UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

EVERETT HADIX, et al.,	)	
	)	
Plaintiffs,	)	
	)	**Case No. 4:92-CV-110**
v.	)	
	)	**HONORABLE ROBERT J. JONKER**
PATRICIA CARUSO, et al.,	)	
	)	
Defendants.	)	
	)	

PLAINTIFFS' TRIAL BRIEF[1]

I. DEFENDANTS DO NOT ADEQUATELY IDENTIFY PERSONS WITH SERIOUS MENTAL HEALTH NEEDS.

The current mental health system in the Michigan Department of Corrections ("MDOC") routinely and predictably fails to identify persons with serious mental health needs, and it has never demonstrated the ability to identify through its screening procedures a percentage of prisoners for treatment consistent with national data on the prevalence of mental illness in correctional settings. Pls.' Exh. 1A (Kupers Rpt.) at 2-4; Pls.' Exh. 7 (Bureau of Justice Statistics Report) at 4; *see also* T., 4/28/08 (Calley) at 226 (Michigan's rate of identifying the seriously mentally ill has been lower than that of other states) T., 6/11/08 (Walsh) at 663-669 (previous study showed that 23% of Michigan prisoners had a major mood disorder and 4.6% had psychotic disorders); T., 6/12/08 (Dlugacz) at 873, 875; T., 4/28/08 (Metzner) at 59, 65 (Defendants will have to justify their low rate of 7-9% of prisoners admitted to the caseload; he did not assess Plaintiffs' assertions of under-diagnosis or delays in mental health treatment).

[1] The Court approved in advance the filing of overlength briefs. *See* T., 6/12/08 at 1058.

The Office of the Medical Monitor ("OIMM") concluded that mental health care within the *Hadix* facilities reflected a "[s]ubstantial failure to identify serious mental illness on intake." Fourth Rpt. of the OIMM, 4/24/08 (Dkt. No. 2773) ("4th Report") at 3. That report notes that there is no reason to assume that Michigan has a lower rate of mental illness among its prisoners than other states; that the referring diagnoses of serious mental illness of over half of a sample of incoming prisoners have been downgraded by the RGC psychiatrists; and that one psychiatrist assigned an Axis I diagnosis other than substance abuse only 5% of the time. The report also provides a number of examples of inappropriate decisions that treatment was not required ("TNR"). *See* discussion *infra*.[2]

One result of the system's failure to identify those prisoners who need mental health treatment during the Reception and Guidance ("RGC") process is that large numbers of prisoners must be admitted to the caseload later. In fact, most of the caseload at any given time is made up of persons who were originally not designated for treatment. *See* Pls' Exh. 45 (Calley Dep., 12/12/07) at 37-38 (at time of deposition, 7.1.% of incoming prisoners were on the caseload at the end of the RGC process, but 30% are admitted to the caseload at some point in their sentence).[3] Unfortunately, a large number of prisoners are housed in facilities that lack an out-patient mental health team ("OPT"), so the process for identifying such prisoners is necessarily haphazard. *See*

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[2] "TNR" is a standard anagram used as a noun and verb by mental health staff in the system to mean that the OPT staff, usually a psychiatrist, has determined that a prisoner is not in need of treatment.

[3] In fact, there is substantial reason to question the accuracy of Royal Calley's figures. Plaintiffs' psychology expert, Robert Walsh, Ph.D., reviewed Defendants' underlying data on RGC admissions for the period November 2006-February 2007. During that period, the monthly rates of admission to the OPT ranged from 2.2% to only 3.2% – at best slightly over half the rate reported by Mr. Calley. Pls.' Exh. 2A (Walsh Expert Rpt.) at 5.

Defs.' Exh. AA (transfer grid, showing that a large number of prisons lack an OPT and are not suitable for confinement of prisoners who need mental health treatment).

After years of claiming that no constitutional violation exists regarding mental health care,[4] Defendants have now abandoned that argument and allege that they are encouraging the enrollment of prisoners with functional mental health impairments. *See* Pls.' Exh. 104 (Calley Dep., 6/3/08) at 172-173. Unfortunately, Defendants' proffered solution to the failure to identify the mentally ill in need of treatment, by relying on the jails rather than their own psychiatrists to identify the seriously mentally ill, cannot solve the problem of under-identification – it can only obscure its existence at RGC.

At the recent hearing Defendants claimed that, although the MDOC website indicates that only 5.9% of MDOC prisoners are on the OPT caseload and thus eligible to receive treatment from the Department of Community Health ("DCH"),[5] during a three-month period just before trial, 15.9% of incoming prisoners at RGC were admitted to the OPT caseload. T., 4/28/08 (Calley) at 129. All of the evidence presented by the parties, however, indicates that this jump in the caseload is almost entirely an artefact created by Defendants' bridge order policy. The bridge order policy provides that if a prisoner comes into RGC with a verified prescription for a psychotropic medication, that medication will be automatically continued by staff until the prisoner sees a psychiatrist; the policy also requires that if a bridge order is issued, the prisoner is to be evaluated by a psychiatrist within ten days. Defs.' Exh. A (Bridge Order Policy) at 1.

Once the bridge order results in a prescription for psychotropic medication, the prisoner is

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[4] *See, e.g.,* Defs.' Mot. to Terminate Inj. Relief, Nov. 20, 2007 (Dkt. No. 2684) at 25-26.

[5] T., 4/29/08 (Kupers) at 259.

automatically added to the OPT caseload for purposes of RGC caseload statistics. T., 4/28/08 (Calley) at 129; T., 4/30/08 (Rushbrook) at 577-579 (stating that a person who appeared on RGC caseload because he was continued on medications pursuant to the bridge order but was then found not to be in need of treatment by the RGC psychiatrist would thereafter be classified as "inactive" on the caseload but would exit the caseload under the "K plan" in a few months; such a person would never be classified as a TNR).[6] Thus, persons on the bridge order are temporarily added to the OPT caseload. Once the prisoner is actually evaluated by a psychiatrist, however, the psychiatrist is free to decide that the prisoner does not require treatment. Defs.' Exh. A (Bridge Order Policy) at 1; *see also* Defs.' Exh. Q (Mental Health Program Criteria and Guidelines) at 12 (providing that a prisoner whose psychotropic medications have been discontinued but who has been receiving psychotropic medications for less than 30 days need not be maintained on the OPT caseload);[7] T., 4/28/08 (Calley) at 208. Thus, as Defendants' own mental health expert Jeffrey Metzner, M.D., testified, the bridge order produces an "artificial elevation" in the statistics of those in treatment when they "initially get on the mental health caseload." T., 4/28/08 (Metzner) at 36-37.

Even though the bridge order was implemented in early March 2008, over 18% (81 of 442) of prisoners coming in on psychotropic medications in the period January-March 2008 had their medications discontinued. Pls.' Exh. 104 (Calley Dep. 6/3/08) at 24 (bridge order implemented in early March); Defs' Exh. SS at 1 (unnumbered questions and answers 4 and 7) (giving data on medication discontinuations). Prior to the bridge order, 23% of incoming patients had their verified

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[6] The reference to the "K plan" is a reference to persons whose psychotropic medications have been discontinued but by policy will stay on the caseload for thirty days. *See* Defs.' Exh. Q at 12.

[7] *See also* note 6, *supra.*

psychotropic medications discontinued in the months March-June 2007. Defs.' Exh. X (Performance Improvement Narrative Report 2007-2008) at 2.[8] Defendants' own outside expert agreed that this rate of discontinuation of verified medications prescribed by outside practitioners was a "bad practice" and is not done in systems in which he worked. T., 4/28/08 (Metzner) at 99-100.[9]

Defendants presented no evidence at all that prisoners who are listed at RGC as having been placed on the caseload because of the bridge order have actually been continued on medications at higher rates than previously when they see the psychiatrist. Pls.' Exh. 104 (Calley Dep., 6/3/08) at 9. Defendants suggest that their psychiatrists will be more likely to continue medications if it involves a little more work for their psychiatrists to discontinue the medications than to continue them. This theory is both thoroughly implausible and an indication of the low opinion that Defendants themselves hold of their psychiatrists; no serious mental health professional would allow his or her psychiatric diagnoses to be dictated by whether it takes a little more time to document one diagnosis than another. T., 6/11/08 (Walsh) at 661-662. Indeed, Mr. Calley testified that at the time he explained the bridge order to the RGC psychiatrists, he did not tell them that they should be broadening their diagnostic criteria for admission to the caseload. Pls.' Exh. 104 (Calley Dep., 6/3/08) at 128-129.

Dr. Metzner could not endorse Defendants' practice as a solution to the under-diagnosis

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[8] About 10% of prisoners previously came in on medications while 7.1% were accepted into the caseload at RGC. Pls.' Exh. 45 (Calley Dep., 12/12/07) at 37, 40-41. In 2007, 12.5% of newly arrived prisoners came into the system on medications, while the percentage of admissions to the caseload at the end of 2007 was only 8%. T., 4/28/08 (Calley) at 126-127; *see also id.* at 182.

[9] Metzner was asked about a discontinuation rate of "up to a quarter" rather than the actual MDOC discontinuation rate of 23%. *Id.* at 100.

problem; not only could he not predict a lasting elevation of the admission rate but also he condemned the lack of clinical judgment that the bridge order represents. T. 6/30/08 (Metzner) at 36-37 (use of the bridge order to continue medications is "not exercising great clinical judgment"; "What my concern is [,] is what's going to happen when you actually get to exercise clinical judgment?"). In short, only if the RGC psychiatrists fully abdicate the decision of whether a particular prisoner receives mental health treatment to the vagaries of the practices of individual local jails can the bridge order possibly affect the numbers of persons who stay on the caseload after RGC. *See* T., 6/11/08 (Cohen) at 765-767 (the quality of information MDOC receives from jails varies; the bridge order does not cover all incoming prisoners in need of treatment).

Defendants are not even attempting to find out if their supposition that the psychiatrists will change their evaluation practices is true. Although asked about outcome data from psychiatric evaluations for prisoners who were continued on medications as a result of the bridge order, Mr. Calley indicated that Defendants had no such data and were not attempting to track this issue. T., 4/28/08 (Calley) at 223. Indeed, Defendants' entire approach to the performance of the psychiatric staff at RGC is one of neglect and passive acceptance, as illustrated by the treatment of concerns raised by a number of other staff for many years about the performance of Vinh Thai, M.D. *See* T., 4/28/08 (Calley) at 181, 186; Pls.' Exh. 103 (memoranda from staff expressing concerns about Dr. Thai's behavior); *cf.* T., 4/28/08 at 188 (discussions of individual cases handled by Dr. Thai in the reports of the OIMM were not a concern to Mr. Calley because "I look at basically systematic findings"); *see also* Pls.' Exh. 104 (Calley Dep., 6/3/08) at 16-17.

Despite Mr. Calley's announced focus, Defendants are in fact remarkably uncurious about consistent discrepancies related to the work of Dr. Thai and the other psychiatrists. Between

December 1, 2007 and April 17, 2008, Fazal Khan, M.D., evaluated 261 prisoners for admission to the case load and TNRed 34, or 13.0%. He found that 17.6% of those he admitted to the caseload had a major mental illness and an additional one percent of those for whom he refused admission. Defs.' Exh. Y (OPT Statistical Rpt.) at 5. Significantly, four of those TNRed by Dr. Khan were diagnosed with major mental disorders and therefore should have been automatically admitted to the caseload. *See* Pls.' Exh. 104 (Calley Dep., 6/3/08) at 94; *see also* Defs.' Exh. Q (Mental Health Program Criteria) at 12. In contrast, Barbara Zara, M.D., TNRed none of the 108 prisoners referred to her, and found that 30.6% suffered from a major mental illness. *Id.* Dr. Thai saw 179 prisoners and TNRed 62, or almost 34.6% of them. He found that only 6.7% of the persons he evaluated suffered from a major mental disorder. *Id.* at 12.[10] Thus, Dr. Thai TNRed prisoners at a rate several times higher than that of either of the other psychiatrists, and he diagnosed major mental illness at a rate only half that of Dr. Khan and several times lower than that of Dr. Zara.

In the time period July-August 2007, although one of the psychiatrists was different, the discrepancies are equally apparent. Aleksandra Wilanowski, M.D., TNRed 19 of 175 prisoners, or 10.8%. She found that 39.4% of the prisoners she evaluated suffered from a major mental illness. Defs.' Exh. Z at 5. Dr. Khan TNRed 15 of 119, or 12.6%. He found 41.1% of the sample to have a major mental disorder. *Id.* at 6.[11] Again, one of those he TNRed he diagnosed with a major mental disorder. *Id.* Dr. Thai TNRed 78 of 156, or 50%. He found only 3.8% to suffer from a major mental disorder. *Id.* at 11. Again, Dr. Thai consistently TNRed prisoners at a rate several times that of any

[10] Failure to diagnose a major mental disorder is highly significant even if the patient is admitted to the OPT caseload, because absence of such a diagnosis makes it easier to remove the patient from the caseload later. T., 6/11/08 (Walsh) at 653; *see also* T., 4/28/08 (Calley) at 209.

[11] This percentage was calculated from the data provided.

of his colleagues.

Dr. Thai is thus consistently an outlier, regardless of the identity of the other psychiatrists to which he is compared. Further, Defendants are indifferent to the discrepancies. Even though both reports demonstrate an apparent violation of policy by Dr. Khan going back to 2007, there is no indication that anyone paid any attention to the report until it happened to come up in Dr. Calley's deposition in June 2008. *See* Pls.' Exh. 104 (Calley Dep. 6/3/08) at 95; *compare to* Defs.' Exh. Z (OPT Statistical Rpt.) at 6. Defendants' own experts agreed that the system needs to assess why the discrepancies exists between Dr. Thai and the other physicians. *See* T., 4/29/08 (Metzner) at 96; *see also id.* at 89-91 (stating that the significant discrepancies between the diagnostic rates of Dr. Thai and other psychiatrists were a concern); T., 6/12/08 (Rome) at 988-989.[12]

The statistical evidence of under-diagnosing and discrepant psychiatric practices in RGC is supported by graphic evidence of the harm caused by this failure to diagnose and designate for treatment in RGC.[13] For example, the Fourth Report of the OIMM provides several case studies, including that of MH2, who had been diagnosed by a psychiatrist at the Huron Valley ("HVM") in-patient facility as having an Axis I diagnosis of severe Bipolar Disorder with psychotic symptoms. The patient had come from the Michigan Training Unit Residential Treatment Program, an in-patient treatment program for the severely mentally ill. He also had a history of mental illness during a

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[12] Dr. Metzner raised the issue of whether differences in assignments of the psychiatrists could explain the diagnostic variations. *Id.* at 90. Dr. Calley indicated that there was no such explanation. T., 4/28/06 at 234 (Calley).

[13] It is interesting that although Defendants' experts expressed concern about the statistics, they did not review any actual medical records to determine whether the statistical anomalies reflected actual failures to diagnose. *Id.* at 991-992; T., 4/28/08 (Metzner) at 59. Further, in the one specific case that Dr. Metzner discussed, he agreed that Dr. Thai had wrongly TNRed the prisoner. T., 4/28/08 (Metzner) at 95.

previous prison term and had been diagnosed with depression when he re-entered RGC. 4th Rpt. at 14-15. He was transferred to Duane Waters Health Center ("DWH") where he was placed in an observation cell, held in restraints and given repeated anti-psychotic medications by injection. He was unresponsive, not eating or drinking, and was reported by the nurse to be engaging in psychotic behavior. Nonetheless, when Dr. Khan evaluated him, Dr. Khan found him simply a "malingerer." Subsequently, the MDOC started guardianship proceedings for this prisoner, who also had very serious medical problems and almost died as a result of forced feeding initiated at DWH. *Id*. at 15-17.

MH4's case is similar. His screening form indicated numerous suicide risk factors as well as symptoms of mumbling and paranoia. He was placed in a holding cell. When seen by staff from the Psychological Services Unit ("PSU"), he was noted to have signs of psychosis and was referred to the psychiatrist for disorganized thoughts and confusion. MH4 indicated that he had been prescribed anti-psychotic medications and had been diagnosed with paranoid schizophrenia in the jail. He was placed in the Special Management Housing Unit ("SMHU") because of concerns about unpredictable behavior and possible deterioration. When seen by a psychiatrist, MH4 was said to refuse medication and was TNRed.[14] The psychiatrist did not discuss the PSU diagnoses or the symptoms they reported. *Id.* at 19-20; *see also id.* at 24-26 (regarding Dr. Thai's failure to treat

[14] Dr. Metzner testified that in the past prisoners who refused medications were TNRed, but that he and Lee Rome, M.D., had worked with Defendants "early on" so that such persons are not discharged from the caseload. T., 4/28/08 (Metzner) at 61. Dr. Metzner filed his report in this case in August 2007. Defs.' Notice Regarding Mental Health Expert Rpts., Aug. 24, 2007 (Dkt. No. 2610). MH4 was TNRed in February 2008. 4th Rpt. at 20. The practice of TNRing prisoners who refuse medication in fact continues unabated. *See* discussion in Section III, *infra.*

MH6).[15]

These case studies bear out the assessments by Plaintiffs' experts Terry Kupers, M.D., and Robert Walsh, Ph.D. For example, Dr. Kupers' Report discusses K20, a prisoner with a childhood history of psychiatric in-patient treatment and a long history of prescribed anti-psychotic medications. K20 came to RGC on prescribed psychotropic medications but the psychiatrist he saw persuaded him not to continue his medications; when evaluated by Dr. Kupers after 45 days without his medications, K20 was crying and showing a slowing of thoughts and behavior, typical of depression, and other signs of depression. Pls.' Exh. 1A (Kupers Expert Rpt.) at 7-8; *see also id.* at 11-12 (K19, with a similar psychiatric history since childhood, was taking psychiatric medications at time of prison entry and he was hearing voices; he was assessed by Dr. Kupers as very depressed; he had been TNRed by Dr. Thai); at 12 (despite a history of Bipolar Disorder, psychotropic medications at the time of RGC entry, and Dr. Kuper's assessment of current depression, K22 was dissuaded by Dr. Thai from taking medications; Dr. Thai assessed no symptoms of mental disorder); at 28 (re TNRing prisoner who had jumped from a three-story building "trying to fly to God" and who defecated in his cell; the PSU worker involved in the deaths of TS and PH, discussed in the October 2006 hearing, decided that there was no current mental illness); at 39-40 (K6, found guilty but mentally ill, has been mentally ill all his life; he is usually diagnosed as paranoid schizophrenic; hears voices; and has been in and out of mental hospitals all his life, is not on the OPT caseload; he currently carries no diagnosis on Axis I; psychologist allowed K6 off the caseload; the psychologist believed that the patient has never suffered from serious mental illness; Dr. Kupers found him on

[15] *See also* T., 4/30/08 (Baker) at 478-481 (prisoner TNRed by Dr. Khan over objection by PSU staff thereafter was transferred to a Residential Treatment Program); Correction to 4th Rpt., Spreadsheet, 6/10/08 at 3; *compare to* Sealed Prisoner Key, 6/10/08 (Dkt. No. 2800-3).

assessment to be suffering from paranoid schizophrenia and deteriorating in segregation). Dr. Walsh's report notes similar findings. *See* Pls.' Exh.2A (Walsh Rpt.) at 5, 8-9 (noting conclusions based in part on Prisoners W01, W04, W19, W27, and W28); at 11-12 (re staff discouraging prisoners from accepting psychotropic medications and admission to the caseload) at 16 (re W01); T., 6/11/08 (Walsh) at 675-677; *id.,* (Cohen) at 802; *see also* discussion of Walden patients in Section V, *infra.*

The structural causes of the failure to identify the mentally ill are rooted in policy as well as deficient practice. The behavioral metric used by mental health staff (the Global Assessment of Functioning, commonly known as GAF) is set too high. Pls.' Exh. 1A (Kupers Rpt.) at 9-12. In addition, the revised initial screening form to be administered by the nurse or correctional officer,[16] is wrongly scored,[17] and the criteria for referral from PSU to OPT for consideration of admission to the caseload have been become inappropriately stringent over the years, resulting in missing persons with major mental illness. Pls.' Exh. 2B (Walsh Rpt.) at 9-11; T., 6/11/08 (Walsh) at 683-684 (example of critical information not picked up in screening process). The correctional officers should be taken out of the initial screening process. *Id.* at 638. A response to any of the suicide-risk questions should result in a referral. *Id.* at 637.

The new forms proposed by Defendants are lacking in necessary instructions definitions. *Id.* at 639. In addition, Defendants have chosen an instrument that was designed for use with incoming jail detainees, not sentenced prisoners. Jails are short-term facilities, and this screening mechanism is designed for placed with sparse mental health staffing and few other resources. *Id*. at 640. Many

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[16] Pls.' Exh. 46 (Gartland Dep.) at 56.

[17] *See* T., 4/29/08 (Kupers) at 350; T., 6/11/08 (Walsh) at 637-638.

prisoners coming into the prison system are reluctant to report suicide thoughts because of the consequences of being identified as having mental health needs, and prisoners can attempt either to minimize or exaggerate their mental health symptoms; the MMPI-2 (which Defendants plan to eliminate as a screening tool) is a useful part of the screening process just for this reason, and because the testing is useful if the prisoner's mental status changes during incarceration. The MMPI-2 picks up people who would otherwise be missed in the screening process *Id.* at 641-649. Prisoners with functional disabilities resulting from organic causes, including developmental disabilities, fetal alcohol syndrome, and closed head injuries are also not appropriately tested or identified at intake. T., 4/29/08 (Kupers) at 351.

Defendants claim that their TNR studies demonstrate that the low numbers of prisoners admitted to the caseload within 60 days after RGC rebut the claim of failures to identify prisoners in need of admission to the caseload. Only at RGC, however, do mental health staff actively look for mental illness in the formal evaluation process and, as noted above, most of the prisons in the MDOC do not have an out-patient team to evaluate prisoners. *See* Pls.' Exh. 1A (Kupers Rpt.) at 6; *see also* Defs.' Exh. AA (transfer grid showing presence of OPT units at certain MDOC prisons). Further, previous TNR diagnoses at RGC, particularly when made by a psychiatrist, cause the PSU staff to view subsequent symptoms of mental illness as reflecting malingering rather than mental illness. *See, e.g.,* Pls.' Exh. 1A (Kupers Rpt.) at 44 (when diagnosis of mental illness is missed, prisoner will be viewed as merely malingering and will be likely to end up in segregation when he breaks rules or becomes assaultive).

In addition, Mr. Calley, who conducts the TNR studies, reaches implausible conclusions about them. In the Statewide Performance Improvement Study Narrative Report 2006/2007, Mr.

Calley states that two prisoners, out of 465 TNRed by RGC psychiatrists during the year, from a total of 1329 cases sent to the psychiatrists by PSU, were admitted to the caseload within 60 days with a major mental illness. Defs.' Exh. X (Performance Improvement Narrative Rpt. 2006-2007) at unnumbered 4. Aside from the fact that this statistic becomes relevant only if one makes the unsupported assumption that such prisoners will come to the attention of OPT staff and be properly identified within 60 days, this statistic does not include prisoners who were wrongfully not referred to OPT by PSU. It also excludes prisoners added to the caseload within 60 days of being TNRed at RGC, but not diagnosed with a major mental disorder at the time of admission. *See id.* Only a small minority of prisoners admitted to the caseload are diagnosed with a major mental disorder. *See supra* at 7-8.

One other TNR study conducted by Mr. Calley looked at persons involved having a non-psychiatrist re-examine a 25% sample of prisoners TNRed at RGC by psychiatrists during a three-month period. That study reported that three prisoners, amounting to 6.5% of those referred but TNRed, were found to be in need of admission to the OPT caseload. *Id.* By simple extrapolation, that study suggests that an evaluation of all prisoners TNRed at RGC during by the psychiatrists during that year would find 48 such prisoners.[18] To this number, again, one would have to add those prisoners TNRed, or not even referred to OPT by PSU, who were found to require admission to the caseload within a short time of completing the RGC process. *See* Pls.' Exh. 104 (Calley Dep., 6/3/08) at 74-75 (admitting that in order to determine whether there was a systemic problem, one would have to look at prisoners missed at RGC by both PSU and OPT). The better way to look for

[18] Since it was a one-fourth sample, one could extrapolate 12 cases in the three-month period, and 48 over the year who needed to be admitted to the caseload. Obviously, the actual number over a year's time could be either higher or lower.

missed diagnoses of persons with serious mental health needs would be by surveying prisoners assigned to segregation. T., 4/29/08 (Kupers) at 283; T., 6/11/08 (Cohen) at 773; *id.,* (Walsh) at 660.

Most significantly, all the experts unaffiliated with Defendants identified a problem with wrongful TNRs by psychiatrists. 4th Rpt. at 3, 8-11, 14-17; 19-22; 24-26; (Walsh) at 651-653; 675–676, 680-681, 684-686, 691-692, 696-698; T., 6/12/08 (Dlugacz) at 870-871; T., 4/29/08 (Kupers) at 262, 275-276, 284; T., 6/12/08 (Walden) at 1047-1048. When, as discussed above, even Defendants' own expert will not endorse their announced mechanism for fixing the continuing under-identification of the mentally ill, Defendants cannot mask the deficiencies of their system by artificially, and temporarily, manipulating the percentage of prisoners identified for the caseload.

II. MENTAL HEALTH CARE IS FREQUENTLY DELAYED OR DENIED BY A DYSFUNCTIONAL SYSTEM.

Mental health services are fragmented into several different administrative lines of authority and reporting. The private medical contractor, Correctional Medical Services, Inc., ("CMS") provides physician and mid-level medical services, the MDOC provides nursing services, the Department of Community Health provides OPT services, and MDOC provides separate mental health services through PSU. Thus, three separate agencies, each with its own lines of supervision and policies, employ staff who should play a critical role in mental health diagnosis and treatment. Although Defendants promised in their August 2007 Mental Health Plan to integrate PSU and OPT, there is still no actual integration and Defendants made no claims during the evidentiary hearing as to when, if ever, integration would occur.

These divided lines of authority frequently leave prisoners in a deadly limbo. Defendants' own statistical reports indicate that while most staff referrals to PSU result in timely initial contact,

on those occasions in which a referral is delayed, that referral is often delayed for a dangerously long period. According to Defendants' own records, during January and February 2008, the time between an emergency referral from staff to the first contact by PSU was as much as 14 days. Defs.' Exh. H (2/2/08 Rpt.) (Patient 429421) at 1. For the same time period, the maximum time between an urgent referral and PSU initial contact was 73 days, and the maximum time between a routine referral and initial PSU contact was 61 days. *Id.* (2/2/08 Rpt.) (Patient 453612) (routine referral) at 5 & (3/1/08 Rpt.) (Patient 578884) at 3. Terry Kupers, M.D., noted that policy allows a delay of 28 days for a staff referral to a psychiatrist, which is too long. T., 4/29/08 (Kupers) at 293. He also found a number of evaluations that had been delayed for several weeks, and he testified that delays in treatment were exposing prisoners to a substantial danger of serious harm. *Id.* at 295-296.

Indeed, the claim in Defendants' Exh. SS that the average time for an OPT response to a PSU referral is 1.15 days is simply not true. Although not stated in Defendants' Exh. SS, this supposed average was calculated, not by calendar days, but by business days. Thus, the underlying records show that a delay between PSU referral and OPT response that was coded as ten days actually took 17 days, and a delay coded as eleven days actually took 18 days. Mr. Calley does not know what the real average is. Pls.' Exh.104 (Calley Dep., 6/3/08) at 17-20.

The minutes of the February 13, 2008 PSU Staff Meeting at RGC reflect the following:

> Dr. Gartland shared that Dr. Pramstaller (Chief Medical Officer) hates the PSU Transcase Reports. . . . It was unclear whether the general disgruntlement with our performance was a reflection of the poor identification of MI[19] that is being made, the people slipping through the cracks or OPT's inability to fulfill their mission due to poor staffing.

[19] Plaintiffs believe that, from context, "MI" stands for mental illness.

Pls.' Exh. 102 (PSU Staff Meeting 2/13/08) at 328377.

The PSU meeting of February 27, 2008 noted parallel concerns about performance of the OPT staff:

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

Id. (PSU Staff Meeting, 2/13/08) at 328378.

The minutes of the Monthly RGC PSU Staff Meeting in March 2008 indicate that Dr. Gartland found it necessary to instruct PSU staff that "staff is to continue to make referrals to the [OPT] even if it is questionable that they will be picked up or not." Defs.' Exh. BB (3/26/08 Minutes) at 3. The same minutes also document substantial tension between the two agencies:

> Complaints about OPT must be in writing to Dr. Gartland. . . . If there is concern of a policy violation, staff may request an investigation. Examples of concerns might include no documentation, pressure to change the urgency of a referral, instructing an inmate that they will have to stay at RGC longer if they are on psychotropic medication, etc. Most of these are regular complaints. Please be prepared to put it in writing if you have a complaint because it may not get followed up on unless it is.

Id. at 2.

While Defendants claim in Exhibit SS that persons coming into RGC with verified prescriptions for psychotropic medications get those medications in less than a day, that is also simply not the case. At Mr. Calley's June deposition regarding the reliability of Exhibit SS, Mr. Calley

agreed that he had not made available the underlying records, and that the medical records that Plaintiffs produced at the deposition demonstrated that the summary document he provided failed to support the claim that Defendants had accomplished same-day delivery of medical records; the document he provided read as if the date that the medications were entered into the pharmacy computer was the date the prisoner entered RGC, although the actual medical records showed discrepancies of up to two weeks. Pls.' Exh. 104 (Calley Dep.) at 35-47.

In fact, the Fifth Report of OIMM documents that, contrary to the claim of reliable same-day delivery of verified psychotropic medications since the implementation of the bridge order, almost exactly a third of the prisoners arriving with verified psychiatric medications had delivery of those medications delayed two or more days; one prisoner experienced an eight-day interruption of his medications. Fifth Report of the OIMM, June 6, 2008 (Dkt. No. 2797) at 3. In addition, the Report found a number of significant medication errors, delays in seeing a psychiatrist, and questionable mental health decisions. *Id.* at 4-14. Further, by definition the bridge order does not address the problem of prisoners who come in on unverified medications, or otherwise need medications but do not have a verified prescription. In these circumstances, same-day medications are ordered only in emergencies. Pls.' Exh. 48 (Thai Dep.) at 71-76.

Defendants claim that the case management meetings perform all the necessary coordinating functions. This argument fails on its face because the minutes of the case management meetings contain no evidence that PSU and OPT use this forum to discuss mental health issues regarding prisoners who are not admitted to the caseload. *See* Defs.' Exh. E (case management minutes, 1/3/08-4/15/08); T., 6/12/08 (Rome) (no TNR discussion occurred in the case management meeting he attended); T., 6/12/08 (Dlugacz) at 880. Similarly, Prisoner 281804, identified by Mr. Baker as

someone PSU believed OPT had wrongly TNRed, never appears in the case management minutes. *See id.; compare to* T., 4/30/08 (Baker) at 478-481. Given that the case management meetings are not used to resolve disputes about TNRing and that improper TNRing by OPT is a major component of the pattern of under-diagnosing mental illness, by definition the meetings cannot substitute for real staff integration and supervision. *See also* T., 4/28/08 (Metzner) at 54 (case management meetings are "not the avenue to do integration.").

It is also hard to imagine how the case management meetings could play any significant role in coordinating care because only a handful of people attend. Few prisoners are placed on the list of high-risk prisoners, and some of those names appear to be on the list because of medical rather than mental health issues. Further, the notes are so sparse that it is hard to see how they could provide any assistance to staff who do not attend the meeting. *See, e.g.,* Defs.' Exh. E. (Case Management Meeting Notes, 1/3/08) (No CMS physician, PSU, or OPT representative attended; only ten prisoners identified as high risk outside of SMHU, plus one prisoner within SMHU; no notes other than a few words about each of these prisoners); (Case Management Notes, 4/145/08) (no CMS physician and custody representative attended; only ten prisoners identified, none identified in SMHU; prisoner notes are brief). Given the extremely limited attendance at these meetings, the cryptic notes about a handful of prisoners can scarcely substitute for the meaningful integration that the system needs.

The suffering of Chad Childers presents a textbook case of the effects of this dysfunctional system on one vulnerable human being. Mr. Childers, age 26, who has a history of mental illness from his late teens, with a diagnosis of schizophrenia, paranoid type, should have been the very easiest of cases for the system to handle correctly. Pls.' Exh. 34 (Childers Dep.) at 4-5. Mr. Childers has a loving family that did everything possible to make certain that the MDOC was fully informed

and prepared to deal with his illness, which had stabilized on a three-drug regimen. *Id.* at 7. His mother, Diana Childers, gave the probation officer extensive information about her son's history and condition for his pre-sentence report and the jail records, and she reviewed the pre-sentence report to make certain that it was accurate. *Id.* at 9-11; Pls.' Exh. 19 (Pre-Sentence Rpt.) at 326925, 326938.

Mr. Childers arrived in prison on March 28, 2007, but did not receive any of his medications until April 1[20] even though the medical records received from the Lapeer County Jail documented his history of schizophrenia and his current psychotropic medications and doses, and included the letters from his mother and his case manager. Pls.' Exh. 33 (Childers Medical Rec.) at 3270005, 327007-327008; Pls.' Exh. 32 (OIMM Mem.). He did not receive one of his prescribed medications, Zoloft, for over a month. Pls.' Exh. 31 (Hladki Mem.) at 327002.[21]

Critically, although Mr. Childers was admitted to the OPT on March 29, 2007, the day he arrived at RGC, there is no evidence that he received any significant OPT treatment other than medications, even as he proceeded to decompensate. T., 6//11/08 (Walsh) at 704-705; Pls.' Exh. 33 (Childers Medical Rec.) at 327017. He was housed in a filthy cell on the fourth tier (five floors up) although a Nurse Practitioner had ordered a base cell for him. Pls.' Exh. 20 (Childers' Letter) at 326945; Pls.' Exh. 33 (Childers Medical Rec.) at 327018. Placement on the fourth tier was harmful

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[20] Pls.' Exh. 32 (OIMM Mem.). According to Mr. Childers' letters to his mother, he received his Wellbutrin first but did not receive his Seroquel until April 4. Pls.' Exh. 21 (letter from C. Childers to D. Childers) at 2.

[21] According to Mr. Childers' letters to his mother, he was discouraged from taking Zoloft by the RGC psychiatrist's discussion of the increased risk of cancer associated with use of Zoloft. Pls.' Exh. 20 (C. Childers' Letter) at 326946. Dr. Walsh noted that in his investigation he had found a number of cases in which staff discouraged prisoners from continuing their medications, and that the Childers "refusal" may have been another such case. T., 6/19/08 (Walsh) at 711-713.

to someone with Mr. Childers' mental health problems; walking on the fourth tier is frightening because of the fear of falling or being pushed over the railing by other prisoners. T., 6/11/08 (Walsh) at 704.

On April 22, 2007, Mr. Childers was scheduled for transfer to the SMHU for observation due to his "agitated, bizarre, hostile behavior." Pls.' Exh. 31 (Hladki Mem.) at 327001. He was diverted from the SMHU only because one of the correctional officers noticed that Mr. Childers' leg was red and swollen. Instead, he was transferred to DWH where he was diagnosed with cellulitis and started on intravenous antibiotic therapy. Upon arrival at DWH, staff characterized Mr. Childers as "delusional and paranoid." *Id.* Mr. Childers repeatedly pulled out his intravenous lines, complicating his recovery. *Id.* at 327002.

After Ms. Childers received her son's first letter regarding his lack of medication, she made numerous telephone calls to staff to attempt to assure that her son received the psychiatric medications he needed. Pls.' Exh. 34 (Childers Dep.) at 18-21, 25-28, 30-33, 36-37, 41-42. By the time she received her son's third letter, she believed that he was decompensating mentally. *Id.* at 22-23. After more telephone calls to staff, she learned of the transfer to DWH. *Id.* at 26-27. She was told that his medical records from RGC had not gone to DWH, so she faxed his medication history to staff. *Id.* at 35-36; Pls.' Exh. 36 (Faxed list). Ms. Childers spoke to her son at DWH and learned that he had substantially regressed and his paranoid symptoms worsened. Pls.' Exh. 34 (Childers Dep.) at 43. When she saw her son at DWH on May 17, 2007, she found him experiencing the worst psychotic break she had seen with his illness. *Id.* at 43-46. Because of the cellulitis, Mr. Childers could not be transferred to the Crisis Stabilization Unit at HVM, where staff said that he needed to be. *Id.* at 41-42.

Mr. Childers ultimately had to be transferred to the in-patient Residential Treatment Program and is still, one year later, recovering from his severe psychotic break. *Id.* at 57. Dr. Walsh noted that, despite the wealth of information made available to staff, staff failed to maintain his established and effective medication regime, and failed to monitor or treat him as he became increasingly paranoid and delusional. These failures reflected a profound lack of coordination and cooperation between medical and mental health services. Dr. Walsh also expressed the opinion that, had Mr. Childers received psychotherapy or other therapeutic contact, the gradual deterioration that resulted in the acute exacerbation of his psychosis might have been discovered and prevented. Further, Dr. Walsh noted, Mr. Childers suffered mentally and physically because of the failures in his care. T., 6/11/08 (Walsh) at 702-707.

Dr. Kupers' Report also documents the pattern of delays and failures of coordination, resulting to harm to prisoners occasioned by this divided responsibility. One of these patients was K9, who had prostate cancer that had gone untreated for over a year. During the period that diagnosis for the patient's cancer was delayed, the CMS physician made a direct referral to a psychiatrist but PSU stopped the referral – a direct and inappropriate consequence of the dysfunctional relationships among CMS, PSU and OPT. Pls.' Exh. 1A (Kupers Rpt.) at 14-15.[22] Dr. Kupers also noted that the institutional separation between PSU and OPT plays a significant role in the failure to diagnose mental illness during the intake process as OPT staff disregard findings by PSU staff and in the delay of urgent referrals from PSU to OPT. Pls.' Exh. 1B (Kupers Decl.) at 14-15.

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[22] Although Defendants claim that any prisoner prescribed psychotropic medications is automatically placed on the OPT, this claim is untrue. After K9 eventually saw a psychiatrist, she prescribed Zoloft for him but did not place him on the caseload. Only after the OIMM complained was K9 added to the OPT caseload. *Id.* at 15; *see also* Section V, *infra.*

The Fourth Report of the OIMM also documents the serious consequences from the dysfunctional organization of mental health care. For example MH1, who had received a diagnosis of severe major depressive disorder, with psychotic features, at the end of December 2007, and who had previously attempted suicide while incarcerated, was placed in restraints in DWH and given telephone orders by a psychiatrist for injection of haloperidol (haldol), a major anti-psychotic, and for restraints, on April 1, 2008, the day he arrived at DWH. The psychiatrist discharged him on April 3, 2008 to a non-*Hadix* MDOC prison without ever doing a comprehensive psychiatric evaluation even though staff considered MH1 to be severely suicidal and on a hunger strike. 4th Rpt. at 12-14.

MH3 experienced his third PSU evaluation when he was placed in the SMHU. The PSU staff member made an OPT referral for medication evaluation, but did not indicate the degree of urgency, even though later that day MH3 was referred to the DWH emergency room because of crying, withdrawal and expressions of severe hopelessness and helplessness. At that point, PSU made an urgent OPT referral. The patient was seen that day by a psychologist from OPT, who could not prescribe medications. The OPT psychologist decided that MH3 would benefit from a psychiatric evaluation; the plan was for PSU to monitor. It took two additional days before this patient saw a psychiatrist, who then prescribed psychotropic medication. This patient had previous suicide attempts and psychiatric hospitalizations. It took 17 days to get to the psychiatrist following his arrival at RGC. *Id.* at 17-19; *see also id.* at 24-25 (MH6, discussed *infra* in Section V) & 26-28 (it took 14 days to obtain a comprehensive psychiatric evaluation of a patient who came in with a history of spending most of the last year in a mental hospital and who was placed in a DWH observation cell prior to his evaluation).

Only full integration can solve these problems. Until that full integration, which Defendants

did not promise at this hearing, prisoners will continue to be harmed by this dysfunctional system. T., 4/29/08 (Kupers) at 340-343 (there is an urgent need for integration; prisoners are being harmed by the lack of integration); T., 6/12/08 (Dlugacz) at 880-881; T., 6/11/08 (Walsh) at 682-684; T., 6/12/08 (Walden) at 1047-1048; Pls.' Exh. 47 (Rushbrook Dep.) at 50; Metzner Rpt., 8/24/07 (Dkt. No. 2610-02) at 19; T., 4/28/08 (Metzner) at 107-109; 4th Rpt. at 3.

III. THE FAILURES OF THIS DYSFUNCTIONAL SYSTEM ARE EXACERBATED BY THE LACK OF SUPERVISION, PARTICULARLY IN VIEW OF THE RELIANCE ON LIMITED-LICENSE STAFF.

Unfortunately, this is a system without meaningful supervision of staff. There is one fully-licensed psychologist in PSU to supervise twelve limited-license staff. Pls.' Exh. 46 (Gartland Dep.) at 9. There is no fully-licensed psychologist in the OPT at RGC. These limited-license staff require supervision by a fully-licensed psychologist. T., 4/30/08 (Baker) at 452.[23] Dr. Metzner fully agreed with this need for supervision, particularly because he believed that the use of limited-license psychologists was undesirable. T., 4/28/08 (Metzner) at 84. Dr. Metzner also stated that it was even more of a concern that the unit chief for OPT at RGC was not a licensed psychologist, because

[23] Jared Baker identified Diane Gartland, Ph.D., as his supervisor, and he described two forms of direct supervision from her. She had accompanied him on a number of rounds in the SMHU and she has monthly meetings with the PSU psychologists. *Id.* at 453. Mr. Baker was the person doing regular rounds at the SMHU. *Id.* at 451. Dr. Gartland did not provide similar supervision of rounds for anyone other than Mr. Baker. Pls.' Exh. 46 (Gartland Dep.) at 58. Indeed, the quality of those weekend rounds is vastly different. T., 4/30/08 at 492 (Baker states that minimum time it took him to do SMHU rounds was about 35 minutes); *compare to* Defs.' Exh.D (SMHU Round Rpts. for March 2008) (entry for 3/10/08) (Zang reports that weekend rounds took five minutes to complete); *see also id.* (entries for 3/30/08, 3/15/08; 3/9/08; 3/2/08; 3/1/08) (additional weekend rounds completed in twenty minutes or less). The second form of supervision described by Mr. Baker was the monthly meetings with Dr. Gartland. T., 4/30/08 (Baker) at 453. Significantly, Defendants' expert indicated that he was unable to state an opinion as to whether the supervision provided limited-license staff, including the monthly meetings, provided sufficient supervision. T., 4/28/08 (Metzner) at 85-86.

supervision needs to be done by fully-licensed staff, and he repeatedly declined to state an opinion that supervision in the system was adequate. *Id.* at 85-87, 105.

Dr. Kupers noted that limited-license psychologists were performing critical functions such as competency examinations and determinations of whether to release a prisoner from suicide observation, functions that should never be done by such staff. T., 4/29/08 (Kupers) at 305-306. Limited-license staff were also inappropriately stopping referrals from somatic physicians to psychiatrists. *Id*. at 307. Appropriate supervision would require more than monthly staff meetings or reviewing a few files each month; it would require that the supervisor actually see some patients with the person being supervised, so that the supervisor could develop an informed opinion of the quality of the work done by those he or she supervises. *Id.* at 310-311; T., 6/12/08 (Dlugacz) at 878. When Dr. Walsh worked in the *Hadix* facilities, this is how psychologists were supervised. T., 6/11/08 (Walsh) at 709-710.

There is no clinical supervision for the work of the psychiatrists; their administrative supervisor is Craig Crawford, a limited-license psychologist. T., 4/28/08 (Metzner) at 88-89; T., 4/30/08 (Rushbrook) (limited-license psychologist reviews whether psychiatrists follow policy but does not review quality of clinical performance); Pls.' Exh. 104 (Calley Dep., 6/3/08) at 137 (Crawford essentially making certain that the psychiatrists had proper documentation). This lack of clinical supervision allows the several-fold discrepancies among the percentages of patients accepted for treatment, discussed in Section I, *supra,* to persist. T., 6/11/08 (Cohen) at 779-780; *see also id.* at 781-782 (a psychiatrist is needed to supervise the work of the other psychiatrists); T., 4/28/08 (Metzner) at 96 (MDOC needs to give an explanation of the discrepancies between Dr. Thai and other

psychiatrists).[24]

Another dimension of the lack of supervision in the system is the chasm between what supervisors think is happening in the system and actual practice. For example, Dr. Metzner was told that no one was kept in SMHU because of mental illness, and he would be concerned if anyone was kept there because of mental health issues. T., 4/28/08 (Metzner) at 112-113. In contrast, the OIMM's review of medical records of prisoners assigned to the SMHU noted cases such as Prisoner 6, who was moved to the SMHU for refusing to take haldol and depakene. Correction to 4th Rpt., 6/10/08 (Dkt. No. 2800-2) (SMHU spread sheet) (comments re Prisoner 6); *see also id.,* comments re Prisoners 11, 25; Defs.' Exh. NN (SMHU Log for 2/6/08) (prisoner listed as confined for "NOI [notice of intent]; Psy Observation"; first so confined on January 30) & (SMHU Log for 2/14/08) (again referring to same prisoner as confined for "NOI-PSU Observation"); Defs' Exh. OO (SMHU Log for 3/13/08) (prisoner listed as confined for "Psy Observation – Remain Pending Psy Release"; listed as first confined in SMHU on February 29,) & (SMHU Log for 3/25/08) (same prisoner as March 13 log entry listed as "Psy Observation" pending Residential Treatment Program transfer; listed as again placed in SMHU on March 19).

Similarly, Defendants told Dr. Metzner that, although this practice is not required by policy, prisoners prescribed psychotropic medications are not housed in the SMHU; if someone is on psychotropic medications, he is removed in "a couple of days." T., 4/28/08 (Metzner) at 112. Ironically, Mr. Baker, on direct, described his interactions with Prisoner 678759 as part of his testimony about the SMHU rounds. He noted that this prisoner was receiving psychotropic

[24] This is another way in which mental health care in the system has been downgraded. When Dr. Walsh practiced in the *Hadix* facilities, the complex had a supervising psychiatrist, which is needed now. T., 6/11/08 (Walsh) at 657.

medications. T., 4/30/08 (Baker) at 455. According to Defendants' SMHU housing log, this prisoner was confined in the SMHU ten days. Defs.' Exh. PP (log entry, 4/9/08) (showing Prisoner 678759's cell in SMHU and noting that he entered the SMHU on March 31, 2008). If the practices Dr. Metzner was told about existed, one would have expected Mr. Baker to know about them.

As another example, despite supervisors' claims that prior records have long been sought, and attempts to find examples of such efforts, there is still no evidence that the asserted practice is occurring. *See* T., 4/28/08 (Metzner) at 96-97 (he talked to staff about seeking medical records; would expect them to be able to get around 20%); *id.* at 195 (Calley) (between October 2007 and February 2008 Mr. Calley found one instance in which medical release was obtained from a prisoner at RGC); Pls.' Exh. 47 (Rushbrook Dep.) at 58-59, 62-63 (as of December 2007, in the proceeding "couple of months" policy had been implemented to get medical records of everyone admitted to OPT); Pls.' Exh. 104 (Calley 6/3/08 Dep.) at 47-52 (while preparing Defs.' Exh. SS in April 2008, Mr. Calley asked Mr. Crawford how many requests for medical records there had been and Mr. Crawford recalled only one; it was Mr. Crawford's and Dr. Rushbrook's responsibility to see that medical records were requested; Mr. Calley also asked them in writing in April 2008 to do this; Mr. Crawford had told him early in 2008 that staff had stopped requesting records); *see also* T., 6/12/08 (Dlugacz) at 889. This evidence also demonstrates why Dr. Metzner was careful to make clear that he made minimal claims about Defendants' actual implementation of claimed policies. These failures to request previous records result in missed diagnoses, and cause harm. T., 6/11/08 (Walsh) at 684-686; T., 4/29/08 (Kupers) at 271, 395-396.[25]

[25] Although Defendants imply that attempts to obtain prior medical records would be futile, there is no apparent basis for such claims. Dr. Rome admitted that the Wayne County Jail had a process to provide requested records to the MDOC within one to three weeks, and faster if

A similar chasm between policy and practice affects the treatment of prisoners who decline to take psychotropic medication. By policy, such prisoners are to be continued on the OPT caseload. Pls.' Exh. 45 (Calley Dep., 12/12/07) at 54. In fact, such prisoners are routinely discharged from the caseload. *See* Pls.' Exh. 48 (Thai Dep.) at 63; 4th Rpt. at 20; Kupers Rpt., 8/24/08 (Dkt. 2609-02) at 11-12. Yet another example is the practice of discontinuing psychotropic medication prescriptions when a prisoner enters RGC. When Dr. Rushbrook was deposed on December 11, 2007, he testified that he believed that such discontinuations rarely happened. Pls.' Exh. 47 (Rushbrook Dep.) at 27. In fact, as noted above, prior to the revision of the bridge order, 23% of all prisoners with verified medication orders were losing their prescriptions.

Dr. Kupers and Dr. Walsh testified that there was a substantial danger of serious harm from the effects of lack of supervision and staff integration. T., 4/39/08 (Kupers) at 308 (noting toxic effects from lack of supervision for limited-license staff include mistakes in diagnosis and cutting people off from treatment); at 313 (noting harm to prisoners who by luck of draw are evaluated by Dr. Thai); at 316 (noting substantial danger of serious harm from lack of staff supervision); at 340 (noting urgent need for integration, many breakdowns from the separations of the two services, harm from the separation of PSU and OPT); at 342 (death record of 142490 an example of harm from lack of integration); *see also* 4th Rpt. at 3.

IV. THE *HADIX* FACILITIES NEED MORE MENTAL HEALTH STAFFING AND MORE ACCESS TO IN-PATIENT BEDS.

Prior to the re-opening of the mental health issues in this case, Defendants deliberately set about to reduce the quality and quantity of mental health services to prisoners. In July 2006, the

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the records were needed as a priority. T., 6/12/08 (Rome) at 959-960.

Department of Community Health ("DCH") announced its intention to "downsize" and "streamline" mental health services by moving prisoners out of the program. The plan was to modify the referral process to the OPT by being slower to make referrals to such staff and by moving prisoners out of the OPT caseload. Pls.' Exh. 97 (Performance Improvement Region II Health Care Servs., 07/11/06).

This downsizing was accompanied by a substantial reduction in the access of *Hadix* class members to in-patient treatment beds. DWH eliminated a 22-bed mental health treatment unit program; it was downgraded from hospital status after it lost its hospital accreditation. T., 4/29/08 (Kupers) at 268-269. This downgrade was particularly damaging because DWH was the only place in the system that could care for a prisoner who needed in-patient medical treatment as well as access to on-site (as contrasted to on-call) psychiatric care. When Dr. Walsh was at RGC, the psychiatric beds at DWH were kept full. The closing of those beds creates a gap for prisoners with both major medical and mental health needs, particularly because DWH has no pyschiatric or psychological on-site coverage. *See supra* at 20 (Childers could not be transferred to HVM because of his medical needs) *see also infra* at 39 (patients who need restraints cannot be transferred to HVM; no on-site psychiatric coverage at DWH). The HVM in-patient mental health facility also lost its accreditation and the self-mutilators unit, formerly available to *Hadix* prisoners, closed. *Id.* at 269-270. While the MDOC once planned that 4.4% of its beds would be in-patient mental health beds,[26] that fraction is now about 1.0%. *Id.* at 270, 393 (about 700 mental health beds in MDOC; state prison population is approximately 50,000). No mental health beds have been added for several years, despite the increase in prison population. *Id.*

Thus, it is no accident that more in-patient mental health beds are needed for *Hadix* prisoners.

[26] Pls.' Exh. 36 (Rpt. to MDOC, 7/2/87).

Defendants presented statistics regarding the available beds at HVM through February 2008. *See* Defs.' Exh. HH (Monthly Rpt. for 2/08). According to that document, the authorized number of beds for the long-term unit ("RTS")[27] at HVM was 120 and the average census for February 2008 was 120. The authorized number of beds for the Crisis Stabilization Program ("CSP") was eight and the average census in February was 15. The authorized number of acute beds was 40 and the average census in February was 35. *Id.* Mr. Calley testified that all three units were in the same building at HVM, and also testified that there was a separate residential treatment program ("RTP"), where he claimed that the average census was about 235 and the authorized capacity was 260. T., 4/28/08 at 210-213.[28] Mr. Calley also testified that there are persons who have been discharged from HVM and are awaiting transfer to another prison facility; sometimes there are 15-20 such persons. *Id.* at 213. The combined data from Mr. Calley and Defendants' Exhibit HH show the following as of February 2008, the last month for which data are available:

HVM Capacity and Average Census

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

These figures mean that, as a practical matter, there are on average fewer than ten available beds out of a total of 428. Assuming the higher average number of empty beds (eight), this means

[27] *See* T., 4/28/08 (Calley) at 125.

[28] Defendants' reports do not include the RTP.

that the entire facility is running at an average census of over 98% of capacity. Even if one ignored the beds filled by discharged patients, and counted the average census as only 405, the facility is running at more than 95% of capacity. As Defendants' expert Dr. Metzner testified, prisons and hospitals are designed to run at 90% of capacity in order to avoid waiting lists. Dr. Metzner also agreed, in the context of a discussion of the CSP, that delays in admission would be expected at that level of population. T., 4/28/08 (Metzner) at 70.

While Defendants admit that they need 40 more beds at HVM,[29] there is no guarantee that such beds will actually be provided, and at best they will not be authorized until FY 2009. *Id.* An additional 80 beds are needed now. S*ee* T., 6/11/08 (Cohen) at 801 (Defendants' recent data show them above capacity at HVM); T., 6/11/08 (Dlugacz) at 896 (need for 80 additional beds at HVM).

Of further significance, Defendants claim in their Exhibit SS that all referrals from RGC to CSP were accepted by CSP, and arrived there, within one day. Defs.' Exh. SS (unnumbered question and answer 3). No underlying documents were supplied to support the claim regarding the CSP admissions,[30] and Defendants' own monthly reports are inconsistent with that claim. *See* Defs.' Exh. DD (Monthly Report for 11/07) (entries related to 665043) (psychiatric evaluation completed on November 3, 2007; discharged from RGC to HVM on November 7, 2007); Defs.' Exh. EE (Monthly Rpt. for 12/07) (entries related to 632973) (psychiatric evaluation completed on December 5, 2007; discharged from RGC to CSP on December 7, 2007).[31]

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[29] Defs.' Exh. SS at unnumbered 4.

[30] Pls.' Exh. 104 (Calley Dep.) at 21-22.

[31] The other monthly reports filed by Defendants are missing some part of the necessary data to determine the length of time between psychiatric evaluation and referral.

Contrary to Defendants' assurances that beds are always available for *Hadix* prisoners at HVM, the internal documents of the mental health staff tell a different story. The PSU Monthly Meeting Notes report the following directions that suggest the obstacles to making a transfer to HVM:

> During the week, OPT has the responsibility of sending the inmate to CSP. PSU will be responsible on the weekends. . . . If the psychologist is told there are no beds available at the CSP, call the RGC Control Center. . . . As a last resort, Health Care Director for Region III, Duncan Howard may be reached on his cell phone[.]

Defs.' Exh. BB (PSU Staff Meeting, 12/20/07) at unnumbered 2.[32] These same minutes suggest possible shortages in the availability of observation cells in DWH. *Id.* (prisoners are supposed to be kept in the observation cells for a maximum of 48 hours; the cells are not to be used to hold dementia patients;[33] such patients can be held in the SMHU by doing the proper paperwork; if all four observation cells are full, such prisoners can be placed in regular patient rooms); *see also* T., 6/12/08 (Dlugacz) at 895 (staff acted as if there was a shortage of beds).

With the exception of the four observation cells at DWH, there are no mental health beds in the *Hadix* complex. The lack of an RGC mental health unit leads to the use of the SMHU for confining mentally ill prisoners. *See* Correction to 4th Rpt., 6/10/08 (Dkt. No. 2800-02) (SMHU spread sheet) (comment entries for Prisoners 6, 11, 15, 27); *see also* T., 6/11/08 (Walsh) at 705-706; Pls.' Exh. 31 (Mem. re Childers). Most of the mentally ill prisoners who are placed in the SMHU, however, are not placed there explicitly because of their mental illness. Rather, because of these prisoners' mental illness, they have difficulty conforming their behavior to the staff's expectations,

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[32] Defendants' Exhibit BB is not properly labeled in their Exhibit List. These meeting minutes follow unrelated documents at the beginning of the document.

[33] Dr. Metzner was unaware that the SMHU was used to house dementia patients, and stated that it was wrong to do so. T., 4/28/08 (Metzner) at 75.

so that they receive disciplinary violations; they have trouble following the norms of the prisoners' culture; or their mental illness leaves them defenseless to predatory fellow prisoners so they are sent to SMHU for protective custody. T., 4/29/08 (Kupers) at 276-277 (mentally ill cannot conform to expectations so have problems with the disciplinary system; they also cannot conform their behavior to unwritten prisoner code, and they are at increased danger of rape and other assaults); at 317 (mentally ill end up in protective custody in segregation); T., 6/12/08 (Dlugacz) at 891 (mental health unit needed to have full range of services).

Segregation is toxic for persons who are mentally ill. *Id.* at 319. In fact, PSU staff raised the issue of the problem of fearful prisoners with mental health issue being confined in the SMHU, but the warden's response was that "it is normal to be fearful." Defs.' Exh. B, (PSU Staff Meeting, 1/23/08) at 2. OPT staff noted that some of these fearful prisoners had a mental disability. *Id.*

Mental health staffing for the *Hadix* facilities requires major increases. Defendants have admitted that the RGC OPT needs an additional 1.5-2.0 psychiatrists and an additional 3.5 other qualified mental health professionals, based solely on the planned changes in the evaluation process; this estimate does not include additional staffing for RGC screening or assessment process. Defs.' Exh. SS at unnumbered 4. Further, this estimate does not address the need for on-site coverage at DWH, a lack of coverage that leads to acceptance of six-day delays in responding to an immediate referral to OPT. T., 6/12/08 (Crawford) at 940.

Nor would providing these additional staff necessarily assure that RGC is not left completely without any on-site psychiatric coverage, as it was in December 2007, when the only availability was from a psychiatrist off-site at another prison to cover any emergencies. T., 4/30/08 (Rushbrook) at 568-569. Finally, of course, there is no assurance that these suggested staff positions will even

materialize; shortly before trial PSU staff were told that there even a possibility that a vacant psychologist position would not be filled. Pls.' Exh. 102 (RGC PSU Staff Meeting Minutes, 1/23/08) at 328384. Given that, in the last month for which statistics were available, the OPT caseload at RGC was at 211% of recommended capacity, additional staffing is critical because the system is at the breaking point. Defs.' Exh. RR (caseload statistics for March 2008); *see also* T., 6/11/08 (Cohen) at 802; Kupers Rpt. at 53-54; T., 4/28/08 (Metzner) (if system is identifying 15% of prisoners for the caseload, then more staff are needed); Kupers Rpt., 8/24/08 (Dkt. No. 2609-02) at 54.

V. THE NEEDS OF PRISONERS WITH BOTH MAJOR MEDICAL AND MENTAL HEALTH PROBLEMS ARE IGNORED.

There is no routine access to a psychiatrist for prisoners confined in DWH; patients' only access is through the on-call psychiatrist. T., 4/30/08 (Rushbrook) at 567-568. The involvement of Mr. Crawford, the only psychologist who covers DWH, is also minimal. T., 4/29/08 (Kupers) at 321, 323. As a result, patients who suffer from terminal or other serious physical illness and also suffer from major mental disorders lack meaningful access to mental health care, and the psychiatrists take no responsibility for the patients in DWH. The other physicians are left unassisted in caring for the behavioral manifestations of such patients' needs.

As discussed below, the psychiatric abdication of responsibility for these patients is virtually complete. While for other prisoners only psychiatrists prescribe and monitor psychotropic medications, for these patients it appears that psychiatrists are usually not even involved in prescribing or monitoring medications, and use of a psychotropic medication does not prevent the psychiatrists from TNRing a patient. Further, patients can be too sick for in-patient mental health treatment; the closing of the DWH mental health unit means that prisoners with complex mental health and medical needs simply do not get all those needs addressed.

For example, Mr. Crawford, a limited-license psychologist and unit chief of the OPT, who has some on-call responsibilities at DWH, discussed a patient, 291035, at DWH as an example of mental health services provided there. T., 6/12/08 (Crawford) at 906-907. This patient was a paraplegic who had known MRSA (methicillin-resistant *staphylococcus aureus*) since May 2007 and also suffered from a serious pressure ulcer. He had been non-compliant with needed treatment for his pressure ulcer. Pls.' Exh. 106 (Cohen Mem.) at 331216.

Although Mr. Crawford was aware of delusional writings by this patient, during the summer of 2007, he did not chart anything about those delusions. *Id.* (describing letter to OIMM from patient complaining that he was hooked to machine that could hear his thoughts); T., 6/12/08 (Crawford) at 939. On September 28, 2007, a social worker asked Mr. Crawford to see the patient immediately. At that point, the patient was refusing a CT scan necessary to diagnose a suspicious mass in his pelvis. Mr. Crawford did not see the patient until October 3, 2007, when he found the patient to be delusional. His explanation for the six-day delay was that "we see him as soon as we can." *Id.* at 940. Thus, the delay in seeing this patient in a medical crisis reflects the lack of mental health coverage at DWH, just as does the subsequent delay of another week before the patient was seen by a psychiatrist. Pls.' Exh. 106 (Cohen Mem.) at 331216-331217. Further, Mr. Crawford waited four weeks to see him again, even though he knew at that point that the patient was refusing the CT scan necessary to rule out a bone tumor. *Id.*; T., 6/12/08 (Crawford) at 941-942. Although Mr. Crawford agreed that the need for the CT scan is urgent, the first steps for seeking a guardianship procedure did not take place until January 2008. *Id.* at 943.[34] As is typically the case in DWH, the patient's

[34] It seems likely that guardianship proceedings were started only in response to the December 5, 2007 letter from Dr. Cohen suggesting competency proceedings if the patient continued to refuse care.

psychiatric medications were prescribed by a non-psychiatrist. Pls.' Exh. 106 (Hladki Mem.) at 331232.

At the May 28, 2008 meeting of the parties, Dr. Cohen asked why there had been no attempt to panel the patient, given that the guardianship hearing had not taken place, because his deteriorated mental condition might explain his refusal of necessary medical treatment. T., 6/12/08 (Crawford) at 944. Only after that meeting did Defendants take any steps to panel the patient; the result of starting the paneling process was that Defendants agreed to stay the guardianship hearing in June 2008 to allow the paneling process to go forward. *Id.* at 944-946. In short, despite the patient's refusal of critically-needed treatment nine months ago, Defendants have done virtually nothing to resolve the issue – in a case Defendants presented as an example of their efforts regarding guardianship. As of the time of the June hearing, he remained without treatment or diagnosis. This is a patient whose lack of access to necessary mental health care in DWH may well result in his death.

Plaintiffs' medical expert Jerry Walden, M.D., reviewed death charts and documented the essential lack of mental health care given patients in DWH. For example, Patient 142490 suffered from liposarcoma, a cancer, in his lower back. He was also being treated with an anti-psychotic medication (Risperdal) as well as an anti-depressant. Aside from the medication prescriptions, he had minimal mental health attention. At one point a psychiatrist stated in the record that she would change his medications but she did not in fact do so. As a result of his cancer he had an ostomy (surgically-created opening) between his bowel and his skin. He picked at the ostomy site, and as a result apparently the ostomy device came off. He would use the ostomy tube to spread feces in his room and on his body. The medical records do not suggest any involvement by mental health staff in attempting to plan a strategy to address the behaviors, although this behavior may have led to the

development of sepsis. Given the patient's complex needs, he required a team approach from medical and mental health staff, including the psychiatrist, which did not occur. In addition, when he was sent to Foote Hospital for medical treatment, DWH sent no information about his mental health issues, with the result that the hospital staff lost treatment time doing a competency examination there. T., 6/12/08 (Walden) at 1020-1024.

Patient 241294, only 42, had a heart problem. He was also prescribed Risperdal. In December 2007, an outside hospital changed his Risperdal to a different anti-psychotic because of a potential side-effect of Risperdal that could have exacerbated his heart problems. When he returned to DWH, the psychiatrist did not monitor his response to the new anti-psychotic. His mental status deteriorated, and he went off his medications. When he was transferred to Foote Hospital, again without the relevant mental health records, physicians there questioned whether he was competent, and the next day he was found to be floridly psychotic. By that time, when the Foote psychiatrist declared him not to be competent to make medical decisions, it was too late and he died. Again, the record does not contain any indication of communications between the DWH medical staff and any mental health staff to discuss treatment for this man. *Id.* at 1024-1027.

Patient 116272 died of myeloma (a blood cancer). In September 2006, a PSU (limited-license) staff member did a competency examination at DWH and decided that the patient was competent.[35] The same day, the patient was sent to Foote Hospital, and found not to be competent. The hospital started the patient on Risperdal and began guardianship proceedings. After the guardian was appointed, an RGC psychiatrist saw the patient at DWH and, despite the guardianship and the

[35] Limited-license staff are not qualified to find a patient competent without a subsequent confirmation by qualified staff. T., 4/29/08 (Kupers) at 304-305.

prescription for Risperdal, TNRed the patient, without any explanation of why she disregarded the evidence of a serious mental disorder.[36] Her medical record note indicated that the patient should contact her if he wanted follow-up, but it was clear from the record that the patient was not capable of initiating a request for follow-up. *Id*. at 1027-1028; *see also* T., 6/11/08 (Walsh) at 686-698 (finding actual harm to this patient from the treatment failures; he was not admitted to the OPT caseload despite noting symptoms of mental illness, and inability to rule out possibility of psychosis; PSU noted that he suffered from belief (a delusion) that the physicians were trying to kill him).

Patient 574859 came into the prison with diagnoses of coronary artery disease, Hepatitis C, Bipolar Disorder, and possible mild mental retardation. There was a 13-day interruption in his psychotropic medications when he arrived at RGC. Although he told the psychiatrist that he had been scheduled for coronary by-pass in the community, she did not communicate this information to the non-psychiatric physicians. From the record, he appeared to be a candidate for by-pass surgery, but he was never seen by cardiology while in prison. He died suddenly, presumably of a heart attack or similar cause. *Id.* at 1033-1035.

Patient 196312 had Hepatitis C, liver cancer (hepatic carcinoma), cirrhosis of the liver, and diabetes. He might have been experiencing confusion because of his liver problems, because of repeated low blood sugar problems, or because of digitalis toxicity.[37] Nonetheless, he was being prescribed haldol and ativan (an anti-anxiety medication) by a physician's assistant. He needed a

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[36] Given the practice at DWH, the TNR may well not have resulted in a discontinuation of the Risperdal. At a minimum, however, it meant that psychiatry was not involved further in monitoring the Risperdal prescription or his general mental health needs. *See* T., 6/12/08 (Walden) at 1032.

[37] Because of the digitalis toxicity issue, Foote Hospital discontinued his digitalis prescription. *Id.* at 1041.

psychiatric consultation to manage his medication, which he did not get. *Id.* at 1040-1041. Patient 071481 suffered from terminal lung disease and heart disease. He was prescribed psychotropic medications and other medications that increased his risk of falling. He needed, but did not receive, coordinated care with psychiatry was needed to develop his medication regimen. *Id.* at 1042.

Another patient, 147311, apparently died from this lack of coordinated consideration of his medications. He was supposed to be followed by psychiatry, but there was no record that this occurred. He had colon cancer and was also prescribed Risperdal and morphine. These medications lowered his blood pressure, thus increasing his risk of falling. After he suffered an episode of falling, he fell again and sustained a cerebral hemorrhage, which apparently was the cause of his death. *Id.* at 1043-1044. In an in-patient setting like DWH, it is the community standard for the psychiatrists and other physicians to consult on patients with both serious mental health and medical problems. *Id.* at 1044-1045.

Dr. Walden also found that mental health care failed to provide necessary counseling for these patients to address their mental pain and suffering, such as depression from facing a terminal illness. These cases included 176609 (anxiety from rape during previous prison sentence); 241702 (lack of assistance in working through recommendation to change his status to indicate that resuscitation should not be attempted); 366350 (lack of counseling regarding compliance with HIV medication regimen). *Id.* at 1035-1037. Similarly, although psychiatry has special expertise in pain control issues, there was no sign that psychiatry was involved in developing or monitoring pain control programs for terminal patients. *See id.* at 1038 (Patient 062740) (psychiatry not involved in pain management for patient with lung cancer despite use of anti-anxiety medications); *id.* at 1039 (Patient 122274) (similar problem related to patient with throat cancer); *id.* (Patient 149988) (similar problem

related to patient with lung cancer with brain metastasis); *id.* at 1039-1040 (Patient 238304) (similar problem related to patient with lung cancer and heart disease).

Dr. Walden's findings mirror those of the OIMM with regard to the treatment of patients in DWH. The OIMM provides a case study of MH2, diagnosed by a HVM psychiatrist as suffering from severe Bipolar Disorder with psychotic features who was nonetheless transferred to DWH for possible forced feeding and psychiatric evaluation. MH2 was continued in restraints for a number of days, while he developed MRSA. He was then force-fed for the next four weeks. After he began eating, he was sent back to Huron Valley until he again stopped eating and began to decompensate. At that point, he was psychotic and severely dehydrated, and was again placed in four-point restraints. The restraints were continued without a medical services provider (physician, nurse practitioner, or physician's assistant) evaluating the patient.

An OIMM nurse practitioner happened to observe this patient and expressed concern about his medical status. As a result, MH2 was found to be suffering from hypernatremia (abnormal concentration of salt in the urine) as well as severe dehydration. Dr. Khan then decided that MH2 was malingering, at about the same time that the patient found to be septic. For the next three days MH2's condition deteriorated but his sepsis was not treated as the medical emergency it was. Only after his temperature climbed to 104°was he taken as an emergency transfer to Foote Hospital where he was found to be septic, hypotensive (suffering from low blood pressure) and also suffering from extensive pneumonia. He almost died from the effects of forced feeding. 4th Rpt. at 14-17.

Dr. Walden, who also reviewed MH2's medical record, noted that the medical record reflected that the patient could not be transferred to HVM because the in-patient mental health facility did not have any beds that were attached to the floor (and therefore could be used to apply restraints). T.,

6/12/08 (Walden) at 1046. This is not the only case in which a patient who had both major medical and major mental health needs could not receive necessary medical care. Mr. Childers, as previously noted, could not be transferred to needed in-patient mental health treatment at HVM because of his medical condition. *See supra* at 20. Had the DWH psychiatric unit not been closed by Defendants, the system would have had available a unit where both medical and psychiatric care could be provided.

Another case study described in the Fourth Report is MH6. MH6 has neurofibromatosis, which results in many non-malignant tumors throughout the body. He also has a large pelvic mass with bone destruction suspicious for a malignancy. He was transferred to DWH where he refused medications and was non-verbal with infantile reactions. Staff requested a psychiatric consult and he was given an injection of haldol[38] and lorazepam, a combination used to treat severely agitated psychosis. A psychiatrist visited after the injection and described the patient as psychotic and in need of guardianship. He was then changed to extended care, meaning that he would receive a physician visit only once a month. 4th Rpt at 24-26. Five days after a psychiatric assessment was requested, Dr. Thai TNRed the patient.[39]

The Fourth Report also notes the case of MH1, who was given repeated injections of major psychotropic medications including haldol pursuant to an RGC psychiatrist's telephone orders. He was also placed in four-point restraints pursuant to a telephone order from a nurse practitioner and was continued in restraints pursuant to telephone orders. No DWH psychiatrist completed a

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[38] Dr. Walden, who also read the medical record of MH6, testified that the medical record indicated an allergy to haldol.

[39] *See* T., 6/12/08 (Walden) at 1029.

comprehensive assessment of the patient even though he was transferred there because he was considered to be seriously suicidal and despite the use of four-point restraints and haldol injections. *Id.* at 12-14.

The lack of on-site mental health staffing, combined with the failure of leadership and the lack of interdisciplinary integration, predictably harms patients. T., 6/12/08 (Walden) at 1046. In Dr. Walden's review of the death records, he did not find any patients with serious mental health needs who actually received the services they required. *Id*. at 1047. He also concluded that there was a substantial danger of serious harm to the general medical care of the patients from the deficiencies in mental health care. *Id.* at 1048. Indeed, Dr. Walden found that actual harm was likely to have occurred, ranging from the premature death of three patients, to emotional harm from the lack of appropriate end-of-life care. *Id.* at 1048-1049. Dr. Walden also concluded, to a reasonable degree of medical certainty, that, absent change, other prisoners will suffer physical and emotional harm based on the deficiencies he noted. *Id.* at 1049; *see also* 4th Rpt. at 3 (finding failure to provide urgent and emergent psychiatric consultation for severely decompensated mentally ill prisoners).

VI. PLAINTIFFS' MOTION FOR FURTHER RELIEF SHOULD BE GRANTED.

The evidence that demonstrates a continuing violation of the Eighth Amendment resulting from the lack of mental health care also supports granting Plaintiffs' request for further relief. Plaintiffs note that supporting evidence below.

A. Deadline for Integrating PSU and OPT.

The only way that mental health services can be made to work in a reasonable period of time is to require Defendants to carry out their announced plans for integration of PSU and OPT. *See* Defs.' Revised Mental Health Care Plan, Aug. 20, 2007 (Dkt. No. 2601) at 9 (noting intention to

producing a functional merging of the mental health identification and treatment activities at of PSU and OPT at RGC as well as the Southern Michigan Correctional Facility until it closes); *see also* 4th Rpt. at 29; Pls.' Exh. 2A (Walsh Rpt.) at 28-29. Defendants promised the Court that they would do so in the plan of August 2007, but nearly a year later there is still no sign of integration in practice. *See also* Metzner Rpt., 8/24/07 (Dkt. No. 2610-02) at 19. Defendants are required to integrate the two services in the Court's Order of May 4, 2007. Order, May 4, 2007 (Dkt. No. 2408) at 1-2.[40] Absent integration, the failures of the system that leave mentally ill prisoners in a hopeless limbo will persist. *See* Section II, *supra*. Because, absent integration, the constitutional violation cannot be cured in any reasonable time frame, Plaintiffs request that the Court require functional integration by a date certain, after allowing Defendants to participate in establishing the required date.

B. Development of Plan for Staff Supervision

The consistent and persistent failures of staff to follow announced policies, the continuing failures to address the extreme discrepancies between the RGC staff psychiatrists in their performance of their core duty of identifying prisoners in need of mental health treatment, and the widespread use of limited-license staff who intrinsically require substantial oversight in the performance of their duties demand a structured plan for real supervision, as requested by Plaintiffs in their motion for further relief. *See* Section III, *supra; see also* 4th Rpt. at 29; Pls.' Exh. 1A (Kupers Rpt.) at 53.

C. Timely Referrals to Psychiatrists

Because the lack of integration and resulting waste of mental health resources, combined with the failure to supervise staff, leads to repeated harmful delays in referrals to the psychiatrists,

[40] This Order was remanded to this Court but never vacated, so it continues to be binding on Defendants.

Plaintiffs' motion for further relief seeks an order requiring emergent referrals on the same day if possible but in any event within 24 hours; urgent referrals within 72 hours; and routine referrals within seven calendar days. *See* Section II at 14-17, *supra*; *see also* Section V, *supra* (discussion of delays in referrals to OPT and failures of meaningful psychiatric involvement for patients in DWH); 4th Rpt. at 30 (recommending supervisory review of instances of psychiatrists failing to respond to emergency requests for evaluation of severely mentally ill prisoners).

D. Revision of Screening Instruments

Although Defendants promised some improvements in the initial screening instruments for mental health needs at RGC, those instruments continue to need changes to prevent persons with serious mental health needs from being missed in the screening process. *See* Section I at 11-12; *see also* Pls.' Exh. 1A (Kupers Rpt.) at 53. Plaintiffs ask that the screening instruments be revised to require automatic referrals if the prisoner has ever received disability benefits on psychiatric grounds or has a history of significant mental health needs, and that prisoners referred because of possible suicide risk be seen the same day by a psychologist.

E. Requirement to Seek Past Mental Health Records

The evidence indicates that it is critical to implement policy that requires staff to seek relevant past records of mental health treatment, including the MDOC's own records from previous sentences. The evidence is equally overwhelming that, despite policy, such records are never sought. *See* Section III at 26, *supra.* Further, policy does not require any attempt to obtain any mental health records prior to a prisoner's admission to the OPT caseload. T., 4/28/08 (Calley) at 83. Defendants should be required to make reasonable efforts to obtain previous treatment records involving psychotropic medications, diagnosis of a major mental disorder, psychiatric hospitalizations, or

suicide attempts, and such reasonable efforts should include attempts to obtain medical releases and to determine the custodian of such records. T., 6/11/08 (Cohen) at 768; T., 4/29/08 (Kupers) at 396; 4th Rpt. at 30 (recommendation for obtaining previous records, including previous MDOC records).

F. Maintenance on OPT Caseload of Prisoners Seeking Psychotropic Medication

Despite policy to the contrary, the mental health records reveal that refusal of medications continues to lead to automatic TNRing of prisoners. *See* Section I at 9; Section III at 26-27. Indeed, outside of DWH, where psychiatrists have virtually no involvement in psychotropic medication prescriptions, *see* Section V, there is not a single example in the record of a prisoner who was reported to refuse medications and yet remained on the OPT caseload. Plaintiffs seek an order requiring implementation of policy, because such patients require continued contact to assure that they are encouraged to resume their necessary medications, and to assure that if their condition deteriorates after they refuse medications, they can be monitored and encouraged to resume treatment. T., 4/29/08 (Kupers) at 300-302.

G. Appropriate Testing During Screening for Organic and Developmental Disorders

The RGC screening process fails to test prisoners for closed head injuries, mental retardation, and similar conditions that significantly affect their mental functioning. *See* Section I at 12. Such prisoners, like mentally ill prisoners, are highly likely to be unable to conform to prison rules and to the unwritten rules of the prison culture, and thus are particularly likely to end up in segregation or in protective custody, or suffer physical and emotional harm in general population. Plaintiffs therefore seek an order requiring Defendants to develop a plan for testing and evaluation of developmental and other brain disorders.

H. Excluding Prisoners with Serious Mental Health Needs and Prisoners on Mental Health Observation Status from SMHU

The evidence demonstrates that some prisoners are assigned to the SMHU solely because of their serious mental health needs. *See* Section IV at 31. Many other mentally ill prisoners end up in SMHU because of behavioral problems, or because they need protective segregation. Segregated confinement has severely debilitating effects on seriously mentally ill prisoners. *Id.* at 31-32. *Hadix* prisoners also need immediate on-site access to a real mental health unit, with assigned staff, not just the observation cells in DWH. *See* Section IV at 28; 4th Rpt. at 29; Pls.' Exh. 1A (Kupers Rpt.) at 54-55; Pls.' Exh. 2A (Walsh Rpt.) at 27. Plaintiffs therefore seek an order excluding such patients from the SMHU.

I. Evaluating the Need for In-Patient Mental Health Treatment Beds

The in-patient beds available at HVM, or at some other facility, must be significantly expanded. 4th Rpt. at 29-30. The mental health unit at DWH must also be reopened, and a staffing pattern in which psychiatrists and psychologists are on-site, rather than just on-call, must be restored. Such a unit at DWH is critical, even if beds at HVM are expanded, because the closing of the previous DWH mental health unit resulted in removing the only beds from the system that could provide both on-site psychiatric care and in-patient medical care for *Hadix* prisoners.

J. The Need for Staff Training

Defendants have failed to implement the order for staff training by unilaterally deciding that only staff assigned to segregation should receive such training. Defendants' interpretation of the training requirement has no basis in the text of the Court's November 2006 and May 2007 orders. In addition, the pervasive and persistent failures of staff to follow policy (*see* Section III at 25-27, *supra*) require, along with meaningful supervision, a reconstituted and reinvigorated training program

to assure that future *Hadix* class members with serious medical and mental health needs do not die, like several of the patients reviewed by Dr. Walden, or suffer serious harm, like Chad Childers, from the predictable failures of the mental health system.

K. A Plan for Quality Assurance

Defendants lack a meaningful quality assurance program. 4th Rpt. at 11; Pls.' Exh. 1A (Kupers Rpt.) at 55; Pls.' Exh. 2A (Walsh Rpt. at 26); T., 4/28/08 (Metzner) at 109-110 (there are a variety of quality improvement indicators that should be monitored such as length of stay in the observation beds and discrepancies in diagnostic practices). Dr. Metzner in his report agreed with the OIMM that the revised quality assurance program for the *Hadix* facilities should include monitoring and addressing problems identified and problems averted. Metzner Expert Rpt., 8/24/07 (Dkt. No. 2010-2) at 20-21; *see also* Pls.' Exh. 1A (Kupers Rpt.) at 55.

Nothing submitted by Defendants suggested development of a quality assurance program that is focused on identifying problems and then fixing them. In fact, many of the quality assurance documentation Defendants submitted demonstrated serious deficiencies in their practices. *See* Defs.' Exh. P (Regional Quality Assurance Rpt. 2007) (all but two indicators fell below 90% threshold, including the RGC comprehensive psychiatric assessment, which received a score of only 68%); Defs.' Exh. R (Regional 2007 3rd Quarter Rpt.) (all six indicators audited regarding the interpretative summary fell below threshold; five of six fell below 50%; requirement that summary contain basic identifying information was met in only 67% of records sampled; requirements of history of illness, suggested therapeutic interventions, and treatment plan goals fell below 50%);[41] Defs.' Exh. T

[41] The scores would have been lower, but outdated treatment plans were not audited. *Id.* at unnumbered 3.

(Regional 2007 1st Quarter Rpt.) (treatment plan requirements fell below threshold at 71%; OPT admission requirements fell below threshold at 70%).[42] John Rushbrook, Ph.D., the Central Region Manager for OPT, who is involved in Central Region quality assurance and staff evaluations, testified that he could not recall any category of these reports in which RGC met the 90% threshold, and he could not recall RGC quality assurance audits that had not been submitted. T., 4/30/08 (Rushbrook) at 510-511, 570-573.

Indeed, there is a complete absence of evidence that, even when quality assurance studies are performed, any specific actions are undertaken to address the findings. In order to be meaningful, the quality assurance plan must be targeted to identify serious problems of the system. In addition, it is critical that Defendants use the quality assurance findings, along with real supervision of staff to fix the problems identified. To that end, Defendants should be ordered to develop and submit for approval an appropriate plan for quality assurance.

CONCLUSION

The record overwhelmingly shows a violation of the Eighth Amendment by reason of the known failures to provide "basic mental health services" to the *Hadix* class; the consequences of these consistent failures are "unnecessary and painful mental deterioration." 4th Rpt. at 28. Accordingly, Defendants' motion for termination of mental health relief must be denied. The record also demonstrates that the relief requested in Plaintiffs' motion for further relief should be granted in order to cure that violation.

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[42] With the exception of the RGC comprehensive assessment, and the TNR reports, none of the quality assurance reported proffered by Defendants were specific to RGC.

Respectfully submitted,

s/ Elizabeth Alexander

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