitals where interns and residents can be placed and provide critical care while they are learning. To more broadly deal with the recruitment and retention problem, the state could consider offering student loans to attract health care professionals to corrections, and loan forgiveness for committing to a predetermined number of years working in the prison health care system.

Attachment B

MENTAL HEALTH CARE IN MICHIGAN PRISONS: A FOLLOW-UP LOOK AT CARE IN THE SEGREGATION UNITS[1]

Robert R. Walsh, Ph.D.

2007

[1] A slightly edited version of this paper is to appear as a chapter in an upcoming special report on health care in Michigan Prisons.

The Michigan Department of Corrections (MDOC), along with the Michigan Department of Community Health (MDCH) are jointly responsible for prisoner mental health care, which is managed by MDCH through the Corrections Mental Health Program (CMHP). The MDOC's stated intent[2] is to provide a continuum of care ranging from inpatient acute care to outpatient follow-up services. In addition to the presence of a diagnosis of schizophrenia, bipolar disorder, schizoaffective disorder, major depressive disorder or other psychosis, the CMHP's criteria for mental health care includes a prisoner's satisfying the state Mental Health Code definition of mental illness, or the presence of a serious mental illness associated with significant suicide risk. Under Chapter 4 of the MMHC, mental illness is defined as "a severe disorder of thought or mood that significantly impairs judgement, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." The program statement goes on to state that "Statutory requirements for admission to the CMHP... are less stringent than those typically applied in civil psychiatric settings," and that "these are bold guidelines rather than inflexible rules, so that exceptions can be made as needed to best suit the needs of patient/prisoners and resources of the mental health system." [3]

Unfortunately, MDOC practice often does not follow these criteria, and violations appear to be common-place. We have found that a large number of mentally ill and severely psychologically disturbed prisoners end up placed in MDOC's segregation units and in most cases, are denied mental health treatment. Many of these men had previously been in psychiatric treatment for an MDOC diagnosed, major mental illness, but, following repeated major misconduct, were abruptly undiagnosed and declared to be malingering and suddenly no longer mentally ill. Subsequent placement in administrative segregation without mental health treatment frequently has resulted in their further psychological decompensation, usually manifest in increased assaultiveness, self-mutilation, suicide attempts, bizarre behavior, and more rule violations. In other cases, some at risk but non-mentally ill prisoners placed in long-term segregation as a consequence of management problems, actually appear to have developed major psychological disturbances and became mentally ill as a consequence of their ongoing exposure to these severe conditions of confinement. The end result in both types of cases is increased psychological deterioration followed by further administrative isolation as punishment, which, as we will show, actually increases the assaultiveness and risk of harm to the prisoner and everyone in contact with him.. While MDOC maintains that such indefinite, long term segregation is not punitive but rather administrative and based on security concerns, the effect is virtually universally experienced as punitive and its result serves to undermine security and staff safety.

Background

As expert witnesses and consultants for Prison Legal Services of Michigan (PLSM) in the *Cain, et. al v MDOC* lawsuit, I, along with psychiatrists Terry Kupers, M.D. and Stuart Grassian, M.D., interviewed and evaluated a number of pre-selected prisoners in segregation units in

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[2]MDOC Policy Directive 04.06.180, "Mental Health Services."

[3]DCH Corrections Mental Health Program Admission/discharge Criteria & Guidelines, p.2 (?)

various Michigan Prisons in 2002. Specifically, prisoners in segregation status at Marquette Branch Prison (MBP), Ionia Maximum Correctional Facility (ICF), Standish Maximum Correctional Facility (SMF), Southern Michigan Correctional Facility (JMF), Kinross Correctional Facility (KCF), Alger Maximum Correctional Facility (LMF), Baraga Maximum Correctional Facility (AMF), Chippewa Correctional Facility (URF), Huron Valley Men's Facility (HVM) and the Michigan Youth Facility (MYC) were selected on the basis of either reports or other indicators suggesting that they may be mentally ill. Selection criteria included the following: information submitted by corrections officer staff or other inmates, a previous history of major DSM IV Axis I diagnosis[4] and/or record of prescriptions for major psychotropic medication as indicated in MDOC computer lists, or very disjointed, bizarre-like correspondence. I performed follow-up evaluations on an additional, smaller sample of long-term segregation prisoners in early fall of 2005. Together, these two samples present a picture of the state of prisoner mental health care in Michigan, and reveal a critical gap in services whereby many mentally ill and severely psychologically disturbed prisoners are left to languish for long periods of time in isolation cells designed primarily for punishment.

The underlying reason for conducting these evaluations was the strong stance by the MDOC that, with the possibility of rare, isolated exceptions, no mentally ill prisoners were housed in its segregation units, yet there were indicators that a significant number of such people were in fact being so housed. Specifically, as we initially looked into individual cases brought to our attention, we noticed what appeared to be a very disturbing pattern of prisoners diagnosed as mentally ill and receiving major psychotropic medication, suddenly being "un-diagnosed, and re-labeled as "malingerers" or "antisocial personality disorders." Medications were frequently abruptly discontinued, and many of these prisoners were confined to the isolated status of administrative segregation. A large number of these men appeared to be seriously mentally ill and suffering from a variety of conditions, including psychoses and major affective disorders. It is well established that imprisonment in isolated, solitary type confinement for significant lengths of time can have profoundly destructive psychological effects on otherwise healthy people (Grassian, 1983; Haney, et al., 1973; Kupers, 1997; Toch, 1992; Toch & Adams, 2002), and confining actively mentally ill under these conditions is unusually cruel and barbaric. Similar findings and long-term mental health detrimental effects have been reported in many other jurisdictions utilizing isolation in long-term segregation as an indiscriminate means of control of prisoners (Human Rights Watch, 1997). The corrections department has been aware

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[4]The *Diagnostic and Statistical Manual of Mental Disorders, fourth edition,* classifies mental disorders on 5 axes or domains of information believed helpful to treatment planing and outcome prediction. Axis I is for recording Clinical Disorders other than Personality Disorders and Mental Retardation, which are recorded on Axis II. Axis III is for recording General Medical Conditions, Axis IV for Psychosocial and Environmental Problems affecting the person and disorder(s), and Axis V is a scale for recording the Clinicians judgement of the person's overall level of functioning. While Axis II conditions can be every bit as severe and incapacitating as those on Axis I, most mental health codes, as interpreted by psychiatrists and psychologists, exclude them from legal definitions of mental illness. This practice is especially rampart in the MDOC, despite the Manual specifically cautioning that "The coding of personality disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that of disorders coded on Axis I." (DSM-VI, p.-26). Unfortunately, that is just what many MDOC/DCH mental staff do, and a significant part of the reason so many severely mentally disordered prisoners are excluded from treatment and handled punitively instead.

of the extreme debilitating effects of isolation as early as 1857, when Michigan's first prison began using solitary confinement and found in 1861 that 9 of the 20 men had become "insane."[5]

Undiagnosing these men as no longer mentally ill and rediagnosing them as malingerers with only personality disorders also serves as an excuse for not having to deal with the cost of acknowledging and having to treat much larger numbers of mentally ill prisoners that are confined in our prisons. The MDOC, unfortunately, has steadfastly refused to acknowledge the prevalence and incidence data on mental illness found by an extensive epidemiological study (Neighbors, *et. al*, 1987) of the Michigan prison population. While this study is now dated, it still compares well with current national data on prevalence and incidence of mental illness in correctional populations (*Bureau of Justice Statistics,* 2001). In fact, because mentally ill prisoners in Michigan are more likely to have trouble following rules, receive more major misconducts and spend more time in segregation than non-mentally ill prisoners, they are less likely to be paroled and thus actually accumulate in the prison population, adding to the percentage in the corrections population at any given time. By ignoring and trying to define away these prisoners as non-mentally ill, the MDOC actually undermines the very heart of the CMHP commitment, and call into serious question the very integrity of that program.

To our surprise when we began this undertaking, we found a very large number of potential cases were initially identified by our search of computer records, but the list had to be pared down due to limited resources, court mandated time limits imposed in the *Cain, et al.,* case, and less than complete MDOC cooperation. Identification of potential cases, assistance in structuring the evaluations, and file reviews were provided by Drs. Kupers and Grassian, two nationally recognized authorities on the subject of the effects of segregated confinement on prisoner mental health. Dr. Kupers evaluated, primarily through file reviews, 20 of these pre-screened segregation prisoners. In consultation with Drs. Kupers and Grassian, I conducted face-to-face interviews with 37 prisoners from our lists, and performed file reviews on an additional 10 prisoners, completing written psychological evaluations on 23 of the prisoners he interviewed, and written reports on 2 of the prisoners from file reviews only. Of the remaining 14 prisoners I interviewed, many had incomplete records and appeared to not show significant psychotic-like symptomology in the file material which we were provided by MDOC. In other cases, the MDOC failed to provide mental health and institutional file records in time to allow for the evaluations to be completed within court imposed deadlines. In several instances prisoners identified for evaluations were found to have been transferred to other prisons when we arrived at the facility, and in at least one case at ICF, we were denied access to a prisoner scheduled for evaluation.

As a follow-up, I interviewed and evaluated a second group of long-term segregation prisoners 9/1/05 and 10/11 - 10/14/05 at the request of PLSM to determine if there was any significant improvement in the MDOC's provision of mental health services to these people, when

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[5] Reported in MDOC's "news bulletin for employees, entitled *FYI,* Vol. 14, No. 1, 1/9/03, p.-3. Even with the department-wide dissemination of this information, the MDOC and its mental health and custody staff continue to heavily utilize this barbaric practice which actually causes many people to breakdown and become psychotic in an iatrogenic-like fashion.

compared to our earlier findings. We were also interested in ascertaining whether or not some of the more negligent and inappropriate practices of MDOC/DCH mental health staff, which we had found during our earlier evaluations, had been corrected. Owing to various restrictions on who we could evaluate and what maximum security prisons we were allowed to visit during this follow-up, 4 men were evaluated at the maximum security prison at Standish (SMF), 1 at Marquette (MBP), 2 at Baraga (AMF) and 3 at Alger (LMF).

Description of the Samples and Findings

My 2002 sample consisted of 25 prisoners who were psychologically evaluated, of which 14 were African American, 4 were Hispanic and 7 were White. They ranged in age from 19 - 52 years old. Each of these men were interviewed face-to-face either in a private office in their housing unit or one of various types of visiting areas permitted by the facility. The interviews were conducted in space with auditory, but not visual privacy, as most areas used were glass enclosed. MDOC staff were not present in the rooms during the interviews. The prisoner's often extensive medical and mental health records were extensively reviewed, and allowed cross-validation of prisoner accounts as well as opportunity to fill in missing details in patient histories.

At the time of prisoner interviews, the facility security levels were as follows: 7 were housed in Level VI (so-called "Super-Max"), 10 in Level V (Maximum), 7 in Level IV (Close) and 1 in Level 2 (Minimum). At least 13 had documented, pre-incarceration histories of mental illness (usually psychosis or major mood disorder), and of these, 11 had pre-incarceration histories of having been on anti-psychotic and/or other major psychiatric medication. Another 13 had histories of significant head trauma (CHI, TBI, depressed skull fracture). Review of Reception and Guidance Center (RGC) and Riverside Reception Center (RRC) intake psychological evaluations revealed that MDOC mental health staff missed or failed to identify at least 15 of these men as having histories of mental illness. Only 4 were correctly identified as having a major Axis I disorder (other than substance abuse or adult antisocial behavior), this conclusion supported by our review of later MDOC receiving facility and/or mental health program diagnoses.

At least at one point in their incarceration, MDOC/DCH mental health staff did diagnose these men as follows: 14 with some type of psychosis, 7 with a major mood disorder, 1 with mild mental retardation, and 1 with dementia. Eventually however, they "undiagnosed" 19 of these men. Four were not undiagnosed, and 2 were never diagnosed as having ever had a major mental disorder. Of those who were subsequently undiagnosed by MDOC mental health staff, 13 were labeled as malingers, and 5 were changed to either "No Diagnosis" or "Diagnosis Deferred" on Axis I. Many were also labeled as Antisocial Personality Disorder or Borderline Personality Disorder on Axis II. While some had correctly carried the Axis II personality disorders in addition to their major Axis I conditions from the start, the Axis I diagnosis was subsequently removed and the Axis II focus served as the justification to terminate access to treatment. Interestingly, at least 17 of these undiagnosed men had at one time been prescribed significant dosages of anti-psychotic medications, and 16 had been prescribed other psychoactive

drugs (e.g., mood stabilizers, anti-depressants, etc.) Seventeen of these men had at one time been prescribed drugs from multiple categories, while only 4 appeared never to have been prescribed any psychoactive drugs. Time spent in segregation for this sample ranged from 1 - 120+ months, with an average of approximately 49 months.[6]

My second sample consisted of a follow-up group of 10 men with backgrounds of long term segregation confinement who at the time of interview, were housed in maximum security prisons in northern Michigan. Most of these men were interviewed with auditory privacy, although in several cases, with the prisoner's permission, a records office staff member was present so that we could review the health record during the interview. Custody level was Level V, Administrative Segregation, for all but one of these men, who had been recently released from the segregation unit. Nine of these men were African American and one was White. They ranged in age from 28 to 54 years old, and had spent an average total amount of time housed in segregation of at least 60 months, ranging from 12 - 96+ months.

All ten of the men in the follow-up sample showed substantial evidence of major mental disorder on Axis I, of a chronic or long standing nature. Eight of the men were diagnosable as psychotic, three of which were schizophrenic, two schizoaffective, and two with major affective disorders with psychoses. The remaining two had major affective disorders without psychosis, including one with Bipolar I Disorder and one with Major Depressive Disorder. All appeared to be extremely stressed, anxious and intense in their symptomology. All ten of these men were comorbid for significant personality disorders, nine of which were Antisocial Personality Disorder, sometimes in combination with Borderline Personality Disorder. The rate of closed head injury history was quite high, and documented in at least 50% of the cases evaluated. In addition, three of these men had previously been diagnosed as either mildly mentally retarded or significantly learning disabled. As was the finding in the 2002 sample, most of the prisoners in this sample had at one time previously been diagnosed as mentally ill by MDOC/DCH clinical staff, only to later be un-diagnosed and declared as personality disordered malingerers. Further, at least eight of them had been previously prescribed major anti-psychotic, anti-depressive, mood stabilizer and/or anti-anxiety medication by DCH psychiatrists.

Conclusions and Recommendations

As we were reviewing and abstracting the massive amounts of data we obtained from interviews, evaluations and file reviews on these men, we were alerted to a number of cases of mentally ill prisoners in segregation units who had actually died as a consequence of extreme negligence and apparent indifference to their suffering by prison staff charged with the responsibility for their safety and well being. Two of these men died from dehydration and at least 2 more from starvation, with the cause of death in the other cases stilling awaiting our access to autopsy results. The two men who died from dehydration had, prior to death, been shackled to concrete

[6] These are minimum figures that were based on computer records supplied by the MDOC, going back only to 10/93. Some of these men had been in segregation before then, and in some cases records were incomplete.

slabs in their cells with 4-point restraints in so-called "observation" cells, although one was technically removed to an undesignated cell prior to his death. Based on documents obtained and reported in federal court as well as from litigation discovery by next-of-kin, these truly horrific deaths all appear to have been preventable if these extremely punitive and unnecessary practices had not been used. It also appears that staff, custody and health care, responsible for their safety and well-being, stood by and did nothing substantive to intervene. Most of these were discovered in spite of the MDOC's efforts to report them as deaths due to "natural causes," and what actually happened could have easily gone undisclosed to loved ones. How many more like these have occurred? These add to the urgent need that the recommendations summarized below be implemented as soon as possible, to prevent more such unnecessary and preventable deaths from occurring as a consequence of brutal correctional practices and a badly broken mental and medical health care delivery system. Effective action to overhaul this dysfunctional system is needed, and needed now. While recommendation #11 will require legislative and executive approval, it is our understanding that the other 10 recommendations could be implemented by the Governor and/or the MDOC.

Finding 1: MDOC continues to heavily employ the practice of undiagnosing previously diagnosed mentally ill prisoners as a consequence of their difficult-to-manage behavior. Eighty-four percent of the men in our sample 1 had previously been diagnosed by prison mental health staff as having some form of mental illness, but over 90% of them were later undiagnosed as mentally ill and re-diagnosed as malingerers or antisocial personality disorders. This results in placement of these prisoners in long-term administrative segregation, often with further deterioration in their mental state and exacerbation of their mental illness, denial of critical mental health care, increased risk of self-injury, and increased risk of assaultiveness towards staff. Once in long-term administrative segregation status, the likelihood of further misconduct and behavioral management problems is great, further insuring their continued confinement in isolation. The practice is counterproductive from both a treatment as well as management perspective, and endangers staff as well as the mentally ill prisoner.

Recommendation 1: The practice of undiagnosing a person with a previously established diagnosis should be an isolated occurrence that is severely restricted and subject to critical supervisory/peer review. Every such occurrence must be well documented and the re-diagnosis not used to ignore future behavior that may be due to reoccurrence or emergence of mental illness. A well documented justification for the undiagnosing should be provided with appropriate feedback to the original staff who made the incorrect diagnosis, and if necessary, relevant training provided.

Finding 2: MDOC continues to grossly overuse long-term confinement in the isolated environment of administrative segregation as their only major tool for controlling prisoner behavior, and it is failing, as we encountered too many men with hundreds of major misconducts and 50+ staff assaults who are even more dangerous and assaultive as a result of years in these units. The very practice singularly depended on to reduce or stop staff assaults and reduce major misconduct is actually having the opposite effect and is causing it!

Recommendation 2: The practice of subjecting prisoners to indefinite, long-term confinement in administrative segregation should be discontinued, as it serves no one well because it does little to help the prisoner bring his disruptive behavior under control. In many instances, it actually contributes to further management problems and increases the risk of staff assaults. Prisoners should be confined no longer than minimally necessary to calm them down and bring their behavior back under control, following which they should be transitioned back into general population at an appropriate security level. Placement in administrative segregation should be limited to no more than 14 days duration, at which time weekly joint custody and psychological services in-depth, out-of-cell reviews should be undertaken and well documented. Prisoners who are unable to bring their behavior under adequate self-control within the first 2 weeks of segregation confinement should be closely evaluated for the presence of a significant mental disorder minimally requiring regularly scheduled individual psychotherapy sessions for as long as necessary.

Finding 3: Undiagnosing a prisoner as mentally ill and re-labeling him as a malingerer inevitably results in that label becoming an absolute type of filter through which all future behavior is viewed as manipulation and symptom feigning. It is entirely possible, and actually quite common, for mentally ill prisoners during either periods of partial remission, or as a consequence of the re-emergence of influence from a co-existing personality disorder, to exaggerate and even feign symptoms for secondary gain. The occurrence of even several instances of this should not, in and of itself, be viewed in a vacuum and used to permanently deny that person future treatment.

Recommendation 3: Both a major mental illness and an act of symptom exaggeration or feigning can occur simultaneously in the same person and should never serve as justification to undiagnose a major mental illness and permanently deny the person future treatment. Motivation for the prisoner's behavior should always be carefully examined, and reasons other than simply trying to get more "pleasant" housing, such as a "cry for help," failure of coping mechanisms, high and traumatic stress levels, etc., should be explored. Even if he appears to have escaped the deleterious effects of segregated confinement, those effects on the person's current behavior need to be explored in detail and dealt with constructively, as there can be a delayed reaction to the effects of the experienced trauma.

Finding 4:. The characterization of "manipulation" as a necessary and sufficient reason to deny prisoners access to mental health care continues to be a common practice among MDOC and MDCH mental health staff, who frequently use it as though it was an actual diagnostic condition. Once so labeled, the designation typically sticks with the prisoner for the rest of his incarceration and is used a filter through which to view future behavior that might have otherwise been seen as occurring because of a significant mental disturbance.

Recommendation 4: The characterization "manipulation" is not a valid diagnostic entity and should never be used as such by mental health staff. It rarely adds anything to the diagnostic task at hand and has the unfortunate stigma of automatically excluding all other sources of

explanation. Everyone, including the mental health professional using this label, manipulates, even if it is simply to justify "dumping" the case on to other staff. The fact is that it is not uncommon for mentally ill and seriously disturbed people to also exaggerate their symptoms in an effort to obtain help from a mental health professional who appears not to be taking their condition very seriously. This is especially true in the case of much suicidal behavior, which most of the time does have a manipulative component to it. Most suicidal behavior that is unsuccessful is often a desperate attempt to obtain help, made by a very conflicted and ambivalent person (in the sense of simultaneously wanting to escape an intolerable situation by death, but not really wanting to die) in an acute crisis. Labeling and basically discrediting the behavior (and person) as manipulative and "non-genuine," is inappropriate, and should cease. There appears to be widespread abuse of the personality disorder label on the part of many MDOC/MDCH mental health staff, and an apparent misunderstanding of the interaction between major Axis I or mental illness conditions and Axis II personality disorders. We found it all too common, once the prisoner starts to become hard to manage, to ignore the presence of his mental illness and instead exclusively focus on the personality disorder, using it as an excuse to suddenly deny previously approved treatment. Many, if not most mentally ill prisoners, when adequate history is obtained, can be found to have pre-morbid personality disorders. Sometimes, during an at least partially successful response to treatment, the more negative aspects of the personality disorder can emerge, and may temporarily overshadow the Axis I condition. Clinically, it can be very difficult to sort out and isolate these behavioral effects as purely based on the personality disorder as opposed to being caused by the mental illness, and it is even harder to separate out when the behavior is the result of an interaction effect between the two conditions. When this does happen, it may very well be associated with the frustration experienced by the mental health staff in dealing with this multiple diagnosis situation that is the basis for the "revelation" that the problem is not one of mental illness but instead, simply a personality disorder.

Finding 5: MDOC staff continue to misuse the diagnosis of personality disorder as a reason to undiagnose mental illness and/or misdiagnose it by ignoring the high rate of occurrence of co-morbidity for both in this population. MDOC staff also ignore both the CMHP program statement caution against using only certain Axis I conditions to limit access to treatment, and the DSM-IV warning against misinterpreting Axis II conditions as being of lesser severity and pathogenesis..The result is widespread relegation of severely mentally disordered and mentally ill prisoners to the punitive conditions of segregation and denial of much needed mental health treatment.

Recommendation 5: Many MDOC prisoners, almost by definition, because of their history of youthful maladaptive behavior, have personality disorders, and this applies especially to mentally ill prisoners who often end up in administrative segregation. Prison mental health staff must stop using this as an excuse to deny treatment to previously diagnosed mentally ill prisoners just because they become harder to manage due to the more prominent emergence of characteristics that might be due to a comorbid personality disorder. If the behavior is prominent

and disruptive, the personality disorder can be simultaneously treated with psychotherapy as an adjunct to the pharmaceutical treatment of the mental illness. MDOC should provide specific training to all prison mental health staff in recognizing and therapeutically managing the all too common comorbidity of mentally ill prisoners with significant personality disorders and help break the cycle of "dumping" them on custody in administrative segregation when they become disruptive and hard to manage. This is critical, because most mental health staff hired by corrections come with little if any prior training in correctional mental health care, and tend to develop bad habits early in their employment because the models and concepts learned in school and the community often don't apply very well to prison inmates. Severe personality disorders are major mental disorders that can be as needy of treatment as the Axis I disorders commonly identified with mental illness, and it is inappropriate to treat them otherwise.

Finding 6: In MDOC segregation units, cell-side or cell door "mental health evaluations" continue to be in very widespread and standard use for following up on the mental status of prisoners.. Quite often, prisoners will refrain from talking to the psychologists doing these evaluations in this fashion because there is no privacy and a real danger of being over heard by other prisoners. It is very naive to think this is inconsequential, as personal information in this type of prison environment is both a commodity to be exchanged and a source of potential physical harm to the prisoner making the revelation. It appears from our evaluations that many significant signs and symptoms of mental illness are missed by psychologists doing these superficial "screenings," and thus many problems go unnoticed until they become so pronounced that they are obvious even to non-mental health staff. This practice, although convenient for both custody and mental health staff, is a major flaw in the mental health care service delivery system that undermines the effectiveness of the whole process. The potential violation of patient confidentiality, is, in our opinion, a probable violation of professional ethics and is an inexcusable, unprofessional practice.

Recommendation 6: Immediately cease the practice of conducting any segregation psychological evaluations and/or screenings (including required 30 and 90 day screening) cell-side. Such evaluations must be conducted in the privacy of a room where at least auditory confidentiality can be maintained. Regular housing unit daily or semi-weekly rounds can continue to be made cell-side as long as every effort is made to engage the prisoner in enough non-confidential small talk for the practitioner to believe no major disturbance might be present. If there is any indication that the person may be experiencing significant psychological decompensation, custody should be contacted and asked to escort the prisoner to an enclosed room in the unit where a confidential and more thorough evaluation of the prisoner's condition can be made. The only exceptions should be when the prisoner refuses to leave the cell voluntarily, or where there is a real danger of serious injury to either staff or the prisoner. In such circumstances the clinician should make every effort to determine the reason for the prisoner's behavior, and give serious consideration to a referral for more intensive mental health care.

Finding 7: Our tours of segregation units at the prisons we visited and brief perusal of unit log books suggest that mental health staff making policy-required segregation rounds are actually spending very little time interacting with the prisoners. In fact, it was not uncommon to find that the per-prisoner time spent amounted to an average of one minute or less, hardly sufficient time to ascertain the mental status of prisoners in general population, let alone one subjected to the extreme stresses of isolation in segregation cells.

Recommendation 7: Mental health staff making segregation screening rounds need to allow a bare minimum of 5 minutes per prisoner to be able to get a valid impression of each prisoner's general mental state, and more time if any suggestion of psychological decompensation is suspected. The current practice of most MDOC psychologists providing these rounds appears to be that of spending an average of one minute or less per prisoner, and that is part of the reason many major mental problems go undetected until they reach extreme and sometimes tragic levels.

Finding 8: We found that the manner in which placement of a suicidal or seriously self-injurious prisoner into a so-called "observation" cell or room is actually practiced is extremely punitive and non-therapeutic at best, if not bordering on thinly disguised forms of possible torture. This was found to be especially true of prisoners housed in administrative segregation, who report the conditions they were subjected to in these cells were far more restrictive and punishing than they experienced in their regular administrative segregation cell. We found it all too common to encounter segregation prisoners, some with clear signs of major mental illness, who stated that they would deny and not report suicidal thoughts and preoccupation to staff out of intense fear of being placed in one of these observation cells as a consequence, based on their own past experience. We find it inherently wrong for a suicide prevention policy to recommend such placement when in practice, it actually puts increasingly higher levels of stress and trauma on people already contemplating taking their own lives, and actually punishes them for asking for help.

Recommendation 8: The MDOC's "Suicide Prevention" policy should be critically re-examined and changes made to put more safeguards in place to prevent these practices from occurring. If there is any reason to believe that the behavior is anything but extremely superficial, the person, regardless of segregation status, must be referred to an appropriate treatment unit where he will receive mental health services, not more punitive detention. Further, clinical supervisors should more closely supervise and monitor the behavior and practices of their staff in terms of their use of observation cells as a treatment intervention to avoid its being used punitively. Any prisoner placed in such cells as a result of possible suicidal or self-injurious behavior should automatically be afforded intensive, short-term individual psychotherapy sessions at least several times a week until the crisis is resolved.

Finding 9: We believe that the use of in-cell, top of bed, 4-point restraints by the MDOC to be excessive and initiated more for the convenience of the staff than for the actual protection of the prisoner. It appears to be too common a practice for suicidal and self-injurious prisoners to be placed in a so-called "observation cell" and have their hands and feet shackled to a concrete or

metal "bed" for long hours, when they instead should be transferred to a treatment setting. The relatively recent rash of deaths of mentally ill prisoners undergoing such restraints underscores the need to eliminate this practice except under extremely rare conditions, and then only with onsite direct medical supervision. Prisoners we interviewed who had undergone such "self-protection" measures universally report experiencing these restraints as extremely punishing and torturous. Any prisoner who, in the opinion of MDOC staff, continues to require such restraint after 2 hours, should be immediately seen and evaluated by a physician and considered for transfer to a prison hospital setting.

Recommendation 9: Use of in-cell, top of bed, 4 point restraints should only be used as an absolute last resort, and then only under strict time limits and direct medical authorization and supervision. The restrictions imposed on use of these restraints by the Federal District Court in *Hadix et al. v. Johnson, et al.,*Order and Injunctive Relief filed 11/13/06, should be adopted state- wide in all state correctional facilities.

Finding 10:. We have found that prisoners who engage in self-injurious behavior (SIB) are almost universally treated by MDOC staff punitively and are rarely provided with any meaningful treatment in any of the prisons in which we studied and evaluated them. Self-mutilative behavior (SMB), a subset of SIB is known to have multiple causes and has neurochemical components. Research has demonstrated that much of this behavior is maintained by the release and binding of dopamine and endogenous opiates/opioids, or both, to receptors in the tegmentum and nucleus accumbens (Sandman & Touchette, Thompson, *et al*., 1995). People in highly stressful situations naturally release large amounts of dopamine triggering a cycle of excessive arousal, release, and re-arousal, a pattern we have seen frequently in many people locked up in long term segregation who repeatedly self-mutilate during the arousal state. Research has also demonstrated that some medications that block serotonin reuptake (e.g., the tricyclic anti-depressant Clomipramine, a SSRI and dopamine receptor antagonist) can break the cycle and reduce the SIB/SMB. Administered conjointly with psychotherapy, this behavior can be successfully treated in many people with SIB, bringing the anxiety/panic attacks and high stress levels experienced back under control (Schroeder, *et al*., 2002). This stress, along with isolation, loss of meaningful social contacts and the sleep deprivation/sleep cycle disruption that occurs in segregation serve to act negatively on the seronergic neurons in the brain, triggering and recycling many of these behaviors that correctional mental health staff incorrectly and improperly view and punish as volitional acts of defiance. The initial triggers in most of the cases we see in prison segregation units appear to be environmental, but once started, the behavior is maintained and recycled by neurochemical changes and effective interventions must take that into account.

Recommendation 10: MDOC staff must cease treating SIB/SMB behavior in prisoners as volitional defiance and stop punishing people who, by virtue of the environmentally induced trauma and stress, deteriorate to that level of extreme desperation. Significant staff training in the multiple causes of this behavior is critical, as well as implementing a major change in staff attitudes towards prisoners who engage in SIB/SMB. Treatment must always minimally consider the biochemical as well as psychological and environmental components that trigger

and maintain this behavior and provide appropriate therapeutic interventions that address these factors.

Finding 11: We find that mental health services staff in the MDOC are increasingly relying on checklists and similar forms as replacement for narrative evaluations in an apparent cost saving and streamlining measure. As applied to segregation psychological screening, we found the manner in which the CHJ-551 (Segregation Psychological Screening Form) is being used actually undermines the purpose and integrity of the screening process it was created to enhance. If one were to accept the results recorded on the overwhelming majority of these forms, one could only conclude that placement in long-term segregation confinement has absolutely no significant negative effects on these prisoners. The facts are clearly otherwise. We reviewed form after form on the men in our samples and usually found there was no indication recorded of signs of mental illness in people who often had documented histories of psychoses and/or major mood disorders. Yet when we spent some time actually evaluating these same prisoners in a private room without other prisoners and custody staff overhearing our conversation, we found widespread depression, anxiety and sometimes suicidal preoccupation, and psychotic symptoms, including delusions and hallucinations. But many of the forms were completed time after time with the same brief comments and "none observed" checked off or written beside the symptom indicator on the checklist. In at least several cases we found examples where the forms appear to actually have been pre-filled out, using the same identical comments in the same identical handwriting, except for the dates of the screening, which were different and showed some expected variation in how the same numbers were written. These appear to have been mass photocopied and then dated and put in the prisoner's health record on the date the cell-side screening was required! In another case the forms were also blank in the spaces for the prisoner's name and number, suggesting that the same pre-filled form without significant findings may have been used for more than one prisoner.

Recommendation 11: These required screenings were originally implemented as a consequence of an agreement between two U.S. District Courts and the MDOC in partial settlement of some of the mental health claims in *Hadix, et al. v MDOC,* and *USA v Johnson, et al.* This consent decree agreement acknowledged the vulnerability of prisoners to mental illness and severe psychological decompensation as a consequence of the conditions of confinement in long-term segregation housing, and accepted the periodic psychological screening of these prisoners as a necessary safeguard to assume prompt identification and referral for treatment of these men when such symptoms began to emerge. The current dilution of this screening into little more than a cursory "paper chase" undermines the integrity of the whole process, rendering it virtually indistinguishable from the wholly inadequate processes that existed prior to the consent decree and which resulted in both court and USDOJ intervention. The check lists should be discontinued and be replaced by a narrative format with strict content guidelines requiring some documentation of the clinician's conclusions. These should be subjected to at least 10% random sample, in-depth supervisory review of the quality of the report, and a 3-5 % random sample review of the prisoner's health record, along with a brief supervisory interview of the prisoners in that latter sample.

Finding 12: MDOC appears to make very little effort to identify, early in the incarceration process, prisoners with psychological vulnerabilities that place them at increased risk of decompensation if placed in segregation. In the cases we reviewed, we were unable to find mental health staff identifying and flagging such conditions as making such people especially vulnerable for breakdowns if subjected to the intense stress of long term segregation There is an extensive body of research documenting the extremely detrimental effects incarceration in general, and isolation in particular, have on people (e.g., Haney, 1998, 1997; Haney, Banks & Zimbardo, 1973; Human Rights Watch, 1997; Grassian, 1983; Kupers, 1999; Toch 1992; Toch & Adams, 2002), and this needs to be taken into account by prison mental health and administrative staff. From this and other research we do know that individuals with developmental disabilities, prior histories of mental illness, past suicide attempts, histories of brain injuries (e.g., CHIs, TBIs,) as well as other conditions., are at increased risk of breakdowns under the harsh stimulus deprivation of prison segregation.

Recommendation 12: MDOC should develop and implement an early identification and tracking system for prisoners with significant, pre-existing vulnerabilities for breakdowns in their coping mechanisms, if placed in segregation. This would alert mental health and custody staff to more carefully monitor these people for early warning signs that might otherwise be ignored, and to intervene early if necessary to prevent the emergence of more severe conditions under such intensive and prolonged stress.

Finding 13: In reviewing the videotape that recorded the death of Timothy Souders in an "observation cell" at JMF we were struck by the appearance of what looked like indifference or even acceptance as "normal" of what was happening to this young man on the part of custody, mental health and medical staff, as his condition slowly deteriorated and he died as a consequence of the lack of intervention. Anyone who can walk away from the pain and suffering this young man (and too many others we have learned of) endured, and accept it as "okay" or "normal," has at bare minimum been working in the debilitating conditions of the segregation units too long.

Recommendation 13: The MDOC be compelled to immediately take the necessary steps to ensure that all staff working in segregation units (including mental health, medical and custody) be placed on mandatory rotation schedules fixing the amount of continuous service they are allowed in those units before transferring to non-segregation assignments. We suggest this be limited to a 6 month assignment followed by at least 12 months in non-segregation assignment before another segregation assignment is allowed. We believe this is critical to help prevent staff burnout and desensitization to the conditions and suffering of people confined to these units. We further recommend specific awareness training be provided to staff preceding assignment to segregation units, and Traumatic Incident Stress Management (TISM) debriefing be provided staff and prisoners in these units following any death, near death, or very serious suicide attempt or SIB occurrence.

Finding 14: The health care delivery system in the MDOC is a poorly managed, dysfunctional and confusing operation that has, according to well documented federal court findings, resulted in the unnecessary and avoidable suffering of hundreds of prisoners, and the untimely deaths of others. As the recent deaths of prisoners Timothy Souders, Jeffery Clark, Philip Hayes and Anthony McManus, reported in the media as well as court documents demonstrate, there is little, if any, coordination between medical and mental health services. These deaths are not isolated incidents but rather appear to be "the tip of the iceberg," as we have been informed of other cases of deaths of prisoners attributed to gross medical neglect, indifference and malpractice. Such deaths rarely appear to be brought to public attention and too often appear to go undisclosed. The mental health system in particular has a wide service gap that too many severely mentally disturbed prisoners fall into, inappropriately dumped into segregation units where they deteriorate further. It is badly bifurcated, with service delivery split between MDCH and MDOC staffs. Much money is being spent on a clumsy, haphazard and confusing health care system with little accountability or significant oversight.

Recommendation 14: In the short run, all mental health services should immediately be merged under a single department with responsibility for all mental health services. An independent study committee, without any ties to special interests, should be appointed to study the best way to organize, manage, deliver and supervise a single, unified prisoner medical and mental health delivery system, and submit its findings and recommendations in a timely fashion. We believe this should still be directly under the state and not privatized, as federal court findings have clearly demonstrated that MDOC's current experience with medical privatization has resulted in many of the problems described throughout this report. Whatever system emerges as best for our state needs to be open to public scrutiny and accountability, something that has failed to happen under the current system. What goes on behind closed doors in the MDOC can be both very deadly and costly, and we as taxpayers who ultimate foot the bill need to know.

Finding 15: Finally, and beyond the power of MDOC to change, is the widely recognized failure of the community mental health system to provide a meaningful safety net for many people with significant mental health problems. It is a massive scale, community-wide human tragedy that grew out of the closing of state mental hospitals and the mainstreaming of people in need of treatment, not to promised residential treatment centers, but rather to the streets and homeless shelters, and ultimately, into our state prisons and county jails, where they can and do suffer horribly, and sometimes die unnecessarily.

Recommendation 15: There is a need for the statewide establishment of mental health courts to function in a way similar to drug courts that would allow, whenever possible, the diversion of non-violent mentally ill offenders away from jails and prisons into treatment programs.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* Washington, DC: Author

Bureau of Justice Statistics. (2001a) *Mental Health Treatment in State Prisons.* Washington, DC: U.S. Department of Justice.

Bureau of Justice Statistics. (2001b). *Sourcebook of Criminal Justice Statistics.* Washington, DC: U.S. Department of Justice.

Cain, et al. v. MDOC, No.s 96-16341-CM, 93-14957-CM & 88-61119-AZ. State of Michigan, Court of Claims.

Hadix, et al. v Johnson, et al. USDC-ES-80-73581. Consent Decree. U.S. District Court, Eastern District of Michigan, May 8, 1985.

Hadix, et al. v Johnson, et al. Case No.4:CV-110Y. Findings of fact and conclusions of law, U.S. District Court, Western District of Michigan, Southern Division, October 29, 2002.

Hadix, et al. v Caruso, et al. Case No. 4:92-CV-110. Document 2186. Opinion. U.S. District Court, Western District of Michigan, Southern Division, November 13, 2006

Hadix, et al. v Caruso, et al. Case No. 4:92-CV-110. Findings of fact and conclusions of law. U.S. District Court, Western District of Michigan, Southern Division, December 7, 2006.

Grassian, S. (1983). Psychopathological effects of solitary confinement. *American Journal of Psychiatry, 140,* 1450-1454.

Haney, C. (1997). Psychology and the limits to prison pain: confronting the coming crisis in

eighth amendment law. *Psychology, Public Policy and Law. 3,* 499-588.

Haney, C. (1998). The past and future of U.S. prison policy. Twenty-five years after the Stanford prison experiment. *American Psychologist, 53,* 709-727.

Haney, C., Banks, W. & Zimbardo, P. (1973). Interpersonal dynamics in a simulated prison. *International Journal of Criminology and Penology, 1,* 69-97.

Human Rights Watch, (1997). *Cold Storage: Super-Maximum Security Confinement in Indiana. New York: Author.*

Kupers, T. (1999). *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It.* San Francisco: Jossey-Bass.

Sandman, C.A. & Touchette, P. (2002). Opioids and the maintenance of self-injurious behavior. In Schroeder, S.R., *et al.,* (eds.) *Self-Injurious Behavior: Gene-Brain-Behavior Relationships.* 191-204.

Schroeder, S.R., Oster-Granite, M.L. & Thompson, T., eds. (2002). *Self-Injurious Behavior: Gene-Brain-Behavior Relationships.* Washington, DC: American Psychological Association.

Thompson, T. & Caruso, M. (2002). Self-Injury: knowing what we're looking for. In Schroeder, S.R., *et al.,* eds., *Self-Injurious Behavior.* Washington DC: American Psychological Association, pp. 3-22.

Thompson, T., Symons, F., Delaney, D. & England, C. (1995). Self-injurious behavior as endogenous neurochemical self administration. *Mental Retardation and developmental Disabilities Research Reviews, 1,* 137-148.

Toch, H. (1992). *Mosaic of Despair: Human Breakdowns in Prison.* Washington, DC: American Psychological Association.

Toch, H. & Adams, K. (2002). *Acting Out: Maladaptive Behavior in Confinement.* Washington, DC: American Psychological Association.

Walsh, R. R. The Mentally Ill in Michigan Prisons: An out of Control Crisis. *Prisons and Corrections Forum of the State Bar of Michigan,* Vol. VI, No. 1, Summer, 2004, 1-5, 25-32.

Attachment C

REVIEW OF THE PRISONER INTAKE SCREENING PROCESS AND ITS ROLE IN INITIAL CLASSIFICATION IN THE RECEPTION & GUIDANCE CENTER OF THE MICHIGAN DEPARTMENT OF CORRECTIONS: PLSM CONSULTANT'S REPORT

Robert R. Walsh, Ph.D.

August 4, 2003

Introduction

The information in this report is based on a combination of two separate, day long tours of the Reception and Guidance Center (RGC) of the Michigan Department of Corrections MDOC) at Jackson, Michigan, review of documents pertaining to RGC and prisoner classification provided by the MDOC through discovery. This report also draws upon my approximately 25 years experience working in that center as a clinical psychologist, Chief Psychologist, Psychology Department Director, and Administrator of Psychological Services for the Jackson area prisons. During my tenure with the MDOC, I was directly involved in the creation of many operating procedures and policy directives pertaining to most aspects of RGC prisoner intake processing, including initial prisoner classification. I also personally helped develop, with staff assistance, many of the psychological screening criteria that were used to identify prisoners with mental health needs.

The first tour occurred on 7/2/01, when the RGC was physically located in a former prisoner housing pole barn structure located southeast of cell block 7. The second tour occurred on 6/19/03, when the RGC had been relocated into remodeled facilities in the Egeler Correctional facility on the north side of what used to be called "Central Complex." During the first tour a large number of RGC staff were interviewed, including people from Psychological Services, Outpatient Mental Health Services, Transcase Processors, Medical Records, Nursing, and Classification. During the second tour, most of my time was spent interviewing people from Psychological Services and Outpatient Mental Health Services. Other components and staff from the intake processing in RGC were interviewed by the two Prison Legal Services of Michigan (PLSM) Classification Experts, Charles Montgomery and Roderick Brewer, who did a follow-up tour on 6/27/03. I was accompanied on the 6/19/03 tour by Ms. Sandra Girard, Assistant Attorney General Alan Soras, and Ms. Barbra Hladki.

Unfortunately, too much of the information I requested through PLSM via Discovery from the MDOC was never provided. In some instances we were told it did not exist (when in fact it had existed at the time I retired from the MDOC in June, 1999), or was lost and could not be found (I believe it was required to be kept at least that long according to the MDOC document retention schedule, and copies were stored with more than one person in different locations). This made finishing this report, as well as others I prepared as a consultant to PLSM for this litigation, very difficult to complete as thoroughly as I would have preferred. Nevertheless, there have been very tight time restraints placed on bringing this case to closure, and I have endeavored to do the best job I could under the circumstances with the incomplete information provided by the MDOC.

The format of this report will first follow the sequence of the 21 problems found during the earlier tour of 07/02/01, and I have updated the status of items as needed. Following this will be a summary of additional problems identified during this tour and more proposed remedies. My first report is contained in Appendix A of this document.

DISCOVERED RGC DEFICIENCIES AND PROPOSED REMEDIES

1. There is an immediate need for R&GC Psychologists (as well as MDCH Psychiatrists, Psychologists and Social Workers), when interviewing new prisoners, to have auditory as well as visual privacy during their interview/evaluations.

Discussion: This is no longer true. Reception Center mental health (MH) staff have moved into a new facility at the Egeler Correctional Facility (SMN) and now have decent private offices for conducting prisoner interviews, apparently as of 7/02. While the MDOC is to be acknowledged for finally attending to this previously glaring deficit, the fact remains, however, that for approximately 4-1/2 years, MH staff conducted these evaluations in a setting where their private psychological, psychiatric and other interviews with prisoners could be overheard by other prisoners and non-mental health staff, violating the most basic and fundamental rights of patients to privacy.

2. Comprehensive Educational Assessment to determine each prisoner's needs should be done at R&GC and serve as the basis for program recommendations to be implemented after the prisoner transfers to a receiving facility.

Discussion: As required by MDOC Policy Directive PD 04.01.105, this testing has now been re-instated in RGC, some time after 07/02. The RGC Chief Psychologist, Diane Gartland, Ph.D., and the Michigan Department of Community Health (MDCH) Regional Mental Health Services Director, John Rushbrook, Ph.D. did not, however, appear to know much about this testing, which is no longer administered by psychological services. We were advised that R&GC now has a new educational services unit, and they provide this testing separately. We were informed that this testing now includes the TABE (Test of Adult Basic Education) and an additional test for "non-native speakers of English,", identified as the BEST (Basic English Skills Test) which they are reported to be using in making educational program recommendations.

3. If comprehensive educational needs assessment as presented in item 2 above, cannot be achieved, and if it is true that appropriate testing is done on new prisoners once they leave RGC, there is a need to provide basic reading level testing at intake, prior to any further psychological testing.

Discussion: As noted previously, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

requires a reading and comprehension level of at least 6th grade, according to the test publishers, but it appears that the results of educational testing are still not being used to determine whether or not to administer psychological testing. Granted that the MMPI-2 testing was reported to be administered in both auditory and visual modalities, R&GC psychological services staff administer the tests without this information (the prisoner's reading comprehension level) and examine validity later, partly because their stated emphasis is on expediting the prisoner through the Reception processing and not waiting for the educational testing results (in this case the TABE locator test). I believe that the results of the TABE Locator Test should be reviewed by psychological services, ideally before administration of the MMPI-2, but no later than the time of psychological interview so that this information is available to assist in evaluating the validity of MMPI-2 results, and the need for administration of additional relevant psychological testing minimumly dependent on reading comprehension level.

4. Comprehensive Vocational Assessment should be performed on all new prisoners in RGC to determine occupational needs assessment and serve as a basis for appropriate program recommendations.

Discussion: As required by Policy Directive 04.01.105, this testing is now administered in RGC by the education unit, although for many years no educational testing was performed and the policy directive was flagrantly violated. The test used is the CareerScope, a vocational interest and aptitude battery, and it is reported to be used in making vocational training and related program recommendations. This is a vast and much needed improvement over past practice.

5. RGC Diagnostic Assessment should include screening new prisoners for the presence of histories of head injury(s), whether symptomatic or not at the time of intake.

Discussion: According to Dr. Gartland, there is no systematic screening for head injury history in RGC unless prisoners are currently obviously symptomatic or determined to have "indicators" on the Draw-a-Person (DAP), Symbol Digits Modalities Test (SDMT)- written mode, or the Rotter Incomplete Sentences Blank (RISB). Neither the DAP or the RISB are designed as tests of cerebral impairment, and results can easily be associated with many other factors. The SDMT is specifically designed as a test of possible cerebral dysfunction associated with trauma or disease induced brain lesions, but must also be administered in the oral mode, which can be done in the individual interview and usually takes under 2 minutes. This was reported as not being done, although other individual testing was cited as sometimes used in these interviews, including the Bender Visual-Motor Gestalt Test (BVMGT), subscales from the current version of the Wechsler Intelligence Scale (WAIS) and subscales from the Wechsler Memory Scales (WSM), according to the Chief Psychologist. The BVMGT was reported to be no longer routinely administered, but the rational was unclear, as it can also be used as a supplemental projective type test that can provide valuable information on people who are unable to comprehend the MMPI-2 items. Records on how frequently these tests and subtests were administered were said not to be kept, but it appeared that they were very infrequently used. Also, a Pre-Sentence Investigation (PSI) reported history of head injury, without substantial current symptoms of residuals of head trauma, is still not considered as sufficient reason for referral to a psychologist for interview and evaluation. My basic findings, as reported in the 7/01 report, are still valid on this deficiency. No records are being kept on the number or

proportion of prisoners processing through the R&GC with head injuries, and since these prisoners often incur adjustment and disciplinary problems later in incarceration, it is critical, both from a management and treatment perspective, that they be identified early in the process and tracked.

6. RGC Diagnostic Assessment should include screening new prisoners for Attention Deficit Hyperactivity Disorder (ADHD) as a routine part of the intake process.

Discussion: Dr. Gartland stated she continues to disagree with this diagnosis being a valid one and believes prisoners generally manipulate these symptoms/complaints to obtain stimulant-type medication. My findings on this deficiency, as described in my report of 7/01, are still accurate and unchanged.

7. RGC Diagnostic Assessment should include screening new prisoners for the presence of Learning Disabilities/Disorders as a routine part of the intake process.

Discussion: Dr. Gartland indicated that there is no systematic screening by her psychology staff for learning disability. She indicated that if it is an issue, the RGC psychologist will call the educational unit for input, but stressed that it was of paramount importance Reception Center staff "get closure," ASAP, meaning that the prisoner is to be expedited through the process with little delay. She said she did not know what the education unit is doing to screen for learning disability, but the discovery response indicates they ask every prisoner if he has been in "special education" and attempt to get his records if he consents to sign a release. They, however, are not tracking this information and can provide no data on incidence or prevalence. While this is some improvement over my last visit, there is still much that needs to be done, and there remains an apparent lack of sensitivity on the part of psychological services to the role such problems play in adult behavioral and adjustment problems later in incarceration.

8. RGC Diagnostic Assessment should include screening new prisoners for Mental Retardation as a routine part of the intake process.

Discussion: There continues to be no systematic screening of incoming prisoners for mental retardation in the RGC. We were informed that if mental retardation is suspected, usually on the basis of symptomatic behavior, the person would be referred to a psychologist for determination of possible referral to the Social Skills Development Unit (SSDU). Additional testing is optional on the part of the psychologist, and may include the WSM, the BVMGT and/or the Rivermead Behavioral Memory Scale (RBMS), although none of these are really appropriate for assessing either intellectual functioning or impaired adaptive behavior. To correctly diagnosis the condition (per the Diagnostic and Statistical Manual of Mental disorders, 4th Edition { DSM-IV} and many other sources), requires the proper use of standardized individual IQ Tests (full test, not select parts) and documentation of impairment in adaptive behavior, usually by use of a standardized adaptive behavior scale. We were informed, upon pressing further about the frequency of additional, specialized testing, that it was in fact very infrequently performed. Therefore, it appears that the previously identified deficiency under this item continues to exist.

9. R&GC Diagnostic Assessment should include identification of all prisoners with histories of

mental illness. even if currently asymptomatic, and initiation of a system for tracking them in the MDOC.

At risk prisoners with prior mental health histories that are asymptomatic at the time of entry continue to be overlooked in RGC. Only prisoners who were actively mentally ill within the last 2 years, or were on psychotropic medication at the time of entry, or who are exhibiting symptoms of mental illness, are evaluated by mental health staff. If the history of mental illness treatment is over 2 years old with no current symptoms, it is felt to be insufficient justification for a referral. Reception Center staff do not attempt to get copies of records of earlier mental hospitalizations because, we were told, the information in the PSI is "often inaccurate" and "it's not possible for us to do because we don't have the time (to write for the records)." A third rationale cited by Dr. Gartland was reluctance to "slap a label on someone" because of information in the PSI. This deficiency in identifying people with prior mental health histories who are at increased risk of disciplinary problems and psychological breakdown in segregation, as cited in my earlier report, continues to exist essentially unchanged from what was found on my 7/01 visit to RGC, and needs remediation.

10.. Critical evaluation of the effectiveness of the MDOC's Substance Abuse Screening Program in RGC and more direct involvement of Psychological Services in the evaluation process needs to be undertaken.

Discussion: We were informed by Dr. Rushbrook that the substance abuse programming was now under the Bureau of Health Care Services and no longer Educational Services. Dr. Gartland indicated that her staff do administer the Substance Abuse Subtle Screening Inventory (SASSI), but that she is unaware of how that information is used by her psychologists during evaluation, at one point indicating "it's optional," or at the discretion of the psychologist. Dr. Rushbrook indicated that the Outpatient Mental Health Teams (OPMHT) did look at the SASSI scores on prisoners referred to them, and that they were making "an effort" to be sensitive to the significance of "dual diagnoses" and integrate this information into their evaluation. While this is some improvement, many of the concerns expressed in my 7/01 report remain.

11. There should be required, meaningful follow-up Mental Health Services of a minimum of 6 months on all prisoners who have made a suicide attempt, and longer if problems associated with that act persist or recur.

Discussion: Dr. Rushbrook indicated that prisoners who meet their current version of the "K Plan" (originally from the consent decree, although we were informed that there was no finally agreed-to common mental health "K Plan") are followed for either 1 month (K-1) or 6 months (K-6), depending on their length of stay in an Acute Care Program or length of time they were on maintenance psychotropic medication (greater than 30 days to qualify for K-6). Follow-up consists of one evaluation per month for the plan limit, with weekly evaluations if the prisoner is in administrative segregation. The problem continues to be, as we have seen in visits to higher security facilities with administrative segregation units around the state, that these contacts often are very cursory "cell door" type interviews, and staff still frequently rely far too much on subjective judgements of "genuine" and "non-genuine" suicidal behavior, as well as essentially discounting suicidal behavior they believe to be "manipulative." I believe this follow-up by

mental health staff still needs to be better codified and improved in quality of the contacts, particularly given the severe environmental and social stressors inherent in all aspects of the prison, especially administrative segregation. As stated in my 7/01 report, this process needs to begin in RGC with early identification and tracking of all these cases, not just the ones judged severe at the time.

12. RGC Psychological Services and MDCH Correctional Mental Health Staff must routinely request community records on prisoners with prior mental hospitalizations and/or treatment, and follow-up on those records once received, even if the prisoner has been transferred to a receiving facility.

Discussion: As noted above, under factor No. 9, this is still not being done and remains a glaring deficiency that undermines efforts to identify at risk prisoners early in the Reception process. It would take very little effort and time to ask a prisoner to sign a release for those records, and then mail it, and in my experience, most prisoners have been willing to sign the release. Another option would be to require the PSI investigator to routinely request and obtain this information prior to sentencing, and then to include it with other medical records transported with the prisoner to RGC. Failure to even attempt to obtain these records when they exist, places mentally ill prisoners at increased risk of misdiagnosis and unnecessary delays in receiving needed mental health care.

13. MDOC should require acceptance into the Social Skills Development Unit (SSDU) of all Developmentally Disabled (DD) Prisoners who otherwise meet the Criteria, except for being on psychoactive medications, if they are either being followed by Outpatient Mental Health Teams (OPMHT) or are capable of being so followed.

Discussion: I was informed by Dr. Rushbrook that the SSDU now will accept for admission into the program DD prisoners meeting program criteria who are also mentally ill and receiving psychoactive medication. I was also advised that the policy directive has recently been revised to reflect this change. If so, then this deficiency would appear to now be remediated. I later learned, however, from documents finally provided by discovery, that following the closure of the Riverside Reception Center (RRC) and absorption of it's youthful intake into the new RGC at SMN, that the number of referrals from this population to the SSDU actually dropped dramatically, which is a cause of concern and need for further scrutiny. Also, some of the Regional Psychology Director's Monthly Reports (Region II) indicated that Psychological Services staff were having considerable difficulty in getting MDCH staff to treat SSDU prisoners in need of more intensive, OPMHT support services.

14. Psychologists or other mental health professionals and the specialized information they possess should play a meaningful role in RGC prisoner security classification, especially given the very arbitrary and capricious manner in which the existing policy guidelines are ignored.

Discussion: There was no indication during this visit that there has been any change in this deficiency. Information that could be useful, and at times actually critical, to classification, which is obtained by Reception Center Mental Health staff and psychological testing, still does not appear to play a significant role in prisoner placement decisions. As one example,

information from the Megargee MMPI-2 Classification System is routinely obtained by RGC Psychological Services, but is not used by RGC Classification staff. This information, validated in the research literature on both federal and state male prisoner populations, basically classifies most prisoners into one of 10 separate groups based on a combination of personality characteristics, behavioral expectations, psychopathology, and other characteristic associated with predicting adjustment to incarceration. It has been very successfully used in other prison systems as a component of "management classification," and has been reported to assist in helping to substantially reduce prisoner assault rates as well as other major misconducts. As another example, RGC classification is performed without active participation of psychological or other MH staff, thus it is not multi-disciplinary and it negligently ignores or overlooks mental health information critical to prisoner classification. In fact, sometimes vital psychological information contained in the narrative psychological evaluations prepared by RGC psychologists are not available for RGC classification to even see, as they typically sit in large typing pool backlogs until long after the prisoner has been classified and left RGC, because of a failure to adequately provide typing resources. A qualified mental health professional (QMHP) should be a significant member of a true multi-disciplinary classification team or committee in RGC. Most of the categories of information discussed previously (i.e., items number 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13) should be made available to the classification team and its significance clarified by the appropriate team member at the time of classification.

15. <u>All prisoners producing invalid test results,(especially if the current practice of giving psychological evaluations to far less than 100% of the prisoners is permitted to continue), must be provided with an individual psychological interview and evaluation.</u>

Discussion: According to Dr. Gartland, her staff now interview prisoners who produce abnormal psychological test results. There are now available abbreviated or brief evaluations performed by RGC psychologists, done in lieu of a full evaluation, that are provided to these prisoners. At the time of this tour and interview with Dr. Gartland, I still had not obtained a copy of the criteria/guidelines for performing these evaluations, and that we requested in discovery. The Assistant Attorney General present declined to allow Dr. Gartland to provide me with a copy at the time, indicating he needed to consult with the Attorney General's Office on the matter. I subsequently did receive what was identified as the referral criteria in current use by RGC, as contained in the response to Discovery Request No. 38, and will address this further under item 19, below. Suffice it to say here that the criteria does require prisoners producing invalid MMPI-2 test results to be referred for individual psychological evaluation. There was, however, no criteria or description provided that explains what actually comprises an abbreviated or brief psychological interview/evaluation, and absent that, I can only find this situation, although improved, still not fully remediated.

16. <u>Individual Psychological Interviews and Evaluations should be routinely performed on all RGC prisoners who have not had such an evaluation in the last 12 months.</u>

Discussion: According to Dr. Gartland, all prisoners who have not been tested in the last 12 months do receive updated psychological testing when re-entering R&GC. She stated that sometimes, if there is a need, a prisoner may be provided updated testing even if the old testing

is less than 1 year old and it is determined to be warranted. Dr. Gartland stated that she believes approximately 2/3's of the prisoners processing through R&GC go on to have individual psychological evaluations, either full or abbreviated, although she confirmed that data are not kept on this, nor on how many prisoners are provided with psychological testing. Comparable data is readily tracked by the education unit for their testing, and should be by psychological services as well, and they in fact used to track it, at least up until 6/99 when I retired. I also will re-affirm my belief, reinforced by my interviews of administrative segregation prisoners around the state, that all newly committed prisoners to the MDOC should have a psychological evaluation as part of their routine processing. The "two-track" system I proposed in the 7/01 report could be employed to restrict time spent with people who do not need it, but you really cannot properly determine that without at least a brief interview. RGC's current use of an abbreviated interview on prisoners with invalid test results may be a step in that direction, with appropriate guidelines and criteria, but much still needs to be done to identify seriously at risk prisoners early in the process. Failure to perform a psychological evaluation on all new prisoners also appears to violate the American Correctional Association (ACA) Standards for Correctional Institutions, especially ACA Standard No. 3-4273, which requires a "summary admissions report for all new admissions" to the corrections department be prepared, that includes, among 11 specific pieces of information, a "psychological evaluation." The standard briefly specifies a purpose for obtaining this information, and that is to identify "areas for follow-up," and to be used "in developing the inmate's program." (ACA standards manual, 3rd edition, p. 92). These intake evaluations should be performed by properly qualified, licensed psychologists, and consist minimumly of a review of the prisoner's institutional file (including the PSI), the health record, current and prior (including prior psychological testing) and prior institutional files if prisoner is a repeat offender, psychological testing, a face-to-face clinical interview in a private office, and administration of additional, specialized testing, if warranted. This should culminate in a professional narrative report whose length is determined by the clinical judgement of the evaluating psychologist, and not arbitrarily predetermined by supervisory staff. These reports must be promptly typed and made available to classification in a timely matter. It is totally unacceptable to substitute either a "check list" type form or a hand written brief form that has limited categories. As I have found in my review of the files of many cases of MDOC prisoners in segregation, such forms already in use in the MDOC are too easily completed improperly, are often illegible, lack much important information that is excluded because of the forms limitation. The RGC intake psychological evaluation sets the stage for the prisoner's later treatment and how all levels of staff are inclined to view him, and must be provided in a thorough and professional manner.

17. Psychologists must be given more latitude and time to perform specialized individual testing when the need is present and the information important to the prisoner's treatment and care.

Discussion: this continues to be a deficiency of concern, especially if staff do not have enough time to even ask a prisoner to sign a release for access to prior mental health treatment records/hospitalization. Specialized, non-routine psychodiagnostic testing appears to be rarely performed, and when done, Dr. Gartland indicated that usually only a portion of the test (e.g., a subtest from it) is actually administered. Appropriate, psychodiagnostic testing must be completed in the RGC at the time of entry into the MDOC, based on the prisoner's needs and suspected problems, and not ignored or overlooked until these problems begin to emerge under

the stresses of incarceration and result in sometimes avoidable major disciplinary infractions and placement in segregation.

18. Creation of appropriate data bases on all categories of Mental Disorders, Learning Disabilities and Descriptive Demographic statistics of prisoners entering the MDOC and their needs.

Discussion: This still remains a major deficiency in need of remediation. If the prevalence and incidence of major mental disorders are not identified and tracked by the MDOC, then it becomes impossible for needs to be assessed and services budgeted and provided. The result is that many seriously mentally disordered and mentally ill prisoners go untreated, have significant and sometimes severe adjustment problems, and end up in the debilitating isolation of long term segregation, where they typically deteriorate further. At the time of my retirement in 6/99, much of this information was being gathered in RGC and kept in a data base that was in the processed of being refined. I do not know why it was stopped, but it should be re-instated and updated as required, to provide a factual basis for valid program need assessment and resource allocation.

19. Develop appropriately descriptive, written, detailed operations procedures and guidelines for all aspects of reception center prisoner processing, including orientation, mental health, physical health, security, housing assignment, classification, transfer, etc

Discussion: Even though an RGC operating procedure is required per policy directive PD 04.01/105, Dr. Gartland indicated that, to the best of her knowledge, one did not exist. She did report that there are "informal" written guidelines describing the process with instructions/criteria for various decision points, and I was advised that staff will check with MDOC central office
and the Attorney General's office for permission to provide me with a copy. Dr. Gartland did advise that much of the criteria used to determine referral for psychological evaluation based on testing abnormalities were similar to ones I had established when I was Administrator of Psychological Services for the Jackson area prisons. Even if correct, these will need to be examined closely, as many things have changed since I last validated those criteria, and we know more about what happens to people who are at increased risk of developing problems after they leave R&GC for other facilities.

I subsequently did receive a copy of these criteria in response to Discovery Request No. 38. This consisted of 3 pages of semi-redundant "screening criteria," and a 7 page memo with attachments dated 11/18/92 that I authored when I was Administrator of the Psychology Department for the Jackson Regional Clinical Complex of prisons, entitled "REVISED CRITERIA FOR SCREENING TEST FILES OF NEW PRISONERS FOR DETERMINATION OF PSYCHOLOGICAL EVALUATION RECOMMENDATION - DRAFT." This draft criteria essentially represented a tightening up of our previous screening criteria to reduce what was then believed to be a high rate of over-referral (i.e., a high false positive rate) assumed to be occurring by an MDOC psychology consultant, Joel Dvoskin, Ph.D., who believed that the very limited MDOC mental health resources should be directed more towards treatment of already identified, actively mentally ill. The draft criteria was developed as a good faith effort in response to that need, on orders from MDOC's Bureau of Health Care Services (BHCS). It was never intended to

be final, as the concluding paragraph stated "Like any screening criteria, it is subject to critical review and periodic evaluation based on experience gained by using it. Feedback, along with empirically based suggestions for changes, is strongly encouraged, and revisions will be made as needed." While partially an administrative solution based on the MDOC's unwillingness at the time to provide adequate MH staffing, it did appear to us at the time to work adequately. Since then, I have learned, from following up on prisoners who have later developed major mental health and adjustment problems resulting in their placement in long term segregation, that the criteria needs updating and revision as it is too loose, in the sense that there appear to be far too many false negatives slipping through the process. It did significantly reduce the number of prisoners referred for psychological evaluations, but at too great a cost of missing less symptomatic prisoners who later went on to develop and/or reactivate symptoms of major mental disorder. In this regard, it appears that the criteria it replaced, summarized in a memo by me dated 3/23/90, has turned out to be more accurate than the 11/18/92 version, although I did not learn that until recently when I had the opportunity to follow-up on some of the prisoners screened out by the criteria.

20. RGC prisoners should have similar visitation privileges as prisoners in other facilities, with the possible exception that the visits be limited to non-processing hours, i.e., evenings, weekends and holidays.

Discussion: I reiterate my strong concern that prisoners in RGC should be afforded similar visitation privileges as general population prisoners have, and the MDOC once did that without major problems that I can remember. RGC prisoners were allowed to have visits during non-processing periods, which included evenings (after 4:30 PM), weekends and holidays. This is an immensely critical period for new commitments, and to deprive them of this often vital social and emotional support is unnecessary and harmful to those having problems adjusting to the harsh realities of incarceration. As noted in my 7/01 report, initial arrival in prison is cited as a critical period of increased suicide risk in the MDOC's own policy directive on suicide prevention (PD 04.06.115).

21. No prisoner should be allowed to be received into RGC without a record of sentence/judgement of sentence, a PSI, a fully completed Sheriff's Questionnaire, and an identifiable photo.

Discussion: While deemed quite rare by the staff interviewed, this can still happen and thus remains an area of deficiency which could result in harm to at risk prisoners because of the non-provision of required information by the Sheriff's Department or other authority delivering prisoners to the RGC. To be helpful, the Sheriff's Questionnaire must be completed by jail staff who know the prisoner, and whenever possible, supported by copies of appropriate records. It is a completely unacceptable practice to require the deputy transporting the prisoner to complete the form on a prisoner he does not really know, as the risk of harmful misinformation being taken as factual by staff is avoidably high.

ADDITIONAL PROBLEMS/FINDINGS

22. Psychologists are no longer routinely receiving a copy of the prisoner's health record to review at the time of psychological evaluation, and thus appear to be preparing their reports without access to this often critically important information.

Discussion: Dr. Gartland did state that R&GC staff psychologists do have access to computerized health record data entries, but these often are incomplete and even when available lack considerable, and sometimes important, detail. Missing from the computer record would be any progress notes made early in incarceration, along with notes of emergency interventions, and any mental health treatment records forwarded from the county jail. This record can become even more critical on repeat offenders re-entering RGC, where, we were informed, it usually takes 3-5 days from their date of entry to receive the old health record from storage. Unfortunately, RGC psychology staff, according to what we were told, typically interview these prisoners on the third or fourth day of their incarceration. At the time I retired in 6/99, I had, after considerable resistance from medical records staff at the time due to logistics, set up a system where these files were pulled and placed with each psychologist's "call-out" material, which included the institutional file and the psychological test results packet of protocols. This appeared to work well, despite some initial resistance, and I believed it helped close a gap where some people in need of intervention and/or identification, were being missed simply because the psychologists were unaware of the information in the health record. This practice needs to be re-instituted and mental health staff should review the health record file on all prisoners they interview.

23. The psychologist's narrative reports are not being typed in time to transfer with the prisoner when he leaves RGC, delaying dissemination and availability of this information to other treatment providers and staff who may need access.

We were told that it is quite common for the prisoner to be classified and transferred to a receiving facility well before the narrative psychological evaluation prepared by RGC is typed, and it is mailed to the facility later in the process. This appears to be basically related to staffing shortages in the word processing center and could be readily remediated by hiring more people or sharing the workload with Waters Hospital medical transcriptionists. These reports are too important to be delayed like this. Following this tour, I finally received some copies of the Discovery Requested Monthly Psychological Services Reports (Discovery Request No. 14), although many of these requested reports were mysteriously missing. A note from the discovery response read "Not all of these reports for each month could be located from Region I and Region III. There are no narrative reports from Region I and only some reports could be located for Region III. All the requested reports from Region II are enclosed." The problem with this response is that these monthly reports have always been required from the Regional Psychology Directors (RPDs), and they are required to be kept available consistent with the MDOC's document retention schedule, per policy. Further, in addition to each RPD, copies of these reports are sent to each Regional Health Care Administrator (RHCA), who also keeps them on file. Copies historically are circulated to psychology staff in each facility in the region, and often further copied and retained by the various facility Chief Psychologists. The few reports that were provided contained quite disturbing information about the deteriorating quality of mental health services and prisoners' access to those services. Of especial relevance here is a report by Region III Psychological Services Director Hampton Walker, Ph.D., dated 12/5/02, discussing

the backlog of untyped psychological evaluations in RGC which had grown to "almost 700 dictations." Dr. Walker went on to write "Fortunately, RG&C{sic} is not required to complete long typed reports any longer. Reports are expected to be approximately 1 page as opposed to 3 pages." This is a very disturbing trend, as I have found that if anything, more effort and detail are needed in these psychological evaluations, and forcing them to cut out information to help reduce a backlog that should never have been allowed to grow so large, is a very dangerous practice harmful to the mental health care of prisoners later in their incarceration. The dangers of this overly expedient and improper approach to the backlog problem were apparently recognized by Dr. Gartland as well. In a later monthly report dated 4/7/03, Dr. Walker wrote "RG&C{sic} continues to have backlog cases to be typed. Dr. Gartland reports at this time there are 438 reports which remain to be typed. There is a significant resistance on her part to adhere to the recommendation to reduce reports to one page as suggested by the SERAPIS format. Clerical staff were given 20 of {sic} hour overtime permission by the RHA to catch up." While I am in disagreement with some of Dr. Gartland's practices, she is to be complemented for having the integrity and courage to stand up to a practice that can only contribute to further harm to, and misclassification of, prisoners, by virtue of what appears to me to border on deliberate indifference to their mental health need to gain negligible short term cost savings. It will be a lot less costly in the long run to simply hire adequate typing staff to handle the case load, rather than continue to callously further cut back the quality of the psychological evaluations.

24. As noted earlier, RGC stopped routinely administering the BVMGT, a test that has been used as part of the intake battery since at least 1974, and there has been no replacement test substituted.

Discussion: Because some of the MMPI-2's are invalid and the RISB requires some reading ability, only the DAP and SDMT are left for non-verbal tests, it is important to have some additional sources of personality assessment available if the MMPI-2 is not interpretable. The BVMGT has served this purpose well in the past, providing additional information about visual-motor functioning as well, and either should be put back in the routine battery or replaced with a comparable test that does not depend on verbal ability beyond comprehension of simple instructions.

25. There does not appear to be very close coordination between various RGC units with regard to information exchange and integration of services.

Discussion: Except for possibly the coordination between the Outpatient Mental Health Team (OPMHT) and Psychological Services, there appears to be significant fragmentation between the two mental health services and education, classification, Transcase processors (RGC counselors) and the medical units. Mental Health and Psychological Services did not appear to be very aware of details and information available in these other units, nor were they aware of what happens with various testing and other information obtained by these other units. Also, their involvement in the classification process appears to be minimal, at best. There needs to be more direct communication and sharing of information about each other's operation between these units, and most importantly, with classification.

26. Far too much of an emphasis is being placed on processing time, i.e., the speed with which a prisoner goes from entry to classification, at the expense of doing a more thorough job.

Discussion: We were repeatedly informed that important tasks such as reviewing the health record at the time of interview, performing additional, specialized psychological testing on prisoners that need further assessment, writing for records of past community mental health treatment or hospitalization, etc., could not be done because staff "did not have the time," and/or "we need to get closure" by expediting the prisoner through the process. Dr. Gartland informed us that prisoners usually complete the process and are ready for classification within 10 days, yet the policy directive on Reception Facility Services, PD 04.01.105 specifically states "Intake processing shall normally be completed within four weeks after arrival at the reception facility." (p.-8, dated 3/18/02). In addition, we learned that a large number of men, once classified, cannot be transferred right away anyway, due to lack of facility bed space availability at the time, so they are warehoused in cell block 7 (the old RGC facility) until they can be transferred. Thus, a rush to classification to build a transfer pool seems to be the overriding factor driving the process, and it significantly compromises the psychological screening operation. This needs to be corrected and the internal processing time clock set more realistically, to allow adequate screening and evaluation before the person is sent to classification.

27. Relevant to the previous item, the processing system does not fully evaluate and test prisoners who fall out of the normal routine because of serious medical problems, psychiatric treatment, or disciplinary/behavioral housing issues.

Discussion: Prisoners who are taken out of the process early to be placed at Duane Waters Hospital (DWH), or in an observation cell for at least several days, or are placed in RGC's version of segregation in cell block 1 which they call "special management housing," are not usually given psychological testing nor complete screening, indicating that serious mental problems could be missed, and thus also are not made available to classification. This was supported by my reading of Judge Richard Enslen's recent "Findings of Fact and Conclusions of Law" order in the "Consent Decree Case,"(Case No. 4:92-CV-110) dated 10/29/02, in which at least several instances of prisoners with serious medical conditions were missed or overlooked by the Reception Center processing and screening operation. One such case involved an HIV+ prisoner with a seizure disorder who was overlooked by R&GC screening and went on to have 2 suicide attempts by hanging, and to further compound the negligence, received no follow-up upon discharge from the hospital. I asked Drs. Gartland and Rushbrook how this could have happened, but they said they were unfamiliar with the case and could not answer. There were other similar cases mentioned in Judge Enslen's findings. This processing system must be taken off this "fast track" obsession and made more accurate and responsible by allowing sufficient time to properly evaluate new prisoners and follow up on those most likely to be removed from the routine sequence, such as those with medical, psychiatric, learning disability, behavioral and adjustment problems.

28. Finally, I believe it is time for MDOC to critically evaluate the problems created by having a duplicative, overlapping yet non-comprehensive mental health care system that leaves many problem prisoners untreated, and gives the responsibility to a custody staff ill-equipped to deal with them properly or effectively.

The current system depends on a contractual arrangement with another state department, Community Health (MDCH), to manage its programs for mentally ill prisoners under a variety of levels ranging from outpatient (in the prison population) to inpatient hospitalization at Huron Valley Center. Non-mentally ill prisoners, self-mutilative prisoners and developmentally disabled prisoners are basically the responsibility of the MDOC. Yet, there is considerable overlap, with many prisoners presenting atypical or non-mainstream symptoms of mental illness, as well as the existence of people with severe personality disorders also requiring intensive treatment, and many levels and manifestations of suicidal and self-injurious behavior that frequently do not fit neatly into our statistically discrete diagnostic categories. In my 25 years as a correctional psychologist and psychological services manager, I have seen many prisoners bounce back and forth between mental health services and custody, with no one taking responsibility for people who were characterized as both "mad" and "bad." In fact, each side typically only saw one side of the prisoner, especially if the prisoner was violent, and that was too often determined to be the other party's responsibility. This intense conflict and disagreement over responsibility for these services is repeatedly reflected in statements from the monthly reports of the RPDs for Regions II and III, where there are statements accusing MDCH staff of outright refusing to even accept anywhere from 25% up to 50% or more of the prisoners referred to them by Psychological Services staff as needing more intensive mental health intervention and care. There is also indication that MDCH staff in turn accuse Psychological Services staff of making "inappropriate" referrals. The resulting conflict directly places prisoners with serious mental health problems at direct risk of harm, and when left unresolved, easily could result in these prisoners being misclassified to segregation. Prior to 1992, the conflict was often viewed as psychiatry vs psychology vs custody, after that it was MDCH staff vs MDOC psychology staff vs custody, with the prisoner usually ending up in segregation, after bouncing around the system between services. MDOC needs one single, merged mental health service that custody can refer problem people to and where, regardless of whether the person is viewed as mentally ill or personality disordered, that unified mental health service will take responsibility for treating that person. Cooperation in the current RGC seemed better than I have witnessed in the past, but there were still many problems and potential gaps between the services that allow people in need of treatment to be overlooked. Dr. Gartland did state that "anyone they won't take we will," but it should not have to come to that to ensure treatment continuity, and such a system is ultimately only as good as the dedication of the people providing it. It is time to consider merging the systems into one single management operation.

In summary, I find the physical plant of the new Reception Center a major improvement over the old one, and some of the deficiencies I previously identified have been remediated, and MDOC's efforts in this regard are to be commended. There are however, still too many holes or gaps in the processing system where prisoners with serious mental health problems can be missed or overlooked. Further, prisoners that MH staff are capable of identifying in RGC, tracking, and providing with meaningful intervention early, who are at increased risk of acting out or emotionally decompensating due to increased vulnerability to prison stress because of their condition, are being missed by the current manner of screening which focuses almost exclusively on active symptomatology. Some of these people, in relatively stable remissions or early prodromal phases of mental illness, may very well be asymptomatic in RGC, but will become increasingly unstable later in incarceration. Early intervention could prevent considerable harm

and suffering to both these people and the staff they sometimes strike out against. I have found the RGC staff that I have met and interviewed on these tours to be very dedicated, hardworking and conscientious, and because of that, they often make a very flawed and limited system work, at times amazingly well. But the system is subject to easy breakdown and mis-identifying people, and causes avoidable human suffering and harm to prisoners, usually as a consequence of mis-classification resulting from failure to adequately identify problems and needs. The staff, available positions (if unfilled vacancies are allowed to be filled, and adequate typing staff are provided) and many of the tools needed to correct this, appear to be in place or could be made available without unreasonable cost. However, there needs to be changes made in the processing system, cooperation, integration and coordination between units and use of the information they obtain, along with much less of an obsession with speed of processing time.

Robert R. Walsh, Ph.D.
8/4/03

Attachment D

THE MENTALLY ILL IN MICHIGAN PRISONS: AN OUT OF CONTROL CRISIS

Robert R. Walsh, Ph.D

Paper presented at the Prisons and Corrections Section of the Michigan Bar Association's Annual Meeting, Lansing, Michigan, September 11, 2003.

THE MENTALLY ILL IN MICHIGAN PRISONS: AN OUT OF CONTROL CRISIS

Scope of the Problem

Over the last 3 1/2, decades we have witnessed a steadily increasing number of mentally ill and severely mentally disordered people entering our prison systems across the nation, and a concomitant decrease in the number of people confined in state mental hospitals. In Michigan, as a result of "de-institutionalization" and "mainstreaming," the number of mentally ill confined to state hospitals went from over 19,000 in 1960, to approximately 1,600 in 1995, and most state mental hospitals were closed. Community mental health services were supposed to fill the gap and provide a safety net of much less costly out-patient treatment and support services , but in fact these were significantly underfunded and neglected. A recent study (2003) by the National Mental Health Association (NMHA) found mental health care across the nation to have major deficits, and Michigan was rated as having the most inadequate care for the mentally ill of any state.

In addition to the thousands of people released back to the community from the state mental health system to face inadequate support services, the same treatment availability limitations were faced by new cases of mentally ill, as well as by the large number of outpatients and people in remission who also ended up with little or no care from poorly funded community mental health agencies. During this period, there was a massive increase in the number of people being committed to state prisons nationally. In Michigan, between 1960 and 1995, the Michigan Department of Corrections' (MDOC) incarcerated population spiraled from 9,622 to 40,510. While much of this obviously was a consequence of harsher sentencing ("three strikes" type laws and mandatory sentencing), reduced use of parole, and cutbacks in "good time" allowances, some of this increase was accounted for by the mentally ill, especially those without adequate resources to survive independently in the community. The result has been the transformation of many prisons and state corrections departments into defacto mental hospitals, by default, not choice, as corrections departments have been ill equiped and ill suited to deal with this massive problem.

How big is the problem? Many corrections departments, including Michigan's, appear not to want to face up to the size of the problem. On a national level, Kupers (1999) has estimated that between 10 - 20% of all prisoners in state and federal corrections facilities have a severe enough mental disorder to require intensive treatment over the course of a year, and the U.S. Department of Justice (USDOJ) estimates are similar, indicating that between 15 - 20% of the U.S. prison population is mentally ill. Nobody really knows for sure, because accurate statistics are not uniformly kept, and definitions as well as interpretation and application of diagnostic criteria still vary and are overly subjective, despite the existence of widely accepted, standardized guidelines such as the *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM-IV) and the *International Classification of Diseases-Tenth revision* (ICD-10). In Michigan, intake diagnostic screening in the Reception and Guidance Center (R&GC) for physical and mental disorders are required by state statute, but the MDOC still does not gather and maintain psychodiagnostic data on its incoming prisoners. To do so would be tantamount to admitting that the mentally ill population in MDOC facilities is much larger than the department has been

saying it is over the last 25 years, and it would then require that the MDOC provide these people with adequate treatment. The problem is that at least since the Consent Decrees in *USA v. State of Michigan* and *Hadix, et. al. v. Johnson, et al.*, signed in 1984 and 1985 respectively, MDOC has consistently disputed estimates of the mentally ill in its prisons that exceeded what it was willing to accept as manageable, especially from the standpoint of having to create and staff various treatment level beds in its prisons. This included disagreement with both its own mental health staff, as well as outside experts who investigated conditions of confinement in the 3 prisons that erupted in riots in 1981 at Jackson, Ionia and Marquette. The U.S. District Court finally ordered an epidemiological study of the prevalence of mental disorders in Michigan prisons, and an unprecedented, state of the art study was completed in 1987, jointly performed by the University of Michigan's Survey Research Center and Michigan State University's Department of Psychiatry, along with other affiliated departments from both universities, and with assistance from MDOC mental health and administrative staff. This study was unique in its rigorous methodology and was regarded as the most comprehensive study of the prevalence of mental disorders in an entire prison system that had ever been done at the time. It found, among many other things, a prevalence rate of psychosis (all categories) of 10.4% of the prison population, and for mood disorders, a rate of 29.6% (Neighbors, *et al.* 1987). The majority of the mood disorders were people with Major Depression (20.7%) and the majority of the psychotic disorders were Schizophrenia (5.8%). Obviously, not all of these people would require intense treatment at the same time, and instead would be in various stages of the condition, ranging from remission to active exacerbation. A more direct assessment of current intervention needs at the time of the survey were ascertainable from the "Primary Diagnosis" data used in the study, which would reflect the focus of clinical attention, i.e., currently active cases. The percentage of the total Michigan prison population with a primary diagnosis of a psychosis was found to be 4.6%, and that for mood disorders, 22.7%.

Even following completion and release of the results of this massive study, MDOC administrators chose not to accept the results, and instead proposed alternatives for estimating needs that were not based on prevalence data. The fact is that this study's data, while showing somewhat higher than national averages, is consistent with trends that have been occurring in Michigan for many years, and are consistent with my approximately 20 years experience in managing the psychological screening of incoming prisoners in the RGC. Sadly, based on a recent communication I reviewed, the MDOC once again has down-played the relevance of the epidemiological study of mental illness in its prison population, this time on the grounds that it is now over 15 years old and thus outdated. To the contrary, I believe it is still very relevant and in all probability, the rates of mental illness/severe mental disorder in the Michigan prison system are actually higher now, as such prisoners tend to be denied parole and are kept longer than comparable but non-mentally ill prisoners.

Its important to clarify to what I am referring when I talk about mentally ill and severely mentally disordered prisoners so there will be no misunderstanding. I am using these terms clinically, and not necessarily limited to definitions in the Michigan Mental Health code, although most of the conditions I refer to would meet this criteria if properly applied. Thus, in addition to the traditional interpretation, usually restricted primarily to active psychoses and

severe major mood disorders, I include any mental disorder classified in the DSM-IV on Axes I or II (including personality disorders), that is so severe as to result in major impairment in the person's thought or mood which significantly affects their judgement, behavior, capacity to recognize reality, or ability to cope with basic demands of life. This, incidently, is consistent with the MDOC's definition, as contained in the most recent "Criteria and Guidelines" used by the Michigan Department of Community Health's (MDCH) Bureau of Forensic Mental Health Services (BFMHS) for their Corrections Mental Health Program (CMHP), although as we will explore later, the very restrictive application of these guidelines excludes many prisoners from treatment who actually do meet their criteria. There is a large gap between policy and practice when it comes to diagnosing and treating the incarcerated mentally ill.

MDOC's Mental Health Treatment Program

In the aftermath of the 1984 Consent Decree, the MDOC continued to be in non-compliance[1] for many years, and the MDOC, following orders from the Governor's office, contracted out care of the mentally ill to the then Michigan Department of Mental Health (MDMH). While this department hired a new bureau chief for its forensic services division, it filled the overwhelming majority of its institution level positions (both clinical and supervisory) with the same mental health staff that had worked for MDOC and whose views and clinical practice with regard to the incarcerated mentally ill were the very ones that had kept the MDOC in non-compliance with its Consent Decree-agreed to, mental health services plan. The fact is that from 1984 until relatively recently, whenever the various mental health experts from the litigants toured the Consent Decree prisons, they found fairly large numbers of severely mentally ill prisoners left untreated and often locked up in the extremely punitive and dehumanizing confinement of prison segregation units. This was significantly related to the fact that too many of the MDOC (and now MDMH) staff incorrectly viewed many of these prisoners as simply non-mentally ill, personality disordered manipulators and malingerers. The 1992 transfer of responsibility for treating the mentally ill and seriously mentally disordered prisoners to the MDMH formally bifurcated mental health services into two separate, unequal, and often conflicting service delivery systems, under different state departments. MDOC kept psychological services under its control but restricted its role largely to identifying and referring mentally ill and suicidal prisoners to BFMHS staff, to RGC screening of new prisoners, and to providing group psychotherapy services to an ever decreasing prisoner base, which was basically limited to some sex offenders and some assaultive offenders, whose own access to treatment has been increasingly defined away by very restrictive eligibility requirements.

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[1] We are dealing only with the mental health portions of the Consent Decree here, as the agreement was broad-reaching and covered many aspects of prison life, including fire safety, food service, sanitation, etc. In fact, non-psychiatric medical portions of the Decree are still in non-compliance and effect the health and safety of prisoners, cf. recent court findings and ruling in *Hadix, et. al., v. Johnson, et al., Case No. 4:CV-110Y*, October 29, 2002.

Historically, there had been a division and conflict between psychological and psychiatric services in the MDOC, going back to the creation of the RGC in 1956, and perhaps even earlier, as an investigator of the 1952 Jackson prison riots suggested (Martin, 1953). Typically, this has been manifest in disagreement over whether disruptive prisoners were psychotic (or insane) or simply personality disordered (or psychopathic). The psychiatric services, formally called the Clinical Services Unit (CSU), ran the inpatient units in the prison system for treatment of the mentally ill, and rarely interfaced with the general prison population. The Psychological Services Unit (PSU) served as a filter or screening service for the CSU when it was not doing RGC intake or pre-release parole evaluations, and helped reduce "inappropriate" referrals from the custody staff. Both units were staffed primarily by psychologists, and the CSU does not appear to have had a full time psychiatrist assigned to it until later in the 1970s. The CSU staff were the ultimate gate keepers, determining who was "genuinely" mentally ill, and thus would be admitted for treatment, and who was merely psychopathic or simply manipulating. A significant number of mentally disordered prisoners were already screened out by PSU staff and never made it to the CSU, but, in addition, many of those who PSU staff believed to be mentally ill were rejected by the CSU, and in many cases, ended up being treated as disciplinary problems and confined to the harsh and punitive environment of segregation units, where their conditions often deteriorated further. It is against this back-drop that the problems with the current system are best seen, as it is, in many practical aspects, simply a re-packaging of the same process and narrow philosophy that has failed to provide appropriate and much needed mental health treatment to many mentally ill prisoners in the MDOC who still end up in the isolation of segregation units. Much money has been spent addressing the problem, and yet many mentally ill prisoners remain lost between the two large mental health bureaucracies that have evolved in the MDOC's attempts to get out from under the mental health portions of the Consent Decree. MDOC developed some well-written and comprehensive policy directives for screening and identifying mentally ill prisoners in segregation, but actual practice has continued to reflect the old views. Many severely mentally ill prisoners continued to be neglected and denied treatment, unable to gain acceptance to BFMHS staff caseloads (Walsh, 1998).

Conflict Over "Mad" Versus "Bad" Prisoners

The debate over "mad" versus "bad" prisoners has gone on almost since the beginning of the legal system's developing recognition that some actions by severely mentally ill people may be due to their mental condition and not under voluntary control. While appearing to be a very simplified dichotomy, this characterization really underscores the clinical decision-making process and determines who will be treated and who will be punished for their behavior, both in the community and in prison. Our concern here is how it influences clinical judgement in the prison setting. Prisoners in the MDOC who most mental health staff agree are mentally ill usually receive mental health intervention and treatment, although the adequacy of that treatment varies. Typically, these are people who have well-documented histories of a relatively recent psychosis, clearly meet all or most of the DSM-IV diagnostic criteria, and generally are uncomplicated by other conditions, such as personality disorders and/or substance abuse disorders. There is usually little disagreement here, unless the prisoner also becomes assaultive

and difficult to manage and control. Then there is a good chance that he will be "undiagnosed" as mentally ill, and re-diagnosed as a personality disorder or malingerer. Variations in a person's condition that would strongly suggest the presence of an "atypical psychosis," not unexpected in a harsh prison environment that itself is very atypical of the "free world," are often overlooked or dismissed as malingering.

At the other end of the spectrum, there are a large number of prisoners mental health and custody staff generally agree are "bad," i.e., their behavior is primarily if not exclusively volitional, and is not the product of mental illness. These people are often diagnosed by mental health staff as having personality disorders, usually of the antisocial (historically, psychopathic or sociopathic) or borderline type. They are typically regarded as "management" problems, and are left to custody staff to deal with, usually in a punitive mode that strips them of most prison privileges, restricts their movement and isolates them from other prisoners. Levels of severity of these personality disorders are acknowledged, but significant mental health treatments are usually not offered or believed effective. It is ironic that despite advances in our understanding of human behavior, we all too often overlook our past and persist in viewing what is now labeled antisocial personality disorder as a unified entity, when in fact it is extremely varied with many identifiable subtypes differing in their responsiveness to treatment initiatives, as described by Kahn in 1931.

Most people do not fit neatly into pre-conceived diagnostic criteria, and many people who become management problems in prison often exhibit varying degrees of both "madness" and "badness," i.e., clinically, they have multiple disorders, generally a psychosis or major mood disorder and a personality disorder. Toch and Adams (2002) have characterized these people as exhibiting "disturbed-disruptive syndrome," recognizing the fact that people who are problems can and do also have problems. Yet these people often are characterized as just "bad" or disruptive, and are considered to be management problems best handled by a custodial rather than treatment approach. Sometimes however, even custody staff recognize that some of these people are severely mentally disturbed and that they cannot manage them in segregation cells. It is not unusual to find severely decompensated prisoners locked up in the isolation of Michigan segregation units who repeatedly smear themselves and their cell with their own feces, experience command hallucinations, assault staff, and/or severely inflict major physical injury on themselves. All too frequently, when custody staff try to obtain mental health intervention for some of these people, they run up against a closed door to treatment. PSU staff are often reluctant to refer many of these people to BFMHS staff because they either view the prisoner as manipulative, or they are fearful they will be criticized as being naive or inexperienced by the BFMHS staff. If they do refer these prisoners to BFMHS staff, they run a high probability of having the prisoner returned, diagnosed as a manipulator, malingerer, or antisocial personalty disorder, thus beginning a cycle that often repeats itself during incarceration many times. If a prisoner is so deteriorated and psychotic that his antisocial features are suppressed or overwhelmed by the psychosis, there is a chance he may be admitted to inpatient care for a short period, generally with a tentative or "provisional" diagnosis of the mental disorder. If, however, he starts to act out or not cooperate fully with mental health staff, he runs a high risk of being undiagnosed as mentally ill and re-diagnosed as a malingering personality disorder.

Mislabeling Mentally Ill Prisoners as Manipulative and Undiagnosing

Why do mislabeling and undiagnosing happen? A combination of factors seem to contribute to the enduring phenomenon of ignoring mental illness in personality disordered people. In prison settings, there are many prisoners with significant aspects of antisocial personality disorder. Long term patterns of conflict with social norms and laws, impulsiveness, as well as disregard for the rights of others, are part of the diagnostic criteria used to establish the condition. Graduate schools for psychology and psychiatry rarely prepare students for a career in corrections, and prisons are still regarded as an undesirable place to work by many mental health professionals. Thus, many mental health staff who go to work in prisons are ill-prepared for dealing with an aggressive and disturbed clientele who are often manipulative, deceitful, will malinger, are disruptive, sometimes assaultive, threatening, and sometimes also are mentally ill and psychotic! As Kupers (1999) has repeatedly stressed, mentally ill people who are not receiving needed treatment will sometimes exaggerate their symptoms and manipulate to get access to the treatment they need as an adaptive means of drawing attention to their plight, and this frequently happens when confined in segregation units where access to mental health staff is very limited. This does not mean that they are not mentally ill, but unfortunately, this type of manipulation obscures their need and they are often denied treatment. It is actually not uncommon at all for a person to be mentally ill or suicidal and to manipulate! The manipulation is there and is recognized by staff, but is inappropriately allowed to mask the underlying psychosis or other severe mental disorder. It is improperly and incorrectly used frequently by prison mental health staff as a diagnosis, but it is not, as Berger and Diamond (1989) stressed, a valid diagnosis and it should not be entered into patients' medical charts.

Another problem that occurs is related to the formal MDOC new employee training, which, as is typical with most corrections departments, overly stresses the manipulative, antisocial characteristics of inmates in general. While it is important to stress the risk posed to non-prisonwise, new staff, and to emphasize the "us" versus "them" line that cannot be crossed, the MDOC's over-emphasis dehumanizes the prisoner population and essentially equates any legitimate act of compassion or feeling of empathy with weakness, naivete, risk to self, and/or endangering the safety and security of other staff and the institution. The effects of this training are profound and can directly effect the clinical practice of mental health staff.[2] Many experienced mental health staff, including supervisors and administrators, perpetuate and continue to impose this philosophy on new employees, who then risk negative appraisal, censure and ostracism from colleagues who view them as naive, inexperienced and threatening to the status quo. This has been described elsewhere (Robinson and Walsh, 1990) as "Jail House

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[2]The pervasiveness of this prohibition is so strong that it is encoded in the MDOC Employee Handbook of work rules as "over-familiarity" with prisoners, and it has serious disciplinary consequences. While intended to discourage clearly inappropriate relations between staff and prisoners, I know of psychologists who were accused of this infraction for simply showing concern and trying to get needed medical attention for prisoners. In other cases, it was used as a threat to prevent disclosure of possible staff abuse of prisoners.

Syndrome" (JHS), and in state prison systems it can become very controlling. In fact, it sometimes can reach the level of not so subtle threat by custody or administrative staff that if the mental health employee is too much of a "bleeding heart" in dealing with disruptive prisoners, that employee is endangering staff safety and thus might not be able to count on staff support if he/she is in danger of being assaulted or taken hostage. I believe this implied threat, implicitly understood early by most staff, enters into the phenomenon that many mentally ill prisoners who assault staff are found responsible for their behavior by prison mental health staff, and thus eligible for full disciplinary sanctions, rather than "getting away" with that behavior because of mental illness. For many mental health staff, compliance becomes a matter of survival in the prison, subtly translated into either conform, leave, or face ongoing conflict with other staff. What we are characterizing as JHS is a perceptual set and predisposition on the part of mental health staff to view most prisoners as manipulative and deceptive when asking for mental health services, that is developed and reinforced over time by the prison environment.

One last factor is briefly worth examining in considering why it is so difficult to properly deal with mentally ill people in prison, especially when they violate rules and act out, i.e., the inherent nature of the prison environment itself. In this regard, it is easy to overlook the powerful and shocking effects on people of the need to conform to authority, which was uncovered in some of the great social psychology research of the last half of the twentieth century, in an effort to try to understand the great atrocities and crimes against humanity committed with the knowledge, if not complicity, of whole nations. Thus, e.g., the unsettling findings of Milgram (1974) from a series of experiments on the extent to which ordinary people will go in terms of their obedience to authority, even if it means subjecting others to injury, also help to explain the development of the JHS response set among prison staff. This is escalated in the rigid, highly structured, para-military environment of prisons, where perceived deviation from the norms are punished swiftly, whether they be by inmate or staff. The incredibly dehumanizing nature of these environments was dramatically demonstrated by the so-called Stanford Prison Experiment (Haney, Banks & Zimbardo, 1973), which revealed that even in a simulated prison environment, many otherwise normal and reasonable people, when placed in roles as guards and custodians of people identified as prisoners, could very easily become quite negative, hostile, dehumanizing and aggressive. Also, many of those placed in prisoner roles became very depressed, anxious, intensely angry, and developed other symptoms of emotional disturbance. The point is that the social, psychological and physical characteristics of the prison environment itself takes its toll on people, prisoners and staff alike, and those at increased risk because of mental illness or pre-existing psychological vulnerabilities are going to be greatly influenced by it in a very destructive way. The problem is not limited to Michigan, as Human Rights Watch (1997) found similar and widespread mislabeling of mentally ill prisoners in Indiana's super-maximum prison and segregation units, and it appears to be true in other systems as well.

The Plight of the Mentally Ill in Prison

People with mental illness and severe mental disorders face special problems in prison because of the fact that many of the symptoms they experience are exacerbated by the general prison environment and its demands for strict rule conformity. Generally, actively mentally ill people do not follow, understand or adhere to rules very well, and those wishing to gain compliance need to be patient and supportive in dealing with this. Confrontation, threats and punitive approaches seldom work well, and lead to more conflict with prison rules, corrections officers and prison administration. Disciplinary sanctions eventually ensue, and without meaningful mental health intervention, can lead to increasingly long stays in disciplinary, and eventually administrative, segregation. This is why early intervention and placement in secure treatment settings in prison helps to manage behavior that could otherwise easily escalate into major confrontation.

Another source of pressure and stress on the mentally ill comes from other inmates in general population who quite openly express their dislike and sometimes fear of living with people they stigmatize as "bugs" and "crazies." In addition to not having any social support or affiliation with non-mentally ill prisoners, many of these people, depending on the behavior they are exhibiting, are at increased risk of assault by other prisoners as a desperate means of getting them moved out of the housing unit. For many non-mentally ill prisoners trying to "do their time," there is little tolerance or empathy for people whose mental illness is manifest in openly paranoid behavior, hallucinations, delusional beliefs and other bizarre characteristics.

If not accepted as mentally ill by the prison's mental health care system, many of these prisoners end up placed in segregation units, where the punitive and sensory deprivation characteristics of the environment serve to accelerate their psychological deterioration and mental breakdown. Many experts agree that the confinement of large numbers of mentally ill prisoners in segregation units is a national crisis, common to most corrections systems, and has evolved as part of the very punitive and non-rehabilitative approach to managing these institutions (e.g., Kupers, 1999; Haney, 1997; Haney & Zimbardo, 1998; Grassian, 1983; Toch, 1992, Toch & Adams, 2002). Further, many prisoners who may not have been mentally ill when they were placed in long term administrative segregation, eventually decompensate and break down under the very dehumanizing and socially isolated conditions they are subjected to in these environments. Toch and Adams (2002) have noted that many of the mental disorders and pathological behaviors that occur in these units are iatrogenic, i.e., specifically induced by the conditions of confinement that the people housed in these units are subjected to as a means of control. Instead, the conditions of isolation, stimulus deprivation, 23 hour or more per day cell confinement, sleep disruption/deprivation, very infrequent, limited, non-contact visitation, loss of most prisoner privileges, constant exposure to poorly ventilated, stagnant air, full restraints for all out of cell movement, small caged solitary exercise areas with very limited access, and virtually no other contact with the outside world except by mail, all designed to help eliminate disruptive behavior, actually end up causing more disruptive behavior by contributing to emotional breakdown in these prisoners. Prolonged exposure to such conditions tend to cause prisoners to engage in further acting out and rule violations, guaranteeing that their chances of leaving segregation before their sentence ends will be minimal or non-existent.

It has long been recognized that prolonged exposure to the stimulus deprivation conditions of solitary confinement produces mental illness in many prisoners. As early as 1823, officials at the New York State Prison at Auburn experimented with the solitary confinement model of Pennsylvania's Eastern Prison with 80 "hardened convicts" and found that following 2 years of this deprivation, many of those men became "insane" and suffered other illness (Allen & Simonsen, 1995), although that did not stop Auburn from using it as a punishment for rule violators. In Michigan, the fact that lengthy placement in solitary confinement results in severe mental illness for many prisoners so placed was known as early as 1861, when, following placement of 20 prisoners in the then new solitary confinement building at the Jackson State Prison in 1857, 45% of them were found to have become insane (MDOC's FYI Newsletter, 2003). Similar effects have been observed and identified in other primates kept in isolation in laboratory cages. Reinhardt (2002) reported the results of his experience as a research veterinarian with over 700 rhesus macaques kept locked up in small, solitary cages. He found that most of these monkeys developed a variety of sterotypal, abnormal behaviors, ranging from compulsive body swaying and limb biting, to smearing feces on their cage walls. He reported that other research accumulated from observation of approximately 15,000 solitary caged macaques found over 10 % of these animals became so distressed by their conditions of isolated confinement that they engaged in self-mutilation! Sound familiar? It is the same behavior observed and reported in hundreds of prison segregation units across America. Significantly, Reinhardt also reported that efforts aimed at ending the brutal way these monkeys have been confined in isolation has been undertaken by the U.S. Department of Agriculture and the National Research Council. It also is rightly a major focus of efforts by the ASPCA, the Animal Defense League, the Anti-Vivisection Society, the Humane Society and a number of other animal welfare organizations. But what are we doing to help human beings kept in long term isolation in our prison segregation units? Appropriate prisoner control, safety and security can be readily achieved and maintained without resorting to the extreme brutality of long term confinement in administrative segregation units as currently practiced. Yet, many states, including Michigan, continue to use it as a method of both punishment and control of disruptive prisoners, often regardless of the effects on their mental state.

Solitary confinement today is admittedly different in some respects from that of the 19th century, in that prisoners are not literally locked up in total darkness and fed just bread and water. But the differences begin to end there. Disruptive prisoners may have their solid cell door slots closed, windows, if they have them, blocked, their water cut off, and if they are considered a possible suicide risk, they may end up tied down in 4 or 5 point restraints to either a metal bed or a concrete slab in a so-called "observation cell," which in most cases is experienced by the men as even more punishing than regular segregation cell placement. Additional restrictions may include the provision of food in the form of a loaf usually created from combining the contents of a regular meal into one single mass, termed either "nutra-loaf" or "food loaf," and generally described by prisoners as horrible in taste. In place of confinement in total darkness, there often is confinement without any darkness, with lights on all the time for the stated purpose of staff being able to observe the prisoners, as well as ease of doing the prisoner "count." There too frequently is exposure to temperature extremes, generally heat and humidity, with resulting

heat-related serious illness and even death.[3] The result often is persistent sleep deprivation and disruption, almost constant fatigue, hopelessness, fear and uncertainty about the future, which over time can cause a variety of severe psychological symptoms. This type of treatment has long been known as a major ingredient used to break down prisoners of war (Hunter, 1956; Sargent, 1957). In varying degrees, the stresses of long term segregation cell placement produces psychological decompensation and mental breakdowns, greatly intensified by imposing further restrictions and/or observation cell placement. Sadly, the use of observation cells, intended as a means of protecting prisoners from suicidal and self-injurious acts, often serves to intensify and further exacerbate the symptoms such prisoners are experiencing. While the MDOC policy on observation cell use imposes guidelines and restrictions, according to many of the prisoners I have interviewed, these are often violated, and prisoners sometimes are kept much longer than supposedly allowed, usually with control rather than protection from self being the motive. Mentally ill prisoners, under these conditions, usually decompensate further, and non-mentally ill prisoners become increasingly vulnerable to becoming mentally ill.

The SHU Syndrome

Many prisoners who experience long term placement in segregation-type confinement have been found to develop a distinct, psychotic-like symptom complex that has been referred to as the Security Housing Unit (SHU) syndrome (Grassian, 1983; Kupers, 1999). While usually described in relation to confinement under conditions of extreme control associated with so called "Super Maximum Security" Prisons (e.g., Pelican Bay, Ionia Maximum, Wabash Valley, Marion, etc.), these conditions appear in prisoners kept in long term, isolated segregation status in non-super maximum security prisons as well. Generally, the symptom complex these prisoners develop may not precisely fit currently established, specific DSM-IV categories, but they present mixed components of severe mental disorder manifest in anxiety, mood, psychotic and organic-like conditions. Specifically, Grassian (1983) who identified the syndrome, found the presence of massive free-floating anxiety, hyper-responsiveness, hallucinations, derealization, impaired concentration, impaired memory functions, acute confusional states, dissociative features, aggressive fantasies, persecutory ideation, delusional beliefs, motor excitement, violent destructive and/or self-mutilative outbursts, in prisoners subjected to long term solitary confinement. Not every prisoner placed in solitary confinement will develop all of these symptoms, but in varying degrees, many who do not become fully psychotic exhibit an alarming number of them. Common to prisoners experiencing the SHU Syndrome is what Grassian described as a "rapid reduction" of many of these symptoms when these prisoners are removed from isolation. This sudden recovery may also partially help explain why some BFMHS mental health practitioners will confuse what is happening with malingering, after they have examined a person referred by MDOC PSU staff for exhibiting some psychotic like

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[3]Among the recent findings of the Federal District Court cited in footnote 1 were 12 cases of heat related illness and 1 death occurring in 8/01. The Court also found that mentally ill and elderly prisoners in administrative segregation units were at serious risk of harm because of the heat and lack of ventilation. There has been at least one other heat-related death in segregation.

behavior, but who suddenly appears to be functioning much better than the referral source description. In these cases, mental health treatment is still critical, as many of these people will exhibit lasting effects of the trauma they experienced in the isolated confinement of segregation, and will need meaningful follow-up after-care to prevent relapse. Instead, under the current MDOC disruptive prisoner management system, they can expect to be returned to the segregation unit from which they were referred to BFMS staff, and the process of cycling between segregation, deterioration, acting out, mental health referral, and return to segregation starts all over again.

What Can be Done

I will only briefly touch on this, as it is more appropriately the subject of a separate paper itself. There are many excellent recommendations discussed in detail by Kupers (1999) that anyone interested in improving mental health care in our prisons should study and bring to the attention of policy makers who are genuinely more concerned about our values as a society, than they are with demagoguery over punishing criminals and turning their backs on the needs of the mentally ill. While there are many promising approaches to diverting from prison the mentally ill who run afoul of the legal system, such as mental health courts, I will concentrate on reform of the manner in which the mentally ill in Michigan prisons are treated. Obviously, the problem is deeply rooted in our social values and priorities, and ultimately must begin with the way we treat the mentally ill in our community as a whole, which has usually been quite negligent.

Based on my experience of 25 years with the MDOC, I believe that many changes can be made that are not unusually costly , nor will they undermine or weaken the safety and security of staff or the institutions. Some of these include the following:

1. The first and foremost concerns the need for dealing directly with the early identification and tracking of not just currently mentally ill prisoners, but also those with prior histories of mental illness and/or serious mental disorder, as they are at increased risk of their condition exacerbating as a consequence of the "normal" stress, conflict and structure of the prison environment.

2. When "at risk" prisoners begin to experience significant adjustment problems, often first manifest by lesser, non-assaultive rule violations, mental health assessment, intervention and treatment should start early in the process, as a preventive measure for reducing the probability of the prisoner's condition deteriorating and the acting out becoming more severe.

3. If major disciplinary action is contemplated, a thorough mental health evaluation, including current psychological testing, should be undertaken to determine if treatment intervention is warranted. Whenever possible, if staff or other prisoner safety is not an issue, placement in a secure treatment setting, not punitive detention, should be seriously considered.

4. Extensive mental health staff training should be implemented, and should include recognition of the psychological effects of long term segregation confinement, recognizing the presence of mental illness/severe mental disorder when co-existing with serious personality disorder, proper diagnostic protocol for assessing malingering (including appropriate psychological testing), the inappropriateness of dismissing symptoms based on the presence of manipulation, and assessment of atypical or non-traditional manifestations of mental illness.

5. End the practice of indefinitely confining prisoners to administrative segregation but instead use this level of confinement only long enough to bring specific dangerous behaviors under control. Strict guidelines and protocols for this placement must be developed and enforced, subject to outside or independent review whenever exceeding the guidelines is believed necessary. Most segregation, when necessary as a specific sanction, should be limited to a fixed period of disciplinary segregation placement, and the prisoner must be carefully monitored for the development of signs of significant psychological decompensation during that period.

6. Improve the quality of mental health assessment of segregation prisoners to include requiring a thorough evaluation in a private office, and end the practice of allowing brief "cell door interviews" by mental health staff to substitute for such assessments, and the convenient but inadequate use of checklists in place of full narrative evaluations.

7. Stop the rampant practice of undiagnosing previously diagnosed mentally ill prisoners, and require strict, comprehensive protocol for changing a diagnosis, that includes appropriate psychological testing and full explanation and justification of the change. Part of the protocol should include supervisory review, and review and input from the practitioner who made the suspected incorrect diagnosis, along with provision of appropriate, remedial training for either party found to have made the incorrect diagnosis.

8. End the practice of automatically returning a mentally disordered prisoner back to segregation following referral and treatment of that person in a mental health treatment unit. Only under the most extreme circumstances where a prisoner is a clear risk to other people should this option be available, and then only under very strict supervision by security and mental health staff.

9. Create a significant number of high security level residential treatment beds in all security level prisons, especially close, maximum and super maximum level facilities.

10. Stop placing mentally ill prisoners in administrative segregation completely. If higher level security is needed, then place them in a treatment unit in an appropriate security level prison.

11. Take action to reduce the more psychologically destructive aspects of solitary confinement in segregation by allowing more activity, social interaction and privileges. Also, provide psychotherapy in a secure but out-of-cell area in the unit. This can be accomplished without compromising safety and security in these units.

12. Remove the Self-Mutilator Prevention Unit (SMPU) from administrative segregation and re-

frame it as a treatment rather than, or in addition to, being simply a behavior control program.

13. Provide anger management training to prisoners placed in segregation longer than 30 days, as well as supportive psychotherapy services.

14. End the practice of keeping some prisoners in segregation status until their actual discharge from their sentence and release back to the community. A security level "step-down" process should be provided for all prisoners prior to their release, as a critically needed psychological decompression process.

15. Relax the current, Draconian restrictions on prisoner visitation, allowing more frequent visits and an expanded visitor list. The basic, humanizing contact and emotional support derived from frequent family contact goes a long way in helping prisoners cope, adapt to incarceration, and socially and emotionally prepare for eventual release back into society. It is counterproductive to punish all prisoners with the current level of restrictions in force simply because of the abuses of a few, and the past failure of managers to better supervise the visitation process.

16. Merge the two separate prisoner mental health treatment services (BFMHS and PSU) into one, cohesive mental health service with a single chain of command, bureaucracy and administrative structure, in one state department (either MDCH or MDOC) that would be held accountable for treating all mental health problems that arise, including the mentally ill, the non-mentally ill seriously mentally disordered, severe personality disorders, behavior/management problem prisoners, suicidal prisoners, and self-mutilative prisoners. I believe that up to 50% of the current duplicative supervisory, managerial and administrative positions could be eliminated at great cost savings to the state, and personnel currently in the proposed positions to be eliminated, could effectively be reassigned to providing direct patient care in currently vacant staff positions.

Rationale for Change and Expected Consequences

It is time for the corrections aspect of the American justice system to go back to a reformative rather than a vindictive emphasis, because well over 90% of those who are incarcerated are not serving natural life sentences and will at some point be returning back to society. How we treat them in prison has an influence on what they will be like when they return to society, and we all have a stake in that outcome. We have now had a chance, in recent times, to again experience what Haney and Zimbardo (1998) among others, have characterized as the "meanness" of the American system of Justice, and what has it really wrought? As a nation we have one of the highest rates of incarceration in the world, with even a larger number of people on probation and parole status, yet these tougher laws, longer sentences and harsher conditions in our penal institutions have not had much of an impact on recidivism rates. A recent USDA study of over 272,000 prisoners released from prisons in 15 states reported a re-arrest rate for felony or serious misdemeanor, within 3 years of release, of 67.5 % (Langan & Leven, 2002). There appeared to be a "mixed" or slight correlation between reduced recidivism and longer prison sentences, but

the apparent effect was quite small and could have been due to statistical artifacts in the data collection and analysis process. The size of the overall recidivism rate, however, does suggest that whatever we are doing in our prisons is not having much of a deterrent effect on crime. The question needing to be addressed is whether our current practices of incarcerating so many people so indiscriminately is worth the cost in human suffering and in monetary funding, especially given current costs of incarceration? The cost of incarceration per inmate in Michigan prisons was $68.18 per day, or $24,886 per year, according to figures reported to the USDOJ (corrections Yearbook, 2001), and appears to have increased substantially since then. The actual cost of re-offending is extremely high, and goes far beyond the simple cost of re-incarceration. In addition to the cost of re-arrest, jail, investigation and evidence gathering, indictment, prosecution, trial, defense for the indigent, and victim assistance, other often forgotten costs include lost productivity, possible welfare and support for the offender's family, hearing appeals, and the social-emotional damage to new victims that might have been prevented were the justice and corrections systems doing its job.

Then there is the question of our own moral leadership as a great democracy, especially as it relates to our overuse and abuse of solitary confinement as an additional, non-sentenced punishment, manifest in our use of administrative segregation and super maximum security prisons, and its role in producing mental illness and severe psychological disorders. We as a people and nation were signatories to the International Covenant on Civil and Political Rights and the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment, treaties that prohibit inflicting severe pain or suffering, physical or mental, from being inflicted on a person to obtain information or confession, to punish, coerce or intimidate for any reason. We, as a nation, were also instrumental in developing the United Nations Standard Minimum Rules for the Treatment of Prisoners, as well as other minimum guidelines for protection of imprisoned people. Yet we seem to be slipping backwards in the manner in which we are now treating our own prisoners. It is simply outrageous that we continue, in the twenty-first century, to treat the people we imprison in an inhumane way, and it is totally egregious and unacceptable that we do this to the incarcerated mentally ill. It is time we regain our focus and our moral leadership, and stop burying our heads in the sand about what goes on in our prisons. The need for public access, oversight and intervention is critical. What goes on behind closed prison doors needs to be open to public scrutiny and review, before it becomes a national tragedy that will effect generations to come. There is absolutely no justifiable reason to exclude the media and concerned citizen groups from reasonable access to our prisons and segregation housing units, unless the taxpayer-financed civil servants paid to manage these facilities do indeed have something awful to hide.

References

Allen, H.E. & Simonsen, C.E. (1995). *Corrections in America.* Englewood Cliffs: Prentice-Hall.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, fourth Edition.* Washington, DC: Author.

Berger, B. & Diamond, J. (1989). Labeling patients. *Hospital and Community Psychiatry, 40,* 3.

Bureau of Justice Statistics. (2000). *Corrections Yearbook.* Washington, DC: U.S. Department of Justice.

Bureau of Justice Statistics. (2001a). *Mental Health Treatment in State Prisons* .Washington, DC: U.S. Department of Justice.

Bureau of Justice Statistics. (2001b). *Sourcebook of Criminal Justice Statistics.* Washington, DC: U.S. Department of Justice.

Grassian, S. (1983). Psychopathological effects of solitary confinement. *American Journal of Psychiatry, 140,* 1450-1454.

Hadix, *et al.* v. Johnson, et al., USDC-ES 80-73581. Consent Decree. U.S. District Court, Eastern District of Michigan, May 13, 1985.

Hadix, *et al.* v. Johnson, et al.,. Findings of fact and conclusions of law, Case No. 4:CV-110Y, October 29, 2002. U.S. District Court, Western District of Michigan, Southern Division.

Haney, C. (1997). Psychology and the limits to prison pain: Confronting the coming crisis in Eighth Amendment law. *Psychology, Public Policy and Law. 3,* 499-588.

Haney, C. (1998). The past and future of U.S. prison policy. Twenty-five years after the Stanford prison experiment. *American Psychologist, 53,* 709-727.

Haney, C., Banks, W. & Zimbardo, P. (1973). Interpersonal dynamics in a simulated prison. *International journal of Criminology and Penology, 1,* 69-97.

Human Rights Watch. (1997). *Cold Storage: Super-maximum security confinement in Indiana.* New York: Author

Hunter, E. (1956). *Brainwashing.* New York: Farrar, Straus, and Cudahy.

Kahn, E (1931). *Psychopathic Personalities.* New Haven: Yale University Press

Kupers, T. (1999). *Prison Madness: The Mental Health Crisis Behind Bars and What We Must*

Do About It. San Francisco: Jossey-Bass.

Langan, A & Leven, D.J. (2002). Recidivism of prisoners released in 1994. *U.S. Department of Justice Report No. NCJ193427.* Washington, DC: Bureau of Justice Statistics.

Martin, J. B. (1953). *Break Down the Walls.* New York, Ballantine.

Michigan Department of Community Health. (2001). *Criteria and Guidelines, Corrections Mental Health Program, Revision 4-2-01.* Ypsilanti: Author

Michigan Department of Corrections. (1996). *Employee Handbook.* Lansing: Author.

Michigan Department of Corrections. (2003). Michigan Department of Corrections Turns 50. *FYI:A news Bulletin for Employees of the Michigan Department of Corrections, 14,* 3.

Milgram, S. (1974). *Obedience to Authority: An Experimental View.* New York: Harper & Row.

National Mental Health Association. (2003). *Can't Make the Grade: NMHA State Mental Health Assessment Project.* Alexandria, VA: Author.

Neighbors, H.W., Williams, D.A., Gunnings, T.S., Lipscomb, W.D., Broman, C. & Lepkowski, J. (1987). *The Prevalence of Mental Disorder in Michigan Prisons.* Ann Arbor: University of Michigan.

Reinhardt, V. (2002) I know why the caged monkey cries. *ASPCA Animal Watch,* Spring, 6.

Robinson, S.W. & Walsh, R.R. (1990). *Jail House Syndrome.* Unpublished manuscript. Michigan Department of Corrections, Duane Waters Hospital, Jackson, MI.

Sargent, W. (1957). *Battle for the Mind: The Mechanisms of Indoctrination, Brainwashing and Thought Control.* Baltimore: Doubleday.

Toch, H. (1992) *Mosaic of Despair. Human Breakdowns in Prison.* Washington, DC: American Psychological Association.

Toch, H. & Adams, K. (2002). *Acting Out: Maladaptive Behavior in Confinement.* Washington, DC: American Psychological Association.

United States of America v. State of Michigan, *et al.*.,Civil Action No. G84-63CA. Consent Decree. U.S. District Court, Western District of Michigan. July 16, 1984.

Walsh, R.R. (1998) The mentally ill in our prisons: An insiders view. Report of testimony before the Community Health Subcommittee, Michigan House Appropriations

Committee, as reported in *MI-CURE News,* February, 1998, 2.

Attachment E

Referral Criteria

At MDOC approximately two thirds of incoming inmates require direct contact for further evaluation by a psychologist.

Approximately one half of these require only verbal feedback regarding psychological issues for the purpose of preparing them for group therapy.

One third of incoming inmates require more extended evaluation and crisis intervention, referral to MH or SSDU or follow-up.

Referral Criteria

Inmates who arrive on medication from the jail or who are previously identified as GBMI are seen by psychiatry. All others must go through the psychological processing before referral is made.

The following criteria are used for assessing who among the other inmates must be seen by psychologists for a full evaluation

1. Anybody referred by nurses at the bubble or custody or non custody staff for behaviors of concern or suicide potential.
2. Kites which indicate psychological distress either due to symptoms (self report) or signs (the way the kite is written or history).

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MICHIGAN DEPARTMENT OF CORRECTIONS

RECEPTION AND GUIDANCE CENTER

Psychological Services Unit

Criteria for Referral to Psychologists

Criteria for Referral to the Psychologist

Emergency Evaluations – Anybody referred by nurses at the bubble or custody or non custody staff for behaviors of concern (Roberta R) or suicide potential (SPS screen)

Kites – Kites which indicate psychological distress either due to symptoms (self report) or signs (the way the kite is written or history).

MRO – Medical referral - Usually this is an HIV+ patient who, per policy, requires an evaluation by a psychologist. The evaluation is brief and limited to a SOAP note unless suicidality or other mental health issues are present.

Accelerated Movement – In some cases, inmates are moved quickly to a receiving facility and there is no time to take the tests. There are three instances in which this usually occurs. Dialysis patients or patients with some type of unusual disability who will be leaving the Jackson area promptly will often need to be seen in the bubble upon arrival. In this case, the clinician gives a mental status and takes a history. The clinician would need to immediately enter findings into Serapis or a SOAP note form so that the clearance for psychological reasons can accompany the patient when he is moved. In the case of well known individuals who will be moved quickly (same day), the same basic procedure should be employed. For young adolescents, **16 years and under**, every effort should be made to get some testing material on them but they will need to be special handled and individually tested after the group testing and promptly referred to the psychologist. **All young adolescents are seen at the bubble and also after testing, preferably by the same psychologist. At a minimum, they should be given a suicide screen, MMPIA, Drawings and Sentences with a Bender if needed or some other SSDU assessment.**

Follow-ups (NEI) – Anybody the psychologist needs to continue to see due to a suspicion of psychological instability or a refusal of a referral by OPT. These are scheduled by the psychologist or assigned by the supervisor.

Partial Psych Evaluations (Brief Transcases) – **Sex offenders and Assault Offenders who are psychologically stable.** These evaluations consist of a brief meeting with the psychologist during which the inmate is given some feedback about his test results in order to begin to develop goals for his group work at some time in the future. He is assessed for group eligibility based on clinical judgment, whether he has assaultive or sexual offense(s) currently or in his history and whether he has had group before. If he is a Lifer, he is called out to briefly apprise him of whatever programs may be available to him at the given time or if his sentence is somehow reduced on appeal. Lifers are not recommended for groups but, given the import of their sentence, we want to make sure they are stabilized on intake. Some of these offenders may have minor signs of anxiety on their testing or in a kite sent to us and we will do some intervention at the time of the interview. But, for the most part, they are considered to be psychologically stable based on their test results and lack of mental health history. These interviews take approximately 10 to 15 minutes apiece.

Full Psych Evaluations (Regular Transcases) – These evaluations consist of a lengthier meeting with the inmate and a report which **describes and explains** his psychological functioning. The purpose of the evaluation is to provide direction for any interventions that the psychologist should make during the intake processing (i.e. crisis intervention, behavioral management etc.), to determine the need for special services such as mental health, social skills development, SMPU, special handling by custody, PSU follow-up etc. and to make recommendations accordingly. The following groups are always seen for a full psychological evaluation:

1. History of suicide attempts or ideation within the last 5 years. **Check with CMIS if the inmate has a prior incarceration.** This includes people who come through the bubble with an indication that they want to kill themselves or who were suicidal in county jail. Men who indicate that they were not suicidal in jail when seen for a 179 don't need to be transcased if they also do not have significant test results or DSI.

2. History of psychiatric hospitalization or mental health treatment within the last two years. **Check with CMIS if the inmate has a prior incarceration**

3. History of heinous acts of violence, notorious crimes, "high profile" offenders.

4. History or suspicion of predatory homosexuality which may be a problem in the prison setting.

5. History of being Guilty but Mentally Ill

6. All those who, for one reason or another, cannot be tested. They refuse testing, have a physical disability such as deafness or blindness, are hospitalized or are on dialysis or have other confining medical problems, are on segregation status due to notoriety or violent behavior, have an emotional, behavioral or mental disability which precludes testing (psychosis, mental retardation etc.), have language or cultural differences or are absent from the facility for a prolonged period of time. (e.g. at court).

7. The primary method of referral for a full psychological evaluation will come about from a **screening of the test data** on each inmate. Following certain criteria, the screening psychologist will refer those suspected of being mentally ill, mentally retarded, neuro-psychologically impaired, psychologically unstable and/or dangerous to themselves or others.

Criteria for Test Battery Screen

Crime Category Only – Code "SO", "AO", "High Profile" (notorious, heinous) Brief eval for SO or AO or SO hx or SO hx only. Full eval for AO+ test indicators, SO+ test indicators or High Profiles.

History Factors – Code "8" for hx of MI, MR, suicidality (defined as above) or heinous crimes. Person may have a prior psychological report with a diagnosis of serious mental illness.

MMPI2
Refer for further psychological evaluations if T is greater than 70 on any scale except 4, 5, 6 or 9. Mild elevations on 1, 3, 6 **or** 7 are also acceptable or 0 if seen for a partial eval due to assaultive crimes. However, if they have elevations on many of the scales they should be seen. Those with high scores less than 70 on 2 and/or 8 but with signs on other tests or observations in testing, in housing unit which support depressive or thought disordered should also be referred. Extremely high scores on any scales except 4 should be referred.

T greater than 70 on scale 9 if Harris Lingoes Psychomotor Acceleration or Ego Inflation T scores are greater than 70 particularly if drawings look expansive or there are other signs of impulsivity or hypomania.

F-K > or = + or- 18, and L, For K > or = 70T

All invalid profiles in which the invalidity could be a "cry for help" or an indication that the person is confused or doesn't understand the questions or is trying to make himself look good **despite indications otherwise**. Invalidity which, nevertheless, shows that there are spikes in critical areas of depression or psychotic thinking should be referred.

K > or = 75 where drawings and sentences show some degree of psychological instability, TRIN >or = 79F, VRIN > or =80, more than 30 "cannot say" before item #270, Fp > or = 100, L scale > or = 80 with other clinical signs, F>or = 80 with other indicators, Fb >or=90 with F 30T below.

On Supplemental - T>70 on PK and PS with other signs

On Content - T> 70 on DEP, BIZ, ANG with other signs

DSI (any marked True)
303. Most of the time I wish I were dead.
506. I have recently considered killing myself.
520. Lately I have thought a lot about killing myself.
524. No one knows it but I have tried to kill myself.

Other items which should be looked at with caution and referred if other indicators are present:
96. I see things or animals or people around me that others do not see. T
138. I believe I am being plotted against T
162. Someone has been trying to poison me.
228. There are persons who are trying to steal my thoughts and ideas. T

MMPI2 indicators coded "2"

SDMT
Scores greater than **2** standard deviations below the mean, age and educational level

Cutoff scores are reproduced below:

	Age Range					
	18y-24y	25y -34y	35y-44y	45y-54y	55y-64y	65+y
< or = 12th grade	38	37	35	28	27	15
> or = 13th grade	42	40	32	35	31	21

SDMT indicators are coded "6"

Draw a Person
Referral is based on trained clinical judgment. Generally, individuals producing grossly pathological drawings should be referred for individual psychological evaluation if this test protocol **and** the RISB is also seriously pathological.

DAP indicators are coded "4"

Mental Retardation
If RISB and/or DAP and/or SDMT indicate primitive/rudimentary renderings in the judgment of the screener, the person should be referred for possible SSDU placement and given a Bender and measures of practical intelligence. They may also be given Wechsler subtests, Rivermead Behavioral Memory, GAMA, Street Survival Skills Questionnaire, SSDU referral form etc.

MR indicators should be coded "9" and further testing is indicated.

Rotter Incomplete Sentences Blank
Referral is based on trained clinical judgment. Generally, if there are **major** indications of idiosyncratic thinking, eccentricity, depression or suicidality, or low intellectual level, illiteracy etc. the person should be referred. This should be checked with DAP.

Other - People who cannot be tested or who need to be referred for full evaluation for any other reason are coded "11".

Key to Referral Reasons

DSI Person is being referred because he has one or more indications on his DSI that he may be thinking of suicide.

1. There is no longer a "1"

2. Person is being referred for a full evaluation based on MMPI-2 results.

3. There is no longer a "3"

4. Person is referred, at least in part, due to a problematic DAP

5. Person is referred, at least in part, due to problematic RISB

6. Person is referred, at least in part, due to problematic SDMT

7. A prior psychological report which indicates retardation, significant psychological distress (not ADHD), psychosis, major mental illness.

8. Mental health history (possible suicidality within 5 years, OP or IP treatment within 2 years not including SA counseling or ADD or intervention for characterologic problems or criminal activities).

   Heinous, notorious, bizarre, sadistic crimes.

   Possible Gender Identity issues.

9. Suspected mental retardation, learning disability with poor functioning, developmental disability, dementia, closed head injury with poor functioning from history, test factors. Referred for futher screening and eval.

10. Borderline cases (screener is referring them despite equivocal test results), persons for whom no testing is available, test refusals, cross national/cross cultural.

11. Anybody who, in the judgment of the psychologist, needs to be seen, regardless of other factors.

AO – Person is referred for preliminary assault offenders assessment.

SO – Person is referred for preliminary sex offenders assessment.

Ψ – Person is referred for a full psychological evaluation

*Screeners' initials and the date screened are always to be entered on the packet reviewed.

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Adolescent Evaluations

Inmates who are 16 years of age and under are automatically seen and evaluated by a psychologist. Due to time constraints, they may not get the full evaluation. The standard battery for those 18 and under is MMPI A, DAP, RISB, SDMT. Clinicians should use the Interpretive Guide for the MMPIA.

Suicide Ideation (Adolescent DSI)

#177 I sometimes think about killing myself.
#283 Most of the time, I wish I were dead.

Critical Items

#88 I don't seem to care what happens to me.
#92 I see things or animals or people around me that others do not see.
#132 I believe I am being plotted against.
#155 Someone has been trying to poison me.
#399 The future seems hopeless to me.
#428 There are persons who are trying to steal my thoughts and ideas.
#439 I often hear voices without knowing were they come from.

Mean Scores for Adolescent Boys on SDMT

14 y 45.49
15 y 48.73
14-15y 47.30
16 y 49.27
17 y 53.01
16-17 y 51.04

Two SD below Mean

14 y 29
15 y 29
14-15 y 29
16y 27
17 y 28
16-17 y 28

Updated: 03-09-06

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