

**Expert Report of Terry A. Kupers, M.D., M.S.P.  
Eastern Mississippi Correctional Facility**

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## CONTENTS

Assignment	3
Summary of Opinions	3
Qualifications	3
Compensation	8
Facts and Data Considered in Forming Opinions	8
OPINIONS AND BASIS AND REASONS FOR OPINIONS	10
OPINION 1: The conditions in isolated confinement housing at EMCF are so shockingly harsh and inhumane as to subject all prisoners housed there to a significant risk of serious psychiatric symptoms and breakdown, and to subject the less healthy prisoners to significant risk of very severe and possibly irreversible psychiatric consequences, including psychosis, mania or compulsive acts of self-abuse or suicide.	10
I.A. The Known Effects of Long-Term Solitary Confinement	10
I.B. MDOC's Awareness of the Damaging Effects of Prolonged Isolated Confinement	14
I.C. Conditions for Prisoners in Isolated Confinement	15
I.D. Abandonment by Staff and Profound Neglect of Prisoners' Basic Needs	20
I.E. Punishment for Seeking Staff Attention to Urgent Needs	23
I.F. Degrading and Dehumanizing Treatment by Staff	25
I.G. Some Illustrative Cases	26
OPINION 2: Mental health care at EMCF for prisoners with serious mental health needs is so grossly deficient that it subjects all prisoners with serious mental health needs to significant risks of psychiatric deterioration, worsening prognoses, permanent psychiatric damage, and extreme suffering.	30
II.A. Staffing Levels and Competency of Staff	30
II.B. Deficiencies in Levels of Mental Health Care	32
<i>Inpatient care</i>	32
<i>Intermediate level of care</i>	33
<i>Outpatient Mental Health Treatment</i>	36
II.C. Gravely Deficient Care for Patients in Psychiatric Crisis	37
II.D. Inadequate Medication Management and Over-Reliance on Psychotropic Medications as the Only Available Treatment Modality	41
II. E. Unreliable, Inaccurate and Incomplete Mental Health Records	49
II.F. Effect on Prisoners' Mental Health of Systemic Excessive Force	52
CONCLUSION	54

**Assignment**

Plaintiffs have asked me to evaluate the mental health impact, if any, of the conditions of confinement in the segregation units at East Mississippi Correction Facility (EMCF) on prisoners confined to those units; and to evaluate the adequacy of the system at EMCF for providing treatment for inmates with serious mental health needs.

**Summary of Opinions**

I have formed the following opinions in this case:

The conditions in isolated confinement housing at EMCF are so shockingly harsh and cruel as to subject all prisoners housed there to a significant risk of serious psychiatric symptoms and breakdown, and to subject the less healthy prisoners to significant risk of very severe and possibly irreversible psychiatric consequences, including psychosis, mania or compulsive acts of self-abuse or suicide. Taken as a whole, the conditions in solitary confinement at EMCF are the worst I have witnessed in my 40 years as a forensic psychiatrist investigating jail and prison conditions. These conditions can accurately be described as torture according to international human rights agreements and standards. They press the outer bounds of what most humans can psychologically tolerate.

Mental health care at EMCF for prisoners with serious mental health needs is so grossly deficient that it subjects all prisoners with serious mental health needs to significant risks of psychiatric deterioration, worsening prognoses, permanent psychiatric damage, and extreme suffering. Gross and unacceptable deficiencies in the areas of staffing levels, staff competency, medical records, screening for risk, crisis intervention, inpatient care, intermediate level of care, and outpatient care, and failure to obtain informed consent for treatment with psychotropic medications, among other things, make the mental health care shockingly substandard. The effects of these deficiencies are compounded by the neglect of patients' basic human needs, and by abuse by staff, and for those in the segregation units by the conditions there.

**Qualifications**

I am a medical doctor and have been licensed to practice medicine in the State of California

since 1968. I am a Diplomate of the American Board of Psychiatry & Neurology (Psychiatry, 1974, for life).

I am on the staff of the Alta Bates Medical Center in Berkeley. I am Institute Professor in the Graduate School of Psychology at Wright Institute in Berkeley, and have been on the faculty of the Wright Institute since 1981.

I am Distinguished Life Fellow of the American Psychiatric Association and a member of the American Academy of Psychiatry and the Law and the American Association of Community Psychiatrists. I have served as President of the East Bay Psychiatric Association (local branch of the American Psychiatric Association) and I served for several years as Co-Chair of the Committee on Persons with Mental Illness Behind Bars of the American Association of Community Psychiatrists. I have conducted a private practice of psychiatry since 1974 and I currently maintain a clinical practice in Oakland, California.

I have testified as an expert in over thirty criminal and civil proceedings, in federal and state courts regarding jail and prison conditions, their effects on prisoners, the quality of mental health services, and the problem of sexual assault in correctional settings.

I have extensive experience investigating the conditions of confinement and the treatment of mentally ill prisoners in Mississippi, and in collaborating with the Mississippi Department of Corrections in efforts to ameliorate those conditions. I testified as an expert in two class action cases involving treatment of mentally ill prisoners and the psychiatric effects on prisoners of solitary confinement and other conditions in Mississippi prisons. In *Russell v. Johnson* (2003) I testified about the psychiatric effects of the conditions of confinement on Mississippi's Death Row at Parchman. In *Presley v. Epps* (2006), I testified about the abuse of mentally ill prisoners in Unit 32, the 1,000 bed supermax unit at Mississippi State Penitentiary. In both cases, the Court entered remedial decrees.

In *Presley v. Epps*, I assisted MDOC in the implementation of a consent decree that reduced the population in solitary confinement from 1,000 to 150 prisoners and reformed treatment of

prisoners with serious mental illness. In 2009, in collaboration with officials from Mississippi Department of Corrections (MDOC) and MDOC's private health contractor, Wexford, I published an article about this experience, "Beyond supermax administrative segregation: Mississippi's experience rethinking prison classification and creating alternative mental health programs."<sup>1</sup>

I have had prior experience at EMCF in connection with my work in implementing the decrees in *Presley v. Epps*. In 2008 I toured EMCF and met with the mental health program director for The GEO Group ("GEO," the private company then running EMCF on contract with MDOC), in an attempt to understand the resources available for prisoners with serious mental illness in Unit 32 at Parchman who, under the terms of the consent decree in *Presley*, were to be transferred to EMCF for treatment. In January 2011, under the terms of a later decree whereby Unit 32 was to be permanently shuttered and all prisoners with serious mental illness who had been housed there were to be transferred to EMCF absent exceptional circumstances, I investigated the conditions of confinement and mental health treatment at EMCF and consulted with MDOC officials and their mental health contractor, GEO, in collaborative efforts to improve mental health treatment at EMCF. I again toured EMCF, conducted interviews with staff and prisoners, and met with custody and mental health administrators from MDOC and GEO, including MDOC's Deputy Commissioner Emmitt Sparkman and GEO regional Medical Director for Psychiatry, Dr. Cassandra Newkirk, to make specific recommendations to them. In October 2011, I reviewed and responded with specific recommendations to a proposal by MDOC/GEO for the creation of a Special Management Unit at EMCF, designed for prisoners on Unit 5.

In addition to the Mississippi cases in which I have testified as an expert, I have testified in the following cases, among others: *Hadix v. Caruso* (2008), regarding mental health care in Michigan prisons; *DAI, Inc. v. NY OMH* (2006), regarding mental health care in the New York Department of Correctional Services; *Austin v. Wilkinson* (2005), regarding the proposed transfer

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<sup>1</sup> Kupers, T. A., Dronet, T., Winter, M., Austin, J., Kelly, L., Cartier, W., ... & McBride, J. (2009). Beyond supermax administrative segregation: Mississippi's experience rethinking prison classification and creating alternative mental health Programs. *Criminal Justice and Behavior*, 36(10), 1037-1050.

of Ohio death row prisoners to Ohio State Penitentiary (a supermax facility); *Jones 'El v. Berge* (2001 and 2002), on the effects of isolated confinement on Wisconsin prisoners suffering from serious mental illness; *Everson et al. v. Michigan Department of Corrections* (2001), about prison staffing; *Westchester County in Westchester Co. Correction Officers Benevolent Assoc., v. County of Westchester* (2002, in deposition), about mental health care and prison staffing; *Bazetta v. McGinnis*, 2000, about the effect of visitation and its restriction on Michigan prisoners; *Cain v. Michigan Dept. of Corrections*, 1998, about conditions of confinement and their effect on mental health; *Coleman v. Wilson*, 1993, about conditions of confinement and the quality of mental health treatment for prisoners with mental illness in the California Department of Corrections; *Gates v. Deukmejian*, 1989, regarding the availability and quality of mental health services at the California Medical Facility at Vacaville; *Toussaint/ Wright/Thompson v. Enomoto* (1983), regarding conditions of confinement and effects of double-ceiling in the Security Housing Units of the California Department of Corrections; *Neal v. Michigan DOC* (2008), regarding custodial misconduct and sexual abuse of women prisoners.

I received a B.A. in Psychology from Stanford University with distinction and a Masters in Social Psychiatry degree from UCLA. I received my degree in medicine from UCLA School of Medicine where I was elected to Alpha Omega Alpha Honor Society. I completed an Internship in Medicine/Pediatrics/Surgery at Kings County Hospital/Downstate Medical Center in New York, a Residency in Psychiatry at UCLA NPI (Los Angeles) and Tavistock Institute (London), and a Fellowship in Social and Community Psychiatry at UCLA Neuropsychiatric Institute (NPI). Between 1974 and 1977, I was Assistant Professor in the Department of Psychiatry and Co-Director of the Psychiatry Residency Training Program of the Charles Drew Postgraduate Medical School in Los Angeles, and I was a staff psychiatrist and Co-Director of the Outpatient Clinic at Martin Luther King, Jr. Hospital in Los Angeles. From 1977 to 1981, I was staff psychiatrist and Co-Director of the Partial Hospital Program at the Richmond (California) Community Mental Health Center.

I have published extensively on the subject of mental illness in correctional settings. I have published more than two dozen articles in scholarly journals including “Beyond Supermax Administrative Segregation: Mississippi’s Experience Rethinking Prison Classification and

Creating Alternative Mental Health Programs,” Criminal Justice and Behavior, 36, 1037-1050 (2009); "What to do with the Survivors?: Coping with the Long-Term Effects of Isolated Confinement,” Criminal Justice and Behavior, Vol. 35 No. 8, August (2008), pp. 1005-1016; “Malingering in Correctional Settings,” Correctional Mental Health Report, 5, 6, 81-, March/April, (2004); "Violence in Prisons, Revisited," (with Hans Toch), Journal of Offender Rehabilitation, 45,3/4, 49-54, (2007); “Toxic Masculinity as a Barrier to Mental Health Treatment in Prison,” Journal of Clinical Psychology, 61,6,1-2, (2005); “The SHIJ Syndrome and Community Mental Health,” The Community Psychiatrist, Summer, (1998); “Trauma and Its Sequelae in Male Prisoners,” American Journal of Orthopsychiatry, 66,2, (1996), pp. 189-196.

I have published a book on the subject of mental illness in prison, Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It, Jossey-Bass/Wiley, (1999), and co-edited another, Prison Masculinities, Temple University Press, (2003). Among book chapters I have written on the subject of mental illness in prison are “Psychotherapy with Men in Prison,” in A New Handbook of Counseling & Psychotherapy Approaches for Men, eds. Gary Brooks and Glenn Good, Jossey-Bass/Wiley, (2001), “Posttraumatic Stress Disorder (PTSD) in Prisoners,” in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, (2005), and “Schizophrenia, its Treatment and Prison Adjustment,” in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, 2005). I wrote the Foreword for David Jones (Editor), Working with Dangerous People: The Psychotherapy of Violence, Oxon, UK: Radcliffe Medical Press Ltd., (2004); "The Role of Psychiatry in Correctional Settings: A Community Mental Health Model," Correctional Mental Health Report, Vol. 13, No. 3, September/October, (2011); "A Community Mental Health Model for Corrections," Correctional Mental Health Report, Vol. 13, No. 5, January/February, 2012, and “Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?,” The Routledge Handbook of International Crime and Justice Studies, Eds. Bruce Arrigo & Heather Bersot, Oxford: Routledge, (2013), pp. 213-232. I am Contributing Editor of Correctional Mental Health Report.

I have served as a consultant regarding prison conditions and the quality of correctional mental health care to the U.S. Department of Justice, Civil Rights Division. I have conducted trainings

for correctional and mental health staff in several departments of corrections. I serve as consultant to several public mental health agencies.

I testified as an expert to the National Prison Rape Elimination Commission, which was created by Act of Congress to investigate the problem of rape in U.S. prisons and jails and make recommendations for its elimination.

I have lectured and presented on mental illness in prison, at many professional meetings, including a Symposium Presentation, “The Experience of Individuals with Mental Illness in the Criminal Justice System,” at the May 20, 2013 Annual Meeting of the American Psychiatric Association in San Francisco.

I received the Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI) at the annual meeting of the American Psychiatric Association in 2005; and the William Rossiter Award for “global contributions made to the field of forensic mental health” from the Forensic Mental Health Association of California in 2009.

I attach to this Report a copy of my current curriculum vitae, which includes a list of all the publications I have authored in the past 10 years and a list of all the cases in which I have testified at trial or deposition during the past four years.

#### **COMPENSATION**

My rate of compensation in this case is \$225/hour for all work except deposition and testimony at trial, for which my rate is \$450/hour.

#### **FACTS AND DATA CONSIDERED IN FORMING OPINIONS**

In forming my opinions in this Report, I considered the information I gathered during the three days I spent at EMCF, April 23 – April 25, 2014, touring the facility, discussing various practices and policies with staff, and interviewing prisoners. I conducted individual interviews of 23 prisoners in a private meeting room and conducted an additional 27 individual interviews of prisoners on the units while touring. In addition, I conducted group interviews of more than



25 other prisoners in groups that I assembled by entering general population Units and asking several prisoners, randomly selected, to sit with me and discuss their prison experience and programs. I also met for approximately a half hour with six prisoners, most from Unit 4, in the waiting room of the medical clinic. My tours included visits to Units 5 and 6 on 4/23/14. I spent approximately an hour and a half entering pods, speaking with staff and with prisoners locked in their cells or the showers. I returned to Unit 5 on 4/24/14 and visited the day room on one pod and the control booth. I visited the Crisis Unit in the Medical Department (Observation Cells) and spoke with the prisoners in Observation. I toured Unit 3 C and talked with approximately 20 prisoners individually and in groups in the dayroom. I toured Units 1A, 2A, 2B, 3A, 3B, 4A, and 4C and spoke with prisoners in each location.

I reviewed electronic medical/mental health records (EMR) for over a dozen prisoners that are mentioned in this report, and reviewed the summaries of EMRs prepared and submitted by Dr. Bart Abplanalp. I reviewed a transcript of the Deposition of Captain Matthew Naidow. I reviewed the July 19, 2012 Contract for Medical Services at EMCF between MDOC and Health Assurance, LLC. I reviewed numerous policies of MDOC and Health Assurance, LLC; lists of prisoner grievances; incidents reports; audits; email correspondence of Dr. Carl Reddix; MDOC monitor reports; Reports in this matter by Dr. Bart Abplanalp, Eldon Vale and Dr. Marc Stern; the summary prepared by Madeleine LaMarre of the case of one individual prisoner; and numerous other documents provided in discovery. I reviewed sworn prisoner declarations by prisoners #11, #31, #65 and #66. I reviewed eight videos of use of force episodes, including medical treatment in some cases. I reviewed photographs taken of the facility in April 2014 by environmental health expert Diane Skipworth and by the ACLU and SPLC.

Exhibit B to this Report contains a complete list of the documents I considered in preparing this report.

I have created a numbered Name Key, Exhibit C. I will refer to prisoners throughout this declaration by their number on that Name Key.

I expect to consider additional documents, data and facts as they become available to me and to

modify or supplement my opinions if need be in light of any such new materials.

### **OPINIONS AND BASIS AND REASONS FOR OPINIONS**

In forming my opinions, I have relied on my training in general psychiatry, social and community psychiatry and forensic psychiatry; my decades of experience as a clinician, educator, researcher, and consultant in the areas of the delivery of mental health services in prisons and jails, and on the effect on mental health of solitary confinement and other conditions of confinement; my experience as an expert in other cases, including in the Mississippi Department of Corrections and my earlier investigations regarding the treatment of prisoners with serious mental illness at EMCF; my experience as a clinician who has visited correctional facilities and interviewed many administrators, staff and prisoners in numerous states; my familiarity with the literature of psychiatry and the social sciences; my experience as a trainer and consultant in correctional settings; and my extensive clinical practice in my office and in public agencies where I have treated and trained others to treat patients who have been imprisoned; my familiarity with position statements by and guidelines and standards of professional organizations.

**OPINION 1: The conditions in isolated confinement housing at EMCF are so shockingly harsh and inhumane as to subject all prisoners housed there to a significant risk of serious psychiatric symptoms and breakdown, and to subject the less healthy prisoners to significant risk of very severe and possibly irreversible psychiatric consequences, including psychosis, mania or compulsive acts of self-abuse or suicide.**

#### **I.A. The Known Effects of Long-Term Solitary Confinement**

For the purpose of this Report, I will utilize the following definition of isolated confinement or solitary confinement:

Segregation from the mainstream prisoner population in attached housing units or free-standing facilities where prisoners are involuntarily confined in their cells for upwards of 22 hours a day or more, given only extremely limited or no opportunities for direct and normal social contact with other persons (i.e., contact that is not mediated by bars, restraints, security glass or screens, and the like), and afforded extremely limited if any access to meaningful programming of any kind.<sup>2</sup>

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<sup>2</sup> Haney, C. (2009). The social psychology of isolation: Why solitary confinement is psychologically harmful. *Prison Service Journal*, 12.

The locations of isolated confinement at EMCF include approximately 120 prisoners in long-term segregation in Unit 5, approximately 30 prisoners in short-term segregation in Unit 6D, and any or all housing units at EMCF when they are on lock-down status, which occur when prison officials deem that a security problem exists requiring round-the-clock cell confinement of all prisoners, including those in general population. During lockdowns, prisoners are almost entirely isolated and idle and often are not even permitted to go to the yard for recreation. Lockdowns occur frequently at EMCF and can last weeks or even months at a time. (Naidow Declaration, p. 20). I should note that patients in psychiatric observation or the medical unit may also be subjected for extended periods of time to conditions that are the equivalent of isolated confinement. Thus a significant proportion of the prisoner population at EMCF experiences isolated confinement for extended periods of time.

Long-term confinement (greater than three months) in an isolated confinement unit is well known to cause severe psychiatric morbidity, disability, suffering and mortality.<sup>3</sup> It has been known for as long as solitary confinement has been practiced that human beings suffer a great deal of pain and mental deterioration when they remain in solitary confinement for a significant length of time. In 1890, the U.S. Supreme Court found that in isolation units, “[a] considerable number of prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.”<sup>4</sup>

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<sup>3</sup> For reviews of this research, see: Smith, P. S. (2006). The effects of solitary confinement on prison inmates: A brief history and review of the literature. *Crime and justice*, 34(1), 441-528; and Arrigo, B. A., & Bullock, J. L. (2008). The psychological effects of solitary confinement on prisoners in supermax units: Reviewing what we know and recommending what should change. *International Journal of Offender Therapy and Comparative Criminology*, 52(6), 622-640.

<sup>4</sup> *In re Medley*, 134 U.S. 160 (1890).

It has been known for decades that suicide is approximately twice as prevalent in prison as in the community. Long-term consignment to segregation is a major factor in the high suicide rate among prisoners. Recent research confirms that of all successful suicides that occur in a correctional system, approximately fifty percent involve the 3 to 8 percent of prisoners who are in some form of isolated confinement at any given time.<sup>5</sup>

In 2005, in an amicus brief to the United States Supreme Court, leading mental health experts summarized the clinical and research literature about the effects of prolonged isolated confinement and concluded: “No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects.”<sup>6</sup>

It has been my experience, from prison tours and clinical interviews of prisoners held in long-term near-24-hour cell confinement similar to the segregation pods on Units 5 and 6 at EMCF, that isolated confinement is likely to cause psychiatric symptoms such as severe anxiety, depression and aggression in relatively healthy prisoners, and cause psychotic breakdowns, severe affective disorders and suicide crises in prisoners who have histories of serious mental illness or are prone to mental illness.

There is a rich research literature on the effects of long-term solitary confinement in prison.<sup>7</sup> Hans Toch provided early narrative reports from prisoners at the highest levels of security and

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<sup>5</sup> Mears, D. P., & Watson, J. (2006). Towards a fair and balanced assessment of supermax prisons. *Justice Quarterly*, 23(02), 232-270; Way, B. B., Miraglia, R., Sawyer, D. A., Beer, R., & Eddy, J. (2005). Factors related to suicide in New York state prisons. *International Journal of Law and Psychiatry*, 28(3), 207-221; Patterson, R., & Hughes, K. (2008). Review of completed suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004. *Psychiatric Services*, 59(6), 676-682.

<sup>6</sup> *Wilkinson v. Austin*, U.S. Supreme Court, No. 04-495, Brief of Professors and Practitioners of Psychology and Psychiatry as Amicus Curiae in Support of Respondent, 2005.

<sup>7</sup> For an overview of supermaximum security and isolated confinement, see Rhodes, L. (2004). *Total confinement: Madness and reason in the maximum security prison*, Berkeley, CA: University of California Press; and Shalev, S. (2009). *Supermax: Controlling risk through solitary confinement*, Portland, Oregon: Willan Publishing.

Isolation.<sup>8</sup> Craig Haney has researched the detrimental effects of long-term isolation,<sup>9</sup> including feelings of anxiety and nervousness, headaches, troubled sleep, lethargy or chronic tiredness, nightmares, heart palpitations, obsessive ruminations, confused thinking, irrational anger, chronic depression, and fear of impending nervous breakdowns. Nearly half suffered from hallucinations and perceptual distortions, and a quarter experienced suicidal ideation. Stuart Grassian has conducted similar research.<sup>10</sup>

Sheilagh Hudgins and Gilles Cote performed a research evaluation of penitentiary inmates in a Super-maximum Security Housing Unit and discovered that 29% suffered from severe mental disorders, notably schizophrenia.<sup>11</sup> David Lovell has described typical disturbed behavior.<sup>12</sup> I have reported my own findings from litigation-related investigations.<sup>13</sup>

Whatever form of serious mental illness the prisoner suffers, there is a strong tendency for it to be exacerbated by long-term isolated confinement such as exists at EMCF on Units 5 and 6 and during lockdown on other units. Prisoners prone to psychotic episodes will predictably have a “breakdown” triggered by the stark isolation and idleness of segregation, and prisoners prone to despair, self-harm and suicide will tend to have crises and harm themselves. On average, I can generalize to a reasonable degree of medical certainty, the longer prisoners suffering from or

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<sup>8</sup> Toch, H. (1975, 1992). *Mosaic of despair: Human breakdown in prison*, Washington, D.C.: American Psychological Association.

<sup>9</sup> Haney, C. (2003). Mental health issues in long-term solitary and “supermax” confinement. *Crime & Delinquency*, 49(2), 124-156.

<sup>10</sup> Grassian, S., & Friedman, N. (1986). Effects of sensory deprivation in psychiatric seclusion and solitary confinement. *International Journal of Law and Psychiatry*, 8(1), 49-65.

<sup>11</sup> Hudgins, S., & Cote, G. (1991). The mental health of penitentiary inmates in isolation. *Canadian Journal of Criminology*, 177-182.

<sup>12</sup> Lovell, D. (2008). Patterns of disturbed behaviour in a supermax population. *Criminal Justice and Behaviour*, 35(8), 985-1004.

<sup>13</sup> Kupers, T. (1999). *Prison madness: The mental health crisis behind bars and what we must do about it*. New York: Jossey-Bass/Wiley.

prone to serious mental illness are consigned to isolated confinement, the more severe their mental disorders become and the worse their disability and prognosis.

### **I.B. MDOC's Awareness of the Damaging Effects of Prolonged Isolated Confinement**

MDOC is well aware of the damaging effects of prolonged isolated confinement on all people, and especially on persons with serious mental illness. I testified to those effects in 2003 in the Mississippi death row trial, *Russell v. Epps*, and again in 2006 in the Unit 32 supermax case, *Presley v. Epps*. The *Presley* case resulted in a consent decree reducing the solitary confinement population by eighty-five percent and the creation of a mental health step-down unit, and the publication in 2009 of an article jointly authored by me and MDOC leadership and its mental health providers and classification experts recounting the need for and the success of these reforms.<sup>14</sup>

I toured EMCF again in 2011, and met with and made recommendations to MDOC's Deputy Commissioner, and GEO's regional Medical Director for Psychiatry concerning the treatment of prisoners at EMCF. Specifically, I recommended that no prisoner should be consigned to the segregation units, Unit 5, and Unit 6D indefinitely; all prisoners must be provided a series of incremental phases they can traverse to gain transfer out of segregation; the phases must be very brief, and the rate of movement of prisoners out of Unit 5 would be the measure of success for the program. I recommended removing prisoners with serious mental illness from long-term segregation on Unit 5. I also pointed out in no uncertain terms that there were insufficient mental health treatment and rehabilitation programs on Unit 3C, where, I was told, the most intensive mental health treatment programs were located. I also pointed out that it was entirely unacceptable that the men in that unit are almost totally idle and lack meaningful treatment. I explained how psychotropic medications are a part of a mental health treatment plan, but not in themselves adequate treatment. I pointed out problems with the Crisis Intervention component of mental health services, specifically that there was "recycling" whereby prisoners would be

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<sup>14</sup> Kupers, T. A., Dronet, T., Winter, M., Austin, J., Kelly, L., Cartier, W., ... & McBride, J. (2009). Beyond supermax administrative segregation: Mississippi's experience rethinking prison classification and creating alternative mental health programs. *Criminal Justice and Behavior*, 36(10), 1037-1050.

transferred from segregation to Observation, and after a brief tenure there would be transferred back to segregation, where there would be too little follow-up treatment and they would again become acutely suicidal and a high risk of self-harm.

In October 2011, after reviewing a remedial proposal submitted by GEO and MDOC, I responded with recommendations, which were well received. There was consensus among all parties to that discussion that no prisoner should be consigned indefinitely to Unit 5, that incremental rewards and advancement to greater freedom and eventually general population should be built into each phase of the program on Unit 5, and that the phases should be relatively short. Because of that consensus, I was hopeful that EMCF might become a model facility for the housing and treatment of prisoners with serious mental illness.

It was therefore with great shock that I witnessed the actual conditions at EMCF today for prisoners housed in isolated confinement, and the treatment of those with serious mental illness. The situation at EMCF has deteriorated badly since the last time I visited in 2011. A large group of prisoners, very many suffering from serious mental illness, are consigned to long-term segregation in Unit 5 for years and seemingly have no exit route. The conditions on Unit 5 are inexcusably horrible. Meanwhile, there is practically nothing in the entire institution that would qualify as mental health treatment other than an occasional stint in an “Observation” cell for prisoners who evidence acute suicide risk, and the administration of high doses of psychotropic medications, often under duress and without informed consent.

### **I.C. Conditions for Prisoners in Isolated Confinement**

Taken as a whole, the conditions in solitary confinement at EMCF are the worst I have witnessed in my 40 years as a forensic psychiatrist investigating jail and prison conditions. These conditions can accurately be described as torture according to international human rights agreements and standards. They press the outer bounds of what most humans can psychologically tolerate.

The treatment of prisoners in isolated confinement at EMCF is likely to cause them significant psychiatric damage. They are subjected to profound isolation from human contact and sensory

deprivation, deprived of access to any meaningful activity, and deprived of access to minimally adequate mental health treatment. Staff are shockingly inattentive to the prisoners basic human needs. Furthermore, the toll that isolated confinement takes on these prisoners is enormously exacerbated by appallingly cruel features of the segregation pods at EMCF that cause further psychiatric damage.

A large proportion of prisoners consigned to long-term segregation or isolation in recent decades suffer from serious mental illness, and this is certainly true at EMCF. Security and mental health staff at EMCF are well aware that there are many seriously mentally ill prisoners consigned to the solitary confinement units at EMCF. (Capt. Naidow Deposition, p. 70).

The many prisoners in segregation on Units 5 and 6 whom I interviewed gave me consistent accounts of the classic symptoms of long-term isolated confinement. For prisoners who had not suffered significant symptoms of mental illness prior to being housed in isolated confinement, the conditions of their confinement, especially the profound, unremitting isolation and idleness, the dark cells, the filth, and the neglect by staff caused profound depression and anxiety and in many cases repetitive, compulsive acts of self-harm such as cutting. For those who had pre-existing serious mental illness, the conditions in segregation at EMCF greatly exacerbate their psychiatric disorder and worsen their disability and prognosis. These prisoners exhibited many of the psychiatric symptoms that are widely understood to be induced by extended time in isolated confinement.

One of the most shocking conditions in the isolated confinement cells in Units 5 and 6D is the deprivation of light. Many, perhaps most, of the prisoners housed there are forced to live in the dark for weeks or months on end. The solid metal cell doors have a small “window” that does not open and a food port. A prisoner in the cell is isolated behind the solid door even from people passing by on the tier, more so than he would be if the door was constructed of bars. Then, in most cells I visited on Unit 5 and 6D, and in the cells of prisoners I interviewed, the light bulb, which is supposed to be screwed into a fixture on the ceiling of the cell, is broken or entirely missing. The small horizontal window on the exterior wall of the cell is more than six feet high and does not provide significant light in their cell. Thus the cells are in near total



darkness 24 hours per day. During my tour of EMCF, a large majority of the cells in the segregation units were dark in the middle of the day, and most of the inhabitants of the cells were lying on their bunks in darkness. I have never, in my 40 years touring prisons, seen anything like this.

Captain Matthew Naidow, who works as a captain of security at EMCF, confirms that many cells lack light, but explains that the prisoners break the light bulbs. (Naidow Deposition, p. 19 & 45) But many prisoners told me that they have spent weeks or months in total darkness because their light bulb has been missing since they moved into the cell, or it broke because there are no light switches in the cell and they had to screw and unscrew the bulb in order to turn it off or on, and staff either ignore their requests for a replacement or tell them that bulbs are not available.

Depression and paranoid thinking are severely exacerbated by excessive darkness. The prisoner consigned to a dark cell is left entirely alone to ruminate about self-deprecating or paranoid themes, and there his psychiatric condition is almost certain to deteriorate on account of the stark isolation and idleness. Living in excessive darkness also results in loss of diurnal rhythm (the steady alternation of day and night that provides human beings with orientation as to time). Human beings require diurnal changes in lighting to maintain their sanity. These diurnal changes foster the rhythm of night and day that provides not only a sense of orientation, but also makes possible the physiological processes that we require to function as human beings. Individuals suffering from mental illness are especially harmed by a lack of diurnal cycles of light and dark.

Another consequence of the loss of diurnal rhythm is sleep deprivation, which greatly exacerbates the tendency to suffer psychiatric breakdown and become suicidal. Loss of sleep creates fatigue and magnifies cognitive problems, memory deficits, confusion, anxiety, and sluggishness. All of the prisoners I interviewed from the segregation pods on Units 5 and 6 reported great difficulty sleeping at night.

A large proportion of the prisoners in isolated confinement at EMCF suffer from serious mental illness, and some of these prisoners are prescribed relatively high doses of psychotropic

medications, often by injection and, in some cases, over their objection. Lack of initiative, passivity and lassitude are very disabling symptoms of Schizophrenia, and all of these symptoms are exacerbated when the patient is administered tranquilizing medications and not provided any kind of congregate activity or meaningful productive pursuits. Drugged and sedated, they spend their days in a dark cell, sleeping much of time, and not able to engage in productive activities of any kind. This combination of factors is well known to worsen mental illnesses of all kinds.

Some of the prisoners told me they are glad to be drugged so they can sleep all day as a way of escaping the despair produced by their environment. But the drugging and sleeping all day have very damaging effects on the prisoners' psychiatric condition and their long-term prognosis. Social connections and meaningful productive endeavors are a big part of the treatment for depression, even while psychotropic medications are prescribed. In the short-run, these heavily-sedated prisoners in isolated confinement may be relatively quiet and docile, but in the long-term, the extended period of sedation results in the withering away of their social skills and ability to engage in meaningful and productive pursuits. The possibility of their adjusting to life in the general population or the community at the end of their stint in isolated confinement is greatly diminished.

As I toured the segregation pods on Units 5 and 6 I observed portable telephones stored outside the door to the pods. They seem to be phones that can be wheeled to the cells. Yet prisoners in segregation universally told me that they are denied phone calls, and those phones are never wheeled onto the pods and are never made available to the prisoners.

Contact with loved ones is one of the most effective measures to support the mental health and eventual rehabilitation of prisoners. Prisoners who have maintained quality contact with loved ones (parents, partners, children and so forth) throughout a prison term have an impressively lower recidivism rate than those who have lost or been denied contact with family and friends. When a patient in a psychiatric hospital experiences an acute crisis, the staff make every effort to contact the family and involve them in the treatment. It makes no sense at all that prisoners in segregation at EMCF are denied telephone contact with loved ones. Cutting them off from family and friends in the community has the effect of worsening their psychiatric condition.

I was disgusted by the shocking level of filth and lack of sanitation I witnessed in the common areas of the segregation pods and in very many cells in the segregation pods of Units 5 and 6. When I walked onto the pod, I saw Styrofoam trays and food waste scattered all around, mixed with large puddles of water and what appeared to be excrement and/or blood. There was a stench of garbage and excrement. The prisoners I interviewed reported that overflowing toilets are a very common problem, that the unit is infested with rodents and that their cells are filled with rat droppings.

The prisoners I interviewed from the segregation units without exception reported to me that they do not receive basic cleaning materials to keep their cells clean. Prisoners are issued a small bar of soap each week, by their report not even enough soap to clean their bodies; yet many prisoners report using that tiny bar of soap to clean their unbearably filthy toilets and cells. Several prisoners report putting an arm through the food port when an officer opens it to deliver a food tray, and refusing to remove it until someone brings some cleaning supplies (or takes them to medical, or to a shower, etc.), even though they realize that this desperate measure of seeking help will most likely result in a disciplinary report and perhaps a violent take-down and gassing.

Evidence of feces smeared on the walls in the segregation pods on Units 5 and 6 reflect extreme neglect of the prisoners by staff. Compulsive smearing of feces is a commonplace phenomenon in institutions where individuals with mental illness are severely neglected and experience total lack of control over their environment. In the segregation units at EMCF there is so much severe and inadequately treated mental illness, such gross inattention by staff, and such intolerably filthy and harsh conditions that the smearing of feces becomes a predictable response by mentally ill prisoners to their dreadful plight.

There are serious medical and mental health ramifications when living units are as filthy as the ones I viewed at EMCF, where the staff do not clean the units and the prisoners are given no cleaning supplies and must live in cells filled with rat droppings and where toilets have overflowed and feces has been smeared on the walls.

When I toured EMCF in 2011 with nursing expert Madeleine Lamarre, I noticed that many prisoners appeared to be malnourished, and many prisoners reported to me that they were always hungry and had lost significant weight after spending a few months at EMCF. Ms. Lamarre found that significant weight loss, of up to twenty or thirty pounds, was documented in the medical records of a number of prisoners. During my recent tours, I again noticed that many prisoners appeared malnourished, and several prisoners told me that they were always hungry and had lost significant amounts of weight over several months in segregation.

#### **I.D. Abandonment by Staff and Profound Neglect of Prisoners' Basic Human Needs in Solitary Confinement**

I do not believe I have ever witnessed in a prison the level of neglect on the part of staff that I witnessed at EMCF. The level of neglect by line staff in the segregation pods on Units 5 and 6 is incredible, abhorrent, and far beneath all standards of correctional care and decency.

The prisoners in segregation unanimously reported that staff rarely come by to check on them, and they are unable to get the staff to pay attention to their basic needs, whether for a light bulb for a dark cell, electricity that shuts down, cleaning supplies, toilet paper, repair of a toilet that is backing up and flooding their cell with excrement, or to see a doctor or mental health clinician for an urgent medical or mental health need. Eldon Vale documents in his report an unconscionable lack of regular 30 minute cell checks by custody officers (see Eldon Vale Report).

Many prisoners report that their emergency call button does not work, or even if it works staff do not respond when they press it. I did a test of the call buttons. I went to the control booth overlooking one of the segregation pods on Unit 5 where an officer is stationed and controls the opening and closing of unit and cell doors, and there are multiple video camera monitors and control technology for the entire Unit. An attorney went to the cells of several prisoners and asked them to press their emergency buttons. Over half of the emergency call buttons did not register in the control booth, and when the call did register, there was no sound so it would only

be detected if the officer in the control booth happened to open the window on her computer screen where the call buttons registered.

Often the officers do not even take the prisoners to yard for their allotted recreation time, or to showers, for weeks on end. Furthermore, quite a few prisoners report that when officers do take them to the yard or the shower, they sometimes leave them locked in the exercise area of shower cubicles for many hours. During my tour of Unit 5 I talked to three men locked in the tiny shower cubicles, who told me they had been locked in the shower for a couple of hours. Captain Naidow confirmed that prisoners can be left locked in the showers for hours (Naidow Deposition, p. 46). Madeleine LaMarre and I observed this exact same phenomenon when we visited EMCF in 2011, and reported this issue to MDOC officials.

Over half of the prisoners I interviewed who were housed on Unit 5 or Unit 6D spontaneously and independently told me that not only are the officers absent from the segregation pods most of the time, and not only does no staff come when they scream or bang on their cell door, but also that security is so lax on the pods that it puts them at grave risk. Many prisoners report, and Captain Naidow confirmed, that inmates can manipulate the locks on their cell doors, and that in addition inmate-on-inmate attacks occur when staff permit certain prisoners in the segregation pods to be out of their cells and unsupervised (Naidow Deposition, pp. 37-40).

Prisoners also told me that staff are so inattentive that when they escort a prisoner back to his cell after showers or yard, the prisoner can simply stop in front of a cell that is not his and the officer will unlock that cell door and let him enter, without checking if it is his cell and whether there is another prisoner in that cell. After the officer leaves, the prisoner who has gained entry to another's cell can assault or obtain willing or coerced sex from the inmate who lives there.

Prisoners #3, #8, #9, #10, and #11 independently told me about staff leaving prisoners free on the Pod where they can harm other prisoners. Prisoner #26 reports that while he was being escorted in handcuffs by an officer from his cell in segregation on Unit 5 to the showers, he was forced to walk very close to the cells along the way, and that another prisoner reached through the food port and stabbed him multiple times. Quite a few prisoners told me that they are forced to take

sedating psychotropic medications and then, in a “doped up” state, they are more vulnerable to attack and less able to defend themselves. This fact, added to the lack of security in their segregation cells, makes them quite anxious about their safety.

Captain Naidow testifies that some officers are corrupt, some are involved with the gangs or with individual prisoners in illegal smuggling of contraband and drugs and in extortion, prisoners can defeat the locks on their cell doors in segregation and get loose on the segregation pods to harm other prisoners, and some corrupt officers do let certain prisoners out and collude with their assaults on other prisoners (Naidow Deposition, p. 37-40, 89, 92-93). He does not believe sexual assaults happen often, but they do happen. Eldon Vale documents in his Report that senior officials in the MDOC are aware of the security problems reported by the prisoners and confirmed by Captain Naidow. Eldon Vale also notes that the contraband report for August, 2013 reflects that 62 weapons were found by staff, 20 of them in Units 5 and 6.

Thus the prisoners’ perceptions are frighteningly accurate: EMCF is a very dangerous place. This fact weighs very heavily on prisoners with serious mental illness, for example they need to think seriously about how their tranquilizing medications will slow them down and make them more vulnerable to attack, and this concern plays into many prisoners’ reluctance to cooperate with the administration of their psychotropic medications. Prisoner #12 explained to me that “the shots slow me down, then I get threatened by other prisoners, and that’s why I don’t want to get the shots.” Prisoner #23 told of being attacked by another prisoner who threw scalding water on him, scarring him on the left arm, “It happened the same day as the shot, you’re sleepy, you can’t respond when someone attacks you.”

The prisoners’ reports of custodial staff’s indifference to the most basic prison security were also corroborated by the extraordinary amount of contraband openly strewn about the Unit. When I toured Unit 5, I saw many improvised strings or ropes – “fishing lines” - that are used by prisoners to communicate from cell to cell. And many of the windows on cell doors were completely covered, which is also against the rules as a security risk. Staff on the pod at the time I visited seemed entirely unconcerned about the fishing lines and the covered windows, as if they are a frequent occurrence and staff do not remedy the situation.

There is much objective basis for the prisoners' fear and their panic that nobody will heed their cries for help and they will die of a stabbing, or a heart attack. Dr. Marc Stern concluded his report on medical care at EMCF that he found ample evidence that inmates at EMCF do not have timely access to urgent care.<sup>15</sup> Dr. Stern discusses a Patient #23 (for the purpose of my report, he is Prisoner #68). This 43 year old African American man died in the custody of EMCF. He suffered from very severe heart disease with hypertension and anemia, as well as Schizophrenia. He spent several months in Observation in the Medical Department before being sent back to a segregation cell on Unit 5 for a month, and then died there on December 18, 2013. (Stern Report, Prisoner #23) Dr. Stern describes the repeated and systematic neglect of this man's legitimate and emergency medical complaints by both custody staff and medical staff.

This tragic case evidences abominable and inexcusable neglect by staff, both custody and medical. Prisoners universally complain of precisely this kind of neglect and failure to heed prisoners' cries for help, and that neglect then leads many prisoners in segregation cells to commit bizarre, illegal and ineffectual actions they believe to be the only way to get the urgent attention they need. Prisoner #68 (my numbering system) reportedly set fire to his cell the day prior to his death and in the medical record a nurse (L.P.N.) wrote "the patient set fire to his cell to get medical attention." In fact, when someone like Prisoner #68 dies unattended, the prisoners in surrounding cells become very frightened, fearing the same neglect would happen to them if they had a heart attack or other emergency medical crisis, or if they were attacked by another prisoner.

### **I.E. Punishment for Seeking Staff Attention to Urgent Needs**

The prisoners' desperate pleas for help are likely to be either met with staff callousness or even abuse. The staff views these inmates as troublemakers, and responds to them in an increasingly insensitive, punitive or even abusive manner. But when human beings are subjected to extremes of isolation and idleness, and deprived of every vestige of control over their environment, and in addition are denied social contact and all means to express themselves in a constructive manner; then it is entirely predictable that they (or almost any human being) will resort to increasingly

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<sup>15</sup> Dr. Marc Stern Report, Patient 23

desperate acts to achieve some degree of control of their situation and to restore some modicum of self-respect.

Prisoners are harshly punished for violating the rule against putting their arm through the food port, even when the purpose of the gesture is to summon urgently needed help. The prisoner may be issued a Rule Violation Report (RVR); furthermore, a group of officers in riot gear likely shoot immobilizing gas into the prisoner's cell, or even directly at his face, and then storm his cell to perform a take-down. Often there are injuries sustained during the take-down. All of the prisoners I spoke with on the segregation pods tell me that the use of immobilizing gas is quite frequent and that they be put back in their cells without the opportunity to decontaminate either their bodies or cells. Eldon Vail's analysis of videotapes corroborates the prisoner accounts. Prisoners resort to other extreme behaviors to try to summon help for emergency needs. The prisoner "floods the range," meaning he stops up his toilet or sink and lets water run over the floor of his cell and out onto the common spaces on the pod, or they light fires in an effort to summon help or call for attention. I saw a number of cells with burnt areas on and around the door. Prisoner #23 set a fire in his cell on 12/28/13 and had to be removed from that cell and monitored for breathing problems. In the EMR for that date it is noted "he had set fire in his cell because he felt his life was in danger and that was the only way he could get any help." Or the prisoner resorts to self-harm in an effort to summon urgently needed attention and assistance.

In a prison where staff are this neglectful and prisoners so often perform bizarre acts of self-harm in order to gain staff attention to needs the prisoners consider urgent, it is inappropriate for staff to issue Rule Violation Reports for the inappropriate behavior without actually responding to the needs the prisoner is expressing in an inappropriate way. In other words, it is not acceptable for the staff to fail to ameliorate the neglect, and then merely penalize the prisoner for taking measures to seek needed help.

For example, an RVR was issued to Prisoner #67 by a mental health staff member on April 26, 2013, for "Faking an illness or injury by reporting he was going to cut himself due to security-related issues" (RVR No. 01288802). In the electronic medical record for Prisoner #67 there are several entries on April 25 and 26, 2013, reflecting that the prisoner is very upset about being on lockdown on Unit 1 (essentially he is in isolation during lockdown, and he complains he is



experiencing symptoms of isolation), is very fearful that someone is going to die when the lockdown ends, is clearly nervous and agitated, is seen by staff tying a ligature around his neck, asks several times to talk to mental health, and then is seen on rounds by the mental health counselor who wrote the RVR. At the time of their encounter, the prisoner was scraping a razor blade against the wall “to sharpen it” (quote from MHC’s note on the EMR).

The mental health counselor ignores the prisoner’s anxious, agitated state and very real concerns (i.e., when the lockdown ends, somebody is going to die, which upsets this prisoner quite a lot) and opts to issue a Rule Violation Report (RVR) instead of offering to talk to the prisoner about his anxiety and concerns. At EMCF, where staff are appallingly neglectful of prisoners’ urgent needs including the need to talk to a mental health staff member about a perceived deadly situation, the issuing of such an RVR is merely another reflection of staff callousness.

#### **I.F. Degrading and Dehumanizing Treatment by Staff**

The extremity of the neglect of prisoners by staff at EMCF comes to a head in a repetitive drama on Unit 5 involving the prisoners who put an arm through the food port of their cell door in order to gain staff attention to their urgent needs.<sup>16</sup>

Officers require prisoners who have previously broken the rules by “bucking the tray flap” (refusing an order to remove an arm from the tray slot) to kneel on the floor at the back of their cell and to put their mattress on the floor next to the cell door when it is time for the food tray to be delivered, so the officers can throw the container of food through the food port onto the mattress. If the prisoner refuses to put his mattress on the filthy floor and kneel on the floor behind it the officers refuse to deliver the meal. Some prisoners say that at times they go hungry rather than accept the humiliation of being fed like an animal.

Prisoners # 11, 31, 65 and 66 submitted declarations describing this dreadful procedure. Prisoner #65, confined in segregation on Unit 5B, declares: “When the food tray is thrown into my cell, the food that is on the tray spills out onto the floor. If I refuse to go to the back of my cell, I cannot eat because the officer will refuse to give me my food tray. I have gone without eating

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<sup>16</sup> See Declarations of Prisoners #11, #31, #65 and #66.

approximately 4 or 5 times in a two week period because I would not go to the back of my cell and have my food thrown onto the floor.... I refuse to go to the back of my cell because having my food thrown at me makes me feel like an animal..” The electronic medical record of Prisoner #65 contains this entry for April 29, 2014: “Chief Complaint: Referred to this provider with report that the offender has cut himself - presents with superficial cut to right forearm. Reports reasons for cutting himself – ‘got mad....they messing with our trays..want us to go to the back of the cell and get on our knees...we ain't no dogs...’”

### **I.G. Some Illustrative Cases**

The following examples are typical of the descriptions that prisoners gave me of their existence in the segregation units at EMCF.

Prisoner #2, a 29 year old African American man, has been in long-term segregation on Unit 5 for a year. He reports ongoing hallucinations and on the mental status examination I conducted he is quite obviously suffering from a psychotic process. He is prescribed powerful anti-psychotic medication but is not undergoing any kind of congregate activity, talking therapy or rehabilitation, and spends all of his time, 24 hours per day, idle in a dark cell with no light and a solid metal door increasing his isolation. This harsh environment will further damage his mental condition, his disability and his prognosis. In the Electronic Medical Record (EMR) his diagnosis is Schizophrenia, he is prescribed Haldol Decanoate 150 mg. by injection every 28 days. There are notes indicating medication compliance had been an issue and the patient does better when continuity is maintained with 28-day injections. Interspersed between notes about his psychotic symptoms, non-compliance with medications, and assaultiveness, are notes by mental health counselors stating he is not having problems and mental status examination is normal. The alternation between notes reflecting psychiatric crises by the psychiatric nurse practitioner, and notes by mental health counselors stating the prisoner is doing fine, is a problem in many of the EMRs we reviewed.

Prisoner # 7 is a young African American man who has been on Unit 6D (Short-term punitive segregation) only for a few days, though he had been there previously. On mental status exam there is apparent depressed affect and slowness (psychomotor retardation), signs of depression.

He was sentenced to a period in segregation for refusing housing with “gang bangers.” He says he did not have a hearing, and does not know how long he will remain in segregation. He has become increasingly depressed even after a few days on his current segregation pod. Not knowing when he will be released from segregation and not being able to do anything to hurry his release make him more depressed. There was no light in his cell when he moved in, and when he pointed that out the officer said they do not have any replacement bulbs. He remembers becoming much more depressed after being moved into the segregation unit. He would think seriously of cutting himself. “It’s a dark cell. What do you do? You sit there’ (he laughs).”

Prisoner 7 also tells me that there are never any officers around the pod, and the buzzer in his cell does not work, so there would be no way for staff to know if he were in a medical crisis. He adds, “You can yell, but they don’t hear you.” He tells me mental health staff mostly do not talk to prisoners during rounds. He estimates a mental health counselor enters the pod and leaves within 5 minutes, meanwhile not really talking to anyone.

Prisoner 7 tells me he has a G.E.D. and would like to write letters to his family, but he can’t write from ‘the hole.’ “The guards here don’t care about you, they do a lot of gassings (spraying of prisoners with pepper spray or another immobilizing gas).” He tells me that just about every day there’s a fire on the pod. “The CO’s just put out the fires and leave all the burnt stuff there.” He tells me the voices he hears get louder and more persistent when he is in segregation, especially when it is dark in his cell all day, he gets much more anxious and depressed, and he thinks constantly of cutting himself, which happens only when he is in segregation. He shows me a large, ugly scar on his arm from cutting himself while in segregation. In segregation he almost compulsively slashes his arm, he says, to try to get sent to the medical department. He has also attempted suicide by hanging in the past. He avers hearing voices, talking to spirits, and on at least two occasions being imminently suicidal “because of the situation in this prison.” He admits he should be in prison, but “I don’t deserve the torture going on in this prison.”

Prisoner #10, an African American man who is housed in segregation on 5B. He complains that his cell is dark 24 hours per day and it has been like that for months, the officers never respond to requests for supplies or assistance, prisoners with mental illness throw feces on the pod,

officers leave prisoners in situations that are very dangerous, the toilet overflows when the prisoner upstairs flushes his toilet and it backs up into Prisoner #10's toilet, which overflows and then there are no supplies to clean up the mess, and many prisoners are sprayed with immobilizing gas and then the officers do not decontaminate their cells. Prisoner 10 states, "I feel trapped in a box and I can't take it anymore," "I try to stay calm but I'm not very successful at it," "I can't sleep, I have a lot of trouble falling asleep and I wake up very early in the morning," "I get mad and don't want to talk to anyone, then I talk in my cell to my dead grandmother," "I pace constantly in my cell," "there's no light in my cell so I can't read," "I keep getting angry, I can't control it, and I'm afraid I'll go off on someone and get into more trouble," "when I get mad my thoughts become cloudy," "I get paranoid." Prisoner #10 had been in segregation at another prison within the Mississippi DOC, the Southern Mississippi Correctional Institution (SMCI), a prison where physically abusive treatment of prisoners in segregation was prevalent in the period when he was there. But he tells me that Unit 5 at EMCF is much worse even than SMCI.

Prisoner #8 is an African American man who was recently released from segregation on Unit 6. He cut himself a month prior to my visit, on March 18, 2014. When I asked why, he told me he gets desperate to talk to someone who can help him, "but staff don't come to see me, so I have to cut myself to get them to notice I need help - but even in Observation, they don't talk to you." Prisoner #8 has a long history of multiple serious suicide attempts beginning when he was 10. He says he does not want to take psychiatric medications. He cuts himself in order to get someone to talk to him. He says the tendency to cut himself is worse when there is no light in the cell which is most of the time, the cutting is driven by anxiety and not a wish to die, and he has cut himself multiple times while in segregation at EMCF. He tells me that after he cut himself the staff put him in an Observation Cell in the Infirmary. He was naked in Observation and says that no staff came to talk to him and uncover his history. He tells me he was forced to accept injections of Haldol, even though he did not want them. He was not offered a form to document treatment refusal. On Prisoner #8's electronic medical record, he is noted to be manipulative and attempting self-harm as a way of gaining something from staff. He has been diagnosed with serious mental illnesses and he is prescribed several psychotropic medications, including antidepressants and Haldol Decanoate by injection.

Prisoner #5 is a 41-year-old African American man who was housed on Unit 5, D Pod when I encountered him. He says he suffers severe depression. There is no light bulb in his cell. It was missing when he moved into the cell and officers keep telling him no new supply of bulbs has arrived in the months he has been in the cell. He had not been permitted to leave his cell to shower or go to recreation in two to three weeks, so he was in his cell 24 hours per day in the dark. He told me that he was in what is supposed to be a stepdown program, in which some prisoners are permitted to go to recreation in the company of a few other prisoners; after 6 or 12 months on a stepdown unit, prisoners are supposed to be transferred to a general population unit. However, he had been in the “stepdown” unit for over 2 years with no progress toward being transferred out, and he told me that was the case with most of the other prisoners in the stepdown program. Consequently, he feels hopeless about ever getting out of Unit 5, and that has led to despair and thoughts of suicide.

Prisoner #11 is a 25 year old African American man housed in long-term segregation on Unit 5B. There has not been any light in his cell for months. Since being in a segregation cell on Unit 5 he has felt agitated. He admits he puts his arm out the food port when it is opened because, he tells me, he needs emergency medical attention for blood in his stool and weight loss, and he is very anxious that he might have cancer or some other serious condition. He has been sprayed with immobilizing gas repeatedly, the last time a few days prior to our meeting. He was sprayed because he put his arm out of the food port and then he was left in his cell for a couple of hours without medical attention or decontamination of his body or his cell. He tells me that he puts his arm through the food port repeatedly because it is the only way he can think of to get the officers to take him for medical attention, but when he does so he has been beaten by several officers. A month earlier he was held down by several officers and given an injection against his will. He says, “I know I’m doing time, but this is extreme punishment.” He has not been permitted to use the phone to call his family, and this increases his anxiety. He reports that other prisoners can get out of their cells and attack him, so he is always anxious. He feels despair, is convinced he will not be moved out of Unit 5 until his sentence is finished, and this causes him to think often of suicide. He saves up his pills and he has tried overdosing several times. He lit a fire outside of his cell the day before our interview, and said this is the only way he can get staff to

come see him when he needs emergency medical attention. “If I get beat up, it’s worth it, I need to see a doctor.”

**OPINION 2: Mental health care at EMCF for prisoners with serious mental health needs is so grossly deficient that it subjects all prisoners with serious mental health needs to significant risks of psychiatric deterioration, worsening prognoses, permanent psychiatric damage, and extreme suffering.**

The Mississippi Department of Corrections uses EMCF as a primary mental health facility for housing prisoners with serious mental illness<sup>17</sup> Despite the fact that MDOC houses over a thousand prisoners suffering from serious mental illness at EMCF, it has failed to provide a functioning system for the delivery of basic mental health care for these prisoners’ serious mental health needs. The grossly sub-standard mental health care provided by MDOC and its contractor, Health Assurance LLC, subjects all these prisoners to extremely severe risks of serious injury.

What follows is a discussion of the extreme and unacceptable deficiencies in essentially every aspect of the mental health care system at EMCF.

### **II.A. Staffing Levels and Competency of Staff**

The staffing levels at EMCF are grossly inadequate. There are two ways for an investigator or auditor to assess staffing levels. One is to use a standard formula for staff-to-prisoner ratios: For

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<sup>17</sup> A spokesperson for MDOC was recently quoted in the Jackson Clarion-Ledger saying that the Mississippi Department of Corrections has 3,637 mentally ill inmates, with the largest number of those — 1,193 — at East Mississippi Correctional Facility.<sup>17</sup> The 2010 termination of the Decree in the *Presley v. Epps* litigation regarding Unit 32 at Mississippi State Penitentiary provides that MDOC “will no longer house any persons with serious mental illness at Unit 32 and they will transfer all persons with serious mental illness to East Mississippi Correctional Facility or, in the rare and extraordinary case where a seriously mentally ill prisoner cannot safely be housed at EMCF, then another appropriate facility.” In the 2010 Annual Report of MDOC, EMCF is designated a “Special Needs Facility.” Available at <http://www.mdoc.state.ms.us/Annual%20Report%20PDF/AnnualReport2010/12%20-%20Institutions.pdf>

example, there is the American Psychiatric Association's recommendation that a correctional psychiatrist should have responsibility for no more than 150 patients on psychotropic medications. The other way to assess the adequacy of staffing levels is to evaluate the quality of mental health care: where care is seriously deficient in important areas, these deficiencies are likely to reflect insufficiency in terms of staffing levels.

By either measure, the staffing levels at EMCF are grossly inadequate. There are 844 patients at EMCF on psychiatric medication, and only one psychiatrist working only two days per week, plus one psychiatric nurse practitioner working full time. This would constitute a serious staffing shortfall even if we doubled the American Psychiatric Association's recommendation that a psychiatrist should have no more than 150 patients on the medication caseload.

What is more, there are massive shortfalls in services that provide strong evidence of understaffing. Few mental health treatment options are available other than medications and psychiatric observation. Even in Unit 3C, which is supposed to be the place where the most intensive mental health services are provided, there is little meaningful mental health treatment.

From my review of the medical records and my interviews with prisoners, it appears to me that Nurse Dunn, the psychiatric nurse practitioner, is a caring and conscientious clinician, who is simply overwhelmed with too many patients to treat, and too little time to spend with each. The quality of her notes is far superior to that of other mental health staff. For example, she wrote on the chart of Prisoner #8 (see # 75): "Although thought processes organized and coherent, he presents with severe poor insight/ poor judgment/ poor impulsivity, with severe impulse control issues, which places the offender at a severe danger to himself. Therefore he is being placed on a Level 1 Suicide Watch with 1:1 observation." Here as elsewhere, she writes coherent notes that contrast with the superficial and seemingly 'cut-and-paste' notes about "no problem" that are written repeatedly by mental health counselors as if they either did not see the prisoner (mostly this occurs with prisoners behind solid cell doors in segregation) or they did not take the care to actually examine the prisoner. But even these more rigorous notes usually do not include adequate suicide risk assessments, treatment plans, or ongoing follow-up.

Having carefully considered the patient summaries prepared by Plaintiffs' mental health expert Dr. Bart Ablanalp, the chief psychologist for the Washington Department of Corrections, I conclude that competency of staff at EMCF is extremely inadequate. I agree with Dr. Ablanalp's conclusion that the overwhelming majority of clinical encounters documented in the records "were essentially meaningless and of virtually no diagnostic or therapeutic value whatsoever." Further, I question the ethical fiber and integrity of several of the mental health counselors at EMCF after reading their notes stating "no problem" where there is overt psychosis. I was unable to find any evidence of meaningful supervision, peer review or quality assurance. Staffing at every level needs to be massively upgraded in qualifications, training and supervision, and security staff needs to be upgraded in terms of qualifications and training to manage prisoners with mental illness (Captain Naidow expresses a similar opinion on that latter point).

## **II.B. Deficiencies in Levels of Mental Health Care**

People with mental illness must receive treatment at a level of intensity that meets their individual needs. The basic levels of care for any mental health system are inpatient care, intermediate care, and outpatient care.

Inpatient care is the equivalent of what is provided by a psychiatric hospital in the community: that is, care for people so psychiatrically impaired that they cannot function on their own, and require the highest level of care available. Intermediate level of care is for higher-functioning patients who are able to be in a less restrictive environment but who still need greater supervision and care than they could receive in a general population housing unit. Outpatient mental health care provides care for patients who can function well on their own but who require periodic or regular treatment that can be provided in a general population setting.

***Inpatient care:*** There is no inpatient level of care at EMCF and I could find no indication that psychiatric patients are ever transferred to psychiatric facilities outside of EMCF. If a prisoner cuts himself badly enough, or has major medical complications from an overdose of medications, he is sent to a nearby hospital for medical attention. But in the several charts I reviewed where that has occurred, there is never any psychiatric attention at the outside hospital, and the prisoner is referred back to EMCF for mental health assessment and treatment – which does not occur.



Unit 3 is the place at EMCF where the most intensive mental services are offered, and supposedly the place where the most seriously mentally ill patients are housed.<sup>18</sup> But it does not qualify as inpatient care. Apart from medication -- sometimes by forced injections of heavy sedating drugs, with insufficient informed consent -- the mental health services provided in Unit 3 are almost nonexistent. I toured Unit 3 repeatedly, at different times of the day on two separate days, and found the men to be entirely idle, roaming the day room of the unit or opting to remain in their cells, often in the dark, even when they are permitted to be in the day room.

I interviewed quite a few men in Unit 3, and they gave consistent accounts of life on the Unit. Practically no group or individual therapy is available. There is a case manager who comes to the unit (she was present the days of my tours), but I am told by the prisoners that she does not come to see them on a regular basis, and their meetings with her are very brief, usually occurring in the day room of Unit 3 and lasting a minute or a few minutes. There are a few groups -- including substance abuse groups, anger management, religious meetings, educational classes -- but the prisoners tell me that except for religious meetings and classes, they rarely occur; there might be a group on the unit once a month or once every two months. There are no milieu meetings. With an occasional exception, the patients do not receive any individual psychotherapy. There are almost few or no programmatic activities such as vocational rehabilitation, group therapy, psycho-education, or just about any form of psychiatric rehabilitation. And there do not seem to be any vocational rehabilitation programs for any of the prisoners at EMCF. An adequate inpatient unit must be able to provide *intensive* treatment, including multiple modalities and several hours per day of structured programming and treatment. Psychiatric observation, as practiced at EMCF, does not constitute an inpatient level of care.

***Intermediate level of care:*** The Intermediate Level of Care is a crucial component in any correctional mental health program. The generic term for this type of treatment program is "step-down mental health unit." Whatever they are called, the clinical staffing and the programming in these units are not as rich as in inpatient psychiatric hospitals, but are far richer

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<sup>18</sup> Capt. Naidow Deposition, p. 68: "Question. The -- is there -- are there special areas of the prison where prisoners with serious mental illness are housed? Answer. Yes. Q. And where are those areas? A. The most highly severe cases are housed on our Housing Unit 3."

than in outpatient clinics. For example, an inpatient unit has nursing staff 24 hours per day, whereas an Intermediate Care Unit might have nursing staff present only during the daytime shift. In the community, equally intensive treatment programs are called halfway houses, day treatment centers or psychiatric rehabilitation programs.

An intermediate level of care is an essential component of an adequate mental health care system in a prison because the safety and encouragement provided in the step-down treatment program helps prisoners remain infraction-free, avoid victimization and avoid punitive or long-term segregation. When prisoners with serious mental illness are placed in an intermediate level of mental health care, they are much less likely than otherwise to be victimized or to run afoul of the disciplinary system, and therefore they are much less likely to be consigned to long-term administrative segregation.

An illustrative example of the critical importance of this level of care is provided by the *Presley v. Epps* litigation, in which I participated as a psychiatric expert, then as a court-approved monitor, and later wrote about the experience there with the use of Intermediate Treatment.<sup>19</sup> *Presley* involved conditions of confinement and their destructive effects on prisoners with serious mental illness in the approximately 1,000 bed Unit 32, supermaximum security facility in the Mississippi State Penitentiary at Parchman. The remedy included removal of prisoners with serious mental illness from administrative segregation, and their transfer either to a psychiatric hospital at another facility (EMCF was the first choice) or to a step-down mental health treatment program then being established at Unit 32. The result was a marked decrease of violence as well as a stunning decrease in the number of disciplinary infractions (RVRs or rule violation reports) given to prisoners suffering from serious mental illness.<sup>20</sup>

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<sup>19</sup> T. A. Kupers. (2010). Treating those excluded from the SHU," *Correctional Mental Health Report*, 12 ,4, 2010.

<sup>20</sup> Kupers, T. A., Dronet, T., Winter, M., Austin, J., Kelly, L., Cartier, W., ... & McBride, J. (2009). Beyond supermax administrative segregation: Mississippi's experience rethinking prison classification and creating alternative mental health programs. *Criminal Justice and Behavior*, 36(10), 1037-1050.

The intermediate level of mental health care is almost entirely lacking at EMCF. EMCF refers to Unit 2A as a “therapeutic community” and offers more programming than in other parts of the facility but still falls short of an adequate intermediate level of care. Also, Unit 2A houses only minimum- and medium-security prisoners who are near their time of release from prison. There are 66 spots in the twelve month program,<sup>21</sup> which is limited to prisoners at minimum and medium security levels. The prisoners on that unit tell me that they are happy to be in this Unit: because there are fewer violent “take-downs” and some groups. But the prisoners also tell me that prisoners with Serious Mental Illness are not admitted to Unit 2A. In other words, the treatment program that seems the richest in programming at EMCF is not available to the many prisoners at EMCF who are higher than Medium security and who suffer with serious mental illness. Thus, most prisoners I interviewed who are housed on Units 5 and 6D are excluded from Unit 2A. Other than Unit 2A there are no mental health treatment programs at EMCF that qualify as “Intermediate Mental Health Treatment.”

Furthermore, it appears that the Therapeutic Community on Unit 2A at EMCF excludes prisoners who break the rules or harm themselves. Thus, Prisoner #1, who I interviewed twice during my tour while he was in an Observation Cell in the Medical Department because of life-threatening suicidal behavior (he cut his abdomen very badly), had previously been in Unit 2A’s therapeutic community, and then was expelled from that program. A “Final/Behavior Contract” dated 1/24/13 documents that he had been in the Therapeutic Community, but because he “continued to cut on himself” he was expelled. The contract stipulates that inmates in the therapeutic community will not cut themselves, will not be absent from class without an excuse from the medical or substance abuse staff, will not participate in sports, and will not talk about harming himself. In other words, the inmate has to be emotionally stable already in order to remain in the therapeutic community. So it is not a treatment program for prisoners with serious mental illness. Prisoner #1 has on at least two occasions cut his abdomen badly enough to expose his intestines, he repeatedly and compulsively cuts himself badly, and he is a constant risk of killing himself. Obviously he needs more intensive mental health treatment than EMCF is capable of providing.

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<sup>21</sup> see 2010 MDOC annual report, available at <http://www.mdoc.state.ms.us/Annual%20Report%20PDF/AnnualReport2010/12%20-%20Institutions.pdf>

***Outpatient Mental Health Treatment:*** Patients in Outpatient Mental Health Treatment can be housed in any prison setting and receive mental health care. Outpatient mental health care is provided on all of the Units at EMCF, but it is entirely inadequate.

In general population units at EMCF (I will discuss mental health care in segregation next) outpatient care is provided, but it consists of medication alone plus Observation at times of suicidal and other crises. Nursing staff bring a cart with oral medications to the door of each Unit and distribute pills. There is a case manager, but the case manager does not spend more than a few minutes talking to each prisoner, and the prisoners tell me they might not see her for long periods of time. Case management, even when delivered consistently and with adequate time to talk, is not sufficient mental health treatment in itself and does not substitute for the other treatment modalities.

This kind of outpatient mental health treatment is very deficient. There need to be multiple modalities of mental health treatment, including individual and group psychotherapy and a variety of psychiatric rehabilitation programs, which are all lacking at EMCF except in Unit 2A. It is not the case that every patient requires every modality of treatment. But the modalities of treatment must be available so that the patients who require individual or group psychotherapy, for example, can be provided those services. At EMCF, as I have described, there are almost no treatment modalities except medications, short-term Observation, and very thin “case management.” This is entirely substandard and unacceptable mental health treatment.

Outpatient mental health treatment in the segregation pods at EMCF is even more deficient. There is a growing national consensus that prisoners with serious mental illness should not be housed in long-term segregation. Their mental illness becomes worse, as does their disability and their prognosis. Yet at EMCF, judging by the large number of prisoners suffering from acute and very disabling mental illness on the segregation pods, segregation seems the very place to which many prisoners with serious mental illness are relegated.

For prisoners in segregation at EMCF there are far too few confidential clinical encounters. There are mental health “rounds” on the segregation pods at EMCF, but these are sadly

inadequate. Prisoners tell me that the mental health counselor conducting the rounds never talks to them or only talks to them for a minute through their solid cell door, and spends only five minutes going through an entire pod. These brief cell-front interviews become the prisoners' only contact with mental health staff absent a crisis where the prisoner is taken to an observation cell in the Medical Area. Cell-front interviews are entirely unacceptable except as a method for mental health clinicians to attempt to identify those who need to be taken to an office for a confidential clinical encounter.

### **II.C. Gravely Deficient Care for Patients in Psychiatric Crisis**

Every mental health care system must have (1) a program for intervening with and stabilizing patients in acute psychiatric crisis, and (2) an active program to prevent suicide. Meaningful crisis intervention and suicide prevention programs do not exist at EMCF.

Crisis Intervention as well as Suicide Prevention and Treatment must include a number of components. One formulation, provided by the National Commission on Correctional Health Care,<sup>22</sup> enumerates the following elements: Training of mental health and custody staff on recognition and intervention regarding prisoners at risk, identification (i.e., screening at admission to the prison or the segregation unit as well as ongoing suicide risk assessment as clinically appropriate), referral (to the appropriate mental health practitioners and programs), evaluation (comprehensive mental health examination including past suicidal and self-harm crises and incidents as well as current stressors), housing (for example, transfer to an Observation cell, or after a period of Observation, to a location where the patient will be safe and appropriately monitored), monitoring (this means not only intensive observation during the immediate crisis, but also ongoing monitoring at incrementally less frequent intervals as the prisoner demonstrates diminishing risk of self-harm), communication (between custody and mental health staff and also between the various mental health and medical providers), intervention (including but not limited to observation and monitoring, for example meaningful talking psychotherapy must occur if the staff are to get to the issues driving the prisoner to despair and contemplate or attempt suicide), notification (of family members, and so forth), reporting (in the electronic medical record according to widely accepted standards in the medical

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and mental health fields), review (peer review, quality assurance, etc., with the assumption that where programmatic deficiencies or lapses in staff interventions are discovered they will be corrected), and critical incident debriefing (which are essential if flaws in the mental health program are to be addressed). It does not appear that any of these elements are in place at EMCF. I found little or no evidence in the medical records that Dr. Abplanalp and I reviewed of a functioning crisis intervention or suicide prevention program at EMCF. I agree with Dr. Abplanalp that EMCF is a system is a system that breeds crises because it lacks a system to provide adequate care, and yet it is completely incapable of responding to the crises it creates.

At EMCF, the mental health staff rely too much on “self-harm contracts.” These are written statements that the prisoner agrees not to harm himself. When a self-harm contract is used instead of talking to the prisoner about his despair and reasons for self-harm, they are almost always useless. As an aide to talking, i.e. when staff ask the prisoner to sign the contract in the context of talking to him and covering the important issues related to his self-harm, the contract can constitute a symbolic act where the prisoner takes a step toward healthy behavior and commitment to the treatment. But the “self-harm contracts” I discovered on the EMRs seem to be signed in the absence of any real face-to-face intervention or treatment, and where that is the case they are next to useless or worse, provide staff a false sense that the prisoner will not harm himself.

Continuity of care is absolutely essential in crisis intervention in prisons. Often prisoners complain to an officer that they are suicidal, the officer refers them to the mental health staff, and they are transferred to an “Observation Cell,” often in the Infirmary. But after a few days they tell staff they are no longer feeling suicidal. They are then transferred back to prison housing, perhaps to a segregation cell where they were confined prior to the suicide crisis. When suicides actually happen in prison, it is quite likely this will be the period when they occur.

Thus, a prisoner must not be sent back to his prior housing after his stay in Observation without a detailed treatment plan that includes recommendations on housing (for example, if the prisoner has been known to attempt self-harm in segregation in the past, it could be very dangerous to transfer him back to a segregation cell), the frequency of monitoring, the kind of ongoing mental

health treatment he will receive (this might include medications, and must include some talking psychotherapy so the mental health staff can assess ongoing suicide risk and the prisoner can be helped to become more functional).

Unfortunately, at EMCF, following a crisis patients are often transferred from Observation Unit back to population – sometimes back to a segregation cell—without treatment plan or follow-up. This results in patients cycling back and forth from Observation to population, over and over and over. Thus, it is not unusual to see patients housed in the Observation Unit for weeks and months at a time, when the purpose of such a unit should be short-term stabilization.

I briefly interviewed several of the patients on Suicide Observation and Psychiatric Observation in the course of my tour and interviews, and I spoke to quite a few prisoners who had been in suicide observation or psychiatric observation in the past. They universally tell me that staff do not spend much time at all talking to the patients in Observation cells. The prisoners inform me that mental health staff and nursing come by each day to check on them, but nobody really asks them about their past suicidal behaviors or what might be causing the current despair. Nobody other than N.P. Dunn provides more than perfunctory care, or actually spends more than a few minutes talking to the patients. Rather, a prisoner is identified as a suicide risk or noted to be decompensating, and he is sent to Observation in the Infirmary. There are windows on the front of the Observation cells and he is observed by staff each day he is there. But essentially the Crisis Intervention service is deficient in most if not all of the NCCHC-required components I listed above.

These frequent and sometimes long-term stays in the Observation Unit are psychiatrically damaging. Typically, patients on suicide precautions have their clothes removed and they are provided only a suicide-proof gown and blanket; usually there are no other amenities or possessions in the Observation cell, and the patient does not get out of the cell for recreation. He is even more isolated and idle and uncomfortable in the Observation cell than he would be in a segregation cell. These deprivations may be necessary for safety while a patient is being stabilized, but they become problematic when imposed for extended periods of time.

Some prisoners tell me that they eventually say they are no longer suicidal, simply because they are so uncomfortable in the Observation cell and nobody talks to them anyway. They are then sent back to the unit they came from – sometimes to a segregation pod on Unit 5 or Unit 6. There is little or no follow-up except that they may be prescribed psychotropic medications.

The case of Prisoner #29 illustrates the lack of inpatient care as well as the dangers of using the Crisis Unit, that is, the Observation cells in the medical unit or Infirmary, for the treatment of prisoners who clearly need to be admitted to a psychiatric inpatient hospital ward. I encountered Prisoner #29 in the medical unit, where he was locked into an Observation Cell. This 37-year-old African American man appeared disheveled. On mental status examination he evidenced severe thought disorder with rambling sentences, tangential references and disturbed orientation and judgment, a clinical picture consistent with Schizophrenia or Schizoaffective Disorder. He had been on observation in the medical unit continuously for at least three months, during which time he has spent 24 hours per day in the observation cell with no recreation or other out-of-cell or congregate activities. His medical record contained the diagnosis Schizophrenia. He has been prescribed Haldol Decanoate by monthly injection off and on since August, 2011. There is little documentation in his chart about his symptoms or functional impairment. A Psychiatric Note by Nurse Dunn on 1/17/14 reflects “increased psychotic agitation on the unit.” He is given the anti-psychotic medication, Haldol, by injection. The psychiatrist writes (4/1/14 & 4/23/14) that Prisoner #29 has been in the Crisis Intervention Unit since January and remains acutely decompensated (psychotic).

There are no adequate treatment plans in Prisoner #29’s medical record, and, with a few exceptions, there is little mention of the signs and symptoms that are the focus of specific treatments. For example, it is noted that there are side effects from medications, but the side effects are not listed. Medications are changed with no explanation in the chart of any reason. In other words, treatment plans are either entirely lacking or are deficient.

Prisoner #29 has been suffering a psychotic episode with regressed behavior, thought disorder, hallucinations and delusions almost continuously for three months, and he has been retained in an Observation cell that entire time. Obviously this man belongs in a psychiatric hospital where



he can receive adequate mental health treatment. A Crisis Intervention/Suicide Observation bed in a medical unit/infirmery such as the one at EMCF must have a time-limit, for example 24 hours or even 48 hours, and then at the end of that time-limit, the patient must be declared ready for return to a housing unit or a lower intensity mental health program, or if he continues to require intensive mental health treatment he must be admitted to a psychiatric inpatient unit. That is the way Crisis Intervention Units are designed to operate.

Not surprisingly, Prisoner #29 continues to exhibit signs and symptoms of acute psychosis in spite of the very high dosages of psychotropic medications prescribed for him. A patient this regressed and disabled needs to have mental health clinicians spend a significant time talking to him, and he needs a structured therapeutic environment consisting of therapy groups and various supervised activities if he is to regain a sense of orientation and appropriate goal-directed behavior, and if he is to regain the capacity to relate appropriately to others. But the Observation cell where he is confined is simply another kind of isolation cell. He is alone in that cell 24 hours of every day, he does not even get out for recreation. He has practically no possessions or amenities, and no provisions for meaningful activities. He frequently smears feces all over the cell. Staff do not talk to him except for brief visits when he is asked how he is feeling.

Thus, the conditions of isolated confinement in the Observation cell are exacerbating this patient's psychosis, and he is not being provided the kinds of treatment and programs that are needed and only available in a psychiatric hospital, that is, in-patient level of care. The combined effect of the isolation and idleness in an Observation Cell and the shortfalls of treatment are that his psychotic condition is becoming more persistent and disabling, and his prognosis is becoming much worse.

#### **II.D. Inadequate Medication Management and Over-Reliance on Psychotropic Medications as the Only Available Treatment Modality**

Over-reliance on psychotropic medications, as the only available treatment modality, is commonplace at EMCF. It appears that the most frequently prescribed psychiatric medications

are the older generation anti-psychotic agent, Haldol, and Tegretol, a seizure medication prescribed in psychiatric practice as an alternative to Lithium for mood stabilization.

Haldol has very dangerous side effects, including Extrapyramidal Syndrome (EPS), Tardive Dyskinesia (TD), and, when given by injection and the accumulated dose is relatively high, neuroleptic malignant syndrome. Extrapyramidal Syndrome (EPS) is an acute neurological side effect of anti-psychotic medications involving muscle spasms, excess salivation and tremor. It can be very frightening and dangerous. It usually disappears when the medication causing it is discontinued, and there are medications, including Cogentin, Benadryl and Artane, that can be given orally to reverse this side effect. Tardive Dyskinesia involves a different set of neurological side effects of Haldol, which take a longer time to appear but usually involve permanent brain damage and do not cease when the medication is discontinued. Other serious side effects include changes in the eyes, heart arrhythmias, other cardiovascular effects including hypotension or dangerously low blood pressure, obesity and diabetes, liver damage and neuroleptic malignant syndrome.

Neuroleptic malignant syndrome is an often fatal side effect of Haldol, which can include high fever, severe muscle rigidity and death. It is a rare side effect except when Haldol is given by injection at high dosage – but injections of relatively high dosages are at issue at EMCF, especially when emergency involuntary injections are added to the standing order for monthly long-acting Haldol.

On some of the electronic medical records I reviewed the dosage of Haldol Decanoate by injection is 100 mg. or 150 mg. every 28 days, which is a relatively high dosage. Then, the same patient might receive several additional injections of 5 mg. of Haldol, and the long-acting and subsequently injected Haldol combine in a relatively high accumulated dosage, which makes neuroleptic malignant syndrome and other side effects much more likely.

I encountered quite a few prisoners who told me how the Haldol “shots” slow them down so they do not feel like doing anything, make them feel “like a zombie,” drool or make their jaw muscles cramp (E.P.S.) or cause a tremor (T.D.), and that in their slowed down state they are very vulnerable to assault by other prisoners

Why are so many patients prescribed Haldol while so few are prescribed other anti-psychotic agents such as the new generation atypical anti-psychotic medications? This makes no sense, clinically speaking. A psychiatrist must have a wide choice of psychotropic agents in order to create an individualized treatment plan for each patient, “one size” does not “fit all.”

When psychotropic medications are given in the absence of a mental health treatment program, they tend to have the effect of merely tranquilizing the patients, and then long-term prognoses worsen. This was a big problem in the state hospitals, the so-called “snakepits” of the 1940s and 1950s. Many patients were turned into chronic patients or “zombies” in the state hospitals through the administration of high doses of anti-psychotic medications. It was the public’s outrage about the warehousing and drugging of mental patients in the asylums that brought on the de-institutionalization movement and the down-sizing of state mental hospitals since the 1960s.

Patients on psychotropic medications must have periodic monitoring and follow-up. The frequency of this monitoring and follow-up must be based on the patient’s individual needs. A fixed follow-up interval of ninety days might be adequate for some patients, but extremely inadequate for others. From the records that Dr. Abplanalp and I reviewed, it appears that there is no individualized determination of the intervals for follow-up.

For example, the antipsychotic medication Clozaril requires close monitoring of white blood cell counts, sometimes on a weekly basis or even more frequently. The reason is that Clozaril, often the strongest and most effective anti-psychotic medication for individuals suffering from severe and unremitting psychosis, is also very dangerous. Two of the potentially lethal side effects of this medication are agranulocytosis and suicide. Agranulocytosis is the rapid reduction of white cell count in the blood, a condition that can lead to rapid death from infection. The patient prescribed Clozaril must be monitored closely, laboratory tests including frequent white cell counts must be done and quickly reviewed so that if agranulocytosis occurs, the medication can be halted immediately and precautions can be set up to decrease the risk of death from immune failure.

Dr. Abplanalp reviewed the chart of a patient on Clozaril at EMCF. This patient's medication management was dangerously inadequate. According to the medical record, Prisoner #64, a man in his early twenties with a diagnosis of Paranoid Schizophrenia, had been very psychotic and difficult to manage until he was started on Clozaril in 2009 or 2010. His psychiatric condition improved markedly. But then his white cell count dropped beneath the normal range beginning in October, 2012, indicating a possible evolution of agranulocytosis. When a patient's white cell count begins to fall he must be monitored very closely because the medical team do not yet know whether the slightly lower white cell is the beginning of a plummeting white cell count, which would be a medical emergency and possibly fatal.

But the psychiatrist failed to follow up on these abnormal results for months, even though they caught the attention of the primary care physician at the prison. And six more months passed before the psychiatrist documented a clinically adequate "risk/benefit" analysis, that is, the risk is agranulocytosis (or a continuing and rapid fall in the white cell count) and the benefit is that Clozaril is the only medication that has proved capable of controlling this patient's severe psychotic condition.

The psychiatrist eventually opted to continue the Clozaril at a slightly lower dose and supplement the anti-psychotic effect with another psychotropic agent. This is an acceptable clinical practice. The problem is that there are delays of many weeks or months between the lab tests that reflect a falling white blood cell count and the psychiatrist's attention to and response to the lab tests. Again, I have to conclude from the medical record that the psychiatrist is present at the facility too infrequently or has too many patients to be able to respond in timely manner to the lab tests that indicate a serious and urgent risk. This kind of time delay in responding to blood tests is quite frequent at EMCF (as is discussed in the reports of the other experts) and this makes the prescription of a medication like Clozaril very dangerous.

Another major deficiency in medication management at EMCF is the failure to consistently obtain patients' informed consent for treatment with psychotropic medications.

Informed consent is a fundamental ethical consideration in the practice of medicine, including psychiatry. Patients have a right to accept or reject any recommended treatment, and that right cannot be meaningfully exercised unless the decision is informed: that is, the physician must explain to the patient the material facts about the nature, consequences, and risks of the proposed treatment, examination or procedure; the alternatives to it; and the prognosis if the proposed treatment is not undertaken. This fundamental principle of the requirement of informed consent applies in prisons just as it does in the community.

The National Commission on Correctional Health Care (NCCHC) articulates the requirement of informed consent as follows: “Informed consent is the agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the proposed treatment, examination or procedure; the alternatives to it; and the prognosis of the proposed treatment is not undertaken.”<sup>23</sup> Further, If at any point the patient indicates refusal, the medication must not be forced: the right to refuse treatment “is inherent in the notion of informed consent....”<sup>24</sup>

MDOC’s own policy recognizes the right to refuse treatment.<sup>25</sup> MDOC Policy #25-04-A, “Offender Right to Refuse Medical Treatment,” spells out the prisoner’s right to refuse treatment, including psychotropic medication: “An offender can refuse medical evaluation or treatment being offered by medical staff. Refusal must be in writing using the Release of Responsibility form.”

At EMCF, the requirement of obtaining informed consent to treatment is frequently ignored. I was told by very many prisoners taking psychotropic medications that they were never given an explanation of the medications they would receive, they were not permitted to decline the treatment, nobody ever showed them a “Release of Responsibility form” or they would have signed it, and they were never given a hearing to determine if emergency involuntary

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<sup>23</sup> National Commission on Correctional Health Care, Standards for Mental Health Services in Correctional Facilities. Correctional Mental Health Care: Standards & Guidelines for Delivering Services, 0262008, M-I-104.

<sup>24</sup> Ibid, M-I-03, p. 146.

<sup>25</sup> MDOC Policy #25-04-A.

medications would be permitted. Instead, they nearly unanimously reported, they witness frequent “take-downs” by the “goon squad” and it is only their fear that the same violent action will be taken against them if they refuse that leads them to comply with medication administration by mouth or by injection.

In some very limited circumstances, it may be clinically appropriate to administer medication in the absence of consent. The NCCHC standard for Emergency Psychotropic Medication calls for a “protocol for emergency situations when an inmate is dangerous to self or others due to a medical or mental illness and when forced psychotropic medication may be used to prevent harm, based on a provider’s order. NCCHC Standards for Mental Health Services in Correctional Facilities (2008) (essential standard MH-I-02). The standard “supports the principle that psychotropic medication may not be used simply to control behavior or as a disciplinary measure. *Id.* The NCCHC standard requires that the provider document in the inmate’s record the inmate’s condition, the threat posed, the reason for forcing medication, other treatment modalities attempted, if any, and treatment goals for less restrictive treatment alternatives as soon as possible. *Id.*

The required documentation regarding consent and forced medication in the EMRs I reviewed is far from adequate. I saw a few notes about emergency medications, and sporadic mentions that the prisoner is a danger to himself or others. I did not find any reference to consideration of less restrictive alternative interventions (and I know from my tour and interviews that practically no significant alternative treatment modalities exist at EMCF). Occasionally progress notes in the EMR document the acuteness of the prisoner’s danger to self - for example, he has cut himself - but more often there is insufficient documentation in the chart for the reviewer to figure out the reason for the involuntary injection, and even if it is in fact involuntary. Frequently there is a “p.r.n.” or “as needed” order in the EMR. The prisoners I interviewed all told me that very little talking and reasoning occur; rather if they refuse to take their medication or become agitated, they are required to have an injection, and if they refuse they are “taken down” by a team of officers.

For example, there is the case of Prisoner #21. This 36 year old African American man was in two mental hospitals before coming to prison. His medical record contains a diagnosis of Paranoid Schizophrenia with suicide ideation, and he is prescribed Haldol Decanoate by injection every 28 days. He evidences an intense, flat stare. He tells me he has received "... the shots, half the guys on 3C get shots." He has received a Haldol injection once a month, and another "shot" if he gets agitated. He does aver hallucinations, and when he sees the psychiatrist they talk about that. Their visits last about 6 to 10 minutes. He sees other prisoners being taken down by the "goon squad" and that frightens him, so when they would come and tell him it is his turn to get a shot he cooperated. But he did not want the shots and told staff he is very willing to take pills. He says he was not given an opportunity to refuse the shots. He has never been presented with a form to refuse medications. There has never been any kind of hearing to determine he needs involuntary medications. He has been in punitive segregation twice in Unit 6 at EMCF, and tells me that if you refuse a shot of medications there they will do a cell extraction where a bunch of officers charge into your cell and hold you down while they give you an injection against your will. He tells me there is no real mental health assessment done on prisoners entering Unit 3C, and mostly nobody from mental health staff to talk to.

More than a few prisoners complain about involuntary medications, and especially about the many "take-downs" that are done where several officers grab the prisoner, force him to the floor and hold him while a nurse pulls his pants down and gives him an injection in his gluteal muscle. Viewing video footage of "take-downs," I have to agree with the prisoners that it may entail an extremely brutal use of force and, besides the physical pain and risk of serious physical injury, it is humiliating for the prisoner.

For example, I watched a video of Prisoner # 23 taken on 5/5/13. There was no evidence in the video or chart that he posed the sort of danger that would have justified involuntary medication. However, the medication was nonetheless administered over his objection.

It might seem that if the patient cuts himself, involuntary medications would be appropriate under the emergency exception to the requirement of consent. But again, the emergency provision requires consideration of less restrictive alternatives. Mental health staff should take

the time to talk to the patient, trying to understand the reason for the patient's self-harm, and negotiating a response other than an involuntary injection. For example, the patient might be convinced to take pills orally, or even to halt the unacceptable or self-destructive behavior. That kind of intervention – attempting to find a less-restrictive alternative - is what is required by the standard of care in the community.

There are cases, and they are relatively rare, where non-emergency medication-over-objection is clinically indicated. However, in such cases, due process is required, including an “Involuntary Medication Hearing” and determination, with the prisoner notified in writing 24 hours prior to the hearing. After that, there must be a due process hearing and determination.<sup>26</sup>

I believe that the use of involuntary medication is not uncommon at EMCF. I reach this conclusion based on the absence of adequate informed consent, the lack of alternative treatments to exhaust, the coercion implicit in frequent “take-downs” in view of other patients, and the incredibly poor documentation in the EMRs about the reason for the injection or the treatment plan the injection is a part of, and the reports of the prisoners.

An example is Prisoner #20, a 23 year old man housed on Unit 3C who tells me he has been in prison for 7 years. He tells me “I get shots, they slow me down and they don't help me.” He tells me he does not see a psychiatrist for a year at a time and, indeed, his chart shows that he went for months without seeing a psychiatric provider in 2011. He thinks he is allergic to Haldol, and the medical staff have switched him to Prolixin, but he gets the kind of “shots” that last a month. He has never been presented with a form to refuse medications, though he would like to refuse the medications and he says he tells that to staff. There has never been any kind of hearing to determine he needs involuntary medications.

In Prisoner 20's medical record he is diagnosed Schizophrenia, Disorganized Type and mild Mental Retardation. He is currently prescribed Prolixin/Fluphenazine Decanoate, 25 mg, by injection every 14 days. A 10/1/13note in his EMR reflects his concern he is allergic to Haldol,

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<sup>26</sup> *Washington v. Harper*, 494 U.S. 210 (1990) addresses non-emergency involuntary medication in prison.



and becomes “locked up like the exorcist” (a poignant description of a likely case of EPS or extrapyramidal syndrome, a side effect of Haldol). NP Dunn switched his prescription to Prolixin (Fluphenazine). He is administered anti-psychotic long-acting medications by injection, yet there is no documentation of informed consent or refusal to take the medication. The patient received a Haldol Lactae shot for agitation but it is not clear from the record whether it was voluntary or involuntary. There are notations of visits with the psychiatrist on 2/2/13, psychiatric NP on 10/1/13, and the psychiatrist on 1/11/14.

### **II. E. Unreliable, Inaccurate and Incomplete Mental Health Records Reflecting Substandard Assessment and Treatment**

Accurate, complete and reliable records are the essential foundation for adequate mental health treatment (and indeed for all medical treatment). Screening instruments and all assessments must be carefully documented in the clinical chart. Contacts with prisoners, laboratory reports, diagnoses, medication prescribing, changes in status and so forth must be carefully and accurately recorded according to the accepted standard of care in the community. In addition to the psychiatric history, observed signs and reported symptoms, diagnoses and other pertinent information, there must be a treatment plan on the chart covering every point in time. Shifts in the treatment must be documented as changed treatment plans, and explanations of the changes must be included in the electronic medical record (EMR).

There are very dangerous problems with documentation in the records at EMCF. There are large gaps or absent documentation in Medication Administration Records (MARs). These are forms on which nursing staff document the delivery of medications per orders from the physician or nurse practitioner. The many gaps in the MARs and missing or incomplete notes are consistent with reports from Ms. Madeleine LaMarre about irregularities in the delivery of prescribed medications (see Ms. LaMarre’s Report). This kind of inconsistency and error is very dangerous when it comes to psychotropic medications, which must be given in a consistent and continuous manner or there will be great harm to the mental state and safety of the patients.

In addition to gross omissions and gaps in the electronic medical records, Dr. Abplanalp and I found a systemic pattern of utterly unreliable and suspect notes by mental health counselors.

This kind of widespread unprofessional practice and unreliable medical record-keeping at EMCF violates basic professional standards of care and contributes to all of the other utterly unacceptable deficiencies in the provision of mental health care at EMCF.

To illustrate the pattern of unreliable clinical notes: There are a number of notes on Prisoner #29's electronic medical record indicating no mental health problem during times when he was obviously acutely psychotic. Thus, on 2/3/14 there is a note by one provider, "patient too disorganized to participate and has ongoing, nonstop psychotic symptoms." By that time he was in a crisis intervention cell in the Infirmary and noted by another mental health clinician to be "too disorganized to take part in the interview." Still, notes by Mental Health Counselor Roger Davis on 2/17/14 and 2/21/14 indicate "no problem reported or observed." This is incredible, given that on the same day that MHC Davis documented "no problem reported or observed, Prisoner #29 was in an Observation Cell and was noted by another provider to be acutely psychotic ("loose and disorganized thoughts with symptoms of mania - standing on bed at interview - rambling and disorganized conversations...").

Many notes in the EMRs by Mental Health Counselors are entirely useless and misleading. One wonders whether Mr. Davis saw the same patient Ms. Dunn is describing as floridly psychotic and/or manic, or whether he simply left a boilerplate note (where even the typos match the typos in notes he writes about other patients) without even seeing Prisoner #29. In fact, on 4/6/14, Mr. Davis writes: "He is asleep on his mat, no body movement, or response. No... hallucinations, ...or any threats to harm self observed. IM (inmate) is able to weigh the risks and consequences of his behaviors. No mental health issues."

This is ludicrous. How can a clinician assess the presence of hallucinations, suicidal thoughts and the patient's ability to weigh risks and consequences when the patient is asleep during the examination? If this kind of egregiously false charting occurred with only this one patient, I would conclude this counselor's unacceptable behavior is an issue his supervisor and the mental health staff need to address in the course of their supervision and peer review process. But he is not the only counselor to write this kind of note, and this kind of falsity in the medical records is not a rare occurrence. In fact, there seems to be a system-wide pattern of this kind of false

documentation, which is quite dangerous – it camouflages the patients’ real and possibly urgent mental health problems.

Very many of the entries by mental health counselors are entirely unreliable. Prisoner #56 is a 54 year old African American man on Unit 3C. He is diagnosed in the chart Undifferentiated Schizophrenia and prescribed Depakote 1,000 mg twice daily plus an intramuscular injection of Haldol Decanoate, 200 mg per month. He has delusions involving “pythons and a 72-year-old man living inside (him);” he claims he can hear his ancestors talking and he has been observed talking to himself. He “believes he is a ‘mud cat’ and a combination of other things.” He denies special powers. On 2/14/13, Sergeant Hardy requested that Prisoner #56 be seen by mental health due to his exhibiting “bizarre behaviors.” The prisoner was noted to be exhibiting delusional beliefs including both that a python and a “72-year-old man” were living inside of him.

The following day, on 2/15/13, Mental Health Counselor Ms. Lockett conducted rounds and stated that Prisoner #56’s mental status was within normal limits. No concerns were noted and there was no indication of any psychotic or delusional processes. It seems readily apparent from this note that MHC Lockett did not see nor interact with Prisoner #56 at all, unless his delusional and psychotic behavior resolved completely within 24 hours – which is clinically very unlikely.

This kind of alternation between notes reflecting psychotic ideas and behaviors and notes indicating no mental health problem continues throughout the chart of Prisoner #56. Thus, for example, in a note reflecting a 03/18/13 Quarterly Treatment Team Review, MHC Lakeisha Prude reported that Prisoner #56 states that he “hears his ancestors daily and believes he is a mud cat” and “can be seen talking to self.” That same day there is a note by Marshall Powe: “Inmate is medication compliant, and has no auditory visual or tactile hallucinations. He reports hearing his mother’s voice daily. Inmate has eccentric behavior, he describes himself as a ‘silver back gorilla.’” On 03/19/13, 03/30/13 and 04/01/13, “Mental Health Rounds” evidenced “no problems.” But then a nursing note 04/03/13 indicates Prisoner #56 came to medical for an “as needed” injection of Haldol. If, during rounds for several weeks, there was no problem, why was an “as needed” injection given? There is no explanation to be found in the record.

Part of the ethical and professional duty of psychiatrists as well as other mental health professionals is to carefully review the patient's medical records, identify any irregularities, and bring them to the attention of the proper person to address them. It appears from the medical records that this most basic kind of review and follow-up is simply not occurring at EMCF in the treatment of prisoners with mental illness.

When there are almost simultaneous notes in the medical record, one saying that the prisoner is fine with no complaints, the other describing a serious psychiatric crisis replete with hallucinations or very high suicide risk, this anomalous pattern is a sign of fraudulent record-keeping. It is the duty of supervising mental health professionals to notice this kind of irregularity and remedy it.

#### **II.F. Effect on Prisoners' Mental Health of Systemic Excessive Force**

The general principle that underlies the standard of care in the community as well as correctional health care standards, is that the use of force must be a last resort, and it should only happen very rarely when all other, less restrictive options have been attempted and failed. The first option, always, is to talk, perhaps to negotiate, compromise, whatever it takes to avoid violence.

Eldon Vale comments in his Report about a pattern of use of excessive force at EMCF: "While many of the use of force events occur in units 5 and 6 at the prison, there are many in the other units as well. There is a pattern of dangerous and abusive practices that run through many of these events putting the prisoner population at significant risk of serious harm." Mr. Vale proceeds to analyze several videos of use of force incidents, pointing out the failure of staff to put energy into de-escalating situations so use of force would not be necessary, the failure of staff to provide de-contamination when immobilizing gas is employed, and so forth. He concludes this section of his report: "It is clear from the information made available to me that the incompetence of the custody staff at EMCF is profound, deeply troubling and places the inmates, as well as themselves, at risk of serious and significant injury."

It is very obvious from my review of videos involving use of force and from Eldon Val's very carefully conducted investigation into the use of force at EMCF that there is very little in the way of talk and negotiation that precedes the multiple uses of force portrayed in the videos we reviewed.

The video I reviewed of Prisoner #4, incident date 3/7/13, provides a vivid example of this pattern. The video shows Prisoner #4 being handcuffed, then he is told he will be stripped, and he starts to resist. But the officers do strip him. Then they try to move him to another location, he is thrown to the floor by several officers, one pushing his face into the floor. Prisoner #4 repeatedly insists he is not resisting, saying they are hurting him and he is not resisting. In a little while the prisoner starts to cry, and says on the video: "That man just punched me in the face, too." His lip is bleeding. They stand him up and move him. Prisoner #4 says to a specific officer: "I see you trying to slam my head." Prisoner #4 is upset and about not getting regular showers, being stripped, and that an officer ordered him to be taken down when he wasn't doing anything wrong." He proceeds to threaten the officers. Eventually he is examined by a nurse, and then talks to a mental health counselor, to whom he says "It's just wrong that an officer punched me in the face with my hands behind my back and everyone saw it and didn't do anything." Prisoner #4 confirms he took his medications and says he was just angry, he has been telling people that he has been handled too roughly, choked and threatened with a gun by the officers, and he is afraid they are trying to kill him. The prisoner is crying and talking about how he tried to do better when he moved cells and the mental health counselor gets up and leaves while he is speaking.

Added to the shocking absence of talking, and trying to reason with prisoners on the part of staff at EMCF prior to initiating the use of force, is the dreadful callousness on the part of staff, the insensitivity that is immediately apparent to the visitor or viewer of these videos. Officers, on average, talk very little to the prisoners. The officers on the segregation pods do not even enter the pods much of the time to check on the prisoners' safety. And in the general population units, the officers spend very little time talking to prisoners. Mental health staff usually spend a very short time, minutes, talking to the prisoners, even in the crisis intervention or Observation cells. There is a remarkable callousness that permeates the staff at EMCF, both custody and mental health staff.

The keyword is trauma. Prisoners generally, as a class, have been multiply traumatized throughout their lives. We know that from a large amount of literature about prisoners and traumas that occurred prior to

their incarceration. Prisoners with serious mental illness are more susceptible to trauma than the average prisoner in two ways: Prisoners with serious mental illness are disproportionately victimized by fellow prisoners and disproportionately selected for disciplinary action and punishment by Correctional Officers; and trauma in prison, including “take-downs” by officers and involuntary injections, tend to trigger or exacerbate acute breakdowns or self-harm crises in this population. For these and other reasons, prisoners with serious mental illness are very vulnerable to trauma, and the traumas that occur in the prison environment become “re-traumatizations” and cause significant psychiatric damage.

## **CONCLUSION**

MDOC has created a totality of conditions in the segregation units at EMCF so harsh and extreme that they are incompatible with mental health. Prisoners are isolated, abandoned, forced to live in abject filth and darkness, subjected to violence and danger, and denied care for their most basic human needs. Each of these conditions, individually and taken together, inflicts tremendous psychological suffering and places each prisoner at significant risk of serious harm.

There is no functioning mental health care system at EMCF. The availability and quality of care fall far short of what is minimally required to meet the needs of the population. As a result, on a systemic basis and regardless of diagnosis, acuity or history, MDOC denies patients the care necessary to meet their mental health needs. Mental health care at EMCF is inexcusably indifferent, reckless, and provided in a manner that places all patients at risk.

I first placed MDOC on notice of these dangers more than three years ago. Since that time, I have seen no evidence that they have taken responsibility for the safety, wellbeing, or mental health of prisoners at EMCF. The predictable result has been ongoing violence, suicide, and the unconscionable suffering of prisoners with mental illness. Absent remediation on a systemic level, these phenomena will continue unabated.

Respectfully Submitted,

A handwritten signature in black ink that reads "Terry A. Kupers". The signature is written in a cursive style with a large, sweeping initial "T" and a distinct "A" before the last name.

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

June 16, 2014

