

EXHIBIT 8

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General and Forensic Psychiatry

EVALUATION OF MENTAL HEALTH SERVICES
East Mississippi Correctional Facility
Report Submitted December 29, 2016

Introduction

This evaluation was completed by the undersigned at the request of Plaintiffs' counsel in connection with a law suit involving the East Mississippi Correctional Facility (EMCF), a Mississippi Department of Corrections (MDOC) institution. My task was specifically to evaluate mental health services at EMCF.

The opinions rendered in this report are those of the undersigned alone and are rendered within a reasonable medical probability and certainty. My opinions are based on my background, education, training, clinical practice and other professional experience; my review of the materials; and my knowledge of the relevant medical and scientific literature. I reserve the right to add to or otherwise modify my opinions should additional data be made available to me.

Resource documents include, but are not limited to, National Commission on Correctional Health Care standards and the American Psychiatric Association's Correctional Guidelines. These resource documents are not used as a measure of the standard of care for this report but to guide inquiry into relevant topic areas to assess the array of services needed in a correctional mental health system. These standards and guidelines are designed to help systems identify the functions, services, and policies necessary to deliver adequate care. The standard here is a Constitutional one focused on a substantial risk of serious harm.

I do not use the American Correctional Association standards as a guide; they are insufficiently comprehensive with regard to mental health delivery. Their emphasis is much more on correctional standards for custody rather than correctional health care.

In terms of methodology, it is important to make two comments. First, the data provided by MDOC was very limited in terms of aggregate and summary data. This amounts primarily to data that would be expected to be used in a quality assurance/quality improvement program. Given such limited data, it was necessary to utilize medical records reviews, patient interviews, direct observation, and review of the documents that were provided, such as incident reports and policies, as the foundation for my opinions.

Second, the medical record reviews and detailed patient interviews I conducted were intentionally not random. It is essential that the most seriously ill patients are taken care of as they represent the greatest risk; thus I emphasized interview and review of patients with serious mental illness and repeated self-harm. It can be argued that this limits the ability to generalize my findings. However, this is a specious argument for the most part. For example, if MDOC cannot provide access to care for its most ill, it is highly unlikely that access for the less ill is any better; it certainly should not be and were this the case, it would be a deeper indictment of the system. Further, I would not expect certain kinds of services to be delivered to the less seriously ill, such as regular therapy or structured activities. Thus, if medication management and crisis services are adequate for the most ill, they are likely adequate for the less ill when rendered (and likely to have similar problems as well). In short, emphasizing the most ill is the most narrow and conservative approach, in that it focuses on the highest risk population, the population EMCF must serve adequately.

On the following page is a table of contents organized by general topic areas and sub-topics. The database for this report is detailed in Appendix 1. Clinical summaries are provided in Appendix 2. Appendix 3 is a patient key matching names and MDOC numbers with the de-identified data in the body of the report and the clinical summaries.

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QUALIFICATIONS

I am a board certified psychiatrist licensed to practice in the State of Washington. I am certified in General Psychiatry and Forensic Psychiatry by the American Board of Psychiatry and Neurology. I completed my undergraduate training at the Massachusetts Institute of Technology, receiving a degree in chemistry. I then went to medical school at the University of Washington, completing my degree in 1983. Following a year of post-doctoral fellowship training in physiology, I completed an internship and general psychiatry residency at Cambridge Hospital/Harvard Medical School, where as chief resident I did specialty training in forensic psychiatry.

After two years in a clinical and teaching position with UCLA at the Sepulveda Veterans Hospital, I joined the faculty at the University of Washington (UW) at The Washington Institute for Mental Health Research and Training located at Western State Hospital (WSH). I remained at these institutions in various roles until 2008 when I became Chief of Psychiatry for the Washington State Department of Corrections (WA DOC). I was the founder and Program Director of the UW Forensic Psychiatry Fellowship until 2008. I hold an appointment as Clinical Associate Professor at the UW.

Throughout my career, I have evaluated and treated thousands of patients for behavioral disorders, including numerous mood and psychotic disorders. Currently, I do limited direct care, consult on challenging clinical cases for WA DOC, conduct forensic evaluations (including private cases), provide correctional monitoring services and evaluation, correctional mental health consultation, and teach residents and other trainees in the areas of mental illness and forensics. I am a member of the Psychopharmacology Committee of the American Academy of Psychiatry and the Law.

With regard to correctional experience specifically, I began as a member of a collaboration project between the UW and WA DOC in 1993 that concluded in 2003. My role included development of a residential treatment unit, modification of transfer processes for the mentally ill, consultation on complex cases, and development of a specialized consultation team with the WA DOC. While at the Center for Forensic Services, I regularly visited jails in my forensic capacity and also provided consultation to the Pierce County Jail through my position with the state. My monitoring and evaluation has included monitoring of the development of mental health and general rehabilitative services in the Division of Juvenile Justice in California. I have conducted evaluations of the Orleans Parish Prison in Louisiana and the Escambia County Jail in

Florida. I am currently the mental health subject matter expert in suits involving the Los Angeles County Jails and the Riverside County Jails in California. I have also done comprehensive assessments and provided consultation on mental health treatment and system development for the Santa Clara County and Sacramento County Jails in California and the Nebraska prison system.

A copy of my *curriculum vitae* is attached, which includes a listing of all publications I authored in the past ten years.

Trial Testimony and Deposition Testimony in the Last Four Years

Trial Testimony:

2015:

State of Alaska v. Karan Clifton (Superior court of Alaska, Third Judicial District)

2014:

State of Washington v. Isaac Zamora (Skagit County Superior Court, Washington)

Sheard v. Daniel Habeeb and Robert Polakoff (King County Superior Court, Washington)

2013:

Lashawn Jones, et al., and the United States of America v Marlin Gusman, Sheriff
In the Estate of Akagi, (Snohomish County Superior Court, Washington)

Deposition Testimony:

2016:

James Joshua Mayfield, et al. v Ivan Orozco, et al.

2015:

In re the Estate of Bernard (King County Superior Court, Washington)

2014:

Sheard v. Daniel Habeeb and Robert Polakoff (King County Superior Court, Washington)

2013:

In the Estate of Akagi, (Snohomish County Superior Court, Washington)

Watson v Dyncorp International and The Continental Insurance Company (U.S. Department of
Labor, Office of Administrative Law Judges)

COMPENSATION

I am being compensated at a rate of \$350 per hour and reimbursement for travel costs. At the time of submission of this report, my total billing has been \$ 80,232.55, including travel.

OPINIONS

In my opinion, the mental health care system at EMCF both places mentally ill inmates at an unreasonable risk of harm and has resulted in actual harm. There are three general topic areas to evaluate: facility conditions, systems and policies, and individual treatment and management of the patients. Facility conditions include both the physical plant and the general custodial environment. Systems and policies contemplate topics such as organizational structure (including contractual terms), systems functions (e.g., grievances, access to care, privacy, ancillary services), staffing, policies, and quality assessment and quality improvement functions. Individual treatment and management contemplates the services actually rendered to individual patients as well as their quality.

The facility conditions in EMCF are a major source of potential and actual harm. The rampant violence, staff indifference to the serious mental health needs of the inmates, lack of safe settings for the seriously mentally ill, and decrepit and ill-kept physical plant all contribute to a highly stressful environment where actual injury both at the hands of others and self-injury in response to the conditions are commonplace. Such conditions make it impossible to provide adequate treatment of the seriously mentally ill. Here it is important to emphasize that these conditions are present on the units where the seriously mentally ill are housed, not just in restrictive housing settings.

Systems and policy problems consist primarily in staffing, access to care, patient privacy, and quality assurance and quality improvement. There are also problems with some policies and contract provisions, but even more problematic are failures to adhere to the requirements of both. While such problems are rarely the direct cause of harm, failures in these areas underlie the deficiencies in facility conditions and individual treatment and management.

The lack of access to adequate treatment is a major source of actual and potential harm to the mentally ill. The state must provide adequate mental health treatment to the seriously mentally ill and those at risk of harm to themselves and others as a result of their mental illness. This requires both access and provision of adequate services. The potential and actual harm that ensues from failure to adequately manage and treat psychotic disorders, major mood disorders, and conditions associated with self-harm and danger to others is substantial and systemic, not isolated to a few cases. The inadequate treatment of these conditions is associated with higher rates of suicide and self-harm, danger to others and actual assaults, and worsening of the condition of the mentally ill, including reducing the likelihood of response to treatment in the future. The longer a person remains seriously ill, the poorer the prognosis becomes.

Suicide prevention is a point of significant convergence of systems issues and individual patient treatment. Nowhere are the failures in both areas more evident at EMCF. The profound deficits in suicide prevention are detailed in the body of the report in the section by the same name. Owing to failures in suicide prevention, there has been an abundance of preventable injury and at least one preventable death. Not only does this result in death and physical injury that may

impact these people for a lifetime, but the failure to mitigate self-injury and self-harm leaves many of these individuals prone to such behavior both during the remainder of their incarceration and after release.

Lastly, it is important to point out that the State is abundantly aware of the violence and self-injurious behavior. Given that this facility is designated by the MDOC for providing services to the mentally ill, the State must be acutely aware that the population needs treatment. Further, their own data show many of the incidents and trips to the hospital as a result of self-injury and violence perpetrated by the mentally ill. Walking on the units, the smell of smoke from all the fires set by inmates is pervasive and it is clear that staff have become so accustomed to this behavior and do not consider it out of the ordinary in much the same way the staff accede to the violence in the facility. Further, it is well-known that mental illness is associated with suicide, self-harm, and danger to others, especially when the mentally ill are in a decompensated (acutely ill or untreated) state. Failure to adequately manage and treat this population is thus well-known to be associated with harmful outcomes. In short, the State could not be unaware of the risks posed by this population and to this population.

EXECUTIVE SUMMARY

Mental health services at EMCF, as well as medical and dental services, are provided through a contract between MDOC and Centurion of Mississippi, LLC pertaining to the Mississippi State Penitentiary (MSP), Central Mississippi Correctional Facility (CMCF), Youth Offender Unit (YOU), South Mississippi Correctional Institution (SMCI), East Mississippi Correctional Facility (EMCF), Wilkinson County Correctional Facility (WCCF), Walnut Grove Correctional Facility (WGCF), and Marshall County Correctional Facility (MCCF).. The contract was executed as of 7/1/15¹. Accordingly, the vast majority of my assessment has focused on the subsequent period. Many of the clinical summaries include information from prior periods, but this is primarily to orient the reader to the nature and duration of the patients' mental illnesses and to demonstrate that there has been little change in that nature and quality of services delivered. This is perhaps not surprising as most of the mental health staff from the previous vendor continued on with Centurion.

Almost all functions related to mental health are deficient in some manner. While some of the deficiencies are doubtless related to staffing problems, my focus is on the adequacy of services irrespective of how many and what types of staff are available. The primary areas related to harm and the potential for harm include:

- Facility conditions

¹ Prior to that time, the health services contract was held by Health Assurance, LLC.

- Violence and victimization
- Physical plant
- Access to means of harm
- Systems and policies
 - Access to care
 - Access to services
 - Placement of the mentally ill
 - Privacy
 - Responsiveness of staff
 - Medico-legal
 - Involuntary treatment
 - Competency and consent
 - Quality assurance and quality improvement (QA/QI)
- Individual treatment and management
 - Assessment
 - Treatment
 - Crisis intervention
 - Psychotropic medications
 - Individual and group therapy
 - Programming and activities
 - Reentry services
 - Documentation
 - Suicide prevention

Facility Conditions

While the focus of this report is mental health treatment, it is important to recognize that mental health treatment is far more dependent on general conditions in the prison than are other aspects of healthcare. The primary reason for this is that living conditions have a more profound impact on those with mental illness, with stressful conditions naturally having a negative influence. In addition, because the mentally ill often do not recognize their mental illness or have difficulty expressing themselves and asking for help, it is vitally important for the custody staff to play an active role in identifying those having potential mental health problems and in reporting essential observations to mental health clinicians. In order to effectively manage and treat this population, it is key for there to be an active partnership between custody and mental health both to assure the mentally ill and those at risk of suicide or self-harm are promptly detected and to create reasonable conditions for the mentally ill within which adequate treatment can be provided. But mental health staff must also retain their clinical orientation, recognizing that their primary responsibility is the welfare of their patients.

The lack of structure, violence on the living units (both interpersonal and self-directed), lack of custody responsiveness to crises, overly punitive attitudes embodied both by staff and policies,

and neglect of safety and security on the part of custody staff create an extremely stressful environment and institutionalizes neglect of the mental health needs of the inmate population. Inmates are largely left on their own with limited access to activities and programs, especially for some of the most seriously mentally ill. There is virtually no structure on the units (also referred to colloquially as “zones”) in terms of scheduled activities and treatment or even the regular presence of staff. What scheduled activities there are, such as pill call, often occur unreasonably late.

There is a substantial degree of violence on most of the units at EMCF with frequent stabbings and self-directed violence, including on the residential mental health units. The mentally ill are often housed with the non-mentally ill, putting the mentally ill at risk of victimization; it is well-known that the mentally ill are far more often victimized than they are victimizers.

Inmates regularly set fires in their cells; the facility smells of smoke throughout. Staff response to these events is less than prompt, even lackadaisical.

Policies are regularly ignored and/or not enforced. Custody staff routinely ignored obvious safety and security problems such as open cuff ports, the presence of obvious “fishing” lines (used by inmates to exchange items), and even systems in place allowing inmates to open their own cells after being locked in by custody. Inmates are able to access cells of other inmates when they are supposed to be locked. One inmate showed me how he was able to both open his locked cell and prevent his cell from locking. While I was on site, I even found myself called upon by my training in safety and security to close security doors (doors that are supposed to be locked except to allow movement in order to prevent inmates from accessing restricted areas) left open by EMCF staff. These failures place both staff and inmates at risk and create a highly volatile and dangerous environment.

It is the responsibility of custody staff to notify mental health staff whenever they detect mental health concerns or inmates present them with mental health requests or concerns. It is the responsibility to mental health staff to respond to serious mental health needs. Mental health staff are not part of the custody team and must put their patients’ needs first. This is not consistently the case at EMCF, where mental health staff often do not act in their patients’ own best interest and often act in a manner more conducive to the custody mission. While they do have a responsibility to prevent future harm, which may require notification of custody regarding potential risks on a need to know basis and/or treatment to reduce harm (including involuntary treatment), they must always recognize their primary duty is to their patients and they must act in accordance with their patients’ best interests. In this regard, when mental health staff act to prevent future harm, even though they may have to break confidentiality or deliver involuntary care, they must do so recognizing that this serves not only to protect others, but to protect their patients; it does their patients no good to engage in violence to others or themselves.

The physical plant is in poor condition, including conditions on the living units such as non-functional toilets, lack of lighting in some cells (primarily in restrictive housing), malfunctioning locks, and the availability of multiple methods of harming self and others. With regard to the latter, it is astonishing how often those on active watches for the purpose of preventing self-harm in the infirmary (also referred to as the “clinic” by staff) are able to secure items to cut themselves, hang and strangle themselves, and start fires. Any prison must be able to assure that such means are not available to inmates on watches. These conditions pose obvious, serious risks of harm to mentally ill inmates and have resulted in actual and repeated harm.

Systems and Policies

The mentally ill at EMCF are denied timely and reliable access to available care and are denied access to certain kinds of care altogether, such as access to hospital-level care. Access to care is the single most important component of harm prevention as without access, there is no treatment.

In this regard, it is important to note that mental health staff have no meaningful ability to secure placement of the mentally ill in residential settings and their recommendations are frequently not followed. Notes in medical records commonly indicated that mental health staff had no say over placement decisions, including to residential mental health units, and demonstrated instances where recommendations for placement in residential treatment units was not followed. This results in some with serious mental illness being on units not designated for that population and some without mental illness being placed on the units designated for the seriously mentally ill. In addition, while mental health staff could generally place patients who were in crisis in the infirmary in order to be placed on watch (to prevent harm and/or provide close supervision), sometimes there was no infirmary bed and they were unable to direct placement in an alternative, overflow location (the intake area).

Mental health and custody are jointly responsible for creating a safe and structured environment within which necessary treatment can be rendered. They must work together in order to assure access to care and that treatment occurs on time and with maximal privacy. In many cases, what should be confidential patient interactions are held in common areas, at cell front, and frequently with custody present. By way of analogy, privacy and confidentiality are to mental health care as sterile conditions are to surgery. Without privacy, meaningful assessment and treatment are virtually impossible. While it is reasonable for custody and mental health to conduct monitoring rounds together, such rounds were the sole form of mental health intervention other than medications in the majority of cases.

Access to care is compromised in a variety of ways related both to the failure of custody to reliably facilitate access and the failure of mental health to provide essential services. Many inmates talked about custody staff refusing to forward requests for services, including both emergent and routine requests. Many also reported that custody would even tell them they were not really suicidal. The general skepticism towards the complaints of the inmates was not

limited to custody staff. Some, but not all, mental health staff exhibited an unprofessional, skeptical attitude as demonstrated both by their charting and by their behavior on video footage. While malingering and other behaviors designed to affect the environment, including self-injury, are clearly part of the correctional landscape (and clinical work in general), both are actually indicators of real underlying problems requiring treatment in many cases. In short, such behavior should be the beginning of assessment and raise concern about the possibility of serious illness rather than representing an end to clinical inquiry and treatment.

The failure to provide adequate treatment was thoroughgoing. Other than psychiatric prescribers, few of the mental health staff at EMCF engage in any substantial treatment and typically neglect the evident treatment needs of the population. It was the exception to see any documentation of a therapeutic interaction other than by two of the psychiatric prescribers.

While policy provides for due process for administering long-term involuntary antipsychotics, EMCF psychiatric prescribers do not utilize any such process. However, it is clear that such involuntary treatment is occurring. Involuntary treatment is essential to properly manage some with serious mental illness but it must be authorized only in emergencies or, for long-term treatment, with due process to protect the rights of those subject to such invasive treatment.

Informed consent is inconsistently documented. Despite the fact that many of the patients lacked competence or were of dubious competence, I saw no assessments of competence and no efforts to obtain guardians, even for the most obviously incompetent (e.g., Patients 30). Again, there is policy that provides for these measures but they are not utilized.

Quality Assurance and Quality Improvement (“QA/QI”) processes are deficient. In this instance, the contract and policies mandate only minimal and superficial QA/QI. There is no provision for population characterization, overly narrow outcome measures, limited requirements to track service delivery, and inadequate provision for tracking and assessment of sentinel events. A sound QA/QI program is necessary not only to improve services but to prevent their degradation; there is no possibility of meaningful system improvement without a sound QA/QI program.

Individual Treatment and Management

In order to provide adequate care, there must be an assessment of a patient’s condition. Intake screening is not, and should not be, an assessment. Once identified as having a potential mental health problem, whether at intake or upon subsequent referral, a proper assessment that results in a diagnosis and a formulation of the patient’s needs is essential. I saw no complete assessments and, in many instances, no assessment whatsoever.

The services provided at EMCF are essentially limited to crisis response, rather than intervention, and psychotropic medications, both of which are also problematic. The crisis response is substantially deficient in terms of access, sufficiency of assessment, and delivery of appropriate crisis services. Crisis response typically consisted of only a recitation of events and

placing the patient under restrictive conditions and/or referral to a psychiatric prescriber; there was virtually never evidence of efforts at de-escalation, let alone a plan to address the underlying issues leading to the crisis. There is virtually no individual therapy, extremely limited group therapy that is offered to only a minority of those in the residential mental health units, and even for those, it consists usually in just one or two groups even across months and years. Almost every single treatment plan has generic statements about providing individual and group treatment but never specify any treatment targets for treatment and, again, only a small minority receive any groups. I saw no evidence of any courses of individual therapy, even for those in crisis or for those with obvious longstanding needs. Individual therapy may be needed to promote clinical engagement, to come to an understanding of what is driving the patient's behavior (more akin to a protracted assessment), to address issues that cannot be addressed by medications or groups (often highly sensitive personal history or problems), or simply to bring the patient to the point that they are willing to try treatment. Some individual work requires highly skilled clinicians but most of the work in a correctional setting will be straightforward application of basic cognitive behavioral therapy and motivational interviewing.

To be clear, even if the facility conditions at EMCF were outstanding, the behavioral problems of many of these patients would still be severe and highly dangerous with many engaging in violence towards themselves and others. It is precisely for this reason that competent custodial and mental health services are needed in a correctional mental health facility.

To be more specific, other than two psychiatric prescribers, no clinicians demonstrated any serious attempt to understand their patients and why they engaged in the behaviors that were the focus of their documentation. Mental health clinicians appear as mere reactive reporters of behavior rather than pursuing an understanding of how their patients' mental illnesses contribute to their behavioral problems and then trying to help their patients address the underlying mental health issues. This endeavor is the fundamental role of mental health clinicians and serves to reduce the risk of violence as well as addressing the patients' mental illnesses; the vast majority of EMCF clinicians utterly fail in this regard. Custody staff are perfectly capable of observing and documenting behavior and then making a referral. They do not need mental health clinicians to do that for them but this is what is happening; when mental health staff are contacted by custody or the patient, they merely respond, document the behavior, and refer to a psychiatric prescriber. If the mental health staff are to perform their duty, they must engage with their patients in a proactive effort to understand and address their patient's illness and its contribution to their behavior – that is the essence of the mental health task. In most instances, this can be done in groups but some modalities and some types of problems require individual therapy, especially for some of those who engage in repeated self-harm. Other than the two psychiatric prescribers, I saw no evidence of, or even an effort to, establish such engagement. Given that they are not rendering any treatment, one must wonder whether this is a problem of capacity or a failure to understand their clinical mission.

The mentally ill also have very limited access to structured programming services such as education, work, or guided recreation; most have none. The vast majority of treatment plans indicated that patients were not in any such programming. While such programming is not necessary for all patients at EMCF, such services are essential for the seriously mentally ill and those at risk of serious self-injury. Keeping busy and feeling useful are just as important for the mentally ill as for others.

Psychotropic medications were generally appropriate for the listed diagnoses but there are a number of aspects of this service that pose risks, including problems with access to psychiatric prescribers, documentation by psychiatric prescribers, medication monitoring, continuity of care, limited range of psychotropic medications, and treatment planning.

Those in restrictive housing are rarely properly assessed and receive no treatment other than psychotropic medications.

Documentation is also extremely poor. As noted, there are virtually never adequate assessments of patients and documentation is almost always substandard and brief, even cursory. Treatment plans are boilerplate and generic. Many notes repeat the same verbiage and almost all lack sufficient detail to give a clear picture of the condition of the patient. There are also numerous inconsistencies in the observations and characterization of patients' problems both within notes, across time, and between clinicians. These include frankly contrary observations (such as saying within a note that the patient both has and does not have symptoms, such as hallucinations) and reports of clinical findings near in time to each other that are so disparate that they defy clinical possibility. Mental health clinicians, especially non-prescribers, also frequently write in the record that they will offer some form of therapy or assessment and then do not follow through. Many patients commented on this behavior as well. This sort of failure creates breakdown in trust, which is necessary for effective mental health treatment.

Given these conditions, it is no wonder that self-harm is at epidemic proportions at EMCF. Inmates have ready means for self-injury and no other means of getting help or gaining access to a safer setting, even if that setting is highly restrictive. Patients commit self-harm (and set fires) to secure a safe setting or to get staff to respond to their needs (real, perceived, or imaginary) and/or simply to gain access to staff, in addition to committing self-harm for reasons intrinsic to their illness.

Policy and contract provisions for reentry are minimal and only speak to provision of a 30-day supply of medication and making initial medical or mental health appointments. There is no expectation of assistance in obtaining housing or benefits, even though many of the seriously ill would be unable to procure either on their own.

The deficiencies in mental health services at EMCF are most clearly demonstrated in the area of suicide prevention. From failures of custody staff to notify mental health, to crisis responses that

consist solely in isolating and restricting patients but providing no treatment other than medications, to lack of proper monitoring, to the ability of those on monitoring to obtain items to harm themselves, to the actual harm and death that have resulted, EMCF demonstrates serious deficiencies at all points. The case of Patient 10 stands as a powerful example of many failures. This patient engaged in repeated self-harm, including while on watch in the infirmary, and yet received no treatment other than medications. He ultimately strangled himself to death while in the infirmary under psychiatric observation status.

In summary, the mentally ill at EMCF are in a terrible predicament. Conditions on the units are dangerous and stressful and there is no meaningful treatment other than medications. Their only option when they are decompensated or unable to manage the stress is to engage in behavior that will force the staff to respond. But this only results in their being placed in what amounts to isolation in the infirmary or in restrictive housing; they get no additional treatment, are locked down virtually 24/7, and they have less contact with peers and staff. In short, they can either reside in an out-of-control living unit or act out and be placed in isolation.

Before proceeding, it is important to note that this evaluation is based on the conditions at EMCF at the time of my review. While I have considered reports from previous points in time, they were only used as guides to areas of inquiry and to provide a view of the trajectory of change in relevant services and conditions at EMCF. In this regard, I want to specifically note that, in my opinion, EMCF has made improvements in some areas since the reports of Drs. Abplanalp and Kupers, including intake to EMCF (which is being done reliably by both medical and mental health) and elimination of the use of “as needed” injections of antipsychotics. EMCF has also changed policy such that it is no longer necessary for patients to be off medications to qualify for transfer out of EMCF, though it continues to be challenged to assure that the patients and staff understand this and that staff adhere to the new policy (e.g., Patient 31).

Despite these minor improvements, EMCF mental health treatment remains notably deficient in most areas.

SUMMARY OF SALIENT INFORMATION

The following is the foundation for the above opinions. The general topic areas correspond to the major areas of deficiency noted above: Facility Conditions, Systems and Policies, and Individual Treatment and Management. The database that serves as the source of this summary is enumerated in APPENDIX 1. Patient interviews and clinical reviews of the care of individual patients, which serve as an important element of the database, are provided in APPENDIX 2.

FACILITY CONDITIONS

I visited a variety of locations in the facility including living units of all types.

The facility was in a general state of poor repair. There were numerous plumbing problems including a malfunctioning toilet and another toilet that ran all the time, both in occupied cells. The malfunctioning toilet overflowed and had been out of order for a week despite custody staff being notified at the time the problem arose; both inmates in the cell confirmed this. The running toilet had been out of order for two days and the problem was also reported the same day it began. Shower areas showed evidence of leaking. One shower was running continuously; this had been previously reported but was as yet unrepaired. It was common to see garbage on the floors of dayrooms (garbage was also visible in many videos). Many cells in restrictive housing had no functioning lights. Finding occupied cells with days of food detritus was common. It was also very common to see long inmate-fabricated lines that were either used for “fishing” (a means of inmates exchanging items while locked in their cells, contrary to policy) or set up to be able to unlock their cells. These were in plain sight and staff did nothing to collect them; it was clear that both inmates and staff considered this normal.

In general, hallways, program areas, and staff areas were more consistently clean and orderly. Inmates were commonly seen in hallways but rarely in program spaces. When they were in program spaces there were usually very few present.

Most striking throughout the facility was the smell. In almost all living areas there was a pervasive smell of smoke. There was evidence of fire on the walls and windows of many cells in a variety of locations.

At the same time, many units were malodorous from ill-kempt and unwashed inmates. Many inmates reported periods of limited access to showers. While we were on unit 5, a number of inmates reported that they had been denied showers for the previous two weeks. It was their understanding that this was because some of the inmates refused to close their cuff ports (food ports). Letters from inmates, as well as reports, complained that yard access, especially to the large yard, was less than it was supposed to be (e.g., Patients 6, 12, 21, 41). Almost all who reported stated that they virtually never went to the gym. Patient 5 commented that he had “only been to the gym once since I got here. We don’t even get to go.” Patient 6 similarly offered that they never went to the gym, stating, “They quit that a while back. We don’t even go in the big yard anymore.” Patient 12 stated, “They haven’t had gym call in years. I thought the gym was shut down. We can’t even get a deck of cards to play spades with if we’re indigent.”

Inmates on unit 3-C reported that they would sometimes be locked down in their cells which often included denial of showers; this was reportedly not a sanction following a Rule Violation Report (RVR) but simply initiated by unit staff, including the Sergeant. Many inmates, especially

those with serious mental illness, also did not avail themselves of showers when available; there is no program to assist these debilitated patients in their activities of daily living.

The intake area was basically a linear cell row with barred cells; there was a screening desk at the end of the row that did not provide for privacy. Other inmates on the row would be able to overhear conversations from the intake as would any staff members in the area. In short, there was no privacy. Though these cells have no beds, are not intended for overnight use, and are not monitored regularly by staff, they are used as overflow from the infirmary for those needing special monitoring.

The infirmary, which also smelled of smoke, consisted of a central station where custody and clinical staff aggregated. From this station, there was no direct sight and sound access to cells; during the two hours I was in the infirmary, few staff ventured out from this station and almost none had contact with patients other than those accompanying me. Inmates were housed in single cells arrayed around the central station. Monitoring of inmate-patients was by video feed from cameras outside the cells. The view into the cells was poor in many instances both owing to limited camera angles, lack of light in the cell, damage to cell windows by fire, other damage to the windows, inmates covering their windows, and simply dirty windows. Those in the infirmary had very limited belongings. Even those in the infirmary for medical reasons had limited belongings and no television or other distractions. Inmate-patients reported that they did not get access to the yard when in the infirmary. Infirmary cells were varying states of cleanliness as were the inmate-patients themselves, with one obviously seriously mentally ill patient (Patient 8) having a particularly filthy and grossly malodorous cell. Most beds were being used for suicide monitoring and psychiatric observation rather than for medical care. The infirmary was run essentially as a restrictive housing unit.

I also visited unit 3, reportedly the unit designated for the most seriously mentally ill. Pods A, B and D housed medium and minimum custody inmates; pod C housed close custody inmates. Unit 3-C smelled heavily of smoke and a general burnt smell. Many patient cells were dirty with papers and food detritus on the floor.

I spoke with a number of patients while on this unit. I also interviewed a number of them extensively later. All were consistent in their reports that there is very little in the way of structured activities on the unit. They reported spending most of their time in the dayroom or sleeping. They stated that there are no or very few groups available to them; one patient (Patient 6) reported that a particular staff member (who he believed was medical staff rather than mental health staff) provided some structured, regularly scheduled groups; medical record review was consistent with this impression. They reported that they met with their psychiatric prescriber on a relatively regular basis but that they received no individual counseling or therapy. Most contacts with mental health counselors were brief and typically in response to a patient crisis call rather than a planned meeting.

Those on unit 3 are generally allowed out of their cells from 0500-2300 on weekdays and 0500-0100 on weekends. However, numerous inmates reported that individual patients might be locked down and not allowed out of their cells at all. As noted above, this appeared to be at the discretion of individual custody staff including the unit Sergeant rather than a practice related to formal sanction. During the day, the cellmates of those locked down in this manner were unable to access the locked cell to use the bathroom and were forced to use bathrooms in other inmates' cells, contrary to policy. It was only after I heard about this lockdown practice that I was able to make sense of the disparate inmate reports of daily out of cell time.

All inmates in unit 3 were very clear that they had almost daily access to the small yard. However, access to the large yard was rare, typically once every one to two weeks. They virtually never go to the gym. These latter two are substantial reductions from previous access. A very small minority of patients on unit 3 had jobs or were involved in education.

I visited units 4-B and 4-C, designated as medium custody general population settings. The former housed the Pathway to Change program which was a modified therapeutic community. Inmates ran groups after getting some training from staff, who were reportedly addictions specialists, though these inmate group leaders were not supervised on a regular basis. Groups reportedly focused on substance abuse, coping skills, anger management, and emotional management. Inmates reported being in groups for four hours per day. There were several groups about to meet when I came on the unit, none with staff present. I met with one of the groups. None of the inmates involved had any overt evidence of mental illness. All were enthusiastic about the unit and were consistent in their reports that it was likely the safest and most therapeutic setting the facility.

I visited restrictive housing unit 5. Units 5-A and 5-B are long term maximum custody, 5-C is short term restrictive housing, and 5-D is a step-down unit for transitioning inmates out of restrictive housing. At the time I visited, the unit was very hot and humid and had a very notable burnt smell. A number of cells showed evidence of fire damage to the windows. It was also the loudest unit with a constant din of inmates yelling and banging. I was informed that the HVAC unit had turned off following a fire and had yet to be reset. The dayroom area had food and garbage on the floor as well as a large amount of water. There were two inmates showering at the time I visited. However, several inmates complained that they had not been allowed to shower for two weeks. Consistent with later reports, one stated that staff said this was because they refused to close their cuff ports. Despite being a restrictive housing unit, this unit had some of the most obvious evidence of inmates in possession of manufactured strings for "fishing" and a number of cell windows were covered. A number of inmates on this unit had histories of self-injurious behavior and some complained of psychotic symptoms. One inmate showed me a festering ulcer on his lower leg; the nurse who was with us had already identified the need to follow-up with the inmate. Some occupied cells had no lightbulb.

Unit 6-C is one of four close custody pods, each with 30-32 beds, in unit 6. Inmates noted that they are generally out in the dayroom all day and that they go to recreation every other day, more than on the mental health unit. There were a substantial number of inmates who were on psychotropic medications on this unit and some who were floridly psychotic, including patient 23. Inmates reported that mental health generally responded to requests to be seen but that the only ongoing treatment was psychotropic medication.

The April 2016 memo from Coach Marshall gives a schedule that provides for inside recreation (gym call) for the following units, each for an hour per week: 1-D; 2-A, B, C, D; 3-A, B, C, D; 4-A, B, C, D; and 7/CS. There was no report of how often these gym movements actually occurred. Outside recreation simply noted that units 1, 2, 3, 4, 6, and 7 were afforded outside recreation two days each week except only one day for unit 6. Again, there was no report of how often outside recreation was actually held.

The Recreation Department report for 3/16/16-3/31/16 lists 8 events varying in length from 1.25 to 3.75 hours. There were 15 basketball games with 15 teams comprising 96 total participants for 18.75 total hours. Most units had 6-8 participants from housing units 1, 2, 3, and 4. The residential mental health units had only 6 participants, all from unit 3-C. This constitutes only a small fraction of the inmate population.

None of the living units were suicide proof, including those designated for the seriously mentally ill and restrictive housing units. There were numerous anchor points (objects or fixtures that a prisoner could use to hang himself) and a variety of other problems including non-recessed fixtures, deteriorating grouting, poor cell visibility, and breakable fixtures. The infirmary area was more suicide proof but had some non-recessed and breakable fixtures and poor visibility into cells. Anchor points were otherwise adequately mitigated.

As we toured the facility, I rarely saw staff in the living areas except when they were with us. Inmates consistently reported that custody staff were rarely on the living units and often did not conduct cell checks at the required frequencies; a commonly reported pattern was of staff only coming on the units when there was a dire emergency or to conduct periodic inmate counts. Inmates reported that one of the reasons there were so many fires was that this was the only way to get staff to respond. Videos also demonstrated that staff were commonly not on the units when inmates were in the dayroom.

Here I will note the surprisingly lackadaisical response by some staff to fires in cells; this was captured on video. DEF-028099A – [inmate name]#170573.avi begins with the camera directed at a cell door with cloth hanging out the cuff port. Smoke is streaming out the port. Staff are trying to get something out of the lock but cannot. The officer directs staff to try to talk to the inmate. Staff try to talk but there is no audible response. Staff pull the cloth out through port. The cell is dark. Staff ask for a flashlight, saying “I can’t even see him.” They say that they need to get him out. A flashlight finally comes. It looks like they bring a fire extinguisher but

do not use it. Staff cough. They note that there is a “pile that is smoking.” They do not appear to see the occupant because of smoke. There is no sense of urgency; some staff can be heard laughing. They talk about not being able to do anything until they can get into the cell. They pound on the cell; there is no response. Smoke continues to come out of the port. 17 minutes in, a staff comes with tools to fix the lock. They are finally able to access the locking mechanism. The inmate is lying on the floor and staff pulls him out. They then decide to call medical – “code blue.” The inmate is moving and exhibits tremor-like motion of his hands, almost a flapping motion. They cuff his hands behind his back but his hands continue to flap. He is rolled back over in a very awkward position. When medical arrives, staff sit him up. He is still flapping and is unresponsive to smelling salts. Medical has the cuffs removed. No oxygen has been applied. There is no urgency in their actions. They finally try to put on an oximeter and check vital signs. At 32 minutes they load him onto a stretcher, still unresponsive and flapping. Oxygen is finally administered at 37 minutes into the video. Nobody has done any neurological examination. At this point he appears to be holding his arm up and puts it down when asked and begins to respond. He denies taking anything. The oxygen is removed at 43 minutes and he is chained to the gurney, likely for transport. The oxygen is put back on at 48 minutes. The video ends.

Several things are notable in this video. First, the utter lack of urgency, and even laughter, on the part of staff, despite the obvious and substantial smoke in this inmate’s cell, is very disconcerting and highly unprofessional. Second, the failure to have medical on location when the inmate is removed from the cell is extraordinarily dangerous and demonstrates their lack of concern. Third, the lack of an urgent response by medical staff is also notable. This situation called for prompt application of oxygen, an immediate basic neurological assessment, and rapid removal to a medical area.

DEF-029294A – Major Rice 6-22-15 SUOF.avi shows a dayroom with inmates milling about. Suddenly, substantial flames appear in a cell on the lower tier at 1050. Inmates begin to gather. Flaming items come out of cell. Inmates sweep it up. No staff have responded. Staff arrives, walking, at 1053. By this time there are no visible flames. Inmates and staff stand in front of the door. At 1056 two more staff amble up. The cell door is finally opened. Two inmates walk out of the cell. The camera pans across to two inmates fighting, which is broken up by staff. Many staff converge on the unit but the inmates calm down and there are no further altercations or problems captured on the video.

Here again, the lack of both urgency and prompt staff response are very concerning. It is clear that this has become almost routine. It is also unusual that inmates, who were in the dayroom together before staff arrived, would start fighting when staff arrive. Usually, fighting is something inmates try to hide. While this may be an unusual event, it may be that it is simply considered normal and thus not something to hide.

Consistent with the preceding, Patient 1 reported, “Half the time they put the fire out and just walk off.”

The video DEF-027433A – 1[inmate name].avi shows a dayroom with inmates milling about. At 0712, a fight breaks out. Several inmates are assaulting an inmate and pull him off camera. At 0721, the camera pans to show three inmates, one with a stick, beating another. Staff can be seen through the window but none respond to the scene. The inmates stop beating the one inmate and another escorts him to the door; staff open the door and let him out. Staff do not go on the unit until 0722, after the fighting has stopped. Custody escorts one inmate off the unit. Photos of the victim of the assault demonstrate facial lacerations and contusions and arm contusions. Here again, the slow response and failure of staff to intervene is notable.

Another problem many inmates reported was inmates defeating cell door locks. Other inmates actually enter others’ cells or are out of their cells in common areas at times when all inmates were supposed to be locked down. Many inmates reported that this would sometimes lead to fights and/or sexual assaults, though sometimes they engaged in what might be called social visits. The 8/2/16 letter from Patient 40 is representative. In that letter and its three page attachment, Patient 40 reports on how he was raped by another inmate when he visited that inmate’s cell late in the evening of 8/1/16. He called the PREA (Prison Rape Elimination Act) hotline early the next morning. Most disconcerting is his statement that when he reported the rape to custody a few hours later, the officer reportedly “made a joke of it and never called medical.” Fortunately for Patient 40, he happened to come into contact with a nurse on his way to the law library. This nurse told him to come back to the infirmary later, which he did, and was assessed and sent to the emergency room for completion of the rape kit. Patients reporting unauthorized entry of inmates into others’ cells included Patients 6, 11, and 23.

Inmates almost uniformly reported a frighteningly high degree of interpersonal violence among the inmates, excessive use of force by staff (especially, liberal use of oleoresin capsicum – sometimes without giving them an opportunity for decontamination), and frequent, often bloody, self-harm behavior. I will comment on self-harm throughout this report but will not address the other forms of violence as these are more properly addressed by a correctional expert.

An incident I witnessed while interviewing a patient is indicative of staff attitudes. While I was interviewing this patient, another inmate walked by and said through the window to the room we were placed in “you might as well cut your throat.” The staff accompanying the other inmate only smiled. The patient I was interviewing said, “See how they pick with me [sic]?” It was clear from the behavior of the inmate and staff as well as the comments by the patient that this kind of behavior was not only tolerated but was common and even acceptable.

Many inmates reported nurses participating in the diversion of medications, notably diphenhydramine (Benadryl) and gabapentin. Inmates reported that one nurse would regularly give diphenhydramine from another patient to particular inmates, though not to all who would

ask. Another nurse reportedly diverted gabapentin. The consistency and multiplicity of these reports was notable. Many inmates also reported bartering with medications, especially diphenhydramine. I will also report here that several inmates told me that staff would even give them tobacco, marijuana, and even spice (synthetic cannabinoids).

SYSTEMS AND POLICIES

Organizational Structure and Centurion Contract

The contract states that Centurion “will provide such services consistent with applicable American Correctional Association (“ACA”) standards, National Commission on Correctional Health Care (“NCCHC”) standards, constitutional, federal, state, and local laws, court orders, consent decrees, local regulations and MDOC policies and procedures governing healthcare service delivery.” Thus it is clear that Centurion itself recognizes and values relevant standards and includes NCCHC, which I named as a source document, among them. It is instructive to note that, per the contract, several other institutions are required to maintain NCCHC accreditation, while EMCF is only required to maintain ACA accreditation, which has much lower standards for health care including mental health. This is difficult to understand or justify given the mission of EMCF to care for the most mentally ill.

Review of documents, primarily letters complaining about health care sent by inmates, demonstrated that there is at least one person who is assigned by MDOC as a contract monitor. I did not see further evidence of monitoring of the contract. Monitoring such an extensive and complex contract requires careful review and auditing of relevant documentation, primarily quality assurance data, which is entirely deficient. Thus it is no surprise that there are frequent failures to follow the terms of the contract and policy with little evidence of any awareness of the deficiencies, let alone the many needed corrective action plans.

Salient problematic contractual terms include the lack of a true staffing plan and excessive deference to funding as the driver of staffing, limited provision for mental health leadership, no provision for enhanced staffing at EMCF (MDOC’s designated mental health facility), and lack of robust Quality Assurance and Quality Improvement (QA/QI) specifications. There are also inconsistencies between the contract and some policies; given the poor adherence to both terms of the contract and policies, it is unclear how important those inconsistencies are in practice, but they should, of course, be corrected.

Staffing needs should be driven by clinical needs which must be based on an assessment of the mental health conditions of the inmates at EMCF; such assessments are entirely lacking.

The contract has no specific provisions for mental health leadership. In terms of leadership, there is provision for a facility medical director, director of nursing, and site managers at the facilities. The relationship between these providers, MDOC staff at the facility or state level, and MTC is not specified. It states only, “Centurion will design and implement a process to report to the

MDOC chief medical officer or designee problems and/or unusual incidents in the performance of this agreement, including but not limited to medical, security -related and personnel issues that might adversely impact the delivery of healthcare services.” and “The Centurion on-site medical director will apprise the superintendent/warden or designee of all relevant information regarding inmate participation in Centurion -related programs, as well as management and security implications of specific health care situations.” I did not receive anything that was identifiable as such a mechanism. However, emails indicate that there are (or at least there were in early 2016) a MDOC Director of Mental Health, a Centurion Director of Mental Health, and an EMCF Director of Mental Health.

The contract specifies that Centurion will provide “24 hour, seven day per week physician or mid-level practitioner coverage on-site or on-call telephone coverage for the Facilities.” At EMCF, there must be coverage on-site 16 hours per day on weekdays. It does not specify psychiatric or mental health coverage hours so it would appear that there is no requirement to have mental health staff on site after-hours, despite this being the primary mental health facility for the state. It requires that emergency services “be available for acute illness or conditions that cannot wait until scheduled sick call. Emergency services will be available through physicians, other health care staff; Centurion arranged local ambulance services.” The contract specifically includes mental health care in this 24 hour emergency service provision, though it may include “on call availability.” The contract requires “appropriate qualified health care professional staff on-site twenty-four (24) hours per day, seven (7) days a week.” This is inadequate for MDOC’s primary mental health facility, especially when there is no access to licensed level psychiatric care either within MDOC or in the community.

Per the contract, there is to be “a program of Continuous Quality Improvement (CQI) Program and Professional Peer Review at each Facility and Satellite Facility, which will include, but not be limited to, audits and medical record review.” Peer review may take many forms but typically involves review of clinical work by peers in the same field; however, I received only one incomplete peer review document for one psychiatrist that did not include any data other than patient charts reviewed and that included no assessment of the adequacy of the psychiatrist’s performance. The contract also specifies that inmate deaths are also to be reviewed. The contract provides that “quality management support services shall be system-wide and shall be in place within six (6) months following commencement of services under this agreement.” The contract specifies that these services must be documented. I did not receive any such documentation other than some limited death reviews (see below).

The contract also calls for medical staff to meet “monthly with MDOC representative(s) and staff to discuss issues relevant medical care in the system.” Documentation of this meeting is specifically required. I did not receive any such in the CQI documentation provided.

The contract also speaks to those in any form of isolation or segregation. Per the contract, with regard to mental health, those in administrative or disciplinary segregation “shall be evaluated in accordance with ACA and NCCHC standards and MDOC policies and procedures. Centurion shall provide mental health services and treatment plans for inmates housed in administrative and disciplinary segregation.” Review of medical records demonstrates frequent failure to meet standards, including NCCHC standards requiring mental health staff review of medical records of those placed in segregation, daily medical staff and weekly mental health rounds (for those in extreme isolation in segregation or the infirmary), and provision of mental health services according to a treatment plan.

The contract also specifies the following:

“A physician or designee will examine all inmates isolated for psychiatric purposes within 24 hours of confinement. Medical evaluation will support medical confinement of inmates based on risk of physical danger to self or others. A medically trained professional and/or a qualified mental health professional will make rounds in the housing unit for all inmates who are segregated from the general population a minimum of three days a week. Only a physician or licensed mental health professional, after consulting with designated MDOC officials, may determine when an inmate should be returned to the general population. All inmates referred for mental health evaluation will receive a comprehensive diagnostic examination, including update to the psychosocial history and a mental status evaluation. Examination will include an assessment of suicidal risk, potential for violence, and special housing needs.”

Presumably this applies to those placed on some form of psychiatric or suicide watch (rather than disciplinary segregation), which are done in the infirmary at EMCF. This does not comport with the NCCHC standards cited above with regard to the frequency of rounds given the extreme isolation patients are subjected to while in the infirmary. Further, I received no documentation demonstrating adherence to these provisions. Medical records demonstrate that initial psychiatric examinations are not being done timely in many instances and in most cases either do not include, or provide an inadequate update to, the psychosocial history, mental status examination, suicide risk assessment, or assessment of the potential for violence. Rounds on those in the infirmary are generally documented but in many instances, the documentation reports that the patient is asleep (see especially Suicide Prevention below); this is not adequate. More importantly, there was no evidence of any treatment other than psychotropic medications. It is also important to point out that the Centurion policy “Mental Health Watch Procedures” also demands daily evaluation of those on suicide watch by mental health. While this should constitute more than rounds, rounds were not even daily on these patients.

The following general mental health responsibilities are articulated in the contract:

“a. Completing and submitting psychological evaluations requested by MDOC;

- b. Screening and referring inmates for psychiatric or psychological evaluation;
- c. Crisis intervention to all inmates;
- d. Crisis assistance through an established on-call system;
- e. Completing diagnostic and classification reports designated by MDOC;
- f. Individual and group therapy;
- g. Providing and/or assisting with critical incident debriefing;
- h. Providing additional mental health information and/or evaluations;
- i. Providing monthly face-to-face interviews with every inmate on psychotropic medication.”

It also names specific programs that must be included: “crime victim awareness, sex offender, and anger management.” It also states, “Individual and group counseling will be provided based on inmate need. Inmates with serious mental illness will receive priority in receiving the services. Topics for group therapy will be determined by the need of each Facility inmate population.” As noted repeatedly below, such counseling is being provided only on the rarest of occasions and not to the most ill. I also did not see evidence of the specified groups except anger management being provided. Such groups should not be run by mental health staff anyway; mental health staff are needed for the provision of services for the mentally ill rather than providing such services to the general population that could be rendered by correctional programming staff.

Among other provisions, the contract requires that those referred for routine psychiatric evaluation on intake must be seen “within five (5) working days for initial urgent mental health screenings and 14 (14) calendar days for all of the referrals.” Those prescribed medications must be seen monthly for three months and then every 90 days thereafter. While these psychiatric evaluations and follow-ups are often not timely, it is clear that these providers are making an effort to render relevant services but are just too few to live up to timelines and associated standards (see Access to Psychiatric Services and Psychotropic Medication below).

The contract also states that psychiatrists in other facilities are responsible for coordinating transfers to EMCF through the MDOC Administrative Psychologist. This was apparently modified by an email from Centurion’s Amy Hodgson on 4/27/16 which provides for psychiatrists to make changes in levels of care, which then drive transfers. For those with more serious mental health needs, the email specifies that Ms. Hodgson is notified but what happens thereafter is not specified.

Attached to the contract is Exhibit A which includes proposed staffing patterns, including for EMCF. With regard to mental health, it specifies a chief psychiatrist, five Masters level professionals, one mental health director (to be a psychologist), two activities therapists, one and a half mental health secretaries, and three psychiatric nurse practitioners. See Staffing below for further information on policies and data provided regarding EMCF staffing.

The contract specifies that “licensed nursing staff provided by Centurion will assume the duty to administer medication.” However, MDOC policy provides that custody staff can “issue” medication to inmates (see “Medication Administration” below).

Medico-Legal Considerations

Competency and Consent

Documentation of informed consent is inconsistent. I saw no evidence of assessment of competence to give informed consent, despite meeting with a number of patients who were of dubious competence and clear incompetence. Although the process for guardianship is spelled out in the Centurion policy “Procedures for Appointment, Coordination and Termination of Healthcare Guardianship,” I saw no evidence of attempts to secure guardianships or even discussion of the possibility. It is clear to me that they have many patients who are incompetent both to consent to individual medications and some who are in need of guardianship.

Centurion appears to have adopted the practice of securing a global consent. The consent reads in relevant part: “I hereby give consent to the [MDOC] Contracted Medical Vendor, its employees and agents to perform any diagnostic laboratory procedures; examinations, including tele-health; mental health; x-rays; oral or injected medications; or other procedures recommended by the physician treating me.” ... “I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.” However, this form is not present in all records. Some records contain language consistent with informed consent such as the discussion of the risks and benefits of medication and others report the patient consented. There are still many records that have no evidence of consent to psychotropic medications of any kind. The Centurion policy “Psychotropic Medication” states: “informed consent should be obtained from patients and (new) Psychotropic Medication Informed Consent form signed in the following situations....” These situations include medication initiation, following bridge orders, doses above recommended levels, changes in a medication’s profile, and when there is a “significant change in a patient’s functioning related to medication.” I saw no such forms. While other mechanisms for consent are adequate, there should be universal consent for initiation of medications and this was not the case.

I was also told by patients that they were required to refuse medications in writing, in contravention of both policy and accepted standards.

Note also that the Centurion policy “Informed Consent and Right to Refuse” requires informed consent “except in emergency situations.” This is not accurate. A competent patient may refuse emergency treatment in most situations unless the patient poses a danger to self (excluding certain end of life situations and depending on state law) or a danger to others.

The same policy requires “written informed consent” for all psychotropic medications. This is not done reliably. It also states that “Patients may not be punished or disciplined for refusing

healthcare services” yet patients may be given an RVR for refusing health care appointments as noted above.

This is further evidence of a general disregard for accepted standards.

Involuntary Treatment

There is no formal process for instituting involuntary treatment with psychotropic medications at EMCF. While the Centurion policy “Emergency Psychotropic Medication” provides for an administrative review process (“Harper hearing”), this process has not been instituted at EMCF (the details of the process are provided in the Centurion policy “Involuntary Psychotropic Medication: Administrative Review”). However, records demonstrate that involuntary medications are being administered on both a short-term and long-term basis, primarily antipsychotics and side effect medications. While emergency medications may be given without consent and without a court order or Harper hearing (as detailed in the Centurion policy), long-term involuntary medications, including injections of long-acting medications such as the antipsychotic haloperidol decanoate, are inconsistent with a patient’s right to refuse in the absence of a court order or Harper hearing.

The practice of writing PRN (“as needed”) orders for injections of short acting antipsychotics appears to have been halted during the summer of 2015 as I saw a number of such orders canceled or changed during that timeframe. This practice is tantamount to a standing involuntary order as it allows nursing staff to administer these medications involuntarily without a prescriber’s participation in the determination of an emergency situation. In most cases, recent records demonstrated ample documentation of the need for emergency injections but this was far from consistent. Patient 38 continued to be subject to such “as needed” antipsychotic injections after 7/1/15.

Patients who reported getting involuntary injections or who had medical records suggesting involuntary treatment included: Patients 2, 4, 5, 7, 8, 9, 10, 15,17, and 24. Patients 7 and 24 specifically told me that they were on injections that they did not want to take. Patient 9 received an emergency injection of the antipsychotic haloperidol on 7/16/16 with a subsequent note on 7/18/16 stating “Patient refused to talk.” The note sent on, “He was given [the above medications] after he assaulted both an officer and a medical staff member that day.” There was no documentation of the relationship of any mental health symptoms to these actions. Given the history of the patient, it was likely warranted but justification was not documented. Patient 10 received an emergency injection of the antipsychotic haloperidol on 2/7/16. There was a nursing note regarding the patient being agitated and having stated he was on “ice”. He was also pulling out stitches and had threatened to hang himself. There was no documentation by the psychiatric prescriber and the nursing note does not explain why an injection of an antipsychotic, as opposed to other measures, was indicated. This same patient received another haloperidol injection 3/6/16 when he was “agitated” but without supporting documentation of the indication for an

antipsychotic injection, including no note from the prescriber. Patient 15 specifically complained that injections were used “as punishment,” though had not had an injection for about a year.

There is substantial use of long-acting depot antipsychotics, primarily haloperidol decanoate. While in some instances it is clear that the patient has rendered consent, there are many cases where it is not clear, including Patients 4, 5, 7, 17, 24, 36, and, in particular, Patient 9. In that case, a psychiatric progress note explicitly states: “Because his compliance with Zyprexa was poor, it may be a while before we consider allowing him to take oral meds.” This was the same day he received the short-acting injection noted in the previous paragraph. Language in a note from Patient 7 also strongly suggests that injections of Haldol were being involuntarily administered: “He is psychotic and a danger to himself and other [sic] and will be medicated with Haldol decanoate 150 IM, Haldol lactate 10 mg IM, and Benadryl 100 mg IM today to assist his regaining control of his behavior and reducing psychosis. Preferably unit security staff will bring him to medical where he will get his injections. If this is not possible, medical staff, supported buy [sic] security will assist his receiving injections on his unit.” Patient 8 has a similar entry by the PNP: “Discussed case with [a psychiatrist] last week, if continues noncompliant, will go ahead and recommend long-acting Haldol to offer stabilization and then reconsider oral medications....”

Videos also demonstrate that involuntary injections are given. DEF-028602A – idk 005.avi is a video of a “spontaneous use of force” to give an involuntary injection. An involuntary injection should virtually never require a spontaneous use of force; it should always be a planned use of force except in the most unusual circumstances. The inmate in DEF-027821A – 3-12-15 001.avi mentions getting a shot and not feeling that it was warranted. DEF-031077A – Video 6.wmv also shows an inmate getting a shot “that the doctor ordered.” He did not want the shot and, at the time it is administered, he is calm, which should have led to a cancellation of an emergency injection. He had previously assaulted an officer. Other videos demonstrate him moaning and talking to himself and he seems to be saying “live or die,” among other unintelligible verbiage. Videos also show him having a wound cleaned and he was decontaminated from oleoresin capsicum usage. In the video DEF-031251A – SUNP0008.avi, a mental health staff comes to cell front to speak with the inmate and interacts in an argumentative, less than therapeutic manner. The inmate speaks about “going to war” because he was lied to. He tells staff to get “Haldol,” a reference to an antipsychotic frequently used as an emergency injection at EMCF, and starts yelling.

Patient 8 and 38 are clear examples of patients who should have been subject to involuntary antipsychotics. It is unreasonable to fail to provide some mechanism to properly provide for involuntary treatment under appropriate legal authority or in a psychiatric hospital setting. Given that the usual standard for such administration is mental illness resulting in danger to others,

danger to self, or grave disability, failure to provide such treatment when needed clearly increases the risk of harm.

Policies and Procedures

As I was not allowed to interview staff, I am unable to convey staff understanding of policies. Much of the documentation reflects serious shortcomings with regard to adherence to policy in many areas.

In general, policies address necessary topic areas. Important policy provisions and shortcomings relevant to the topic areas are embedded in corresponding sections. In what follows I address those policies and topics not addressed elsewhere.

Crisis Stabilization Program

The purpose of the MDOC policy “Crisis Stabilization Program (CSP)” is to establish a “plan for offenders who engage in repeated dangerous and/or assaultive conduct that may threaten the safety of staff, offenders, the public and the security of the facility.” If included in this program the inmate is placed in the Crisis Stabilization Unit.

This policy requires that a mental health professional perform a psychological assessment to determine whether the inmate “is knowingly, willingly and purposefully engaging in the assaultive and/or dangerous behavior” and the “assessment suggests that the inmate may benefit from the program.” However, there is no discussion of or provision for consideration of other ways in which mental illness may impact dangerous behaviors or the potential deleterious impact on the mentally ill who might be assigned to this program. Of note, the mentally ill who would be likely to meet criteria for this program would virtually never be unable to “knowingly, willingly and purposefully engage” in such behavior. Intentionality is not lost in mental illness; contact with reality and the accuracy of the perceptions that drive the purposeful behavior are where the problems lie. Thus, the standard provides no protection for the mentally ill. It might be hoped that the typically low likelihood that such a program would benefit them would discourage their enrollment.

Emails regarding this program from after 7/1/15 demonstrate that some seriously ill patients have been in this program. A 12/4/15 email from Cynthia Franklin noted two patients who were LOC E (the most serious level of mental health care need) who were now in the Crisis Stabilization Unit on “Psychological Observation.” A 3/30/16 email (with embedded emails dating back to 3/29/16) from Amy Hodgson speaks to two patients who had been at EMCF but were now in this program for “security reasons,” both on suicide precautions; one of them was one of the LOC E patients mentioned in the previous email. Thus, it is unfortunately clear that some seriously mentally ill are being placed in this program.

I will not comment on the nature of this program, other than to say that it has serious shortcomings including being behaviorally unsound and reflects a profound failure to understand the nature of the impact of mental illness on behavior.

Use of Force

The MDOC policy “Use of Force” fails to include provisions for prevention of use of force when such use would be inappropriate for medical or mental health reasons. While there are certainly situations where there is no time to make such an assessment, any planned use of force should include a prior consideration of medical and mental health problems that might arise when using force or might be contraindications to using force. Failure to do so places inmates at unreasonable and unnecessary risk.

Similarly, the MDOC policy “Use of Oleoresin Capsicum Spray or Chemical Agents” includes no consideration of medical or mental health problems with regard to using such agents. The policy specifies that procedures be developed; I was not provided with any such procedures. If such procedures do not exist or do not address medical or mental health contraindications, this also places inmates at unreasonable and unnecessary risk.

Restraint and Seclusion

Despite EMCF’s use as the prison in the Mississippi system that is supposed to provide care for the seriously mentally ill, there is no clinical restraint or seclusion at EMCF, that is, seclusion or restraint ordered by a suitably credentialed clinician for clinical purposes. Even though the Centurion policy “Use of Therapeutic Restraint” provides for healthcare staff to order clinical restraint, they do not. It is important for clinicians to use such restraint to prevent harm to self and harm to others by reason of mental illness; custody staff are not qualified to make such judgments. The Centurion policy “Use of Therapeutic Restraints” appropriately states that “When any staff observe patient behavior indicative of a possible need for therapeutic restraint (consistent with self-harm or severe agitation), an immediate mental health assessment will be completed by a psychiatrist, nurse practitioner, licensed psychologist, physician, licensed psychologist [sic], or registered nurse....” There was no evidence in the records for any consideration of restraint, despite numerous cases of severe agitation, repeated self-harm, and active self-harming behavior.

It may be that part of the reason restraints are not used is that patients who are that ill are essentially kept in seclusion. However, the clear and repeated evidence of patients committing self-harm in the infirmary demonstrates that the measures that were being used there were inadequate (for more on this issue, see Suicide Prevention below). When other measures are inadequate to prevent harm, clinical restraints should be utilized.

The MDOC policy “Use of Restraints” specifies that restraints are not to be used as punishment and lists an array of appropriate and typical circumstances when restraints may be used. I will confine my comments to those related to mental illness. The policy specifies that restraints may

only be used “with the approval of the warden/superintendent or designee.” In terms of health contraindications to restraint, only pregnancy is mentioned.

When four or five-point restraints are used (but apparently not for other types of restraints), an inmate must have their medical and mental health condition assessed; the “health authority or designee must be notified to assess the inmate’s medical and mental health condition, and to advise whether, on the basis of serious danger to self or others, the inmate should be placed in a medical/mental health unit for emergency involuntary treatment with sedation and/or other medical management....” Below this section it states that if the inmate is not transferred to medical or mental health unit, “Direct visual observation by staff must be continuous prior to obtaining approval from the health authority or designee.” What this “approval” contemplates is entirely unclear as there is no other direction. It is not even clear whether this entails prior healthcare authorization prior to placement in four or five-point restraints, whether this means only noting that the inmate is not pregnant, or whether it means something else. It goes on to mandate subsequent fifteen minute observations (again, presumably only for those in four or five-point restraint) and that “restraint procedures are in accordance with guidelines endorsed by the designated health authority.”

The MTC policy “Use of Restraints” is a very minimal policy governing custody restraint that does not clarify the MDOC restraint policy. However, it provides that “immobilizing restraints may be ordered by the Shift Commander as a last resort to control and protect an inmate who threatens suicide, who experiences a violent episode of mental instability, or who needs to be completely subdued for a very short period of time after behaving violently toward another person.” “Immobilizing restraint” is defined as any restraint that prevents an inmate “from rising from his bed, using toilet facilities, or eating.” There is no mention of any role for healthcare staff or any specified observation in this situation. This is seriously problematic as such restraint carries many medical risks including airway restriction, circulatory restriction, peripheral nerve damage, deep venous thrombosis, and others. Specific provisions for health care staff monitoring of those in restraint must be included.

The Centurion policy “Use of Therapeutic Restraint” requires that “Policies and procedures specify:

- i. The types of restraints or conditions of seclusion that may be used
- ii. When, where, how, and for how long restraints are seclusion [sic] may be used
- iii. How proper peripheral circulation is maintained (when restraints used)
- iv. That proper nutrition, hydration, and toileting are provided.”

It later enumerates monitoring of “Respiration and circulatory status,” “Skin integrity,” “Vital signs,” and “Mental status.” These are appropriate considerations but I was provided no corresponding policy or procedure about how this is to be done, the frequency, or what is to be

done if there are any findings. Note also that these provisions do not apply to restraints applied by custody staff.

The same policy goes on to speak to clinical responsibilities when custody uses restraints “for security reasons” (it is unclear why this is included in a policy governing therapeutic restraint). It requires health care staff to be immediately notified and to “[r]eview the patient’s health record for any contraindications or accommodations required which, if present, are immediately communicated to appropriate custody staff.” But neither this nor the MDOC or MTC policies indicate what is to be done with such information.

It also requires that healthcare staff must “[i]nitiate health monitoring, which continues at designated intervals as long as the patient is restrained. If there are concerns for the health of the patient, the concerns are immediately communicated to an appropriate custody staff.” Again, these are appropriate but no associated policies or procedures were provided.

In short, the policies are poorly integrated and lack specificity. The custody policies are unduly vague, especially with regard to the role of healthcare professionals; they do not even mention the option for therapeutic restraint.

None of the records I reviewed included any episodes of restraint or seclusion so there is nothing to say about their practice. However, there should be provision for therapeutic restraint used for in appropriate clinical circumstances such as the prevention for imminent danger to self or others by reason of mental illness. Failure to use such restraint places patients and others at unreasonable risk and its use may have prevented many instances of injury. With regard to seclusion, the most important point to make is that placement in the infirmary is tantamount to seclusion. There is no reason that this should be so. Isolation and profound property restriction are not the answer to every crisis and in fact can exacerbate acute problems. Those who are psychotic are predisposed to sinking further into their psychosis and losing touch with reality. Those who have limited coping skills and poor distress tolerance are placed in a highly stressful environment with even less access to the support of peers and clinicians. The lack of property compounds these problems by not affording distractions that may serve to limit the impact of such isolation. Further, the extreme conditions of being strip-searched, placed in a suicide smock, and having utensils and other property removed is a traumatizing, often humiliating experience. While such measures are sometimes necessary, they should not be the rule. As the problems related to this practice are covered by another expert, I will withhold further comment.

Medication Administration

I did not formally monitor any pill lines. Inmates reported numerous irregularities with medication administration. In addition to staff participation in diversion, already noted above, inmates reported periodic problems with medication availability at the pill line. They were not always sure why they were unavailable, other than when witnessing diversion, but some were aware that medications were sometimes not re-ordered timely or that they were just not on the

pill cart. Chart review demonstrated occasional failure to update medications prior to expiration as well as failures to fill prescriptions by the pharmacy; in one instance mental health staff noted that custody did not allow pill call on the unit (Patient 8). The magnitude of these failures was difficult to determine but was common enough to be periodically noted by both patients (e.g., Patients 12, 15, 17, 20, and 22) and clinicians in their chart notes. Correspondence reported similar problems (e.g. Patient 41, Patient 45 and 2/17/16 email from Brenda Delaine regarding Patient 55).

The 12/22/15 email from Marina Moss regarding “Mental Health Concerns Housing Unit 2B/2D” also notes that one patient “missed evening medications several times due to medical staff hold [sic] pill call after midnight.” Such late pill call is consistent with the report of Patients 15 and 18 as well. That same email also noted three patients who were not receiving ordered psychotropic medications. This corroborates the inmate reports.

The MDOC policy “Offender Segregation” provides that “restricted medications (i.e., psychotic medication [sic], insulin, any mind altering medications) will be issued to administrative segregation offenders by Medication Officers.” First, this is an unworkable definition as there are so many medications that may be “mind altering” that without a list there is no way to operationalize this policy. Second, and more important, it is unreasonable to have officers administer medications in this setting. Clearly, the reason for limiting access to medications is concern about their misuse. But as officers cannot administer medications and must therefore give the container of medications to the inmates in the form in which they are delivered, they cannot properly regulate inmate medication-taking behavior. This process would be workable only if the medications were single dosed, day by day. Patient 18 specifically reported on officers giving medications and added, “You can check it on the camera.”

Monitoring of medication adherence and the accuracy of the medication administration record (MAR) are problematic. While mention of compliance issues in prescriber notes was not uncommon, actual reports of non-adherence by nurses were not in evidence (except when reported by patients or found by laboratory examination); I rarely saw nursing charting regarding nonadherence or prescriber charting of reports of nonadherence from nursing, even in cases where non-adherence was identified and repeated. Treatment plans repeatedly include language indicating that one of the patient’s responsibilities is “Compliance with medications and treatment goals on a daily basis....” Only Patient 9, per a 6/28/16 treatment plan, had other than this generic goal regarding adherence; the goal was “Client will not miss no more than [sic] two pill calls a week for the next three months.” Yet according to the MAR for June of 2016, the patient was taking all of his medications. Either the MAR is incorrect or this was an inappropriate treatment goal. Given that the treatment plan was not the typical generic statement about compliance and given his history of being on long-acting injectable medications, it seems likely that adherence was a known problem and thus that the MAR was likely incorrect.

In a similar case, Patient 35 was prescribed Tegretol. The April 2016 MAR shows near-total adherence. However, a Tegretol level drawn on 4/25/16 shows a level < 0.5 micrograms per milliliter, in essence undetected. The PNP appropriately deemed this noncompliance. Clearly, the MAR was not accurate.

It is important to note that despite repeated problems with adherence, only Patient 9 had any evidence of any attempt to by clinical staff to address adherence. And in that case, there was no evidence that the plan was followed. Treatment for adherence is a standard practice. Improving adherence reduces symptoms of mental illness and associated violence to self and others. Failure to utilize this simple type of intervention is seriously deficient and places patients, other inmates, and staff at risk of harm related to under-treated mental illness.

Ancillary Services

There was evidence of access to laboratory studies. I saw no cases where neuroimaging or electrophysiological studies were in the record despite several instances where it was indicated. These are standard assessments in cases of cognitive decline of unknown etiology and in some cases of new onset psychosis, among other less common conditions. Failure to properly diagnose such conditions places patients at unreasonable risk. Not knowing the contribution of central nervous system pathology may lead to inappropriate or ineffective pharmacological treatment. It also leads to failure to adopt appropriate behavioral measures to address associated dangerous or other problem behaviors. Patient 38 is a good example of this deficiency.

Medical consultation is available on site; see Dr. Stern's report for details of access to medical care.

Training

I received a limited amount of training material.

The training entitled "Healthcare Screening/Intake Screening" included training on transfer screenings, which is relevant to EMCF. It notes that "Transfer screenings typically are required to be completed within 12 hours of inmate's arrival at the facility." Staff had told me their understanding was that there was a 48-hour window but that they did it typically on the day of arrival. It also included segregation placement screening. It specifies that "screening is completed when correctional staff provide notification that an inmate is to be placed in segregation." It goes on to say that the "goal of screening is to identify medical or mental health issues of the inmate that may contraindicate segregation placement or require special accommodations." As noted, such screening is not occurring reliably.

The Centurion training "Introduction to Corrections" is of mixed quality. While there is an appropriate consideration of good boundaries between staff and inmates as well as addressing the potential for staff to be compromised, some of what is provided is not consistent with good

mental health care values and approaches. In the discussion of boundaries, there is too little discussion of psychological boundaries; it primarily focuses on physical boundary violations. The training also directs staff to behave in a manner that is “fair, firm, and consistent” which is a correctional perspective, not a mental health perspective as mental health staff are expected to behave differently depending on the clinical needs of the patient. There is also a message that inmates who want to talk to someone may be manipulative to achieve that contact. While this is true in a minority of instances, there are of course many situations where it is appropriate for inmates to desire mental health contact, including helping them avoid regression when they lack the intrinsic capacity for self-management. It also specifies that health care staff should not do things such as bring in magazines for an inmate. It is sometimes appropriate for mental health staff to give patients reading materials, including workbooks and leisure reading. However, it is true that this should be done systematically and programmatically, not personally, but this is not addressed. This same training also talks about the importance of privacy and that “all health care encounters should occur in an area that protects and inmate’s privacy.” This is clearly not observed by mental health staff. At the same time, this training states that custody staff may be considered part of an inmate’s treatment team. While custody staff may have a role in providing information and elements of treatment, unless specially trained and credentialed to provide treatment, they should never be considered members of the treatment team in the same sense as clinicians. Protected healthcare information should be shared with custody only on a need to know basis or as required by law, or with such specially trained custody staff.

Staffing

I was provided a Centurion employee list. It appears that this list was printed 2/16/16 and it states on it that it is a full employee list from 7/1/15 to current. This list does not appear to be accurate as there are some on this that are not working at EMCF, for example psychiatrists Donald Guild and Rory Reeves are both listed as the chief psychiatrist though both are shown as locum tenens psychiatrists (temporary psychiatrists hired through an agency) and I was told neither worked at EMCF. I was also told that there was no longer an activities therapist though Mercedes Webb is listed as full time. As in other instances, this information is clearly not accurate. The table shows the following mental health staffing:

- Mental health director - one full-time
- Psychiatry - one full-time
- Psychiatric nurse practitioner - one full-time
- Locum tenens psychiatrists - two
- Masters mental health professionals - three full-time, one per diem
- Mental health professionals - three full-time
- Activities therapist - one full-time
- Mental health administrative assistant - one per diem

From this it is not clear how many full time equivalent (FTE) positions are expected to constitute the mental health workforce; the above is approximately 10 FTE, excluding the per diem staff whose hours are unknown. The Centurion contract with MDOC includes a proposed facility staffing pattern. It shows 13.5 mental health FTE as follows:

- Mental health director (specified to be a psychologist) - one full-time
- Chief psychiatrist – one full-time
- Psychiatric nurse practitioner - three full-time
- Masters mental health professional - five full-time
- Activities therapist - two full-time
- Mental health administrative assistant - 1.5 positions

The policy Centurion policy “Access to Care” states: “Staffing and resources for healthcare services are allocated based on assessment of inmate/patient serious medical, mental health and/or dental needs, community standards of care and constitutional mandates.” I did not see any evidence of such an analysis.

The Centurion policy “Staffing” has similar provisions regarding providing sufficient staffing. However, it states “A *staffing plan* lays out the full-time equivalent staff coverage required, lists current incumbencies and vacancies, and addresses helpful coverage that will be accomplished if all positions are not filled.... A staffing plan is a detailed schedule on which classifications of staff are assigned to *posts* and *positions* for the healthcare unit.” This is not a true staffing plan but a roster of positions. A staffing plan is a plan specifying how staff must be arrayed depending on the types of services and numbers of patients that must be served. It goes on to specify that the “staffing plan is established by contract with the MDOC.” However, it does not say anything about how needs will be determined, making it a contract and administrative function rather than staffing being dictated by clinical need. The closest this policy comes to addressing true need is that “Timeliness of the provision of healthcare services will be a major indicator in this review.” But it says nothing about adverse outcomes, patient needs, adequacy of services, or any of the truly clinical markers of the adequacy of staffing. This is highly problematic.

In my opinion, staffing is substantially below what would be necessary to afford basic, constitutionally adequate care. There must be sufficient staff to provide not only crisis services and limited psychotropic services (for which the current psychiatric staffing is inadequate) but also structured treatment for the seriously mentally ill.

Structured treatment in this context requires primarily structured activities and basic rehabilitative groups and services for those with psychotic disorders and mood disorders and group and individual therapy for those with disorders poorly responsive to medications but highly associated with adverse outcomes (including self-injurious behavior) such as severe

personality disorders. These services are virtually absent, at least in part due to insufficient staff. Not only must the numbers of staff be adequate but the discipline (staff type), training and performance of these staff must be sufficient as well. I saw abundant evidence of very substandard care. A clear and concerning example is that while EMCF provides essentially only crisis services, even these services are inadequate. I discuss this further specifically with regard to Suicide Prevention below.

The actual staffing needs are difficult to assess owing to the fact that MDOC did not provide information on the nature of their mentally ill population. Based on my observations and chart reviews, there are a large number of inmates with psychotic and mood disorders as well as a large number with serious personality disorders. Establishing an adequate staffing pattern depends on many variables including classification, physical plant, correctional programming breadth and depth (and availability), and custody willingness/ability to provide for treatment opportunities (in groups, in clinics, on units, and so on).

On-Call Psychiatric Services

There is one psychiatrist and one psychiatric nurse practitioner (PNP) who share call duties. They alternate weeks with one being first call and the other being second call. Records demonstrate their availability for after-hours telephone calls. They reportedly may come in on weekends but this happens only rarely. Considered in conjunction with the limited psychiatric staffing, it is likely that limited weekend and after hours services are contributing to such deficiencies as failing to assess those placed in the infirmary on some form of watch or observation status within 24 hours. With more substantial mental health response to crises, adequate daytime psychiatric staffing, and a robust on-call system that included prompt response to the facility, this approach would likely be adequate.

Access To Care

Inmates have three ways to request services: signing up for sick call, completion of a medical request form, and directly asking staff, mostly requests to custody in a crisis situation. There was clear consensus among the inmate population that responses to requests were highly variable. Specifically with regard to mental health, responses might be the same day, the following day, several weeks, or not at all. In general, they reported that it did not matter which method was used – it was not reliable. Many reported that custody staff would sometimes refuse to convey their verbal requests to mental health staff, even when expressing suicidal ideation. There was general consensus that almost all mental health staff would respond promptly when they heard about a problem but that transmission of requests for services to the mental health staff was not reliable. As patient 15 succinctly put it, “If you tell the officers about being suicidal they don’t do anything. They only do something if you do something.” Patient 1 offered, “Mental health can only help if the officers call. They don’t want to do anything – its tray flaps and feeding for them. There’s no security checks – somebody could be hanging and they wouldn’t know.” Asked if he tried sending a medical request form he replied, “Yes, you

can try that but you never know what will happen to that. If mental health gets it, they respond.” He later added, “You can only get attention by acting out. When you try to come like a normal person, they just brush you off.”

Other patients reporting that custody often did not relay concerns to mental health included Patients 1, 5, 10, 13, 14, 15, 18, 19, and 22. Correspondence from inmates similarly reported on problems accessing health care (e.g., Patients 41, 42, 43, 46, 47, 44, 49, 51, 52, and 53).

It was also clear from the medical records and patient report that clinic and laboratory appointments are often cancelled by custody staff, e.g. Patient 38.

I was provided no data on responses to requests for care, an important quality indicator. QA/QI data provided and associated policies indicate that Centurion and EMCF do not collect such data. While the Centurion contract provisions for the Continuous Quality Improvement Program specify that sick call requests are triaged within 24 hours and routine referrals are to be seen by a clinician within seven calendar days, it does not specify that such data must be collected and reported.

The Centurion policy “Access to Care” states: “Patients sustaining self-inflicted injuries or injuries from aggressive behavior will not qualify for patient copayment waiver.” Also, MDOC continues to administer an RVR to patients who engage in self-injurious behavior. This strictly punitive approach is entirely unreasonable and in many cases amounts to punishing an inmate for being ill. While I recognize that many may use self-injury for instrumental purposes, this is not the case for all by any means. And even those who do so are at elevated risk of actual suicide in almost all instances. To fail to appreciate this is a dramatic representation of the underlying values and attitudes that are reflected in the profoundly counter-therapeutic atmosphere and approach throughout EMCF, even in the residential mental health settings. These deficiencies act as a deterrent to access to care and undermine the opportunity to create a therapeutic alliance as mental health staff are put in a position where they must judge whether a self-harm act was truly a suicide attempt, and if they deem it was not, must charge the patient a copay and subject them to potential sanction through an RVR.

The same policy also provides for administering an RVR for failure to keep an appointment. While this is reasonable for consented care (though a copayment for a no show would be more similar to how the community operates) and certain medical functions that prisons have a right to require (e.g. DNA testing), it is not reasonable as a blanket policy. Again, it acts as a deterrent to seeking care in that patients experience punishment when they attempt to engage in care but fail owing to their illness – best to simply decline care and thereby not put oneself at risk of punishment. Further, the mentally ill often have difficulty remembering their appointments. Without help from staff (and generally custody staff rather than health care staff would be in a position to offer assistance), inmates will often miss appointments and, once again, be punished for being ill.

The Centurion policy “Mental Health Caseload: Admission & Discharge Criteria” includes the statement: “Patients placed on the mental health caseload receive regular follow-up by mental health staff.” It specifies follow-up “in accordance with the treatment plan, no less than every 90 days.” The Centurion policy “Outpatient Mental Health Services” adds that those with “serious mental illness are monitored by a mental health professional no less than every 30 days.” However, most medical records demonstrated that follow-up was to be “as needed” and put the burden of seeking follow-up on the patient. This was often stated explicitly in the plan and a standard element of the boiler plate mental health treatment plans. This is not consistent with mental health staff having the affirmative burden to follow-up with their patients, a burden that is appropriate and is certainly the standard of care for the seriously ill or those at risk of self-harm. To fail to assume that burden with the most seriously ill, who often are too ill to desire or ask for follow-up, places these patients at undue risk. It is also a demonstration of the lack of any on-going or structured courses of treatment.

The Centurion policy “Outpatient Mental Health Services” states that “The range of outpatient mental health services delivered by mental health staff is determined by Centurion’s contract with MDOC.” It goes on to enumerate the potential range of services:

- a. Intake screenings
- b. Response to staff referrals and patient self-referrals
- c. Crisis intervention
- d. Monitoring of inmates/patients placed on segregation status
- e. Evaluations
- f. Individual and group therapy
- g. Case management
- h. Supportive counseling
- i. Medication management
- j. Psychiatric follow-up

While the principle that outpatient services may be rationed based on available resources is reasonable to some degree, there are certain of these enumerated services that must be available and not subject to funding limitations. These include a., b., c., d., and i. To allow any of these services to be unavailable to the general population exposes these inmates to undue risk. Those in residential mental health settings need access to the full range of services enumerated above and should be administered on the basis of patient need rather than staff availability.

Sick Call

Per the Centurion contract, sick call requests are to be triaged in “face-to-face encounter with a licensed registered nurse trained in triage” within 24 hours of receipt. It goes on to specify that, “Non-emergent requests shall be evaluated by the physician or mid-level practitioner within seven (7) calendar days of the original receipt.” I received no documentation demonstrating

adherence to this provision. Documentation demonstrates that these timelines are usually but not consistently met by mental health.

Consistent with inmate reports, review of sick call documentation for sample of 23 inmate requests to see mental health in January 2016 demonstrated that when mental health received medical requests, they generally responded promptly. All but three were seen by a clinician within three days of the request. None took longer than eight days.

However, when the responding clinician was not a psychiatric prescriber (e.g., was an LSW or MHC), the timeliness of being seen by a psychiatric prescriber upon subsequent referral was mixed, sometimes requiring submission of a second request by the patient, but only three of the 23 were not seen within two weeks (four were not seen within the one week required by the Centurion contract). Unfortunately, one of them was never seen.

Access to Licensed and Residential Care

There is no access to licensed level of care (i.e., inpatient hospitalization in a facility credentialed to care for the mentally ill). The EMCF facilities are not licensed and staff is unable to secure psychiatric care in an off-site licensed facility. Centurion policy “Hospital and Specialty Care” specifically states they are to “provide access to clinically indicated healthcare services that are not available in the facility or are not provided by healthcare staff members” and “[p]atients who meet mental health involuntary commitment criteria are recommended for transfer to an appropriate psychiatry hospital.” Such services are provided for the medically ill but this is clearly not the case for the mentally ill. It is also important to note that the Centurion policy “Mental Health Watch Procedures” also states that when patients in “safe cells” do not demonstrate resolution of the crisis “within 72 hours and unless there is clinical justification for continuing the patient’s treatment at the institution, the patient is transferred to a higher level of healthcare.” No such referrals are being made despite clear evidence of patients who meet commitment criteria, need services not provided by Centurion, and/or need hospitalization. There is not even evidence of consideration of such an option. This is a serious shortcoming associated with obvious risk; it is no different from failing to hospitalize a medical patient needing hospital level services.

Mental health staff have too little input into the placement of the mentally ill into appropriate settings; I spoke with several seriously mentally ill in units other than the pods on unit 3 (the residential settings for the most seriously mentally ill) and many less seriously ill on unit 3. It is essential to place inmates on the appropriate unit; EMCF fails utterly in this regard. Even though the units are really no different in terms of services, aggregating the mentally ill together limits their victimization by others to some extent. The mentally ill are far more frequently victimized than those without mental illness and are in fact more likely to be victims than perpetrators of violence. However, in their current form, even these residential mental health units are not safe, owing to the failure of staff to properly and timely treat, monitor, and intervene.

Staff at the facility reported that placement decisions in residential mental health settings are made by MTC staff, reportedly a movement Sergeant. Other than custody level, it was not clear what drove those decisions. Mental health staff reported that those who are within 30 months of release may be placed on unit 2-C and those with anger management needs would be prioritized for units 1, 2, and 4. When inmates with those needs were placed there, mental health would be notified and expected to provide anger management services (an inappropriate use of mental health staff – they should be providing services to the mentally ill only). Housing unit 3 is designated as the location for the more seriously mentally ill. The intake mental health staff member noted that if there is an inmate that is vulnerable or on psychotropic medication, that would prompt notification of the movement Sergeant. When asked about release from the residential unit the staff member responded that patients are usually left on unit 3 “if they are comfortable.” The Centurion policy “Mental Health Caseload: Admission and Discharge Criteria” provides that when a “patient poses a clear danger to self/others or his/her level of functioning does not permit him/her to remain safely in general population due to his/her mental status ... an appropriate level of mental health care will be determined and arrangements will be made for the patient to be transferred to an appropriate location.” I saw no corresponding correctional policy that would provide for mental health staff to effect such a transfer.

In the record of Patient 10, a Licensed Master Social Worker (“LMSW”) specifically noted having “no control or knowledge about transfers.” The record of Patient 38 noted that MTC staff governed placement. It was clear that the treating PNP felt that Patient 38 needed to be on the residential mental health unit but the patient often is not placed such a setting. Many other records also contain similar statements by mental health staff.

Access to Psychiatric Services

Almost all patients reported on the reasonable availability of psychiatric prescribers. The record demonstrated regular contact with those on medications. Consistent with Centurion data, it was rare that a patient would go longer than 90 days without a psychiatric contact and many were seen on a weekly or even more frequent basis when in crisis. Patients complained that requests for routine services might sometimes take weeks but I did not see evidence that routine services were unreasonably delayed.

Access to Individual and Group Therapy

There was virtually no evidence of courses of individual therapy. There is no access because the service is not provided. A minority of patients had medical record entries demonstrating involvement in groups. The Centurion policy “Outpatient Mental Health Services” specifies that the following groups are offered: “sleep hygiene, stress management, anger management, cognitive restructuring, effective communication, activities of daily living, medication education, and problem-solving.” However, I saw no evidence of such groups being run except anger management. The most common groups included Accepting Mental Illness, Activities Group, Social Skills, and Handle Anger Better, all of which were run by one staff member. The only

group run by another mental health staff member was a self-esteem group; I saw evidence of one patient participating. A minority of patients received any group therapy and these group programs ran only for a small portion of the patients' time at EMCF.

The Centurion policy "Mental Health Group Treatment" states that groups will be "based on identified need and availability of staff resources." Here again, if the treatment is needed to prevent harm, it must not be subject to the availability of staff resources; such resources must be provided. The policy appropriately prioritizes groups for those "on a mental health unit." But until seriously mentally ill patients are reliably placed on such units, this is problematic.

Many patients were in need of such treatment. Only 8 of 25 patients had medical record evidence of receiving group therapy since July 2015. These groups included: Music Appreciation, Maintaining Daily Living (more about community living skills actually), Accepting Mental Illness, Activities Group, Social Skills, Self-Esteem and Handle Anger Better. Most of these are not mental health groups, though may benefit some mentally ill. Most of those that were healthcare groups were provided by a single staff member, who reportedly is out with an illness. Further, only one patient was enrolled in three groups, most had just one and many groups were only a few sessions long. In short, consistent with patient reports, there are almost no groups being run at EMCF. There are no groups that are designed to address the many patients engaging in recurrent self-harm. There are no groups targeting mood disorders. Accepting Mental Illness and Activities Group might be appropriate for the seriously mentally ill but without a curriculum, it is difficult to tell. There are an abundance of off-the-shelf, evidence-based groups for these problems that EMCF could readily acquire.

Inmates reported that they cannot be in a group until they have been RVR-free for six months. I found no policy stating this. However, I saw no clear evidence of those who had received a recent RVR being in a group and the one patient that did have a history of substantial group involvement had been RVR-free. This is entirely unreasonable as many mentally ill are receiving RVRs because of their mental illness yet they are barred from the very treatment they need.

The document "MTC Programs Listing" provided a list of groups and programs. It is important to distinguish between programs and treatment groups. Those included in the "MTC Program Listing" are not treatment groups, such as Adult Basic Education, Bible Studies, Parenting (Inside Out Dad), Moral Reconciliation Therapy, Music Appreciation, Thinking for a Change, Thinking for Good, Workforce Readiness, Offender Orientation, and vocational offerings. Most of these would not be appropriate for the most ill patients.

It appears that this is a list of groups that were active as of the date on the document, 8/25/16. I was provided no information on the number of these groups run or patients attending them, an important quality indicator. There was similarly no accounting of how many mental health groups were run or who attended them.

There are some chemical dependency groups such as Pathway to Change, Choice and Change, and something called Residential Drug Abuse Program. The Pathway to Change offering has a capacity and enrollment of 66, so this is unlikely to be a structured treatment group; it is likely to be the inmate-run groups on unit 4-B by the same name. Similarly, the Residential Drug Abuse Program has a capacity of 4 groups of 60, making it unlikely to represent an actual group but a program; there are 187 enrolled in that program. Thus, there are 12 Choice and Change groups with a capacity of 15 each but with a total enrollment of only 37. None of these were attended by any of the mentally ill patients whose charts I reviewed, this despite the fact that substance abuse is a common problem in the mentally ill that is highly associated with elevated risk of violence.

Groups in the “MTC Programs Listing” that appear to have a mental health treatment component (i.e., that appear to be run by mental health staff and have titles that suggest a possible mental health treatment orientation) include: Managing Co-occurring Disorders, Making the Most of Yourself, Responsible Living, Self-Management, and Stress Management. Managing Co-occurring Disorders shows a capacity of 14 groups of 10 but with an enrollment of only 51. Making the Most of Yourself had a capacity of two groups of 10 and one group of 60; thus it is unclear that this is a group in the strict sense of a treatment group and may be a program. Regardless, there are only 7 listed as enrolled. Responsible Living shows a capacity of 10 with 6 enrolled. Self-Management shows a capacity 10 with 0 enrolled. Stress Management shows a capacity 10 with 0 enrolled. Thus, excluding the substance abuse and mental illness group Managing Co-occurring Disorders, there are only at most 13 patients in purely mental health treatment groups. None of the patients whose charts I reviewed attended any of these groups.

There are also 80 slots shown for Anger Management (which may or may not be therapeutic, depending on the clinical need of the patient) but only 47 inmates were enrolled.

It is notable that this same document lists Individual Counseling for 11 counselors, each showing a one hour time slot at 0900 except one that lists times as 0800-1700. Each has a capacity of 30; there are no patients enrolled. This is consistent with the absence of individual therapy noted above.

Access to Chemical Dependency Treatment

As already noted, I saw no evidence of chemical dependency treatment in the medical records of any of the mentally ill patients whose records I reviewed. This is consistent with the lack of groups and individual services in general.

Access to Mental Health Services in Restrictive Housing

The Centurion contract dictates that the mental health staff must evaluate these inmates “in accordance with ACA and NCCHC standards and MDOC policies and procedures.” The MDOC policy “Offender Segregation” covers procedures for placement of offenders in segregation. It includes provision for medical staff to “review the offender’s medical record for medical, dental,

or mental health conditions that could be detrimental to confinement or that would require special accommodations. The record will also be reviewed to identify those offenders receiving mental health treatment.” However, what is to be done with this information is not specified, though the intake training (see below under Training) specifies that mental health staff are to be alerted if the inmate is receiving mental health services and that “healthcare staff will collaborate with correctional staff in developing an appropriate plan” when accommodations are needed. Note that the NCCHC standard is for mental health staff to review the record, not medical staff. A face-to-face assessment is far preferable as it is well known that placement into segregation (a restrictive housing setting) is a time of high risk for suicide and self-injury and because behavioral problems are often a sign of deterioration in mental health. But a review of some sort with appropriate referral is minimally adequate.

The medical staff reviews were sometimes present in the medical records of those placed in segregation but adherence to this important provision was inconsistent. It was not always possible to determine when and whether an inmate was placed in segregation but when they were, there should be such an assessment. Clear instances of failure included Patients 13 and 38. I also saw no evidence that such an assessment ever resulted in diversion of a mentally ill inmate from restrictive housing. Referrals or alerts to mental health were also not in evidence in the majority of instances when it could be determined when an inmate was placed in segregation. Failure to consistently conduct these assessments, divert appropriately, and refer the mentally ill for assessment and treatment is a serious source of potential and actual harm. Those in restrictive housing at EMCF commit acts of self-harm regularly and there is no evidence that this is being addressed through treatment or behavioral plans.

Records and interviews demonstrated that individuals with serious mental illness are commonly in restrictive housing. Other than Patient 38, I saw no evidence in the medical records that mental health staff considered whether a patient’s mental illness rendered placement in restrictive housing clinically unreasonable or dangerous or assessed the potential the impact of restrictive housing on the inmate’s mental health. It is notable that in the case of Patient 38, it was one of the psychiatric prescribers who was making the case for alternate placement, not the rounding mental health staff or staff assigned to segregation.

I did see mental health staff on video opining that there was no mental health reason for a particular inmate’s problem behavior and that the disposition of the matter was therefore up to custody. However, I did not see documentation of such evaluations and the bases of such evaluations are entirely unclear. The video DEF-028654A – DSCF0043.avi does not demonstrate a sufficient assessment to make such a judgment and what is more concerning is the accusatory rather than clinical stance the clinician takes in relation to the inmate; the interaction is very unprofessional. The inmate tried to talk about his mental health problems and how they contributed but the clinician talks over him and then asks closed ended questions in a very brusque and accusatory manner; the questions have nothing to do with what the inmate was

trying to say about “mood swings.” When the inmate says that he was upset that he had to close his tray slot, the clinician stops the inquiry and states that is “not a mental health concern.” But there was no inquiry into the nature of his response to that event or how his mental illness might have contributed. Whether or not the clinician was accurate (which is not clear), this was no clinical assessment and certainly could not serve to determine whether his mental illness, if any, played a role in his behavior.

After some limited interaction with an inmate in a public hallway, the clinician in DEF-029277A – DSCF0082.avi faces the camera and basically states that the inmate was belligerent and upset with custody staff, which the clinician opines is not a mental health issue. Again, the basis for this determination is unclear.

Further, clinical staff should not be providing such evaluations; this undermines the treatment alliance and demonstrates a custody orientation rather than a clinical orientation. Further still, given that this is essentially a forensic examination, ethical standards are clear that treating clinicians should not render such opinions about their patients. More importantly, for mental health staff to have a meaningful role in the disciplinary process, their input should be confined to what is in the interests of their patients and what might be detrimental to their patients, not opining that custody is free to punish their patients. It is self-evident how this undermines the treatment role and the treatment alliance with the patients. This practice has been condemned by correctional mental health bodies such as NCCHC and the correctional standards of the American Psychiatric Association. Other cases where this clearly occurred included Patients 31 and 38.

The policy also specifies that hearing officers “will include an evaluation of the following offender information,” which include “Psychological make-up” but again there is no direction on what to do with such information. I saw no evidence in the medical record that such input was provided or that it had any impact on the placement or conditions placed on the mentally ill placed on segregation status.

The MDOC policy “Offender Segregation” provides for both medical and mental health staff to “make frequent rounds in the administrative segregation housing unit.” The frequency of such rounds should be specified and should be at least weekly for mental health in the most restrictive settings (housing unit 5); mental health staff generally met this target, though those rounds were often superficial, just as in the infirmary. The Centurion contract also specifies that nursing staff make daily rounds in segregation. Nursing rounds were not conducted daily in many cases as documented in the medical records, most clearly Patients 32 and 38.

Medical records demonstrated instances of mental health “segregation rounds” being conducted. It is not possible to precisely determine the frequency and regularity of these rounds from the database as records of rounds were not provided and medical record entries did not always specify the nature of the contact. Further, it was not always possible to ascertain exactly when an

inmate was in restrictive housing from the available records. However, the available information suggests that the frequency is variable. Patient 1 had charting indicating segregation rounds on 6/3/16, 6/6/16, 6/13/16, and 6/21/16. Patient 10 had charting indicating segregation rounds on 2/17/16 and 2/23/16. The record is clear that he was not in restrictive housing 2/12/16 and that he was placed in the infirmary on 2/24/16. From this it appears that rounds are done approximately weekly but likely are not done every week as required by existing standards and the Centurion contract. As documented in the appendix "Patient Interviews and Clinical Reviews," these clinical rounds are cursory at best. In almost all cases they document only that the inmate is "awake, alert, and calm" and that his cell is clean. The associated form, though not often used, provides for much more information, including the mental status examination. Such limited rounds are especially problematic at EMCF because the patients are not getting any other treatment contact except occasional visits with a psychiatric prescriber. Correctional mental health standards contemplate rounds being done in the context of more robust patient contact and treatment (for those who need it), providing more information on patient status. In the absence of such contact, these cursory rounds often fail to detect psychiatric decompensation and risk for self-harm, as demonstrated repeatedly in the medical records.

There is provision for "Management Isolation" though the reasons for using it are not specified. There is no mention of consideration of mental illness in decisions about whether to so isolate an inmate. The deleterious effects of isolation are addressed in a separate expert report.

The same "Offender Segregation" policy also provides that inmates will have access to a shower three times per week. Thus the ubiquitous inmate reports of having been denied showers for two weeks on unit 5-B demonstrate a violation of this policy, as they do of the policy requirement that lighting be provided.

There is a section in the MDOC policy "Offender Segregation" entitled "Medical/Mental Health Procedures" requiring that those "in segregation longer than 30 days be interviewed by a qualified mental health professional and a written report prepared." The policy does not specify the content of the report or what is to be done as a result of this report. It similarly requires a "psychological assessment" every three months if confinement goes on. Again, the policy does not specify the content of the report or what is to be done as a result of this report. I saw no evidence of such reports in the medical records. Given that these are psychological reports they should be placed in the medical record.

I note in passing that this policy includes provisions that appear only punitive and to have no facial valid purpose. For instance, offenders who spit on others are required to be placed in a disposable paper gown. There is, of course, no discernible connection between being in a paper gown and spitting. Similarly, those on administrative segregation pending disciplinary action are always to have a spit mask placed over their head to cover their mouth. The rationale for this is not clear as there can be no presumption that such patients are a spit risk. It is a form of restraint

being used without cause. This is further evidence of the excessively punitive orientation of EMCF.

Patient reports and records demonstrated that mental health services in restrictive housing are limited to crisis response, medication administration, and occasional visits with a psychiatric prescriber. I saw no evidence of other forms of treatment as are required by the Centurion contract, let alone by basic clinical standards.

The clearest example of this is Patient 8 who at the time of placement in restrictive housing was known to be seriously and acutely mentally ill. Patient 8 had a “pre-lockdown health evaluation” on 7/3/16 (though had been the subject of segregation rounds on 6/21/16) but was not referred to mental health. It was not until he had been in restrictive housing for well over a month that an LSW evaluated him other than on the basis of cursory rounds that document only that he was awake, alert, and calm and that his cell was clean. On 7/26/16, the LSW referred him to psychiatry. The psychiatrist “[d]iscussed case with [a psychiatrist] last week, if continues noncompliant, will go ahead and recommend long-acting Haldol to offer stabilization and then reconsider oral medications....” He was finally placed in the infirmary where I saw him; he was agitated and clearly profoundly mentally ill. None of the records I reviewed demonstrated any treatment in restrictive housing other than psychotropic medications.

There is one Licensed Social Worker (“LSW”) assigned to units 5 and 6, representing about 250 inmates in restrictive custody and close custody respectively. Thus it is no surprise that the services on these units are extremely limited.

The MDOC policy “Administrative Segregation Long-Term Status” defines long-term segregation as lasting more than 60 days. It includes provision for a Unit Review Team that is “responsible for reviewing offenders assigned to lockdown status.” However, despite the fact that this is a mental health facility, there is no mental health representation on this review team. Given the length of this kind of isolated segregation status, it is critical that the impact on mental illness be strongly considered. It is well-known that isolation of this population is problematic. This is addressed in more detail by Dr. Kupers. I will simply note here that there is no mention of mental health considerations in this policy.

Institutional Transfers

Guidelines for transfer between institutions are nebulous at best. As far as I could glean from policy and the limited information I received from staff and the medical records, it appears that transfer to EMCF is sometimes driven by a clinician diagnosis. That said, there are several cases where obviously and seriously mentally ill patients are retained at other facilities for extended periods of time prior to transfer to EMCF. It is also clear from numerous interviews that there are many inmates at EMCF who were not seriously mentally ill.

An email from Amy Hodgson to numerous staff dated 4/14/16 addresses changes in level of care (LOC) for mental health. The LOC system is intended as a measure of the intensity of services needed by a patient with A being the lowest need progressing to E, the highest need. It notes that those with LOC-A and LOC-B can be transferred out of EMCF. However, the email states that mental health staff are not to contact custody about a potential transfer, leaving that responsibility to the inmate; this is entirely unreasonable, especially if EMCF is to be run as a mental health facility. Bed management is the responsibility of staff, not inmates. The email also directs mental health staff to contact custody for transfer those whose LOC increases to LOC-C, LOC-D, or LOC-E, presumably because of increased clinical needs. The email also specifies that only the psychiatric prescribers, under supervision of the psychiatrist, have the authority to change LOC at EMCF. This changes the policy "Hospital and Specialty Care." There appears to be reference to these changes in the minutes of the "Centurion of Ms [sic] Mental Health Update Meeting" from 4/29/15 but there are no additional details. These changes are not reflected in the policies I was provided.

Historically there is a practice of mandating that patients be off their medications for 90 days prior to transferring to a different facility. Records also demonstrate that some patients refusing medications who had been off them for 90 days were transferred as well, including patient 5, a seriously mentally ill patient, in October of 2015. This practice has reportedly been curtailed, but some patients and staff believe it is still in effect and there are some patients who expressed a desire to come off their medication and some who had stopped their medications in order to be transferred. It is important that this practice be entirely stopped as only level of clinical need should drive these transfers.

Review of medical records demonstrates that intakes are completed when inmates transfer between institutions. Patients report that medications are generally seamlessly continued upon transfer. However, there are instances where some medications have failed to be continued; this was corrected promptly in the cases I reviewed.

The case of Patient 8 raises concerns about the promptness of transfers to EMCF of the seriously mentally ill. This patient came into MDOC on 2/25/16 on a medication regimen consistent with serious mental illness. He arrived at EMCF 4/4/16. When finally seen by a PNP, he showed evidence of serious symptoms.

Patient Privacy

Patient privacy is a recurring problem. Privacy is not a luxury in mental health care. By way of analogy, privacy and confidentiality are to mental health care as sterility is to surgery. Privacy is necessary for the open expression of highly personal information; without this information, it is not possible to identify and address the fundamental problems plaguing a patient. The assurance of confidentiality is equally important; in order to feel comfortable revealing sensitive information, patients must know that such information will not be inappropriately shared.

Patient privacy is to be maximized per the Centurion policy “Privacy of Care.” The policy states that custody is to be “present only if the patient poses a probable risk to the safety of the healthcare professional or others.”

The privacy of clinical interactions is highly variable. In most cases, psychiatric prescribers meet privately with patients in offices either on the units or in the medical clinic. However, most contacts with other mental health clinicians are at cell front or in common areas. Patients report that it is rare to meet privately with one of the mental health clinicians in an office. Record reviews are consistent with these reports in that many contacts are brief and take place during rounds or in that the documentation explicitly states that the visit was at the cell front or in the cell. Many notes indicate that rounds and other clinical interactions were conducted with custody present, even contacts that are clearly clinical in nature such as those designated “office visits.”

As noted above, intakes are not at all private. They are done within earshot of both other inmates and custody staff. Further, clinician intakes are conducted in tandem with non-clinician intakes, such as staff conducting evaluations to assess programming needs.

Privacy is vitally important to mental health treatment. Without privacy and a general expectation of confidentiality, it is almost impossible to conduct mental health treatment. In order to address their problems, patients must discuss issues they would never reveal to custody or peers. This may include matters directly related to danger to self and/or others, and the failure to ensure privacy compromises the efficacy of mental health treatment, placing patients at risk.

Quality Assurance And Quality Improvement (QA/QI)

Quality improvement functions are profoundly sub-standard. Quality improvement is necessary not only to improve services but to prevent the degradation of existing services. There is no possibility of meaningful system improvement without a sound quality system.

A QA/QI program is necessary to measure outcome, track adherence to policies and contracts, observe trends in the population, and quantify service delivery and access to care. Collecting and analyzing relevant data provides the foundation for corrective action plans and allows tracking of their implementation. This is a standard approach to system maintenance and system improvement. For the mental health component, this necessitates collecting data on admissions and discharges to different levels of care, bed occupancy, patient demographics, diagnostic distributions in the population, service delivery (type, frequency, time to service, and availability/access measures), medication usage, key outcome measures (e.g., length of stay, frequency and types of patient encounters, timeliness of services, completeness and quality of documentation, transfer to lower levels of care, use of involuntary treatment, seclusion and restraint, placement on monitoring or observation status, prescribing patterns, adherence to policy and treatment guidelines, grievances, patient Rule Violation Reports), and sentinel events

(i.e., suicide, self-harm, serious assaults, hospital admissions, emergency room visits, and other adverse events – which may also be viewed as outcome measures).

I received very few QA/QI materials despite policies specifically mandating QA/QI functions including data collection, data analysis, and associated committees with required minutes. I received data from May and June 2015, which was prior to Centurion's involvement, and therefore is not germane. I also note that the data provided included virtually no mental health data, though information was from the company contracted to provide mental health services at the time. It is possible that the data are incomplete, but I must assume this reflects the previous company's total data; it did address both medical and dental services, but did not capture the range of measures that would be required for even a basic QA/QI program.

I also received two Centurion QA/QI spreadsheets from July and August 2015. While these data are very limited, they confirm some findings gleaned from patient interviews and medical record reviews detailed elsewhere. The methodology was the manual review of just 25 patients' medical records each month; it is not clear how the records were selected. The fact that chart review is the methodology suggests that Centurion has limited or no capacity for generating automated, aggregate population data from its electronic health record. The five mental health measures reported therein are included in the following tables:

July 2015

CRITERIA	Results			
	Yes	No	NA	%
1 Urgent referral evaluated within 24 hours	21	0	4	100%
2 Urgent referral seen by Psychiatrist within 5 calendar days	5	16	4	24%
3 Routine referral evaluated within 5 working days	5	16	4	24%
4 Routine referral seen by Psychiatrist within 14 calendar days	5	16	4	24%
5 Inmates on psychotropic [sic] meds seen by a Psychiatrist at least every 90 days (includes telehealth)	20	1	4	95%

August 2015

CRITERIA	Results			
	Yes	No	NA	%
1 Urgent referral evaluated within 24 hours	21	1	3	95%
2 Urgent referral seen by Psychiatrist within 5 calendar days	12	10	3	55%
3 Routine referral evaluated within 5 working days	14	3	8	82%
4 If in segregation, Mental health services completed and documented rounds per policy	0	0	25	
5 Inmates on psychotropic [sic] meds seen by a Psychiatrist at least every 90 days (includes telehealth)	15	0	10	100%

The primary conclusions from these data are that crisis response and routine psychotropic follow-up are occurring fairly reliably; these conclusions are consistent with patient reports and medical records review. However, it is important to note that this data would not capture custody's failure to report an urgent referral to mental health.

The data also demonstrate that timely access to psychiatric care is inconsistent and inadequate. Further data to determine trends would be necessary to draw further conclusions. It is also problematic that there is no tracking of emergent responses. It is also apparent that the data give no information on segregation rounds, as it appears from the data that none of these patients had been in segregation.

There are no other mental health data in the CQI reports provided. Thus, it is not possible to comment on population data (e.g., diagnostic distribution, numbers of mentally ill), service characteristics (i.e., types and amount of services delivered to populations), or population-based clinical outcome measures. These data should have included, at a minimum, information regarding the numbers of patients with various diagnoses (at least those with serious mental illnesses), the numbers and types of patient encounters by mental health staff, psychotropic

medication usage (including involuntary medication usage), sentinel events particular to mental health (including suicides and serious self-injury), usage of clinical seclusion and restraint, and admissions and discharges to residential mental health beds. Throughout this report, I will point out data and measures that are lacking. Failure to collect and analyze such important data is a clear marker of an inadequate system and bespeaks a “head in the sand” attitude on the part of leadership.

Further demonstrating these failures, the associated policies regarding QA/QI do not call for the degree of specificity and depth of analysis that would be required for basic QA/QI. For instance, the Centurion policy “Administrative Meetings and Reports” requires the Medical Audit Committee to collect data on and analyze for trends only for the following categories:

- a. Number of inmates receiving services by category
- b. Operative procedures
- c. Referrals to specialists
- d. Serious infectious diseases
- e. Hospital admissions
- f. Emergency services
- g. Inmate deaths

This information is clearly very thin on general outcome measures and focuses on activities more likely to be associated with costs rather than quality of care. The categories listed from b to f above involve clearly expensive services but only, at best, indirectly measure patient outcome. Again, there is nothing specific to mental health outcomes or types of services rendered and almost nothing with relevance to mental health at all except for the self-harm that happens to be captured by the last three categories. None of the other elements of basic QA/QI data are included in this list.

The Centurion policy “Patient Safety” requires “patient safety systems to prevent adverse and near miss clinical events.” Unaccountably, it provides only for a voluntary system of staff reporting. This is inadequate as there are many other means of detecting such events. To fail to take such steps for these types of events clearly places inmates at risk. Further, no data on such events were provided, let alone any analysis or corrective action plans.

The incident reports I received are not summarized or aggregated in a usable form and, as noted below, the reports themselves are not complete, making it impossible to generate my own data.

The lack of this data and QA/QI information necessitates that, for the purpose of this report, evaluation of services must be based primarily on medical record review, direct observation, and patient interviews. Presumably, these are the only methods available to Centurion as well.

In summary, there is no requirement to collect any of the specific mental health data detailed above. These data are essential to be able to determine what the needs of the population are and should drive staffing, service types, and bed capacity. The QA/QI system is completely inadequate. Failure to detect, measure, and correct problems identified by such processes clearly places patients at unreasonable risk of harm.

General Prison Data

Per the warden, the capacity of the facility is 1155 but the warden reported that it could exceed that with some double-bunking. The warden reported the census was about 1,170 at the time of my visit. The Warden estimated there are 10 admissions to the facility each month. The MDOC web site states that the authorized capacity is 1,362 and is expandable to 1,500 beds (accessed 12/7/16).

No other general population data were included in the materials provided.

Grievances

Summary grievance data was provided from July 2013 through July 2014, excluding February 2014. There were from 147 to 272 grievances each month, 21 to 60 of which involved health care.

The MDOC policy “Grievance Procedures” specifies that “the quantity and nature of offender grievances are aggregated and analyzed annually.” The Centurion policy “Grievance Mechanism for Health Complaints” has a similar provision for analysis (evaluation). These analyses were not provided. Similarly, the MTC Medical policy “Grievance Mechanism for Health Care Complaints” provides for the tracking of grievances and their review in “CQI meetings to identify trends and opportunities to improve health services through corrective action.” No such CQI documents were provided.

EMCF has grievance policies. One problem I will note here is that time frames provided in the MDOC policy “Grievance Procedures,” paralleled by the Centurion policy, are unreasonably long. The first step response is not expected until 40 days after submission of the grievance. The overall process can be up to 90 days and extensions are allowed. Provision for emergency grievances does not overcome this deficiency.

Incident Reports

I received and reviewed incident reports from 7/1/15 – 2/29/16 (47 total). This is a small number of incident reports for a facility this size. However, it is clear that the data are incomplete, since three incident reports from that period that I subsequently received are not included in the set of incident reports originally provided, though the subsequent emergency room visit and hospital admissions appear on the hospital/ER log for the two incidents that occurred in January (I did not receive logs for February 2016). These three incident reports detail self-harm events, one of which was quite serious.

Of the 47 incident reports, 21 of them involved self-harm, a very high percentage. I comment further on the self-harm events in the section Suicide Prevention. From the above, we know there were at least three more self-harm events.

In comparing these incident reports with reports regarding hospital admissions and emergency room visits, it became apparent that many important incidents are not captured in an incident report. From July 2015 to February 2016 (for hospital admissions) and from July 2015 to January 2016 (for emergency room visits), the logs of emergency room and hospital admissions demonstrated 12 cases that clearly articulated self-injury as the cause of the medical condition that was severe enough to necessitate medical treatment outside the facility. Of these, seven (over 50%) have no associated incident report. This included two hospitalizations and emergency room visits for abdominal wounds, hanging, and a variety of lacerations. Given that some of the other incident reports detailed events that were not as serious, it is clear that incident reports should have been done for virtually all of these cases. I will also add that these logs demonstrated other injuries that were highly likely to be self-injuries, some of which were captured in incident reports. Regardless, to have missed this number of severe events is highly concerning. Further demonstrating this general failure to report, there are almost no incident reports regarding fires set in cells. When fires are mentioned, it is almost always peripheral, such as being cited as the reason for a spontaneous use of force. All fires should be reported on an incident report. This makes it clear that either incident reporting is grossly inadequate or I have not been provided anywhere near complete data.

In this regard, I also note that there are many incidents of other serious medical problems and other events resulting in hospitalization or emergency room visits that are not included in incident reports. As a notable example, one hospital admission on 9/11/15 resulted from multiple stab wounds, but there was no associated incident report. At about the same time (shortly after 0400 that day), another offender was taken to the emergency room with multiple stab wounds. If these events were related, it is doubly concerning that the events did not result in an incident report. As these types of incidents are more properly addressed by medical and correctional experts, I will not analyze this further; but the examples are important to offer in that they demonstrate how thoroughgoing the failure in incident reporting and tracking is.

I did receive some incident reports with associated Incident Debriefing Forms. Several detailed self-harm incidents involving Patient 36. This patient had a history of recurrent self-harm. He cut his abdomen on 1/21/16 and 1/29/16. On 1/21/16, he set a fire and, when placed on 72-hour property restriction, cut himself on the abdomen and had to be treated in the emergency room. The debriefing report bizarrely states that there was no impact on the offender. The "corrective action taken" was that the "Offender was placed in medical for observation." There was no further corrective action or plan for improvement. Clearly, placing the offender on observation is not a corrective action but normal procedure. On 1/29/16, he was in restrictive housing unit 5 after being on watch and asked for property that he was reportedly not allowed to have; he then

cut himself deeply three times on the abdomen in front of the officer. He required hospitalization. There was no corrective action or plan for improvement. On 2/19/16 he used a razor to cut himself while in the clinic. No comment was ever made about his repetitive self-injury or how he had gotten an instrument to cut himself or how he set the fire.

The 1/28/16 incident involving Patient 37 is similarly reported. The inmate cut his leg and was sent to the emergency room. He reported that he “rubbed it against [his] bed,” an unlikely source of laceration. The report notes that he was “allowed to talk to mental health” upon his return and was placed back in the same cell on unit 6-C. No problems or corrective plans are identified.

The reports are no different for the 2/1/16 report regarding Patient 10 who inserted glass in his arm and was sent to the ER (and who two months later killed himself), the 2/2/16 report regarding Patient 38 who was admitted to the hospital for his self-injury (a deep wrist laceration) done while in restrictive housing unit 5-B, and the 2/27/16 report regarding Patient 39 who put shards of glass in his arm while in restrictive housing unit 5-B. In none of these is there any discussion about how the inmate got the instrument to harm himself, despite the fact that all were in restrictive housing.

In summary, incident reports cannot be regarded as complete, and what few debriefings are available are wholly inadequate. This means that any associated overarching conclusions on the part of EMCF, Centurion, or MDOC regarding incidents would be highly suspect and in most cases would need to be disregarded. What is more concerning is the general failure of the system to accurately and assiduously track the most serious incidents occurring within the facility. This demonstrates a profound failure in QA/QI data collection. Failure to accurately track and correct problems detected through such incidents clearly places inmates at risk of harm.

Death Reviews

The document “Listing of Inmate Deaths in Custody of EMCF Offenders from 2014 to May 23, 2016” reports on 6 deaths, in two of which the cause of death is still pending (from 6/4/15 and 1/30/16). Two deaths are from ligature strangling; one is noted to be a homicide and the other is the suicide I review in this report (see Suicide Prevention) and is summarized in the Appendix “Patient Interviews and Clinical Reviews.” The other two deaths were from medical causes.

I was provided one Mortality/Death Review regarding Patient 57 who died of pneumonia; I defer to the medical expert with regard to the medical care on this case.

I was provided two Mortality/Death Worksheets from EMCF regarding the deaths of Patients 10 and 58. The latter is a review of a patient who had a cardiac arrest but for whom the cause of death was reported as unknown on the list of deaths noted above. However, the notes on Patient 58’s Worksheet raise several concerns related to mental health and competency. The patient died on 1/30/16. On 1/24/16, he was seen by a nurse and a nurse practitioner; he had urinated on himself. His blood pressure was elevated at 160/100, his pulse was 99, and his blood sugar was

144. He was given clonidine 0.1 mg (for blood pressure) and was sent to the emergency room. The note goes on, "Returned from ER – 1-24-2016 8:15 PM. [Inmate] not talking – ER doctor cannot find emergency nature. 1-29-16 9:00 AM – [Decreased level of consciousness,] weakness. Sent to Rush [Hospital]. Returned 1-29-2016 1:29. Did not speak. 5:39 found in infirmary in cardiac arrest." This patient was taking a variety of medications, including an antipsychotic, mood stabilizer medications, and antianxiety medication. The fact that he was not talking and had urinated on himself raises concerns about the possibility of delirium and psychosis, both of which might very well impact competency for medical decisions. In the summary section "Clinical Mortality Review" there are three questions:

- Could the medical response at the time of death be improved?
- Was an earlier intervention possible?
- Independent of the cause of death, is there any way to improve patient care?

Only the first is answered – "no." Given just the limited facts reported above, it is clear that more detailed inquiry was needed into the nature of his problems, possibly his competency, and whether more should have been done on 1/24/16 to ascertain his condition. It is possible that this is just a preliminary report, but this is by no means a thorough review. I also note that this form does not provide any cues or space for the development of corrective action plans, further demonstrating the incompleteness or preliminary nature of this review.

The review for Patient 10, dated 4/7/16, is wholly inadequate. I reviewed this case in detail, finding numerous problems both in the treatment of this patient and with operations in the infirmary where, while on watch, he had repeatedly harmed himself and ultimately was able to kill himself. The review addresses only the events following the discovery of him lying in his cell with a ligature around his neck. There is absolutely nothing regarding his prior treatment, his numerous episodes of self-harm (many occurring while on watch), or how he was able to kill himself in the infirmary while on watch. Yet all three of the questions listed above were answered "no." This case was a clear demonstration of a multitude of obvious deficiencies. There thus could be no clearer demonstration of a failed process of review. I address many of these issues in greater detail under Suicide Prevention below.

Other than these reviews, the documentation provided consists only of reports of events surrounding the discovery of the inmate and the associated emergency response. There is no review or analysis of the deaths or any corrective action identified for the remaining deaths.

INDIVIDUAL TREATMENT AND MANAGEMENT

Because access to many important services is virtually absent, there is little to say about the delivery, appropriateness, or quality of services.

Upon medical record review, I found not a single patient who had an appropriately targeted treatment plan.

Other than Patients 12 and 24, who had no discernible need for therapy, none of the patients whose medical records I reviewed received any individual therapy and none received adequate group therapy.

Intake Screening

Staff at the facility reported that they do approximately 10 intakes per month. I watched part of one intake conducted in the intake area. The clinician did not review the medical record and did not appear to have access. A mental health clinician (a social worker) and a custody program staff member conducted a joint interview. The mental health staff member was completing the mental health screening form, and the custody program staff member was assessing the inmate for program needs. This is a violation of patient privacy as the program staff member is not a clinician.

The intake area is also used as overflow from the infirmary when needed for additional suicide watches or other purposes. However, staff reported that mental health clinicians are not able to admit people to this area; only custody staff have that authority. The medical record of Patient 10 specifically noted that mental health did not have this authority and thus could not secure a placement when the infirmary was full. In the case of patient 36, the PNP reported that there were no infirmary beds available and that the patient had to be put on observation status on unit 3-C.

On the day I visited the intake area, there were three newly admitted inmates. I witnessed a mental health staff screening of one of the inmates. The mental health clinician asked the inmate whether he was there for security reasons or for mental health reasons; it was clear that the clinician did not know why this person was there.

I first made contact with Patient 1 in the intake area. He had been placed there on a suicide watch, and he had a history of repeated suicide watches. Thus, he was not a new intake but an overflow from the infirmary.

EMCF does not conduct admission intakes to the MDOC system (CMCF is the intake facility for MDOC), but conducts intra-system (transfer) intakes. As such, a great deal of information should be available to the intake team. Records reflect that intake screening of those new to EMCF is occurring reliably.

In reviewing records, I noted that intakes varied in terms of their content. Normally they included a nursing intake based on inmate self-report that included historical elements, despite the fact that such elements should already be present in the record. Further, the mental health history recorded by the medical staff was often in conflict with the known history, though these discrepancies were not mentioned or reconciled (e.g., Patient 18).

The content of the mental health intake screening is marginally adequate in some cases and inadequate in others. The mental health intake usually consisted of a checklist called the Suicide Potential Screening and sometimes an additional narrative note (which was almost uniformly limited and inadequate) while others utilized a semi-structured interview form. By itself, the Suicide Potential Screening form is an inadequate intake as it does not capture other aspects of mental illness that represent potential risks, including potential danger to others. Patient 32 was an example of a patient receiving only the Suicide Potential Screening. Mental health intake also sometimes contained incorrect information (e.g., Patient 32) but was more accurate than the medical screening in terms of mental health information.

The intra-system intake should be standardized with clear triggers for a formal suicide assessment or other need for immediate clinical assessment. As it is, the intake often does not result in appropriate placement and referral. Patients 16 and 38 are examples of seriously mentally ill men who were not promptly referred for mental health treatment and/or were not directed to a residential mental health unit.

The case of Patient 8 raises concerns about the ability of the intake process to detect and refer the seriously mentally ill for transfer to EMCF. Patient 8 was admitted to MDOC on a regimen consistent with very serious mental illness, including an antipsychotic and two mood stabilizers, as well as medications for anxiety and side effects. Once he finally got to EMCF on 4/4/16, he was seen at intake. Despite the fact that he was on these medications and was noted to be “distracted during interview [sic] and was unable to focus and had to be redirected often,” there was no prompt referral for treatment. He was not seen by a psychiatric prescriber until 5/17/16. At that time the PNP noted that he was “very agitated,” “distracted and guarded,” and “very paranoid.” The PNP states that he “denies delusions,” which makes no clinical sense – a delusional patient by definition does not recognize he is delusional. He was diagnosed as having bipolar disorder, severe, with psychotic behavior. Despite his serious mental illness, he was placed in segregation.

Mental Health Assessment

In order to identify those in need of services, an adequate assessment must be done. The intake process serves only as a screening process to identify those who need emergent care or referral for further assessment. A sufficiently comprehensive assessment is needed in order to determine whether treatment is needed and, if so, what kinds of treatment. Similarly, those submitting requests for service, presenting for sick call, or having been seen in response to a crisis may

require an assessment. Medical record review demonstrated almost uniformly poor or absent assessments. Assessment requires at a minimum a history of the present illness, social and family history, psychiatric and medical history (including appropriate laboratory and ancillary studies), chemical dependency history, mental status examination, diagnosis, and treatment plan. In rare cases, the PNP provided most of these elements; the psychiatrist usually provided some of them though almost never most. Most of these notes were in “SOAP” format: subjective, objective, assessment, and plan. This format is used for follow-up notes but is not appropriate for an assessment. Other mental health staff virtually never conducted anything remotely resembling an assessment. Again, this is a standard and vital part of a course of treatment; without a sufficiently thorough assessment, the ability to make an accurate diagnosis and effective plan of care is seriously compromised.

Upon medical record review, I saw no examples of a complete psychiatric or mental health assessment. The quality varied, but most records demonstrated nothing approaching an adequate assessment.

Additional studies and testing are necessary in some cases, such as for those with possible cognitive limitations. The Centurion policy “Mental Health Services for Patients with Neurodevelopmental Disorders” expressly recognizes the need for such testing, yet I saw no evidence of such, including examples of this deficiency in cases of patients having cognitive limitations (e.g., Patients 4, 6, 7, 13, 17, 19, and 22).

Crisis Care

As I note repeatedly through this report, crisis care is the primary service provided for the mentally ill other than psychotropic medications. Chart notes by mental health clinicians reflect this (see Delivery of Services and Suicide Prevention for discussion of quality of care).

However, crisis intervention is not consistent with basic community standards. In MDOC, crisis intervention consists of responding to the crisis and writing what amounts to an account of the crisis and either placing the patient on watch, referring him to a psychiatric prescriber, or doing nothing other than “monitoring,” a word used so ubiquitously by the mental health staff regardless of the reason for contact that it ceases to have meaning. There was virtually no evidence of any crisis interventions such as short term solution-focused therapy, supportive therapy, or attempts at problem resolution. On rare occasions, a mental health staff might mention skill utilization but even then, this amounted to encouragement to use the patient’s own “skills” to manage the crisis, which of course makes no sense as the patient evidently lacks such skills and is thus in crisis; attempts to teach skills were almost never in evidence.

The need for crisis response may occur in any setting. Subject to the caveats regarding inconsistent mental health notification by custody staff under Access to Care, mental health staff respond to crisis calls. However, their assessment and “treatment,” as shown by the medical

records, is rarely more than a recitation of the events and a determination of whether or not to put the inmate on a watch status, almost always in the clinic, and/or refer him to a psychiatric prescriber. I address assessment of those considered at risk of suicide in Suicide Prevention below. For others, there is occasionally a limited mental status examination but almost never evidence that the clinician explored the cause of the crisis. When there is evidence of consideration of this, it usually amounts to expressing the opinion that the inmate is engaging in some form of manipulation or is having a negative response to a custody interaction. Despite enumeration of a limited but reasonable basic set of alternatives for actual crisis intervention detailed in the Centurion policy “Mental Health Crisis Intervention,” I saw almost no evidence of any such interventions being utilized and no instances of the use of a “crisis intervention plan” that is appropriately provided for in the Centurion policy “Mental Health Watch Procedures.” Some mental health staff would occasionally mention skill utilization but other strategic measures such as “[c]onsultation with correctional staff regarding patient management” or “exploration of options to resolve or ameliorate the crisis or distress” were not in evidence. Most concerning, I saw virtually no use of the option to render an “[o]ffer of follow-up or short-term treatment focused on coping with the crisis.” As such, crisis intervention primarily consists in placing the inmate in conditions of varying degrees of isolation and deprivation of property and privileges. With regard to this, it is notable that the Centurion policy “Mental Health Watch Procedures” specifically states that such watches are to be “used only when other less restrictive measures are not effective or clinically appropriate.”

It bears mentioning that when the response to declaring a crisis is deprivation and isolation with no discernible treatment response, this amounts to a behavioral program designed to discourage patients from declaring a crisis in that the response of the staff is essentially aversive. The fact that patients nonetheless declare crises is a testament both to the severity of their untreated conditions and to the deplorable conditions on the living units such that escape to an isolated setting with no activities and virtually no belongings is preferable to remaining on the living unit. In short, it is a measure of their desperation.

The policy “Access to Care” states that patients are to “receive care that is ordered.” This is clearly not occurring. Numerous treatment plans include express provisions for individual and group therapy, yet charting does not support such services being delivered in the vast majority of cases. Without encounter data (patient clinical contacts with clinicians), it is not possible to assess the quantity of such services delivered; chart review is the only way to assess provision of these services.

Treatment plans are extremely boilerplate in almost all instances as well. They almost universally lack any patient specificity and fail to address obviously important clinical problems reflected by charting, most of which is crisis response charting. This failure exists despite provision in policies such as the Centurion policy “Mental Health Group Treatment” that “[p]atient assignment to specific groups will be related to and included on the patient’s treatment

plan.” In many cases, treatment plans are simply absent or not done at intervals specified by policy.

Continuity of care, addressed in the Centurion policy “Continuity and Coordination of Care During Incarceration,” is clearly no more than aspirational. Virtually all records demonstrated repeated changes in clinicians. This introduces risk in that a clinician does not have the chance to see the effect of treatment; it undermines the patient-clinician relationship that is essential to mental health; and, coupled with the poor charting, virtually assures that there will be no reliable way to measure progress or the lack thereof. Even more concerning is that, with the profound problems in charting noted below, the ability of a responding clinician to get a reasonable idea of the clinical problems and their status is seriously compromised, placing patients at unreasonable risk.

General Population Mental Health Services

These consist almost entirely of medications, rounds, and crisis response. In many instances, this is sufficient for inmates who are not seriously mentally ill. However, I saw many inmates in units not identified as residential mental health who had serious mental health needs beyond what would be expected in a general population setting. These patients were not receiving the level of service needed to improve their condition, let alone to prevent their deterioration.

Residential Mental Health Care

Residential unit mental health services were virtually indistinguishable from those on other units. Groups on the residential mental health unit were notably less frequent than on the unit with inmate-run groups, all of whom were much healthier than the population on the residential mental health units. (Note: the mentally ill should not be in inmate-run groups as inmates do not have sufficient training and are not licensed to render formal mental health treatment.) The residential mental health units were bereft of any special services such as basic rehabilitation or structured activities. Patients spent almost all of their time in their cells or in the dayroom. There was no evidence of groups or activities posted on the walls. The units also ran no differently from other units of similar custody levels; residential mental health units should be designed to afford a more measured response to this population in recognition of their different needs or limitations. Such units almost always require some degree of modification of access to work and programming in order to maximize patients’ opportunities for rehabilitation in a traditional correctional sense. They are also necessary to afford reasonable opportunities for access to activities and work that are important both in terms of limiting isolation and reducing unstructured time as well as promoting mental health. This is expressly provided for in Centurion policy “Basic Mental Health Services,” yet there was no evidence for such an approach.

It should be noted that unstructured time places both patients and staff at risk as many in this population have poor executive function (including self-motivation, planning, critical reasoning, and impulse control). When in unstructured settings, the risk of intrusions by others and other problem interactions goes up dramatically, significantly increasing the risk of assaults and fights, as well as resultant stress which worsens mental illness. Those who lack self-motivation will languish and often isolate themselves and become steadily more preoccupied with their symptoms of their mental illness, leading to further deterioration and more problem behaviors as well as the risk of suicide.

In addition to deficiencies in access to care mentioned above, routine monitoring of the residential mental health units through regular mental health rounds is also lacking. While notes and treatment plans almost invariably refer to an intention to “monitor” patients, the primary form of monitoring provided for in policy and normally available on such units is rounds. Medical records and patient reports alike demonstrated that rounds were far from regular and when done were almost always done with custody present, limiting privacy and decreasing the likelihood that patients will reveal meaningful and important information.

These units are not run in a manner that is conducive to mental health and thus represent an unreasonable level of risk of worsening mental illness and the attendant adverse outcomes that are evident in chart review and interview.

Medical Infirmary (Clinic)

While the infirmary is ostensibly the most acute setting for the mentally ill, services were, if anything, even fewer than in other settings. While there was evidence of regular rounds, there was no evidence of intensified services. The unit is essentially run as a restrictive housing unit, regardless of the nature of the symptoms, type of crisis, or even custody level of the patient. There is no rational reason for this to be so. Many of those who are suicidal and suffering acute decompensation of a psychotic or mood disorder will almost always worsen under such conditions. Placement on the unit acts as more of a punitive measure than a clinical response. Significantly, the infirmary seems to add no measurable degree of safety since those in the infirmary continue to get access to things to harm themselves, set fires, or even kill themselves in this supposedly safe setting. These critical deficiencies underline that the medical infirmary is an unsafe and restrictive environment where clinical services are so deficient that the seriously mentally ill and those at significant risk of self-harm cannot be treated there. More than any of the other serious deficiencies in mental healthcare I have noted, this setting represents a serious and demonstrable risk of harm.

Restrictive Housing

The situation in these units was similar to that in the medical infirmary, except absent the regular rounds. In short, medications and crisis response were virtually all that was in evidence.

Psychotropic Medication

This is one relatively functional area of service although it still demonstrates some important deficits. Before proceeding, I wish to emphasize that I have no questions about the clinical values and caring attitude of two of the psychiatric prescribers who do the vast majority of the mental health treatment at EMCF and admire their effort. The two of them are simply not enough to provide services for the many seriously mentally ill at EMCF. Thus it is no surprise, as noted above, that there is a problem with access to psychiatric services. But once patients get access, prescriptions are generally reasonable based on the recorded diagnoses, though there are limited second generation antipsychotics and I saw only one patient on clozapine despite a good deal of poorly treated psychosis (clozapine is an antipsychotic known to be the most effective for treatment-resistant psychotic disorders and beneficial in reducing self-harm). Without prescribing data (which, as noted above, were not provided), I can only assume based on a number of records reviews that this is a problem area. When antipsychotics are indicated, they are generally provided, albeit with excessive prescription of haloperidol. The limited formulary deprives patients of ameliorative treatment, and the excessive use of haloperidol and many other older antipsychotics in common use at EMCF places the patients at risk of excessive adverse outcomes including tardive dyskinesia and other severe side effects. Modern psychiatry has moved away from the use of antipsychotics with a high propensity for these side effects owing to their severity and the negative impact of such side effects on adherence. These medications are less expensive than new agents, but there are now many reasonably priced newer antipsychotics (often referred to as “atypical” or “second generation” antipsychotics).

One clear problem with regard to medication availability is that the Centurion policy “Pharmaceutical Operations: Controlled Medications” excludes EMCF from having benzodiazepines. Given that EMCF is expected to house the mentally ill, this is entirely unreasonable. These medications are rapid-acting and low-risk, have injectable forms, and are the most effective at providing prompt reduction in agitation. They are critical for the treatment of acute agitation, especially when due to mental illness, and not having them available places patients, other inmates, and staff at risk. While it is reasonable to substantially limit long-term use of benzodiazepines (owing to their abuse and long-term addictive potential), an absolute bar is dangerous.

The Centurion policy “Psychotropic Medication” specifies that such medications “should not be the first treatment provided for patient reports of sleep problems. Sleep disturbance should initially be addressed through sleep hygiene counseling.” I saw no such counseling but saw many patients explicitly provided Benadryl and other medications for sleep. This is further demonstration of the lack of services outside of medications and crisis response.

Even more problematic was medication monitoring. While appropriate laboratory studies were occasionally done, appropriate monitoring was very spotty, with many patients lacking drug

levels, screening for metabolic syndrome (a routine part of care with those who are on second generation antipsychotics) and other common adverse reactions, and testing for tardive dyskinesia (routine testing with the Abnormal Involuntary Movement Scale is expected for all on antipsychotics). There were almost no instances where there was evidence of appropriate baseline laboratories and other studies (such as an EKG) being ordered prior to the inception of medication treatment. Examples of patients with inadequate laboratory monitoring were Patients 1, 2, 5, 8, 13, 16, 18, 31, and 32. Those with inadequate Abnormal Involuntary Movement Scale (AIMS) monitoring included Patients 1 and 38 (though others were not done timely, at least they were eventually done).

While the prescribing itself was generally reasonable based on the established diagnosis, the associated charting was almost always deficient. It lacked sufficient detail to be sure that the full range of potential psychopathology had been explored, which is the primary reason why the prescribing patterns cannot be fully affirmed as being reasonable. There was almost never evidence of a medication plan or target symptoms or any reason specified for a medication change. Mental status examinations were absent or minimal, especially in follow-up. Attention to side effects was variable as well. Though it was clear that side effect medications were being used, the justification of these medications was rarely included. Based on chart reviews, it appeared to be common practice to simply put patients on side effect medications regardless of an identified need in many cases, and commonly for patients treated with haloperidol. This is not accepted practice and puts patients at unnecessary risk as any medication has attendant risk. It was also clear that the liberal use of Benadryl was causing many problems related to misuse and diversion, making it apparent that these medications are prescribed in many cases in which they are not needed.

A related and serious problem is that even when laboratories were done and demonstrated abnormalities, these abnormalities were virtually never addressed in the medical record. This was especially true for lipid abnormalities indicative of metabolic syndrome (and associated with diabetes, heart disease, and other chronic illnesses) and abnormal blood counts, which can represent life-threatening reactions to certain medications, and therefore must be routinely monitored.

While, in general, psychotropic prescribing was a relative bright spot, there were also numerous problems in prescribing. This included lack of foundation for starting medications, inappropriate stopping of medications, starting medications at too high of a dose (inadequate titration), poor medication choice (e.g., not using first line, effective agents first or not changing when patients responded poorly), and not making changes based on side effects, laboratory abnormalities, or adverse reactions. Examples of patients with poor prescribing included Patients 1, 2, 6, 7, 10, 13, 16, 17, 18, 21, 28, and 38.

Reentry Services

The Centurion contract makes no mention of reentry services. The Centurion policy “Discharge Planning” specifies only that releasing patients are provided of a 30-day supply of release medications and appointments for medical or mental health follow-up. There is no mention of benefits, housing, or coordination of care. I saw no evidence of reentry planning in any record I reviewed. It is not that patients do not release from EMCF, but rather there is just no release planning, which should start well before release, generally at 6 months prior for those with substantial needs. This results in releasing patients in danger of harm by virtue of inadequate follow-up and lack of attention to housing and need for supports (monetary and otherwise) for those who are disabled, which includes many I reviewed at EMCF including at least Patients 4, 7, 8, 9, 13, 16, 17, 18, 21, 22, 23, 27, 28, 32, and 38. As their release dates are not in the medical record, it is difficult to determine which patients should have been getting release planning; in any case, none received any.

Record-Keeping

I spoke briefly to medical record charting with regard to psychotropic medication prescribing practices. While that charting was very limited and certainly would not meet the standard of care, the remainder of mental health charting was even more deficient. As noted elsewhere, a complete initial psychiatric or mental health assessment was almost never done. In order to initiate treatment, an initial assessment is necessary to generate an individualized treatment plan. An initial assessment should include a chief complaint, history of present illness, psychiatric history (including substance use), medical history, social history, family history, mental status examination, formulation or assessment, diagnosis, and an initial plan. The assessment then drives a formal treatment plan that is tailored to the needs of the patient. The treatment plans found in the EMCF records were almost all generic and almost identical, only in rare instances showing any individualization. The treatment plan, or notes in preparation for formulating a new treatment plan, should address progress or lack of progress in treatment. I saw no evidence of such notes except by psychiatric prescribers. This is perhaps not surprising, given that other mental health staff are not rendering any treatment.

It is also important to emphasize the inconsistent charting. Both within and between notes, there are gross inconsistencies. Within progress notes, clinician notes often report contradictory things such as noting a patient reports hallucinations in one part of the note and reporting that he denies hallucinations in another. Similarly, one clinician reports no evidence of psychosis and then another on the same day or otherwise within a short period of time reports the presence of psychosis.

Safe and effective care requires accurate and sufficiently complete charting to support and reflect sound clinical work and to communicate essential information to other clinicians. Though there are occasional good notes, clinician charting in general is substandard, inconsistent, and incomplete, and in the aggregate exposes prisoners with serious mental health needs at EMCF to

very serious threats of lasting injury and deterioration of their health, and in the cases of those struggling with the urge to harm themselves, poses a significant risk of death.

Suicide Prevention

I was not provided any summary data on self-harm at EMCF. Again, this is basic QA/QI data that should be routinely collected and analyzed in order to drive corrective action plans.

There is a very high rate of self-injurious behavior at EMCF. As noted above in the discussion of incident reports, even though many self-injurious episodes are clearly not captured by these reports, they still constitute a disproportionately large percentage of incidents, nearing 50%. Review of medical records, incident reports, and hospital transports also demonstrates a high degree of repetitive and often serious self-injury. In very few of these cases was any treatment targeted at the self-injurious behavior. Reports from inmates regarding the frequency and severity of self-injurious behavior only serve to reinforce this data.

It is important to clearly state that medications by themselves are not adequate to address such behavior in the vast majority of cases, essentially only when they eradicate psychotic symptoms driving self-injury (which is not a common cause of self-harm in this population) and when they effectively treat serious depression. Even if these medications will eventually prove effective, it typically takes weeks to months for them to sufficiently control symptoms. During the interim, only support services, therapy, careful proactive monitoring, and, when necessary, limitations on belongings and movement are effective at keeping patients safe. Further, behavior management plans for repeated self-injurious behavior were nonexistent, even though provided for by the Centurion policy "Behavior Management Plans." Moreover, the reliance on medications alone to control self-injurious behavior reflects a much larger failure of mental health care at EMCF because, across the range of mental health problems, there is almost no attempt to treat underlying conditions other than by rendering medications.

Suicide prevention requires attention to four primary domains: risk assessment, treatment of underlying conditions related to (potential) self-harm, connectedness to others, and means restriction. EMCF does poorly on all fronts. Mental health clinicians do not conduct adequate suicide risk assessments which must include, at a minimum, historical factors (e.g., past self-harm, psychiatric history, family history, trauma history), current stressors (e.g., interpersonal problems, loss of support, isolation, recent bad news), protective factors (e.g., social or family support, coping skills, treatment engagement), type of suicidal ideation (e.g. passive or active), degree of intent to commit suicide, and planning and preparation.

The Centurion policy "Suicide Prevention Program" enumerates a number of recognized risk factors and explicitly speaks to the need to assess both static risk (primarily historical factors) and dynamic risk (stressors, protective factors, underlying conditions, and means). In almost all cases, assessments amounted to documenting whether or not the patient expressed suicidal ideation and sometimes whether or not the person expressed suicidal intent. Occasionally, there

were comments on whether a patient would “contract for safety” and even formal signing of “No Harm Contracts,” a practice that has been determined to be ineffective. In short, impulsive patients are unable to make meaningful contracts, and suicidal patients and others intent on self-harm may agree to a contract in order to gain access to the opportunity to harm themselves. This practice has been abandoned by the field. A thorough suicide risk assessment that identifies risk factors and guides targeted limitations to property, restrictions on activity, and associated targets for treatment is necessary. Failing to complete such an assessment substantially increases the risk of harm, and this failure is evident in the profound degree of self-injurious behavior seen in EMCF. Examples of this included Patient 1 whose medical record notes that he contracted for safety and the following day was again expressing suicidal ideation and stating he would overdose. Examples of poor or absent suicide risk assessments included Patients 1, 2, 3, 4, 9, 10, and 27.

As is likely evident from all that has come before in this report, attention to connectedness is virtually nil. Clinicians clearly do not see their role as providing this kind of interpersonal support and connection to their patients.

Means restriction, which is about the only approach taken to prevent suicide other than medications, is done very poorly at EMCF. In my opinion, EMCF fails to take obvious measures, well-known throughout the field of mental health care, that are needed to protect patients from self-harm. Their failure to adequately restrict means even when ordered to do so amounts to reckless disregard for the welfare of those on watch status and means restrictions.

Patients needing special monitoring are supposed to be placed in the infirmary. However, I saw several instances in the records of clinicians not being able to place patients in infirmary beds, including Patients 10 and 36. There is reportedly an option for overflow in the intake area but mental health cannot place patients there themselves, as a clinician entry in the record of Patient 10 specifically stated, with the result that the patient was not placed immediately on watch. Further, the intake area is not appropriate for such monitoring. The cells do not have beds and there are no regular staff assigned there. The cells are also in a linear configuration with no cameras, making true observation impossible without placing a staff member in front of the cell, which was not in evidence in any of the records I reviewed.

Patients on suicide watch in the infirmary had orders for varying degrees of checks, primarily 15- and 30-minute checks. At the time of my visit, there was nobody on a one-to-one watch. Since these patients are essentially in isolation while in the infirmary (which, as noted under Facility Conditions, is run like a restrictive housing unit), NCCHC standards would expect them all to be under constant observation, which would not be satisfied by camera monitoring.

I asked to see the log of the checks. Custody staff conduct these checks and produced a logbook with dates and times of checks. Custody did not maintain individual logs for each patient on watch, which is accepted practice and of course necessary when patients are on different degrees

of watch. The log also did not document offering food or water, access to the toilet, level of activity, behavioral observations, or visits by clinicians, as appropriately mandated by policy. Custody staff reported that these were cell front checks rather than video checks. I looked at several days of the logbooks, and it was very clear that checks were not being done every 15 minutes. The logbook for 7/31/16 showed entries at 0803, 0841, 0920, 1023, 1104, 1202, 1240, and 323, 1352, 1420, 2304, 2332, and 2400. The logbook for 8/1/16 showed entries at 2434, 0100, 0200, 0230, 0300, 0400, 0500, 0600, and 0708. This pattern was representative of other days I examined in the log. Further, the Centurion policy “Mental Health Watch Procedures” mandates that documentation includes “[c]ompleted inmate activity or observation sheet forms documenting correctional officer monitoring filed in patient’s health record.” This is not being done.

There are three levels of watch status: level 1, level 2, and psychiatric observation. I was able to speak to one mental health clinician about the nature of each type of watch. While initially unclear about level 1, the ultimate report was that it was a one-to-one watch. Level 2 provided for 15-minute checks, a suicide blanket, a suicide smock, a suicide mattress, finger food only, and no utensils. Psychiatric observation consisted of 30-minute checks, normal clothing and bedding, and regular trays. With regard to the latter, Centurion policy actually states that when a patient is “placed on psychological/mental health observation, the patient will be provided with clothing and other personal property as determined by designated mental health staff member [sic] or psychiatric staff.” This provision for mental health to set conditions is essential. It is reasonable for the most restrictive conditions to be standardized; the provision for mental staff to set property when a patient is on “psychological/mental health observation” would allow for appropriate restoration of property and other materials in a stepwise manner to ensure that the patient can manage them, especially items that have been utilized for self-harm, before being taken off watch. This is simply not being done in this individualized manner. Note also that the infirmary has cameras directed into the cells with monitors in the central station that is always staffed. However, as noted previously, views into the cells were often blocked or hindered, including occupied cells.

I also note that the Centurion policy “Suicide Prevention” specifies three levels of watch that are consistent with the preceding: “constant observation” for those who are “[a]cutely suicidal (active) inmates” and “suicide precautions or psychological/mental health observation as determined by a designated mental health professional or psychiatric provider.”

The medical record of Patient 10 indicated that he had been on one-to-one watch, but I did not see formal logs detailing such an observation or other evidence of such a watch in the medical records.

The MDOC policy “Offender Segregation” specifies that custody “will ensure more frequent observations are conducted for suicidal offenders, mentally disordered offenders and offenders

who demonstrate unusual behavior.” The determination of frequency of monitoring, as well as conditions of confinement, should be determined by mental health staff on the basis of the suicide risk assessment. It is entirely unreasonable to give this responsibility to custody staff in any form. They are not experts in mental illness, let alone suicide risk assessment. This places inmates at unreasonable risk.

The Centurion policy “Mental Health Watch Procedures” appropriately mandates a daily evaluation of those on suicide watch. Rounds do not constitute an evaluation. An evaluation is designed to determine what level of watch a patient needs and what sorts of services are indicated. Only the psychiatric prescribers did anything like an evaluation, though these generally did not include a suicide risk assessment. The record demonstrates repeated instances when the mental health staff does not do even a limited evaluation during rounds because the patient is asleep. This is largely because rounds were done early in the morning when many patients, especially those on nightly medications, may struggle to awaken. It is reasonable to allow the patient to sleep but then the mental health staff must return later and conduct an evaluation. Patients on suicide watch who clearly did not get daily rounds while in the infirmary included Patients 27 and 38. Virtually none who stayed more than a few days received daily evaluations.

It also bears mentioning again that a number of patients spoke about themselves and others resorting to self-harm or other acting out behavior to get access to health services. This included Patients 1, 7, and 15.

A possible instance of this dynamic may be documented in one of the video clips I reviewed. The video associated with incident report DEF-031845 shows a great deal of blood in the cell of an inmate who had deeply cut his wrist. When the inmate arrived at the hospital, he was found to have several medical problems in addition to injuring a tendon and artery as a result of the self-harm. He had an elevated Dilantin level and ascites (fluid in the abdomen usually associated with liver disease and likely the reason that a liver biopsy was documented in the medical record). Most surprising, he had a right colon resection during this same hospitalization, though the discharge note does not say why. That such serious and obviously urgent medical problems were only discovered because this man seriously harmed himself is highly concerning. Whether this inmate harmed himself in order to get medical attention is unknown. Regardless, the evident inattention to his medical needs is astonishing.

Follow-up of those released from watch is also highly variable. I did not see evidence of a clear follow-up plan as dictated by the Centurion policy “Mental Health Watch Procedures.” Those released from watch should be seen within 72 hours to assure the crisis or associated mental health symptoms are continuing to resolve or at least the patient is stable enough to remain in the setting. Documentation of such an assessment was almost always lacking, even when the patient was seen timely.

The suicide of Patient 10 stands as a marker of the degree of deficiency in suicide prevention. This patient exhibited severe and recurrent self-injurious behavior. Despite being on watch in the infirmary for months, there was no evidence of active treatment other than medications. Charting demonstrates that clinicians viewed his behavior is primarily related to secondary gain, in essence using self-harm to control his environment. While this is at least likely part of the clinical picture, it does not diminish the fact that the patient was at elevated and well-known risk. Thus, the information available to staff begs for a careful suicide risk assessment and a thorough mental health assessment, neither of which was present in the medical record. Such assessment should have led to the development of appropriate behavioral and therapeutic interventions, which were also never done. Further, even medications were discontinued shortly before his suicide, because the prescriber believed it was “dangerous to continue [olanzapine] in the midst of reported substance abuse.” In fact, the standard of care is to treat symptoms of those who are using substances in circumstances such as this. In short, the care of this patient was grossly substandard in light of known serious risks.

On one occasion in the course of his repeated stays in the clinic, a note in the medical record reported that, “Officers state they could not find any shroud for the inmate.” It was fortunate that this did not result in any untoward outcome on this occasion, especially given his propensity to use a variety of materials to harm himself. This should never happen; EMCF must have sufficient and available suicide gowns.

Perhaps more concerning is the fact that Patient 10 was able to repeatedly harm himself, sometimes seriously, while on suicide monitoring and psychiatric observation in the infirmary. And, finally, he actually managed to kill himself while on psychiatric observation status in the clinic. The psychiatrist had discontinued the suicide precautions on 3/21/16, indicating that if the patient committed any self-harm in the following two weeks he was to be placed back on suicide precautions. What is more, on the day of his death by strangulation, an LMSW had noted that his mattress was “foam with no factory covering on it and asked client to explain. He reported that he did not like the covering and ‘my mattress is warmer without it.’ Provider asked about the covering and the client reported that he did not have it in his cell because ‘I gave it to the security officers.’” There is no evidence that this was addressed or that his claim of giving the materials to officers was verified. A few hours later, the LMSW returned and reported that the patient’s arm was hanging out of the cuff port, dripping blood. The note comments on how the patient reported that he was not suicidal. He was reportedly angry about being mistreated by security with regard to showering. Two hours later he was dead from a “string tied around his neck...”

This kind of repeated self-harm and actual death in the infirmary should not occur. It demonstrates a degree of lack of observation, failure to provide appropriate conditions of confinement, and lack of treatment that is inexplicable. It is important to restate that such problems were not confined to this case but were consistent with staff responses to other patients. I saw no evidence of good care of those in the infirmary for suicide watch and only occasional

instances of adequate basic care, and the latter were usually because the crisis was either readily resolved, for example by getting medications refilled or restarted, or self-limited.

This concludes my report.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Bruce C. Gage, M.D.", written in a cursive style.

Bruce C. Gage, M.D.

APPENDIX 1

DATABASE

I requested a broad array of information (see “Assessment of Mississippi Mental Health Prison” dated 5/2/16 attached as Appendix 2) but received only a small portion. While at the facility, I attempted to interview staff members but was told by defendant’s attorney that was not permissible. I was to confine my inquiries to leadership. This made it more difficult to determine whether staff knew and understood policy, adhered to policy, or had a grasp on the clinical issues with regard to the patients I met.

The following constitutes the database for this report.

1. Site visit 8/1/16 – 8/4/16
2. Agreement Between the State of Mississippi Department of Corrections (MDOC) and Centurion of Mississippi, LLC for Onsite Inmate Health services, dated 7/1/15
3. The following Centurion policies, procedures, and practice guidelines:
 - a. A-01 – Access to Care
 - b. A-01a – Copayment for Healthcare Services
 - c. A-02 – Responsible Health Authority
 - d. A-03 – Medical Autonomy
 - e. A-04 – Administrative Meetings and Reports
 - f. A-05 – Policies and Procedures
 - g. A-06 – Continuous Quality Improvement Program
 - h. A-07 – Emergency Response Plan
 - i. A-07b – Emergency Response Plan: Medical Supplies
 - j. A-07d – Emergency Response: Man Down
 - k. A-08 – Communication on Patients’ Health Needs
 - l. A-09 – Privacy of Care
 - m. A-10 – Procedure in the Event of an Inmate Death
 - n. A-11 – Grievance Mechanism for Health Complaints
 - o. B-02 – Patient Safety
 - p. B-02a – Medication Occurrence Reporting and Follow-Up
 - q. B-02b – Adverse Drug Reactions
 - r. B-03 – Staff Safety
 - s. B-04 – Federal Sexual Abuse Regulations
 - t. B-05 – Response to Sexual Abuse
 - u. C-01 – Credentials
 - v. C-01a – Job Descriptions
 - w. C-02 – Clinical Performance Enhancement
 - x. C-03 – Professional Development
 - y. C-04 – Health Training for Correctional Officers
 - z. C-05 – Medication Administration Training
 - aa. C-06 – Inmate Workers
 - bb. C-07 – Staffing
 - cc. C-07a – Volunteers and Students

- dd. C-08 – Healthcare Liaison
- ee. C-09 – Orientation for Health Staff
- ff. D-01 – Pharmaceutical Operations: Procurement, Storage, Disposal and Medication Management
- gg. D-01a – Pharmaceutical Operations: Controlled Medications
- hh. D-01b – Pharmaceutical Operations: Formulary, Non-Formulary Request, Quality Inspections and Monitoring
- ii. D-02 – Medication Services: Medication Orders
- jj. D-02a – Medication Services: Medication Administration
- kk. D-02b – Psychotropic Medication
- ll. D-02c – Monitoring Psychotropic Medication Compliance
- mm. D-02d – Psychotropic Medication and High Temperature/Sunlight
- nn. D-02e – Psychiatric Issues with Interferon Treatment for Hepatitis C
- oo. D-02f – Discontinuing Psychotropic Medication
- pp. D-02g – Crushing Medication
- qq. D-03 – Clinic Space, Equipment and Supplies
- rr. D-04 – Diagnostic Services
- ss. D-04 – Hospital and Specialty Care
- tt. E-01 – Information on Health Services
- uu. E-02 – Healthcare Receiving Screening
- vv. E-03 – Healthcare Transfer Screening
- ww. E-04 – Comprehensive Health Assessment
- xx. E-05 – Mental Health Screening and Evaluation
- yy. E-07 – Non-Emergency Health Care Requests and Services
- zz. E-07a – Staff Referrals for Healthcare Services
- aaa. E-08 – Emergency Healthcare Services
- bbb. E-09 – Segregated Inmates
- ccc. E-09a – Mental Health Consultation to Disciplinary Process
- ddd. E-10 – Patient Escort
- eee. E11 – Nursing Assessment Protocols and Guidelines
- fff. E-12 – Continuity and Coordination of Care During Incarceration
- ggg. E-12a – Telehealth Policies and Procedures
- hhh. E-13 – Discharge Planning
- iii. F-01 – Healthy Lifestyle Promotion
- jjj. F-02 – Medical Diets
- kkk. F-03 Use of Tobacco
- lll. G-01 – Chronic Disease Services
- mmm. G-02 – Patients with Special Health Needs
- nnn. G-03 – Infirmary Care
- ooo. G-04 – Basic Mental Health Services
- ppp. G-04a – Mental Health Crisis Intervention
- qqq. G-04b – Mental Health Watch Procedures
- rrr. G-04c – Mental Health Caseload: Admission and Discharge Criteria
- sss. G-04d – Outpatient Mental Health Services

- ttt. G-04e – Mental Health Group Treatment
 - uuu. G-04f – Mental Health Services for Patients with Neurodevelopmental Disorders
 - vvv. G-04g – Mental Health Services for Adolescents in Adult Institutions
 - www. G-04h – Behavior Management Plans
 - xxx. G-05 – Suicide Prevention Program
 - yyy. G-06 – Patients with Alcohol and Other Drug Problems
 - zzz. G-07 – Intoxication and Withdrawal
 - aaaa. H-01 – Health Record Format and Contents
 - bbbb. H-02 – Confidentiality of Health Records
 - cccc. H-02a – HIPAA Compliance
 - dddd. H-03 – Management of Health Records
 - eeee. H-04 – Access to Custody Information
 - fff. I-01 – Use of Therapeutic Restraint
 - gggg. I-01a – Healthcare Responsibilities Related to Security Restraints
 - hhhh. I-01b – Use of Therapeutic Seclusion in Correctional Facilities
 - iiii. I-02 – Emergency Psychotropic Medication
 - jjjj. I-03 – Forensic Information
 - kkkk. I-05 – Informed Consent and Right to Refuse
 - llll. I-05a – Hunger Strikes
 - mmmm. I-05b – Involuntary Psychotropic Medication: Administrative Review
 - nnnn. I-05c – Procedures for Appointment, Coordination and Termination of Healthcare Guardianship
4. The following Management and Training Corporation (MTC) policies were provided
 - a. 906.210 Grievance Mechanism for Health Care Complaints
 - b. R905.04 Emergency Plans
 - c. R905.10 Use of Restraints
 5. The following Mississippi Department of Corrections Policies and Procedures were provided:
 - a. Policy 20-08 Grievance Procedures
 - b. SOP 20-08-01 Grievance Procedures
 - c. SOP 19-01-03 Administrative Segregation Long-Term Status
 - d. SOP 19-02-01 Crisis Stabilization Program
 - e. Policy 17-04 Emergency Plans
 - f. SOP 19-01-01 Offender Segregation
 - g. Policy 16-13 Use of Force
 - h. Policy 16-23 Use of Oleoresin Capsicum Spray of Chemical Agents
 - i. Policy 16-15 Use of Restraints
 6. The following Centurion training materials:
 - a. Healthcare Screening/Intake Screening dated 1/14/14
 - b. Introduction to Corrections dated 1/14/14
 - c. Access to Healthcare dated 1/14/14
 7. Emails:
 - a. From Dennis Gregory to Gloria Perry, et al. dated 2/1/16 (and associated report by Dennis Gregory dated 1/30/16)

- b. From Tony Donald to Jerry Buscher, et al. dated 8/19/14
 - c. From Matthew Naidow to Norris Hogans, et al. dated 9/8/14
 - d. From Amy Hodgson to Renee Eubanks et al. dated 4/14/16 and to Gregory Dennis dated 4/27/16
 - e. From Brenda Delaine to Yolanda Odom, et al. dated 2/17/16
8. Correspondence from Patient 40 to Alesha Judkins dated 8/2/16 with three page attachment
9. Correspondence from inmates to Marshall Fisher, MDOC Commissioner and responses
 - a. Patient 40 dated 2/5/15, 2/18/15, 2/26/15
 - b. Patient 41 dated 1/25/15
10. Correspondence from inmates to Richard McCarty, Acting MDOC Commissioner
 - a. Patient 40 dated 11/26/14
11. Correspondence from inmates to Vernell Thomas, MDOC Contract Manager and responses from staff
 - a. Patient 42 dated 10/30/14
 - b. Patient 43 dated 9/16/14, 9/17/14
 - c. Patient 44 dated 9/1/14, 9/4/14
 - d. Patient 45 dated 9/11/14, 9/12/14
 - e. Patient 46 dated 9/14/14
 - f. Patient 47 dated 9/10/14
 - g. Patient 43 dated 9/12/14
 - h. Patient 48 dated 9/10/14
 - i. Patient 49 dated 9/11/14
 - j. Patient 50 dated 9/4/14 (addressed to T. Evans, contract monitor but responded to by Ms. Thomas)
 - k. Patient 51 dated 9/23/14
 - l. Patient 52 dated 10/12/14, 10/20/14, 11/2/14
 - m. Patient 53 dated 11/18/14
12. Correspondence from inmates to Ms. Naidow
 - a. Patient 44 dated 9/1/14
13. Training Format: MTC/EMCF Mental Health Counselors by Lakeasha Boyd, MHC; Carolyn Powe, MHC; Dr. Dennis Huggins, Jr., Director of Mental Health dated 7/3/14
14. Centurion employee list dated 2/16/16
15. Video recordings involving use of force and other sentinel events such as self-harm behavior. The file names of these videos are as follows:
16. Summary of grievances (administrative remedy program) from August 2013 to July 2014 (excludes February and April)
17. Review of incident reports from 7/1/15 – 2/29/16 (47 total)
18. Incident report (Unusual Occurrence Report), Incident Debriefing Form, and associated emails for 1/21/16, 1/29/16, and 2/29/16 self-harm episodes involving Patient 36, 1/28/16 self-harm episodes involving Patient 37, a 2/1/16 self-harm episode involving patient 10, a 2/2/16 self-harm episode involving Patient 38, and a 2/27/16 self-harm episode involving Patient 39
19. Review of January 2016 sick calls and chart review for mental health follow-up
20. Hospital admission logs from July 2015 through January 2016

21. Interviews and/or medical record reviews of 58 patients (and numerous additional brief inmate contacts and inspection of additional medical records)
22. Group interview of 14 patients on 4B
23. Report of Bart Abplanalp, Ph.D. dated 6/16/14
24. Report of Terry Kupers, M.D. dated 6/16/14
25. MTC Programs Listing for EMCF dated 8/25/16
26. Memo from D. Marshall entitled "Recreation Department Available Activities" dated 4/27/16
27. Memo from Coach Marshall regarding the schedule for inside recreation (gym call) and outside recreation dated April 2016
28. A report entitled "Recreation Department Special Event Report" from 3/16/16-3/31/16
29. A document that seems to be dated 8/17/16 that appears to list correctional staff terminations from 2014 and 2015
30. A document that seems to be dated 8/8/16 that appears to list correctional staff terminations from 2016
31. Undated document entitled Personnel Action Codes – KEY
32. MDOC Listing of Inmate Deaths in Custody of EMCF Offenders from 2014 to May 23, 2016
33. Memo from Cole Vest regarding the death of an offender dated 1/30/16
34. MDOC Death of Offender Report from J. Newbaker regarding family notification following a 1/30/16 inmate death
35. MTC checklist by Captain C. Vest dated 1/30/16
36. MDOC Incident Detail regarding a 1/30/16 inmate death dated 1/30/16
37. Email from Cole Vest regarding a 1/30/16 inmate death
38. MDOC Offender Data Sheet of the inmate who died 1/30/16
39. MTC Unusual Occurrence Report by Captain C. Vest regarding a 1/30/16 inmate death
40. Summary of Call Detail for Death of Inmate dated 1/30/16
41. Handwritten timeline of inmate death dated 1/30/16
42. MTC Log Book detailing times of events around the 1/30/16 inmate death
43. Email from Ollie Little regarding a 1/30/16 inmate death
44. Certificate of Death for an inmate who died 6/4/15
45. Memo from Norris Hogans regarding the death of an offender dated 6/5/15
46. Partial copy of policy 25-19-A "Death of an Inmate"
47. MTC checklist by Captain Donald dated 6/4/15
48. MDOC Incident Detail regarding a 6/4/15 inmate death dated 6/4/15
49. Email from Tony Donald regarding a 6/4/15 inmate death dated 6/4/15
50. MDOC Offender Data Sheet of the inmate who died 6/4/15
51. MTC Unusual Occurrence Report by Captain Donald regarding a 6/4/15 inmate death dated 6/5/15
52. EMCF Unusual Occurrence Report by Officer A. McGrew regarding a 6/4/15 inmate death dated 6/4/15
53. EMCF Unusual Occurrence Report by Officer M. Austin regarding a 6/4/15 inmate death dated 6/4/15
54. EMCF Unusual Occurrence Report by Bobbie Hunter, RN regarding a 6/4/15 inmate death dated 6/4/15

55. EMCF Unusual Occurrence Report by Kimberly Townsend, LPN regarding a 6/4/15 inmate death dated 6/4/15
56. EMCF Unusual Occurrence Report by S. Taylor, RN regarding a 6/4/15 inmate death dated 6/4/15
57. MTC Log Book detailing times of events around the 6/4/15 inmate death
58. MDOC Death of Offender Report from J. Newbaker regarding family notification following a 6/4/15 inmate death
59. Emails from Ollie Little and Norris Hogans regarding a 6/4/15 inmate death dated 6/4/15
60. EMCF Unusual Occurrence Report by C. Smith, RN regarding a 6/4/15 inmate death dated 6/4/15
61. Memo from Norris Hogans regarding a 4/29/15 inmate death
62. EMCF Incident Debriefing Form regarding a 4/29/15 inmate death dated 4/29/15
63. MTC checklist by Captain [illegible] dated 4/29/15
64. MDOC Offender Data Sheet of the inmate who died 4/29/15
65. Email from Christopher Dykes regarding a 4/29/15 inmate death dated 4/29/15
66. MDOC Incident Detail regarding a 4/29/15 inmate death dated 4/29/15
67. MTC Unusual Occurrence Report by Captain [illegible] regarding a 4/29/15 inmate death dated 4/29/15
68. MTC Unusual Occurrence Report by M. Anderson regarding a 4/29/15 inmate death dated 4/29/15
69. MTC Unusual Occurrence Report by Christopher Cook regarding a 4/29/15 inmate death dated 5/29/15
70. MTC Unusual Occurrence Report by [illegible] regarding a 4/29/15 inmate death dated 4/29/15
71. MTC Unusual Occurrence Report by M.W. Berry, III regarding a 4/29/15 inmate death dated 4/29/15
72. MTC Unusual Occurrence Report by Lisa Stevenson regarding a 4/29/15 inmate death dated 4/29/15
73. MTC Unusual Occurrence Report by T. Ford regarding a 4/29/15 inmate death dated 4/29/15 at 0550
74. MTC Unusual Occurrence Report by T. Ford regarding a 4/29/15 inmate death dated 4/29/15 at 0600
75. Inmate Injury Reporting Form regarding a 4/29/15 inmate death by Mims Berry, RN dated 4/29/15
76. Memo from Captain C. Dykes regarding the timeline of a 4/29/15 inmate death dated 4/29/15
77. MTC Log Book detailing times of events around the 4/29/15 inmate death
78. EMCF Unusual Occurrence Report by Officer P. Mosley regarding a 4/29/15 inmate death dated 4/29/15
79. MDOC Death of Offender Report by Chaplain Newbaker regarding a 4/29/15 inmate death dated 4/29/15
80. MDOC policy "Death of an Inmate"
81. MDOC policy "Responsibility for Notification of an Offender's Death"
82. MDOC Incident Detail regarding a 6/10/14 inmate death dated 6/10/14
83. MDOC Death of Offender Report by Chaplain Newbaker regarding a 6/10/14 inmate death dated 6/10/14

84. MDOC Death of Offender Report by Chaplain Newbaker regarding an 8/1/15 inmate death dated 8/1/15
85. A series of emails regarding an 8/1/15 inmate death from John Newbaker, Patrick Thomas, Ollie Little, Gloria Perry, Tony Compton, and Norris Hogans dated from 8/1/15 to 8/7/15
86. Mortality Review Worksheet dated 2/22/16 regarding Patient 55 who died at SMCI
87. MDOC Mortality/Morbidity Survey Report Form dated 2/20/16 regarding Patient 55 who died at SMCI
88. Text file with what appear to be minutes entitled “Centurion of Ms Mental Health Update Meeting” from 4/29/15
89. Email from Marina Moss dated 12/22/15 regarding “Mental Health Concerns Housing Unit 2B/2D”
90. Undated Health Assurance, LLC EMCF Mortality/Death Review regarding Patient 56
91. Boswell Pharmacy Services Pharmacy Policies and Procedures Manual, undated (does not include formulary)
92. Health Assurance, LLC Continuous Quality Improvement (CQI) Data Collection regarding EMCF from May and June 2015
93. Mortality Review Worksheet for Patient 57 dated 2/9/16
94. MDOC Mortality/Morbidity Survey Report Form dated 1/19/16 regarding Patient 58 who died at “MSP0002” [Note: This does not appear to be an EMCF inmate and is not listed among the EMCF deaths.]
95. MDOC Mortality/Morbidity Survey Report Form dated 4/7/16 regarding Patient 10 who was an EMCF inmate
96. Email (and embedded emails) from Vernell Thomas to Victoria Rivera dated 10/14/15
97. Spreadsheet of Centurion CQI data regarding EMCF from July 2015
98. Spreadsheet of Centurion CQI data regarding EMCF from August 2015
99. Untitled and undated documented with no ascribed author that appears to be a summary of July 2015 CQI data for EMCF sent as file CENT-DOCKERY-ELEC-003306
100. Peer review information from Centurion:
 - a. Email from Ollie Little to Sandy Adams regarding psychiatric peer reviews dated 3/10/16
 - b. Peer Review Verification from regarding Gail Williams, MD completed by Kim Nagel MD and dated 3/3/16
 - c. Email (and embedded previous emails dating back to 3/17/16) from Barbara Harris to Sandy Adams and phall@winstoncounty.org regarding peer reviews dated 3/22/16
 - d. Email from Sandy Adams to Ollie Little and Sandy Adams regarding Dr. Nagel Peer Reviews dated 3/10/16
101. Email correspondence regarding the Crisis Stabilization program
 - a. Email (and embedded previous emails dating back to 3/29/16) from Amy Hodgson to Cynthia Franklin, Chrystal Harvison, and Kimberly Allen dated 3/30/16
 - b. Email (and embedded previous emails dating back to 4/26/16) from Amy Hodgson to Cari Duff dated 4/27/16
 - c. Email from Cynthia Franklin to Chrystal Harvison and Sandy Adams dated 12/4/15

APPENDIX 2

PATIENT INTERVIEWS AND CLINICAL REVIEWS

Prior to beginning each interview, each person was told that the interview was voluntary and that our request to speak with them was in the context of a lawsuit, and the limits of confidentiality were explained. Each person gave permission to use the complete interview and none refused the interview. All were eager to speak and many asked to testify.

I conducted the interviews during my 8/1/16 – 8/4/16 visit to EMCF. Some chart reviews were conducted at that time, others afterwards.

While conducting the reviews, several things stood out. The difficulty of finding relevant information in the records was especially notable. The records were replete with repetitive information and notices of records that had been scanned into the record (rather than entered directly into the medical record); the scanned and electronic records were in different sections, making it difficult to follow the clinical course across time. Notes themselves were highly repetitive, often including exactly the same or very similar language both within and between patient records. The vast majority of notes by mental health staff consisted in cursory and unhelpful notes of rounds, which were themselves sporadic. Similarly, mental health treatment plans, when present (and many were not done every 90 days per policy and standard practice), were almost all generic and virtually identical in terms of the plan itself; there was some limited clinical information pertaining to the individual patients at the top of the plan, but not always. A representative sample is included at the end of this appendix. Throughout the following, I make reference to generic and/or boilerplate treatment plans; I am referring to this example.

There were also no complete psychiatric assessments or other form of comprehensive assessment. Not a single patient had any psychological testing done. Even assessments focused on danger to self or others were absent, despite recurrent problems of both types.

There was absolutely no evidence of any courses of individual psychotherapy, even brief courses. On rare occasions, mental health staff administered some supportive interventions at random times, generally in response to a crisis, most of which were done by the psychiatric prescribers rather than the far more numerous mental health staff (primarily counselors and social workers). Mostly, these mental health staff responded to sick calls with brief reports of events but not any sort of evaluation of the patient or intervention and then merely referred the patient to the few psychiatric prescribers. This amounts to observation and referral, a function that could be done by custody and does not require any clinical skills; in short, these mental health staff were serving no meaningful clinical function.

Very few patients attended any groups and those few who did were in very few sessions. What groups there were often were not targeted at the seriously mentally ill, including some not intended for the mentally ill (which is reasonable, as long as the patient is ready for such a group). There was so little evidence of any structured activities, rehabilitative services, or habilitative services that these basic, essential mental health services are essentially absent.

Non-adherence to medications was a common problem but nurses never reported this to prescribers and the medication administration records (MAR) generally indicated full compliance; even this repeated non-adherence was never targeted with formal treatment interventions.

Notes commonly contradicted each other both within notes and between notes by different clinicians that were so close together in time that the substantially different findings would be virtually clinically impossible or would represent so dramatic a change as to call for an urgent response, which did not occur.

Patient 1

This patient was in the infirmary on watch when I privately interviewed him on 8/1/16. He began the interview by telling me that he was transferred to EMCF on 3/7/14 and the following day had set a fire in his cell, reportedly in a suicide attempt. As he put it, “I was fine until the door shut behind me.”

At the present time, he reported being on a watch because he “just recently lost [his] daughter” whom he had not seen for five years, hearing of her death a week and a half prior to our interview. He spoke of other losses, including a son who died at 6 months of age. He described going “into deep depression” and how he went “through a lot of flashbacks in [his] life.”

When I asked if he had requested help, he replied, “Mental health can only help if the officers call. They don’t want to do anything – it’s tray flaps and feeding for them. There’s no security checks – somebody could be hanging and they wouldn’t know.” When asked if he tried sending a medical request form, he replied, “Yes, you can try that but you never know what will happen to that. If mental health gets it, they respond.” He also talked about how there are often no envelopes available to allow the form to be confidentially submitted.

During the interview, he also reported that he had come from Unit 5 where he had no light in his cell. He had broken the light but stated the officers would not give him a new one. He then added, “You can only get attention by acting out. When you try to come like a normal person, they just brush you off.”

When asked about his fire setting he noted, “Half the time they put the fire out and just walk off. A number of times I’ve been sprayed through the flap when I won’t close the flap. They don’t put that solution in your eyes [to relieve the pain from oleoresin capsicum and similar sprays]. Mostly, they don’t even bring you to medical.” He also talked about a lieutenant trying to choke him; he had several abrasions related to cuffs and, by his report, takedowns.

In general, he felt that mental health staff treated him well but also noted that he was “supposed to get a one-to-one evaluation every week but that doesn’t always happen – they have hundreds of inmates and other things. If they don’t come, I just send another request.” He also reported that mental health met with him primarily at cell front and that custody often refused to take him out for mental health meetings, which was “especially a problem if I have said something or acted out....”

This man reported a history of mental health treatment beginning in childhood. He had a history of childhood trauma (abuse and having weapons pointed at him), Attention Deficit Hyperactivity Disorder (ADHD) treated with Ritalin, hospitalizations, and day treatment. He also reported a history of cocaine and opiate analgesic abuse.

He reported that lithium (a mood stabilizer) and olanzapine (an antipsychotic) were started the day of our interview for “mood swings and voices.” He reported auditory hallucinations of his son, daughter, grandmother, and the devil. He also reported nightmares of past traumas which he noted medications had not helped. He reported that the practitioner discussed the risks and benefits of medications with him.

I conducted a review of his medical record that revealed the following:

He carried a diagnosis of Bipolar Affective Disorder, most recent episode manic, severe, with psychosis and nicotine dependence. He had carried the bipolar diagnosis for some time. The record demonstrated that he had been treated with olanzapine starting in March 2015 but had been on no medications from June 2015 through September 2015. Lithium had been started the day of our interview. In the past he had been treated with the antidepressants fluoxetine and mirtazapine; the antipsychotics risperidone, trifluoperazine, and haloperidol; the side effect and sedating medication diphenhydramine; and the mood stabilizer Depakote (which had been used prior to trying lithium).

Despite being on the above medications, there were no renal function studies since February 2014, no valproic acid level (for monitoring Depakote), and no Abnormal Involuntary Movement Scale (AIMS) (done to assess for a serious and potentially permanent movement disorder that is caused by antipsychotic medications) or metabolic studies (for monitoring the side effects of antipsychotics). The record stated that lab draws were cancelled multiple times due to lack of security escort, but there is no evidence such studies were ordered.

The available records included a very limited assessment. There was some question about the veracity of his complaint of psychotic symptoms, which were consistent with those he reported to me and across time in the record, but there was no psychological testing or evidence of any effort to clarify the diagnosis.

He was seen by a psychiatric nurse practitioner (PNP) on 3/7/16, who noted his chaotic upbringing and substance abuse, but he nonetheless had a very limited mental health history. The limited mental status examination was essentially unremarkable except that he reported hallucinations and “mood disturbances.” The plan at that time was to stop trifluoperazine, an antipsychotic, and start the antidepressant mirtazapine and the antipsychotic risperidone. The note indicated discussion of medications and consent.

That same day, he signed a no harm agreement with mental health staff, a practice that has been discarded by the field as ineffective. The following day, 3/8/16, the PNP indicated that he “is saying he is suicidal...hearing voices...has some pills...threatening to take some pills.” He also reported numerous psychotic symptoms, including saying, “I am the devil.” He reported the

devil telling him to harm himself. The PNP noted he is “organized and coherent” but “withdrawn and guarded.” The plan was to stop oral medications and give intramuscular haloperidol, though the note also indicated that he stated he did not like needles. The note stated that the “risks/benefits of the medications discussed.” However, there was no evidence of consent in the record or foundation for emergency medication including no report of agitation. There was no evidence that he was offered oral medications. He was placed in the infirmary on suicide precautions where he remained for a short time.

The PNP next saw him on 5/27/16. Custody referred him due to expressing thoughts of harming himself and others. He was having a conflict with the unit manager and had been found to have shanks. He was “irritable” with delusions of “persecution” and reported auditory and visual hallucinations. He showed manic symptoms as well and the diagnosis was a manic psychosis. The plan was to return to the clinic for follow-up in 1 to 2 weeks but he remained on no medications.

He was later released from the infirmary, and there were notes regarding rounds in segregated housing on 6/3/16, 6/6/16, 6/13/16, and 6/21/16. None had a mental status examination but noted him to be awake, alert, and calm and to have a clean cell, thus providing no foundation for an assessment of his mental condition while in segregation.

On 6/7/16 he saw a licensed social worker (LSW) and described “[d]reams about snakes and seeing his dead grandmother.” The LSW wrote, “Client was inform [sic] to use his self coping skill [sic] that we had taught in his counseling.” He denied hallucinations and thoughts of harming himself or others. He was not taking medication; the plan was to see him as needed and if needed, refer him to the PNP.

He made a 6/13/16 sick call request, asking for “some help” and saying, “I’m not gone [sic] tell you what I’m going to do but know this my blood will be on your hands.” He was seen by a nurse on 6/14/16 and referred to psychiatry, though there was no evidence that his concerning statement was evaluated for a possible emergent problem or to evaluate the risk he presented.

The LSW saw him the following day. He was “[a]nxious and agitated...hearing voices and and [sic] seeing [sic] snakes in his dream client [sic] also said he has been seeing [sic] blood.” He denied suicidal and homicidal ideation but wanted medication. The plan was to “monitor as needed.” However, the PNP saw him that day. He expressed thoughts of harming himself and others. He showed “[e]scalating agitation...” and is “severely agitated/hostile. He continues agitated due to recently placed [sic] on ad-segregation combined with RVRs. He talks of killing others or making somebody kill him.” They discussed medication and his history of non-compliance. The plan was to start Depakote. The note also stated, “He is seeing the MHP staff for 1:1 counseling sessions to target anger/issues.” However, the record does not demonstrate ongoing counseling. The mental status examination was consistent with the above but there were no psychotic symptoms reported, though the note says delusions were “denied.” (Delusions, by definition, cannot be denied by a patient experiencing them; it is the nature of delusions that the sufferer is unaware that they are delusional.) The PNP ordered the Depakote

to start at 1,000 mg twice a day with no titration. This is not appropriate; this medication should be started slowly and gradually increased to avoid side effects and adverse reactions.

On 6/21/16 he made a sick call request for one-to-one counseling and was seen the following day. The note reported, “Client stated he was taking his medication however he stated he was not taking it the way he suppose to [sic] due to the fact he was affaird [sic] the way it made him feel.” He was told to take medications correctly and the patient indicated he was to be called to medical for a Depakote level, for which there was no evidence in the chart except the indication that laboratories had been cancelled due to lack of escorts. The mental status examination was all negative except that his speech was “Loud.”

This patient had clear mental health problems but of a poorly defined nature. Without a proper assessment, it is not possible to render appropriate treatment. There was no suicide risk assessment, no assessment of his danger to others, and no plan for ongoing counseling to address his problems with self-management and recurrent behavioral problems. With this degree of problems, it is likely that both individual and group work would be necessary. The former would be necessary to address the underlying personal issues and to help him develop sufficient motivation to benefit from groups. The latter would be primarily to support skill development and other coping strategies.

Had the patient received adequate assessment and treatment, his recurrent behavioral problems would likely have been reduced or eliminated, with a corresponding reduction in his risk to himself and others.

Patient 2

This patient was in the infirmary on watch when I privately interviewed him on 8/1/16. He had been there since 7/19/16 and had a history of being on and off suicide watch for 11 years. He reported auditory hallucinations of evil spirits telling him to kill himself and to hang himself. He told me that life was not worth living and he had “nothing to live for” and that he was “not worth anything.” He reported that medications had not been helpful and that he wanted to “get away from the facility – maybe get some help.” He spoke about being on a “Haldol shot” that was some help but that his current lithium made his hallucinations worse; he wanted to be back on the Haldol (the antipsychotic haloperidol).

He reported hallucinations, which he believes to be demons, starting at about 16 or 17 years of age. This obviously mentally ill man reported symptoms consistent with schizophrenia, including true hallucinations.

He told me that his medications came reliably.

Review of his medical record revealed the following:

At the time of my visit, he was ordered olanzapine 10 mg nightly (an antipsychotic) and lithium carbonate 600 mg nightly (a mood stabilizer). In the past he had been on haloperidol (having received numerous intramuscular injections historically) with an as-needed injection last ordered from June 2015 through August 2015. The last injection was 9/22/15 (while at CMCF). He had been on olanzapine previously from 9/21/15-11/24/15 and then put back on haloperidol decanoate (long-acting antipsychotic injection) from 11/24/15-4/30/16. He had been on mirtazapine from January 2016 to April 2016. The current olanzapine and lithium were started 7/11/16.

Laboratory studies showed no renal function studies for years and no metabolic studies. There was no lithium level in the record and no evidence of this test being ordered.

Review of the last year of treatment demonstrated concern with the patient's requests for intramuscular injections of haloperidol. During the summer of 2015, the psychiatrist eliminated the diphenhydramine injection that routinely accompanied the haloperidol injection and reported that diminished the behavior.

Notes by mental health staff documented that he was uninvolved in programming and had no formal treatment other than medications.

A 9/14/15 Mental Health Treatment Plan by a licensed clinical social worker (LCSW) showed a diagnosis of Depressive Disorder NOS (not otherwise specified) and Psychotic Disorder NOS. The patient reportedly stated he had no hallucinations. He was "depressed...lack [sic] initiative." There was very little clinical content. The Objectives/Goals were generic: "Symptom reduction or maintenance, Develop or improve coping skills, Increase adaptation to correctional environment, Improve social skills." The physician was to "monitor frequency, medication, progress toward treatment goals [sic]...[e]very 30, 60, or 90 days."

On 9/18/15, a global consent was entered into the record. It stated, "I hereby give consent to the [MDOC] Contracted Medical Vendor, its employees and agents to perform any diagnostic laboratory procedures; examinations, including tele-health; mental health; x-rays; oral or injected medications; or other procedures recommended by the physician treating me." It further stated, "I understand I may withdraw this consent to any specific treatment by refusing the treatment or test." It included a statement about no guarantee of outcome and of transferring medical records. This form of global consent is not adequate for psychotropic medications and any invasive procedures.

He was transferred to CMCF on 9/18/15 where he was placed on suicide precautions on 9/21/16, diagnosed with schizophrenia, and started on olanzapine and haloperidol decanoate (both antipsychotics). He was transferred back to EMCF on 11/20/15 and intakes were done per policy but were limited in scope. There was another generic treatment plan entered into the record that day. He reported fears of there being "a hit" on him. He was prescribed olanzapine, sertraline (an antidepressant), and diphenhydramine (likely for side effects and/or as a sleep aid).

On 11/24/15, a PNP noted a mental health history dating back to seventh grade and a history of numerous suicide attempts. He also had problems with alcohol, cocaine, and marijuana but denied any childhood abuse. The mental status examination was reportedly normal except for reduced sleep. His medications were changed back to haloperidol decanoate and diphenhydramine, reportedly at the patient's request. An AIMS was done which was scored as 0.

He was sent to disciplinary housing on 11/30/15 where he had a nurse screening. A mental health clinician did rounds on 12/1/15, and noted no "agitation or distress" and that "he did not report any suicidal/homicidal ideations or psychosis at the time." He began to refuse the haloperidol injections at the end of December 2015.

He was next seen by a PNP on 1/12/16 following statements of suicidality but at the visit said that he just wanted to be seen because of side effects including drooling, tremors, and poor sleep. The PNP started mirtazapine 30 mg (with no titration, which is an improper starting dose) with a plan to follow up in three weeks.

A 1/13/16 treatment plan included much of the same generic language but did have the specific provision to "maintain a journal to track aud[itory] hallucinations & determine triggers." However, there was no documentation that this was ever done or that mental health staff followed up on it with the patient.

He saw the PNP again on 1/14/16 following expressions of suicidal ideation. He was "tired of doing time." "Staff reports that he cut himself today." He had "two superficial scratched areas." The plan was to give haloperidol 10 mg and increase haloperidol decanoate to 125 mg. However, the mental status examination was normal except he was "anxious" though it also reported he was "calm" and had "depressed mood."

Thereafter, the record reflected frequent suicidal statements and attempts to secure contact with staff and to get Benadryl (diphenhydramine). He was very needy and was in the infirmary off and on for suicide monitoring.

On 7/30/16 he was seen by the psychiatrist who noted, "Patient is using complaints of mental illness frequently to get admitted to the infirmary or to get injections of Haldol and Benadryl." The note indicated this was "almost every day." The Benadryl injection was discontinued but not the haloperidol decanoate; the note indicated possible Benadryl abuse. The accompanying mental status examination was completely normal – including denial of hallucinations.

There was no evidence of any individual or group treatment to address the identified problems and behaviors, including his repeated requests for injections and his repeated suicidal threats and self-injury. It would be necessary to work with him individually to sufficiently understand the motivation for his behavior in order to develop an appropriate treatment plan. Then it might be possible to use a combination of groups and individual therapy to help reduce these behaviors.

However, there were only unstructured responses to crises and to the patient's requests to be seen. There was no evidence of a suicide risk assessment, an important part of determining what kinds of responses would be necessary to keep him safe without imposing unneeded restrictions.

Had the patient received adequate assessment and treatment, his recurrent behavioral problems would likely have been reduced or eliminated, with a corresponding reduction in his risk to himself, including the risks associated with repeated injections, many of which were unneeded.

Patient 3

This patient arrived at EMCF on 7/15/16 after he suffered an alleged sexual assault at the hands of another inmate at a different MDOC facility. He was placed in the infirmary on watch at the time of admission and remained there when I interviewed him on 8/1/16.

This man reported that he wanted to be in the infirmary owing to fears of retaliation related to his reporting the sexual assault. He expressed concerns about organized gang retaliation. These concerns may be valid but may also be delusional or magnified by paranoia. There is no evidence that this has been addressed. When asked about treatment following the alleged assault, he reported being on mirtazapine (an antidepressant), which he reported was to help with sleep. When asked about counseling, he replied, "She comes by five days a week and asks if I'm OK and if there is anything I want to talk about. I discussed some things with her and she said I have an anger issue. And to me, it's more like I can't get no help."

He also wanted to convey his concerns about another patient (Patient 9, who is the subject of a chart review – the patient would not speak to me, likely owing to severe symptoms of mental illness). He expressed his concerns as follows: "They're torturing the guy in the cell next to me. They're putting Haldol in his food because he won't take it. They slide his food under the door on the floor. They refer to him as an animal." When asked if the staff were ever going into the cell he replied, "No, they're not going in. He hasn't had a shower in two weeks. They won't let him out. He grabbed an officer and slammed him to the ground so they're scared of him and punishing him. He's on suicide watch and he has a sheet." He also reported that the obvious evidence of fire on the window of this other patient's cell was from a fire set by the previous occupant.

Medical record review revealed the following:

This patient had a history of being treated with risperidone (an antipsychotic), bupropion (an antidepressant), carbamazepine (a mood stabilizer), and trifluoperazine (an antipsychotic) in 2011 and before. He had been started on mirtazapine on 6/23/16 but was on no other medications.

Records included an intake by an LSW at EMCF during which the patient exhibited "agitated behavior and his mood affect [sic] was depressed and anxious." He also expressed fear of being hurt "on the zone." He denied suicidal ideation but was placed on "psychiatric observation" and

moved to “sheltered housing” in the infirmary. The same LSW wrote a more complete note on 7/18/16 that reported the patient was “paranoid about why he was here and where he was going to be housed. Client informed MHP that he had been rape [sic] by his cellmate who is a gangster and he was affaird [sic] for his life due the fact [sic] the gansters [sic] are well informed that he told security and medical of the rape.” The LSW saw him initially on “unit one – B”. He was reportedly not doing well and stated “he had already been approached by several gansters [sic] regarding the rape and he felt unsafe.” He was thus sent to the infirmary for observation. There was no assessment of his need for treatment related to the reported rape.

On that same date there was a note from a master’s social worker (MSW). The patient expressed similar fears of retaliation and offered, “I’m 100% man, I’m not gay or bi or anything like that. This has really done something to me with how I feel as a man. I just real bad [sic], I feel like I’m not shit...and this is the first time I’ve talked to anybody about it since everything happened.” The patient reported no help from medications. He again denied suicidal ideation but there is no suicide risk assessment beyond asking about ideation, despite substantial risk factors being present. The plan was, “Client was advised that he would be able to get counseling once placed on a unit and assigned to a specific counselor.” There was no other plan other than to monitor him and refer him to a psychiatric prescriber. Why he could not receive counseling in the infirmary was not explained.

That same day he was seen by a psychiatrist whom he told that he wanted to stop medications. The psychiatrist noted, “[Patient] is fairly regressed at present and acting somewhat child-like. He appears very different than he was at Wilkinson when I saw him for a good amount of time on 3 different occasions. The rape has taken a toll, but he certainly is afraid of a whole new set of threats now at EMCF.” Mental status examination showed he was “sad;” had “poor” judgment; exhibited depressed mood; and had poor concentration, sleep disturbance, irritability, and flight of ideas. The plan was to stop medications and follow up “in a few weeks.” However, the patient’s mirtazapine was decreased to 15 mg on 7/19/16, not discontinued.

Subsequently, he had regular check-ins during rounds but there was no evidence of any treatment other than medications. A 7/20/16 note showed him to be jumping from topic to topic: “work on myself...Judge told me he’d throw me away if I came back...anger...drug and alcohol problem...I don’t think that medicine is good for anybody...I hear them shoot another guy up last night and he was crying and begging for them to not...I think doctors and psychiatrists talk and don’t listen a lot...how old are you? I need to know if I’m working with a grown person or a child.” This was noted in the assessment which also noted that he said he knows psychology and about “messing with minds.”

A 7/21/16 MSW note showed that someone had given him some sort of book about anger as the patient stated, “I looked over that anger book you gave me, it’s a bunch of psychological mind shit...but there are some things I can use out of it...” The MSW’s plan was to monitor him.

On 7/25/16 a registered nurse (RN) reported that the patient stated, “They putting [sic] psych meds in my food.” He was “shouting at officers,” “agitated,” and “hostile.” Then the following

day, an MSW note indicated that the patient reported “feeling well today and presented in good mood.” There was no mention of the previous behavior. The plan again was to monitor.

On 8/1/16, the day I interviewed him, he was seen by a PNP. The patient was still fearful but did not want protective custody (reportedly not available at EMCF anyway). He instead wanted transfer to unit 3-C. The note documented discussion of substance use but not the rape, his paranoia, or the other behavioral problems noted above.

The notes from late July and his presentation with me suggested that he might be getting psychotic. This was not properly assessed despite clear foundation for concern. What is more problematic is that this man received no treatment, despite having asked for it, regarding the recent rape, which was seriously troubling him. He was clearly distressed and functioning at a much lower level than his baseline. There is no reason that treatment needed to be delayed until after being out of the infirmary, especially since he was placed there for his own protection. The fact that he had to be placed in the infirmary for his protection is also a serious indictment of the ability of custody to provide a safe environment. His other reports were also very concerning about facility conditions and conditions in the infirmary specifically. His reports regarding Haldol administration in food or the way staff were treating other mentally ill represent egregious rights violations and possible criminality, not to mention a degree of brutality that places inmates at risk of harm.

Failure to provide treatment prolonged this man’s suffering and left him at risk of suicide; as noted, he had substantial risk factors for suicide.

Patient 4

This patient estimated he had been in the infirmary for one to two weeks and reported he was slated to return to unit 3-B the day I interviewed him, 8/1/16. He demonstrated overt psychosis; his presentation was consistent with schizophrenia. This included thought disorder, responding to internal stimuli, and delusions. He reported auditory hallucinations of family members, which he took to be “a miracle.” He had an obvious tremor as well. While he could not say what his medications were for, he agreed he needed them and offered that if he asked about what the medications were for, his clinicians would tell him. He reported being on haloperidol decanoate (a long-acting antipsychotic) for “about three years” and that he had discussed a different medication to address his tremor, which he reported was “another shot.”

He reported being in the infirmary because of hearing voices and for getting into a fight on his previous unit, 3-A. When on the unit, he noted that he would meet with mental health staff “once in a while” but reported that there were no groups and no individual counseling. He spent most of his time sleeping. He reported getting to the yard about three days per week where inmates might play basketball but where there were no structured activities.

Medical record review revealed the following:

At the time I interviewed him, he was ordered benztropine 1 mg twice daily (for side effects), haloperidol decanoate 150 mg every 14 days (a long-acting antipsychotic), divalproex sodium 1000 mg twice daily (a mood stabilizer), and propranolol 20 mg twice daily (an antihypertensive sometimes used to treat side effects). He had been on sertraline (an antidepressant) from November 2015 to March 2016 and risperidone (an antipsychotic) from December 2016 to March 2016. The haloperidol decanoate was started while he was still on risperidone. He also received intramuscular injections of short-acting haloperidol (used in emergencies) on 12/2/15, 2/15/16, 3/6/16, 3/7/16, 3/12/16, and 3/31/16.

Laboratory studies demonstrated a valproic acid level of 70.8, normal complete blood count, and normal liver function tests on 5/12/16. These are appropriate tests for monitoring divalproex sodium. There were no tests for metabolic syndrome in the record. An AIMS was done 11/22/15.

At admission intake screening on 11/9/15, he reported that he was taking psychotropic medication, had a history of a past suicide attempt in September 2015, and that he had medical and mental health needs. The formal mental health intake was limited in scope but notable for anxiety, recent loss, a psychiatric history, previous suicide attempt (he denied current suicidal ideation per this entry), being on psychotropic medication (divalproex sodium, risperidone, and benztropine), a diagnosis of chronic paranoid schizophrenia, 6-7 psychiatric hospitalizations, outpatient psychiatric treatment, chemical dependency treatment, a history of violence, limited cognitive abilities (though a twelfth-grade education), and a history of traumatic brain injury and seizures.

On 11/11/15 there was a more complete assessment (yet still not a full assessment) by a PNP that included a basic history of present illness, which finally reported that he had tried to hang himself in response to auditory hallucinations two and a half months previously. He denied current thoughts of harm. He complained of tremor. Mental status examination was notable for paranoia, depressed mood, decreased interest, psychomotor disturbance (but it does not say of what nature), and auditory hallucinations. The clinician did not find evidence of delusions. Diagnoses include cocaine and alcohol abuse, depressive disorder NOS (not otherwise specified), and chronic paranoid schizophrenia. The plan was to medicate with the antidepressant sertraline 50 mg nightly (with no titration), the antipsychotic risperidone 4 mg nightly (with no titration), and the side effect medication benztropine 1 mg nightly. No reason was given for not continuing the divalproex sodium, a mood stabilizer.

On 11/15/16 he was placed on observation status after reportedly seeing a “woman on the wall and a gun” and reporting “I hear the voices in my head saying about the woman someone will kill, and [people] talking all the time about killing and shooting on the wall in there.”

He was transferred to EMCF on 3/21/16 where he remained except for being at CMCF from 6/1/16 to 7/12/16.

On 3/22/16 he was seen by a PNP who left a brief note. The patient complained of auditory hallucinations of voices of family members. The limited mental status examination was notable for his mood being “up and down” but yet having “appropriate” affect. The PNP started him on haloperidol decanoate 100 mg every 4 weeks but gave no reason for the change, though the note stated that the risks and benefits were discussed with him; there was no formal consent.

On 3/30/16 he was referred for mental health evaluation, presumably by custody. He was “very agitated and belligerent, with constant flight of idea’s [sic]. Patient states he see’s [sic] and hear’s [sic] thing’s [sic]...He states ‘I shot my own mother’. Patient thought’ [sic] are irrational at this time with rambling thoughts.” He also presented with a variety of other delusions and evidence of thought disorder. The response was to place him in a new cell. No reason was given for this intervention. There was no plan for any additional clinical intervention, despite his obvious and severe symptoms.

A psychiatrist saw him the following day. The patient reported much the same as noted in the previous paragraph, including his believing that he had killed somebody. He “is loud and disruptive and took off all his clothes and was masturbating of [sic] the unit. He says he quit his meds and has used spice in the last week. He needs to be held in the infirmary till [sic] he settles down.” The psychiatrist charted that the patient “denied” delusions and hallucinations. (Again, it makes no clinical sense to report that delusions were “denied.” This problem appeared repeatedly in the records but I will not note every subsequent instance.). The patient’s thought was reportedly “coherent.” The psychiatrist noted symptoms of mania. The diagnoses were Bipolar I, most recent manic, severe, with psychosis; cocaine abuse; alcohol abuse; depressive disorder NOS; and chronic paranoid schizophrenia. (Note: Some of these diagnoses are mutually exclusive, e.g., Bipolar Disorder and schizophrenia and Bipolar Disorder and Depressive Disorder NOS. This problem was also noted repeatedly in the records but I will not go on noting it.) The psychiatrist ordered an intramuscular injection of haloperidol that day.

He reportedly improved over the next few days. On 4/4/16, a different PNP saw him and did not change the diagnoses. The patient reported, “I’m feeling a lot better and I’m ready to go back to my unit. I’m not suicidal or feeling so upset.” The PNP doubted he was adherent to risperidone, speculating “there may have been side effect concerns that inhibited his compliance” and despite concerns about adherence (without which clinical response would, of course, be expected to be poor), went on to offer that “he responds better to Haldol.” He was returned to his unit that day.

The following day he wrote on a Medical Services Request Form: “I hear voices. I need some medication for hearing voices.” The reviewing LMSW declined to refer him to psychiatry as he had been seen recently and had follow-up with psychiatry planned in one month.

A different PNP saw him on 5/9/16; the diagnoses were unchanged. He had been placed on observation status, again reported having smoked spice, and had also gotten into a fight. His mood was elevated, his speech was “pressured and rambling,” and he exhibited “elevated/hyped” affect and “loose” associations. He denied hallucinations and reportedly “denied” delusions. The chart indicated he had no suicidal or homicidal ideation. The PNP ordered haloperidol

decanoate increased to 150 mg every 14 days to start on 5/16/16. No reason or treatment goal was offered.

He was not seen again at EMCF until after his return on 7/12/16 when he had the intake package completed; it appeared to be accurate. The divalproex sodium that had been stopped at EMCF for no clear reason was restarted at CMCF.

Yet another different PNP saw him on 7/14/16, reportedly at his request while the PNP was on the unit. He complained of tremor and paranoia but reported no hallucinations “since the medicine,” but it is not clear which medication he is referring to. The PNP added propranolol 20 mg twice daily, most likely for tremors, though this was not stated. The note also indicated consideration of a change to the antipsychotic olanzapine. On 7/21/16 the same PNP saw him and his tremors were “much better.” The PNP also wrote, “Alternative treatment plan discussed and offered.” The note did not make it clear whether this was a reference to the olanzapine or something else.

A PNP who had seen him months previously assessed him on 7/25/16. He “reported not doing too good. He reported hearing voices, his meds not working to help clear his mind. He reported he might hurt his roommate if he continue [sic] to snore loudly at night. ... He also reported being off his meds for 2 weeks and he started taking them 4 days ago. His sleep was not too good.” The patient also reported “that he choked his roommate last night until he told him to stop. He planned to choke him tonight if he continue [sic] to snore loudly.” The mental status examination showed: “mood miserable, affect little anxious [sic], [positive auditory hallucinations], hears voices that say to hurt self by choking himself with a sheet. No command to hurt others. No suicidal ideation. He denied that he wanted to harm himself, but reported want[ing] to stop his roommate from snoring loudly in the room. [Positive homicidal ideation], he discussed he might choke him during the night.” He endorsed paranoia and the PNP noted the presence of paranoid delusions. The PNP “[i]nformed Commander Brown of security issues.” The plan was to continue medications but there was no evidence of any other form of clinical intervention to address his worrisome homicidal ideation and psychosis. He was simply “[p]laced in medical, per Dr. Nagel and Dunn NP to prevent harm to others...[He is] actively psychotic.” His judgment and insight were poor. Note that despite his report about not taking medications, the MAR indicated that he took all his medications except that there are no entries at all for 7/21/16.

Despite being placed in the infirmary owing to his homicidal ideation and decompensation, infirmary notes through 7/29/16 reported no attention to these issues and simply reported that he was “in no distress,” that he was asleep, or that he took his medications.

A PNP visited with him again 8/1/16 and he reported, “I am good, I am ready to go.” He “denies any voices at interview today. ... Denies any plans to harm self or others.” The PNP “[w]ill inform the security staff and [treatment] team of unit 3 of behaviors presented on last week [sic] [and] [w]ill go ahead and [discharge from the clinic] and continue current medications. [The PNP] recommend[ed] not placing patient in previous room with previous roommate.” Judgment and insight are, reportedly, fair. The rest of mental status examination was within normal limits; absolutely no psychotic symptoms were noted. This was the same day I interviewed him and, as reported above, noted overt psychotic symptoms.

Unaccountably, there was never any attempt to address his homicidal ideation and history of danger to others in treatment or his suicide risk despite a recent suicide attempt. While short term placement on observation was reasonable, it is not reasonable to fail to work with this patient around such issues and actively track and monitor these concerning symptoms, for which there was no plan. This places the patient and others at unreasonable risk of harm.

Additionally, the failure to provide supportive and structured services for this debilitated man critically undermines his chances for recovery or even improved function, both in prison and afterward. Individual therapy would likely not be helpful but groups designed to help him manage his mental illness and learn basic social and coping skills.

Patient 5

This patient had resided at EMCF for an extended period except briefly at the end of 2015 and beginning of 2016. He had been on Unit 3 since May 2016. This is another man who had evidence of ongoing and evident psychosis. He expressed concerns about witchcraft and staff and inmates putting things in his food as well as exhibiting mild thought disorder. He also spoke about God and the devil in a delusional manner.

Asked about what it was like on the unit and the kinds of activities available, he made the following observations: “People are walking around talking crazy on the unit. They all are supposed to be taking meds. They have knives.” When asked about the yard he replied, “We’re not going to yard lately. I never really went. The rec person’s not here anymore. They’ll let you go to the yard but not every day. The trustees help with games and stuff.” He noted that he had “only been to the gym once since [he] got [to EMCF]. We don’t even get to go.” He also noted that “a few inmates on [unit] 3 have jobs but it’s hard to get a job.”

He reported that he met with a psychiatrist or a counselor if he sent a request. He was clear that it was not adequate to tell custody staff; the only way to get a response was to write a request. He noted that he had not seen a prescriber for some time and stated, “I’ve been trying to talk to her and sent a request form a couple of months ago but haven’t seen her.” He did report that a mental health counselor came to the unit 3-4 times per week to ask if anybody wanted to talk.

He was unclear how often custody staff did rounds but offered that it was usually every two hours.

When asked about medications, he reported not taking his medications (divalproex sodium and olanzapine) for a “couple weeks.” He reported not even going to the pill line for “a while.” He offered, “When I came back they put me back on medication and I tried to say I didn’t take meds so he would take me off.” When told he had a right to stop meds, he asked incredulously, “Even if they order it?” When confirmed, he responded, “They used to force shots on us and stuff.” He was clear that he objected.

Medical record review revealed the following:

At the time I saw him, he had current medication orders for olanzapine 10 mg nightly and divalproex sodium (both started in May 2016). In the past, he had been ordered trifluoperazine (an antipsychotic), citalopram (an antidepressant), chlorpromazine (an antipsychotic) – including several injections in 2011, haloperidol, haloperidol decanoate, trihexyphenidyl (a side effect medication), fluphenazine (an antipsychotic), amantadine (a side effect medication), ziprasidone (an antipsychotic), benztoprine (a side effect medication), and fluoxetine (an antidepressant). He had also been ordered as needed intramuscular injections of haloperidol in 2014. Excluding the injections of haloperidol decanoate from February 2016 to May 2016, his last injections of an antipsychotic were haloperidol on 2/7/16 and 2/17/16 when he was not at EMCF.

Laboratory studies show no metabolic syndrome screening and no levels of valproic acid. The record demonstrated a 50-pound weight gain since March 2016; his weight has fluctuated a great deal over time. There was no discussion of possible medication effects related to his weight, though weight gain is a common side effect of olanzapine. An AIMS was done on 8/1/16 and was reportedly zero.

When he arrived at EMCF on 5/13/16, the PNP noted that he had been transferred from EMCF to CMCF in October 2015 because he was not on medications at that time. When he got to CMCF, medications were restarted but it was some time before he was transferred back to EMCF. The PNP noted a diagnosis of chronic paranoid schizophrenia and that he was known to the provider, who felt he was “at his baseline” despite having “increased energy [and] [p]ressed speech/thoughts.” He had a history of “mood/thought disturbance.” He admitted to a history of hearing voices. Despite reportedly being at baseline, he was meeting eight of ten checklist criteria for mania. The plan was to “adjust” both the diagnosis and medications. He was reportedly in agreement with the treatment recommendations and consented to oral psychotropic medications rather than long-acting haloperidol decanoate injections. The PNP changed him to olanzapine (an antipsychotic) and divalproex sodium (a mood stabilizer).

On 5/31/16, the patient submitted a sick call request; he did not include his MDOC number on the “[g]rounds it mite [sic] incrinidate [sic] me.” Then under “services requested,” he wrote “straitness [sic].” A LMSW wrote on the request: “Client stated he had no issues, ‘I’m straight’” and then added “client discouraged from ‘phony’ sick calls.” The plan was “ongoing/no referral.” In a note, she indicated that the patient said “I don’t need nothing. I’m straight.” There appears to have been no inquiry into why the message was sent nor into his odd, almost certainly psychotic, statement about his MDOC number. This does not appear to be a “phony” sick call but a psychotic individual’s attempt to get some form of assistance which the clinician did not attempt to ascertain.

The same LMSW saw him during rounds with custody staff on 6/7/16. The patient reported not sleeping much. He also asked for his level of care to be changed in the belief it would improve his chances for transfer. The plan was “to be routinely monitored, per policy, for clinical concerns and to provide access to healthcare.” Clearly, this is not a plan of care.

A 7/4/16 treatment plan by a mental health professional (MHP) noted problems as “[p]hysical health...[and] coping skills.” The goals were again entirely generic but offer more individuation

than most: the long-term goal was “[t]o maintain a healthy lifestyle through improved mental health and indicate overall treatment success/readiness for discharge,” and the short-term goal, which included a place for target symptoms and obstacles but where none were listed, was that the “client will gain a better understanding of his mental health concerns and how to alleviate/cope with related symptoms. Client will learn the importance of complying with medication.” The intervention was “[t]o provide therapy and counseling, crisis intervention, encouragement, and routine monitoring. MHP will help the patient practice reframing [sic] from negative thoughts/feelings that trigger depressed mood.” Patient responsibilities were “[c]ompliance with medications and treatment goals on a daily basis, keep scheduled appointments, complete Sick Calls as needed. This client will take an active role in mental health treatment by complying and keeping all scheduled mental health appointments.” There were similarly no target symptoms or obstacles for short-term goal #2. The intervention was “[t]o provide therapy and counseling, crisis intervention, encouragement, and routine monitoring. This client will be encouraged to utilize behavioral strategies such as physical exercise and encouraged to practice good eating habits.” Patient responsibilities were: “This client will take a [sic] active role in their mental health treatment by complying with psychotropic medications as prescribed. This client will keep all scheduled mental health appointments. Will engage and practice refocusing negative thoughts to positive thoughts.” In the associated note, the patient is noted to have reported gastrointestinal symptoms, likely from medications, and “sleeping too much in the daytime but not at night.” The clinician reported auditory hallucinations but gave no information about the content of the hallucinations. He “believe [sic] somebody voo dood [sic] him and causing [sic] his sleep and gain weight.” None of these real issues were addressed in the treatment plan. There was no evidence that he was ever provided any counseling, including the promise to help him practice refraining from negative thoughts.

A PNP saw him on 8/1/16. He denied problems and wanted Benadryl. However, the PNP noted that he had not been taking the divalproex sodium for 1 to 2 weeks, complaining of “stomach swelling.” The mental status examination was normal except insight and judgement were noted to be poor. There was no discussion of the potential side effects or adherence problems. Adherence is essential for this man in order to minimize the deleterious effects of poorly treated psychosis.

This patient with severe mental illness and obvious limitations is in need of substantial support and rehabilitative services both to function inside prison and to have a chance of success in the community. His treatment should include medication support services, psychoeducation, and assistance with basic living skills.

He will also need reentry services including housing, benefits, and health care follow-up.

He also needs to be evaluated and monitored more closely for metabolic syndrome given his weight gain. Failure to attend to this places him at risk of long-term complications including heart disease.

Patient 6

This patient had been on Unit 3 (residential mental health) since 2006, and was on unit 3-C at the time of my visit. He reported receiving medications but little other support or treatment. When asked about counseling he replied, “The mental health counselor hardly comes around and does her rounds in the zone no more. And [a clinician] doesn’t do his rounds. ...They used to but they don’t do it no more.” He felt like this came to a complete stop about two months prior to my visit. He spontaneously added, “We even write inmate requests and they still don’t come. We write the MHC counselor in medical and they still don’t come to see us.” When asked about being in groups he replied, “I went to Ms. Williams’ groups. She’s from mental health.... I can’t remember what it was.” He reported she has not been running groups lately and that she was the only one running groups on unit 3.

He also reported that custody staff primarily conduct rounds at count time but rarely at other times. They come on the unit when there is a fight but largely stay off the unit. He reported this was the same on other pods of unit 3 where he had been housed.

When asked about other activities, he noted that most inmates are allowed out of their cells from 0500 to 2300 Monday through Thursday and 0500 to 0100 Friday through Sunday. He added, “We go to the small yard every day [at] different times. D zone may go out this morning and then tomorrow, we’ll go out tomorrow evening.” When asked about the gym, he replied they never use the gym and reported that, “They quit that a while back. We don’t even go in the big yard anymore.” He thought the latter had been for about a year.

He noted that it is common for inmates to pop their cells open and go into other inmates’ cells, sometimes to talk, sometimes to fight. He did not know if there was any sexual activity involved. He also reported, consistent with others, that smoking marijuana and spice are common on the unit.

He also reported that those who did not take medications are sent to another institution. He then complained again about difficulty getting access to mental health clinicians.

This man did not present as overtly psychotic or as having an acute mood disorder but as having cognitive limitations. He endorsed a history of traumatic brain injury and seizures. He exhibited likely tardive dyskinesia, a movement disorder caused by antipsychotics.

Medical record review revealed the following:

His psychotropic medications at the time of my visit were: the antipsychotic olanzapine 20 mg nightly (since August 2015), diphenhydramine (Benadryl) 100 mg nightly (since December 2015), and the mood stabilizer divalproex sodium 2500 mg in divided doses (most recently since February 2016). He was also on the diuretic Lasix, two antiepileptic medications, an antihypertensive, inhalers for asthma, and a stool softener. He had been prescribed a wide variety of antipsychotics, antidepressants, and mood stabilizers historically.

He had a recent complete blood count, liver function tests, and valproic acid level. His triglycerides and high density lipoprotein were elevated on 10/1/15 but they have not been repeated and no medication change was made that would be expected to reduce metabolic syndrome and associated risk. His weight was monitored; it had fluctuated but was at the high end recently and he was noted to have “extreme obesity.” The plan to address that is to limit food but there was no mention of olanzapine or other medications and their potential impact on weight or metabolism. He had an AIMS done on 6/7/16, which was scored as a 4 (consistent with my observations).

His records are extensive. The main feature of his mental health treatment was that he had regular visits with psychiatry who have noted problems with medication-seeking behavior and neediness. Despite this, there was no discussion the advisability of continuing antipsychotics despite evidence of metabolic syndrome and a movement disorder, both of which may be caused by antipsychotics. There was also no discussion of the possible contribution of his traumatic brain injury to his presentation.

He is one of the very few patients whose record had notes indicating participation in groups. One particular therapist was the group leader for several groups: Accepting Mental Illness, Activities Group, Social Skills, and Handle Anger Better. These groups ran from October 2015 through June 2016.

There was no evidence of individual therapy to try to address his medication-seeking behavior or alternative ways of meeting dependency needs; individual therapy would be the only way to approach these problems. Given the antipsychotic side effects noted above, these failures place the patient at risk of harm. He is likely receiving medications he does not need because clinical staff are not addressing his underlying treatment needs.

Patient 7

When I met with this patient, he was obviously ill-kempt with long, dirty fingernails, had a vacant disconnected look, and was quite malodorous.

He had been housed on the short term restrictive unit 5-C for a month. He reported being in his cell for 24 hours a day while on 5-C. When asked about showering, he replied, “Now everybody has to close their tray slot before we get to shower.” He did not remember the last time he had showered. Prior to that he had been on the close custody unit 6-B for a day and prior to that he had been in the intake area for 2 to 3 weeks. He spoke about moving back and forth between 5-B and the intake area as well. He complained that other inmates “threw shit on me” and stated that they did not want him on unit 5-B, one of the long term restrictive housing units. When asked why he thought that was happening, he replied, “Because I was throwing shit on them.” He went on to talk about how other inmates picked on him and tried to get him to “throw on officers.” He reported that he had complied with these pressures in the past but is now better at resisting. He also talked about being attacked by gangs and sprayed by officers. He reported being on unit 6-

A, a close custody unit where he was out of his cell for 2 to 3 hours a day and spoke about similar problems with harassment by other inmates on this unit.

He did not remember the last time that he had been outdoors but was clear that he had not been outdoors while on 5-C or in the intake area.

He also spoke a good deal about officers giving him tobacco and even drugs such as marijuana and spice in exchange for his good behavior or retracting complaints/grievances.

This patient had a history of a great deal of childhood trauma. He spoke at length about memories of childhood sexual abuse and how the interpersonal violence at EMCF reminds him of this abuse and that his aggressive reactions are often related to these reminders.

He had a history of a head injury at six years old when a cousin pushed him off a building; he had lost consciousness and suffered subsequent seizures. He was in special education and only made it through the ninth grade, though can read and write.

He had a history of being on a variety of medications including stimulants for attention deficit disorder and antipsychotics. However, his presentation was much more consistent with a severe personality disorder related to trauma complicated by impulse dyscontrol and cognitive limitations related to his head injury. He has an evident history of self-injury and volatile behavior. He spoke about setting fires in the intake area and reported it was “because I was trying to help somebody.” He went on to speak about another inmate in the intake area who “kept tying things around his neck” and that setting fires “was the only way to get police to come to intake.”

During the interview, another inmate walked by in the hallway and said to the patient, “You might as well cut your throat.” The staff accompanying this other inmate only smiled. The patient I was interviewing said, “See how they pick with me [sic]?”

When asked about treatment other than medications, he noted that about a year ago, he had been meeting with a mental health professional weekly to work on his aggressive behavior. Since that time he reported that he has not had any such treatment and has been in no groups.

He told me that he did not like taking medications and that he had tried to refuse but was not allowed. He said, “They held me down and made me take it. They tell me that I’m too aggressive.” When asked how long this has been going on, he replied, “Since I started refusing.” He reported the last injection had been the previous Wednesday and that the staff had held him down even though he agreed to comply, despite his desire not to take the medication. He reported being on a monthly injection of haloperidol.

The psychiatric prescriber progress note from 7/25/16 included the following:

“Staff is reporting the patient is repeatedly throwing feces, and tossing urine and [sic] officers and medical staff. He also talks of suicied [sic] and has made efforts to hang himself or find other means of trying to die. ... He is psychotic and a danger to himself and other [sic] and will be medicated with Haldol decanoate 150 IM, Haldol lactate 10 mg IM, and Benadryl 100 mg IM today to assist his regaining control of his behavior and

reducing psychosis. Preferably unit security staff will bring him to medical where he will get his injections. If this is not possible, medical staff, supported buy [sic] security will assist his receiving injections on his unit.”

There was no evidence of informed consent, and the above makes it abundantly clear that he is to receive these injections whether he objects or not. As noted above, I saw no evidence of psychosis but of a serious personality disorder and traumatic brain injury, neither of which were being considered or addressed.

This patient needed substantial support and treatment, including a behavior management plan. He represents a substantial risk of harm to himself and others and, without such treatment and joint management between mental health and custody, will almost certainly continue to engage in dangerous behaviors. Involuntary treatment with antipsychotics is not the answer. He does not suffer from a psychotic disorder and such medications place him at risk of long-term complications and only serve to sedate him. Further, there is no evidence that he received any due process to authorize this involuntary treatment.

While treatment would not be expected to completely stop his acting out in the short run, it can reduce the frequency and intensity of his dangerous behavior and substantially mitigate the risk to himself and others, including staff. This would require an individual and group approach. The former would be necessary both to understand his behavior and to help the patient come to a place where he is motivated to change his behavior. At that point, groups might become more beneficial.

Patient 8

I saw this patient in the infirmary while on watch; at that time he was highly agitated. I came back later to ask if he would speak to me but he would not respond. I did a medical record review on him as it was clear that he was a very seriously mentally ill man.

He was admitted to CMCF on 2/25/16 and had his receiving screening done. That was his first day in prison. He denied any suicide attempts but reportedly took “a lot of mental medication [sic].” Despite this, he was directed to general population rather than to one of the residential mental health units. The medical intake noted that in the community he had been on risperidone 4 mg twice daily, lithium 900 mg in divided doses (a mood stabilizer), divalproex sodium 750 mg twice daily (a mood stabilizer), diphenhydramine 25 mg twice daily (presumably for side effects and/or sedation), and Neurontin 300 mg twice daily (presumably for pain).

After admission he was changed to risperidone 3 mg twice daily, lithium 900 mg in divided doses, benztropine 1 mg twice daily (for side effects), and divalproex sodium 1000 mg twice daily. He remained on this same regimen except for a slight increase in divalproex sodium around the time that I saw him.

Clinicians at the intake facility obtained laboratory studies of renal function, liver function, and a complete blood count. They also obtained a valproic acid level, which was sub-therapeutic, but not a lithium level. No thyroid studies or tests for metabolic syndrome were done. Metabolic studies, lithium level, or thyroid testing have still not been done, and there has been no repeat valproic acid level. An AIMS done at intake was zero.

Despite being seriously mentally ill, he was not transferred to EMCF until 4/4/16. Intake documentation was completed at that time. The initial mental health note reported that he was “distracted during interview and was unable to focus and had to be redirected often.” However, no psychotic symptoms were reported except that he denied hallucinations. There was no summary, no diagnosis, and no recommendations. The clinician did do a mood disorder screening which was “positive.”

Remarkably, given the severity of his illness, the next mental health contact was by a PNP on 5/17/16. The note stated, “Patient seen for initial intake.” The PNP obtained history from the patient including that he was taking medications, denied a history of childhood or other trauma, was diagnosed with bipolar disorder as a teen, and was in special education and completed the tenth grade. However, the PNP noted that “[h]e is not very cooperative during interview.” The mental status examination was notable for the following: “His speech is low monotone. ... His insight and judgement are poor. He is very agitated during interview. His affect is flat. He is easily distracted and guarded. His mood appears labile. ... He denies SI/HI. He denies AV/Hall. He reports he used to hear voices. He is however, very paranoid. ... He maintains very poor eye contact. ... He denies delusions, special powers.” The PNP also noted that “[t]he assessment does indicate a previous head injury with plates in his head. Documents indicate he has had an extensive mental health history.” The PNP found evidence for both depression and mania with associated irritability. The diagnosis was bipolar disorder, most recent episode mixed, severe with psychosis. No medication changes were made. The PNP ordered a complete blood count, metabolic panel, thyroid studies, lithium level, and valproic acid level. Subsequent notes indicate that he refused laboratory studies. His refusal was not addressed in the record. An AIMS from that date was noted to be three, strongly suggestive of tardive dyskinesia. There was no evidence in the record that this change in the AIMS score was ever addressed; it calls for a review of medications and consideration of a change to a lower risk antipsychotic.

On 6/21/16 there was a mental health segregation rounds note that indicated only that he was awake, alert, and calm and that his cell was clean. There was no indication about why he was in segregation or what role his mental illness may have played in being placed there.

The medication administration record from June 2016 demonstrated that he did not come to the pill line for about one-third of the days. His poor adherence was not a treatment target; it was simply noted to be a problem.

The next mental health contact was on 7/26/16. It reported, “Client did not engage directly with MHP. He will continue to be monitored, per policy, to address any clinical concerns and to provide access to healthcare.”

That same date there was a note from an LSW that stated, “Office visit with this client per [a staff MHC’s] request.” He was found to be “[h]ostile...disheveled...pressured and loud...angry...broad [affect]...circumstantial [thought].” He “denied” delusions and hallucinations. The LSW met the patient in an intake cell with custody. He was hostile and abusive. “Client did not get his psych medications on yesterday [sic] [due to] a security issue on HU5 ... but it will be given to him on today [sic].” The plan was to refer to psychiatry.

The psychiatrist saw him that day. The psychiatrist reported, “Patient talked very little. He appears to be [sic] responding to boices [sic] and he [sic] is making [sic] odd hand gestures. He answered a few questions with ok [sic] and did not give any specific information other [sic] than saying he hadn’t gotten his medicine recently.” He was given divalproex sodium 1000 mg and risperidone 3 mg after the visit. The psychiatrist then planned to order divalproex sodium 1000 twice daily, lithium 900 mg in divided doses, risperidone 3 mg twice daily, benztropine 1 mg twice daily and wrote: “These dosages have helped him in the past when at EMSH, but at times he has been slow to respond to meds.”

The remaining notes from mental health and nursing rounds offered no real information other than reporting behaviors such as standing at the toilet. He was generally sleeping at the time of mental health rounds because they are done early morning.

On 8/1/16 after I had seen him agitated, a PNP came to see him. The note stated, “He is initially calm at the start of the interview today, he later becomes severely irritable and agitated. He reports taking medications, will need to check with [nursing] staff and review MARS due to recent [history] of noncompliance with medications. ... Discussed case with [a psychiatrist] last week, if continues noncompliant, will go ahead and recommend long-acting Haldol to offer stabilization and then reconsider oral medications....”

This patient was basically in isolation for an extended period of time despite being clearly and seriously mentally ill. It was evident that he was doing poorly in isolation and that his mental illness was not controlled. There is no evidence of any attempt to treat or engage him other than giving him medications, with which he was poorly adherent. There is no evidence that his danger to others was ever properly assessed let alone addressed in treatment. The AIMS showing evidence of a new onset movement disorder was also not addressed; his lab refusal was also not addressed.

If appropriate measures to secure his medication adherence and general cooperation had been taken and failed, this patient almost certainly should have then been placed on involuntary antipsychotics to treat his illness and reduce his risk. Appropriate medication therapy would make it possible to get him out of isolation more quickly. These failures have placed the patient and others at risk of harm and continued at the time of my visit.

Lastly, it must be noted that this patient needed hospital-level care at the time of my visit. As noted in the body of the report, this is not an option.

Patient 9

I attempted to interview this patient in the infirmary. He was very agitated, hostile, and overtly psychotic. He refused to speak to me. I did a subsequent medical record review. He had been in MDOC for four years; the records reviewed began on 7/1/15.

At the beginning of July 2015 this patient was on haloperidol decanoate 150 mg every 28 days and diphenhydramine 75 mg nightly. These medications were reordered by a PNP on 7/17/15.

He was seen by a psychiatrist on 8/8/15. The psychiatrist reported that the patient complained “I’m so restless [sic] I can never [sic] sit still. It’s driving me crazy.” The psychiatrist went on, “Patient has cyclical mood problems with intermittent hallucinations. He has a [history] of cutting himself, but not clear that he wanted to die. He has 7 manic criteria [sic] positive during his upswings which qualify as manic episodes. His current biggest [sic] issues is [sic] his akathisia which is intolerable.” (Akathisia is restlessness which can be caused by haloperidol.) The mental status examination was positive for the following: “agitated,” depressed mood, suicidal, poor concentration, sleep disturbance, irritability, risk taking, increased activity, talkativeness, distractibility, decreased sleep or decreased need for sleep, and auditory hallucinations. Delusions were “[unknown].” The psychiatrist felt he was manic and psychotic. The plan was to discontinue the haloperidol, start the antipsychotic olanzapine 20 mg daily, start propranolol 40 mg twice daily (presumably for treating the akathisia, though the change to olanzapine might have been sufficient as it is less likely to cause this side effect than haloperidol), and increase diphenhydramine to 100 mg nightly. He also diagnosed mild developmental disability and schizoaffective disorder.

On 8/24/15 a mental health counselor documented a Quarterly Treatment Team Review. This review documented symptoms consistent with the previous paragraph. There were no program activities noted. It closed with the very generic “Treatment Team Referrals/Plan Recommendations: Continue to monitor for all psychiatric needs.” The actual treatment plan from that date by the LCSW included the familiar objectives/goals: “symptom reduction or maintenance, develop or improve coping skills, increase adaptation to correctional environment, improve social skills.” The responsibilities of the physician were to “[m]onitor frequency, [sic] medication, progress toward treatment goals.” The responsibilities of the nurse included: “[m]onitor frequency, [sic] medication, progress toward treatment goals...[as needed] for med distribution.” The MH/Psychological Services responsibilities include: “Crisis intervention, Individual therapy, Group therapy...[as needed] by [sick call request], Weekly, Monthly.” Patient responsibilities were: “Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed.” This is useless in terms of guiding any meaningful treatment and clearly embodies no individualization of care.

On 10/27/15 the psychiatrist saw him again. He was reportedly doing better on the new medications. His auditory hallucinations were “usually gone and don’t bother him anymore. Sleep is better, he’s not restless anymore, doesn’t wake up angry like the use [sic] to, and doesn’t have to move around all the time.” The plan was to taper the diphenhydramine, though the note does not say why.

The next note was from 11/19/15 mental health rounds in unit 3-C. It stated: “The client refused mental health services at this time. The client did not report any [suicidal or homicidal] ideation, [auditory or visual] hallucinations, delusions, paranoia, or other mood disturbances.” The plan was only to monitor him.

On 12/7/15 there was another Quarterly Treatment Team Review. The note by the mental health counselor indicated that the patient reported he was “compliant” with medications. He also reportedly denied hallucinations, mood symptoms, and special powers. However, the “Client was observed to rock back and forth, speech was raspy and soft-spoken, and he was ungroomed. He reported that he has thoughts of harming himself on occasion and thoughts of harming others ‘depending on how they make me feel’....When engaged further, he stated he was ‘the king of the world’ and it’s his job to ‘look after all the folks’.” Contrary to the preceding, “He admitted to having ‘special power to reach people’ in conversation, in understanding. Client stated he sleeps ‘off and on’ during the night and his appetite is ‘good’.” He was not in any programming. The plan was to monitor him and included that “Additional mental health services are available upon client request.” There was no evidence of any intention to address his poor hygiene, obvious lack of insight into his mental illness, or his thoughts of harming himself or others.

On 12/15/15, a mental health counselor charted rounds again. The patient reportedly “refused to engage in a mental health consultation on this date.” The plan was to monitor and provide services upon request.

Amazingly, given how ill this man was, there were no further mental health notes until he was at CMCF from March 2016 to June 2016. He returned to EMCF on 6/28/16. At intake the “client was acting very strang [sic] he was loud, smiling and laughing at time [sic] his speech was abundant and excessive. Client stated he was God and he somre [sic] times hear voices and they sometimes tell him to hurt other people.” He also used “bizarre words” and had “loose and poorly organized” thought. Despite this, the plan was still only: “Client will continue to be monitored.”

There was a treatment plan from that same date. It included an entry with regard to the patient’s strengths: “Client knows he should take his medication.” The patient problem list stated: “Client is not showing up for pill calls.” There were no long-term goals or treatment targets. The short-term goal was: “The target obstacle is getting client to understand how important it is for him to be compliance [sic] with his medication daily.” The actual goal was: “Client will not miss no more than [sic] two pill calls a week for the next three months.” The associated intervention was: “MHP worker will check the nurse MARS book weekly to ensure client is taking his medications and continue to provide counseling as needed.” The patient responsibilities were the usual: “Client will take medications as order [sic] by doctor and show up for all pill calls.” Given this focus on medication adherence, it is surprising to find that the June 2016 MAR indicated that he was taking all his medications, which consisted just of divalproex sodium 2000 mg every morning. There was no evidence in the record that anything was done regarding his medication taking, not even a note indicating that his MAR was reviewed as specified, let alone any counseling. Not surprisingly, the record demonstrated continued poor adherence.

A 7/7/16 LCSW note reported symptoms and behavior consistent with florid psychosis and likely mania. The note stated, “Client would not talk or respond to staff and he also was observed walking back and forth inside his cell screaming.” He was not cooperative with the interview. The plan was to refer to a psychiatric prescriber. He was also placed in the infirmary where he remained up through the time of my visit.

A psychiatrist saw him that same day. The psychiatrist reported, “Upon trying to interview him, he was angry and hostile and said that no one should come into his cell for any reason in a very loud voice while pacing in a circle in his room.” The psychiatrist found symptoms consistent with mania and psychosis. The plan was to continue divalproex sodium. There was no discussion of antipsychotics except “Evaluate on Monday for necessity of forced meds due to threats on staff.”

On 7/9/16, there was a note by a nurse following a spontaneous use of force. The note included no account of the event. The nurse documented, “[Patient] noted to be very agitated. Unable to obtain vitals [due to] agitation.”

On 7/10/16, an infirmary note stated: “Patient pacing in cell. Patient came out to go to bathroom and then attempted to come into Medical room. Patient then threw urine into small opening of Medical window. Nurses were dished with urine. ... Patient had to be assisted back into his cell. Patient refused [morning] meds.”

The psychiatrist saw him again on 7/11/16. The note reported that the patient “frequently paces...has cotton in his ears.” (Note: Patients suffering auditory hallucinations will often place something in their ears to try to block the voices.) He was agitated and threatening. Staff reported to the psychiatrist that “he spent a fair amount of time barking like a dog for no clear reason.” The note indicated a previous clinical response to haloperidol but that the patient had severe akathisia. He had also responded to olanzapine. The plan was to start olanzapine 20 mg nightly.

However, the psychiatrist ordered a long-acting injection of haloperidol decanoate on 7/16/16. That same day he also ordered an intramuscular injection of short-acting haloperidol and diphenhydramine. There was no evidence of consent.

On 7/18/16 the psychiatrist wrote, “Patient refused to talk.” “He was given [the above medications] after he assaulted both an officer and a medical staff member that day.” The plan was to repeat the long-acting haloperidol injection on 7/30/16. The psychiatrist added, “Because his compliance with Zyprexa was poor, it may be a while before we consider allowing him to take oral meds.”

The patient continued to be episodically agitated and showed evidence of serious mental illness up until the time of my visit.

This patient presents a serious risk of harm both to self and others and has in fact harmed others due to his mental illness. Despite this, there was no treatment offered other than psychotropic medications. He is also being treated involuntarily with antipsychotics. Though involuntary

treatment was indicated, and should have been done earlier to prevent harm, it was done without any due process review.

Further, the seriousness of his illness was not promptly identified despite clear evidence of being very ill; in adequate assessment is a recurrent issue at EMCF. This almost certainly contributed to his deterioration and placement first in restrictive housing and then in the infirmary owing to lack of timely response and failure to engage him, or even attempt to engage him, in mental health treatment. These failures have contributed to harm to others, continued severe symptoms, and an ongoing risk of harm to self and others.

This patient was also so ill that he required hospital-level care at the time of my visit.

Patient 10

This patient committed suicide by hanging on 4/4/16 after being in the infirmary on watch since 2/25/16. He reportedly expired in the hospital at 3:43 p.m. There was a nursing note from 4:42 p.m. that day that reads as follows:

“1450 Ambulated to client cell with Warden Hogan. Client lying on cell floor with a string tied around his neck. Warden Hogan called for the K-9 unit to assist in entering client cell. When they arrived string cut and client is unresponsive. Very faint pulse which stopped when string finally cut. CPR started and AED in use which continued to suggest no shock response [sic]. Client vomited undigested food. Mouth sweep done and attempts to suction. Dr. A[b]angan present. Client continued to be unresponsive with no pulse or respirations. CPR continued. Metro arrive at 1512. CPR then cont[inued] per Metro Ambulance personnel. IV LT stretcher for transport to local Rush Hosp[ital] ER. Cleint [sic] left medical with CPR in progress, and unresponsive at 1527.”

The following is a review of records starting just prior to his placement in the infirmary leading up to his death.

A PNP saw him on 1/27/16 during a treatment planning conference. She charted that he said, “I am doing alright, but they still got me in the hole, for what? They gave me back my property today. I did not go for blood work today, I was sleep [sic], do you think I need to go up there now?” The PNP went on, “Remains on ad[ministrative]-segregation pending investigation due to his allegations of his roommate raped [sic] him a few days ago.” The PNP noted, “He is mildly elevated/hyper at interview; however, he is cooperative/pleasant.” The mental status examination was notable for: “Mildly elevated” affect, decreased sleep, euphoria, risk taking, increased activity, talkativeness, esteem elevation, and distractibility. There were no psychotic symptoms noted. He reportedly “consents to continue current medications, Haldol Dec[anoate] and Cogentin. He is asking for more Cogentin; however, no [side effects] noted. Will continue Cogentin as is....” The PNP added, “He is in agreement with the treatment plan.” There was no evidence in the record that he was offered any treatment related to the alleged rape.

On 1/29/16 he cut himself on the forearm. Sutures were not required. He was referred to the PNP who saw him 1/27/16. The PNP admitted him to the infirmary. The patient reported that he

had cut himself because of stress. The PNP then stated, “He later reported some mixed reports of recently smoking spice, using meth/ice, using marijuana, cocaine, spic [sic], and oxycontin. He was irritable and agitated at that time with reporting [sic] he has not been sleeping. He was easily agitated at interview earlier today, as this provider attempted to discuss making positive decisions/choices.” The PNP also charted, “He asked for time in medical, and when informed there were no/limited beds, he demanded a bed at intake. He became irritable at the information provided regarding intake, the mental health staff does not have the authority for admission to intake.” However, “He was placed in medical holding tank, the plan was to allow him to remain overnight, and to return in [the morning], did not prefer to keep throughout the weekend due to [history] of becoming disruptive when left in the medical area for extended days. He insisted he had been using a variety of substances, and reported he needed rest.” She also reported, “He is now becoming more and more oppositional with the security staff. Behaviors escalating, with previous [history] of severe outbursts starting in this same sense, and escalates/explodes to the point he assaulted a female officer a few months ago. He is now asking to return to his unit. Reports he can’t stay in medical due to the use of chemical agents was just used on [sic] another inmate. He reports he slept earlier and is ready to return to the unit. Earlier, he reported he was going to cut his throat. He had cut his arm earlier today. He now denies any plans, intents, or thoughts to self-harm. He talked with the warden today with [sic] the warden discussed plans to move him from ad-segregation Monday. Will go ahead and [discharge].” The mental status examination was positive for: “mildly pressured” speech, “poor” insight and judgment, irritability, euphoria, risk taking, increased activity, talkativeness, esteem elevation, distractibility, flight of ideas/racing thoughts, and decreased sleep or need for sleep. There were no psychotic symptoms noted. The diagnoses were: Learning Disorder, not otherwise specified; Bipolar I, most recent episode manic, moderate; and a history of cannabis abuse. The plan was to continue haloperidol decanoate 100 mg every 28 days and benztropine 1 mg twice daily. There was no formal assessment of suicide risk or risk to others, despite the obvious concerns. I found no evidence of any such assessment in the record at any other time either.

On 1/31/16 there was another nursing note. It reported that the patient said, “I cut my arm and stuck some glass in it. I need to go to the hospital to get the glass out.” She went on, “Informed him he would not be going out.” The nurse added, “Cleaned with soap and water. He removed the glass.”

On 2/1/16 a nurse charted that he broke a lightbulb and inserted glass in his arm again. This time he was sent to the emergency room. The return note indicated that he received eight stitches.

On 2/3/16 a generic treatment plan was entered in the record. The diagnosis was bipolar affective disorder with psychosis. The problem list included self-injurious behavior, problems with sleep, and headaches. The target symptom was “psychosis.” This was included despite previous charting indicating he had no evidence of psychosis. The short-term goal was: “Client will gain a better understanding of his mental health concerns and how to alleviate/cope with related symptoms.” The associated intervention was “[t]o provide therapy & counseling, crisis intervention, encouragement, and routine monitoring.” The patient responsibilities were: “Compliance with medication and treatment goals on a daily basis, keep scheduled

appointments, complete Sick Calls as needed.” There was no evidence that these generic treatment goals were ever addressed or that he received any individual or group therapy.

A note from a psychiatrist that same day reported on the patient’s desire “to get off the shot.” The psychiatrist wrote, “Patient has a psychotic bipolar disorder and now wants to shift from Haldol to Zyprexa and possibly later on a mood stabilizer. He says he recently had to cut his arm very deeply with a razor blade to convince th [sic] staff to allow him to come off lockdown. He is plesed [sic] to be back on a regular population unit and wants to be off the heaviness and side effects of Haldol. We agreed upon a trial of 10mg by mouth at bedtime of Zyprexa.” The mental status examination was positive only for the patient’s report of auditory hallucinations. The plan was to discontinue haloperidol and benztropine and to start Zyprexa (olanzapine, an antipsychotic) 10 mg nightly.

On 2/7/16 there was a nursing note following a spontaneous use of force. The nurse wrote, “Spontaneous use of force on HU 3 Hallway and in Medical Hallway. [Patient] noted to be very agitated and fighting and spitting on officers. [Patient] states he is on ‘ice.’ [Patient] put in medical holding tank for further evaluation. [Patient] noted to be pulling stitches out of old laceration to left outer wrist.” The nurse cleaned and dressed the wound. Urine was sent to screen for “ice and meth.” Nursing staff also called the psychiatrist and obtained orders for intramuscular injection of haloperidol 10 mg and diphenhydramine 100 mg. The patient was placed in the infirmary. A nursing note stated, “[Inmate] threatned [sic] to hang self if he did not get his mat per C/O. [Inmate] was calm and pleasant with this writer.”

On 2/8/16, the urine screen came back negative.

On 2/9/16, he was asleep during mental health rounds, a frequent occurrence for the remainder of his stay. Rounding mental health staff did not wake him or change the time of their rounds.

A PNP saw him later that day. The patient reported being “ready to go.” On that date, he reportedly stated that his recent problems were related to spice rather than ice. He was noted to be “calm/cooperative/pleasant”. His speech was “mildly pressured” but the rest of the mental status examination was negative. He was released back to his unit. The plan was to continue olanzapine 10 mg nightly.

On 2/12/16 at 1230, an MSW reported he was again threatening to harm himself and spoke about having something to cut himself. He asked specifically to talk to a particular mental health staff member. The mental status examination showed him to be “Hostile...Neat...Belligerent... Loud...Angry...Illogical.” The MSW also wrote that the patient “held up a battery that had been sharpened on the end and advised that he was going to use it to hurt himself. MHP saw client smile and fist-bump with another offender after telling MHP he needed to go to medical. MHP advised client he could not come off the unit with his weapon...” He refused to give up the battery. Then, “Security was notified about the weapon and client pulled out another weapon, a blade, and proceeded to cut himself in the window of the pod. Client was escorted to medical by security.”

That same day at 1302, a nurse note reported that the patient said that he had tried to hang himself in the yard as well as cutting himself. The nurse wrote, “String cut from neck by Lt

Corney. No broken skin. Neck area red only. [Left] wrist laceration cleaned with soap; and water.”

The PNP saw him that same day and the patient reported the above incidents. He stated that he no longer wanted to be on unit 3, the residential mental health unit, and wanted to be on lockdown. She added, “He readily announces that he is not suicidal. He reports he cut himself and put the object around his neck ‘to get up here...to get moved from unit 3....’ He also admitted using marijuana the night before. He had mild symptoms of mania. She also noted, “Referred to the shift commander to further assess his reports that he does not want to be on unit 3 and is trying to get to lockdown.” No medication changes were planned.

The urine drug screen from 2/12/16 was negative for THC, despite his report of using marijuana.

He was subsequently placed in restrictive housing though the reasons were not documented in the medical record; there was no pre-lockdown screening. He was the subject of mental health segregation rounds on 2/17/16 and 2/23/16, though was only noted to be “[a]wake, alert, calm” and to have a “clean” cell. There was no history of recent events that might have explained his restrictive placement and no mental status examination.

On 2/24/16, a nursing note reported that he had put glass in an arm wound again. He was admitted to the infirmary and placed on suicide watch. A psychiatrist saw him that day and the documentation indicated that the patient had “debts” related to buying drugs “and is afraid of retaliation.” He was reportedly “oppositional...belligerent...irritable...inappropriate [affect]...illogical.” He was also showing increased activity, talkativeness, and decreased sleep. He was paranoid but other psychotic symptoms were marked as being unknown.

On 2/25/16, the patient again stated that he had used ice and spice and was sent to the emergency room.

The following day he was seen again by a PNP. The PNP noted the negative drug tests but also the difficulty testing for spice, though did not explain his report of using marijuana, which would be detected by such testing. The plan was to discontinue one-to-one observation. (Note: There are no logbooks in the medical record demonstrating a one-to-one watch.) She added, “Will [discontinue] Zyprexa [olanzapine], dangerous to continue in the midst of reported substance abuse. Will continue on psychiatric observation, no utensils, recently [sic] self-injurious behaviors.” The PNP also noted that the patient had some manic symptoms.

On 2/29/16, an MHP note reported, “The client stated that he is well and he voiced no mental health concerns, suicidal/homicidal ideations.” However, an X-ray from that same day found a long metallic body embedded in his arm. He reported this to the nurse and he was sent to the emergency room where it was removed.

The PNP saw him again that day and reported on the above events but primarily commented on his efforts to control his location within the prison by his behavior.

The following day, 3/1/16, the PNP saw him again. The note spoke to a plan to transfer him to MCCF. However, she noted, “He is likely not a transfer candidate at this time. [History] of

severe impulsive behaviors, [history of self-injurious behavior], [history] of noncompliance with recommended medications.” Why such a transfer was being considered is not entirely clear though it is clear that his case presented management challenges for EMCF, despite it being the primary mental health facility for the state.

An MHP note from 3/2/16 reported that he denied any problems. There was no mental status examination except that he denied thoughts of harming himself or others and denied hallucinations. A nursing note from that same day reported that the patient said, “You going to miss me when I’m gone [sic].” What he meant was not further explained so it is unclear whether this was a comment on suicidal intent. The nurse added that he “has been pleasant and without any complaints.”

A 3/3/16 nursing note reported that the patient believed the psychiatrist told him he would be in the infirmary for 2 to 3 months. If true, this would be clinically unethical as a patient should be kept under such restrictive conditions only as long as necessary.

A 3/4/16 PNP note reported on a discussion of the case with the wardens. It indicated some question about whether he would be placed on unit 6-D or 3-C. He was still not on any medication.

That same day there was a man-down call. The note reported that the patient “put ligature [sic] around his neck which was promptly removed. Brought to medical. [Patient] stated ‘they want [sic] give me my property so I put a piece of spoon with a hook on it in my arm.’” He was having problems moving his hand, perhaps because he hit a nerve. He was sent to the emergency room and the foreign body was moved.

On 3/6/16, he again inserted a spoon into the wound. He was reportedly belligerent and took an officer’s radio and called a code black. He was agitated and an order was obtained for haloperidol 10 mg by intramuscular injection. Also on 3/6/16, he reportedly had feces in a cup and was threatening to throw it at staff. When the captain arrived, he had a “string around his neck, but inmate was talking to [the captain], so therefore he was not choking.” The string was cut off by a nurse. “Officers state they could not find any shroud for the inmate. Inmate stripped down and cell searched.” It is of course unacceptable not to have a suicide smock available when needed.

He was seen by an LMSW on 3/7/16 who noted that the patient was asking about where he will be going. She reportedly told him that she has “no control or knowledge about transfers.”

This pattern of self-harm continued on. He spoke about his concern that there was a “KOS” [kill on sight] order on him amongst the inmates and that he did not want to go to general population. There is no evidence that this was ever investigated or addressed.

On 3/15/16, he placed a ligature tightly around his neck twice that day. The LMSW wrote, “Provider attempted to engage with client but he continued to use threat of suicide in a manipulative manner to have his requests answered. Security opened his cell door and nursing staff cut the plastic string from his neck. Provider advised nursing staff and security to place

inmate on suicide observation until the psychiatrist/NP could further assess the client.” His cell was searched again and at this time he was placed in a suicide smock.

On 3/17/16 he placed another ligature around his neck. This time as he came to the cell front, he reportedly “swayed in a fainting-like manner falling onto his bed and hitting his head on the concrete block wall as he fell.” The ligature was cut away and no injuries from the fall were noted. That same day, the LMSW told him that he will not be moved from the infirmary if he continues to harm himself. The patient was still not provided any treatment to address the behavior; he was simply told to desist.

The PNP saw him again on 3/18/16. The note reported on his self-harm behavior and some mild manic symptoms.

On 3/21/16, the psychiatrist discontinued the suicide precautions and placed him on psychiatric observations status. The plan was that if he committed any self-harm in the next two weeks, he was to be placed back on suicide precautions.

The psychiatrist wrote a note following a visit with the patient on 3/31/16. The psychiatrist reported, “Patient continues to do disruptive self-destructive behaviors. He says he is safe nowhere except at medical, but having frequent attention seems to be behind his request for [sic] housing in the infirmary. Will continue to explore proper placement.” The associated mental status examination is completely within normal limits. The psychiatrist added, “Uncertain if he has a bipolar disorder, or if his behaviors are erratic due to character disorder and intermittent spice use.” The plan was for the patient to stay in the infirmary.

On 4/2/16 notes indicated he was asking for medication for a headache. There are no notes on 4/3/16.

On 4/4/16, there was a note from a medical physician. The physician reported, “No acute distress noted. No medical diagnosis.” He was to “Remain on psych obs.”

Then there was a late entry by an LMSW. It stated, “provided intervention with [the patient] in the [infirmary] per [security request] at 1045.” Security was trying to get a sharp from the patient. He was uncooperative and agitated, reportedly upset because of getting no shower that morning. He had no new cuts at the time. Per custody, he was to get a shower. He dropped a hard plastic item to the floor through the cuff port. The cell windows were also covered with paper and/or cloth and staff “directed him to immediately uncover his windows.” He did. His bed mattress was reportedly “foam with no factory covering on it and asked client to explain. He reported that he did not like the covering and ‘my mattress is warmer without it.’ Provider asked about the covering and the client reported that he did not have it in his cell because ‘I gave it to the security officers.’” She terminated the meeting; as she was leaving, he began “talking loudly to no person in particular.” She asked him to be quiet and he complied. There is no evidence regarding his claim that he had given the material for the cover to custody staff.

The same LMSW provided a chart note at 1330 on 4/4/16. At that time his arm was hanging out of the cuff port, dripping blood. The patient was shouting. The plan was to get the video camera prior to a use of force. The LMSW reported that the patient stated, “[I]’m not crying, I’m not

mad. I want to see [the warden]. I'm not suicidal." The lieutenant reportedly left the area after being informed of the patient's history of similar problems, presumably calling off the use of force. The patient was angry about how "security treated him when he took a shower." He told the LMSW that he agreed to have his arm dressed.

Two hours later, he was dead. He had strangled himself with a ligature fabricated from materials in his infirmary cell.

This patient never had a suicide risk assessment or any treatment to target his repeated and severe self-injurious behavior. The staff adopted the cavalier attitude that his behavior was entirely instrumental and, apparently, therefore not a risk. The failure to even attempt to work with him to understand and then address these behaviors was dramatic. His substantial need for individual and group treatment was completely ignored. He had obvious and recurrent problems with self-management, interpersonal interactions, and lacked coping skills.

It is important to note that his medication regimen was unlikely to substantially treat his condition. While medications may have only provided limited benefit, they were discontinued unnecessarily; there is no reason to stop antipsychotic medications because a patient is using drugs. In fact, it is appropriate, even indicated, to treat drug-induced agitation and/or psychosis with antipsychotics.

On top of these treatment failures, his ability to repeatedly harm himself while in the infirmary demonstrates abject failure of patient monitoring. These failures contributed directly to this man's death.

Patient 11

This patient came to EMCF in 2009. At the time of our interview, he told me that he wanted a transfer out and reported that he was "stable." He spoke with concern about people dying, specifically mentioning a recent suicide. He was overtly psychotic and disorganized. It was very difficult to follow his speech.

When asked about conditions on the unit, he spoke about difficulty being around violent inmates and talked at length about how he "rigged" his door so that he could "pop that door and stay out all night long." He stated this was important because of his schizophrenia, which makes it difficult for him to be locked up. He offered, "I go crazy if I stay in the cell too much. I do it every blue moon. The medicine helps but it still acts up some time. All the time during the night." He reported that normal out-of-cell time was 0800 to 2300. He also offered, "If I get a bad partner, I just get out of there and move to another cell. I don't care if it's against policy....If [custody finds out], they might put you in the hole. It's a sacrifice but sometimes you have to save your own life."

He also reported that there were no groups or individual counseling. He noted, “I talk to the psychologist every blue moon. I try to get an understanding of what it means and I’m learning about it. I’ve learned from other nurses and doctors over time.”

This man was extremely ill and in need of intensive services that are not being provided. Failure to render the needed level of service places this man at unreasonable risk of not achieving the degree of function he is capable of and may worsen his illness. If his report about popping his door and going into others’ cells is accurate (many patients reported this was in fact a common occurrence), this is especially concerning given how ill he is. Failure to properly supervise the seriously ill places them and others at risk. Many patient reports to me and in medical records demonstrate that assaults are occurring in cells, including by inmates from other cells. Choosing cellmates is an important function to assure compatibility, and it is incumbent on the staff to ensure that inmates cannot get into others’ cells.

Patient 12

This patient had been at EMCF for over a decade.

He complained that sometimes he comes to pill line and his diphenhydramine (Benadryl) is empty when it should not be. He implied that it is being diverted and mentions other inmates who have had the same problem. Other inmates implicate him as being complicit with a nurse in diverting this medication on a regular basis.

He confirmed that there are virtually no mental health groups, noting that “two or three on the zone” might attend a group. He did mention that there are “alcohol and drug and aftercare groups. Already got my diplomas from both.” He was offered this even though he has a long sentence. He also stated that he and others received no individual therapy. He also confirmed the lack of other activities: “Sometimes we’re lucky to get out to the large rec yard once or twice a year....They haven’t had gym call in years. I thought the gym was shut down. We can’t even get a deck of cards to play spades with if we’re indigent. Had a guy in the past that would bring down checkers and chess and some cards but no more. I’ve been asking for a deck of cards for a year.” He described a day on the unit as “like being in a house with a bunch of brothers and you’re just bar fighting every day. They slide the trays under the doors like we’re dogs.” He complained of mold and mildew in the showers and, like numerous others, reported that prior to our visit, there was a substantial effort to clean the institution. He also stated, “You got 66 inmates on the zone and you got over 50 of them that never go out that front door.” He also spontaneously offered, “Sometimes I see the officers throw somebody on the floor and spray them just for trying to ask for his pills. They say they don’t care about our pills.”

I did not see evidence of any significant mental illness or treatment needs despite the fact that he is housed on the residential mental health unit. There were others with much more substantial needs who were not housed in residential mental health. Assuring proper placement reduces risk

of victimization of the mentally ill. Were there meaningful treatment on the residential mental health unit, failure to properly place the mentally ill on these units would also reduce access to services.

His report of lack of treatment and activities is consistent with all others' statements.

Medication administration is clearly an important function that must be consistent and reliable. The diversion of medications and failure to have medications consistently available is a problem noted by several inmates in addition to this patient.

Patient 13

This patient had evident, though mild, cognitive limitations and likely serious mental illness as well. He was unkempt and malodorous.

He reported that he had been at EMCF for 9 years, mostly on Unit 3. At the time of our meeting he was on unit 3-C. He had many complaints about long-standing conditions at EMCF. He offered the following near the outset of our interview: "They dump all these killers and these people fighting and they take over sales and stuff and staff just lets everything go. They don't even care. The only time they come on the pod is laundry, food and count. Three times a day. That's about it. They've gotten to where they don't let you out of the zone even for help. This has been going on for the past...forever." He added, "As of right now I'm sleeping on the dayroom floor because all the inmates have taken over the cells. I gotta hang myself just to get something done." When asked if he was in the dayroom at night, he replied, "Day and night. There's nobody here no more." He complained of staff sleeping while on duty, waste of food in the kitchen while the inmates go hungry, and general neglect by staff.

When asked if he had been assaulted, he replied, "Threatening me, abusing me, trying to fight me, throwing punks at me, these gay dudes and stuff." Another inmate had reported this patient had been sexually assaulted. I asked whether he had been sexually assaulted but he did not answer directly, offering: "I've been in fights and threats and stuff and throwing punks at me." When asked if he had told people about what had happened to him he said, "Yes. They try to cover it up like nothing happened. They keep throwing me back on the same zone or the same cell." Later he said, "They just don't let you off the zone. They let everybody kill each other before they come on the zone."

I asked about activities on the unit. When asked about groups he stated, "They don't have no groups because medical is just like the rest of them and they laid back. Everything is OK and laid back. They cover up a lot of what's real." He reported he had been in no groups and had not been offered any. When asked about individual counseling he noted, "Only time is when I hang myself, then they act like they're going to do something. You gotta hang yourself 10 or 20 times for them to do something. Then they lie and tell you they're going to do something and they don't." He stated that mental health was not rounding on the unit as much as they used to but did say he was generally able to see the psychiatric prescriber when he asked, though was unhappy with the medications he was offered.

Like many others, he noted the preparation for our visit and how staff were behaving differently while we were there, offering, “Like now the guards are watching the zone. Usually the guards just spray you when you want some help.”

He connected his suicidality and self-harm to conditions, describing a “bad case of suicide attempts because these people drive me to suicide because of the way they handle me.”

I conducted a thorough chart review and found the following:

The medical record goes back to 2009. Contrary to his self-report, he had not been at EMCF for 9 years. The record showed that he had an intake done at CMCF on 12/22/09, though it is unclear from the medical record whether this was the initial intake for this incarceration. He reportedly stated he had completed the twelfth grade but was noted to have a “limited” level of cognitive functioning. An associated brief note indicated he was both anxious and had flat affect (an unlikely combination), endorsed decreased sleep, and reported taking Elavil and Prozac (antidepressants) in jail. He was noted to be “acting strange during the interview” but this was not characterized any further. He was referred for routine mental health evaluation.

A psychiatrist saw him on 12/24/09. He reportedly denied any mental health problems but “took Elavil for sleep for 5 months and now has been off Elavil for 2 weeks and has been doing and sleeping well.” There was no mention of the Prozac. And, inconsistent with the medication history, the patient reportedly “denied any [history of] mental illness or treatment otherwise.” The psychiatrist noted a normal mental status examination and did not mention any cognitive limitations. The plan was for no medications and to “close file [sic].” This was a deficient assessment; it did not address the intake findings and was extremely limited in terms of history and mental status examination. As a result, this case was inappropriately slated to be closed.

Four days later, the patient was referred back to mental health by custody staff because he was “acting bizarre and seems confused.” He was seen by the same psychiatrist. The patient reported being depressed and denied psychotic symptoms though was “guarded and suspicious.” The psychiatrist noted mild thought disorder and restricted affect. This was another inadequate assessment. Further, despite the fact that there was no report of agitation or any substantial signs or symptoms of mental illness, the psychiatrist ordered an injection of the antipsychotic haloperidol and an oral dose of the side effect medication benztropine. The psychiatrist then started fluoxetine (Prozac) and trifluoperazine (another antipsychotic).

The psychiatrist saw him again on 12/30/09 at which time the patient reported feeling better but still felt depressed. The psychiatrist went on to note that he had not received any medications as yet. The psychiatrist noted no abnormalities on the mental status examination yet continued the medications. There was a similar note from 1/3/10.

He was assaulted by a peer on 1/7/10 and sustained a black eye and facial laceration, but there was no comment in the record about what had happened.

The psychiatrist saw him again on 1/13/10 and the patient reported still not receiving any medications, yet the psychiatrist reported “no side effects from the meds.” He was now without depression or psychosis, yet the medication orders were continued. The psychiatrist did not mention the recent assault or consider the patient’s risk of victimization or risk to others.

He was placed in restrictive housing and there was a Pre Lockdown assessment on 1/15/10. There was no mental health note or assessment of his mental condition.

The psychiatrist saw him again on 1/20/10 and noted no symptoms. The patient asked to come off medications. The note indicated that he “wants to come off psych obs.” However, there was no previous indication that he was placed on any psychiatric observation status. The medications and the observation were discontinued.

The psychiatrist saw him again on 1/31/10 and again reported no problems and wrote that the patient denied “any side effects from medications,” despite having been taken off medications.

Remarkably, there were no further notes until a note from an LCSW at EMCF from 3/23/11 at which time he was “disorganized” and reportedly had “evidence of a mental disorder due to inhalant [sic].” However, there was no report of how the inhalant use was known (there was no toxic screen in the record) or any other symptoms except that he was “unable to convey his thoughts.” There was a typical generic treatment plan but the patient was on no medications. An addendum read, “Inmate made an allegation about being violated in February 2011.”

A Quarterly Treatment Team Review that same day by a clinician with an M.Ed. noted that the patient “reported no current symptoms of his diagnosed Schizophrenia, Disorganized Type.” However, the clinician went on to report on a variety of symptoms and problems, including that the patient “denied hallucinations, anxiety suicidal [sic], homicidal thoughts, but he admits to being depressed. In a rambling monotone voice he reported being raped by another inmate in February of this year and wanted to get tested for AIDS.” He also wanted to be transferred “to get better medical attention.” The reported rape was never discussed in the record and there is no evidence that the patient was ever offered mental health treatment in relation to it.

On 4/1/11, a nurse reported he was in an infirmary holding cell and was “noted with a sheet draped around his neck. Inmate was stripped, searched, and placed in intake for suicide 1:1...”

An LCSW saw him that day and reported that the “Inmate stated tht [sic] he was attempting to be transferred to the local hospital to get an AIDS test. He stated that he placed the sheet around his neck so he would be sent out to Anderson hospital.” The assessment is “Malingered suicide per medical test [sic].” The LCSW had the patient sign a “NO HARM Agreement.” There was no discussion of why this patient would resort to such actions or any consideration of his potential for self-harm or victimization. He was to receive an HIV test and was returned to general population housing. The HIV test came back negative.

On 4/15/11, he was “involved in an altercation” and was struck in the nose, which was bleeding when he saw the nurse.

A 4/23/11 scanned hand-written psychiatric note reported that he had been transferred to EMCF on medications, though they had actually been stopped, and that there was “consideration of malingering to change placement.” The psychiatrist noted that in May 2010 the patient was “found [with] rope around neck [sic] (didn’t like roommate [sic])” but did not report the recent sheet around his neck. The psychiatrist noted a history of mental retardation and drug use. The patient was noted to demonstrate “very slowed cognitively, hesitant speech, drifts off, [decreased concentration]? [sic] Malodorous, disheveled...” The psychiatrist noted he was in for armed robbery and slated for a 2012 release. The psychiatrist noted a “[history of] selling food and manipulating’ for cigarettes/coffee. Inmate denies this to this examiner. (Though documented previously by [a doctor and mental health staff].” In addition to cognitive limitations, the psychiatrist noted some possible delusions related to cellmates but did not elaborate. He was also noted to have poor sleep and complained of being depressed but there was no assessment of criteria for depression. He was started on mirtazapine, an antidepressant, despite lack of a proper assessment and diagnosis.

On 5/9/11, he reported suicidal ideation and custody took him to the infirmary where he was placed on watch. There were no regular beds in the infirmary or intake so he was placed in a holding cell. A nurse reported that when she asked if he was suicidal, he reported that his cellmate did not want to see him masturbating.

A mental health note that same day reported that the patient said essentially the same thing and that the patient “has a [history] of saying he was suicidal to get off of his zone.” There was no inquiry about what might be going in the unit, his risk of victimization, or his risk of harm to self.

However, during this period there are some brief notes of a stress management group the patient attended, which was a reasonable referral given his obviously limited coping skills. He did not receive any individual counseling.

A 6/13/11 treatment plan noted “poor hygiene” and that he had “disorganized and tangential thinking. Inmate has the worst case of word salad I have ever seen.” It also noted that he sells his food for nicotine. The objectives and goals and interventions are the usual generic ones. They do not address any of the issues detailed in the previous or current notes.

The following day, he was the subject of an emergency call; he was found on the floor with a sheet around his neck. He showed limited responses but “came to” after ammonia tabs were administered. He left three suicide notes reading: “I can’t come back on the zone I Red Tag [sic],” “My life is in danger. They butt to get me Hunger Pains [sic],” and “I want a Red Tag.” Upon awakening he spoke about being charged “more than what I was supposed to [sic] and I aint [sic] got \$20.” He then reported having marijuana for which the sellers wanted more money. He was drug-tested and tested positive for cannabis and methamphetamine.

A 6/15/11 Quarterly Treatment Team Review reported no mental health symptoms; it does not report on any of the above behaviors. The plan is only to monitor him.

A 7/5/11 LCSW note indicated that he met with the patient to “discuss the behavior warning: playing staff against one another.” But it does not explain what happened. His speech was rambling and tangential, he was irritable, and his sleep was decreased. The recommendations are for “closed custody clothing” and the patient was “encouraged to write inmate requests to see that [mental health] counselors [sic]. He also need [sic] to be considered for a cellmate change.”

He was assaulted by a peer on 7/13/11, suffering contusions to both eyes and the back of his head.

On 7/18/11, the patient reported being raped, saying “I feel like I got molested when I went to sleep at night.” He was not sent for emergency room evaluation because it had been more than 72 hours.

Another handwritten psychiatric note from 8/11/11 noted the mirtazapine had not been effective. He had depressed affect and had “mildly tangential” thinking but no other psychotic symptoms. His cognitive limitations were also noted. The mirtazapine was increased; no antipsychotic medication was started.

The next mental health note is a 10/5/11 treatment plan that reported he was on no medication, though there was not a psychiatric note indicating discontinuation and the above note reported continuation and increase in his antidepressant. The plan noted that he had the wrong color pants and that he was having problems with a cellmate, but nothing about his mental condition. The same generic plan was repeated.

On 10/9/11, there was another Pre-Segregation – History and Physical that noted he had lacerations. Again, there was no note about what happened or what role his mental health might have played in events.

On 10/10/11, he reported an intention to harm himself. He complained that peers did not want him on unit 2. The nurse called the LCSW who said to return him to unit 2. The patient put a piece of string around a door handle and threatened again to harm himself and the nurse called the LCSW again; this time he was placed on suicide watch.

Inexplicably, there was no mental health note until a report of a No Harm Agreement on 10/17/11. The accompanying note reported that he had put a ligature around his neck, reportedly because he wanted his property. He had apparently been placed back in segregation but there had been no assessment or note. He expressed fears of being on his assigned unit. The assessment was that he was “manipulating to get moved.” He was returned to segregation.

He was on suicide monitoring from 10/30/11 to 10/31/11 but there was no note preceding this explaining what had happened.

On 10/31/11, he was seen by a psychiatrist who noted the patient’s fears of being killed being the reason he expressed suicidal ideation. It was a cursory assessment that indicated no mental illness and again reported he was manipulating. There was no consideration of his risk of victimization or risk of harm to himself.

On 11/12/11, another psychiatrist saw him and noted a history of psychosis but being on no medications. No psychotic signs or symptoms were noted but the patient again complained of depression and the mirtazapine was reordered (though there had been no formal discontinuation – it must have expired).

There were no mental health notes other than one brief group note until after a 3/26/12 nurse note regarding suicidal ideation. He was placed on watch again. Mental health saw him that day and the patient repeated his housing request, specifically asking to be on the mental health unit. His clothes were returned but he remained on observation. The following day, a brief note spoke to plans to consider a housing change.

There were no further notes until 4/16/12 when an LCSW saw him in the infirmary hallway and noted that the patient “faked a hanging by placing a ligature around his neck and lying on the floor.” The inmate again noted problems on his living unit. He was returned to his living unit.

Another note from a different mental health staff that same day noted “an imprint around his neck” and that he had been “forced out of his cell” by a peer and had been in another cell, not his own.

Next is a 5/15/12 licensed professional counselor (LPC) note that consisted only of a cursory mental status examination that noted multiple psychotic symptoms. It indicated that he was to be held in medical until assigned to a housing unit following a “suicidal gesture” that consisted of a hanging attempt with “ligature marks on his neck.” He continued to complain of problems on his housing unit. This was the last note prior to his release from prison on this charge.

There was a note of a community mental health center appointment for the patient but it just gave the clinic address and phone number and noted that he could go there Monday-Friday between 8 a.m. and 4 p.m. It appears that a referral note indicating only his diagnoses and prescription for mirtazapine was sent to the clinic.

He was readmitted to CMCF on 1/29/13. The Receiving Screening Form reported that he was on medication. Erroneous information included that this was his first incarceration, that he had never tried to kill or done serious harm to himself, that there was no indication that he has been sexually victimized, and that he had no mental problems not otherwise reported (none are reported anywhere on the form).

The Mental Health Screen consisted of a Suicide Potential Screening that reported a recent loss, noted past suicide attempts, reported a history of being on psychotropic medications, and noted a history of psychiatric hospitalization and past outpatient mental health treatment. It also reported that he had not been victimized and had average cognitive function, both of which were inaccurate. It noted that his father had killed himself by hanging. There was a routine referral to a psychiatric prescriber.

That same day there was a Mental Health Treatment Plan that consisted of the usual generic language. There was also a general consent for psychotropic medications, rather than a specific consent for a particular medication or medications. It included general statements about side effects but does not capture all the important side effects for all the medications it covered and it

does not speak to risks and benefits given the particular condition from which the patient suffered. There was also a similar general consent for medical treatment.

On 1/30/13, he saw a psychiatrist who noted a history and current complaint of depression. The mental status examination was consistent with depression without psychosis. He was started on citalopram, an antidepressant. There was also a note to “watch for psychotic [symptoms].”

He was seen by a MSW on 2/5/13 after custody reported he was “acting strange and has been going to restroom [sic] frequently, approximately 10 times within 1 hour.” The patient complained of constipation. He “appeared to be paranoid and delusional. Inmate continuously repeated that he’s been constipated for years.” He was placed on psychiatric observation. The psychiatrist saw him and ordered an injection of haloperidol and started him on risperidone, both antipsychotics. An AIMS was negative.

On 2/13/13, he was removed from watch, reportedly “doing alright.”

The risperidone was decreased on 2/19/13 due to excessive sedation.

On 2/24/13, a psychiatrist saw him and noted suicidal ideation and depressed mood but no psychotic symptoms.

On 2/26/13, he was placed on suicide observation after telling the psychiatrist he heard “God and Jesus talking” and had visual hallucinations. He was paranoid but his mood was improved. His status was similar on 2/28/13. On 3/4/13, he was removed from watch.

On 3/6/13, he was transferred to EMCF. Despite the preceding documentation, the Receiving Screening (done by medical staff) reported no suicidal ideation, no “psychotic medications [sic],” and no history of psychiatric treatment. The Intake Mental Health Screen consisted of a Suicide Potential Screening that noted a psychiatric history and being on medications but no history of suicide attempts. It did note his cognitive limitations. He signed a No Harm Agreement. An associated note indicated he was back on a probation violation for using drugs. It included a brief social history but no mental health information other than that he “denied any anxiety, depressive and psychotic [symptoms].” The mental status examination was brief and incomplete. It concluded with a recommendation for placement on unit 3, the residential mental health unit, and a referral to psychiatry. There was a treatment plan from that same day, despite there being an insufficient assessment for guiding a treatment plan. It was the usual generic treatment plan.

He was seen by a psychologist on 3/8/13 who noted his medications and reported that he “denied internal stimuli,” which is nonsensical; the term is applied to a clinician’s observation of a patient’s apparent attention to something external when there is no corresponding external stimulus (typical of those with true hallucinations). The limited note reported on finding no evidence of any mental health problems other than “intellectual deficits.” The diagnoses he had in the record for an extended period were merely carried forward, despite making no report of mental health problems.

A psychiatrist saw him on 3/9/13 and provided a similarly limited evaluation. The psychiatrist noted he had “been on and off antipsychotic agents” and was now on citalopram, risperidone, and benztoprine but said nothing about what these medications were for. The patient complained of depression and insomnia. The mental status examination was again a checklist with no findings noted. The psychiatrist reduced the risperidone and benztropine, presumably owing to finding nothing, though did not discuss whether the medications might be working as the reason for the patient’s stability.

The next note was listed as mental health infirmary rounds on 3/18/13 but he had a cellmate so this is unlikely. The patient was reportedly toileting on the cell floor. He was told not to and the plan was to report it to his mental health counselor. The same problem was reported on rounds on 3/19/13 and his cellmate said the two of them were, not surprisingly, not getting along. The plan was for a “1:1 visit later.”

The LPC did meet with the patient that day. The LPC noted disorganized thoughts, slow speech, repetitive content, unclean clothing, “strange body odor,” and fidgeting. The LPC goes on to report on signing a No Harm Agreement, though he had denied suicidal ideation and there was no indication of other intent to harm himself. The patient reported it was easier for him to defecate on the floor and spoke about being constipated. He also asked to have his medication increased but the LPC noted he had pills in his pocket, reporting that he had gotten a pill pack at pill call the night before, though they were dated 3/16/13 and 3/17/13. He then admitted non-adherence. The LPC reported “counseling” the patient to use the bathroom and take his medication. The LPC reported the constipation to medical. For unknown reasons, the LPC noted that he was “able to weigh the consequences of his thoughts/actions/behaviors.” He stated he would halt the behavior. There was no further plan to address the behavior and no plan to address his poor self-care, his psychotic symptoms, the interpersonal challenges he faced, or his potential for victimization.

The next contact was cursory rounds on 3/30/13.

There was a Quarterly Treatment Team Review on 4/1/13. It opened with the statement: “Offender states he is compliant with his medication....” It later reported again that he was, in fact, medication-adherent. There was no comment on the above obvious non-adherence from the 3/18/13 note. He was “angry due to other people” but it did not say why or who he was angry with. The following text was also included: “Other: Inmate reports that he was violated for hot urine [sic]. He was cordial ‘thanks I appreciate you’ll [sic].’” What this might mean is unclear but might represent his past reports and ongoing concerns of sexual victimization. None of these issues are addressed in the Objectives/Goals or Interventions and Modalities. These consist of the usual generic elements.

On 4/12/13, a psychiatrist saw him. The patient reported worsening depression, intermittent auditory hallucinations, poor sleep, and hypervigilance. He also told the psychiatrist he had been diagnosed with schizophrenia in the community. On mental status, the psychiatrist noted that the patient was suspicious and agitated, had monotonous speech, exhibited depressed mood and constricted affect, had paranoid delusions, and had coherent thinking. The psychiatrist added

lithium, a mood stabilizer, and increased the mirtazapine. There were no appropriate baseline laboratory examinations and no order for a lithium level. Diagnoses remained cannabis abuse, major depressive disorder, nicotine dependence, inhalant abuse, and psychotic disorder not otherwise specified.

The patient was the subject of mental health rounds on 4/22/13, 5/3/13, 5/20/13, and 5/31/13. They provided no useful observations and demonstrated no interventions.

A 6/7/13 note from an LCSW made cryptic comments about the patient's interactions with his cellmate but did not say what the issues were. It concluded that he will be "reassigned housing."

Mental health rounds continued on 6/17/13, 6/25/13, 7/2/13, 7/11/13, 7/17/13, and 8/3/13.

There was another generic treatment plan on 8/5/13. It reported that he was medication-compliant, though does not say what this was based on. The patient was said to have "adhered to good grooming standards, he reports a decrease in inappropriate [sic] social skills i.e. spitting on the walls." Yet it was clear from the 6/7/13 note that he was still having problems with cellmates.

Rounds continued on 8/7/13, 8/13/13, 8/19/13, 8/30/13, 9/4/13, and 9/10/13. They provided no useful observations and demonstrated no interventions.

On 9/13/13, he submitted a Medical Services Request Form complaining of being taken off psychotropic medications, including risperidone (an antipsychotic) and benztoprine (an anticholinergic). The response indicated that the medication had expired. He made the same complaint on 9/18/13. There was no mention of this from the mental health rounds on 9/10/13 or the next rounds on 9/17/13.

The medications were reordered on 9/21/13 but he still had not been seen by a psychiatric prescriber since 4/12/13.

Rounds continued on 9/24/13, 9/25/13, 10/1/13, 10/8/13, and 10/15/13.

A PNP saw him on 10/21/13. The patient reported taking medications and the PNP ordered appropriate monitoring laboratories. The PNP reported no active mental health symptoms and specifically noted no thought disorder, hallucinations or mood symptoms. There was no comment on delusions. The plan was to follow-up in three months or sooner if needed. The PNP also made a medical referral for a rash the patient reported. He had been seen for rashes multiple times before. The laboratory results on 10/25/13 showed a normal metabolic panel (including kidney function) and thyroid function. However, the lithium level was essentially undetectable, indicating non-adherence.

Rounds continued on 10/22/13 and 10/30/13. The PNP stopped the lithium on 10/29/13, presumably due to non-adherence but there was no discussion or attempt to address his reasons for non-adherence, except for a plan to discuss the labs at a future appointment.

On 11/3/13, he submitted a Medical Services Request Form complaining of depression and mood swings. An MHC saw him that day and the patient presented as "saddened but cooperative;

[and] state[d] ‘I am having anxiety attacks...I need to be placed on some medicine.’ The patient was referred back to the PNP but there was no further characterization of his complaints and no comment on his problems with adherence.

On 11/5/13 rounds, the MHC wrote, “The offender reported that he has seen the doctor and is taking his meds.” The MHC seemed unaware of the above obvious non-adherence. The patient again complained of a rash and the MHC planned a medical referral.

The PNP saw him on 11/13/13 and the patient complained of “increased depression, anxiety and mood swings.” He said he had stopped the lithium because it was not helping, though there was no discussion of what this meant. Despite the PNP noting no abnormalities on mental status, the patient was started on carbamazepine (a mood stabilizer) and bupropion (another antidepressant). The risperidone and benztopine were discontinued but there was no discussion of why this was done. The PNP ordered appropriate follow-up laboratories but no baseline laboratories or eye examination (recommended prior to beginning carbamazepine). The laboratory results came back on 12/13/13 and showed a normal complete blood count and an elevated carbamazepine level at 14.8 (normal 4-12).

Rounds continued on 11/12/13, 11/19/13, 11/25/13, 12/2/13, 12/9/13, and 12/16/13.

The PNP saw him on 12/17/13 because of the elevated carbamazepine level. The patient reported taking the medication prior to getting blood drawn, representing a failure on the part of the lab technician to attend to this (levels are drawn in the morning and should not be drawn if the patient had taken morning medications already). The level was reordered as well as other labs, though they had recently been done already. The level came back low at 3.1.

Rounds continued on 12/23/13, 12/30/13, 1/6/14, 1/14/14, 1/22/14, 1/30/14, 2/3/14, 2/10/14 (at which time the patient asked to see an LCSW; though the reason was not noted, the referral was reportedly made), 2/17/14, 2/23/14, 3/4/14, 3/10/14, 3/19/14, and 3/25/14. By the last rounds, he still had not been seen by the LCSW and the patient also noted he was not getting the mirtazapine.

Rounds continued on 4/3/14, 4/9/14, and 4/15/14.

The PNP saw him on 4/22/14 but did not comment on the low carbamazepine level and did not change the dose. The patient was “slightly loose and somewhat distracted – some rambling conversations at interview – for example informs this provider while laughing ‘going to wine and dine with you when I get out...’ some odd mannerisms/behaviors.” The PNP added trifluoperazine, an antipsychotic, and reported that the patient “consents to continue medications.” Labs, including a carbamazepine level, were ordered.

Rounds continued on 4/22/14 and 5/7/14. The rounds continued to provide few relevant observations.

He was seen by a psychologist on 5/9/14 for a “scheduled appointment” though it was not clear why it was scheduled. The patient reported being medication-adherent and reportedly denied any problems and the psychologist noted no problems, including no thought disorder, and wrote

“Mental status unremarkable.” The actual mental status was primarily a checklist with little narrative. There was no interim history and no evidence of any treatment or intent to provide treatment.

Rounds continued on 5/26/14 and 5/30/14.

On 6/2/14, he submitted a Medical Services Request Form complaining of being harassed by a particular custody officer in the morning and thus wanting his medication changed to evening only. An MHC saw him that day and reported the complaint and noted that the patient was upset with being made to take his medications and doing a mouth check to ensure compliance. The associated checklist mental status examination was all normal. The only action was to counsel the patient on the importance of compliance and referral to a psychiatric prescriber.

Rounds continued on 6/12/14 and 6/26/14.

A Quarterly Treatment Team Review note from 6/30/14 had no interim history, reported that he stated he was taking his medications, and reported no mental status abnormalities on cursory examination. The patient was in no education, no work, no groups, and reported poor family support. The usual generic treatment plan followed.

On 7/2/14, he submitted a Medical Services Request Form complaining of not getting his psychotropic medications. This had not been mentioned in the 6/30/14 note. There was no response to this request.

Mental health rounds continued on 7/11/14, 7/16/14, 7/28/14, 7/30/14, 8/7/14, 8/27/14, 9/6/14, and 9/22/14, none of which commented on the patient not getting his medications and whether this had been resolved.

On 10/3/14, he submitted a Medical Services Request Form asking for medication to help with sleep. He was seen by an MHC that day and he told her he needed his “sleeping pill back.” The checklist mental status examination noted only depressed mood and decreased sleep. He spoke of the unit being “a party zone...They dont [sic] sleep...I can’t sleep because I be [sic] trying to see what is going on....” The MHC encouraged him “to participate in proper sleep patterns a [sic] this plays a significant role in his depression and mood swings.” He was referred to a psychiatric prescriber.

Rounds continued on 10/4/14 and he was seen by a psychiatrist on 10/5/14. The patient complained of mood swings, reported isolating himself, and told the psychiatrist the mirtazapine had expired. The checklist mental status examination noted anxiety, constricted affect, and decreased sleep but no psychotic symptoms. In one place it says he was “clean” and in another it says “poor hygiene.” The patient was also “hostile/angry” and yet “withdrawn.” The mirtazapine was restarted at full dosage of 45 mg, which was unreasonable as he had been off the medication for months.

Rounds continued on 10/12/14 and 10/20/14. At the latter, the patient asked for a new cellmate though denied being threatened. There was no discussion about why he wanted a change and he was simply referred to the “housing unit treatment team.” The MHC wrote, “The offender is

advised that all housing assignments is [sic] under the direction of MTC/Program Classification Staffing.”

On 10/20/14, there was also a Quarterly Treatment Team Review that listed his medications (which still did not include the mirtazapine) and noted that he “reports some depression at times.” The note also stated: “Offender also reports tht [sic] the roommate utilizes his cell to allegedly engage in homosexual acts with other offenders on the pod and he is forced to remain out of his cell during those times.” The only plan is that he “will continue to be monitored....” The associated treatment plan had the usual generic content.

The patient was seen by two different MHCs on 10/22/14. One reported the patient’s challenges with his cellmate, which were characterized as “small irritable things that interferes and prevents him from sleeping” and went on to note that the “Provider was able to help Offender calm himself and understand a more logical approach in resolving this issue.” What had actually happened or what this logical approach was it did not say. The MHC also wrote “Offender is made aware of consequences of his decisions and he is adamant about ‘red tagging’. Provider informed Offender that red tags are for security issues and are not to be used to punish an Offender for symptoms of disorders.” The second MHC later noted that the patient reported his cellmate was “continuously flushing his toilet, getting fully undressed and masterbating [sic] towards him. Offender reports that his roommate ‘throws tantrums’ hits the wall, throwing [sic] chairs in the room, speaking in an aggressive manner towards him.” The patient felt “intimidated and threatened” though again denied verbal threats had been made. The patient reported telling custody staff and the case manager about these issues. The MHC helped him “complete a redtag [sic] on this offender.” Whether there was any resolution or follow-up by clinical staff was not reported in the record.

Rounds continued on 10/30/14.

On 11/4/14, he submitted a Medical Services Request Form complaining of not getting bupropion (an antidepressant) that had been ordered for him. The following day he complained that all his medication was missing. He was seen by an MHC who made the following recommendations: “The offender counselor [sic] on taken [sic] current medication daily and making every effort to get up and received [sic] medication during pill call. The offender current [sic] had medication from 11/4/14 in his shirt pocket, which the offender did not take as prescribe [sic] (hoarding medication). This was also witness [sic] by Nurse [name].” The note does not address the complaint, does not say how many and what pills the patient had, and does not say what was done with the pills he had. There was no plan to address the behavior either. The mental status examination checklist noted that he was “clean, calm, appropriate” and had no psychotic symptoms.

He was seen by a different MHC that same day who the patient again complained to about his cellmate masturbating and flushing the toilet repeatedly. The patient reported that he did the red tab but “they did not move me.” He went on to say “it’s driving me to think about suicide I am not gonna do nothing [sic] but its [sic] taking me there please help me.” The mental status examination checklist noted that he was “guarded, disheveled, agitated” but had no psychotic

symptoms. The MHC spoke with the Shift Commander who reportedly talked to the patient and his cellmate and reported “that the offenders was [sic] OK and they would talked [sic] to the housing manager about changing cells in the [morning].” Whether there was any change was not reported in the record.

Mental health rounds continued on 11/6/14.

A carbamazepine level on 11/7/14 was again low at 2.6 (therapeutic range 4-12).

On 11/8/14 during rounds, he again asked to restart medications. Rounds continued on 11/13/14.

On 11/14/14, he complained of still not getting the bupropion in a Medical Services Request Form.

The PNP saw him on 11/14/14 wherein he reported “current medications ‘balance me out...’” The mental status examination was brief and noted no abnormalities except some mood swings. Despite the complaints of not getting the bupropion, he reportedly said it was “helping his moods.” The plan was to increase the bupropion and carbamazepine (the low level was noted on this occasion). The trifluoperazine and mirtazapine were to continue.

Rounds continued on 11/15/14, 11/26/14, and 12/4/14.

A psychiatrist saw him on 12/13/14. The patient continued to report mood swings and “isolating himself to keep from lashing out” and wanted his medications adjusted. The checklist mental status examination showed no abnormalities. There was no assessment or plan so presumably, the medications were kept the same.

A 12/16/14 carbamazepine level continued to be low at 2.3; a complete blood count was normal. Other necessary monitoring labs were not obtained.

Mental health rounds continued on 12/23/14, during which he told the MHC he had put paper in his ears “to block out some of the noise.” He was “given a sick call and instructed to contact medical.” He had reportedly already been seen on 12/15/14 and 12/22/14 and had been referred to the nurse, though he had actually already seen the nurse who had referred him to a physician.

In December 2014 he submitted repeated Medical Services Request Forms regarding tissue paper being stuck in his ear. On 12/29/14, he submitted a Medical Services Request Form stating that he would hang himself if it was not removed.

Rounds continued on 12/30/14 but the ear issue was not mentioned.

On 1/2/15, a nurse noted a “white substance in left ear” and again referred him to a physician.

Rounds continued on 1/4/15.

On 1/6/15, he was finally seen by a physician who noted the paper was “impacted in the right ear” and referred him to an ear, nose, and throat specialist who finally took care of the paper.

Rounds continued on 1/7/15, 1/17/15, and 1/23/15.

There was a Quarterly Treatment Team Review on 2/2/15. He reported “people are trying to take over the zone. He states he is experiencing a little paranoia at this time as he thinks the gangs are out to get him.” Why this was felt to be paranoia is not clear. There was no plan to help him deal with circumstances or determine the truth of his complaints. The usual generic treatment plan ensued.

On 2/6/15, he was seen by a PNP after the PNP received a phone call about the patient having a rope around his neck. The patient reported being frightened by a MDOC “shakedown” that occurred early in the morning. He felt they “were out to get me.” He had calmed since then and the limited mental status examination was normal except for “slightly loose/pressured” speech. The PNP changed the trifluoperazine to olanzapine, though there was no discussion of why this was done. Olanzapine would not typically be used long-term, owing to long-term side effects, unless the patient’s symptoms were not responsive to other agents. The PNP ordered more labs which came back on 2/10/15 and showed normal complete blood count and a low carbamazepine level of 2.6. Other monitoring labs, such as a lipid profile, were not obtained.

On 2/22/15, he was seen by an MHC after “being found hanging from gym equipment in the recreation yard.” He reportedly denied suicidal ideation and “reported his issues to all be security concerns about his roommate.” He stated the cellmate was a gang member and was “bullying him and attempting to take over the cell. Offender reported his roommate prevents him from going to the bathroom. Offender felt like he was out of options. Security staff spoke with the offender at length specifically regarding why he did not report his concerns to security staff or mental health. Offender was counseled against actions of self-harm in the future.” He was taken to the emergency room for “further evaluation.” A nursing note indicated that he had ligature marks on his neck. The plan was to place him on suicide watch upon his return.

Later that day, an MHC infirmary note recapitulated some of the above and noted the patient “stated no one would listen to him when he was trying to talk about the issue he was having. Offender informed this provider that another peer helped him tie himself up.” He was again told not to hurt himself and to talk to staff, though he stated he had done so already. There was no assessment of risk for self-harm.

He was seen by a PNP 2/23/15 and noted the self-harm event, adding that he was not acting in response to psychotic symptoms and denying it was a suicide attempt. He was psychiatrically stable but unable to manage the conditions on his unit as had been going on for an extended period. The PNP conveyed the housing problems to MTC staff.

During infirmary rounds on 2/23/15, the patient reported being extorted when on units 3A and 3D. Rounds continued on 2/24/15 and on 2/25/15 when he “was very angry and aggressive beating [sic] on the window prior to this provider coming.” He reportedly calmed but complained he had not gotten his medications that morning. The MHC told the nurse who then gave him his medications.

Cursory infirmary rounds continued on 2/24/15 and 2/25/15.

He was seen by the PNP on 2/25/15 who noted he was psychiatrically stable and not suicidal. He was taken off suicide watch but kept in the infirmary on observation with regular clothing and bedding and allowed utensils.

Cursory infirmary rounds continued on 2/26/15 and 2/27/15.

A psychiatrist saw him on 2/27/15 and wrote that the patient “admits to malingering behavior” and “parasuicidal attempt when in conflict with roommate [sic].” The checklist mental status examination was all normal. There was no plan or assessment, though the patient was noted to have “poor coping skills.” Despite the findings, the psychiatrist continued the observation status.

Rounds, some simply noting the patient was asleep, continued on 2/28/15, 3/1/15, and 3/2/15.

A 3/2/15 nursing note indicated that he appeared “to be responding to internal stimuli. Inmate laughing and talking to self.”

The PNP saw him again on 3/2/15. He continued to deny he was suicidal and denied any symptoms; the PNP did not note any problems on mental status examination but did not comment on the nurse note from earlier that day. The PNP discontinued the observation status. The patient was changed to risperidone and the bupropion was to be tapered but there was no reasoning about why these changes were made.

He was returned to his unit the following day. The PNP saw him on 3/5/15 after “a whole bunch of pills” were found in his cell. He denied they were his and that “they were left in there.” He showed some thought disorder but no other psychotic symptoms. He was with the same cellmate. The PNP noted reports of trading bupropion and trihexyphenidyl on the unit. The PNP stopped the bupropion completely and changed the risperidone back to olanzapine “to assist with stability.” There was no mention of what or how many medications were in the cell and whether they corresponded to his medications. There was no plan to monitor for hoarding.

Mental health rounds continued on 3/10/15.

The PNP saw him again on 3/12/15 and the patient asked to go back on bupropion and asked for trihexyphenidyl, a side effect medication. Despite finding no depression, the PNP started sertraline, an antidepressant.

At the next rounds on 4/8/15, he asked to be put on mirtazapine, an antidepressant he had been on previously, and complained of problems sleeping. The MHC counseled him to “try to read or do some exercises at night to help tire his mind and body out.” These are not good strategies; there are well-known cognitive-behavioral treatment approaches to sleep hygiene that were not used.

He saw the PNP again on 4/9/15 and complained of poor sleep. His speech was rambling and loose. The PNP increased the olanzapine, presumably because of these likely psychotic symptoms.

A 4/13/15 complete blood count was normal but the carbamazepine level was undetectable. Other monitoring labs were still not obtained.

The PNP saw him again on 4/21/15 and discussed the low carbamazepine level, noting that he was still rambling and had elevated mood. No psychotic signs or symptoms were noted. He asked for stronger medications. The PNP stopped the carbamazepine and the olanzapine, surmising that he was not taking the latter, though the documentation does not say whether the PNP asked him or whether the MAR was reviewed. She did not see reason for involuntary medication administration.

Mental health rounds resumed on 5/17/15 and 6/1/15.

A Quarterly Treatment Team Review note on 6/15/15 basically noted just that he was not on medications and was “not sleeping.” He continued to be engaged in no programs and no treatment. The associated treatment plan mentioned “poor hygiene” but the plan was the usual generic language except the psychiatric and nursing components were removed since he was not on medications. There was no plan to address his hygiene.

There were no further notes of any sort until 8/3/15 when he was involved in a fight. Even this resulted in no mental health contact.

On 8/10/15, he submitted a Medical Services Request Form asking for help with sleep and complaining that he was not being helped with this, making him want to hang himself. He made a similar request a few days later.

A MHC note from 8/10/15 reported on the complaint and referred him to a psychiatric prescriber. A checklist mental status examination reported no abnormalities other than poor sleep.

A psychiatrist saw him on 8/18/15 and he reported having mood symptoms including depression and periods of “irritability, hyperactivity, and poor sleep and thought racing, but it does not seem to have the intensity and duration to suggest a cyclical mood disorder at present. His depression alosso [sic] has only concentration and sleep problems. It appears that sleep is his main issue and bbecasuse [sic] it fits a mixed depression pattern, I think using a sedating antidepressant with Tegretol [carbamazepine] tocoer [sic] the irritability and hyperness [sic] might be the place to start.” This was the first note that discussed diagnostic criteria or made any basic attempt at some degree of assessment. The psychiatrist started him on carbamazepine 400 mg at night (it should be given twice daily, starting with two 200 mg doses) and mirtazapine 45 mg (which should be started at 15 mg and titrated upwards). No baseline or monitoring labs were ordered.

He was not seen again (including no rounds) until, on 9/25/15, he submitted a Medical Services Request Form stating his cellmate was trying to kill him and requesting a cell change or he would hang himself. He was not seen until 9/29/15. The MHP simply noted what he had said and completed a checklist mental status examination that was reportedly normal (including reporting that he had “good” judgment). The recommendation was that the patient wanted to change cells and then oddly stated the following: “Client is [suicidal and homicidal ideation] [sic] when he is around roommate. Client denied feeling [suicidal or homicidal ideation] at this time, denied visual/auditory hallucinations.” The plan was to refer to a psychiatric prescriber but

there was no risk assessment of his danger to self or others or a plan to address these issues in the near term.

He was not seen by a PNP until 10/14/15 but the PNP did not note the above history and noted only that he had poor sleep and unimproved mood. Regarding dangerousness, the note only reported that he denied suicidal or homicidal ideation. The patient was also disheveled. The plan was to increase the carbamazepine. No labs were ordered.

A Quarterly Treatment Team Review note on 10/19/15 reported, as usual, that he was taking his medications. The note was otherwise almost identical to previous such notes, including the usual generic treatment plan. There was no mention of his problems on the unit.

He was not seen again by mental health until submitting a Sick Call Form on 11/10/15, wherein he complained of side effects described as “locking up,” which could represent the serious side effect dystonia. This can be life-threatening if involving the airway.

He was next seen by a PNP on 11/17/15, though not in response to the Sick Call Form but in routine follow-up. At that time, the patient reported the same side effect of dystonia and also reported being “restless at times,” wanting “Benadryl” for side effects and “then allergies.” The checklist mental status examination was normal except for indicating that he was impulsive. The PNP increased the carbamazepine for unknown reasons (none were given) and again ordered no labs. This was very problematic with carbamazepine as it has a number of well-known potential adverse reactions that are readily detected with routine monitoring.

Mental health rounds resumed on 11/19/15 (the patient was still on the mental health residential unit) and 12/15/15. The patient “refused” mental health services, though there was no evidence he was offered any services – perhaps he did not want to talk much during rounds. But the mental health clinician reported normal mental status findings nonetheless.

On 12/16/15, a PNP saw him in follow-up. He felt depressed but did not have the few other depressive symptoms the PNP asked about. The PNP noted a thought disorder but no other psychotic symptoms.

On 1/20/16, he submitted a Medical Services Request Form complaining of hunger and worries of dying. He had lost over 30 pounds since arrival. The nurse saw him, took his vital signs, and told him to submit another request in a week if he did not feel better. He continued to make similar complaints, including intolerance of some foods. He continued to lose weight thereafter.

He was not seen again by any mental health staff until a PNP visit on 1/26/16. He spoke about “more suffering” and similar terms expressing his difficulty. He reported “sadness and low energy, NO sleep or appetite disturbances.” The PNP did not comment on his weight loss. His mood was “bad” and his affect was “anxious/worried.” The PNP saw no psychotic symptoms but did find paranoia. The plan was to continue current medications. Again, no labs were ordered. And despite his long history of non-adherence, there was no evidence that this patient was being monitored for adherence by any mental health staff.

The next mental health contact was again with the PNP on 2/16/16. By this time, he was long overdue for a treatment plan update. He was noted to be anxious, paranoid, suspicious, and rambling with tangential thinking. He was also irritable and euphoric, distractible, and had decreased sleep. The PNP started olanzapine, presumably for the psychotic symptoms. Again, no labs were ordered either for baseline olanzapine studies or to monitor carbamazepine.

The PNP saw him again on 2/22/16. The patient reported anxiety but was less paranoid and more coherent. Though late, the PNP ordered almost all important monitoring labs on this date. The 3/1/16 lab results showed mild lipid abnormalities, normal metabolic panel, and normal complete blood count. The carbamazepine level was undetectable, indicating non-adherence.

The patient made a sick call request to get help with his dietary requests but made suicidal statements and was thus seen by a LMSW. He was noted to be agitated and his thought disordered but not suicidal; he seemed just to be trying to get someone to pay attention to his dietary problems. The patient had been making steadily more claims about food intolerance that seem likely to be more reflective of mental illness than of actual food problems but this was never considered.

The next mental health contact was again with the PNP on 3/18/16. Despite remaining on the residential mental health unit, being on psychotropic medications, having a history of self-harm, and having a history of mood and psychotic symptoms, he was not being seen on rounds, had no current treatment plan, and was not receiving any services other than medications. He complained of continued problems with sleep. He was “very paranoid” and his speech was “pressured.” The PNP increased the olanzapine. The PNP did not comment on the lab results, including the non-detectable carbamazepine level or abnormal lipids. The patient’s diagnosis was changed to bipolar disorder, manic, with psychosis.

The next mental health contact was again with the PNP on 4/13/16. He complained of being slowed by the medications and feeling the “meds are eating up his brain.” He complained of poor sleep and appetite. His “mood was exhausted” and he was anxious but he was not exhibiting psychotic symptoms. There was still no mention of non-adherence. The olanzapine was decreased slightly, presumably to decrease sedation.

The PNP saw him again on 5/5/16. He continued to feel sedated. The mental status findings were consistent with being more stable, if sedated. No changes were made.

On 5/23/16, the patient reported “I slammed my finger in the door.” Another note indicated he “had his right hand caught in the door,” which makes it seem accidental, though this was not clearly stated. An X-ray showed non-displaced fractures of the third and fourth fingers of right hand. His fingers were taped together.

On 7/4/16, there was finally a new, though again generic, treatment plan. But there was no associated note detailing any interim history, let alone progress in treatment, most likely because he was not getting any treatment other than medications, but even his medication response was never addressed.

That same day, he was seen by a PNP who did an AIMS, which was negative. He reported a poor appetite and not getting enough food. These inconsistent reports were not reconciled. Had they been, perhaps his odd complaints about food would have been addressed. He was otherwise without severe symptoms. Medications were unchanged.

On 7/6/16, he again tied a rope around his neck in the recreation area. His neck was red but he did not require medical treatment. The nurse referred him to mental health but, unbelievably, there was no response.

On 7/12/16, he submitted a Medical Services Request Form expressing concern about having cancer.

On 7/14/16, laboratory results showed worsening lipid abnormalities (consistent with treatment with olanzapine), normal complete blood count, normal urinalysis, negative hepatitis and HIV screens, normal metabolic panel, but no carbamazepine level.

He was finally seen in mental health rounds on 7/18/16 and “reported no mental health concern [sic].” The MHP included generic statements about medication compliance, “having positive behavior with all working staff at this facility,” and “maintaining a healthy lifestyle by filling out sick call for mental or health related issues.” The patient reportedly denied suicidal and homicidal ideation and hallucinations. The plan was to monitor.

On 7/25/16, he submitted a Medical Services Request Form reporting a mental health emergency. The MHP response on the form noted he was “unkempt, unclean, claims people make him suicidal” but denied suicidal ideation. He did endorse hallucinations. The MHP note in the chart indicated he wanted to see a therapist and was “dirty.” But, contradicting the preceding, it says he denied hallucinations. The note goes on to say he wanted to talk to a therapist about housing and he was told “the proper protocol for him getting moved to another zone.”

On 7/28/16, he submitted a Medical Services Request Form expressing suicidal ideation and thoughts of hurting his cellmate. The MHP responded that day and reported that he said “I feel suicidal and want to be moved.” He was again malodorous and “unkempt and dirty.” The MHP noted no other problems on mental status examination. The MHP again just referred him to MTC staff and did not evaluate his danger to self or others.

There was a similar brief MHP note on 8/1/16.

Rounds resumed on 8/15/16 with a note including the same generic comments about taking medications, positive behavior, and maintaining a healthy lifestyle.

An MHP made an emergency visit to unit 3 on 8/18/16 after the patient expressed suicidal ideation to custody. The patient again expressed problems with his cellmate and was simply referred back to MTC. The MHP noted having met with the unit manager and case managers and that he had been moved three times. There was no discussion about why he was having problems. The MHP wrote: “MHP discussed behavior, moral ethical behavior [sic], and cleanliness with client. MHP also discussed with client that this is not mental health and that it is

a security and housing unit issue.” The MHP reported that this was “a manipulation tactic.” The plan was to monitor.

He was not seen again until a PNP saw him on 9/25/16, reportedly as part of a “treatment team review.” He complained of side effects of nausea and drowsiness. He had not taken the olanzapine for over two weeks. The low carbamazepine level from July was finally noted. He was restless but no other mood or psychotic symptoms were elicited. The PNP discontinued the olanzapine but not the mirtazapine or carbamazepine, despite non-adherence with the latter. The reason for the medication changes were not discussed. Given his history of psychosis, it is difficult to understand why the olanzapine was discontinued or not changed to another antipsychotic. The abnormal labs were also not mentioned.

There was another generic treatment plan that same day.

The record ends here.

This obviously cognitively-limited and mentally ill man with poor coping and social skills received nothing other than medications. He was desperately in need of a variety of services to help him cope with prison, interact effectively with others, and find alternatives to seeking help other than self-harm and threats of harming himself or others. He also needed help with self-care and his weight loss and food complaints were never addressed through the lens of mental health. The repeated mention of manipulation and use of words such as “moral” demonstrate a complete failure to appreciate that he was seriously limited. It is fortunate that he has not succeeded in seriously harming himself as yet.

Failures to respond to referrals and to see him regularly also likely contributed to his problems managing his interpersonal situation both because of poor monitoring and loss of potentially supportive contacts, both of which are important to detect problems before they arise or prevent them from becoming serious.

The failure to address his complaints of being raped and otherwise victimized is another substantial failure; not only was nothing done to address his suffering, but also nothing was done to help reduce his risk. The failure to address his potential for victimization and to take appropriate steps also contributed to his victimization.

Medication prescribing was also problematic. Not only was he not properly monitored, but medication choices were questionable and poorly justified or not justified at all. His repeated non-adherence clearly had an impact on medication choice but this was not addressed either.

The patient himself described the poor conditions on his residential mental health unit; such conditions are profoundly non-therapeutic and are unnecessary and inconsistent with correctional standards. Clearly, they contribute substantially to the violence this patient experienced and witnessed.

Patient 14

This patient opened the interview by saying, “I’ve been off my meds 7 months and I’m stable and I want to go to Portman to be near my family. Don’t know why I can’t get there.” He reported that he had only been at EMCF for those 7 months, going off medications two weeks after arrival, yet he was still housed on the residential mental health unit. Asked about whether he had gotten any information about his transfer he replied, “I go see [names a clinician], a MH counselor or something and she types in the computer. [A PNP] says it’s not up to her.”

At admission he had been on haloperidol and a medication he could not remember. As he put it, “They said I was kind of hyper. I scratched my arm a little and they said I was suicidal. I’ll never do that no more. They lie to me about medical. I got colon cancer. Every time I go to the bathroom there’s blood.” When asked about the colon cancer, he described having colonoscopy but does not really explain how he knows he has colon cancer. He then got up and exhibited an ulceration on his penis that he felt had not been adequately addressed; he was given an antibiotic ointment but it had not cleared. Asked about further care he noted, “They supposed to call me up and dress it but they don’t. Been asking all day to get to medical.”

He complained about the violence in the facility and specifically about inmates using the new, hard meal trays to hit others, including officers. Like others, he talked about a nurse diverting medications stating: “The nurse gives some patients others’ meds and withholds them from others.” He believed the nurse does this because those inmates that benefit will protect her. He goes on to say, “There’s supposed to be an officer on the zone and there isn’t. The ones in the booth, they put up books and stuff to block our view and they just sleep back there.” He went on to say that officers were bringing in contraband and that they would try to get inmates to assault each other.

He did say that a young mental health staff who had just started was doing rounds but that the previously assigned clinician had not. There was another mental health staff before that who would do rounds as well.

He did not appear to have substantial mental health needs but it is possible that his somatic issues represent delusions or a somatic preoccupation. Consistent with reports of others on his residential mental health unit, conditions on the unit are chaotic and non-therapeutic.

Patient 15

During our initial brief contact on Unit 3-C, this patient had complained that haloperidol injections were used as punishment. When asked about this during our private interview he replied, “They use it for punishment. You can be depressed or whatever or talk about staff and they shoot you up with Haldol.” He had last had an injection “about a year ago. That’s happening more to the old guys that have been around.” He then spontaneously offered, “You tell the staff you’re suicidal and they just say there’s nothing wrong. Two or three years ago I

cut my throat [He shows the scar].” Asked if custody would call mental health when he told them about suicidal ideation he replied, “No. They just say you just owe somebody, you’re not going to kill yourself.” Asked if mental health responded if he sent a kite he replied, “You might get that back in a week or so.” Talking about custody staff, he also reported, “At night they tell you there is no mental health staff here and medical is full so you just have to wait until tomorrow. They don’t even put you on precautions.”

Like others, he also spoke about nurse diversion of medications. He specifically mentioned a nurse who gave Neurontin to an inmate who sold them for \$1.50 each. He noted that this nurse also diverted Benadryl, “She also gives out Benadryl. She gives them five at a time when they’re not supposed to.” He goes on to note three staff whom he told about this, including some in leadership positions.

Asked about groups he replied, “That’s just out of the question. They do things when you all are coming. They make us clean the zone and stuff and put on the dog and pony show.” He noted that the showers are typically moldy and spoke of inmates having to polish the floors prior to our visit.

Similar to the previous inmate, he noted that there had been an earlier mental health staff assigned to the unit who had done regular rounds but she had been moved and then they stopped. When asked whether there was again a new mental health staff he noted that the new person was doing better but not rounding as regularly as the previously mentioned mental health staff member.

With regard to reliability of medication delivery he had this to say: “Sometimes I’ll be out for a week or two before the pack comes. ... They do pill call. ... It’s supposed to be at 9. Might be 12. The other day it was 1:30. They said they were short of nurses. [At night] you might get pill call at 11. Last night it was 11. We got one nurse [who he names] who comes on time. And she also says if it’s not ordered, I’m not giving it. I like nurse [names again].”

He also reported on the infrequency of custody rounds saying, “They might count once a day. At night time you might have an officer come in one time. This is a mental health facility and you might be rooming with guys hearing voices. And there’s supposed to be somebody watching the cameras but it’s a joke.”

Here again, this patient reports on the poor conditions on the residential mental health unit and the lack of treatment other than medications. This was also another patient who had less serious needs than others that were not housed on residential mental health units.

Patient 16

This clearly mentally ill patient had been on Unit 3-C for a year and a half. He complained about classification and case management services, specifically complaining about not getting a job despite requesting one. He spontaneously offered, “I seen people hang themselves. Heard there

was someone hang themselves [sic] in medical ... [b]ack in April.” Asked about other self-harm he noted, “We got cutters. They’re some pain freaks. I seen [sic] blood all over the floor. I see some snorting pills, selling them for coffee. A lot of Benadryl is coming up missing from the carts. It’s big in prison. It soothes you and relaxes you.” He noted Neurontin was also being diverted and “snorted.” He also stated, “I’ve seen people take a battery and pound it down and scrape the stuff out of it and sharpen it to cut themselves, cut onions, swap it. ... Some inmates give their trays away for coffee, Benadryl, batteries.”

Asked about his medication he reported that he was on Zyprexa and that “[t]hey said it’s for sleeping. I was taking Risperdal but now they’re doing a recall.” When told Zyprexa was normally given for hearing voices and trouble thinking clearly he noted, “Sometimes I talk to myself. Sometimes the spirits talk to me and keep me at ease. I keep to myself so I talk to myself. ... This facility ran off spirits. I call them Shiite/Masonics. That’s what they tell me. They’re like Djinns or something. This place is deep man. It really is.” He also talked about his telepathic abilities.

Asked about mental health staff doing rounds he replied, “They do what they do. The prison runs itself. They’re not going to come every time you call. They come frequently but not all the time. There has to be something extreme like setting a fire.” Asked directly, he stated they did not do regular rounds. Asked about individual meetings with mental health he replied, “You have treatment team you see once every four months or something like that. You can’t just talk to the psychologist.” He reported seeing a psychiatric prescriber every four months in “The case manager’s office next door.”

I conducted a thorough medical record review.

The record prior to July 2015 demonstrated a clear psychotic illness with paranoid delusions, belief in mind-reading, thought disorder, and other bizarre beliefs. He made references to Masons dating back to November 2014. He had been on suicide watch or psychiatric observation for extended periods, including for almost a month after his arrival at EMCF in April 2015. Following his arrival, he had a number of medication changes. Nowhere in the record was there a complete psychiatric or mental health assessment.

At the beginning of July, he was ordered risperidone, citalopram, and diphenhydramine. On 7/27/15 he reported that he was only taking diphenhydramine. There was a signed refusal for morning medications (the citalopram) from 7/9/15. These refusals were noted on the MAR but the MAR indicated that he was taking the nighttime dose of risperidone throughout this time, contrary to his report. In the MHC note reporting the non-adherence, the MHC found no evidence of psychosis; the only finding was “a somewhat sporadic sleep pattern.” The plan was to “monitor for all psychiatric needs.” There was no evidence that his non-adherence was communicated to the prescriber, though the record suggests he was referred to a psychiatric prescriber it is not clearly for this reason.

A Mental Health Treatment Plan from that same day was entirely generic and uses the same language as many other treatment plans. The Objectives/Goals were: “Symptom reduction or

maintenance, Develop or improve coping skills, increase adaptation to correctional environment, improve social skills.” And while there was a brief notation of his non-adherence, the physician intervention was: Monitor frequency, medication, progress toward treatment goals... every 30, 60, or 90 days.” Mental health services were: “Crisis intervention, Individual therapy, Group therapy.” The frequency is “[As needed] by [sick call request], weekly, monthly.” And strangely, though typically, the patient responsibilities were: “Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed.” There was no plan to address his non-adherence and no individualization whatsoever.

A psychiatrist saw him 7/30/15 and noted the non-adherence, though only with the risperidone, despite the signed refusal. There was no indication that his non-adherence had been communicated near the time he stopped taking the medication. In contradistinction to the 7/27/15 MHC note, the psychiatrist noted that the patient is “not logical,” is “depressed,” and exhibits “flat affect” and “tangential” thought. The psychiatrist encouraged medication compliance and planned to follow his compliance and review the record.

Despite this, and being housed on a residential mental health unit, the next mental health note is not until 10/19/15 when he was seen by a PNP who again noted his non-adherence. This PNP had met with him while in a decompensated state and found that, at the time of the current contact, he was in better condition. Because of his refusal, medications were stopped. The plan is for follow-up in three months, despite being off medications and having a history of serious psychotic symptoms.

The next contact was 11/19/15 during mental health rounds by a LMSW. The note indicated that rounds were done with an Officer. The patient “refused mental health services....” It stated that the patient “did not report any [suicidal or homicidal ideation], [auditory or visual hallucinations], delusions, paranoia, or other mood disturbances.” It is unclear whether this meant the patient simply did not say anything about such symptoms or whether he was asked; given the refusal of services, it seems likely that this note simply means he did not say anything as there is no evidence that the LMSW did any assessment. The plan was “No follow-up needed other than to continue monitoring client....”

An 11/23/15 Quarterly Treatment Review by an LMSW reported that the “[c]lient reported that he is compliant with his medications on a daily basis and has no side effects,” yet he was on no medications. He reportedly “denied having any [suicidal or homicidal ideation], [auditory or visual hallucinations], paranoia, delusions, or mood disturbances.” Yet it went on to say he “appeared to ramble about Hurricane Katrina activities on his housing pod, and other random topics.” Despite this indication of returning psychosis, there were “No recommendations or referrals at this time.” Perhaps the clinicians were unaware that he was no longer on medications. It goes on to include the usual verbiage about being monitored.

On 12/15/15, the patient refused to engage during mental health rounds and “will continue to be monitored....”

On 12/30/15, he was seen by a different PNP whom he told that he had been “off meds for 3 months and want to transfer to Marshall County.” He wanted to see his family. The mental

status examination was completely normal, though he had “poor” judgment and insight; if asymptomatic, it is unclear what this meant. There was no plan for follow-up.

He was next seen 2/11/16 by a psychiatrist who found “no evidence of decompensation off meds.”

The patient participated in an anger management group on 2/17/16, 2/24/16, 3/2/16, 3/9/16, 3/16/16, 3/23/16, 3/30/16, and 4/6/16.

The patient submitted a request to see the PNP and was seen by a LMSW 3/3/16 who he reportedly told that the PNP had asked to see him prior to classification review. The LMSW reported he had no mental health symptoms.

He was seen by a PNP who had never met him before (not the one who had asked to see him) on 3/7/16. He again talked about a transfer to be near his family. He requested to talk to someone “to help him through the grieving process, does not want to take medications.” There was no mention of what he was grieving about. There were no abnormalities on the mental status examination.

He was never seen for help around the grieving process.

He was transferred to CMCF 4/11/16. He denied any mental health history on intake. There was no evidence that the receiving facility knew of his mental health history.

On 6/6/16, he was seen by a psychologist and reported being paranoid. The psychologist noted that he was guarded “when attempts made to gather information about his mental health functioning.” He was anxious with constricted affect but no other positive findings were noted.

On 6/12/16, he was “walking around naked” and reported smoking spice, “hearing some voices and feeling paranoid.” He was “distracted” but no other findings were noted. The patient refused intramuscular injections of haloperidol and benztropine. He was placed on observation status.

The following day, he was reportedly doing better but on 6/14/16 he “did not answer many questions, just stared blankly at MHP.” He improved some over the next few days.

On 6/17/16, he asked to take medications. The psychiatrist noted “paranoia” and that the patient complained of auditory hallucinations. The psychiatrist ordered perphenazine, an antipsychotic, as the patient refused risperidone and olanzapine.

Somewhere around 6/28/16, he was transferred back to EMCF. He again denied all mental health history upon intake with medical personnel. He was noted to exhibit “flight of ideas,” to be “illogical,” and to have hallucinations. The MSW wrote that he “presented as actively psychotic during the interview as he stopped at several points during the interview and started off and talked to himself. Client gave MHP several different answers to the questions presented to him for intake.” These findings should have resulted in a prompt referral to a psychiatric prescriber but instead resulted in a routine referral.

Despite this, he was not seen again until a 7/12/16 visit with a PNP. The only finding was a report of hallucinations. Despite this, the PNP changed him to olanzapine 15 mg, a substantial dose.

On 7/18/16, there was a rounds note by a MHP during which he made inappropriate comments of a sexual nature and asked for a cell phone, for which the MHP submitted a RVR. The MHP felt this was “manipulative.” The MHP noted no psychiatric symptoms; there was no evidence the MHP was aware of his history of serious symptoms and did not consider whether his mental illness might be driving his behavior.

On 7/28/16, he was seen at mental health sick call, asking for “some medications for my nerves.” He reportedly denied all other symptoms and the MHP found no abnormalities.

On 8/1/16, at another mental health sick call, he asked why the perphenazine had been stopped, forgetting that he had been changed to olanzapine. The MHP reported that the perphenazine was “reordered.” Fortunately, there was no evidence this was done.

That same day he was seen by a PNP who conducted an AIMS which was negative. The patient reported talking to himself and the PNP found “circumstantial” thought and that he was “hearing the Holy Spirit talking to him.” He was also paranoid. The PNP increased the olanzapine.

There was another generic rounds note by an MHP on 8/15/16 that reported no mental health symptoms.

The same MHP saw him for an “office visit/30 day contacts on housing unit 3c in the hallway with security present. Client did not report any mental, emotion, physical, or spiritual health concerns. Client denied all [auditory, visual, and tactile] hallucinations and [suicidal or homicidal] ideations.”

He attended a self-esteem group on 8/17/16, 8/24/16, and 8/31/16.

A PNP saw him again 8/23/16 and noted no mental health symptoms.

This is another example of a seriously mentally ill man who is not getting the services he needs and describes the poor conditions on the residential mental health unit. My visit with him was almost exactly at the same time he was seen by the PNP on 8/1/16, yet there was no mention of his beliefs about the Masons other than in November 2014, though I readily elicited this from him as well as other delusional beliefs such as telepathy (that he had previously reported) consistent with a psychotic disorder.

The failure to detect or report his active symptoms raises grave concerns about the reliability or capability of mental health staff to properly assess their patients, especially the non-prescribing staff. This likely contributes to the tendency to consider how mental illness may be contributing to problem behavior or that such behaviors might be an indicator of worsening symptoms. This is also likely the reason that he was transferred out of EMCF, only to deteriorate and return in worse condition.

This was one of the few patients who has been in some groups since July 2015, but even so, they were too few to constitute meaningful treatment and did nothing to help him understand his mental illness or medications. Such basic interventions reduce non-adherence and the associated risk due to untreated symptoms and associated behavior problems.

Similarly, he received no individual sessions to address these issues, let alone the request for help with his grief or even any attempt to determine whether it was a significant issue.

His medications were not properly monitored with appropriate laboratory studies, placing the patient at risk of medical complications.

Patient 17

This obviously mentally ill patient had been at EMCF for two years and on unit 3-C for one year. He had been in prison since 2010.

Other than periodic meetings with a psychiatric prescriber, he reported getting no treatment. He was on haloperidol decanoate and Depakote. He reported that he would periodically run out of Depakote for up to a month. With regard to the reason for taking medications he noted, “They said they would help me calm down when I’m having tantrums.” He immediately went on to offer, “The reason I said we need better food is because I’ve been betting my food on the football games and cards. ... sometimes people sell pills for food cuz it’s hard to get canteen.” Asked what pills were sold he responded, “Not Depakote, not Risperdal.... Benadryl. Sometimes people sell Benadryl for a shot of coffee.”

Owing to his thought disorder and preoccupation with psychotic ideas, it was difficult to get much additional information from him. He was quite ill-kempt and malodorous as well.

This patient’s medical record dates back to 2010.

From the date of his admission 5/10/10, it was clear that he had mental health needs and cognitive limitations. He was started on haloperidol, an antipsychotic, and the side effect medication benztoprine the next day.

He also had a seizure disorder, treated with Dilantin, and a history of substance abuse.

While his psychosis stabilized and he settled down, he began to demonstrate problems more related to his intellectual limitations. He made inappropriate sexual comments and overtures. In a 7/21/10 note, a female mental health clinician at SMCI remarked that he “does not have a genuine understanding of his situation; even after it had been explained to him multiple times. Inmate asked a lot of inappropriate questions and made inappropriate statements: Do you like to watch porno pictures? Wouldn’t you try to get out of here if you could? Shouldn’t you be able to date who you want? What do you do with your free time? If you and me slept in the same

bed, I would probably try to have sex with you.” It went on to talk about his impending transfer to EMCF and noted that he “still needs intensive mental health treatment.”

However, he was transferred to CMCF where he remained until June 2011.

While there he exhibited significant psychotic symptoms and was given injections of haloperidol and placed on watch. He acted out sexually, was challenging to officers, and generally caused a commotion. His cognitive limitations and associated behavioral problem interacted in a negative way with his psychotic disorder. He began to have suicidal ideation and was placed on watch. He ultimately stabilized on haloperidol and divalproex sodium but required frequent contacts, almost all with a psychiatric prescriber.

Unaccountably, he was transferred to MSP on 6/11/11. He deteriorated. He stopped taking his medications. Oddly, he was made LOC A in October.

In November, he was assaulted by a peer. After this, he was quiet for a time.

In June 2012, he admitted to auditory hallucinations and was paranoid though not clearly delusional. He was also somewhat depressed. A psychiatrist started him on the antipsychotic, risperidone at a low dose. The patient was pleased not to be on an injection. He had regular contacts with a mental health clinician at MSP. He improved again.

Contact diminished and he deteriorated again, ending up on suicide watch in December 2012 and January 2013. He had cut himself. He again stabilized with medications and clinical contacts (not rounds) about twice each month. These again slowed.

He later deteriorated again and was given emergency haloperidol injections in January 2014. By this time his diagnosis had been changed to schizoaffective disorder. He was again placed on watch, floridly psychotic, believing he was Jesus Christ and talking about being a “porn star.”

He was ultimately put on fluphenazine decanoate, a long-acting antipsychotic, again likely involuntary. He remained in the MSP infirmary for months with minimal contact other than rounds; he did poorly much of that time but slowly settle down. It appeared the problem with the transfer was in part because he had to sign something saying he no longer wanted protective custody before he could go to EMCF.

He was transferred to EMCF 4/15/14. The medical intake was completely negative in terms of psychiatric history of symptoms, clearly highly inaccurate.

The mental health intake consisted of a Suicide Potential Screening form that was accurate except for noting no previous suicide attempts and noting no history of victimization. A Mental Health Treatment Plan that day reported him having substantial psychotic symptoms, anxiety, and poor hygiene. He continued to talk of Jesus and getting messages from the television and he was though disordered, among other symptoms. The Objectives/Goals and Interventions and Modalities were the familiar boilerplate language.

He also met with a PNP that day and expressed more bizarre ideas, including having “50 wives, 50 husbands, and 999 zillion children.” He required a great deal of prompting and other

measures to complete the interview. He was placed in the infirmary on observation status because of his florid symptoms. For unclear reasons, he was changed to haloperidol decanoate, a similar long-acting antipsychotic. Carbamazepine, a mood stabilizer that had been started at MSP, was also stopped for unclear reasons.

He remained in the infirmary through April, showing some minimal slow improvement. He was transferred to a residential mental health unit in May.

He continued to have overt delusions, auditory hallucinations, and other psychotic symptoms. His only contacts were occasional rounds.

On 7/21/14, he was in a fight. It is not clear what happened.

On 7/29/14, he was placed back in the infirmary on observation, still psychotic.

An AIMS from 7/30/14 was 0, showing no movement disorder. A PNP note from that day notes that he had been in 3-4 fights. He had also been refusing medications, including the haloperidol decanoate injection. He was reportedly willing to resume medications. He was given a short-acting and long-acting injection of haloperidol that day and returned to his unit.

During a 9/11/14 meeting with a PNP, he was psychotic and became extremely agitated. He was given an emergency injection of haloperidol (and side effect medication). He was placed in the medical holding tank overnight and returned to his unit.

He continued to be psychotic and bouncing back and forth between the infirmary and residential mental health unit. He was involved in another fight on 2/1/15. The associated PNP note makes it clear that his delusions and rapping, believing he was Tupac Shakur, likely incited his cellmate to assault him, resulting in a fight. The PNP increased the haloperidol decanoate and continued side effect medications.

He assaulted another peer on 3/8/15 and again on 3/15/15. He was placed in the medical holding tank. He was soon returned to his unit. There were a few notes regarding difficulties with cellmates and peers but it was unclear what was done.

He calmed down over the next few months.

On 7/13/15, a boilerplate treatment plan was entered into the medical record.

The patient was seen by a psychiatrist on 8/6/15. He asked to come off medications and the psychiatrist wrote: "I have worked with him in the past and have seen him do quite well on no meds. It is hard to tell if he might have intermittent psychosis, but given that optimistic [sic] and has done well of meds before, I am comfortable trying him off meds." The psychiatrist noted no evidence of mental illness on the mental status examination. There was no evidence that the psychiatrist reviewed the recent course, let alone done an assessment. The medications were stopped.

On 8/24/15, a PNP saw him upon custody referral because he was throwing chairs and aggressive. He was overtly psychotic. The haloperidol was restarted. The PNP wrote, "Discussed restarting long-actin [sic] decanoate medications – he offers objections to restarting

the recommended medications – will give oral Haldol by mouth and oral Cogentin as a boost to restarting the Haldol [decanoate] – may reconsider oral medications in the future – for now – will go ahead with these recommendations to offer [sic] stabilization to [symptoms] [sic]. Risks/benefits discussed – he agrees.”

On 10/5/15, a lipid profile, complete blood count, and metabolic panel were unremarkable.

He was not seen again by mental health until 10/19/15 when the PNP saw him again. He was doing much better. The PNP offered starting a new atypical antipsychotic but the patient reportedly preferred to stay on the haloperidol.

Mental health rounds on the residential mental health unit continued on 11/13/15.

At a Quarterly Treatment Team Review on 11/16/15, he continued to express some psychotic symptoms but much fewer and less intense. The patient reportedly declined any education and had no job assignments. The plan was to monitor. There was no associated treatment plan.

Mental health rounds on the residential mental health unit continued on 12/3/15.

A PNP saw him on 12/29/15. He continued to be stable and satisfied with his medication.

A boilerplate treatment plan was entered into the record on 2/3/16.

He had not been seen again by mental health by the time he was involved in a fight on 3/27/16 and again on 4/3/16.

He was seen by a PNP 4/5/16 who seemed unaware of these altercations. However, other than talking about “needing a woman,” he seemed to be psychiatrically stable.

On 4/8/16, he was seen by a LMSW in response to a sick call request. He wanted help with his canteen, so worried he would not get it in time that he talked of killing himself. He denied actual suicidality and the LMSW apparently did nothing.

On 4/29/16, he was seen by a LMSW for an office visit on the unit. Peers had “voiced complaints about him.” He was defensive and unkempt. He exhibited thought disorder. The LMSW reviewed the MAR; the patient had refused his March haloperidol injection. Apparently, the nurse had not contacted anybody and the mental health staff were not monitoring is adherence. The plan was to refer to a psychiatric prescriber and monitor.

He was not seen by a PNP until 6/2/16. At this point, it was reportedly because security staff referred him after he “kicked an officer on unit 3.” He denied this and spoke about getting his canteen. Custody reported that he “became agitated” but there was no report about what had happened. He was delusional and thought disordered again but not as seriously as before. The PNP reported that the MAR demonstrated he had taken his medications. In fact, the March MAR did note a refusal but he had taken it the following two months. Regardless, the plan was to change him to the oral antipsychotic olanzapine and start the mood stabilizer divalproex sodium; appropriate labs were ordered. [Note: Two medication should not be started at the same time as it will be difficult to tell which causes any side effects and which is responsible for

improvement, not to mention other psychopharmacological complications.] An AIMS done that day showed not movement disorder. He was also placed in the infirmary on observation status.

The PNP saw him the following day. He was more calm but remained on observation.

Mental health rounds were conducted on 6/3/16, 6/6/16,

A 6/3/16 nursing note stated that he did not “want any pills.” He also “hits head against wall and door occasionally.”

The psychiatrist who had previously stopped his medications saw him on 6/6/16. The patient was agitated but no psychotic symptoms were reported. The patient wanted back on the haloperidol shot but the psychiatrist stated this would be considered at the next outpatient visit. He was released from the infirmary.

ON 6/27/16, a lipid profile, complete blood count, urinalysis, and metabolic panel were unremarkable. There was no valproic acid level.

On 7/5/16, the psychiatrist saw him again and he was agitated and psychotic. The psychiatrist wrote, “Poor compliance again has made it necessary for him to restart his Haldol shot tonight.” It was not clear whether this was voluntary at this point.

A generic treatment plan was entered on 7/11/16. Another AIMS that day was negative.

Rounds resumed on 7/18/16.

He was seen by a PNP on 8/1/16. He was again more stable but unkempt.

There were rounds again on 8/15/16 that included boilerplate language.

On 8/16/16, an MHP had an “office visit” with him in the hallway with custody present. It was another boilerplate, uninformative note.

A PNP saw him on 8/25/16. He was referred by custody staff for unknown reasons. His mood was elevated and he was thought disordered and disheveled. The PNP increased the frequency of the haloperidol injection from every 4 weeks to every 2 weeks. She also gave him an IM injection of short term haloperidol. The note says nothing about consent. There was not enough to suggest this was an emergency, in which case any additional medication should have been given by mouth if it was voluntary.

On 9/13/16, a PNP saw him after he assaulted a peer. This was reportedly over an unpaid debt. He was talking to himself but said he was praying. Other than being unkempt, no other problems were noted other than poor insight and judgment. The plan was to “lock him down in his room” and again give him a haloperidol injection.

The record ends here.

This obviously seriously mentally ill and cognitively limited man needs substantial support and monitoring to remain stable. Whenever he was not watched closely and met with regularly, he deteriorated and became assaultive. Mental health staff remained in reactive mode and waited for custody or the patient to call. Even when they did rounds, they failed to detect his decompensation, clearly demonstrating the inadequacy of the rounds.

These failures are thoroughgoing but this case, because he decompensates so quickly, readily reveal the defects in the staff's reactive and "monitoring" stance. Because of this, people got hurt. When this man was on his medications and carefully monitored, he did reasonably well.

Further, mental staff did nothing to help him with rehabilitation or skill development. These interventions and the structure that comes with them would have helped him substantially.

There were also a number of medication management problems pointed out above that contributed to his problems, especially too readily stopping his medications in August of 2015. It is notable that the psychiatrist readily stopped his medications when the patient asked at that point, but on subsequent occasions, psychiatric prescribers were all too ready to administer injections. While this is understandable given the clinical picture, it underscores the need for proper involuntary medication management at EMCF.

Patient 18

This patient was also overtly mentally ill; he exhibited evident thought disorder and delusions. He had been at EMCF for a year and on unit 3-C for about eight months.

When asked whether he had been in any treatment he responded, "I've been going to school, getting my GED. Ms. B's health class. My main problem is medication." He noted that he had previously been on injections of haloperidol decanoate but had been changed to olanzapine, divalproex sodium, and carbamazepine as well as medications for hypertension. He felt the current medications were not working as well: "I keep telling the psych doctor and he won't change my meds back to what I want." He stated that he has been "having homicidal ideation and hearing voices, especially at night. I don't know what it is – some kind of spirit. The medication is not doing any good. Sometimes I get angry. I get RVRs. I talk crazy sometimes and go off. In Social Security they diagnosed me with paranoid schizophrenia and sometimes I black out and stuff. They charged me with a crime I didn't do. Sometimes I don't take the medication. One of those pills, Zyprexa, puts me to sleep. I can't go to school and stuff. We take our meds sometimes at 11 at night and I can't get up in the morning. Sometimes it comes at seven but when it comes so late I sleep through breakfast. I told [the PNP] to put me back on Haldol and Benadryl. She said they're taking away Benadryl from the system. But guys are still on it. So now she's lying to me. I told her if they're not going to give me the right meds, I'm not going to take it. ... She told me she was going to try these medications on me. Trying them on me, what's that about?" When told he did not have to take the medications he responded, "I talked with my family and they tell me to take it because when I don't it's not... I'm not... I used to set fires, try to commit suicide. I ain't seen [the psychiatrist] since [the PNP] took over in January. She claims to be a nice person but she won't put me on Haldol and Benadryl."

Asked if mental health came to the unit and did rounds he responded, “On the zone? No. They have treatment team and you come down to this office here and they ask the same questions and they tell you if you have problems, put in a sick call. If you do, it might be nine more days before they see you.” He offered that one of the PNPs use to come on the unit but doesn’t any longer. He spontaneously reported, “The other night I had a problem and I asked to see a psych doctor and they said I would have to wait until the next morning. If you push it, they’ll jump on you. You wait to the morning and they still don’t come. They might come around once a month. When guys there go off, they just lock them down. This guy [names an inmate] set a fire this morning. They just took him off... they sprayed him and took him down.”

Asked how medications were delivered he responded, “An officer gave them their medications last night. The nurse didn’t come on the zone. Nurse never been on the zone this week. You can check it on the camera.”

He also talked about a number of inmates being “locked down.” He noted that the lieutenant was unaware of these lockdowns and when he found out “The lieutenant told them to took [sic] all those guys who were locked down off. When they do that, their cellies can’t even go in their cell to go to the bathroom.” When asked how inmates get back in their cells he replied, “They open the cells at lockdown.” Asked where they go to bathroom he responded, “Other guys’ cells.” He added, “The sergeant said to one guy that he was going to stay locked down until he was off this unit.”

He also reported on a shower that would not turn off (which I had seen during my tour) and stated, “We told the warden already.” He then talked about fungus and mold on the floors of the showers adding, “We be scrubbing and scrubbing. They just started painting and stuff now. They don’t do anything until you guys come around.”

Review of the medical record revealed that he was transferred to EMCF on 8/20/15. He had requested transfer to a psychiatric facility as far back as October 2012. He had transferred from the Mississippi State Penitentiary. His last psychiatric visit prior to leaving there was on 8/18/15. When the psychiatrist told him that he was transferring to EMCF he “brightened up” and “eagerly shook my hand in gratitude.” The psychiatrist noted that he “has had a marginal adaptation in prison, on and off meds, on and off ‘suicide’ watches. Sometimes gets into naughty masturbation.” He was reportedly “currently stable off psych meds.” The psychiatrist diagnosed only an adjustment disorder with anxiety and antisocial personality disorder. The psychiatrist noted a questionable diagnosis of paranoid schizophrenia.

A medical nurse completed the Intrasystem Transfer – Transferring Facility dated 8/20/15. This note indicated that he was not currently being treated by mental health, that he had no history of suicide attempts, no history of substance or alcohol abuse, and no history of psychiatric hospitalizations, all of which was incorrect except that he was not currently being treated by mental health – owing to his refusal of medications, though was being transferred to a mental health facility.

He was also seen that day at EMCF by an LCSW who completed a mental health intake; it was extremely brief. The patient was noted to be “talking to himself in a very low breath.” There was a very limited mental status examination that does not address hallucinations or delusions or even suicidal or homicidal ideation. In contradistinction to the intake nurse’s assessment, this note reported a history of polysubstance dependence. There was no mention of psychiatric history (including no information on hospitalizations or suicide attempts) or past treatment other than stating that he was not on any medications.

There was a Suicide Potential Screening form conducted by a mental health professional that same day. Several things are of note, especially given their inconsistency with prior notes. The transporting officer reportedly stated that the patient may be at risk of suicide. It also confirmed that he had a previous suicide attempt and previous psychiatric hospitalizations. The author also indicated that the patient signed the No Harm Agreement. He was approved for general population and a routine mental health referral made. Nonetheless he was housed on unit 3-C, a psychiatric pod.

Later, still 8/20/15, he saw a psychiatrist who wrote a brief note. The patient complained of hallucinations and problems with sleep. The psychiatrist noted that the “patient has had moderately severe complaints of depression, mood swings and psychosis for years and it has always been difficult to assess the severity as he has been on a mission to secure a spot in EMCF for years. It is possible that he actually hears voices sometimes, but he has done well on as little as 1 mg Risperdal along with Tegretol from 400 to 800 mg per day. We agreed today at his transfer assessment to put him on his most effective and mild regimen in recent years and he felt fine about this regimen.” The limited mental status assessment is completely negative except for irritability, increased activity, flight of ideas or racing thoughts, and decreased sleep. Despite no report of psychotic symptoms and limited evidence for mania, the assessment is “[Rule out] Bipolar I Disorder, most recent episode mixed, severe with psychosis.” The plan was to start carbamazepine and risperidone with follow-up in three months.

Yet later, a nurse conducted an Intrasystem Transfer-Receiving Screening. That note repeated that he did not have a history of suicidal behavior and had no history of inpatient or outpatient psychiatric treatment as well as no substance abuse. The nurse noted that this was based on review of transfer forms and medical records, which is difficult to reconcile given the medical record content already noted.

On 8/20/15, he also signed the generic and global consent for treatment. He also signed a document entitled “No Harm Agreement.” This was a Health Assurance, LLC document wherein he purportedly agreed to speak to a staff member when feeling suicidal or homicidal. Again, use of such agreements has been determined to not be sound practice.

On 8/21/15, the patient completed a Medical Service Request Form that included a request to see a psychiatric counselor. He wanted help both with his “mental problem and medication.” The mental health professional saw him three days later and noted that he had been seen by a psychiatrist on 8/20/15 and went on to say that the “problem has been address [sic].” However, there was no indication of what the problem was and there was no evaluation.

On 8/22/15, the patient completed a Medical Service Request Form that appeared to report anxiety due to being off side effect medications and requested to see mental health.

An 8/25/15 mental health sick call note by a mental health counselor reported on the patient's requests to see a psychiatrist. The note concluded, "the patient completed two medical service request forms. The patient was seen by the psychiatrist on 8/20/15 please see noted [sic] dated on 8/20/15. The patient will continue to be monitor [sic] for psychological needs." There was no discussion of why he made the requests or what his concerns were.

On 8/26/15, the patient completed a Medical Service Request Form that again included a complaint of anxiety and request to see a psychiatric provider. He was seen that day by mental health professional who noted that he had been seen by a mental health counselor on 8/25/15 regarding his mental health concerns. The assessment indicated that the patient denied suicidal and homicidal ideation and psychosis. The plan was to refer to a psychiatric prescriber and "continue to monitor."

A mental health note from that same date included a very brief mental status examination that was completely within normal limits though does say that he "denied" delusions. Though he complained of anxiety, there was no assessment of this complaint other than that his mood was "normal." The note indicated that he "denied [suicidal ideation/homicidal ideation], psychosis." The plan was to refer to a psychiatric prescriber and "continue to be monitored."

8/31/15 laboratory results included a lipid profile showing slightly elevated triglycerides, non-HDL (high density lipoprotein) cholesterol, and LDL (low density lipoprotein) cholesterol but normal total cholesterol and HDL. The metabolic panel and complete blood count were unremarkable. These results were not discussed by the psychiatric prescribers though his medications may have contributed to the lipid abnormalities.

On 9/2/15, the patient completed a Medical Service Request Form requesting a medication change and complaining of having hallucinations and "doing crazy things and seeing crazy things." He was seen by mental health professional the following day. In addition to the above complaint, the clinician also reported that the patient was "feeling angry and depressed." It also reported, "Split personality. Having flashbacks of the past. Decrease in sleep." He reportedly denied suicidal and homicidal ideation and hallucinations. The plan was to refer to a psychiatric prescriber and "continue to monitor."

On 9/3/15, a mental health professional saw the patient. He stated that he needed to have his medications changed and reported hallucinations and "doing crazy things and seeing crazy things." Despite this, the mental status examination reported that he denied hallucinations. The recommendations appear to be a summary of findings rather than actual recommendations: "patient states he has been doing crazy things, feeling angry and depressed. Patient states he has 'split personalities'. He is having flashbacks of the past and he cannot sleep." There was no plan.

On 9/14/15, the patient completed a Medical Service Request Form he complained of "seeing unreal things and doing crazy things" and requested a medication change. He was seen by a

mental health professional the following day who wrote, “Client had another sick call, already the same issue. Will refer to [a psychiatric prescriber].”

There was a 9/15/15 note by a mental health professional. There was virtually no content in this note other than a cursory mental status examination that was normal. The recommendations were again more of a summary: “client has done two previous sick calls for the same issues. Spoke to [the psychiatric prescriber] regarding the issue and he said to go ahead and refer him to [a psychiatric prescriber].”

On 9/22/15, the patient completed a Medical Service Request Form asking to be changed to Thorazine and Benadryl. He wrote, “please change my medication today-I’m doing crazy things and seeing things unreal [sic].” He was seen six days later. The mental health professional’s assessment was that he denied suicidal and homicidal ideation and denied visual and tactile hallucinations. There was no further evaluation and the plan was to refer to a psychiatric prescriber and “continue to monitor.”

That day, over three weeks since his original complaint, he was seen by a PNP. The patient continued to report that his medications were not working and that he was having “crazy thoughts.” The PNP noted that the psychiatrist had reported the patient had done well in the past on risperidone and carbamazepine. Mental status examination again reported on “crazy thoughts” but the patient “is unable to further elaborate and describe his thoughts.” Other than mild anxiety, the mental status examination was normal. The plan was to increase the carbamazepine from 400 to 600 mg. The PNP also ordered a carbamazepine level and a complete blood count; no results are included in the record. The patient’s level of care was reduced from E to C and the plan was to follow up in one month.

On 9/26/15, the patient completed a Medical Service Request Form requesting a change to haloperidol and diphenhydramine. He was seen that day by a nurse who noted that his current medications were started upon admission to EMCF on 8/20/15. The plan was to refer to a psychiatrist.

The patient was seen by a mental health professional on 9/28/15. The patient continued to request to see a psychiatric prescriber to change back to previously preferred medications. There was a cursory mental status examination and no discussion of what was troubling the patient. The plan was simply to once again refer him to a psychiatric prescriber and “continue to monitor.”

On 10/1/15, the patient completed a Medical Service Request Form and asked to see a particular mental health counselor. This counselor saw the patient that day and noted that the patient wanted to know if he was scheduled to be seen. The plan only noted that he was already scheduled. He reportedly denied suicidal and homicidal ideation and denied hallucinations. There was no further evaluation or explanation why the patient wanted to see that particular counselor. The mental health professional also wrote a note that included a cursory mental status examination that is completely. Again the plan is to have them seen by a psychiatric prescriber.

The patient participated in a group entitled Accepting Mental Illness on 10/1/15. This is the first session and the patient reportedly agreed to participate. Notes reflected that he participated in this group on 10/8/15, 10/15/15, 10/29/15, and 11/5/15.

On 10/24/15, the patient completed a Medical Service Request Form and complained of having mental problems, requesting to see a “mental health counselor and maybe a psychiatrist doctor.” He was seen by mental health professional three days later who noted “no side effect medications for haradol [sic – presumably Haldol].” The patient was not on Haldol at that time; he was on risperidone. The patient reportedly denied suicidal and homicidal ideation and hallucinations. There was no further assessment and he was referred to a psychiatric prescriber and no mention of the request to see a counselor. The mental health professional’s note included a cursory mental status examination and the following recommendations: “Patient want [sic] to have some type of side effect medication for haradol [sic]. He want [sic] it as a precaution. Will refer to [a psychiatric prescriber].” There was no discussion of the side effects he complained of.

On 11/10/15, a psychiatric prescriber began a cross taper from risperidone to olanzapine. The accompanying note reported that the patient complained of “hearing voices” and wanted stronger medication. The mental status examination is unremarkable except for the patient’s report of auditory hallucinations. There was no mention of the past lipid abnormalities, which made this a poor medication choice owing to elevated risk of metabolic syndrome with olanzapine.

On 11/19/15, he participated in a group entitled Social Skills. Notes reflected that he participated in this group on 12/3/15, 12/10/15, 12/17/15, 12/31/15, 1/7/16, and 1/28/16.

An LMSW conducted rounds on 11/24/15 and saw the patient, noting “The client did not have any mental health services at this time.” The note concluded: “no follow-up needed other than to continue monitoring client for any psychiatric/clinical concerns. Provide access to further mental health consultation upon client request.” The LMSW was apparently not aware that he was in a group.

On 12/6/15, the patient completed a Medical Service Request Form wherein he requested to see a “psychiatric counselor” and reported mental and medication problems. A mental health professional saw him the following day during a treatment team meeting. The associated note indicated that the patient was primarily complaining about anger, sleep problems, and “blackout spells when angry.” The note also stated that the patient “admitted to occasionally having delusions such as ‘seeing my family but they all dead now [sic].’” The patient was asked to take these issues up with the psychiatric prescriber. The plan was: “client will continue to be monitored for psychiatric/clinical concerns. Additional mental health services are available upon client request. Client will be seen by the treatment team for 90-day review in March 2016.” There was no plan to work with him around his problems and symptoms other than prescribing medications.

On 12/28/15, the patient completed a Medical Service Request Form wherein he requested to see a “psychiatric counselor. I need to see someone for counseling and psychiatric medication for paranoid schizophrenia [misspellings corrected].” He was seen by a mental health professional three days later, reportedly denying suicidal and homicidal ideation but reportedly “hearing

voices.” The only other assessment was that he was sleeping “OK,” his appetite was “real good,” and he was “kinda [sic] nervous.” The plan was to refer to a psychiatric prescriber.

An LMSW conducted rounds on 12/29/15 and saw the patient and noted, “The client did not report any mental health issues to provider on this date.” The note concluded: “Client will continue to be monitored by facility staff for any symptoms of possible psychiatric/clinical concerns. Access to mental health services is available upon client request.”

A different PNP saw the patient on 12/30/15. He again asked to have his medications changed. A cursory mental status examination was unremarkable except for poor judgment and insight and reported hallucinations. He was continued on the carbamazepine 600 mg and olanzapine 10 mg.

He was seen the following day by an LMSW and again asked for counseling and changes to medications. A cursory mental status examination was again normal except that he reported auditory loosen nations and feeling “kinda nervous.” The note concluded: “no referral needed/client saw [nurse practitioner] 12-30-15. Client will continue to be monitored for clinical/psych concerns.”

Laboratory studies were done 1/8/16 and included a lipid profile, complete blood count, and metabolic studies. He continued to have mild lipid abnormalities which were not addressed.

On 1/12/16, the patient completed a Medical Service Request Form. He complained of being “homicidal and seeing thing [sic] and voices. I need counseling and new medication order [sic].” He was seen two days later by a mental health professional who noted that the patient requested a medication review regarding “hostility & ‘blackouts.’” The plan was to refer to a psychiatric prescriber. The associated note reported the same complaints and that the patient requested counseling and medication changes again. The recommendations stated: “Client denied [suicidal and homicidal] ideation when engaged by provider. He reported that he hears voices ‘sometimes’ and denied any visual hallucinations. The client wanted to engage the provider in a discussion about his diet tray ordered by medical staff.... Client did not have any mental health concerns at this time and clearly denied that he was having any homicidal thought. Client admitted, however, that he was feeling hostility and experiencing blackouts.” The plan was to refer to a psychiatric prescriber and “continue to be monitored for further clinical/psych concerns.” Again, there was no indication that any other mental health staff were going to do anything in the way of treatment.

On 1/18/16, the patient was seen by a PNP for medication follow-up. He complained of sedation and getting his medications late. He also reported the medication not helping and requested Haldol or Thorazine but the note did not specify the way in which the current medications were unhelpful. He reported auditory and visual hallucinations of dead family members and people, though was not experiencing them at the time of the interview. The mental status examination was more complete than previous ones primarily by giving more detail about psychotic symptoms. However, it also says that he “denied” hallucinations in other places in the mental status examination (this was a checklist while the report of hallucinations was a narrative). Similarly, it reported he denied side effects, despite the narrative complaint of sedation. The plan stated that he was to continue olanzapine 10 mg and carbamazepine 600 mg. However, the PNP increased the olanzapine from 10 to 15 mg that same day. There was no discussion of

sedation or the request to change medications or why the increase was indicated, especially since the increase in olanzapine would be expected to increase sedation.

A complete blood count on 1/21/16 showed minor abnormalities. These were never discussed in any notes despite carbamazepine being a possible cause of these abnormalities and potentially representing a serious medical complication.

On 1/21/16, the patient completed a Medical Service Request Form requesting to see a “psychiatrist counselor about mental problems and diet tray.” He was seen the following day by a mental health professional who did not address the apparent request for counseling and simply told the patient to “allow 7 - 14 days for meds to get into his system.” The associated 1/22/16 LMSW note reported a completely normal mental status examination. The note stated the patient “had no new symptoms to report and primarily wanted to discuss his diet tray.” He again complained of sedation. He was told to “allow at least 7-14 days for his body to adjust to the new medications before he asks for another psych consultation unless he experienced some severe side effects.”

A Mental Health Treatment Plan from 2/2/16 listed his medications as olanzapine 10 mg and carbamazepine 600 mg; the MAR indicated that he was getting 15 mg of olanzapine. This treatment plan was another of the generic treatment plans, though with a small amount of different verbiage. The only identified problem was “psychosis.” The short-term goal was “the patient will attempt to gain a better understanding of his mental illness and how to alleviate/cope with symptoms.” The associated intervention read: “the client will be provided with supportive therapy geared toward cognitive restructuring as well routine monitoring, individual counseling, encouragement, and PR and crisis intervention. Client will be educated on contraindications/side effects of prescribed psychotropic medications.” The patient responsibilities were the familiar “The client will comply with medication and treatment goals on a daily basis. The client will keep scheduled appointments and complete sick calls as needed.” There was no evidence that he received any education about medications or any attempt at cognitive restructuring.

The same PNP saw him again on 2/2/16. He again complained of sedation and his feeling that the olanzapine made him “angry and cursing everybody out.” The mental status examination was notable for anxiety, “bad” mood [sic], and poor insight and judgment. However, “He displayed no psychotic symptoms since increase of [olanzapine] to 15 mg....” There was no change to his medications.

Laboratory results from 3/15/16 again show minor abnormalities of the complete blood count as well as lipid abnormalities. Again, these were not addressed in the psychiatric notes though both could be caused by the psychotropic medications he was ordered.

There were no mental health contacts until, on 4/13/16, the patient completed a Medical Service Request Form wherein he again requested to be changed back to Thorazine and Benadryl. He complained again of “seeing things and doing crazy things.” A mental health professional followed up with him two days later and referred him to a psychiatric prescriber. The associated LMSW note recapitulated his complaint and a cursory, checklist mental status examination reported no abnormalities. The LMSW noted, “It appears he may be meeting his treatment plan

goal of coping effectively with psychosis....” The plan was to refer him to a psychiatric prescriber and for him to “continue to be monitored....”

The same PNP saw him 4/18/16. He again complained of sedation. The mental status examination was noted to show no abnormalities except poor judgment and insight. The PNP decreased the olanzapine from 15 mg back to 10 mg on 4/20/16, presumably to decrease sedation.

On 5/8/16, the patient completed a Medical Service Request Form complaining of homicidal thoughts towards inmates and staff. He was seen the following day by a mental health professional who noted that he was having “violent thoughts off and on” but had “no identified target” and he was reportedly using his coping skills, though did not say how or what relevance this may or may not have had to his homicidal thoughts. He was complaining of difficulty with sleep and being hungry, a common side effect of olanzapine, and reportedly denied auditory hallucinations. The plan was for a referral to a psychiatric prescriber and a follow-up review. The associated note by an LMSW reported that he was “disheveled” with “circumstantial” thought and had auditory hallucinations and paranoid delusions. The patient reported being medication compliant but there was no mention of the recent medication decrease or review of the medication administration record. The patient “clearly agreed to continue using his coping skills to maintain stability.” The plan was to refer to a psychiatric prescriber and “continue to be monitored.” There was no discussion of the nature of the paranoid delusions, the content of the auditory hallucinations, or the possible relationship between these symptoms to his homicidal ideation. This was a grossly inadequate assessment.

The same PNP saw him 5/10/16 at which time the patient reported “thoughts to kill inmates and staff.” He reported “hearing weird stuff.” The PNP noted that “[h]e discussed that he was trying not to take [olanzapine], but he denied any problems with it and that the reduction had been “pretty good” for him, denying daytime sedation on the new dose. The PNP reported that he had had command hallucinations to hurt his roommate and staff. He was paranoid but denied homicidal ideation at the time of the visit. The mental status examination reports paranoid delusions but does not report the content of those delusions and whether they involved staff or inmates. There was also no assessment of the patient’s likelihood of following the command hallucinations to harm others. The PNP added divalproex sodium and increased olanzapine from 10 mg back to 15 mg. There was no discussion of other alternatives. Given his past side effects and the laboratory abnormalities noted above, as well as the patient’s preference for different medications, consideration for a change at some point was indicated.

Remarkably, given the nature of the concerns, there was no intervening follow-up by mental health until 6/1/16 when he saw the PNP again. He again requested his medications be changed, except he wished to stay on carbamazepine. He complained of sedation and “‘snapping’ on people [sic].” While the PNP noted that there were “No delusions elicited” and that he denied hallucinations, the note also reported that he remained paranoid with paranoid delusions (again, with no content reported). The PNP made no mention of the recent homicidal ideation. She noted “much improvement” and planned to continue current medications, noting that the “Risk [sic] and benefits of the above plan effectively [sic] communicated to patient [sic].” The PNP also noted that “Alternative treatment plan discussed and offered” but says nothing about what was offered. The plan included an intent to check levels of carbamazepine and valproic acid.

On 6/3/16, the patient completed a Medical Service Request Form requesting a return to his previous psychiatric prescriber. He complained of side effects. He was seen by mental health professional that day and the assessment was that he has “no problems” and the plan was to “continue treatment as is ongoing [sic] [with mental health professional].” No referral was made to a psychiatric prescriber. There was no comment on the side effects or the recent homicidal ideation. The associated note indicated his problems with side effects and then reported his desire for a new prescriber; one can surmise it had to do with the fact that he remained on the same medications despite his side effects and request to change. Despite that, he agreed to continue his medications. He was also noted to have circumstantial thought and, as is common in mental health notes, he reportedly denied delusions [Note again: It makes no sense to state that a patient denies delusions.] The plan was to “continue to have routine monitoring, per policy, to address any clinical concerns and to provide access to care.”

On 6/30/16, a carbamazepine level was 1.5 micrograms/milliliter [normal is 8-12], indicating limited medication taking and/or gross under-dosing. The valproic acid level was 50 micrograms/milliliter [normal 50-100].

On 7/4/16, the same PNP conducted an Abnormal Involuntary Movement Scale (AIMS), a test that should be done annually for those on antipsychotics who have had previous negative tests [quarterly if positive], which was negative. The associated note reported that he wanted “to be taking [sic] off all of my meds so I can transfer to Ranking County, things going on (unit) [sic], I been taking all the meds, want [sic] to come off all the meds to transfer, one [sic] I get transferred I can get back on it when I end up going where I am going.” The low levels were noted but no change of dose was ordered. The checklist mental status examination included no abnormalities except poor judgment and insight.

Laboratory studies from 7/5/16 again showed minor lipid abnormalities and complete blood count abnormalities.

At mental health sick call on 7/11/16, the patient saw a MHP and again requested a transfer, this time to Parchman. No abnormalities were noted on the mental status examination, this time he reportedly had good judgment and fair insight [Note: It is highly unlikely that his insight was changing without any reported changes in his mental status.]. The plan was to refer to a psychiatric prescriber and “continue to monitor...”

A MHP conducted rounds on unit 3 on 7/13/16. The patient “reported no mental health concern.” The plan was for the patient to “continue to be monitored...”

At mental health sick call on 7/28/16, the patient saw a MHP and again requested transfer to Parchman. The mental status examination was the same as on the previous sick call. The note also contained much of the same verbiage as the 7/13/16 note. The plan was to refer to a psychiatric prescriber and “continue to monitor...”

A MHP conducted rounds on unit 3 on 8/15/16. The patient “reported no mental health concerns at this time.” The note contained much of the same verbiage as the previous two notes. The plan was for the patient to “continue to be monitored...”

The same PNP saw him next on 8/15/16. He was noted to have paranoid delusions, paranoid ideation, and visual hallucinations (none of which were noted in recent mental health staff documentation). The same drug levels were again reported but this time the plan was to increase the divalproate sodium (changed to 1500 mg) but no change to the carbamazepine was ordered, despite the fact that it was quite low and the valproic acid level (divalproate sodium level) was at the low end of normal.

He was next seen by the same PNP on 9/7/16. The patient requested medication changes but “was unable to state any problems with his current medications.” However, the PNP later noted that the patient “reported staying hungry,” a common side effect of his medications, especially olanzapine. He again requested a transfer.

On 9/18/16, the patient completed a Medical Service Request Form that read “I need to be tested for HIV. I need to take an AIDS test-I had sex with a EMCF [sic] officer.” The response noted that he “[complained of] having unprotected sex and requesting HIV test.” There was no mention of his allegation that he had sex with an officer. The associated RN note made no mention of the allegation regarding having had sex with an officer. It said that he “[complained of] having unprotected sex and requesting [sic] hiv test.” The plan was only to refer to a physician on a “routine” basis. He was returned to his unit.

Throughout his stay at EMCF, this patient made numerous and repeated sick call requests for a variety of medical, mental health, and dental concerns, including repeated complaints of a rash. Many of these appeared to have no foundation and likely represented either delusions or a somatic preoccupation. The final example was his request for an AIDS test and statement that he had sex with an officer. This was not addressed. It was critical to determine whether this was delusional, a purposeful false report, or something else. To fail to look into this is both a PREA issue and a failure to assess what might have been a serious symptom and even potentially a risk to others, depending on the patient’s reaction to the staff response. It may be that there was a subsequent response not yet in the record, but this should have resulted in prompt action by the nurse, including a mental health referral and prompt PREA response.

There was no evidence that he received treatment other than medications and two brief groups for his mental health problems. Note also that only one formal Treatment Plan was created for this patient. It was entirely generic. He was occasionally seen by mental health staff at rare rounds but mostly in response to his many sick call requests, which never prompted any clinical action other than a referral to a psychiatric prescriber and continued “monitoring.”

He demonstrated limited awareness of his mental illness and made frequent requests to change medications but never received any medication education, despite some of his requests being related to limited knowledge of medication effects and side effects. It is thus not surprising that he demonstrated problems with adherence and associated resurgence of symptoms.

This is another example of a seriously mentally ill man who is not getting the services he needs and who describes the poor conditions on the residential mental health unit. The medication

management lacks important elements of monitoring and some of the prescribing was not within the standard of care. It is also clear that his wishes were generally dismissed.

Patient 19

This patient with evident spinal and hand deformities and facial features consistent with a genetic abnormality had been at EMCF for two years. He was somewhat cognitively impaired and had been in special education but was able to read and write. He repeatedly talked of the importance of reading his Bible. At the time I spoke, with him he had been on unit 3-A for several months. He complained of “drug trafficking” and problems with other inmates coming into his cell as well as others’ cells. He also reported that many inmates abuse Benadryl. He offered, “Mostly, they [staff] do not handle things like they should.” He talked about inmates transferring drugs back and forth while working in the hallway but that staff “don’t do nothing about it. The deputy be standing right there and they don’t say a thing.”

He was aware that he was taking three medications but did not know what they were. He knew one was Naprosyn, another was for seizures, and another was for a thyroid condition.

He was having a good deal of back pain related to his scoliosis and complained that he was not getting attention for this. He complained about access to medical saying, “When you ask like you need to go to medical, they hesitate; when you asked them it’s like talking to a wall. I told them I only speak when something is going on. I’m not like the other guys who were just trying to get off the zone.” He stated that he usually got responses to medical requests but that it might take one to two weeks to get a response. He added, “I didn’t have my eye drops for a long time. Went to the nurse and told her I was sorry for bothering her lunch and she went in the back and it was in the refrigerator; nurse just wasn’t doing her job.”

Like many others, he complained about dirty showers and that they were rarely cleaned.

When asked about mental health rounds on his unit he stated that they came “about twice a month.” However, these visits did not include rounding on each person but simply being available in the dayroom. He was unaware of any groups being run. Similarly, he was not receiving any individual therapy.

This is another example of a man who has less serious mental health needs than others not on a residential mental health unit. He is not getting the services he needs related to his cognitive limitations but such services are quite different from mental health services and should be administered through a specialized program. H also describes the same poor conditions on the residential mental health unit as others.

Patient 20

This patient had been at EMCF since 2001. He had been on unit 3-A since 2004. He spoke of having some memory and other problems since a motorcycle accident. He was ill kempt and malodorous.

Early in our interview, he noted that the judge in his criminal case told him that he needed counseling. He went on, “When I was at Parchman I did get some counseling from the psychiatrist. [The judge] didn’t put it in the court order. I’ve asked for it but I’ve been denied.” He noted that he had gotten some therapy under the previous health vendor at EMCF, but no longer. As he put it, “another lady came and started giving me one to ones until [a named staff member] found out. I was told that if I wanted counseling from medical, you had to pay six dollars and should get it from [mental health]. But I’ve been trying to get that forever and I always hear ‘Okay, I’ll call you down’ but they never call. All they do is sit there and eat candy and play video games [he proceeded to name several mental health staff]. ... They provide no counseling. When [two mental health staff] come down to the housing unit once a month, they jot down a few things but they never respond. Policy says inmate requests must be responded to in 10 days. If they do, it’s usually on the 10th or 11th day. They apologize for not responding and say they will respond and then you don’t hear back from them.”

When asked about treatment, he spoke about therapeutic community on unit 4-B. He went on, “they keep talking about making 3-A a special unit for those who want to take classes since the first of the year but nothing’s been done. [A mental health staff] does anger management or dealing with difficult emotions class that last four or five weeks that he’s given three times now. I got in on the second class. I asked if there was going to be follow-up to it but he didn’t know. I took all the classes from Ms. Williams out of medical. Used to get incentives for going to mental health group, like nine dollars canteen. Once the inmates found out Ms. Williams didn’t do incentive most of the guys will go [leave the group].”

He felt that his medications are “back on track again.” He had positive things to say about the new psychiatrist and one of the PNPs. With regard to medication he stated, “After I went to my last chronic care, the nurse forgot to order my Dilantin and I haven’t been getting it regularly for over a month until last Saturday.” He also reported being on clonazepam and clozapine and reported, “I no longer see shadow demons and the voices are gone. I miss the voices sometimes because they never told me bad things. The shadow demons always wanted to take over my mind and do bad things. Suicidal thoughts are not as often as strong.” When asked whether anybody would respond if he told them about having suicidal thoughts he replied, “I’ll tell somebody and I’ll be up to see [a psychiatric prescriber] immediately.” Asked if mental health counselors respond he replied, “No. They don’t respond to nothing. If I told them I was having suicidal thoughts, they just lock me down. I’m locked down now sometimes because my door has been broken for four months. Sometimes it may be four hours after doors open before they come to open our door. For a seizure patient that can be dangerous. The pill call nurse will not let others bring meds to me because they’re narcotics. Sometimes the nurse comes on the unit unescorted and puts it under my door. She tries to get the guards to get the key but sometimes they just won’t.”

I conducted a thorough chart review of this patient.

Records for this patient with a life sentence date back to 2002 but the current record started in 2011.

From the outset, he was described as seriously mentally ill and diagnosed with schizophrenia and had a past history of a serious suicide attempt via a motorcycle accident. The record described delusions, having “special powers,” auditory hallucinations, and tendency to withdrawal. It also reported mood symptoms, suicidal thoughts, and problems with sleep suggestive of an affective component. He occasionally had commend hallucinations to harm others and was fearful or paranoid of others, worrying a great deal about gang activity.

He was treated with a variety of medications including divalproex sodium (a mood stabilizer), sertraline (an antidepressant), clonazepam (for anxiety), and the antipsychotics loxitane, ziprasidone,

He also suffered from a seizure disorder, related to a head injury suffered in the motorcycle accident, treated with Dilantin and divalproex sodium.

The treatment plans were the familiar boilerplate treatment plans.

9/28/12 AIMS was 12, consistent with moderate tardive dyskinesia. He was not on an antipsychotic at the time.

This was the only patient that had some individual psychotherapy, but only monthly, 9/13-8/14. He initially discussed some childhood abuse, being raped in the military, and other traumas and spoke a good deal about past suicidality and attempts. Then the treatment turned to mundane “goal planning” such as taking medications, completing sick call requests, coming out of his cell, and attending groups and classes (of which he had none). The notes themselves were mostly mental status examinations. He periodically tried to come back to themes important to him but with no success. This was a missed opportunity but he got some benefit from the interaction.

In December of 2013, he had elevated lipids. They decreased when the ziprasidone was reduced in late 2014.

5/26/14 AIMS was 0 while on an antipsychotic (ziprasidone), possibly suppressing the tardive dyskinesia.

On 2/23/15, he received an injection of haloperidol. This followed his reporting to a PNP that his wife had died 12/1/14 and his daughter was suicidal. However, the PNP reported no psychotic symptoms and no agitation. The medication was for “calming.” This is an inappropriate use of injectable haloperidol.

On 7/1/15, he was seen by a PNP. He was sad due to his “upcoming wedding anniversary” and described worsening auditory hallucinations and “moods.” He was not agitated and the PNP found no other evidence of psychosis. He had had suicidal ideation days before but not at the time of the interview. Reportedly, he and the PNP agree to an injection of haloperidol and diphenhydramine. Again, this is not an appropriate use of this medication, especially since he was already on a standing dose of another antipsychotic (ziprasidone) and an antianxiety agent (clonazepam). Either of these medications could have been given but whether any additional

medication was necessary is unlikely; he needed supportive psychotherapy to help him through this time.

He was next seen by a psychiatrist on 7/22/15. He told the psychiatrist he had tried to kill himself “4-5 times a year for most of my life, at least up until 2006. I am a little better now.” The psychiatrist noted the diagnosis of schizophrenia but also reported on a number of mood symptoms. He continued to have chronic psychotic symptoms. They agreed to start clozaril (the only patient I saw on this important antipsychotic) and lithium (a mood stabilizer). Labs were ordered.

His next mental health contact was again with the psychiatrist on 8/26/15 and was less depressed and irritable. The psychiatrist noted akathisia from ziprasidone (the clozaril had not been started yet). The plan was to proceed with the clozaril, which requires regular labs to monitor white blood cells counts.

His next mental health contact was again with the psychiatrist on 10/6/15. He was doing better and the psychiatrist made some minor medication adjustments.

Mental health rounds resumed on housing unit 3, a residential mental health unit, on 11/13/15. He refused to engage, though it is not clear why as he had always been cooperative.

He participated in Social Skills group on 11/16/15, 12/7/15 (now with a different clinician), 12/14/15, 12/21/15 (which involved coloring and writing a letter for the holidays), 1/4/16, 1/25/16 (with the original group leader), 2/1/16, and 2/8/16.

The next contact with a mental health staff was a PNP on 12/1/15. He displayed some movement disorder and tremor but was psychiatrically more stable.

The next rounds were on 12/3/15. He again refused to engage.

The psychiatrist saw him on 12/7/15 and he remained relatively stable. They planned to stop his clonazepam out of “necessity,” presumably because it was no longer allowed since Centurion took over.

Labs on 12/16/15 included a lipid profile, Dilantin level, urinalysis, and metabolic panel. His non-HDL cholesterol was slightly elevated. During this period, he continued to get complete blood counts which remained in the acceptable range.

On 1/25/16, a PNP submitted a non-formulary request for clonazepam. Another PNP saw him the following day; he was out of clonazepam and his tremors had increased. He was without identified psychotic symptoms and had stable mood. The PNP added propranolol for tremors. The noted stated that the risks and benefits had been explained, but there was no formal statement of consent or consent form. It is likely that this patient did or would have consented, it is just not well-documented.

The following day, there was a boilerplate treatment plan.

On 3/14/16, he continued to show slightly more elevation of lipids. His thyroid stimulating hormone was also slightly high. A metabolic panel was normal. Complete blood cell counts remained adequate.

He did not have any other mental health contacts until 4/6/16 when seen by a PNP. He was not taking the propranolol but was doing well. He felt the groups had helped him. The PNP continued divalproex sodium, clonazepam (presumably the non-formulary request was approved), and clozaril.

On 4/25/16, his lipids continued to climb.

He was next seen by a PNP on 5/17/16. He had refused a lab draw that day and was “agitated.” He was upset about challenges getting VA benefits for his daughter (he is a veteran). No mention was made of the elevated lipids. He later got his blood draw, allowing continuation of the clozaril (also the medication likely to be causing the elevated lipids).

On 6/13/16, he started in a group called Maintaining Daily Living. Sessions were held 6/20/16 (which addressed job applications – he had a life sentence), 6/27/16 (about job interviewing), 7/11/16 (job interviews and check writing), 7/18/16 (balancing a checkbook), 7/25/16 (budgeting), 8/1/16 (short stories),

Mental health rounds resumed on 6/19/16. He was “scattered.”

On 6/28/16, there was a boilerplate treatment plan.

A PNP saw him on 6/29/16. A VA evaluation was pending; a psychiatrist at EMCF was going to help. He remained clinically stable.

Rounds continued on 7/11/16. It consisted of boilerplate language.

There was another non-formulary request for clonazepam on 7/28/16.

He was next seen by a PNP on 8/4/16. He had been out of clonazepam as well as other medications for several days. He had some anxiety and panic attacks as a result but was doing better since their restoration.

Rounds resumed on 8/9/16. It consisted of boilerplate language.

On 8/15/16, there was an “office visit” with an MHP that was on the unit with custody, hardly an office visit. It was more like rounds.

He attended self-esteem group on 8/15/16, 8/22/16, 8/29/16, and 9/12/16.

On 8/15/16, he submitted a sick call request that he was not getting his medications again; his writing demonstrated gross tremor. He was rambling and very dirty and unkempt, now unusual for him.

He met with a PNP the following day and complained of not getting different meds each day, saying “every time someone new works it gets messed up.” The PNP noted worsening tremors.

On 9/6/16, he had an office visit with a MHP in a clinic office. He was having more tremors. He had been out of clonazepam for 3 days and was likely experiencing some withdrawal symptoms or possibly breakthrough akathisia (a side effect of antipsychotics). He was anxious but without overt psychosis.

A PNP saw him that day. He spoke about increased tremors since the clonazepam stopped. He was very anxious but again without clear psychosis.

The record ends after some routine lab results.

While there are certainly problems with the management of this case, this is one patient who clearly benefitted from treatment. The addition of clozaril was likely the most important change. The groups were also likely helpful to him. Even though many of them did not address his needs, the socialization and structure were likely a great benefit. This is a great example of why such structured and reliable treatment activities are necessary.

The failure to reliably deliver his medications was a substantial problem that almost led to deterioration and return of suicidality, not to mention putting him through needless physical suffering. These are real harms that could have been much more serious.

Patient 21

This overtly psychotic patient had been incarcerated for four years and had been at EMCF for a year and a half. He has been residing on unit 3-A for about a year. He was very paranoid and was suspicious of why we wanted to speak with him but once we explained why we were there, he engaged as fully as he could but was impaired by his evident distraction by internal stimuli and struggled to keep his thoughts organized. Delusional material intruded regularly.

He immediately began talking about his concerns, offering “small things come up missing around here: pencils, envelopes, soap dish. My rack mate is [names an inmate]. I really don’t much like him. I asked him where it is and he says he doesn’t know.” He went on to talk about how he can’t get a different cellmate and then added, “my mom called and talked to the unit manager, said she can’t do nothing. So what do I have to do, hit somebody?”

He stated that he was not on medications and that he preferred “to live a natural lifestyle. I prefer a lifestyle without drugs.” However, it was clear that he had seen psychiatric prescribers. He also reported that he had been on medications in the community.

Asked whether he spoke to a mental health counselor he replied, “They don’t see to anything being done [sic]. They ask you how you’re doing, get you to a psychiatrist. They don’t do anything about release. No jobs. All we do is sit on the dayroom floor and eat three meals a day. Sit in the back yard and throw basketball.” He reported that they go out to the large recreation yard “maybe once or twice a month. We go to the gym once a week.” When asked about treatment he stated, “They don’t have anything constructive to do. They have drug and alcohol, drug and alcohol.... Drug and alcohol and I already have a GED. I could be in college.”

I conducted a thorough review of his medical record which revealed the following.

Shortly after being transferred to EMCF in October 2012, the patient was the subject of an urgent mental health referral by custody. He was found to be psychotic demonstrating paranoia, poor self-care, and some degree of confusion. He was responding to internal stimuli and was generally not forthcoming. He was subsequently started on antipsychotic medications which he continued until his transfer to EMCF on 10/22/12. At mental health intake, only a Suicide Potential Screening was done. There were numerous positive responses on this form though he denied suicidal ideation. Borderline cognitive function was also noted. He was routed to general population with a psychiatric referral.

On 10/23/12 he was seen by a PNP who noted that he appeared to be responding to internal stimuli and was guarded. He was placed on the At Risk Unit. He was continued on risperidone 3 mg as an antipsychotic. He continued to demonstrate psychosis for several months. He had difficulties with cellmates. The patient wanted to transfer and denied any symptoms but remained guarded.

On 11/8/12 he had screening labs.

He saw a psychiatrist on 12/12/12 and talked about having spiritual visions and messages from the dead. He also felt he was being watched and that his family was in danger. He had a clear thought disorder the psychiatrist ordered an intramuscular Haldol injection, an antipsychotic.

He continued much in the same vein through summer of 2013 when he decided to quit taking medications. There was some thought that his psychosis may have been due to using spice. He was placed on a mental health unit but his medications were stopped. Over the ensuing two years he was seen occasionally by a psychiatric prescriber. Psychiatric prescribers noted odd behavior at times but not sufficient to warrant involuntary medication. During this time he was seen during rounds at varying frequencies but approximately weekly. The associated notes were frequently identical and conveyed little information. There was no effort to engage him in treatment. At quarterly treatment team meetings, treatment plans were developed that were entirely generic with no individualization. These plans never addressed his mental health issues or functional problems.

On 7/6/14, he was seen by a psychiatrist. The patient had no complaints and the mental status examination was noted to be normal except for paranoia. The repetitive weekly rounds notes and the quarterly treatment team meetings continued. However, in the fall rounds became much less regular and sometimes were two weeks apart.

On 4/21/15 there was a note regarding an MHC office visit. The MHC reported the patient saying “some bizarre things.” He was reportedly talking about wanting a stool sample for DNA testing though when asked directly, the patient denied this. The MHC went on to opine that the patient “does not appear to be experiencing any psychosis....” Yet there was no evidence that these bizarre comments were explored for possible psychotic content.

Things continue on again in the same vein until on 6/4/15 there was an LCSW office visit after the patient had contact with his “82-year-old mother.” The LCSW reported that he had been smoking spice for the last two weeks; it was unclear how he knew this as there was no toxic screen or mention of the source. The patient was transferred to another unit. However, this was not addressed in any way.

He attended three social skills groups in November; it was unclear why this ended after only three sessions.

He had altercations with his cellmate and others in December and January. He was a no-show to visits with the PNP for several months. He saw a PNP on 5/12/16 but the note is largely illegible due to copying problems but it appears that there were no findings and no medications were started.

During this time he has numerous skin infections and his self-care was poor.

Despite the fact that he continued on no medications, several MHP mental health rounds notes commented on the importance of compliance with medications. Clearly, these were boilerplate notes and/or the clinician was unaware of the patient’s treatment status.

Matters continue on in the same vein with occasional contacts during rounds and with a PNP. He attended a self-esteem group on 8/22/16, 8/29/16, 9/12/16, and 9/19/16.

This is another example of a seriously mentally ill man who is not getting the services he needs and describes the poor conditions on the residential mental health unit. It is stunning that someone with such overt symptomatology was not seen as being seriously mentally ill and no effort made to engage him in treatment. Certainly, the record is replete with indications of a serious and chronic mental illness. It appears that depth of assessment was insufficient to detect his psychotic symptoms, which persist and place him at risk of worsening illness and poor response to medications in the future. Not surprisingly there was no thorough assessment ever done. Treatment plans were entirely generic and unhelpful. Mental health rounds were cursory and erratic.

It is not surprising that this patient has had difficulties interacting with others and has gotten in altercations, much as he told me he feared would happen again. Yet there was no attempt to assess the patient with regard to the contribution of his mental illness to the reported altercations. Given the likelihood that his mental illness is playing a role, failure to address this puts he and others at risk.

Patient 22

This obviously very cognitively limited patient with a speech impediment reported being at EMCF since 1987. He reported being on unit 3-A for a month or two and being on unit 3-B for a couple months before that. He reported being on unit 6, restrictive housing, a great deal for

“fighting.” He reported that he had to fight “to defend myself. ... To keep people from hitting me.” When asked who was hitting him he replied, “Some of the crazy patients.” Later in the interview he said, “I hit them hard so they leave me alone.”

He reported being on mental health medications but he was not sure what they were for.

He had been in special education and was very limited in reading and writing. Asked how he is able to fill out a medical request form he responded, “I can’t spell. I get someone to help me spell it out.” Asked who helped him, he replied that it was inmates. When I asked if staff would ever help him with that he said, “No. Sometimes they get smart and I have to walk off. They won’t do their jobs.” When I asked whether he meant that when he asked for help, staff would say they were not going to help him and he confirmed that.

He also reported that sometimes medications would not come. He felt that it depended on the nurse with some being better than others. Asked if he ever met with a mental health counselor he replied, “Not here.” He said he had some counseling at Parchman. Asked if mental health did rounds on his unit he replied that they came by “every week or two.” Asked what they do when they come he said that sometimes they come in the dayroom and sometimes they walk around. Sometimes they don’t stay very long. ... 30 minutes to an hour and a half.” I asked again whether he had any meetings with mental health counselors in an office and he replied, “One time.”

Asked what a typical day was like he reported that he slept a lot and sat in his cell.

This is an example of a cognitively impaired man who is not getting the services he needs and describes the poor conditions on the residential mental health unit. As with the previous case of a cognitively impaired patient, this patient needs specialized placement and services, such as habilitative services, for this population.

It is not surprising that he has adopted an approach of doing pre-emptive strikes in an attempt to discourage other inmates from victimizing him. He has not gotten any help to manage these problems in another manner and the staff are unable to contain the high degree of violence at EMCF. Failure to provide a safe environment and the kinds of services that would help this patient find alternative approaches to conflict or victimization has contributed to actual harm and continues to put him and others at risk of violence.

Patient 23

This patient was floridly psychotic with a severe thought disorder. It was very difficult to follow much of what he said. I had asked to see him because during our tour of the facility he had approached the Warden as we were leaving his living unit and I overheard him saying that he was to be released. During the interaction he became increasingly agitated. Officers began reaching for their OC but other inmates inside the unit told the staff that they would take care of him and encouraged him to come back inside the unit, which he did.

He expressed many delusions including that he was President Obama and that he was a rapper. He made several allusions to staff telling him not to push his call button. He talked about other inmates coming in his cell and fighting him. When he was speaking about this he also made reference to being stabbed with needles and said something about how the needles are still stuck in him and something about his leg being cut off. He also said, “They get mad and spray you with mace and stuff.” He also talked about being raped and needing help winning a lawsuit.

Asked the last time he had had an injection he replied, “Not that long ago. Up in the nurses’ [sic]. I protected George W. Bush too. Sometimes he did wrong things to me.”

This is another example of a seriously mentally ill man who is not getting the services he needs. Despite his obvious mental illness, he is not housed on the residential mental health unit and is clearly inadequately treated. Unfortunately, I was not able to review his medical record to provide the reasons for this, but he is clearly very psychotic and obviously a risk owing to the type of behavior that brought him to my attention, which was certainly the result of his mental illness.

Patient 24

This inmate had come to EMCF in 2013. He had been in restrictive housing since he arrived. This man presented not as someone with a mental illness but as personality disordered. He clearly had little compunction about being violent and engaging in other antisocial conduct, even when it was not in his own best interest. He gave vague reports of auditory hallucinations but showed no evidence of responding to internal stimuli or any other psychotic symptoms. He reported cutting himself in the past in order to get moved from the previous facility. Like many others, he also reported setting fires in his cell.

He also reported on the lack of showers for the last two weeks on unit 5-B where he was housed. He complained that officers do “all sorts of crazy shit. They do whatever they want.”

He reported being on haloperidol injections monthly that he stated he did not want to take. However, he said that he did not try to refuse the injections though reported that he had told the PNP that he did not want to take it.

This man has no evident mental health needs. It is not clear why he is at EMCF. There is also no reason for him to be on haloperidol injections. Use of antipsychotic medications to control behavior not related to mental illness is dangerous and violates ethical standards.

Patient 27

This patient was one of the people I spoke with on unit 3C. He reported peers “popping” doors and entering others’ cells at various times. He also stated that he was aware that Patient 13 had been sexually assaulted on the unit. While he did not tell us this at the time, he later sent a letter dated 8/2/16 to Alesha Judkins reporting his own sexual assault at EMCF. He noted that he “tried to report it to the officer but she made a joke out of it. I been [sic] telling these people that it’s been going on in unit 3-C but they act like they didn’t believe me.” He reported that he had been assaulted the previous night after having told staff that this was going on. He goes on to note how he went to the emergency room and had a rape kit done in hopes of pressing charges. What he reported in this letter is the same as what he reported to staff and is documented in the medical record. He also expressed concern that his clothing at the time of the assault was not properly labeled by EMCF investigative staff.

I conducted a thorough review of his medical record. It reveals the following.

The patient’s medical record goes back to 2011. At that time he reported that he had been sexually assaulted in a correctional setting two years previously. He had a history of being on multiple psychotropic medications including antipsychotics, antidepressants, and anti-anxiety agents. This man had suffered a great deal of loss in his life including his wife and two daughters. He struggled around anniversary dates predominantly in February and March. He had been placed on suicide observation in March 2013.

In May 2014 he was admitted once again to the MDOC but was not placed at EMCF. At that time he was started on sertraline, an antidepressant, and risperidone, an antipsychotic. He was diagnosed as having psychosis not otherwise specified and depression, as well as cocaine and alcohol abuse. An AIMS from that time was negative. The risperidone was subsequently changed to Stelazine, another antipsychotic. He was also started on a mood stabilizer, carbamazepine, in May 2014. He had complete labs done except for a carbamazepine level in July 2014. There were subsequent changes to his mood stabilizers and he was ultimately placed on lithium in September 2014. He again struggled with the anniversary dates in February 2015.

He was transferred to CMCF and had an intake done on 8/4/15. At that time he was on Dilantin, for seizures, and carbamazepine, likely both for seizures and mood stabilization. He was also receiving inhalers for asthma. He had cursory initial mental health screening that predominantly consisted of a suicide checklist. Upon routine referral to psychiatry, he was seen 8/15/15 and had reportedly been doing well without medications for four months, despite the fact that he was on the carbamazepine which was not mentioned with regard to its potential psychotropic role. There were no abnormalities noted on the mental status examination. In September 2015, the psychiatrist reported that patient “wants file closed.” This was reportedly done and he was made LOC A, the lowest level of care. On 9/29/15, he overdosed on Tylenol, Dilantin, and ciprofloxacin. He told mental health that he had feared for his life for the last two weeks. He spoke about other inmates popping locks and some reportedly wanting to kill him. He reported that he took the overdose to “take my own self out. Yeah I’m suicidal ‘cause these folks will listen to nothing else until you do something like this.” He exhibited paranoia and flight of ideas. He was sent to the emergency room and then sent to MSP and placed on suicide watch.

He later reported that he had been raped by a peer at CMCF and that this was why he overdosed, “to get help.” There was a brief psychiatric note on 10/15/15. He was ordered no medication and there was no referral for any treatment. He was placed on psychiatric observation. A 10/19/15 mental health note reported that the patient complained, “I just got raped and no one is even trying to help me. I’m fixing to start flashing out and they don’t want me to do that.” He was reportedly “agitated and uncooperative.” The assessment was that the “patient appears to be angry and upset.” The plan was “remain on Southward until evaluated by psychiatrist.” There was no evidence that he received any counseling around the alleged rape. There was a short psychiatric note on 10/23/15 where the patient reportedly stated he was not suicidal and wanted attention. However, the patient was also reportedly “quite volatile, angry demeanor with a lot of self-pity for allegedly getting raped.” The psychiatrist started him on paroxetine, an antidepressant, and carbamazepine, a mood stabilizer. The psychiatrist also wrote, “no clonidine or Seroquel.”

It was clear from these notes that the mental health staff was skeptical of the rape and there is little evidence that it was taken seriously.

On 10/27/15 he began refusing medication, exhibited an elevated mood, and was to remain on suicide precautions. Shortly thereafter he made references to the Bible and remained on suicide precautions. He still received no therapy.

On 11/10/15, he was transferred to EMCF, presumably because of his suicidality and mental health needs. On that same day, the intake screening was done. Despite coming from being on a suicide watch directly from the infirmary, the arresting/transporting officer report regarding suicide risk is that the patient was not a suicide risk. However, much of the rest of the Suicide Potential Screening form was positive, prompting rapid referral to mental health.

He was seen by a PNP that day and diagnosed as having Bipolar Disorder. The recent rape and suicide observation status were noted. The patient was started on lithium (a mood stabilizer), risperidone (an antipsychotic), and diphenhydramine (for side effects). He was continued on psychiatric observation. Appropriate follow-up labs were ordered but no baseline labs were collected. The PNP specifically referred him for one-to-one therapy. He never received any therapy except in intermittent meetings with the PNP and psychiatrist; the other mental health staff provided no active treatment. There was not even a proper treatment plan in the medical record.

This patient remained in the infirmary on varying degrees of watch until 6/28/16, essentially nine months of being locked down. While at times this was due to his mental illness and suicidality, it was also because he felt that he would not get appropriate treatment and could not be kept safe on general population units. He was especially concerned about being placed in a close custody setting and asked to remain in the infirmary until he had a reduction in his custody level and also got through the difficult anniversaries in February and March. While in the infirmary, he was seen regularly by nursing staff who chart very little mental health information. He was also seen most, but clearly not all, weekdays by mental health staff doing rounds. These associated notes were uniformly extremely limited and frequently contained exactly the same verbiage. Even when surrounding notes by nurses and psychiatric prescribers demonstrated clear emotional dysregulation including tearfulness and agitation, the rounds always say or imply that he was

doing just fine. It was also clear that they were doing these rounds with custody in almost all, if not all, instances. He was frequently asleep at the time of rounds but the mental health staff do not wake him up on most occasions. About the most the mental health staff ever did was make referrals to the psychiatric prescribers and the chaplain. They themselves did no counseling, despite the clear need demonstrated by the psychiatric notes addressing the difficulties he was having overcoming his recent rape, not to mention the need for support and treatment of his primary mental health disorder and his challenges around anniversary dates.

A psychiatrist and a PNP carry the load of working with him, to the extent their limited time provided, in addition to their responsibility for prescribing medications. They see him regularly through January, at which point their contact was reduced to every 2 to 4 weeks, despite the fact that he remained in the infirmary. They make reasonable medication adjustments and eventually got his mood lability controlled.

On 11/23/15, the PNP noted that the patient had been hitting his head on the wall and punching the wall over the weekend. None of this was reported in the nursing or mental health notes. He expressed a desire to be in protective custody, seemingly unaware that this was not an option at EMCF (the same PNP later wrote that he should stay at EMCF to get therapy, which he never gets except the brief intermittent sessions with the psychiatric prescribers). Two days later, he told the PNP that he was fearful of harming himself if he was not watched. He was tearful and labile. The PNP helped him call his sister; other mental health staff refused to help him make phone calls to family.

The patient was intermittently non-adherent with medications, both his psychotropic medications and seizure medications. He had several seizures during the course of his stay with some associated trips to the emergency room. He also reportedly hoarded medications and overdosed 12/24/15. He was sent to the emergency room where they reportedly did laboratory examinations but these were not included in the medical record. He told the psychiatrist that he had been saving olanzapine, an antipsychotic, in a bag. Subsequent rounds by an MSW were typically brief. The first mental health contact following the psychiatrist visit was on 12/28/15. The MSW reported on the overdose and noted only that the patient reported that he was "OK now." The PNP saw him on 12/30/15 and reported psychological challenges that the patient was having and recent problems with sleep, none of which the MSW reported. He continued to report occasional suicidal ideation but showed slow improvement in mood stability. The patient was repeatedly frustrated by challenges in contacting his attorneys and his family.

On 1/25/15 he had a low Dilantin level; the psychiatrist wondered about his adherence. Three days later the psychiatrist noted the possibility of his hoarding but there was no discussion of a cell search in the record. In addition to the usual anniversary stressors in February, the patient reported that the peer that had raped him at CMCF was now at EMCF. A 2/12/16 PNP note mentioned that he was singing and talking a lot. Four days later, he had a lithium level that was essentially zero. The MAR showed that he was completely compliant with his medications during this time, which was obviously incorrect. Nursing notes also indicated that he was compliant with medications until much later on 2/18/16 when he was reportedly refusing and wanting his medications changed to nighttime. There was no mention of this low lithium level when the PNP saw him 3/1/16; the PNP even noted that the patient reported that he was compliant with medications.

Another patient committed suicide in the infirmary on 4/5/16. While this was noted by a nurse, there was no evidence that this patient received any counseling or support following the suicide.

During this period he was seen very rarely except in rounds. A nursing note indicated that he was seen by the psychiatrist in an office on 4/19/16 but there was no associated note. Dilantin and lithium levels are close to normal on 4/21/16, suggesting the patient resumed taking medications. On 4/28/16, the PNP reported that his girlfriend and daughter were in a car accident and that his girlfriend was in a coma and his daughter had her leg amputated. There was no further mention of this event in the records and clearly, again, he received no therapeutic support or response to this. He remained on observation in the infirmary. Other than the cursory rounds, he was not seen again until visited by the PNP on 5/30/16. By this point, he was frustrated with being in the infirmary and expresses a preference to be in “lockdown” since he could not be in protective custody.

On 6/9/16, laboratory studies show lipid abnormalities, a potential side effect of olanzapine, and a Dilantin level that was again virtually non-detected. There was no mention of these findings in the record. He was next seen on 6/27/16 and 6/28/16 by the psychiatrist who at that point released him from the infirmary. He was transferred to unit 3-C, close custody mental health.

There was an AIMS in the record on 7/6/16, scored as zero. That same date there is a PNP note that indicates there was a treatment team review. At that time he was reportedly doing well and his mental status examination was unremarkable. His medications were to remain lithium, olanzapine, prazosin, diphenhydramine, propranolol, Synthroid, and Dilantin.

There was a 7/22/16 MHP note that was titled an “office visit” but the note indicated that the meeting was held in a hallway with security present. The patient spoke of “sexual incidents” on the unit and expressed fear of being raped and asked to see the PNP or psychiatrist.

The psychiatrist saw him on 7/27/16 and the patient repeated his fears worrying that he “could be next.” The next note was on 8/3/16 and was reportedly a LMSW office visit with him and a “mental health treatment plan”. There was no treatment plan at all. That same date there was an LMSW PREA note. The patient was anxious and crying and reported being raped the previous night by a peer, consistent with the letter he wrote noted above. He reported that he waited for dayshift to report the incident because he did not trust the night shift to take proper care. However the officer in the morning reportedly laughingly talked “about me getting poked in my little booty.” He was sent to the emergency room and upon return was placed on observation status; he later complained that the peer who allegedly raped him remained in general population while he was in a restricted living setting.

On 8/7/16, the patient reported overdosing on Dilantin, carbamazepine, lithium, and diphenhydramine. He was given charcoal and subsequently vomited. He was not sent to the emergency room. Blood levels of medications were drawn. A cell search was finally done and documented but revealed nothing. His vital signs were stable. The following day on 8/8/16 at 0751, mental health rounds were done with security. The note does not say anything about the overdose and was essentially identical to previous notes. That same day a Dilantin level comes back high at 29.2 and the lithium level is within the normal range at 0.6. That same day he reported to an MSW that he had more pills that he had been hoarding; the MSW reportedly told

the shift commander but there was no documentation of a cell search or any findings. He was also seen that day by the PNP and psychiatrist, neither of which reported on the laboratory results. The PNP did note that the patient gave varying reports about the overdose and told her that he had swallowed the inner parts of a battery. The only intervention was to hold medications.

Subsequent notes by the PNP and psychiatrist indicated their concern about finding him a safe placement and efforts to try to help him process the rape, though their visits are too infrequent to render the kind of treatment he needed. Mental health staff continued to make cursory rounds only.

He was once again discharged from the infirmary on 8/18/16 but this time went to unit seven because of his reduction in custody level.

On 8/24/16, his lithium and Dilantin levels were again essentially undetectable. On 8/29/16, there was another treatment team review note but this time by a different PNP. This PNP noted the low lithium level but it was not addressed in any way. Again, there was no treatment plan and no change in medications. He began getting into more difficulty, resulting in seven RVRs. The possible contribution of his noncompliance was never addressed other than indicating that he stopped his medications. There was no plan to address his poor adherence and never had been.

On 9/13/16, he had a pre-lockdown evaluation by a nurse. This consisted of a medication list and a physical exam, though it was unclear whether there was actual examination. There was no real note. The note indicated that he had no injuries but there was no discussion of whether placement in lockdown was reasonable, which is the purpose of this evaluation.

This case is a clear example of a patient with significant psychological needs and distress. All evidence suggests that he was raped but never was there appropriate therapy for this or his mental illness. This man essentially remained on lockdown because of an inability to keep him safe from himself or others in any other setting, including on the mental health unit itself. Despite this, he never had a suicide risk assessment.

While the psychiatric prescribers prescribed reasonable medications, they failed to consistently monitor and respond to abnormal laboratories. They did their best to provide some supportive therapy which was doubtless of some help but inadequate given the needs of this patient. It is stunning that there is a complete absence of any treatment plan. The superficial and inconsistent mental health rounds are inadequate to provide the kind of monitoring needed in such an acute setting as the infirmary. This is also another patient who, despite being on watch status, was able to hoard and overdose on medications. The nursing notes and MARs suggesting that he was adherent with medications clearly demonstrate inadequate medication monitoring. The failure to regularly search this patient's cell and to have a plan to address his hoarding and nonadherence also clearly placed this patient at substantial risk.

With adequate treatment, this patient would likely not have been in a restrictive setting for nine months. Further, treatment would likely have reduced his risk of overdose and other self-harm.

Patient 30

I interviewed this patient briefly on the unit. He was an overtly mentally ill man who spoke about being an attorney and a judge. He was in the cell with the toilet running constantly.

I conducted a thorough medical record review that revealed the following.

This patient's records go back to January 2009. He had a very clear history of psychotic illness that has been variably diagnosed as bipolar disorder and schizoaffective disorder. He has a history of poor medication adherence and historically had been placed on long-acting injectable medications. He had been in various facilities and most recently came to EMCF on 6/18/14. At that time he was psychotic and had just been started on Stelazine, an antipsychotic. At intake he was overtly psychotic and uncooperative. He was seen that day by a PNP who had known him for years. Despite being overtly psychotic, the PNP did not believe he met criteria for involuntary medication and, because he was refusing medications, stopped the Stelazine. Through June 2015, he had occasional visits with a PNP and sporadic contacts during mental health rounds. At quarterly treatment team reviews he was noted to be psychotic and at times to have poor hygiene. All the treatment plans were entirely generic and did not address his treatment nonadherence or any other individual issues.

On 8/6/15 he complained of blood coming out of his ear after being choked. He was found to have a traumatic rupture of his ear drum.

The first mental health contact after 7/1/15 was on 8/7/15 with a PNP. He spoke about demons being after him and auditory hallucinations. Medications had been stopped in 4/15 due to non-adherence. He agreed to start lithium, a mood stabilizer, but not an antipsychotic.

On 9/8/15, he refused labs previously ordered by the PNP, including a lithium level and baseline lithium studies.

At a 9/14/15 Quarterly Treatment Team Review, he reported being medication adherent and "denied having any mental health issues. None observed [by the author]." The patient "reported that he is enroll [sic] in GED and Drug/Alcohol [sic]." The formal treatment plan noted that he refused labs because he did "not like for them to take my blood." The narrative later added, "[Inmate] did not want to listen to why he needed to have his lab drawn." The plan was otherwise the usual boilerplate, generic treatment plan. This was the last treatment plan in the record.

On 9/16/15, an MHP responded to a 9/15/15 sick call request for unclear reasons. The note is very cursory and includes a mental status examination that is entirely normal [which is highly unlikely] except for a report of "homicidal" ideation. But there was nothing further about this. He was referred to a psychiatric prescriber.

A PNP saw him 9/21/15 but reportedly for the lab refusal. He reportedly denied homicidal ideation, but there was no mention of the 9/16/15 note. He continued to be overtly psychotic and refused blood draws, fearing that if “they take the blood and they be practicing witchcraft.” The PNP opined that he did not meet involuntary medication criteria and stopped the lithium. There was no discussion of alternative medications that would not have required a blood draw.

He attended Music Appreciation Group on 10/6/15, 10/20/15, 10/27/15,

On 11/19/15, he told an MSW during rounds that he would take medications if he did not have to have blood drawn.

On 12/7/15, a PNP noted his continued psychosis, including that he has been kidnapped, that Satan makes him have suicidal thoughts (but he does not want to kill himself), and a host of other symptoms. The PNP had known him over 10 years and noted long stints in segregated housing. The PNP noted that he was not a danger to self or other but did not discuss grave disability or guardianship.

On 2/10/16, a boilerplate treatment plan was entered into the record.

Following a sick call request from 2/15/16, an MSW saw him on 2/19/16 and he complained of being “energized and hyper” and wanted help “coming down.” He remained overtly psychotic. He was referred to a psychiatric provider.

A PNP saw him 2/22/16 and he was even more floridly psychotic and spoke of not wanting to hurt anyone. The PNP started olanzapine 20 mg (above the recommended starting dose) and lithium, though he continued to state he did not want blood work and both require it.

Following a sick call request from 3/15/16, an MSW saw him on 3/18/16. The patient wanted to stop medications because they were “not working for him.” The MSW reported no signs of mental illness, which was highly unlikely unless he had had a profound response to medications unlike any time before.

On 3/28/16, he saw the PNP and complained of “no energy” on the “white pill” (likely olanzapine, which is highly sedating, especially when started at such a high dose). The PNP noted the he “presents to interview asking for medications; however, will not comply with recommended medications.” The PNP stopped his medications.

His next mental health contact was with another PNP on 5/17/16. He continues to be psychotic and requested “uppers.” No medications were started.

Following submission of a sick call request from 6/12/16 demonstrating grossly psychotic content, an MSW saw him on 6/13/16. He was still very psychotic and requesting “meth and coffee” to “level him out.” The MSW referred him to a psychiatric prescriber.

On 8/12/16 there was a 30-day mental health contact with custody present. No psychotic symptoms were noted in this brief note.

On 8/16/16, he saw a PNP who noted he was still not on medications, wanting methamphetamine instead. He was overtly psychotic.

A 9/1/16 office visit with an MHP was the final contact before the end of the record. He exhibited poor hygiene, thought disorder, paranoid delusions, and decreased sleep. The note describes the same overtly psychotic patient I saw during my interviews. The note closes, “MHP will continue to work on client to get him to understand the importance of medication compliance and maintaining a healthy body odor. MHP will see the client in 30 days.” However, the MHP did not say how she intended to meet those goals with sessions 30 days apart.

On 9/25/16, the record ends.

Note that mental health rounds for this patient housed on a residential treatment unit occurred only on 11/19/15, 6/29/16, 7/12/16, and 8/9/16.

There was no evidence of any effort at intervening other than with medications and an abortive attempt at a Music Appreciation Group. There was no attempt to help him with basic activities of living, let alone trying to address his mental illness and poor treatment adherence. Despite being one of the sickest patients I saw, he received fewer contacts with mental health than almost anybody. Rounds on the mental health unit were sporadic at best. Proactive outreach by mental health clinicians was non-existent; they merely responded to his intermittent and bizarre sick call requests and then referred him to a psychiatric prescriber. This amounts to neglect.

The prescriber also did not demonstrate a willingness to try medications that would not require laboratory studies, perhaps because many such choices were not on the formulary, including some mood stabilizers other than lithium that could have been tried. There was no consideration of older antipsychotics which can be used without the kind of repeated lab monitoring than a medication like olanzapine. In this case, every effort, even considering medications that require lab monitoring but with low risks and documenting why they were used even though he refused labs would have been preferable to doing nothing.

Perhaps more important, this man was clearly not competent to consent to treatment. Yet there was no consideration of a guardianship that might have provided a vehicle for getting him treatment with some hope of reduction in his severe symptoms. Failure to secure treatment relegates this man to further deterioration.

Patient 31

This patient in his early 30s has medical records dating back to September 2012. He had an intake at CMCF on 9/21/12. At that point he was identified as having had outpatient psychiatric treatment and had been on antipsychotic medications. He was noted to be anxious, paranoid, and depressed. He reported auditory hallucinations and was felt to be delusional. A generic treatment plan was entered into the record at that time.

When seen by psychiatry on 9/26/12, the patient reported no symptoms and that he did not want medications. He later asked to see the psychiatrist, and on 11/6/12 he was again found to be depressed, anxious, and paranoid. The psychiatrist started him on paroxetine, an antidepressant, and risperidone, an antipsychotic.

Over the ensuing months he was repeatedly placed in restrictive housing and had numerous behavioral problems. At times he was noted to be thought disordered and unkempt as well as depressed and complaining of auditory hallucinations. He periodically would stop his medications. He asked for therapy but never received any.

He moved between facilities and in June 2014, after being stabbed by a peer on 6/6/14 while at WCCF, he requested placement at EMCF where he had been previously housed. He reported that he was having auditory hallucinations that were telling him to kill “somebody.” Though he had no other psychotic symptoms, he was found to be irritable. At that time, the antidepressant was stopped and the risperidone was increased. Diphenhydramine was added, presumably for side effects.

While in restrictive housing during July 2014, he continued to complain of command hallucinations as well as other mental health symptoms including poor sleep. He was also noted to be thought disordered. On 7/20/14, a PNP saw him. He complained of PTSD symptoms and continued command hallucinations to harm others. The PNP referred him for psychotherapy but that never occurred. He continued to do poorly and when seen in restrictive housing in response to an emergency on 8/1/14, the MHC reported that the patient stated that he felt that custody staff were “trying to poison me.” He had cut himself superficially and stated that if he were not moved he would continue to cut himself. The MHC noted that he was “loud, angry, blunted, illogical.”

The PNP saw him again on 9/18/14 and he continued to exhibit thought disorder, irritability, agitation, and paranoia. He was changed to the highest level of care, LOC-E. This eventuated in his transfer to EMCF on 9/26/14.

The Intrasystem Transfer – Receiving Screening noted that he was on “psychotic medications [sic]” but that he was not in mental health treatment, had no history of mental health treatment, and had no mental health complaints. The intake mental health screening consisted of a Suicide Potential Screening and a brief note. These did report on his positive mental health history and previous suicide attempts. He was noted to be depressed. He told the MHC “that his life is in danger with the gangs.” He reported that he “stabbed a gangster and now they are after him.” He went on to speak about “Vice Lords” and how “they took his money and that is why he got stabbed.” He asked to go to protective custody but “was advised that this facility does not have [protective custody] but he will be referred to the investigators for further assessment of protective custody.” He reportedly denied suicidal and homicidal ideation but nonetheless was asked to sign a no harm agreement.

A Mental Health Treatment Plan from the same day included a brief social, mental health, and substance abuse history. Unlike the intake notes, this document reported on his having current auditory hallucinations. It also noted his concerns about the gangs. The Objectives/Goals and Interventions and Modalities used the usual generic verbiage.

He was also seen that day by the PNP, who knew him from WCCF. For the first time, the PNP noted “repeated reports of his assaulting the staff with urine and other substances – ongoing irritability and disruptive behaviors towards the security staff. He had remained in ad-segregation at WCCF since June 2014 due to some physical altercation resulting in him being stabbed and him stabbing another peer - reportedly stabbed a gangster - therefore presenting with security type issues as well.” The PNP reported that he denied hallucinations. While he was paranoid, he was not delusional. There were no evident mood symptoms other than anxiety. He reportedly consented to continue with the current medications.

He was placed in the infirmary but the medical record does not indicate why. There are cursory mental health infirmary rounds notes from 9/27/14, 9/28/14, and 9/29/14.

On 9/29/14, the patient reported being put in a “chokehold” by a Sergeant who also “hit him in the eye.” He was seen by a nurse who gave him ice packs for his swollen eyes.

The mental health infirmary rounds note from that day reported that the patient “began to cry when talking to the provider regarding the altercation with [the Sergeant] earlier. The provider provided emotional support. He thanked the provider. The offender is housed in the infirmary on Security Hold.” This was the first notation about why he was in the infirmary.

Infirmary rounds continued on 9/30/14, 10/1/14, and 10/2/14.

The next note was mental health rounds on 10/8/14 on unit 1.

The following day he submitted a mental health sick call request. He complained of auditory hallucinations though the rounds from the previous day stated that he had denied such; this is highly unlikely. The MHP note also reported that he was thought disordered but “denied” delusions. There was no assessment and, despite his complaints of symptoms and the findings by the MHP, the only plan was to refer him to “MTC program staff to assist with issues and or [sic] concerns.”

On 10/20/14, a note from an MHC office visit reported that he wanted to get a job. The checklist mental status examination was completely normal. The note indicated that the patient asked for the visit regarding getting a job. The MHC wrote only that the patient was “encouraged to consult with his treatment team and is offered inmate request forms to write different departments but he declines at this time.” The record demonstrated no follow up on this request to get a job.

Later that same day, there was a mental health note that reported he had hit a custody staff “because she pushed me and I had to defend myself I was not gonna let her put her hands on me and not do nothing [sic] it all started about my enhance [sic] tray I suppose [sic] to get she let those other guys take and then she want [sic] to start talking stuff I tried to tell folks about her and nobody would listen too [sic] me now look what happen [sic] all of this could be avoided now look it got out of hand she was talking about she was gonna have somebody in one of the other zones jump on me I afraid of being stabbed again and I started hearing voices I don’t suppose [sic] to be in population.” He was rambling and irritable and “appeared to be very upset and shaken.” He was worried “he would start dreaming about the stabbing took place

against him and the voices would come back and he felt all of this could be avoided if someone would have listen [sic] too [sic] him when he was telling the [custody officer] and how she was talking and treating him [sic]. The [inmate] was encouraged not to engage in violent behavior when face [sic] with opposition try to resolve the situation through the proper means of protocol [sic].” He was also “encouraged to continue using what has help [sic] in the past when dealing with anger on how to cope with stressful situations without resorting to violences [sic].” The plan was to continue to monitor. There was no discussion of the possible contribution of PTSD or psychotic symptoms to his behavior.

He was placed in restrictive housing. There was no medical or mental health intake assessment or evidence of mental health.

He was seen by the PNP on 10/29/14; the patient remained in restrictive housing. He again spoke about his problems with the officer and spoke about getting more paranoid. The PNP did not note any acute symptoms of psychosis or mood disorder. There were no changes in medications.

Mental health rounds were conducted on 10/30/14 and 11/5/14. He did not get daily nursing rounds.

The next mental health note was an office visit from 11/17/14. He complained that his “mind ain’t right. I’m trying to get some help!” The LPC noted no abnormalities on the checklist mental status examination. The note text began with the following: “[Inmate] seen for an individual counseling session with [custody officer] present for session [sic]. [Inmate] reported that he is noncompliant with Risperdal, takes it every other day, but that it does help to lessen his anger and increases his sleep. [Inmate] reported bouts of uncontrollable anger. We discussed need for medication adjustment, with possibly adding a mood stabilizer to his regimen.” The plan was to refer him to a psychiatric prescriber. There was no plan to address his anger management problems or any other symptoms through individual or group therapy.

The PNP saw him on 11/19/14. On the basis of his irritability and anger problems, the PNP started divalproex sodium, a mood stabilizer sometimes used to help with impulse control. The PNP ordered appropriate baseline labs. No laboratory results were reported in the record for over a month.

The patient submitted a sick call request and was seen by an MHC on 11/25/14. He stopped taking his medications because it made him “sick and weak.” He was referred to a psychiatric prescriber. The PNP saw him on 11/26/14. The PNP decreased the risperidone and diphenhydramine.

He submitted another sick call request and was seen by an LPN on 12/8/14. He complained of auditory hallucinations, was guarded, exhibited flight of ideas, and had decreased sleep and appetite. He was “very hypervocal and he was fidgety could [sic] not stand still during interview, stated to this provider ‘Please get me off this zone for awhile[sic].’” The plan was once again to refer the patient to a psychiatric prescriber but there was no indication of intent to address any of the patient’s concerns.

The following day he had a Pre-Lockdown Health Evaluation that noted only that he refused medical treatment. There was no comment on his psychiatric history or presentation or on the appropriateness of his being in restrictive housing.

On 12/10/14, he was seen in response to a sick call request. He wanted to get out of restrictive housing; the MHC stated that mental health had no control over housing. He spoke about being treated poorly and needing some help though reportedly denied any mental health problems. The MHC wrote: “the offender is encouraged to adjust to his housing unit as he will have to speak with classification about all of housing housing [sic] and reclassification issues. He is counseled on being responsible and being held accountable for his actions as he is requesting to be placed on certain housing units at this time. The offenders [sic] concerns are security and are non-mental health issues.” The plan was to refer him “to his housing unit Treatment Team for further assessment.” There was no evidence of any referral or further assessment.

During mental health rounds later on 12/10/14, he stated that he had been placed in restrictive housing “for no reason.” However, there was no discussion of why he had been placed there. The plan was to monitor.

The PNP also saw him that day and noted that the patient reported being placed in restrictive housing because “he left the pod to check on his allergies – diet allergies – reports ‘I walked off the zone...was trying to check on my diet...got allergies...’” The PNP noted no psychotic or mood symptoms other than anxiety and being under stress. There were no changes to medications.

A very brief 12/11/14 Mental Health: Seven-Day Segregation Assessment noted no “issues other than property issues and wanting to be moved of [sic] 6D.” The plan was to monitor.

There was a Quarterly Treatment Team Review on 12/15/14. It noted that he has symptoms “when he does not get his medications as ordered.” It also spoke to his reports of “poor impulse control, increased anger and thoughts of hurting others who make him angry and do not act professional.” The associated treatment plan was the usual generic plan. There was no suggestion that his problems with self-control were to be addressed.

The patient was seen for injuries on 12/23/14. He had a knot on his forehead and cheekbone, a laceration on his lip, and had bit through his tongue. The patient reported having had a seizure, though had no history of seizure disorder. There was no further discussion of possible seizure disorder or what had actually happened.

12/24/14 laboratory results show a normal complete blood count and liver panel. The valproic acid level (for following the divalproex sodium) was less than four with a normal range of 50 to 100. Clearly he had not been taking this medication.

Mental health rounds resumed on 12/30/14.

The PNP saw him on 1/1/15 and noted valproic acid level. He was irritable and paranoid. He spoke about an appropriate relations between custody staff and gang members. The PNP again noted that mental health had no say over housing and referred him to MTC staff, though did say

she would speak to the shift commander. The divalproex sodium was stopped but the PNP increased both the risperidone and diphenhydramine.

On 1/12/15, he had an office visit with mental health and reported on gangs trying to get him involved but that he did not want to be in gangs any longer. There was no indication of what was done other than the recommendation stating, “[Inmate] was seen in this provider [sic] office for current stressors and will continue to be seen by [mental health] for his mental health needs.” There was no discussion of how his mental health symptoms may contribute to his difficulties or any attempt to problem solve with him that was reported in the chart.

The next mental health rounds were on 1/22/15.

The PNP saw him on 1/31/15. He was reportedly psychiatrically stable.

Mental health rounds continued on 2/21/15. He had an office visit with a LPC, again requesting a move owing to being unable to “take all the pressure.” He also reported, “I smoke every chance I get!” The note clarified that he had been “using illegal substances.” However, it did not say what and only reported that he was counseled not to use them.

He was seen in response to another sick call request on 2/26/15. The MHC reported that another offender he had stabbed was now housed on unit 6A. The patient reported that he was “having visions of altercations with him and homicidal thoughts about this person.” The MHC reported this to a captain. The patient asked to have medications for anger and mood issues and was referred to a psychiatric prescriber. There was no evidence of any sort of risk assessment.

The PNP saw him on 3/4/15. He spoke about increased paranoia in relation to the peer he had stabbed. He was otherwise psychiatrically stable but requested to go back on the divalproex sodium. No new medications were ordered and the patient was reduced from level of care E to C.

Mental health rounds continued on 3/8/15.

On 3/9/15 there was a Quarterly Treatment Team Review. The patient was not in any groups, education, job, or programming. There was no associated treatment plan.

The next rounds were on 3/30/15.

On 4/6/15 he was seen at custody’s request. The patient complained about his tray having no entrée. The MHC wrote: “Offender was reminded that this provider cannot do anything about his tray but that the Sgt. or Shift Commander could contact the kitchen to see if there was anything else. The offender begin[sic] to get agitated and dismissed this provider. Offender could not be assessed for [mental status examination] at this time due to his violent gesturing and anger. Offender was left in the hands of security staff....” The plan was to monitor.

The same MHC saw him again on 4/17/15 at the patient’s request. The patient reportedly apologized for the above. The note stated this in that there was no “psychosis or mental distress and denied [suicidal or homicidal ideation] and [auditory, visual, or tactile] hallucinations.” The plan was to monitor.

The next rounds were on 4/19/15 and 5/13/15, when he was noted to be masturbating. The MHC merely noted that this was inappropriate behavior and that a mental status examination was therefore not done. There was no consideration whether this might represent any mental health symptomatology.

The next note was a 6/8/15 Quarterly Treatment Team Review. The patient reported taking medications and did not have any side effects. The note incorrectly stated that the patient had not had any mental health care prior to incarceration. The patient “denies having any symptoms of psychosis and denies having any mood, sleep or appetite disturbance.” There was no discussion of any of his other behavioral or PTSD symptoms. The patient again asked to work. The plan was to continue medications and monitor but nothing about a job. There was no associated treatment plan.

On 6/12/15, contrary to the above, the patient complained of side effects. He also reported that he was not getting some of his medications. The MHC noted no signs of overt mental illness. MHC also noted that the medication order was still active and so the patient should have been getting it. He was referred to a psychiatric prescriber. However, he was not seen by the PNP but the PNP did update his medications.

He was not seen again by mental health until 8/6/15. He was referred by custody staff though it does not say why. The patient asked to have “‘restrictions removed’ so that he can go back to school.” He also noted that he was supposed to get “a rewards package for helping to clean during the ACA audit.” The MHC noted that a custody staff said that he did not help with cleaning. The patient also complained of not having hygiene products. More importantly he reported problems with extreme anger and mood swings and “that he feels he is being ‘neglected, ignored, picked on, harassed and set up by staff members.’ He apparently has a personality conflict with one particular staff member.” The MHC and colleagues reportedly “talk with him about how to better handle personality conflicts by reviewing conflict resolution skills.” The plan was to monitor.

The PNP saw him on 8/18/15. He continued to complain of problems with mood swings and anger. He was irritable and reported auditory hallucinations but no other psychotic symptoms were detected. He complained of problems with sleep and the PNP noted that “mood swings evident at interview [sic] - easily agitated at interview – hostile – aggressive - denies depression.” The PNP and patient discussed medications and elected to start lithium and increase risperidone, even though no psychotic symptoms were detected. The PNP ordered appropriate baseline labs.

He was next seen in a Quarterly Treatment Team Review on 8/31/15. At that time his diagnosis was Bipolar I Disorder, single manic episode, severe with psychosis. He was noted to be hostile and angry and “reported having issues on his zone and wanting to hurt someone.” Then the note went on to say that he was calm “but expressed anger/hostility towards his peers.” There was no further discussion of his issues or what might be done about them, let alone exploring his potential risk to others. There was a treatment plan, the usual generic plan.

The PNP next saw him on 9/21/15. He reported taking his medications. No lab results had yet been obtained. The plan was to discontinue the diphenhydramine, the note did not state why, but no other changes were made.

On 9/24/15 a complete blood count, thyroid function, and metabolic panel were within normal limits. Lithium level was low at 0.3 with a normal range of 0.6-1.2.

The PNP saw him on 10/1/15 and increased lithium. The patient reportedly consented to this increase. However, on 11/2/15 a lithium level was undetectable.

He was next seen by a LPC on 11/10/15 for an office visit with custody staff. He complained again problems with his tray. He reported doing “better with my anger.”

On 11/13/15, the PNP saw him. He reported taking his medication though noted he had stopped for two weeks. The PNP wrote about his “[history] of noncompliance with medications, number of trials of various medications, as he has insisted he needed medications [sic]. Again, today, he presents with similar behaviors, he is noncompliant with medications. Discussed, can not [sic]continue medications in the presence of noncompliance. Will monitor off medications. No mood/thought disturbance at interview today.” There was no discussion of whether he had continued to take the risperidone and no mention of obtaining a level to verify his statement that he had resumed taking medications. All psychotropic medications were stopped. He stated that he wanted to stay on medications. His diagnosis was unchanged.

He was next seen by mental health on 1/8/16. A LSW noted no symptoms on a checklist mental status examination. The patient was concerned about assuring that his special diet was implemented.

He was seen again by the PNP on 2/5/16. The patient reported “doing good” despite not being on medications. He reported continued problems with anger and irritability but was “battling it....” The plan was to “monitor off medications due to noncompliance and he is doing well.”

A LSW saw the patient on 2/19/16 at his request. The patient was seeking a haircut and clothing; he was told he needed to ask security at which point he became upset, reporting that custody staff did not listen to him which was why he was coming to mental health. The LSW asked custody and was told that the “clippers was broken [sic].”

During this time the patient had continued to lose weight, a total of about 50 pounds. This was never mentioned by the mental health clinicians. With his frequent complaints about his tray, this should have been examined to determine if he had a problem with eating related to any mental illness.

The LSW saw him again 3/29/16. The patient requested to go back on lithium. He complained of being stressed and not sleeping. The LCSW was going to check with the psychiatric prescriber.

The PNP saw him on 4/4/16. The patient asked to go back on medications and noted that he had not taken his medications “all the time, but I need my medications. Give me another try.” Again, he complained of mood swings and problems with anger and irritability. The PNP noted

increased activity and decreased sleep on the checklist mental status examination. No other motor psychotic symptoms were reported. The PNP restarted divalproex sodium, a mood stabilizer.

The PNP wrote a treatment team note on 4/19/16. He reported continued problems with anger and that he was taking his medications. The patient also noted that he “finally got put in the chaplain’s class.” The patient also noted that a younger sister had had a stroke and he was concerned about her status. No mood or psychotic symptoms were noted. There was no associated mental health treatment plan.

An LCSW saw him on 4/25/16 in response to a sick call request from two days before. Patient complained of his jaws locking up. No abnormalities were noted on the checklist mental status examination. The patient was referred to a psychiatric prescriber. There was no assessment of his complaint, which should have been evaluated by a qualified clinician.

A valproic acid level from 4/26/16 was low at 9.7 (normal range 50-100).

He was next seen by a PNP on 6/1/16. The PNP noted that the patient continued to have “noncompliance issues. Ongoing episodes of asking to get back on medications, and then later, he is noncompliant. He gives some odd reason as to discuss [sic] low Depakote levels, almost none detected.” The plan was to repeat a level in a month and then stop medications if noncompliant. There was no discussion of his “odd reason” for low Depakote levels or the previous complaint of his jaw locking up.

On 6/30/16, a valproic acid level was 40.4, just below the therapeutic range.

He was next seen by mental health staff on 7/24/16. The PNP noted that he had been seen “for treatment team.” The patient spoke to life stressors and reported adherence to medications. The patient reported his mood being better. He was noted to have some pressured speech but no other problems on checklist mental status examination. A generic mental health treatment plan was scanned into the record on 7/25/16.

On 8/10/16, he was seen for a 30 day contact, though it had been much longer than 30 days since last being seen by LSW or mental health staff other than a psychiatric prescriber or on rounds. The note indicated that, in fact, it was the patient who had requested the visit. He expressed feeling a lack of support from his family. The LSW wrote: “client was not suicidal/ and or [sic] homicidal. Client just wanted to vent his thoughts, client was informed to continue [sic] to take his medication he will [sic] continue to be monitored as needed.”

The PNP saw him on 8/31/16 following a custody staff referral. The patient was again upset about his meal tray. The patient was calm and cooperative with the PNP. It was unclear why this was a mental health referral except that he had been upset about repeated problems with his food tray. He reported being free of any RVRs for several months and was hoping to achieve medium custody. There were no abnormalities on the checklist mental status examination and the patient was continued on the same medications.

The final mental health note was from 9/14/16 when he was upset when seen in intake after having come back from court where he had been given a long sentence. He had reportedly also been in a facility riot on his housing unit and reported stabbing a peer. The patient reported that this was related to gang activity. He reported being in fear for his life and stated, “I do not want to kill anybody but I will before I let someone kill me. I’m telling you it’s going to pop off real bad when the faculty [sic] get [sic] off lockdown.’ Client said that the banging was not over and security knew this banging was going to happen but they did nothing to stop it now they have created a very bad thing.’ Client became very tearful and stated he did not want to talk anymore ‘I’m just going to do what I have to do.’” The MHP reportedly informed security about the client’s fears and then “security placed client in segregation on housing unit 5. Client will continue to be monitored and information will continue to given [sic] to security regarding any other riots.”

There was no pre-lockdown assessment in the record. The record ends here.

This patient with likely PTSD (which was never properly assessed) and possible mood disorder received only basic pharmacotherapy. Despite his repeated complaints of problems with impulse control, self-management, and paranoia that he often specifically related to his past stabbing, there was no effort to address these problems through ordinary treatment with individual or group therapy, either of which is an effective treatment for PTSD in most cases. As a result, he made virtually no progress in self-management, resulting in repeated altercations and stints in restrictive housing. Adequate treatment could both reduce his suffering and the likelihood of getting involved in impulsive violence or conflicts driven by unreasonable paranoia.

It is important to note that while non-adherence is sometimes an appropriate reason to stop medications, in this case, the PNP stopped all medications without a careful assessment of whether the patient was truly non-adherent to all his medications; he told the PNP that he had resumed them on the occasion they were all stopped. This was an unreasonable action and put the patient at risk of clinical deterioration.

Further, even though this patient’s problems with adherence were a known problem, no measures were taken to address this, even though there are well-described therapeutic approaches to improving adherence. This was a recurrent failure at EMCF.

Patient 32

At a 6/3/14 intake medical screening at CMCF, the patient reported a history of depression and bipolar disorder and past prescriptions for risperidone (an antipsychotic) and sertraline (an antidepressant). He had an intake mental health screening that day that consisted only of a Suicide Potential Screening form; there was no note and no narrative history. He again reported his mental health history and past medications. He reported previous psychiatric hospitalization and outpatient mental health treatment. He admitted a history of violent behavior but there was

no attempt to address his current dangerousness. He reportedly denied suicidal ideation and past suicide attempts. He was slated for routine mental health follow-up.

There was next a mental health treatment plan dated 6/5/14. However, it was cursory at best. There was only a report of the past diagnoses and objectives/goals consisted only of the generic and unhelpful “symptom reduction or maintenance.” It then had the standard language about interventions and modalities regarding physician monitoring medications every 30, 60, or 90 days in the generic mental health/psychological services standard language: “crisis intervention, individual therapy, group therapy” all to be as needed by “[sick call request], weekly, monthly.” A progress note that same day was also extremely minimal. The patient reported being “depressed, anxious and paranoid and I have problems sleeping.” The mental status examination was very limited but noted the presence of paranoid delusions, though not their content, which is concerning given his report of past violence. There was no formal assessment, just this brief note.

He was seen by a psychiatrist that same day who provided an extremely abbreviated combined history and mental status examination that read as follows:

“Patient seen with [history of] depression and psychosis treated with Zoloft and Risperdal for two years but now he has been off meds for 10 months. Patient reports feeling depressed and also has suicidal thoughts. He has 20 years to serve. Patient also has suicidal thoughts and is unable to commit to his safety. Patient has no [history of] manic or hypomanic symptoms. Patient has never planned or attempted suicide. Patient reports he hears voices of people talking but has no commands. No visual [hallucinations] but feels paranoid and hypervigilant.”

The remainder of the note was limited additional mental status examination that provided minimal expansion on the above paragraph. There was no social history, family history, psychiatric history, medical history, substance abuse history, or discussion of the case, including no proper risk assessment. The psychiatrist made two diagnoses: psychotic disorder not otherwise specified and major depressive disorder, recurrent, moderate. The psychiatrist started the antidepressant sertraline 100 mg (a starting dose above the recommended 50mg) and the antipsychotic trifluoperazine 5 mg. An AIMS done that same day was scored zero. The patient was placed on suicide watch.

On 6/7/14, the same psychiatrist reported that the patient tried to attack the psychiatrist and was “irritable and easily agitated” but also said “no obvious distress noted.” There was no mental status, no interim history, no assessment of medication response, and no violence risk assessment. There was no change in medications ordered.

Another psychiatrist saw the patient 6/9/14 and provided no clinical information other than that the patient was “guarded” and a suggestion that the patient may be minimizing symptoms. The plan was to “continue current observation” and work on EMCF transfer.

On 6/11/14, the first psychiatrist saw the patient and again provided minimal information. The patient was reportedly calm and denied hallucinations and delusions (again note: delusions cannot be denied by a patient). The note indicated the patient had no side effects.

On 6/13/14, another psychiatrist visit specifies a change from suicide watch to psychiatric observation. Note that since being placed on watch 6/5/14, the patient had not been seen by non-psychiatric mental health staff and there were no nursing notes.

There was another psychiatric note 6/16/14. It included additional more information but is still not a complete assessment. The patient was reportedly doing better and no psychotic or mood symptoms were noted.

On 6/17/14, there was a late entry by a mental health staff that indicated he had seen the patient while on observation status. The note otherwise consisted only of a brief checklist mental status examination.

There were similar brief notes by the first psychiatrist from 6/19/14 and 7/2/14.

No laboratory studies were in the record from admission though it appears they were ordered.

The patient was transferred to EMCF 7/3/14. The nurse medical screening reported that he was not prescribed psychiatric medications, was not being treated for a mental health problem, and had no prior psychiatric treatment – all of which were not true. The conclusion of the mental health section was that no mental health referral was indicated.

He had an Intake Mental Health Screen consisting only of a Suicide Potential Screening that same day. The patient was noted to be anxious and to have a psychiatric history and to be on psychotropic medications (though it listed incorrect medications). Despite concluding the patient had an “acute mental health problem,” the patient had a routine referral to mental health and was placed in general population.

On 7/9/14, an MHC saw the patient with custody during rounds on unit 4C. The brief note stated that the patient “voiced no [mental health] concerns” and the plan was to “monitor.”

There were similar limited rounds, most often with custody presence, on 7/15/14, 7/22/14, 7/30/14, 8/6/14, 8/15/14, 8/21/14, 8/31/14, 9/4/14, and 9/9/14. It should be noted that those conducting rounds did not demonstrate any awareness of medication or other status changes that would have been helpful to actually monitor.

The patient was seen on 8/20/14 by a MHC in response to an 8/19/14 sick call request regarding complaints of “mood episodes.” It is not clear why this was not detected at rounds, but privacy limitations are one possibility, as is the cursory nature of the rounds (though this is exactly the kind of thing that should be detected at rounds and followed-up). He complained of depression and spoke of being in a coping skills class in the therapeutic community; there were no associated notes so presumably this was one of the peer run groups. The MHC reported that the patient “was given further counseling on coping skills and stress management.” As he had not received previous counseling, it is not clear what the “further” referred to. He was also referred

to a psychiatric prescriber. He had not seen a psychiatric prescriber since arriving at EMCF on 7/3/14.

He was seen by a PNP 8/22/14 who documented an abbreviated history and limited mental status examination. The plan was to increase the antipsychotic despite no report of psychotic symptoms or mania; the PNP also added a side effect medication, trihexyphenidyl. He was also changed from sertraline to another antidepressant, bupropion, that he had taken previously. The reasons for these changes were not documented and are by no means clear.

On 9/8/14, he was seen for an “office visit” by a MHC who noted under the patient’s subjective report, “Offender is seen reporting... ‘I choked him because he got in my face.’” He had been brought to medical by security after an altercation with a peer. The MHC reported that he was guarded, had “circumstantial” thought (a form of thought disorder typically associated with psychosis) but no other symptoms except being sad with a “constricted” affect. There was no assessment of the possible contribution of mental illness or any form of risk assessment. The patient was “counseled on ways to handle his stress and coping strategies to incorporate into daily living.” There was nothing more specific and the only plan was to “monitor.”

On 9/11/14, he was the subject of a mental health “7-day segregation assessment.” There was no initial nursing pre-lockdown assessment or other nursing notes. The assessment included only a limited mental status examination; it was not an assessment. The recommendation was that “this offender remain in [administrative segregation] pending disciplinary action.”

He was seen for mental health rounds on 9/15/14 and 9/23/14.

There were no nurse rounds.

On 9/18/14, there was a mental health segregation follow-up visit which recommended the patient be released from administrative segregation, but it gave no reason why. He was not released.

On 9/25/14, there was a mental health segregation follow-up visit which recommended the patient be monitored but made no comment on his placement in segregation.

On 9/26/14, the PNP saw him and made no medication changes. The limited mental status examination recorded no abnormalities.

There was a Quarterly Treatment Team Review on 9/29/14. It noted the RVR that led to placement in restrictive housing but provided no assessment of the patient’s needs and included only a cursory mental status examination. There was the same generic mental health treatment plan language documented numerous times for other patients.

He was seen for mental health rounds, though it is unclear whether he was still on segregation status, on 9/29/14, 10/6/14, 10/14/14, and 10/21/14.

On 10/16/14, there was another Segregation Mental Health Status Report that was again very cursory and concluded that the “committee recommends this offender remain in [administrative segregation] pending investigation for protective custody.” There was no mention of why

protective custody was being considered or what, if anything, had happened. In an appended note, the mental health provider indicated the patient wanted to stop psychotropic medications but did not say why and simply referred the patient to a psychiatric prescriber.

Segregation Mental Health Status Reports from 10/16/14 and then 11/6/14 conclude only that he will continue to be monitored.

The next mental health contact was 11/20/14 with the PNP who stopped the medications and noted no current mental health symptoms or signs but noted an “extensive [history] of severe mental illness – schizophrenia and bipolar disorder.” It was not clear why this had not been previously reported. There was still no full assessment.

The mental health rounds continued on 12/3/14, 12/15/14, 1/26/15 and 2/25/15.

The Quarterly Treatment Team Review on 2/19/15 was extremely brief and noted no problems or complaints. The treatment plan was unchanged except for the removal of the psychiatric and nursing verbiage because he was on no psychotropic medications.

The patient made a sick call request 3/12/15 and was seen that day by an MHC. The patient requested to be put back on medication but the reasons were not specified. There was a cursory mental status examination that noted only depressed mood. The plan was to refer to a psychiatric prescriber.

The same PNP saw him 3/16/15. The note indicated only that he wanted to be on medications and that his “moods have been up and down.” There were no findings on mental status examination, yet the patient was started on olanzapine (a different antipsychotic than before) and sertraline (the original antidepressant). The reasons for these changes were not reported. If the PNP had previously stopped the sertraline because of lack of efficacy, it would make no sense to restart it, especially as the trial of bupropion had been inadequate to determine efficacy.

Mental health rounds continued on 3/31/15.

There was no other mental health contact until a “code black” note by a MHC on 4/17/15. He apparently was in a fight or assaulted a custody officer, reportedly because of not being allowed to go to church services. There was no discussion of the incident or any risk assessment. The limited mental status examination was unremarkable. The plan was to “monitor.”

He was also seen that day by the PNP after being placed in administrative segregation. He told the PNP he was upset about some family problems and reported that when he asked to go to church, he reported the officer said “he was going to write me up...kept saying he was going to give me a RVR....” The PNP saw no evidence of psychosis or mood disturbance. The plan was to continue medications unchanged.

There was a “Pre-Lockdown Health Evaluation” done by a nurse two days after placement in segregation.

He was seen for mental health rounds on 4/21/15, 4/29/15, 5/8/15, 5/19/15, 5/24/15, 5/26/15, 5/27/15, 6/3/15, and 6/9/15. However, there were again no nursing rounds in segregation.

There was a mental health treatment plan from 4/22/15 that reinserted the boilerplate nursing and physician verbiage. The associated note made no mention of the assault or that medications were recently restarted or why and no demonstrable intent to do anything other than monitor.

The patient submitted another sick call request 5/3/16 and was seen by an MHP the following day. It was not clear what the patient wanted. The note spoke to referring the patient to MTC regarding “state issue property” and noted that “he has reconsider [sic] to discontinue [sic] psychotropic medications and no longer requesting [sic] a transfer to another facility.” The latter points were already known at the time the patient restarted medications. This note also suggests that there was still a perceived connection between being off medications and leaving EMCF.

On 7/9/15, an MHC conducted a Segregation Mental Health Status Report. It was very cursory and reported no problems and that he was taking his medications.

A 7/13/15 Quarterly Treatment Plan Review was similarly cursory. It noted that he was without current psychotic or mood symptoms but did not comment on his repeated assaults. The one change was an intention to refer him for educational services.

There was another cursory Segregation Mental Health Status Report on 7/16/15.

The patient submitted another sick call request form on 8/3/15 this time requesting “medical/psych service.” The brief mental status is unremarkable and the plan is to refer to a psychiatric prescriber. But there was no assessment of why the patient was making this request or whether a referral was necessary.

There is another cursory Segregation Mental Health Status Report on 8/6/15. The only substantial content was the patient’s request to transfer to another facility, but it said nothing about why.

The next mental health rounds were not until 8/18/15. The patient was still on unit 5, the restrictive housing unit. There were still no nursing rounds.

The PNP also saw him that day and the patient told her he had stopped his medications “since August 2015” and reported on his renewed transfer request. Why this non-adherence was not previously reported is unknown. The PNP did a limited mental status and noted no problems. The medications were discontinued.

A Quarterly Treatment Plan Review the following day noted his medication refusal but there was no plan to address it. It only stated that he would have to be “stable off psychotropic medications for (90) days” in order to be transferred, making it clear that this practice was not yet halted. The associated treatment plan was unchanged except for removing the physician and nursing elements once again.

Mental health rounds in segregation continued on 8/27/15, 8/31/15, 9/4/15, 9/10/15, 9/17/15, and 9/21/15. Still, there were no nursing rounds documented.

A Quarterly Treatment Plan Review on 11/19/15 noted that he was attending GED classes. The patient also reported depressed mood and sleeping only 3 to 4 hours per night. There was no plan to address these new findings. There was also no treatment plan this time.

The PNP saw him 11/30/15; the patient again asked to be placed back on medications and reported depression, anxiety, family stressors (which, typically, were not noted by the treatment team), and poor sleep. He was started on the antidepressant, mirtazapine.

He fell on the stairs and fractured his left arm on 12/31/15 and had surgery three weeks later.

He was not seen again by mental health staff until seen by the PNP 2/8/16. He still had sleep problems but they were improved as was his mood. The PNP commented on the relationship between mood instability and fighting/aggression, a common problem. The PNP did a cursory review for mania and made a diagnosis of bipolar disorder. However, the documentation was far from establishing that this patient met criteria for bipolar disorder. Regardless, the PNP started lithium, a mood stabilizer. Again, the PNP noted an intention to get laboratory studies (there still had been none for this patient).

On 3/1/16, he refused the laboratory studies. As a result, he saw the PNP that day and the patient said he “needs to keep his blood.” There was no evidence that this odd concern was addressed or reviewed for possible psychotic thinking. Regardless, the PNP stopped all of his medications as a result.

The patient submitted another sick call request on 4/10/16 and was seen by a LSW on 4/12/16, again requesting to go back on medications. The LSW noted no mental health problems but referred him back to a psychiatric prescriber.

The PNP saw him on 4/21/16 with the treatment team. He complained of poor sleep, irritability, anger, and depression. He was noted to be talkative and to have increased energy. The PNP started lithium and ordered a lithium level but none of the other baseline laboratories needed to initiate lithium. Subsequent notes indicated the laboratory testing had to be rescheduled multiple times “due to escorts,” presumably custody was unable to provide an escort. A lithium level was finally obtained on 5/24/16; it was essentially undetectable. As a result, the PNP stopped the lithium on 5/31/16 and saw him the following day. The patient “insisted” he was taking the medication. The PNP now noted no problems on history and mental status examination.

The patient submitted another sick call request on 6/13/16 and was seen that day by a LSW who that patient told he was depressed and wanted to be on medication again. The LSW noted no mental health findings but referred him to a psychiatric prescriber.

The PNP dutifully saw him on 6/15/16 but noted that he had no signs or symptoms of mental illness, as well as his history of non-adherence, and declined to order medications.

The patient made another sick call request for medication on 7/2/16 and was seen by an LSW 7/7/16. This time, the LSW declined to refer him to a psychiatric prescriber.

The PNP saw him again with the treatment team on 7/25/16. He again requested medication. He talked about not wanting to have to give blood because he needed his blood “for my muscles.”

He complained of mood instability. The PNP reported the same findings as the previous time when starting lithium and restarted lithium. This time the PNP ordered appropriate baseline laboratory studies. No treatment plan was included in the record.

On 8/9/16, the laboratory results showed a normal complete blood count, metabolic panel, and thyroid function. But the lithium was again undetectable. The PNP again discontinued the lithium on 8/11/16.

On 8/22/16, the PNP again noted that he had no psychiatric signs or symptoms and declined to restart medications.

There were no further mental health contacts by the last note on 9/21/16.

It is unclear how mentally ill this young man is, as there was never an assessment, let alone any psychological testing to clarify the situation. But the fact that he continued to complain of symptoms and ask for medications and then did not take them should have been addressed either clinically (in therapy) or with a thorough assessment of whether he needed medications. Further, his problems with aggression were never properly addressed either with an appropriate risk assessment or in treatment, though the PNP did note a possible association between violence and mood instability.

Laboratory monitoring was deficient until one set of appropriate baseline labs were ordered at the end of the record. But he should have had numerous laboratory monitoring studies for other medications he had been ordered. Failure to properly monitor labs risks not detecting serious medical complications of these medications. Many psychotropic medications have substantial risks associated with them.

There was also a profound failure to properly monitor this man in restrictive housing. Nursing rounds were absent and mental health went extended periods without seeing him. Given his history and the understanding that he had a serious mental illness, this is very deficient. Placement in restrictive housing is a high risk time, especially for the mentally ill and those at risk of self-harm.

Patient 38

I conducted a thorough review of this patient's medical record.

This patient had a life sentence for murder.

2011 clinical notes indicated that he had auditory hallucinations of a female voice with persecutory content, paranoia, ideas of reference, disorganization, delusions, and negative symptoms. Past medications in 2011 included risperidone and chlorpromazine (both antipsychotics), benztropine (a side effect medication), and mirtazapine (an antidepressant). In 2011 he had some support from his sister, which was important to him.

The patient was having serious problems with recurrent seizures in 2011 as well, which continued on for several years. On one occasion he was in the emergency room and pulled out an intravenous line. There was never any discussion in the medical record of the potential impact of his repeated seizures on his mental health or cognitive status. His seizures were not properly controlled until much later.

A note from 9/6/11 indicated that he was having auditory hallucinations that he reported as saying, “I’m no good and need to kill somebody.” The clinician went on to write in the assessment that “The offender is making homicidal gestures and has seriously injured others in the past.” Yet the plan was only to monitor him and place him on observation status. He was later changed from risperidone to chlorpromazine, both antipsychotics. In later notes it became clear that he had been in a fight. There was no assessment of the possible contribution of his mental illness to dangerousness.

Subsequent notes demonstrated that he was struggling with ongoing hallucinations of a persecutory and derogatory nature as well as commands to harm others, though without a specific target.

Clinician notes conclude that he was mentally ill but also a “sociopath,” though how they came to this conclusion is not documented and the possible contribution of brain damage was never considered. Further, the term “sociopath” is no longer used diagnostically.

On 9/13/11, the patient reportedly said, “You may think I’m playing but I will kill somebody.” The associated assessment was simply “[Rule out] Borderline Personality [versus Antisocial Personality Disorder].”

He expressed fears of being raped and also cut himself that same month. He cut himself repeatedly on the neck and arm. At that time he was reported to be both “crying uncontrollably” and “in an uncontrollable rage....” He also had a history of banging his head to the point of drawing blood. The patient reported that his father abused his mother and sister but, inexplicably, the record was silent on whether the patient had been abused by his father or others. Notes indicated that he had been repeatedly bullied and when bullied, tended to violence.

Because of the above history and behavioral problems it was recommended that he have individual counseling on a regular basis.

The plan was to discharge him from watch to protective custody owing to his problems with others related to the above dynamics. However, subsequent notes indicated that he would return to mental health housing. Notes also suggested that he had engaged in “several suicide attempts to circumvent housing assignments.” Some medical notes from the same time period indicated that he was malingering seizures as well, though it became quite clear that he certainly had real seizures.

On 12/25/11, he reported that he “swallowed two razors and part of the sprinkler head because I snitched on my old cellmate about having a shank and the gang members are trying to get me.”

On 2/10/12 he “climbed the top tier fence.” At that time he exhibited psychotic symptoms, was disheveled, and had suicidal ideation. The associated note reported that he had jumped from the top tier in 2007, sustaining back and neck injuries. This incident was certainly much more than an attempt to circumvent housing.

The record was replete with notations about how he used self-harm manipulatively, primarily related to housing or to get somebody to talk to when he was struggling emotionally or psychologically. There was no evidence of any behavioral plan to address this behavior or any therapeutic interventions to address this behavior or his underlying problems. The patient also repeatedly spoke about fears of being harmed by other inmates, including being celled with inmates in possession of shanks or other weapons.

Sometime before 8/30/12, he jumped from a fence resulting in a complaint of back pain for which he was seen on 8/30/12. There was no record in the chart of when or why he jumped from the fence. On 8/30/12, he was also in an altercation with his cellmate. He had not been taking his medication for several days and was noted to have been pacing. On 8/30/12, he was “hostile, angry and defiant under questioning both by this clinician and Sgt. Snowden regarding events that transpired....” His cellmate stated that the patient attacked him without provocation and reported that the patient had been talking about everybody having guns and knives and had paranoid fears that he would be attacked. He refused medications and was placed on suicide watch, though no suicidal ideation was noted in the record. The patient reported that he attacked his cellmate because he was defending himself, though does not say from what. In addition to paranoia, he was noted to have disordered thinking. During mental health evaluation around this time he also reported that he had been “molested” by an inmate at Parchman.

Soon thereafter he accused other inmates of extorting him, which clinicians felt was due to his paranoia. Things were so bad that inmates asked staff to help manage the patient, presumably their job already. Staff were concerned that his behavior might lead to the patient being assaulted. He was placed on watch. He refused medication but there was no effort to address matters psychotherapeutically or through behavioral plan, let alone any attempt to secure a treatment alliance and his cooperation.

On 9/7/12, he told the psychologist that he had “lied that I was crazy to get here (EMCF) to be located closer to dying father [sic].” On the basis of this report, the psychologist recommended medications be stopped. However, there was no evidence that the psychologist reviewed previous notes demonstrating objective observations of psychotic symptoms such as thought disorder and delusions. Psychotropic medications were not stopped by the psychiatric prescriber but the patient continued to refuse them.

The patient stopped eating for an unspecified period of time and became more irritable and labile. He spoke repeatedly of his fears of being stabbed and having seen “many other people get stabbed at this facility....” The same psychologist saw him again and opined that he did not need medications and should be removed from the infirmary.

On 9/14/12 he seriously cut his pinky, almost severing it. He was noted to be agitated, paranoid, talking about having a \$1000 “hit out on my life,” exhibiting rambling speech, and responding to

internal stimuli (a sign of auditory hallucinations). A PNP saw him that day and noted his history of serious dangerous behavior to himself and others as well as his past psychotic symptomatology. The patient was denying any mental illness or need for medications. The PNP felt that he was clearly decompensating psychiatrically. Staff even called his family to check and then reassure the patient that they were not being extorted and were fine. He was placed back on watch and ordered an intramuscular injection of chlorpromazine, an antipsychotic.

Still on watch in the clinic, he was seen by a psychiatrist on 10/3/12. The psychiatrist noted that he was “severely paranoid with severe thought process disturbance.” The patient was also noted to be delusional, disheveled, irritable, and talking to himself in a way that was consistent with hallucinations. His speech was described as “spontaneous, not relevant to anything related to reality.” Involuntary medications were felt to be necessary and he was started on long-acting intramuscular haloperidol decanoate. There was no evidence that any hearing was held or a judicial order obtained. He remained on watch with periodic rounds but there was no evidence of any attempt to intervene beyond administering medications and isolating him in the infirmary.

Owing in part to poor self-care, his finger became infected. He subsequently had deformity and limited movement of the finger.

His treatment plans throughout this time were the typical generic treatment plans with no specific effort to address any of his danger to self or others or his poor self-care.

On 10/22/12, the patient told the PNP that he had seen an inmate “floor walker” giving another patient in the infirmary items to cut himself and also encouraging the same patient to harm himself in order to go to the hospital to get some “Lortabs” to sell. The patient reported that this happened when the officer in the infirmary went to the restroom and left the “floor walker” unattended. The PNP reported this to an investigator.

He was transferred briefly to general population but began flooding his cell immediately and was sent back to the infirmary. The patient did not want to leave the infirmary.

By 11/18/12, he was beginning to stabilize per a PNP note that date. He was again briefly placed in general population but when he could not get his property promptly, began to threaten self-harm and was returned to the infirmary on suicide watch.

He continued to refuse voluntary psychotropic medications and remained on involuntary haloperidol decanoate injections.

On 12/27/12 while the PNP spoke with him through the cell door about moving out of the infirmary; the patient cut himself with a plastic fork. The PNP noted, “He is upset and angry at the mention that he may be moved from camp support to unit 3.” He was kept on suicide watch in the infirmary. Again, other than medications, there was no evidence of any plan to address these behaviors therapeutically or through a behavioral plan.

He remained on watch in the infirmary through the end of January at which time he was reportedly taking the haloperidol decanoate injections voluntarily. However, the chlorpromazine had been stopped owing to his continued refusal.

On 1/10/13, he was seen again by the PNP who noted that his psychotic symptoms were in better control though he remained paranoid. He was cleared for transfer to the At Risk Unit.

Other than a brief visit by a PNP on 1/25/13, contacts with mental health were limited to rounds that amounted only to brief observations of the patient. There was no evidence of any individual or group treatment being administered.

After he flooded his cell on 4/2/13 and said he did not want to continue psychotropic medications and complained of side effects, he was seen by a psychiatrist who noted psychotic symptoms including delusions, auditory hallucinations, and thought disorder. He was also noted to have inappropriate affect, agitation, and irritability. The psychiatrist closed by saying that the patient “will need compulsory medication if not compliant.” The plan was for follow-up in 90 days and there was no change in his ordered haloperidol decanoate injections. Later that day he cut himself and received an intramuscular haloperidol injection and was placed back on suicide watch in the clinic. During the process of transport, an officer pushed the patient back into his cell; the patient reportedly fell and sustained a head laceration. He was sent to the emergency room and returned, then placed on watch.

On 4/10/13, he had a dystonic reaction (a side effect of haloperidol) during which he fell and sustained another laceration to his head. The PNP believed that this was because he refused to take oral side effect medications. The haloperidol was discontinued and more side effect medication was added, including injections for five days. He continued to have problems with side effects in the ensuing month (likely because the long-acting haloperidol was still in his system). While the psychiatric providers spoke to the long-term need for antipsychotics, none were started at this time or any documented consideration of alternative antipsychotics.

On 5/6/13, the PNP cleared him for return to general population Unit 7. He continued to have side effects and was not ordered any antipsychotic medication. He continued to receive no treatment and contacts with mental health were limited to brief rounds.

By 7/30/13, he had still not been seen by a psychiatric provider and had received no other treatment. On rounds that day, he spoke about wanting his “brother-in-law to beg me to kill him, he lied on me and got me put in prison.” He was noted to be slightly agitated and paranoid.

He was finally seen by a psychiatrist on 8/23/13. At that meeting he admitted “to excessive worry but is willing to talk to a therapist.” Mental status examination was completely within normal limits. Plan is to start the patient on citalopram, an antidepressant. There was no evidence of any informed consent. Despite being on no antipsychotics for months, he remained on side effect medications.

On 9/26/13, the PNP started him on buspirone for anxiety and a low dose of risperidone, an antipsychotic. He was subsequently transferred to the residential mental health unit 3D.

The patient was involved in an altercation with another inmate on 10/12/13. An MHC opined that this had nothing to do with his mental health and was “released to security due to no mental health concerns voices or noted at this time [sic].” The MHC added, “the offender is able to weigh the risk/consequences of his actions, behaviors, decisions, and thoughts at this time.” This

gratuitous language appears repeatedly in the records and appears to be a way of saying that the behavior is entirely volitional and has nothing to do with the patients' mental health. This is an inappropriate role for mental health staff to play.

A mental health treatment plan was done on 2/3/14. It noted he exhibited poor hygiene but little else about his status. The plan was the usual generic plan with no plan for addressing his poor hygiene.

On 7/2/14, he reported being assaulted by two other inmates. He sustained minor injuries. There was no evidence that this was addressed clinically. He reported witnessing an assault on the unit on 8/6/14 as well.

He was again involved in an altercation with another inmate on 8/23/14. He stated that the other inmate had threatened him and went to the other inmate's cell with a lock tied to a cord, planning to assault the other inmate. The patient was noted to state that he was "going to start pulling bitches eye out [sic] like I used to do in the county jail." The MHC who saw him at that time did not note any psychotic symptoms but reported he was agitated. The MHC wrote, "The offender is able to weights [sic] the risk and consequence [sic] of his behavior, thoughts, action, and decision [sic] at this time. The offender is released to security for further investigation." There was no discussion of his past assaultive behavior and its relationship to his mental illness. He was placed in segregation.

He was seen by a PNP 8/28/14 who increased all three of his psychotropic medications, clearly believing he was symptomatic.

An 11/10/14 mental health treatment plan was again entirely generic and boilerplate.

On 12/1/14, the patient complained of being more depressed and paranoid. He also "expressed a desire to speak more frequently with [mental health]." The plan was to refer to a psychiatric prescriber and "inform [the mental health] team about the request for more counseling time." There was no evidence that this was ever done or addressed. He certainly received no counseling.

A PNP saw him on 12/4/14; he reportedly denied any paranoia or mood problems. However, the PNP increased both the antidepressant and the antipsychotic.

On 12/5/14, he had a high Dilantin that remained high when repeated 12/15/14; the Dilantin level was then held (temporarily stopped).

On 12/25/14 he cut himself, reportedly because he did not get his Dilantin, which had been held because of a high level. It was not clear that he had been told about the high level or the plan to hold the Dilantin.

There was a 4/2/15 note two days after an altercation with another inmate. It was not clear from the note what happened, though the patient contended the other had hit him first. Most of the discussion involved which of the two should be moved. The MHC responded that "all housing is under the direction of MTC Staffing and Health Assurance Medical and Mental Health Staff has no control over housing."

Later that day, he intentionally slammed his hand in a door and severed his left pinky. He saw the PNP that same day and the patient reported being upset about being potentially moved. He noted having been in several fights on the unit as well. The PNP reported that he was guarded and rambling. The PNP stopped his antidepressant and increased the antipsychotic, risperidone. He was placed in the infirmary on watch following return from the hospital after having his finger surgically repaired.

During mental health infirmary rounds 4/6/15, the patient requested to see the MHC “at length.” The MHC note indicated that he would see the “offender as time permits. [Mental Health] staff will continue monitoring for all psychiatric needs.” There was no evidence that this was ever followed through.

On 4/7/15, a PNP met with him and found evidence of decompensation beyond just his self-amputation. He was paranoid, exhibited disordered thinking, had odd mannerisms, and was again speaking about having thoughts of killing others. However, he refused psychotropic medication. The PNP noted that he would “likely require start of long acting decanoate medication.” The PNP goes on to mention using fluphenazine rather than haloperidol, because of the history of dystonia with haloperidol. There was no mention of the fact that fluphenazine is equally likely to cause dystonia and that other options for long-acting injectable medications are available that would be less likely to cause this side effect. This was presumably not considered because they are not on the formulary.

On 4/11/15, he was seen by a psychiatrist who noted evidence of decompensation including paranoia, agitation, thought disorder, delusions, and hallucinations. There was no assessment or plan.

However it appears that risperidone, an antipsychotic, and buspirone, an anti-anxiety agent, were ordered. Nursing notes indicated that he was taking medications. Mental health notes made no mention of medication taking and quite cursory.

On 4/15/15, a PNP saw him again. He reported that he had not been taking his medication. The PNP stopped the medications noting a fear of hoarding. However, there was no evidence that his cell was searched.

A 4/16/15 MHC note read in part: “Offender is still attempting to justify his unjustifiable the past incident [sic] with an offender on his POD. ... Provider took time to explain that every decision any individual makes either produces positive rewards or negative consequences - and agree [sic] that neither the POD mate nor the offender is correct.” This moralistic type of communication is not therapeutic and serves no clinical purpose whatsoever. There was no evidence that the MHC did any sort of an assessment of what role the patient’s serious mental illness may have had in any behavioral problems or any attempt to help him develop new understanding and approaches to interpersonal problems. This was the same MHC who never followed up on the patient’s request for greater contact.

In a 4/17/15 MHC note, the offender reported: “Sometimes I feel like I am on an island and the only way to get help is beat [sic] and act out.” The MHC instructed the patient to call before

harming himself but there was no suggestion of any treatment to help him manage his self-destructive impulses.

The patient agreed to restart medications during a 4/17/15 meeting with a PNP. There was no evidence that the mental health staff doing rounds in the infirmary evaluated his response to starting medications.

On 4/26/15, still on watch in the infirmary, he was noted to be in possession of fingernail clippers with which he was trimming his facial hair. The MHC reported this to a custody officer. It is unclear what happened as a result.

Throughout his stay in the infirmary on watch, he periodically made statements about homicidal ideation. However there was no evidence that this was ever evaluated or a formal risk assessment undertaken, despite his history of serious violence towards himself and others.

In a 4/27/15 note, the PNP spoke to some of the serious history of violence including how he had chased a peer with a knife (though there was no comment about how he obtained a knife on the residential mental health unit) and scalded another. He also admitted homicidal thoughts. The PNP was hopeful that continued medications would reduce his paranoia. There was no discussion of potential targets or how his symptomatology related to his dangerousness other than the intimation that it was related to his paranoia. He was to continue on risperidone (an antipsychotic), buspirone (an antianxiety agent), and diphenhydramine (presumably for side effects). He was released from the infirmary and taken off watch.

Despite his serious mental illness, he was not transferred back to a mental health unit but to unit 6D, a close custody general population unit.

On 5/22/15, after only two brief intervening rounds contacts with mental health staff, he flooded his cell. He was given an injection of intramuscular fluphenazine, an antipsychotic, and then given an injection of long-acting fluphenazine decanoate. He asked the PNP to go back to Unit 3, the residential mental health unit, and threatened to kill himself if not transferred. He was placed on watch in the infirmary. In a subsequent note, the PNP wrote that the decision whether to place him on Unit 3 was up to MTC.

Subsequent notes indicated that he received additional intramuscular injections on an as-needed basis. On 5/24/15, he again was suffering side effects similar to those he experienced while taking haloperidol. He was given intramuscular injections of side effect medications. It was clear from the notes that he suffered a very serious dystonic reaction requiring multiple injections.

Despite this, the PNP continued as needed injections of fluphenazine, though coupled them with a side effect injection. There was no consideration of a medication less likely to cause this side effect though, again, many alternatives exist.

During a 6/11/15 visit with a PNP, the patient talked about various thoughts he has had about killing himself. He reported a variety of plans. None of these had been elicited by rounding mental health staff who continued to fail to evaluate his danger to self or others. The PNP planned to continue the long-acting injectable fluphenazine.

On 6/13/15, the patient cut himself with pieces of a broken lightbulb.

On 6/14/15, an LPN conducting mental health rounds reported that he expressed suicidal ideation. The LPN then said that he would need to have an injection, which he stated he did not have to accept. The LPN noted that he denied any hallucinations and did not document any psychotic symptomatology or agitation; if accurate this was an entirely inappropriate use of intramuscular injection of an antipsychotic.

He was seen that day by a psychiatrist who wrote a very cursory note commenting on his “continued suicidality” and quoting the patient: “‘ain’t got nothing to live for.” There was no assessment and no plan.

On 6/15/15, a PNP evaluated him again and found a reduction in his psychotic symptoms. There was no change to medications.

On 6/16/15, the PNP removed him from watch status. He reportedly denied any suicidal or homicidal thoughts. The patient believed that he might be considered for Unit 3. Two days later, the PNP saw him again while still in the infirmary on watch. The PNP wrote: “strongly recommend placement back on unit 3 - an extensive [history] of severe mental illness - not likely to function well on any other unit sides unit 3 - the mental health unit.”

On 6/22/15, still in the infirmary, after a nurse denied his request for coffee he, per the nurse, “then started to try to hang himself with a piece of sheet he had in the cell. ... He was given an as needed injection of Prolixin and Benadryl, stripped, and everything removed from his cell. He called me a bitch, started beating on the window when yelling, and gave me the finger and called me a bitch several more times.” This reads more like a punishment than a clinically sensitive response.

Later that day he was seen by the PNP and the patient reported that he “‘got mad at that nurse...that woman... She told me to shut up...so I said I’m going to hang myself...but I was not going to hurt myself...she made me mad with telling me to shut up...like she was talking to a little child or something.” He had been placed back in a suicide smock. The PNP restored his regular clothing and bedding. The PNP noted that there were no symptoms of tardive dyskinesia or extrapyramidal symptoms (side effects) at the time of the interview.

He saw the PNP again on 6/25/15 at which time he continued to be stable. There was still no decision about his placement.

Beginning 7/1/15, there are generic infirmary mental health rounds notes providing no meaningful information, often simply reporting that the patient was asleep, made no complaints, or was quiet and calm. There were never any mental status examination, except repeated reports that he denied (or often, “did not report” – making it unclear if he was even asked) hallucinations, suicidal, or homicidal ideation. They showed no evidence of more than brief interaction, if any. Several of the notes even went so far as to note that the offender was sleeping, yet bizarrely went on to report that the patient showed no evidence of agitation or distress. Such rounds occurred on the following dates: 7/1/15, 7/2/15, 7/6/15, 7/7/15, 7/8/15, 7/9/15, 7/10/15, and 7/13/15.

Nursing notes were more medically informative but provided very little information on the patient's mental health status.

On 7/2/15, he was seen by a PNP. At that point the primary conclusion was that he continued to stabilize and did not exhibit any substantial mental health symptoms. Despite his side effects from fluphenazine decanoate, this medication was continued along with side effect medications. Of note, he was to be continued on as needed injections of fluphenazine. Again, there was no evidence of any due process review to determine whether he qualified for involuntary medications. Further, as needed injections of antipsychotics may be useful in an acute crisis, but not in an intermittent and on-going manner; this practice has been determined to be ineffective.

On 7/6/15, a nurse noted that "his entire body was shaking slightly" and she later evaluated him at the request of the custody officer. He reported double vision, feeling strange, and was continuing to shake. He asked for side effect medication and was given intramuscular diphenhydramine, sometimes used to counteract the side effects of the fluphenazine. The nurse also noted that he had been without phenobarbital for 24 hours as there was "none available for him."

The PNP saw him that same day but did not report on the preceding nursing observations. In fact, the PNP wrote that there was no evidence of "extrapyramidal symptoms" at the time of assessment, though the record reflects that the very same PNP had ordered side effect medications for extrapyramidal symptoms that very day. Psychiatric observation was discontinued and there was no change in medications.

The PNP saw him again on 7/7/15. In that note the PNP reported that the internal medicine physician had concerns about the substantial doses of anticholinergic medications (the side effect medications) the patient was receiving. The PNP discussed this with a psychiatrist who noted that sometimes very high doses of anticholinergic side effect medications were needed with fluphenazine and haloperidol. However, there was still no discussion of using an alternative antipsychotic. The PNP planned to order laboratory examinations but never reported on any results and none were in the record.

There was another note from the PNP the following day wherein the patient asked about going back on risperidone, a medication for which there is a long acting intramuscular formulation. There was no discussion of this request in the assessment or plan but the fluphenazine was discontinued because he continued to struggle with side effects.

On 7/9/15, the PNP noted that he continued to have side effects and also noted the patient's report that he had a fractured right great toe that occurred in "an altercation with 'the guard' a few days previously." Medical documentation from that time indicated only that an officer had stepped on his toe on 7/7/15 with x-ray confirmation of the fracture the following day.

On 7/9/15, laboratory results showed a critically elevated Dilantin level of 34.5. The Dilantin, an antiepileptic, was stopped temporarily again.

On 7/12/15, the PNP started the patient on oral risperidone per his request. The PNP conducted a brief mental status examination and did not note any psychotic symptoms. The PNP discussed his history of noncompliance when allowed to take medications on his own.

On 7/14/15, the PNP saw him again and noted no change in his status. The plan was to place him in the residential treatment unit but no bed was available.

The patient expressed fears about returning to the unit both to rounding mental health staff and a nurse. On 7/15/15, he cut his wrist while still in the infirmary. Following this he stated that he wanted to go to unit 3B rather than 3A. He was subsequently placed back on suicide watch. Later that day he told the PNP that he was ready to go to the unit but remained on suicide watch with a suicide shroud and blanket, no utensils, 15 minute checks, restricted recreation, shower monitoring, and no personal property.

Routine, generic infirmary rounds by mental health continued on the following dates: 7/15/15, 7/16/15, 7/17/15, 7/20/15, 7/21/15, 7/22/15, 7/23/15, and 7/24/15.

A psychiatrist saw the patient on 7/21/15. On the checklist mental status examination, the psychiatrist reported no abnormalities other than some increased activity. There was no change in the medication plan. The psychiatrist recommended return to the residential mental health unit.

The PNP saw him the following day, still in the infirmary but awaiting placement on the residential mental health unit. The PNP again noted an intention to order laboratory studies.

The PNP saw him again 8/5/15, now on residential mental health unit. He was again exhibiting side effects which the PNP attributed to the fluphenazine but did not consider the possibility that the current antipsychotic, risperidone was causing these side effects, which was likely. The PNP ordered side effect medications to begin again but made no change in the antipsychotic.

There was an 8/10/15 quarterly treatment team review. At that time the patient reported having auditory hallucinations but no other substantial problems were noted. He reportedly was having no medication side effects. He asked to be started in an anger management class. The associated treatment plan noted that he was medication compliant despite the fact that he had a history of substantial problems with compliance. It also stated that he had no auditory hallucinations despite the above-noted report from the same day. The patient also reported a history of childhood trauma and that he “often reverts back to this treatment.” It was unclear what this statement meant and there was no explication. The goals were entirely generic and boilerplate. The objectives/goals are: “symptom reduction or maintenance, develop or improve coping skills, increase adaptation to correctional environment, improve social skills.” Physician is to “monitor frequency, medication, progress toward treatment goals.” This is to occur every “30, 60, or 90 days.” The nurse has similarly generic responsibilities. The mental health/psychological services responsibilities are: “crisis intervention, individual therapy, group therapy.” The frequency is noted to be: “[as needed] by [sick call request], weekly, monthly.” The patient’s responsibilities are: “keep appointments as scheduled, complete sick call requests if needed.”

The PNP saw him that very same day and, contrary to the above report, observed “dystonia to bilateral eyes” [NB: technically this is referred to as oculogyric crisis], which the patient had reported to the PNP. The symptoms of his mental illness reportedly remained in remission. The PNP again ordered immediate administration of side effect medications but did not change the antipsychotic.

On 8/17/15, a code blue was called because he was having continued problems with dystonia of his eyes. The PNP noted that he was able to move his eyes and did not make any medication adjustments or orders.

On 8/28/15, he had a seizure requiring evaluation and treatment in the emergency room. He had had intermittent seizures throughout his stay yet had remained on phenobarbital and Dilantin throughout. Finally, he had a newer antiepileptic (levetiracetam) ordered and the phenobarbital was discontinued.

On 9/24/15, there were finally laboratory results in the chart. A complete blood count was within normal limits, a comprehensive metabolic panel was unremarkable, but his Dilantin level was very high at 39.7 (twice the upper limit of the therapeutic range). The Dilantin was once again temporarily discontinued.

There was another quarterly treatment team review on 9/28/15. He had received no treatment other than psychotropic medications since the previous quarterly treatment team review. The patient again requested anger management classes. The generic treatment plan remained unchanged.

On 10/15/15, the patient cut himself once again, but not seriously enough to require sutures. There was no mental health response in the record.

He was next seen by mental health during 11/17/15 mental health rounds, the first recorded since moving to the residential mental health unit, by an LMSW and two officers. The patient asked to see the psychiatrist. The LMSW noted no psychiatric problems and made no mention of the recent self-injury.

That same day, the patient had submitted a sick call request. This was responded to the following day. The patient had requested to “talk to a [mental health] counselor about some serious mental problems and depression I am having. I’m not suicidal; just need to talk to someone soon.” The LMSW noted that he was agitated, had rapid speech, exhibited paranoid delusions, and was anxious. The patient reported concerns about being moved from his housing assignment “due to a RVR he received six months ago. He expressed his desire to remain at his current location.” The LMSW noted that the “client was seen by the same MHP on 11-17-15 during [mental health] rounds and reported the same issue.” It is unclear why the LMSW did not notice the psychiatric symptoms at the time of the rounds. The plan was simply to refer him to the case manager on the unit and continue to “monitor.”

A PNP met with the patient and the warden on 12/2/15 after the patient had again cut himself. The Warden reported that he was being moved because of scalding a peer six months before as noted previously. They discussed the possibility that he may not be moved. The patient raised

concerns about breast enlargement on risperidone and the PNP changed him to olanzapine and ordered fasting lipids. The PNP conducted an abnormal involuntary movement scale (AIMS); it was negative.

Despite the meeting with the warden, the following day he was moved to the close custody mental health residential unit 3C. He reportedly started a fight shortly after arriving and suffered a laceration above his right eye and an injury to his knee. He was moved to restrictive housing. There was no intake assessment and no evidence of a mental health alert or referral. He did not receive daily nursing rounds.

On 12/9/15, an MHC saw him in mental health rounds with custody. The patient reportedly had no mental health complaints but requested to meet with the head of mental health.

On 12/14/15 there was another quarterly treatment team review. Despite the fact that he remained in restrictive housing, the only mention of the previous problems was that he had “several RVRs in the last six months.” The note did not demonstrate any sort of mental health assessment of his current status and there was no associated treatment plan.

On 12/28/15, the PNP saw him again. At that time he reported that he was not getting his medications. The patient reported that he hit a peer on unit 3C “because he was trying to get off” that unit. As the PNP noted, “His plan did not work, he was not moved to ‘B’ pod, his plan resulted him [sic] being placed on lockdown.” The PNP noted no psychotic symptoms and that he denied suicidal ideation and homicidal ideation, though did not comment on his risk of self-injury. The PNP planned to check with nursing about getting his medications restored.

On 1/5/16, laboratory results are entered in the record. A complete blood count, metabolic panel, and lipid profile were unremarkable. The Dilantin level was in the low range. A urinalysis was notable for a small amount of blood in the urine; I did not see evidence that this was noted or evaluated.

There are no mental health notes up until 1/27/16 when he inserted a foreign object in his arm. A PNP saw him the following day during which time the patient requested to go back to the residential mental health unit, reporting that he had heard there were no beds. He reported that he had been “cutting on myself, I stuck a pen in my arm, they took it out. I’ve been thinking about cutting off one of my fingers, I just want to get out of the hole, like the walls are closing in.” The PNP noted that he was paranoid, unkempt, anxious, thought disordered, delusional, and exhibited mildly pressured speech and elevated affect. The plan was to increase the olanzapine.

On 1/29/16, the PNP met with him again and the patient spoke about an intention to cut himself. The PNP planned to check on the status of his move back to a general population setting. She found that he was to move to unit 1C, which is not a mental health residential unit, the following Monday. He reportedly also gave “an object” to custody that he had intended to use to cut himself. The PNP reported continued deterioration of his mental status. As he was exhibiting some manic symptoms, the PNP started divalproex sodium, a mood stabilizer, and ordered appropriate laboratory studies.

Later that day the PNP saw him again. He was agitated and spoke about committing suicide by jumping off the top tier. As he put it, “you know I did it before, I broke my back in three places before. I will cut off all my fingers, I want to go back home. Help me.” The PNP noted that he “is appropriate for unit 3.” He reportedly “agrees to not self-injury [sic] himself this weekend, to allow staff to fully address his issues on Monday. He presents with a [history of] following through on his threats to self-harm.”

It appears he was not transferred, as subsequent notes refer to him being goaded in restrictive housing, but it is difficult to tell from the record.

On 2/2/16, the following Tuesday, he severely cut his left arm near the wrist. Before being sent to the emergency room he had an IV placed and was started on oxygen. He was sent to the emergency room by ambulance. He had damaged his left radial tendon, requiring surgical repair. While at the hospital, he had a 5 minute seizure, prompting a neurological evaluation and brain imaging with CT. The CT demonstrated focal findings consistent with an old stroke and also enlargement of the ventricles. It is very possible that these abnormalities contributed to his mental health problems.

Following his return, the PNP saw him on 2/3/16. The PNP noted that in addition to the tendon damage, “he lost quite a substantial amount of blood.” He reported that peers in restrictive housing were goading him. The PNP placed him on psychiatric observation in the clinic.

His next mental health contact was mental health infirmary rounds on 2/5/16. He was simply noted to be asleep. There was no mention of the recent events. In a 2/8/16 mental health infirmary rounds note, the LMSW noted that the patient “verbalized understanding that he could have died during his last self-injurious behavior and now recognizes the need for him to cultivate positive anger management techniques.” Despite his repeated requests for help with anger management, there was no corresponding response and no treatment provided.

Mental health infirmary rounds, many of which simply reported that he was asleep, were conducted on the following dates: 2/10/16, 2/11/16, 2/12/16, 2/16/16, 2/17/16, 2/18/16, 2/22/16, 2/23/16, 2/24/16, 2/25/16, 2/26/16, 2/29/16, 3/1/16, 3/2/16, 3/3/16, 3/4/16, 3/7/16, 3/8/16, 3/9/16, 3/10/16, 3/11/16, 3/14/16, 3/15/16, 3/17/16, 3/22/16, 3/24/16, 3/25/16, 3/29/16, 3/30/16, 3/31/16, 4/1/16, 4/4/16, 4/5/16, 4/6/16, 4/7/16, 4/8/16, 4/11/16, 4/12/16, 4/13/16, 4/14/16, 4/15/16, 4/18/16, 4/19/16, 4/20/16, 4/21/16, 4/22/16, 4/25/16, 4/26/16, 4/27/16, 4/28/16, 4/29/16, 5/2/16, 5/3/16, 5/5/16, 5/6/16, 5/9/16, 5/10/16, 5/11/16, 5/12/16, 5/13/16, 5/16/16, 5/17/16, 5/18/16, 5/19/16, 5/20/16, 5/23/16, 5/24/16, 5/26/16, 5/27/16, 5/31/16, 6/1/16, 6/2/16, 6/3/16, 6/6/16, 6/7/16, 6/9/16, 6/10/16, 6/13/16, 6/14/16, 6/15/16, 6/16/16, 6/17/16, 6/20/16, and 6/21/16. Clearly, he remained in the infirmary under restrictive conditions for an extended period of time.

On 2/12/16, the PNP saw him. He continued to express his intent to harm himself if he were not sent to a residential mental health unit. The PNP noted that this information “has been passed on to the MTC psychology member who assists with the movements and housing. All housing is determined by the MTC program/classifications staff.” The PNP noted no significant mental health symptoms and there was no change to the medication plan.

On 2/19/16, laboratory results were recorded in the chart. Liver function tests were within normal limits and the valproic acid level was low at 37.3 (normal range 50 to 100).

The PNP saw him on 3/1/16. The patient expressed concern about his nieces and nephews being removed from their home but most of the discussion involved placement. The PNP noted that “The unit 3 psychologist staff reported that they have concerns that he threatened in the past, to kill another inmate on unit 3. Obstacle for this case will be placement. However, he presents with an extensive [history] of severe mental illness with episodes of psychotic agitation.” The PNP noted the low valproic acid level but the plan did not indicate any intention to make medication changes.

On 3/8/16, the PNP noted that he remained on psychiatric observation and that he was compliant with medications. The PNP again noted the problems with housing and that he had “an extensive [history] of severe self-injurious behaviors during times of increased stress/frustration.”

A3/15/16 note from the laboratory staff indicated that security did not bring the patient for a blood draw and that they had “asked security to bring to lab multiple times.”

On 3/17/16, the patient had an “office visit” with a MMHP. The only thing noted was his wish not to be in red pants because they reminded him of “what he did to his wife in the past.” There was no indication of any treatment or intention to address the patient’s many requests for therapy.

Laboratory results from 3/17/16 show a normal lipid profile and unremarkable complete blood count, metabolic panel, and urinalysis.

The PNP also saw him on 3/17/16. He was reportedly without any substantial mental health symptoms but placement was still a problem.

The 5/20/16 mental health infirmary rounds note indicated that he was “thinking about cutting off one of my other fingers... Because I know they getting [sic] ready to move me. I got a bad feeling about it. They gonna move me somewhere bad.” The LMSW who authored the note reported that she informed the provider and her supervisor about this. However, the plan was simply to continue to monitor the patient. Subsequent notes do not address this at all.

He was finally seen again by the PNP on 5/30/16. The patient reported continuing to have thoughts about suicide with “thoughts of jumping off the rail sometimes.” He remained otherwise psychiatrically stable. The housing issue was once again mentioned. He was to remain on psychiatric observation status in the clinic.

On 6/2/16, a psychiatrist ordered an increase of the olanzapine from 20 to 30 mg. The associated note indicated that the patient was having auditory hallucinations “much of the time” but no other mental health findings were noted other than paranoia. The plan was to move him to unit 3C and indicated that there would be “a concerted effort to keep other inmates from extorting money from him, stealing his food, or to write inappropriate letters to his family.” The patient had also “been promised that he will be assigned a caretaker for the purpose of helping him write letters and learn to read better.” The plan was to discontinue the psychiatric observation.

The 6/15/16 mental health infirmary rounds note reported that the patient reported that a patient in the infirmary was selling his food tray to another patient. This, of course, should not occur in a setting for patients on watch.

By 6/15/16 when he was next seen by a PNP, he was still in the infirmary despite being taken off observation status two weeks previously. While the patient reported that he still wish to go to unit 3 and stated that he was not going to hurt anybody, the plan was to place him in restrictive housing. As the PNP wrote, “He was recently seen by the MTC/Centurion [treatment] team with emphasis on reviewing his placement; however, he reported that he would kill his roommate if not housed with a good roommate; therefore, the decision was not to place him on unit 3 and was recommended for lockdown [sic]. However, he admits that he just made those statements because he was upset/frustrated and admits that he tends to make such statements when he is upset/aggravated/frustrated.” The plan was to present the case again to the joint MTC/Centurion team.

A 6/21/16 note by a psychiatrist reported on a meeting with the psychiatrist, the patient, and “the joint MTC-Centurion assessment team.” The patient stated that he “doesn’t want to be violent and he feels he is now ready to return to population. He is still afraid of being assaulted or manipulated and two weeks ago he forcefully stated that he would kill someone if he was assaulted or treated badly. Today he repeatedly stated that he had no intentions to harm anyone. We know that he gets angry and can be impulsive and potentially violent. His age and stature are now rendering him less likely to harm others and more likely to be harmed. He is most concerned about getting a good and non-threatening cellmate.” The plan was to send him to unit 3C.

On 6/23/16, in response to a sick call request from the patient, a MHP saw him on unit 3 with security present. The patient stated, “‘the zone is loud and I want to stay out of trouble. I just came from Medical housing and the guys on the unit are bad. I do not want to get into any trouble.’ MHP observed client speaking very low, his clothing was unkempt, personal hygiene was bad, and the client was shaking uncontrollably. The client stated he is taking his medication daily and has not missed a day since he has been back on unit [sic]. MHP discussed with client the importance of him taking his medication. MHP discussed the importance of behavior staying up to part [sic] and different coping methods he can use to avoid staying out of trouble on the housing unit.” He reportedly denied “hallucinations, and suicidal and homicidal thoughts.” The plan was to refer him to a psychiatric prescriber and monitor him.

He was seen by a psychiatrist on 6/28/16. The patient told the psychiatrist that “his cellmate was insisting that he help them get their door lock to break so the cellmate can wander around at night. James was getting angry about the situation and began to make first disguised and then loud violent threats about retaliating against wrongdoings that he sees frequently on his unit.” The psychiatrist noted that “After the meeting, efforts were begun to transfer James’s cell mate to another unit. This would help the safety of both them.”

Laboratory results from 6/30/16 included unremarkable lipids, complete blood count, metabolic panel, and urinalysis.

He was next seen by a PNP on 7/12/16. An AIMS done at that time was negative. He was reportedly seen at a treatment team review. He complained of his medications making him “shake” and of being “depressed” about his family. He complained of problems sleeping but no other abnormalities were noted on the mental status examination. The plan was basically to continue medications and follow-up in “90 days or sooner if needed.” There was no associated treatment plan.

On 7/18/16, a MHP conducted rounds with custody. The note stated that the patient “reported no mental health concern.” He was encouraged to take medications and “work on having positive behavior with all working staff at this facility.”

On 7/31/16, the patient submitted another sick call request and was seen the following day by a MHP, again with custody present. The note was identical to the note from 6/23/16, which is clearly not credible.

He was seen by a PNP on 8/2/16. He was referred by staff, though it is unclear why. He spoke about his tray being given away and feeling that custody staff were not properly doing their jobs. He spoke about having “flashbacks from when I was abused.” The PNP noted his “borderline intelligence.” The PNP reported on his history of harm to self and others and his poor impulse control. The PNP wrote of notifying a commander “of the situation.” It was unclear what the PNP meant by this. The plan was to add buspirone, an anti-anxiety medication, and follow-up in one week. The patient was noted to be irritable, talkative, distractible, and to have flight of ideas or racing thoughts. He was also noted to be paranoid and delusional. However, the content of his delusions was not reported.

He was next seen by a MHP on 8/15/16 during rounds with custody. The note was virtually identical to the previous rounds note.

The same MHP wrote an “office visit” note the following day. However, the note begins “MHP made office visit/30 day contacts on housing unit 3C in the hallway with security present. Client did not report any mental, emotional, physical, or spiritual health concerns.” The plan was to monitor the patient.

The PNP saw the patient for follow-up on 8/16/16, a week later than intended. The patient reported that the medications were helping with anxiety. The PNP specifically noted that no delusions were “elicited.”

A different PNP saw him on 9/1/16 after the patient told nursing staff “that he had thoughts of hurting himself and needed to talk to someone. The [nurse] reported he later changed [sic] and stated that he was just having a lot of anxiety.” The patient was worrying about family and problems on the unit. He still hoped to go to unit 3B, but expressed concerns about gang members being on that unit. The patient noted that he was “working on getting in classes.” The PNP noted some increased activity but no mood or psychotic symptoms.

On 9/6/16 he refused laboratories. The record ends here.

This is a patient with obvious and very substantial mental health needs. In addition to his psychotic illness and cognitive limitations, he clearly had profound psychological needs related to his traumatic history. His repeated self-injurious behavior was never addressed in a therapeutic fashion nor was his risk to others. He harmed himself and others repeatedly and was himself harmed. He remained for extended periods of time in isolation as the sole means of keeping him safe. During these times, he received only the most superficial of contacts with mental health staff conducting rounds. Here again, the psychiatric prescribers were the only clinicians providing any meaningful clinical contact. He was offered no groups and no individual therapy though had profound needs for both, especially habilitative groups.

Psychotropic medication management was also a problem. There were times that this patient was on no medications, even when threatening to kill others; EMCF should have use the extant involuntary medication policy in such situations. Because they do not use it, they place patients on involuntary medications without due process and/or use repeated emergency injections (which do not require due process review). Use of alternate antipsychotics would not have caused the severe, and often painful, dystonic reactions he experienced, for which he required repeated intramuscular injections of a side effect medication. Not only did this subject this patient to needless suffering, it likely had a negative impact on his likelihood of adherence.

Failure to properly treat this patient resulted in greater harm than was necessary and put him at unreasonable and continued risk of the kind of repetitive self-injury and danger to others that he manifested.

Below is a sample of the generic, boilerplate treatment plan referred to repeatedly in the medical records reviews.

Mental Health Treatment Plan

Care Plan formulated by: Treatment Team

Assessment

Updated Problems:

Hx of PSYCHOTIC DISORDER NOS (AXIS I) (DS4-298.9)

Master Problem List and Objectives

Problems:

Patient is: Reporting hallucinations/delusions, depressed.

Objectives/Goals:

Objectives/Goals: Symptom reduction or maintenance, Develop or improve coping skills

Interventions and Modalities:

Physician

Monitor frequency, medication, progress toward treatment goals

Frequency: Every 30, 60, or 90 days

Person Responsible: MD

Nurse

Monitor frequency, medication, progress toward treatment goals

Frequency: PRN for med distribution

Person Responsible: RN/LPN

Mental Health/Psychological Services

Crisis Intervention, Individual therapy, Group therapy

Frequency: PRN by SCR, Weekly, Monthly

Person Responsible: Psychological Specialist

Patient Responsibilities:

Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed

APPENDIX 3

PATIENT KEY

The following is a key for the patient numbers used in my report. In the report, they are referred to as "Patient 1," "Patient 2," etc. At the bottom is a legend for the symbols appended to each name.

1. [REDACTED] ***
2. [REDACTED] ***
3. [REDACTED] ****
4. [REDACTED] ***
5. [REDACTED] ***
6. [REDACTED] ***
7. [REDACTED] ***
8. [REDACTED] **
9. [REDACTED] **
10. [REDACTED] **
11. [REDACTED] *
12. [REDACTED] *
13. [REDACTED] ***
14. [REDACTED] *
15. [REDACTED] *
16. [REDACTED] ***
17. [REDACTED] ****
18. [REDACTED] ***
19. [REDACTED] *
20. [REDACTED] ***
21. [REDACTED] ***
22. [REDACTED] *)
23. [REDACTED] *
24. [REDACTED] *
25. [REDACTED]
26. [REDACTED]
27. [REDACTED] ***
28. [REDACTED]
29. [REDACTED]
30. [REDACTED] **
31. [REDACTED] **
32. [REDACTED] **
33. [REDACTED]
34. [REDACTED]
35. [REDACTED] ^
36. [REDACTED])^

37.	[REDACTED]	^
38.	[REDACTED]	**
39.	[REDACTED]	^
40.	[REDACTED]	^
41.	[REDACTED]	^
42.	[REDACTED]	^
43.	[REDACTED]	^
44.	[REDACTED]	^
45.	[REDACTED]	^
46.	[REDACTED]	^
47.	[REDACTED]	^
48.	[REDACTED]	^
49.	[REDACTED]	^
50.	[REDACTED]	^
51.	[REDACTED]	^
52.	[REDACTED]	^
53.	[REDACTED]	^
54.	[REDACTED]	^
55.	[REDACTED]	^
56.	[REDACTED]	^
57.	[REDACTED]	^
58.	[REDACTED]	

LEGEND

*** Interview and chart review

** Chart review

* Interview

^ Chart or record excerpt review

Those without a symbol consisted of brief interviews on the units

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Private Practice of General and Forensic Psychiatry
Puget Sound Mental Health PS, Inc. (EIN 46-4608592)
6108 Community Place S.W., Suite 3
Lakewood, WA 98499
(253) 653-6683 (private practice)
(253) 581-1425 (private practice FAX)
Gage@PugetSoundMentalHealth.com (private practice)

Previous employment:

The Center for Forensic Services at Western State Hospital
The Washington Institute for Mental Illness Research and Training & University of Washington
Tacoma, WA 98498-7213, 1990-2008

Positions held: Program Director, Center for Forensic Services (1990-2003); Director,
Electrophysiology Laboratory (1992-2003); Program Director, UW/WSH Forensic
Psychiatry Fellowship, University of Washington School of Medicine (1998-2008);
Supervising Psychiatrist, CFS (2003-2006); Forensic Psychiatrist (2006-2008)

UCLA and Sepulveda Veterans Administration Medical Center
Los Angeles, California, 1988-1990
Assistant Clinical Professor, Department of Psychiatry & Staff Psychiatrist

Education: B.S. (Chemistry) 1979; Massachusetts Institute of Technology; Cambridge, MA
M.D. 1983; University of Washington; Seattle, WA
Postdoctoral Fellow 1983-1984; Cardiovascular Physiology; University of Washington;
Seattle, WA
Medical Intern 1984-1985; Cambridge Hospital; Harvard Medical School; Cambridge, MA
Psychiatry Resident 1985-1988; Cambridge Hospital; Harvard Medical School; Cambridge, MA
Chief Psychiatric Resident 1987-1988; Metropolitan State Hospital; Waltham, MA;

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Instructor in Psychiatry; Harvard Medical School; Cambridge, MA

Experience:

Medical school thesis project on the impact of alexithymia on hypertension. 1982-1983

Post-doctoral research: influence of behavior on the CNS control of blood pressure. 1983-1984

Teaching Assistant for physiology and biophysics graduate course in neuroanatomy. 1983-1984

Research during residency on the prediction of violence and clinical criteria used for commitment. Included grant writing and questionnaire development. 1987-1991

Forensic psychiatry evaluations of fitness for duty, dangerousness, disability, malpractice, competency, criminal responsibility (both insanity and *mens rea*), conditional release, and other matters: Cambridge Court Clinic, Metropolitan State Hospital, Western State Hospital, and private practice. 1987-present

Multi-center research project on the D2-selective antipsychotic savoxepine. 1989-1990

Neuropsychiatric and forensic consultant to the Alaska Psychiatric Institute and Harborview Developmental Center. March 1991-1998

Research through the Washington Institute on assessment of violence and recidivism in the mentally ill offender population. August 1990-2004

Psychiatric consultant, Washington State Department of Corrections. 1993-2003

Site Coordinator, MacArthur Foundation research project on competency to stand trial assessment instrument (MacCAT-CA). 1995-1997

Expert for APA Expert Opinion Survey of Psychiatric Evaluation of Adults. 2011

Mental Health Expert, *Farrell v. Beard*. 2011-2016

Mental Health Expert, *US v. County of Los Angeles and Los Angeles County Sheriff Jim McDonnell*. February 2015-present

Mental Health Expert, *Gray v. County of Riverside*. March 2015-present

Awards and Honors:

Chapter author for Confidentiality Versus the Duty to Protect, Guttmacher award winner, 1991

Outstanding Employee Award, Department of Social and Health Services, 1994 & 1995

Newcomers Award, Community Action for the Mentally Ill Offender, 1996

Delbert M. Kole Outstanding Public Psychiatrist Award, Washington State Association of Community Psychiatrists, 2002

Washington Governor's Award for Leadership in Management, 2010

Chapter author for The Oxford Textbook of Correctional Psychiatry, Guttmacher award winner, 2016

Grants:

Site Coordinator, HRSA grant: *Integrated Mental Health: IPE Infrastructure Development in DNP Education*, 2014-present

Affiliations:

American Psychiatric Association

American Academy of Psychiatry and the Law

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Psychopharmacology Committee member
Washington Psychiatric Association

Teaching Responsibilities:

Conduct seminars for post-doctoral fellows in forensic psychiatry and psychology
Teach resident seminars in clinical, forensic, correctional, and emergency psychiatry

Invited Lectures:

Degenerative Diseases of the Brain—UCLA medical student lectures, 1989-1990

A History of Psychological Theory from the Enlightenment to Freud—UCLA psychiatric residents' didactic, September 1989

Neuroanatomy of Cognition—UCLA geropsychiatry lecture series, February 1990

Forensic Psychiatry—Lecture for Community Psychiatry Seminar at the University of Washington and Alaska Psychiatric Institute, November 1991 and August 1992

Psychiatrists as Cops—Lecture for senior psychiatric residents at the University of Washington and students and faculty at Washington State University, February 1991, March 1992, December 1992, May 1993

Sub-Cortical Dementias—Alaska Psychiatric Institute/Harborview Developmental Center Continuing Medical Education, March 1991

Late Onset Schizophrenia—Alaska Psychiatric Institute Continuing Medical Education, August 1991

Character Disorders—Western State Hospital Continuing Medical Education, November 1991

Geriatric Psychopharmacology—Alaska Psychiatric Institute/Harborview Developmental Center Continuing Medical Education, November 1991

Delirium—Western State Hospital and Alaska Psychiatric Institute/Harborview Developmental Center Continuing Medical Education, December 1991 and February 1992

The Right to Die—panel for Western State Hospital Continuing Medical Education, May 1992

Prediction of Dangerousness—lecture at the National Association of State Mental Health Attorneys Annual Conference, September 1992

Tourette's Syndrome—Alaska Psychiatric Institute/Harborview Developmental Center Continuing Medical Education, February 1993

Fetal Alcohol Syndrome—Alaska Psychiatric Institute/Harborview Developmental Center Continuing Medical Education, May 1993

Genetic Causes of Mental Retardation—Alaska Psychiatric Institute/Harborview Developmental Center Continuing Medical Education, August 1993

Monothematic Delusions: Phenomenology and Management—UW CME Lecture Series, October 1995

Risk Assessment/Risk Management—American Academy of Psychiatry and the Law annual meeting, October 1996

Forensic Mental Health Evaluations—Seattle University Law School, November 1998, October 1999

Mental Disease and Defect in Adults: Causation, Diagnosis, and Treatment—State Superior Court Judges' Conference, April 1999

Antisocial Behavior: A Neuropsychiatric Perspective—DOC In-Service, November 1999

Mental Health Courts—Alaska Psychiatric Association annual meeting (with Judge Stephanie Rhoades), April 2000

Aesthetics and the Human Psyche—Alaska Psychiatric Association annual meeting, April 2000

Risk Assessment/Risk Management—Presentation to providers, judges, and law enforcement in Clatsop County, OR, September 2000

Basic Anatomy and Physiology of the Brain Related to the Dream State—Presentation to the American Academy of Forensic Sciences, February 2001

Risk Assessment—Presentation to the Washington State Bar Association (CLE), April 2001

Unusual Psychiatric Defenses—Presentation to the Washington State Bar Association (CLE), April 2001

Overview of DSM-IV—Presentation to case managers and masters clinicians, April 2001

Mental Health Experts in Criminal Cases, Including Commentary Relating to the Juvenile Court System—Presentation at the Washington Criminal Justice Institute (with Lynne Sullivan, Ph.D.), September 2001

Competency, Diminished Capacity, and Intentionality in Forensic Assessments—Presentation to Pacific Northwest Neuropsychological Society, September 2002

Integrating Risk Assessment/Risk Management Procedures into a Clinical Forensic Program—Presentation to National Association of State Mental Health Program Director's Forensic Division's annual meeting, September 2002

Competency to Stand Trial—Presentation to Alaska Public Defenders Training Conference, October 2002

Psychiatric and Psychological Issues & Neurological Issues—Presentations at "Through the Looking Glass: Mental Illness and the Law", a University of Washington Continuing Legal Education program, October 2002

Research Methodology—Presentation at the annual meeting of the American Academy of Psychiatry and the Law, October 2002

Civil Commitment—Presentation to the Seattle Forensic Institute, April 2003

How to Identify a Client with Mental Illness—Presentation at the Tenth Annual Washington Criminal Justice Institute, September 2003

Competency & Informed Consent; Legal Liabilities for the Professional—Presentation at Mental Health and the Law in Washington, January 2004

Primer on Conducting Involuntary Medication Hearings—Presentation at the Fall Conference of the Washington State Association of Municipal Attorneys (with Mike Finkle, J.D.), October 2004

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Competency and Informed Consent: The Law and the Role of the Clinician—CME for Franciscan Health System, June 2006

Is Evil Good for Psychiatry—Grand Rounds, UW Department of Psychiatry and Behavioral Sciences (with Lorna Rhodes, Ph.D.), June 2006

Competency and Informed Consent: Passive Acceptors and Incompetent Refusal of Treatment—CME for Franciscan Health System, November 2007

Dim Rea: Mental Health Evaluations of Diminished Capacity and *Mens Rea*—CLE, Department of Assigned Counsel, December 2007

Diminished Capacity: Approaches to the Evaluation of *Mens Rea*—Presentation at the Symposium on Diminished Capacity Sponsored by The Washington Institute for Mental Health Research and Training, May 2008

Sentencing Policy for Mentally Ill Offenders—Panel at the National Association of Sentencing Commissions Annual Conference, August 2008

Youth in Corrections—Diverse Youth in Transition: Navigating a difficult Passage, presentation and Panel for the American Psychiatric Association's OMNA on Tour, September 2009

Correctional Psychiatry—Washington Department of Corrections Continuing Medical Education, October 2009

Leston Havens—for the Luminaries of Psychiatry lecture series sponsored by the University of Washington Department of Psychiatry and Behavioral Sciences, December 2009

Involuntary Psychotropic Administration: The Harper Solution—American Correctional Health Services Association Professional Development Conference, March 2010

Securing the Body, Freeing the Mind: Risk Oriented Treatment of the Mentally Ill Offender—Washington Behavioral Health Care Conference, May 2010

Risk Assessment—Co-Occurring Disorders and Treatment Conference, October 2010

Depression and Chronic Pain—Washington Department of Corrections Continuing Medical Education, October 2010

Effective Use of Older Psychotropic Medications—Washington Physician's Assistants Continuing Medical Education, November 2010

Changing Personality or Changing Behavior: Treating Cluster B Personality Disorder—Washington Behavioral Healthcare Conference (with Jude Bergkamp, PsyD, MA), June 2011

Interaction of Psychotherapy and Psychopharmacology—Washington Behavioral Healthcare Conference (with Bart Abplanalp, PhD & Julie Shinn, MA), June 2011

Delirium Is a Syndrome—Washington Department of Corrections Continuing Medical Education, September 2011

Setting Up an Involuntary Antipsychotic Administration Mechanism – The Harper Solution—National Correctional Health Care Conference, October 2011

Don't Panic: Panic Disorder in Medical Settings—Washington Department of Corrections Continuing Medical Education, September 2012

Reducing Liability When Using Physical and Chemical Restraint—Webinar for OmniSure Consulting Group, LLC, December 2012

Involuntary Administration of Antipsychotic Medication: The Harper Solution—American Jail Association Annual Meeting, May 2013

Risk-Need-Responsivity and the Abandonment of the “One Size Fits All” Approach in Corrections and Offender Reentry—Panelist for Seattle University Criminal Justice Department conference entitled “Rethinking Criminal Justice and Mental Health: Evolving Policy in an Era of Risk Assessment and Evidence-Based Practice”, May 2013

Personality Disorders—Washington Department of Corrections Continuing Medical Education (with Bart Abplanalp, PhD), September 2013

Personality Disorders—“HIV/AIDS in the Correctional Setting”, continuing education sponsored by the Northwest AIDS Education and Training Center (with Bart Abplanalp, Ph.D.), February and March 2014

Working with the Potentially Violent Client—CLE for King County Public Defenders, July 2014

Competency and Informed Consent— Washington Department of Corrections Continuing Medical Education, October 2014

Personality Disorders: A Developmental Perspective—Primary Care Conference CNE hosted by the University of Washington School of Nursing, October 2014

Prescribing Controlled Substances in Correctional Settings: Ethics and the Standard of Care—American Academy of Psychiatry and the Law annual meeting, October 2014

Mental Health in the Washington Department of Corrections—NAMI Washington annual meeting, August 2015

Working with Challenging Personalities in the Primary Care Setting—Primary Care Conference CNE hosted by the University of Washington School of Nursing, November 2015

Borderline Personality Disorder in the Medical Setting: Creating and Maintaining an Alliance—Primary Care Conference CNE hosted by the University of Washington School of Nursing, October 2016

Annual didactics to fellows and residents on the following topics: criminal responsibility, competency, risk assessment/risk management, right to treatment/right to refuse treatment, civil commitment, ethics, treatment of the violent patient, conditional release, psychopathy, correctional psychiatry and other topics.

Publications:

Refereed Journals:

Gage, B.C. and Egan, K.J. The Effect of Alexithymia on Morbidity in Hypertensives. *Psychotherapy and Psychosomatics* 41(3):136-144 (1984).

White, K.A.; Beck, J.C.; Gage, B.C. Emergency psychiatric assessment of violence. *American Journal of Psychiatry* 148(11):1562-1565 (1991).

Kruh, I.P., Whittemore, K., Arnaut, G.L.Y., Manley, J., Gage, B., Gagliardi, G. The concurrent validity of the psychopathic personality inventory and its relative association with past violence in a sample of

insanity acquittees. *International J Forensic Mental Hlth* 4(2):135-145 (2005).

Book Chapters:

Gage, B.C. The Violent Inpatient. In Confidentiality Versus the Duty to Protect. Beck, JC (Ed.). American Psychiatric Association press, Washington, D.C. (1991).

Gage, B.C. Working Inside the Walls. In Oxford Textbook of Correctional Psychiatry. Trestman, R; Appelbaum, K; Mteznar, J (Eds.). Oxford University Press, New York (2015).

Other Publications:

Gage, B.C. and Smith, O.A. Cardiovascular Responses to Microinjection of a Neuroexcitatory Amino Acid into Discrete Loci of the Rat Brain. *The Anatomical Record* 208(3):58-59A (1984)

Gage, B.C. Book review: *Insanity: The Idea and Its Consequences*, Thomas Szasz. *Theoretical Medicine* 12:183-185 (1991).

Gage, B.C., Harris, V., and Tomko, R. Criminal Recidivism, Rehospitalization and Revocation of Release in Conditionally Released Insanity Acquittees. AAPL Abstract, 10/95 meeting.

Kruh, I.P.; Arnaut; G.L. Y.; Gage, B.; Gagliardi, G. The psychopathic personality inventory: a validation study with insanity acquittees. Presentation at the Biennial Conference of the American Psychology-Law Society meeting, 3/00.

Gage, B.C. Book review: *Principles and Practice of Forensic Psychiatry* (2nd Ed.), Richard Rosner (ed.). *Journal of Forensic Sciences* 50(1):257 (2005).

Gage, B.C. The Growing Problem of Cognitive Disorders in Corrections. *Iceberg* 19(2) (2009). www.fasiceberg.org/newsletter.htm.

Gage, B.C.; Stern, M. Setting Up an Involuntary Antipsychotic Administration Mechanism – The Harper Solution. DVD through MHM production grant. 2010

Gage, B.C. Reducing liability when using physical and chemical restraints. *Omnisure Risk Management Bulletin*. 2014

IN THE UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

JERMAINE DOCKERY, et al.,)

Plaintiffs,)

v.)

Civil Action No. 3:13-cv-326-WHB-JCG

PELICIA HALL, et al.,)

Defendants.)

DECLARATION OF BRUCE C. GAGE, M.D.

Pursuant to 28 U.S.C. § 1746, I make the following declaration under penalty of perjury:

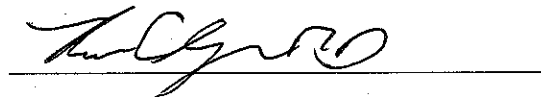
1. I have been retained and designated as an expert by the plaintiffs in this case to evaluate mental health care at the East Mississippi Correctional Facility (EMCF).

2. Attached to Plaintiffs' Memorandum in Opposition to Defendant's Motion for Decertification as Exhibit __ is my December 29, 2016 expert report.

3. The facts and opinions I expressed in Exhibit __ (including my 2016 report) are hereby incorporated by reference into this declaration as my sworn testimony.

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

Executed this 1ST day of SEPTEMBER, 2017 at LAKELWOOD, WA.



BRUCE C. GAGE, M.D.