

**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.)	
_____)	

**BRIEF IN OPPOSITION TO DEFENDANTS’ MOTION TO TERMINATE RELIEF
REGARDING MENTAL HEALTH FOR THE *HADIX* FACILITIES**

I. INTRODUCTION

Contrary to Defendants’ claims, a careful consideration of the evidence reveals that the extraordinary failures that led to the Court’s November 13, 2006 preliminary injunction reflect systemic deficiencies in the mental health system, including the failure to diagnose mental illness, the failure to provide qualified mental health staffing and services, the failure to coordinate mental health services, the creation of barriers to psychiatric consultation for general medical practitioners, and the unreliability of medication prescription and delivery, among others. While many of the examples of these problems were drawn from the experience of the mentally ill at the Southern Michigan Correctional Facility (“JMF”), contrary to Defendants’ claims, these failures prevent necessary medical care, as well as necessary mental health care for those with mental health issues, at all the *Hadix* facilities.

The Court appropriately utilized Fed. R. Civ. P. 60(b)(6) to reopen the issues of the Complaint. In any event, even without a reopening, the Court’s equitable powers allow the Court

to address the mental health issues that serve as a barrier to ending the constitutional violations affecting medical care. Further, there is simply no basis for Defendants' claim that the testimony of Robert Cohen, M.D., and Jerry S. Walden, M.D., was improperly admitted into evidence, in light of the nature of the testimony provided. Also contrary to Defendants' claims, none of the mental health issues are moot.

II. THE FACTUAL BASIS FOR RELIEF ON THE MENTAL HEALTH CLAIMS

A. Evidence of Harm from Mental Health Failures

Defendants' presentation of the facts is remarkable for what it leaves out as well as how its repetition of points that the record flatly refutes. Defendants' first incorrect claim is that the Court based relief solely on two deaths, the death of T.S. in the Southern Michigan Correctional Facility ("JMF") segregation unit, and the death of P.H. as a result of his treatment at Duane Waters Hospital (now, after the facility has been downgraded and lost its accreditation,¹ known as Duane Waters Health Care ("DWH")).

In fact, in addition to these two deaths, the Court cited a number of other "instances of medical treatment failure which were causally related to inadequate psychological and psychiatric services at the *Hadix* facilities." Op., Nov. 7, 2006 (Dkt. No. 2186) ("Nov. Op.") at 13. These include failures to provide mental health services to a dialysis patient who was refusing dialysis, a

¹ Findings of Fact & Conclusions of Law, Dec. 7, 2006 (Dkt. No. 2233) at 2. Defendants failed to challenge any of the findings of fact in their appeal from this order. *See* Attach. 1 (excerpt from Defs.' Final Br. on Appeal, No. 06-2591 *et al.*) (showing that Defendants' Statement of Issues Presented does not include any challenge to the factual findings of the Court with regard to Appeal No. 2591, the mental health appeal or Appeal No. 06-2628, the medical appeal). Having failed to appeal any of the factual findings with regard to mental health or medical care, Defendants cannot now challenge them. *United States v. Adesida*, 129 F.3d 846, 850 (6th Cir. 1997) (law-of-the-case doctrine bars challenge to decision reached at earlier stage of litigation that could have been challenged on appeal but was not).

patient who needed surgery for a drug-resistant “staph” (methicillin-resistant *staphylococcus aureus* or MRSA), a patient with heart failure who refused to take his medication, a patient who died of renal failure without counseling, a patient who refused surgery for a brain tumor, and a patient needing surgery for an arteriovenous malformation in his brain. *Id.* at 13-14.²

The Court also noted a number of additional deaths related to inadequate mental health care, including the death of Patient 165, a death related to lack of care at DWH that rivals that of T.S. in the prolonged agony that the patient was forced to endure. *Id.* at 14-15. When this patient arrived at the Reception and Guidance Center (“RGC”) after losing 60 pounds at another prison, supposedly because of a food strike, the nurse found him covered with feces and lying on the floor of the “bubble” (point of initial screening in the reception process). Despite these obvious symptoms, the nurse decided that the prisoner was neurologically sound because she thought that he “had sneaked a peak at her.” As a result, she gave him a can of Ensure. He was subsequently sent to DWH for evaluation and the next day a physician transferred him to an outside hospital. Once he reached the outside hospital, he was diagnosed with severe neurological impairments, including a “blown pupil” (a sign of severe neurological compromise). He also had aspiration pneumonia, which Dr. Walden noted may have resulted from the Ensure the nurse gave him. Dr. Walden also criticized the nurse’s assumption that the patient was a malingerer and the lack of documentation and care by the two physicians, one at RGC and one at DWH. Jerry Walden Redacted Expert Report, Aug. 4, 2006 (Dkt. No. 2079) at 58. The patient subsequently died of a Glioblastoma, a brain tumor. *Id.* at 57. As the Court notes, the patient was treated as a malingerer without psychological examination although he

² Several of these patients received all or a substantial part of their treatment at DWH. Attach. 2, Walden Decl.

“needed coordinated medical and mental health care.” Nov. Op. at 15.

One of the suicides involved a patient who reported that his medications no longer worked and he needed “to silence the voices.” The psychiatrist was unable to prescribe an effective medication for him because of the formulary limitations imposed on the medical system related to cost. *Id.* at 14-15. Another patient in a DWH general ward was held in restraints for an approximately two-week period shortly after T.S. died. Attach. 2, Walden Decl. The Court quoted from Dr. Walden’s Expert Report regarding the intertwined medical and mental health failures represented by this case and his unmet need for coordinated care by both medicine and psychiatry. Nov. Op. at 15 (quoting Walden Redacted Expert Report, Aug. 4, 2006 at 73-74).

Defendants’ versions of the deaths of T.S. and P.H. are also fundamentally distorted by their failure to include inconvenient facts. Defendants incorrectly state that only an unanticipated human error in communicating a need to transfer T.S. to a mental health treatment facility caused a 21-year-old mentally ill prisoner to die of exposure to excessive heat and dehydration. Defs.’ Br. at 15. This is simply not correct; the death of T.S. reflected the systemic failures of medical staff, mental health staff, and custody to take any actions when the need for action was patently obvious.

T.S. had a history of mental illness, including bipolar disorder, depression, and past suicide attempts. T.S. also had multiple medical problems that placed him at high risk of heat injury. Findings of Fact & Conclusions of Law, Apr. 3, 2007 (Dkt. No. 2375) at 6. On a heat alert day, during a period of time in which the facility had no on-site psychiatric coverage, he was sent to segregation for disobeying correctional officers. Nov. Op. at 3, 6.³ He then attempted to flood his

³ Defendants claim that there was on-site psychiatric coverage. That claim lacks any arguable factual basis. *See* Br. in Support of Pls.’ Mot. to Strike, Nov. 30, 2007 at 5-7.

cell. Custody staff briefly placed him on water restrictions,⁴ then placed him in four-point restraints on a concrete slab in the segregation unit, where he stayed for five days, until shortly before he died of heat injury and dehydration. *Id.* at 3-4; Stip., Exh. A, Nov. 17, 2006 (Dkt. No. 2210) (autopsy report) at 8. For much of the time he was in restraints, he lay naked in his own urine, and he spent much of the time screaming incoherently. *Id.* at 4; Pls.’ 2006 Exh. 4 & Exh. 106B.

Although Mr. Duffy, who was the highest ranking mental health staff in the facility at the time, declared T.S. to be “floridly psychotic,” he noted that T.S.’s psychiatric medications could not be changed because of the absence of a psychiatrist. Mr. Duffy prepared an emergency referral to a mental health unit for T.S., but the referral never took place. Nov. Op. at 4-5. Mr. Duffy knew that the referral had not taken place, but took no further action to transfer T.S. from the observation cell in the segregation unit at JMF. Pls.’ 2006 Exh. 103 at 75-76.

The first two days that T.S. spent in restraints were heat alert days, with heat index readings around 100. The videotape of T.S.’s cell fogs up repeatedly in these two days and it shows the correctional officers perspiring heavily and complaining about the heat. Although correctional officers frequently offered T.S. water and food during the time he was restrained, on most occasions he refused. No staff member, during this period, noted the significance of these repeated refusals, and neither of the limited-license “psychologists” who saw T.S. while he was in restraints (Mr. Duffy and Mr. Small), or a physician who saw T.S. but did not treat his urine burns, made any attempt to obtain an examination by a psychiatrist, aside from Mr. Duffy’s unsuccessful

⁴ Defendants’ brief denies that T.S. was ever placed on water restrictions, but the record is to the contrary. Indeed, it is striking that, although T.S. was on the heat-risk list, the record indicates that Nurse Glasper, a supervisory nurse, approved the water restriction. *See* Br. in Support of Pls.’ Mot. to Strike, Nov. 30, 2007 (Dkt. No. 2690) at 7.

attempt to transfer T.S. Nov. Op. at 6-9. Similarly, neither medical nor mental health staff paid attention to the fact that he was not taking his psychotropic or his cardiac medications (other than a diuretic for hypertension) at all, because there was no detectable level of lithium (for bipolar disorder)⁵ or anti-psychotics in his blood at autopsy. Stip., Nov. 17, 2006, Exh. A, AIT Laboratory Rpt. at 2, 3. There are also no documents in the medical record that indicate that staff were monitoring his medications. *See, e.g.*, Nov. Op. at 6 n.2 (noting that T.S.'s lithium levels were not monitored for a prolonged period prior to his restraint and death). The only medication that T.S. appears to have been taking was hydrochlorothiazide, a common diuretic that places the patient at increased risk of dehydration.⁶ He had more than twice the therapeutic range of this medication in his blood, Stip., Exh. A, AIT Laboratory Rpt. at 1, again reflecting the lack of appropriate monitoring of his condition.

Shortly before T.S.'s death, he was taken for a shower. He needed assistance in rising from the slab and walking to the showers. He was taken back to his cell in a wheelchair by custody staff and placed back in restraints on the concrete slab. Mr. Small then decided not to examine T.S. because he was "sleeping," the reason Mr. Small gave on repeated occasions for not examining T.S. Nov. Op. at 7.

A few hours later, T.S. was removed from the restraints. One minute after T.S. was removed from the restraints, he fell from the slab to the floor. A few minutes later, he fell from the toilet and lay on the floor for almost an hour. At that point, a registered nurse, Charles Boltjes, attempted to

⁵ *See* "Lithium Carbonate," available at <http://www.mentalhealth.com/drugs/p30-102.html> (visited 12/2/07).

⁶ *See, e.g.*, "Hydrochlorothiazide Patient Advice Including Side Effects," available at <http://www.drugs.com/pdr/hydrochlorothiazide.html> (visited 12/2/07).

take vital signs.⁷ T.S. asked the nurse if he got a reading, and the nurse told T.S. that “it’s faint, but I heard it.” *Id.* at 7; Pls.’ 2006 Exh. 106B (excerpted recordings).⁸ The nurse then took no further action to summon emergency care or otherwise treat T.S., and did not even record his findings. An hour later, when the nurse returned to pass medication, he discovered T.S. not breathing, and resuscitation efforts were unsuccessful. Nov. Op. at 7-8.

In short, all the staff involved did nothing, including the mental health staff, Francis Duffy (chief of the Out-Patient Mental Health Team (“OPMHT”)) and Allan Small (Psychological Services Unit (“PSU”) staff), who watched and listened as a “floridly psychotic” man⁹ was held in four-point restraints while screaming incoherently and generally refusing to eat or drink during and after a heat wave. *Id.* at 4-6. Custody similarly recorded T.S.’ continued refusal to accept water, and did nothing. Pls.’ Exh. 106A at unnumbered 2-8. Any single one of these staff members, including the physician who failed to intervene or treat at DWH and the nurse who knew that T.S.’s cardiac input had fallen dramatically, could have prevented T.S.’s death by intervening; none did. *Id.* at 7. T.S.’s death thus resulted from the failures to provide any on-site psychiatric coverage, as well as specific failures of both “psychologists,” the physician at DWH,¹⁰ the nurses Glasper and Boljes, as well as custody. Such across-the-board failures are intrinsically systemic. As Defendants’ Medical

⁷ The nurse was apparently attempting to take T.S.’s pulse or blood pressure, or both.

⁸ This exhibit consists of an edited version of two videotapes: the videotape in the isolation cell, which records periodically, and the videotape made whenever staff enter the cell, which records those encounters continually. The exhibit is approximately fifteen minutes in length.

⁹ *Id.* at 4-6.

¹⁰ *See id.* at 4 (noting that despite T.S.’s removal to DWH on August 4, 2006, he was not treated by the physician there).

Director said in his testimony:

I think in looking at the tapes in particular it was very apparent in the tapes that T.S. was having, number one, mental deterioration, and number two, physical deterioration. I thought that there was ample opportunity for custody officers, for mental health professionals, and for nursing to have intervened and brought in a psychiatrist, brought in a medical doctor, or just done something to intervene. And that was not done.

Id. at 8-9.

Defendants similarly make an unpersuasive, and in this case, internally contradictory argument regarding the death of P.H. Defendants' basic argument is that P.H. was in fact competent to make the decision to refuse treatment, and should have been allowed to make that decision. *See, e.g.,* Defs.' Mot. at 13 ("One can argue with that choice, but it was a choice with a logical connection to PH's desired outcome, that he not be returned to KCF."). At the same time, inconsistently, Defendants apparently endorse the eventual decision of the medical staff to begin the process for appointment of a guardian. *Id.* at 13-14 ("Defendants did, over the course of several months, finally determine that PH's medical condition was sufficiently affecting his cognition that a guardian petition was warranted. . . . No one has suggested that there was a reason why a medical doctor could not and in fact should not have made the determination that a probate proceeding should begin for Mr. PH based on the influence on his cognition of his hyperthyroidism.").

If there is any way to construe Defendants' argument as logically consistent it would have to be that Defendants' staff started guardian proceedings at exactly the right time – not too early and not too late. The problem with that argument is that, once again, it ignores some inconvenient facts. Allan Small, the PSU staff member involved in the death of T.S., saw P.H. for evaluation in January

and February 2005, but did not schedule any follow-up despite the fact that Mr. Small believed that P.H. may have been suffering paranoid delusions because P.H. refused care. Nov. Op. at 11. Another limited-license psychologist, David Arend, who was the head of the JMF PSU Unit, assessed P.H. as not mentally ill on the very day that P.H. was diagnosed with thyrotoxicosis (thyroid levels so high as to be toxic). *Id.* at 11-12. As noted above, it is Defendants' position that P.H.'s cognitive problems resulted from his hyperthyroidism. Defs.' Mot. at 13-14.

Accordingly, the question that Defendants do not address is why it took another year from the time of the diagnosis of thyrotoxicosis to begin guardianship proceedings. In fact, P.H. saw a psychiatrist as a result of the May 2005 diagnosis who noted that P.H. had paranoid delusions and prescribed anti-psychotic medications that he did not take. Corrections Medical Services, Inc., ("CMS") denied a request for follow-up by an endocrinologist. Untreated, P.H.'s health continued to deteriorate through multiple hospitalizations until June 2006, when a physician demanded that mental health staff evaluate P.H.'s competency. A psychiatrist then prepared the necessary statement that P.H. was not competent, but the Central Office of the Michigan Department of Corrections ("MDOC") sat on the statement for more than a month despite the life-threatening emergency. A hearing was set for August 2006, by which time it was too late and P.H. died. Nov. Op. at 12-13. But for the one-month completely unexplained delay by the MDOC, despite the previous year of delays, perhaps P.H. would have lived. In any event, had the competency issue been addressed at the time of the initial diagnosis of thyrotoxicosis, there is no real question but that P.H.'s life would have been spared.

B. The Failure to Diagnose Mental Illness at RGC

As illustrated by the deaths of P.H. and Patient 165 (*supra* at 3), much of the harm from

Defendants' lack of mental health services flows from their failure to diagnose prisoners as mentally ill. This is a problem that is particularly acute at RGC, where prisoners are supposed to be screened and their chronic medical and mental health needs diagnosed. In fact, however, the record evidence shows that, while the PSU staff refer about 14-18% of incoming prisoners for possible admission to the OPMH program, only a small fraction of those prisoners are accepted into the program, with the result that only 2.2-3.2% of incoming prisoners are actually accepted into the OPMH caseload. Walsh Expert Rep., Aug. 24, 2007 (Dkt. No. 2609-5) at 5.

In contrast, surveys indicate that 16% of prisoners nation-wide are receiving mental health treatment of some form and 10% are receiving mental health medications. *Id.* at 5 n.6; *see also* Kupers Expert Rep., Aug. 24, 2007 (Dkt. No. 2609-2) at 2 (noting that epidemiological surveys indicate that 15-30% of prisoners have psychiatric disorders that result in functional disabilities). Indeed, Dr. Kupers cites an article by Jeffrey Metzner, M.D., currently serving as Defendants' psychiatric expert, in which Dr. Metzner says that "[s]tudies and clinical experience have consistently indicated that 8 to 19 percent of prison inmates have psychiatric disorders that result in significant functional disabilities and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration." *Id.*

Aside from the stark statistical evidence of under-diagnosis, the experts found a host of other indications that prisoners were not receiving appropriate diagnoses of mental illness in RGC. PSU staff failed and refused to obtain records of past mental health treatment, with the result that prisoners whose illness was in temporary remission, but likely to reemerge in the stressful atmosphere of the prison, would not be identified. Walsh Rpt. at 6. Large numbers of prisoners who reported extensive histories of mental health diagnoses and treatment were nonetheless labeled

not in need of treatment at RGC:

b. There is a consistent pattern of “under-diagnosing.” By that I mean that prisoners suffering from serious mental illness have their diagnoses downgraded inappropriately to a less severe mental illness or no mental illness at all, and on many occasions have their treatment discontinued. . . . I have found during my tours of the *Hadix* facilities the following widespread patterns of under-diagnosing:

(1) In Reception, individuals who have documented past history of Schizophrenia, Bipolar Disorder or Major Depressive Disorder with suicide attempts, are diagnosed “Adjustment Disorder, “No Axis I Disorder” or merely “Substance Abuse Disorder,” then the treatment plan is “TNR,” treatment not required, and the individual is dropped from or not enrolled in mental health treatment.

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

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

(4) Outside of Reception, many prisoners I

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

Kupers Decl., Aug. 24, 2007 (Dkt. No. 2609-3) at 5-7.

Dr. Kupers’ expert report gives many examples of this pattern of under-diagnosing in RGC. *See, e.g.*, Kupers Expert Rpt. at 7-8 (describing Patient K-20, who was first a psychiatric patient at the age of 9 and has taken psychotropic medications since then; this patient reported his need for his anti-psychotic and antidepressant medication when he came to RGC but despite a kite did not receive any psychotropic medications for 45 days; notes in his chart contradict each other, with some saying there is no psychiatric history despite noting his prior psychiatric medications, or describing psychiatric symptoms but stating that his mental status is unremarkable); at 12 (describing Patient K-22, another prisoner in the Reception process, who had been in treatment for bipolar disorder for

four years, has a family history of bipolar disorder, arrived at RGC with prescriptions for a number of psychotropic medications, and is currently off medications and experiencing clinical depression, but was dissuaded by the psychiatrist from seeking psychiatric medications; the psychiatrist found no psychiatric illness).

C. The Lack of Qualified Staff and Services

Mental health staff are divided into two separate reporting and supervision lines. The OPMHT is operated by the Department of Community Health. PSU staff are MDOC employees, whose duty is to provide the mental health services for the great majority of prisoners in the *Hadix* facilities. *See* Nov. Op. at 15-16. During a two-month period in 2006, including the time that the psychiatrist from RGC was supposed to be covering both RGC and JMF, there were no on-site services at JMF provided by a psychiatrist. *Id.* at 16-17. Among the prisoners referred to mental health services during this period who received no mental health services from either a psychologist or a psychiatrist were a patient on a hunger strike, a suicidal patient, two patients making threats of self-injury, and a patient described as experiencing paranoia. *Id.* at 17.

PSU staff are professionally ill-equipped for the tasks they are assigned to perform. Documentary evidence suggests that PSU staff rarely, in fact, deliver actual services; they appear to be fulfilling rote paperwork requirements when they do see patients. *Id.* at 17. For example, Mr. Small, involved in two deaths, like virtually all of the PSU staff, has only a limited license to practice psychology in Michigan. He was supposedly supervised, as is required under Michigan law, by a fully-licensed psychologist. Mr. Small's only contact with his official supervisor, the PSU Regional Director, was by email, plus one face-to-face contact with that person in the year prior to the hearing. His direct supervisor was another limited-license psychologist, also supervised by the Regional

Director. *Id.* Mr. Small's qualifications as a psychologist consisted of an undergraduate degree in theology and an M.A. in community counseling. Pls.' 2006 Exh. 105. The OPMHT shares the PSU deficiencies. In fact, the supervisor for OPMHT at JMF, Francis Duffy, had qualifications similar to those of Mr. Small. He was a psychiatric social worker, also not fully licensed, even though he was the senior member of his unit. As noted above, he was also involved in a patient death. Nov. Op. at 19.

Aside from the lack of qualifications, there is also a critical lack of available services. As Dr. Walsh notes, only a small minority of the prisoners referred by PSU for mental health evaluation in the RGC screening process are accepted for the OPMHT caseload. Walsh Rpt. at 5. There are also long delays to see mental health staff in RGC. Kupers Decl. at 4, 14. In addition, missed appointments with mental health staff were prevalent, an indication that patient outcomes were being adversely affected by delays in treatment. Nov. Op. at 19. These failures to refer for services and delays occur in the context of system-wide reductions in the availability of mental health treatment. There have been no increases in the availability of mental health beds in the system since at least 2002, despite population increases. In fact, prisoners who need in-patient treatment have lost access to 22 beds formerly available at DWH, and DWH has lost its hospital accreditation. *Hadix* prisoners have also lost access to any accredited MDOC in-patient psychiatric facility, because the Huron Valley in-patient mental health program has also lost its accreditation. In addition, *Hadix* prisoners have lost access to the off-site self-mutilation unit, which Defendants have closed. Kupers Decl. at 9-10.

In short, it is not surprising that so few prisoners are referred for treatment because there is little treatment available for them wherever they are sent. *See also* Attach. 3 (Redacted Cohen

Memo. Dec. 5, 2007). Prolonged failure for psychiatric attention to patient deterioration in DWH. Further, despite the reductions of access to mental health care that have already occurred, the intention of the Department of Community Health (which runs the OPMHT) is to “downsize/streamline treatment” even more. Pls.’ Br. in Opp’n to Defs.’ Mot. to Approve Transfer Plans, Aug. 13, 2007, Attach. 15 (Dkt. No. 2594-16) at 3. As Dr. Kupers noted,

Of course, if sufficient services for prisoners suffering from significant or serious mental illness are not available, one way for clinical staff to feel more comfortable with the shortfall is by not diagnosing mental illness that would require treatment. . . . Thus, one of the PSU clinicians told me during a joint meeting with PHU and OPMU staff that she tries not to refer “too many cases” to OPMH because they are so overloaded with cases. In that straight-forward comment lies the crux of the problem: the only way to decrease the volume of referrals to OPMH is to raise the bar in terms of who is to be referred.

Kupers Rpt. at 6-7.

D. Lack of Coordination of Mental Health Services

The MDOC Medical Director forthrightly admits that the current system of mental health staff divided into PSU staff that it employs, the OPMHT who are part of the Department of Community Services, along with a separate reporting line for the physicians employed by CMS, is not working and cannot work:

Q: Do you think that there are any problems right now in the coordination between the MDOC, the Department of Community Health and – well, let me – and CMS with regard to mental health care and the intersection of mental health and medical care?

A: Yes, I do.

Q: Could you describe what those problems are?

A: Well, because of the supervisory structure and the fact that mental health in and of itself has three lines of supervision, and then you have – so there’s an interface with

custody and then you have an interface with the MDOC, and then you have – which are the nurses, and then you have an interface with the MSP, which is a CMS employee. You’ve got at least six or seven interfaces there.

Pramstaller Dep. Excerpt, Aug. 13, 2007 (Dkt. No. 2594-6) at 16. In fact, Dr. Pramstaller stated that he is “not sure that the Department of Corrections has the expertise to run a good mental health program.” *Id.* See also Kupers Rpt. at 16 (noting that “there does seem to be a serious failure of collaboration between medical and mental health clinicians, as evidenced by delays in psychiatric assessments requested by medical practitioners”; also noting problems between PSU and OPMHT staff based on patterns of OPMHT staff “inappropriately downgrading the diagnoses” and “denying needed mental health treatment”).

Another critical problem is that the Office of the Independent Medical Monitor (“OIMM”) has documented PSU staff reviewing referrals for psychiatric care from general physicians and deciding that no referral was necessary, thus overruling the judgment of the physician that evaluation by a psychiatrist was required, and also making the decision about whether a prisoner placed in observation as potentially suicidal should be evaluated by a psychiatrist. The OIMM notes how inappropriate this practice is:

At the *Hadix* facilities the decision to refer a prisoner to psychiatry rests with the PSU staff member, and it should not.

At the present time, PSU can decide to refer to [OPMHT], which would involve the prisoner being seen by another limited license psychiatrist, or, they can decide not to make the referral. This is another reason why these services should be unified. All prisoners placed in isolation because of a change in their mental status should receive psychiatric evaluation by a psychiatrist.

Cohen Letter, Apr. 26, 2007 (Dkt. No. 2401) at 5-6; *see also* Attach. 4 (Cohen redacted mem., July 6, 2007 and attachments) (showing that a physician attempted to make a direct referral to a psychiatrist but PSU staff blocked the referral; the physician refers to a protocol indicating that physicians are unable to refer to a psychiatrist directly); *see also* First Report of the OIMM, July 10, 2007 (Dkt. No. 2535) at 36.

E. Medication Delays and Interruptions

Patients are denied psychiatric medications, as noted above, as a direct result of the systemic under-diagnosing of mental illness. Unfortunately, they also lose access to medications because the system of medication delivery is simply broken. Defendants depend on a mail order pharmacy in Oklahoma that has proven indifferent to its contractual responsibilities, without provoking a contractual enforcement action from MDOC. As the MDOC Medical Director stated in his deposition:

There seems to be an attitude that we have to accept what they [PharmaCorr, the contractual pharmacy service] give us, almost like they're in the driver's seat and we work for them, which is totally unacceptable in my eyes. We are the person[s] who let the contract, we had the ideas about what we needed in the contract, and on many issues they haven't delivered.

Pramstaller Dep. Excerpt, Aug. 13, 2007 at 39.

Dr. Pramstaller also described a contract requirement requiring PharmaCorr to deliver medications sorted by patient, but in fact PharmaCorr refuses to sort them as required by the contract, so that MDOC staff have to spend "hours and hours" sorting through the boxes to locate all the medications for a particular patient, which may be in three to four different boxes. *Id.* PharmaCorr also refused to carry out its responsibility to establish an electronic link between

SERAPIS, the electronic record system, and its operations on the ground that prior MDOC staff had decided that the electronic link was unnecessary. *Id.* at 40.

The OIMM investigation of medication renewals at the *Hadix* facilities found that there were problems with back-order delays at the pharmacy, automatic renewal delays, medication administration delays, and delays in executing a physician medication order. OIMM First Rpt., July 10, 2007 (Dkt. No. 2535) at 4. The Report also found that, contrary to the announced policy of purchasing medications from a local pharmacy when PharmaCorr could not supply them, the practice is, if medications are not available, the patient will just have to wait. *Id.* at 7.

The Report includes a medication study of RGC. One of its findings was that, of thirteen arriving prisoners on a randomly chosen day, only two of the patients actually received their medications the day that they arrived or the following day. OIMM Medication Rpt., July 10, 2007 (Dkt. No. 2535) at 14-15. On another day that the OIMM studied, only five of 20 patients received their ordered medications on the day of arrival or the following day. *Id.* at 15-16. One of the patients whose medications was interrupted had a history of hearing voices that told him to hurt himself or others. It took four days for him to receive his first dose of anti-psychotic medication, even though he arrived with verified previous medications and an obvious need for medication. *Id.* at 17. In fact, Dr. Kupers found prisoners who experienced three-week interruptions of their psychiatric medications. Kupers Rpt. at 17. This failure to order same-day medications was confirmed in a recent deposition taken by Plaintiffs in which Dr. Thai, a psychiatrist at RGC, indicated that he does not order same-day medications for incoming prisoners who have psychotropic

prescriptions unless it is an “emergency.”¹¹

The OIMM also studied medication interruptions, after the initial prescription, at RGC. By analyzing a sample of medication kites in three of the months studied, the study determined that, had the OIMM analyzed the entire sample of medication kites, the OIMM would have statistically expected to have identified 392 kites filed by prisoners out of one or more medications. OIMM Rpt. at 19-23.¹²

Moreover, because of the limitations of PharmaCorr, the only way to get a “same day” medication at RGC is to utilize the on-site pharmacy at DWH. To do so requires a nurse to walk over to DWH to pick up the medication, taking away nursing staffing time. *Id.* at 26. As the Report notes:

Staff is now, in effect, dealing with two parallel pharmacies, neither of which provides delivery service to the nurses and neither of which appears to be very efficient from an MDOC perspective: nurses must pick up the medication, track and prompt PharmaCorr for undelivered routine medication, and when medication is delivered to RGC for patients who have transferred to other facilities, the nurses have to find out where the patient went and ensure that medication is delivered to the new facility.

¹¹ Plaintiffs will file the appropriate deposition excerpt in support of this statement when it becomes available.

¹² The figures are set forth below:

<u>Month</u>	<u>No. of Kites</u>	<u>Projected Rate of Kites Showing No Meds</u>	<u>Projected Total No Meds Kites</u>
January	166	53%	88
March	247	67%	165
May	190	73%	139

Projected total over the three months: 392

Because not all prisoners who are out of medications file kites, the actual total of prisoners whose medications were interrupted is obviously higher.

Thus, the paperwork tracking is not good and is acknowledged as not good by RGC staff. . . . A quick review of the [keep on person medications] log on June 15, 2007 demonstrated that of 48 medications prescribed on June 5, 2007, only 12 had arrived and only

19 of the 42 prescriptions sent on June 4, 2007 arrived. According to this log, only one-third of the medications ordered were received within 10 or 11 days of their orders.

Id. at 27.¹³

The staff cannot treat their patients effectively as long as components of the mental health system such as the medication renewal system remain broken, so that prescriptions for psychotropics are not reliably filled and administered. For example, a prisoner who arrived at RGC on three psychotropic medications did not receive those prescriptions for varying lengths of time. Deprived of his medications at RGC, his mental status deteriorated rapidly and he became floridly psychotic. He was eventually housed in DWH for treatment of decompensated psychosis and cellulitis. Ultimately, he had to be transferred to MDOC's (unaccredited) psychiatric facility. First Report of the OIMM, July 10, 2007 (Dkt. No. 2535) at 10-12; *see also id* at 17 (similar case). Psychotropic medications prescribed for incoming prisoners are delayed and interrupted because of the systemic problem that SERAPIS cannot be used to order medications directly to PharmaCorr and the other systemic problems with PharmaCorr's services. These problems include PharmaCorr's refusal to accept prescription renewal requests more than five to seven days before a prescription expires, building into the operations a Catch-22 that, given the PharmaCorr shipping delay (and refusal to

¹³ After Defendants ultimately filed a response to this Report, the OIMM refuted its findings, thoroughly demonstrating that there was no merit to Defendants' factual claims. OIMM Resp., Nov. 20, 2007 (Dkt. No. 2685). Although Plaintiffs immediately suggested to Defendants that it would be helpful to resolve any remaining factual disagreements in a conference call, Defendants declined to do so and have since failed to respond in any manner to the OIMM Response.

pack medications in a distribution-friendly manner), guarantees that a number of medications will be interrupted. *Id.* at 36; *see also* Pramstaller Dep. Excerpt at 39 (re packing issues).

These medication disruptions are also particularly serious because “medications become the sole clinical modality available to prisoners with serious mental illness.” Kupers Rpt. at 26.

Further, these critical problems are widespread, as demonstrated by Dr. Kupers:

I discovered many inappropriate discontinuations of psychiatric medications for prisoners with mental illness. I discovered cases where psychiatric medications were discontinued abruptly when prisoners entered the system. I discovered cases where prescribed medications were not delivered to the patient for days or weeks at a time[.] . . . Discontinuation and lack of continuity in the provision of psychiatric medications can have grave effects, ranging from discomfort and insomnia in patients taking mood-stabilizing medications to outright manic episodes in individuals who depend on mood stabilizers to avoid dramatic mood swings. When antidepressant medications are discontinued abruptly, or there is a gap in their use for any reason, a depressive episode is likely to evolve, and it may be complicated by suicidal ideation or actions. When anti-psychotic medications are discontinued abruptly, or there are discontinuities in their delivery, the patients are prone to acute exacerbations of psychosis. In other words, discontinuation and discontinuities in medication delivery can have very dire clinical consequences. I discovered numerous cases of discontinuation and discontinuity among the prisoners I interviewed and the charts I reviewed.

Kupers Rpt. at 10-11.¹⁴

¹⁴ The medication problems are particularly severe for patients who, because of serious medical problems or disabilities, are assigned to in-patient care at C Unit. By policy, such patients cannot be prescribed major psychotropic medications. This policy was confirmed by Dr. Rushbrook during his deposition on December 12, 2007. Plaintiffs will supply the deposition excerpt when it becomes available. While Dr. Rushbrook stated that one of the C Unit patients affected by the policy had been recently transferred to another facility where he could receive psychiatric medications, that transfer does not cure the systemic problem that prisoners are forced to go without these medications as a result of their assignment to C Unit.

III. THE RELATIONSHIP BETWEEN THE MEDICAL AND MENTAL HEALTH VIOLATIONS

Defendants have failed for years to eliminate the Eighth Amendment violation regarding medical care, and the egregious deficiencies in mental health care are interfering with the steps necessary to eliminate the medical violation. One particularly striking example of how reforming medical care is hindered by the constitutional violation involving mental health is the barrier that PSU presents to a somatic physician referring directly to a psychiatrist. *See* discussion *supra* at 16-17. Similarly, as noted above, the record indicates that many patients with life-threatening illnesses declined necessary medical treatment in the complete absence of the appropriate availability of the psychological counseling that could result in prisoners accepting treatment. Such medical treatment failures caused by the lack of appropriate psychological counseling availability will necessarily continue until mental health services are provided.

The record is replete with other examples of the mental health failings exacerbating the medical failings. Policy allows psychotropic medications to be adjusted by off-site physicians, as was the only way medication adjustments were done at JMF during the period that the psychiatrist was absent. This practice poses medical risks to patients, since there are significant physical side effects of psychotropic medications that require monitoring. Indeed, T.S. had no monitoring of his psychotropic medications while the psychiatrist was absent despite his psychological deterioration, and one of his psychotropic medications could not be changed in the absence of the psychiatrist. Pls.' 2006 Exh. 114 bates 152092. Similarly, medical staff were unable to save the life of the hyperthyroid patient because unqualified PSU staff did not refer the patient to a psychiatrist. The record shows a multitude of other patients whose medical care was adversely affected by the absence

of psychiatric or psychological counseling. *See supra* at 2-4.

The Court thus appropriately concluded that it could not address the medical problems of the class without also addressing the mental health issues:

[M]any of the repeated and recurrent problem cases noted by Drs. Cohen and Walden concern the cracks between medical care and mental health care. Without a system that effectively addresses both areas, Eighth Amendment violations will continue as a by-product of unconstitutional mental health care.

Nov. Op. at 24. Defendants have provided no argument attempting to challenge the Court's conclusion.

IV. THE COURT'S DISCRETION UNDER RULE 60

A. The Court Has General Equitable Power to Modify Existing Orders to Cure the Constitutional Violations Regarding Medical Care by Addressing Mental Health Care.

As the Supreme Court said in *United States v. Swift & Co.*, 286 U.S. 106 (1932),

We are not doubtful of the power of a court of equity to modify an injunction in adaptation to changed conditions, though it was entered by consent. . . . Power to modify the decree was reserved by its very terms, and so from the beginning went hand in hand with its restraints. If the reservation had been omitted, power there would be by force inherent in the jurisdiction of chancery. A continuing decree of injunction directed to events to come is subject always to adaption as events may shape the need. . . . [A] court does not abdicate its power to revoke or modify its mandate, if satisfied that what it has been doing has been turned through changing circumstances into an instrument of wrong.

Id. at 114-15; *see also* *Rufo v. Inmates of the Suffolk Co. Jail*, 502 U.S. 367, 378, 383-84 (1992) (holding that consent decrees may be modified pursuant to Rule 60(b) when a party shows that a change in the injunction is warranted by changes in law or facts, as long as the modification is suitably tailored under the circumstances).

All of the remedies required by the Court in the November 2006 Order are in fact critical to fixing the medical violations. The use of in-cell mechanical restraints in non-medical settings presents an unreasonable risk of death or other harm from physical causes for mentally ill prisoners. Similarly, the lack of qualified mental health care staff, in appropriate numbers, and appropriately coordinated with medical care, presents an unreasonable risk of death for prisoners like P.H. or others who do not receive the medical care they need because their untreated mental illness leads them to decline needed medical care. Indeed, as noted this problem has already contributed to a number of prisoner deaths. The practice of limited-license psychologists interfering with referrals from CMS physicians to psychiatrists also exposes prisoners with untreated mental illness, particularly those wrongly classified as “malingerers,” to failures to treat their physical health needs. Thus, whether or not the Court reaffirms the reopening of the mental health issues in the case, the Court has a responsibility to address the barriers to appropriate medical care that the severely deficient mental health care now imposes, and it cannot perform its constitutional responsibility without addressing these mental health issues.

B. The Court Has Unquestionable Power to Reopen Under Rule 60(b)(6).

In *Kokkonen v. Guardian Life Insurance Co.*, 511 U.S. 375 (1994), the Supreme Court affirmatively stated that, when a settlement agreement has been incorporated into a court order, the court has jurisdiction to grant relief by reopening the judgment if the settlement is breached. *Id.* at 381. Notwithstanding *Kokkonen*, Defendants argue that the Court erred because the Consent Decree mental health provisions had been terminated. Termination of a consent decree provision or other injunctive order, however, does not mean that, for legal purposes, the consent decree never existed. *Benjamin v. Jacobson*, 172 F.3d 144, 159 (2d Cir. 1999) (*en banc*); *Inmates of Suffolk County Jail*

v. Rouse, 129 F.3d 649, 662 (1st Cir. 1997). Nor is there anything in the language of PLRA that explicitly or implicitly suggests in any manner that PLRA was intended to deprive either party of remedies otherwise available to it under Rule 60; in fact the language indicates that PLRA was not intended to limit a party's rights to seek reopening under Rule 60. *See* 18 U.S.C. § 3626(b)(4) (providing that nothing in PLRA prevents any party from seeking modification of injunctive court orders "to the extent that modification or termination would otherwise be legally permissible"); *see also Dep't of Hous. and Urban Dev. v. Rucker*, 535 U.S. 125, 133 n.4 (2002) (Congress is presumed to legislate against the background of existing law, and when it legislates in an area but does not address a particular subject, it indicates its intention to leave the law on that subject undisturbed).

Kokkonen held that a federal court cannot enforce a settlement agreement, after complete dismissal of the case with prejudice, *id.* at 377-78, pursuant to its ancillary jurisdiction, if the district court had neither retained jurisdiction nor incorporated the settlement agreement into an order. *Id.* at 381-82. The Supreme Court in so holding reasoned that the settlement agreement in that case was based on state law contractual principles, not on the diversity issues that supported federal jurisdiction in the original case. Further, the Court held that the claims at issue in the original diversity suit were not factually interdependent with the claims related to enforcement of the out-of-court settlement. *Id.* at 381.¹⁵

Thus, for three separate reasons, *Kokkonen* does not support Defendants' position that the Court was barred from reopening the mental health issues. First, this case, unlike *Kokkonen*, was

¹⁵ In *Kokkonen*, the Court also noted that the case before it did not involve the power of a federal court to grant *reopening of litigation* under Rule 60(b) after breach of an out-of-court settlement agreement, it was instead limiting the circumstances under which a federal court could enforce a settlement to those in which the court either retained jurisdiction to enforce the settlement or incorporated the settlement terms into a court order. *Id.* at 378.

never completely dismissed, so this Court always retained unquestioned jurisdiction to enforce its medical orders. *See also Jaynes v. Austin*, 20 Fed. Appx. 421, 2001 WL 1176424 at *2 (6th Cir. Sept. 25, 2001) (holding that the district court was free to amend its orders related to enforcement of the settlement agreement, despite lack of provision retaining jurisdiction in that agreement, because the case had not been dismissed at the time of subsequent orders) (Attach. 5). Second, this Court's power over both the medical and the mental health issues is founded on the Court's jurisdiction over federal questions, so that there can be no question but that the Court has jurisdiction over every aspect of the case. Third, the medical and the mental health claims are factually interdependent, and so in any event, this Court, if it were necessary to do so, could rely on its ancillary jurisdiction. For all three reasons, there is no argument that the Court could possibly lack jurisdiction to reopen the mental health issues under Fed. R. Civ. P. 60(b)(6).¹⁶

C. The Court Appropriately Exercised Its Discretion to Reopen the Mental Health Issues.

Every single case cited by Defendants is one in which all aspects of the case had been dismissed with prejudice. In this case, in contrast, the Court did not dismiss with prejudice and the Court made an unchallenged finding that reopening the mental health issues is necessary in order to allow the Court to effectuate its orders designed to cure the constitutional violations regarding medical care. Various provisions of the Consent Decree and other orders related to medical care and disability care remain pending in this Court. Under the principles enunciated in *Waste Management of Ohio, Inc. v. Dayton*, 132 F.3d 1142 (6th Cir. 1997), there can be no question of that the Court

¹⁶ Defendants did not preserve on appeal any claimed argument that Plaintiffs should not have reopened the mental health Consent Decree provisions rather than the allegations of the Complaint. *See* note 1, *supra*. The Court correctly, and consistent with the Prison Litigation Reform Act, 18 U.S.C. § 3626 (2007), reopened the mental health issues only to the extent necessary to cure the constitutional violation.

appropriately exercised its discretion to grant relief:

[O]nce approved, the prospective provisions of a consent decree operate as an injunction. This court has recognized that this injunctive quality requires courts to: 1) retain jurisdiction over the decree during the term of its existence; 2) protect the integrity of the decree with its contempt powers; and 3) modify the decree should changed circumstances subvert its intended purpose. . . . Courts, therefore, have a duty to enforce, interpret, modify and terminate their consent decrees as required by circumstance.

Id. at 1146.

Although none of the cases cited by Defendants had any open issues at the time the plaintiff sought reopening, there are additional reasons why Defendants' cases are not persuasive in the context of this case. With one exception, the decisions cited by Defendants regarding Rule 60(b)(6) are ambiguous, and consistent with Plaintiffs' position:

If, in this instance, the plaintiffs' trepidation [that unconstitutional conditions will follow the termination of injunctive relief] proves justified, they remain free to initiate a new round of proceedings designed to show that post-termination prison conditions actually do violate their federally protected rights.

Inmates of Suffolk Co. Jail v. Rouse, 129 F.3d 649, 662 (1st Cir. 1997). A "new round of proceedings" as aptly describes a Rule 60(b)(6) motion as it does the filing of a new case. *Vasquez v. Carver*, 18 F. Supp. 2d 503, 513 (E.D. Pa. 1998), *aff'd*, 181 F.3d 85 (3d Cir. 1999), does refer solely to the option of filing a new lawsuit if unconstitutional conditions of confinement return. The fact that the court did not explicitly refer to the possibility of Rule 60(b)(6) relief, however, hardly justifies a supposition that the possibility of Rule 60(b)(6) relief had in fact been considered and rejected by the court.

Hawaii County Green Party v. Clinton, 124 F. Supp. 2d 1173 (D. Hawaii 2000), is the only case Defendants cite that even arguably provides any real support for their position. Defendants cite

the case, however, for only one of three alternative holdings. As to the alternative holding that Rule 60(b)(6) relief is available only if the facts justifying relief were in existence at the time of dismissal, the sole support cited by the court in *Clinton* is a concurring opinion by one Ninth Circuit judge. *United States v. Washington*, 98 F.3d 1159, 1164 (9th Cir. 1996) (Kozinski, J., concurring).

The principle espoused in the concurring opinion, if adopted, would be inconsistent with the decisions of the Sixth Circuit and the great majority of the courts of appeals that have allowed reopening under Rule 60(b)(6) when a settlement agreement has been breached,¹⁷ as well as with the Supreme Court’s analysis in *Kokkonen*. By definition, the events at issue when a settlement agreement has been breached following dismissal take place after the dismissal of the action.

As a practical matter, forcing litigation of the mental health claims in an entirely separate lawsuit would have enormous practical disadvantages, because it would leave Defendants subject to the threat of inconsistent orders in the two cases. At best, the two cases would eventually be

¹⁷ See *McAlpin v. Lexington 76 Auto Truck Stop, Inc.*, 229 F.3d 491, 503 (6th Cir. 2000) (refusing to enforce a settlement agreement that had not been incorporated into a court order and implying that the plaintiff could have sought simple reopening of the dismissed case; stating that the “moving parties were not really trying to reopen the dismissed suit, which would be the effect of a Rule 60(b)(6) motion setting aside the final judgment”); *Hinsdale v. Farmers Nat’l Bank & Trust Co.*, 823 F. 2d 993, 996 (6th Cir. 1987) (stating that the plaintiff could have filed a Rule 60(b) motion to vacate the prior order of dismissal when an out-of-court settlement was repudiated); *Aro Corp. v. Allied Witan Co.*, 531 F.2d 1368,1371 (6th Cir. 1976) (district court, using Rule 60(b)(6), correctly exercised its jurisdiction in vacating order of dismissal based on party’s attempted repudiation of settlement); *United States v. Baus*, 834 F.2d 1114, 1124 (1st Cir. 1987) (the principle that material breach of a settlement agreement incorporated into a court judgment entitles non-breaching party to relief under Rule 60(b)(6) is “well-accepted” and absent such relief, “[m]aterial breach of such a solemn obligation presents an extraordinary situation of permitting a party to benefit from a judgment the terms of which it has deliberately disregarded.”); see also *Vincent v. Reynolds Mem. Hosp., Inc.*, 728 F.2d 250, 251 (4th Cir. 1978) (reversing district court’s refusal to vacate dismissal of case based on settlement due to state court’s subsequent determination that terms of settlement violated public policy; Rule 60(b)(6) relief should have been granted to allow moving party to reopen litigation and pursue new judgment).

consolidated, but the delay required to achieve consolidation would impair resolution of both the medical issues and the mental health issues for no obvious purpose. *See Knop v. Johnson*, 977 F.2d 996, 1014 (6th Cir. 1992) (after affirming violation of prisoner right of access to courts made by two district courts, but vacating the remedy, remanding to a single court to develop a remedy for both cases). More recently, the Sixth Circuit has emphasized the practical value of resolving claims, wherever possible, within the scope of the *Hadix* litigation:

Since the PLRA requires a continuing constitutional violation for the retention of jurisdiction, even were we to find that the district court abused its discretion in exercising jurisdiction over those facilities by misconstruing the Consent Decree, Plaintiffs could immediately file a new lawsuit challenging the constitutionality of prison conditions in Blocks 1 and 2. We would like to avoid that result in the interests of judicial efficiency.

Hadix v. Johnson, 367 F.3d 513, 518 n.7 (6th Cir. 2004). For very similar reasons, Plaintiffs have demonstrated that the Court did not abuse its discretion in determining that the case should be reopened to address mental health claims.

V. THE COURT'S ADMISSION OF PHYSICIAN TESTIMONY

Defendants ask this Court to disturb its judgment that two experts, Dr. Jerry S. Walden, M.D., and Dr. Robert L. Cohen, M.D., should be permitted to testify regarding the adequacy of mental health services at *Hadix* facilities when such testimony fell clearly within the scope of their knowledge and experience. Distilled to its essence, Defendants' argument is simple and absolute: the district court abused its discretion by admitting the testimony of Drs. Walden and Cohen because they are not board-certified psychiatrists.

There is, however, no requirement in *Daubert* – or anywhere else – that only board-certified

psychiatrists may offer expert opinions about the adequacy of mental health services. As the Sixth Circuit has recognized, trial judges should not "rely on labels" when assessing experts. *Mannino v. Int'l Mfg. Co.*, 650 F.2d 846, 850 (6th Cir. 1981) (citing 3 Jack B. Weinstein & Margaret A. Burger, *Weinstein's Evidence* 702, 702-10); see also *Morales v. American Honda Motor Co., Inc.*, 151 F.3d 500, 515 (6th Cir. 1998) (approving of *Mannino* in a post-*Daubert* case). Although Defendants style their protestations as *Daubert*-based challenges, Defendants offer only a passing mention of *Daubert* and the "flexible" evidentiary inquiry it prescribes. *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 594 (1993). Even under the most restrictive reading of *Daubert*, its progeny, and Fed. R. Evid. 702, the opinions of Drs. Cohen and Walden are both relevant and reliable.

Daubert requires trial judges to make a preliminary assessment of both the *relevance* and *reliability* of proffered expert testimony. *Daubert*, 509 U.S. at 597. See *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 152 (1999) (extending *Daubert* to *all* expert testimony); Fed. R. Evid. 104(a) (questions concerning competence of witnesses is a preliminary determination to be made by the court). This is precisely the kind of assessment conducted by the Court in this case. After hearing *voir dire* and briefing on the matter, the Court found the testimony at issue to be wholly admissible. The Court considered the experts' qualifications, experience, and their ability to provide reliable testimony. See *Jahn v. Equine Servs., PSC*, 233 F.3d 382, 393 (6th Cir. 2000) (requiring an adequate record on which to make an admissibility determination); *Morales*, 151 F.3d at 516 (although no formal hearing is required, court considers evidence of experts' qualifications). The Court then concluded as follows:

[Both doctors] are required to make professional judgments as to whether to treat such [mental] illness, treat the illness in consultation with a specialist, or refer for specialist care. Furthermore, Doctors Walden and Cohen have both worked as correctional medical officers and in that role have supervised psychological care

teams. Put simply, their training as physicians and their work experiences make them more than qualified to offer the opinions offered at the recent hearing.

Nov. Op. at 21. Defendants offer no argument worthy of upsetting the Court's previous determination.

Dr. Cohen has served as the court-appointed monitor in this litigation since 2003. He is a board-certified internist with approximately thirty years of experience,¹⁸ and has significant experience in the provision of correctional mental health services. T. 5 (10/11/06). In the 1980s, Dr. Cohen designed a new mental health program at Rikers Island in New York City. As director of the program, he hired new staff and oversaw mental health services for the prison. T. 7-8 (10/11/06). He currently serves as a medical monitor in three open cases and has served in a similar capacity in multiple closed cases. T. 11 (10/11/06); Cohen *curriculum vitae*, Nov. 27, 2002 (Dkt. No. 1667) at 3. In one case, Dr. Cohen served on a three-doctor interdisciplinary panel that authored several reports regarding mental health services for prisoners with HIV infection. At one point, after several suicides among HIV patients, Dr. Cohen was called upon to review available care and to make recommendations to prevent additional suicides. T. 9-11 (10/11/06). Further, in his private practice, Dr. Cohen diagnoses and treats depression, anxiety, and alcoholism. T. 6-7 (10/11/06).

Dr. Walden is a physician with approximately 40 years of experience. He has appointments with the University of Michigan and with St. Joseph Mercy Hospitals, and served for a year as the Chief Medical Officer for the United States Penitentiary at Terre Haute, Indiana. Pls.' 2006 Exh. 1B 1-2. He has provided expert testimony in several prison health care cases. *Id.* at 2). He routinely treats mental illness as part of his family practice. T. 114-16 (10/11/06). Dr. Walden has extensive

¹⁸ Cohen *curriculum vitae*, Nov. 27, 2002 (Dkt. No 1667) at 1.

experience with substance abuse treatment, T.113-14 (10/11/06), which frequently overlaps with mental health issues. T. 118 (10/11/06). Like Dr. Cohen, Dr. Walden frequently collaborates with psychiatrists. T. 114; 119 (10/11/06).

Defendants cannot succeed in their argument because they fail to identify a single opinion or conclusion that exceeds the scope of the experts' knowledge, qualifications, or professional experience. Drs. Cohen and Walden testified regarding the adequacy of mental health care at *Hadix* facilities given the deaths of T.S., P.H., and other failures of care. For example, after considering relevant evidence, Dr. Cohen concluded that: (1) P.H. died from a "very easily treatable illness;" and (2) the lack of interest and care by mental health services ultimately prevented P.H. from receiving the lifesaving treatment he needed. T. 25-26 (10/11/06).

Similarly, Dr. Walden testified that, given the substantial overlap between mental and physical health issues, the breakdown in mental health care at *Hadix* facilities had led to detrimental physical health outcomes in multiple prisoners. *See, e.g.*, T. 122-25 (10/11/06). The conclusions reached by Drs. Walden and Cohen do not require knowledge of complex psychiatric diagnoses, the latest experimental psychopharmacological developments, or other cutting-edge topics in psychiatry. Rather, their conclusions address a more fundamental, macro-level failure. It is a failure that, in light of their professional qualifications and experience, Drs. Cohen and Walden are eminently suited to recognize.

In *Dickenson v. Cardiac & Thoracic Surgery of Eastern Tennessee, P.C.*, 388 F.3d 976 (6th Cir. 2004), a medical malpractice action against a pulmonologist, the district court excluded the testimony of a cardiac thoracic surgeon called to testify on the appropriateness of defendant pulmonologist's decision to extubate a patient. *Id.* at 977-78. Notwithstanding the surgeon's

extensive experience with extubation, the district court found his testimony inadmissible because, *inter alia*, he had no formal training in pulmonology, had never written peer-reviewed articles on the subject, and had never been qualified as an expert witness in pulmonology. *Id.* at 979-80. Noting that Federal Rule of Evidence 702 specifically contemplates that an expert may be qualified on the basis of *experience*, the Sixth Circuit held that *Daubert's* fundamental purposes would not be served by excluding expert testimony "that is supported by extensive relevant experience." Such exclusion, the court of appeals continued, "is rarely justified in cases involving medical experts..." *Id.* at 980-82. Similarly, in *Jahn*, a veterinary malpractice action, the Sixth Circuit found a veterinarian qualified to testify on pre-operative examination and post-operative monitoring even though he had never performed the specific procedure at issue. 233 F.3d at 389.

The case of *Walker v. Soo Line Railroad Co.*, 208 F.3d 581 (7th Cir. 2000), relied on by the Court in its opinion, further reveals the infirmities in Defendants' interpretation of *Daubert* and Federal Rule of Evidence 702. In *Walker*, lightning struck a railroad worker, resulting in electrical trauma. The plaintiff proffered the testimony of the head of the University of Chicago's Electrical Trauma Research Program, Dr. Mary Capelli-Schellpfeffer. The district court refused to admit her testimony concerning the plaintiff's post-traumatic stress disorder because she was not a psychiatrist or psychologist. *Id.* at 585. The Seventh Circuit reversed, holding that Dr. Capelli-Schellpfeffer's experience as the leader of an interdisciplinary medical team rendered her qualified to opine on PTSD resulting from electrical trauma. *Id.* at 589. That she was not a psychiatrist did not preclude her from offering testimony on PTSD.¹⁹

¹⁹ The Seventh Circuit Court of Appeals noted:

The team approach to medical diagnosis and treatment is employed to ensure that all

As recognized by the Court, the cases cited by Defendants are inapposite. Nov. Op. at 22 (cases cited by Defendants "deal with disparate factual scenarios and do not support exclusion of testimony in this instance."). Defendants' reliance on *Smelser v. Norfolk S. Ry. Co.*, 105 F.3d 299 (6th Cir. 1997) is particularly misplaced. In *Smelser*, a biomechanical engineer offered testimony concerning the existence of a seat belt defect and whether that defect caused the Plaintiff's injuries. *Id.* at 301-02. The Sixth Circuit offered multiple reasons why the expert's testimony regarding causation in that case should be excluded; only one of these reasons related to his qualifications. *Id.* at 304-05. The court of appeals noted that the proposed expert was qualified only to discuss injuries in the abstract; a discussion of plaintiff's specific injuries would require a medical doctor. There were several other grounds for finding the expert's testimony unreliable: he had failed to review the plaintiff's full medical history, had failed to consider any pre-existing injuries the plaintiff might have sustained, and had failed to review the plaintiff's deposition or even discuss the accident at issue with the plaintiff. *Id.* at 305. Barring an engineer from testifying about medical matters cannot justify excluding a medical doctor's testimony about mental health issues. Both Drs. Walden and Cohen have worked with mental health issues throughout their careers, and psychiatry is a standard component of medical training. Further, it is common for internists and other primary care

relevant disciplines work together for the good of the patient. The leader of that team is chosen because of her ability to assess accurately the role that each member of the team ought to play and to reconcile, when necessary, competing perspectives. In short, the expertise of the team leader is the capability to evaluate, in light of the overall picture, the contributions of each member of the team.

Id. The interdisciplinary experience that led the court in *Walker* to admit Dr. Capelli-Schellpfeffer's testimony is remarkably similar to Dr. Cohen's experience on the three-doctor interdisciplinary panel in *Doe v. Meachum*. It also parallels Dr. Walden's collaboration with mental health professionals in his private practice. T. 114; 119-20 (10/11/06).

physicians to diagnose and treat mental illnesses. T. 115 (10/11/06).²⁰

In sum, Defendants have offered no evidence to suggest that Drs. Walden and Cohen were unable to offer relevant, reliable testimony on the issues presented to them. The Court did not abuse its discretion in allowing them to testify on matters clearly within the scope of their experience.

VI. DEFENDANTS' CLAIM THAT THE MENTAL HEALTH ISSUES SHOULD BE DISMISSED AS MOOT

Defendants contend that the mental health issues in this case should be dismissed as moot because Defendants have prohibited custody from imposing top of bed restraints in the *Hadix* facilities, now have on-call hours for psychiatrists, and have established daily psychological service rounds and weekly inter-practice case management meetings. Defendants offer no record citation for any of these assertions, but even if they were properly supported by the record there would be no basis for dismissing the mental health issues.

Defendants cite no cases in support of their mootness argument, but when they previously made this argument in the Sixth Circuit they relies upon *Iron Arrow Honor Society v. Heckler*, 464 U.S. 67 (1983) and *Defunis v. Odegaard*, 416 U.S. 312 (1974). These cases do no more than illustrate “the familiar proposition that federal courts are without power to decide questions that cannot affect the rights of litigants in the case before them,” *Defunis*, 416 U.S. at 1705 (internal quotation marks and citation omitted). In *Defunis*, an unsuccessful applicant to a state law school

²⁰ Similarly, Defendants' reliance on *Marquardt v. Joseph*, No. 98-5163, 173 F.3d 855, 1999 WL 196569 (6th Cir. March 30, 1999), an unpublished opinion, provides little support for their position. In *Marquardt*, the Sixth Circuit held that it was not clearly erroneous to exclude a portion of a dentist's testimony when the plaintiff had failed to demonstrate her qualifications to opine on the standard of care owed by an oral surgeon. *Id.* at *1. However, the Sixth acknowledged that the dentist was qualified to testify that, based on the angle of the dental implants at issue, the procedure would not be successful. *Id.* Thus, to the extent that *Marquardt* sheds any light on the issues in the case at bar, it supports Plaintiffs' position.

sued state and university officials on the ground that the admissions policy led to an unconstitutional denial of his application. The Court decided the case was moot because the student was in his last quarter of his final year at the law school and all parties agreed that any decision on the substantive issues would not prevent his graduation. *Id.* at 319-20. In *Heckler*, an all-male honorary organization sought to enjoin the Secretary of Health and Human Services from interpreting a regulation so as to require a private university to ban it from campus. 464 U.S. at 69. While the suit was pending, the university president voluntarily sent a letter to the organization stating unequivocally that, regardless of what the law might require, the university itself would bar the organization from campus as long as it continued its discriminatory membership policy. *Id.* at 69-70. The Court held that this action mooted the case since no judicial order against the Secretary (the sole defendant in the case) could provide the relief the plaintiff sought. *Id.* at 70.

Defendants' position is that current compliance with the Court's remedial order entitles them to immediate termination of the order. There is no support for that position in the law. First, and most significantly, Defendants' possible current compliance (which Plaintiffs do not concede) is under compulsion of a court order; it is not voluntary. If a defendant could argue that an injunction was moot, and therefore the order imposing the injunction should be vacated, simply because the defendant was complying while the case was on appeal, no injunction could ever survive.

Even if Defendants were not under compulsion of a court order, a claim of "voluntarily" ending the challenged practices would not moot the issue. "A defendant's voluntary cessation of a challenged practice ordinarily does not deprive a federal court of its power to determine the legality of the practice," *Friends of the Earth, Inc. v. Laidlaw Env'tl. Servs. (TOC), Inc.*, 528 U.S. 167, 169-70 (2000), for "if it did, courts would be compelled to leave the defendant free to return to its old ways.

” *Id.* at 170. The Supreme Court has repeatedly emphasized that “[t]he standard for determining whether a case has been mooted by the defendant's voluntary conduct is stringent: A case might become moot if subsequent events make it absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur,” and “[t]he heavy burden of persuading the court that the challenged conduct cannot reasonably be expected to recur lies with the party asserting mootness.” *Id.* (citation omitted); *Parents Involved in Community Schs. v. Seattle Sch. Dist. No. 1*, 127 S. Ct. 2738, 2751 (2007) (quoting *Laidlaw*, 528 U.S. at 189).²¹

CONCLUSION

For the above reasons, Plaintiffs request that the Court deny the relief sought by Defendants.

Respectfully submitted,

s/ Elizabeth Alexander
ELIZABETH ALEXANDER
National Prison Project
of the ACLU Foundation
915 15th Street, N.W., 7th Floor
Washington, D.C. 20005
(202) 393-4930

PATRICIA STREETER (P30022)
221 North Main Street
Suite 300
Ann Arbor, Michigan 48104
(734) 222-0088

SANDRA GIRARD (P33274)
Prison Legal Services of Michigan, Inc
119 N. Washington Square, #302
Lansing, Michigan 48933
(517) 702-9830

Attorneys for Plaintiffs

Dated: December 18, 2007

²¹ As discussed in Section I, *supra*, Defendants’ claim that there was “no evidence of showing inadequate mental health care at RGC” lacks any basis in the record. *See* Defs.’ Mot. at 25.