UNITED STATES DISTRICT COURT
DISTRICT OF NEBRASKA

HANNAH SABATA, et. al, **Plaintiffs,** **v.** **NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES, et. al,** **Defendants.**	**Case No. 4:17-cv-03107-RFR-MDN** **CLASS ACTION** **EXPERT DECLARATION OF DR. PABLO STEWART, M.D.**

I, Pablo Stewart, declare:

1. I have been engaged by counsel for the Plaintiffs to study the Nebraska Department of Correctional Services (NDCS) mental health care system, and to evaluate whether it provides safe levels of care for prisoner with serious mental illness, as well as for the larger population of prisoners who may develop mental illness. I provide this declaration in support of the plaintiff's motion for class certification. The Declaration is organized as follows:

I. BACKGROUND AND QUALIFICATIONS

2. I am a board-certified psychiatrist and through June 2018 was a Clinical Professor in the Department of Psychiatry, University of California, San Francisco. Currently, I am a clinical professor in the Department of Psychiatry, University of Hawaii, John A. Burns. School of Medicine, Honolulu Hawaii. My curriculum vitae is attached hereto as **Exhibit 1.**

3. I have over 30 years of experience in correctional mental health care, including serving as the court's expert in class action cases challenging the provision of mental health care to prisoners. In 1973, I earned a Bachelor of Science Degree at the United States Naval Academy in Annapolis, Maryland. In 1982, I received my Doctor of Medicine from the University of California San Francisco, School of Medicine. In 1985, I received the Mead-Johnson American Psychiatric Association Fellowship for demonstrated commitment to public sector psychiatry and was selected as the Outstanding Psychiatric Resident by the graduating class of the UCSF School of Medicine. In 1985-1986, I served as the Chief Resident of the UCSF Department of Psychiatry at San Francisco General Hospital and was responsible for direct clinical supervision of seven psychiatric residents and three to six medical students.

4. Throughout my professional career, I have had extensive clinical, research, and academic experience in the diagnosis, treatment, and prevention of mental illnesses in correctional and other institutional contexts. In my work, I have specialized in

community and correctional treatment programs for individuals with chronic and severe mental illnesses, as well as substance abuse and related disorders. I have also specialized in diagnosis, treatment, and care programs for persons with Major Depressive Disorder and Posttraumatic Stress Disorder ("PTSD"), in the management of patients with dual diagnoses and the application of psychotropic medication to such individuals, and in the history and use of psychotropic medications in institutionalized populations.

5. I have also specialized in the needs of severely mentally ill individuals in sheltered treatment programs in institutional contexts, such as the use of administrative segregation among the population of severely mentally ill prisoners. I have designed and taught courses in correctional psychiatry at the University of California, San Francisco. I have also designed and taught courses on the protocols for identifying and treating psychiatric patients with various disorders and have supervised psychiatric residents in teaching hospitals. I have worked closely with local, state, and federal governmental bodies to design and present educational programs about psychiatry, substance abuse, and preventative medicine.

6. Between 1986 and 1990, I was the Senior Attending Psychiatrist for the Forensic Unit of the University of California, San Francisco, which was located at San Francisco General Hospital. In that capacity, I had administrative and clinical responsibility for a 12-bed maximum-security psychiatric ward and worked as the liaison with the Jail Psychiatric Services of the City and County of San Francisco. My duties in that position included advising the San Francisco City Attorney on issues pertaining to forensic psychiatry.

7. Between August 1988 and December 1989, I served as the Director of Forensic Psychiatric Services for the City and County of San Francisco. In that capacity, I had administrative and clinical oversight responsibility for the psychiatric care provided to the inmate population in San Francisco at both the county jails and in the 12-bed locked inpatient treatment unit at the San Francisco General Hospital. At the time, mental health care in San Francisco's jails was subject to a consent decree in *Stone v. City and County of San Francisco*, 968 F.2d 850 (9th Cir. 1992). During that period, San Francisco's jails were overcrowded, and the *Stone* consent decree included remedies designed to limit overcrowding. While I was working as the Director of Forensic Services in San Francisco, the plaintiffs in the *Stone* case brought contempt proceedings against the City because of overcrowding that they asserted violated the consent decree.

8. I have also served as a psychiatric expert or consultant to various federal courts or other organizations implementing remedial decrees covering the provision of mental health care in correctional institutions. For ten years, between April 1990 and February of 2000, I served as a court-appointed medical and psychiatric expert for the Court in the consent decree case Gates v. Deukmejian, E.D. Cal. Case No. CIV S-87-1636. Among other things, that case involved the provision of psychiatric care to mentally ill inmates at the California Medical Facility ("CMF") in Vacaville, California.

9. My experiences working on the Gates case also informed me about the difficulty of providing mental health services in locked, high security units. As part of the Gates case, CMF was forbidden from housing mentally ill inmates in its Willis Unit, a three-tier administrative segregation unit, because of the severity of conditions and the

acknowledged difficulty of providing mental health services in this type of setting. Housing mentally ill individuals in the Willis Unit was also forbidden because of the difficulty of conducting emergency response in the unit.

10. Between October 1996 and July 1997, I served as a psychiatric expert for the United States District Court for the Northern District of California in the case of Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995), an omnibus case involving psychiatric care and other issues at Pelican Bay State Prison in Crescent City, California. In my work on the Madrid case, I gained first-hand knowledge concerning the severe impact of prolonged isolation in segregation units on mentally ill inmates, as well as additional concrete understanding of the need for constant monitoring of both non-mentally ill and mentally ill inmates in lock up units in order to prevent any further decompensating, since housing in these units by itself sometimes causes, contributes to and/or intensifies psychiatric instability.

11. Between July of 1998 and February of 2004, I served as a psychiatric consultant to the National Council on Crime and Delinquency ("NCCD") and subsequently for the Institute on Crime, Justice and Corrections at Washington University (when it took over monitoring responsibilities from NCCD) in their efforts to monitor juvenile detention and treatment facilities operated by the State of Georgia. In that case, I monitored an Agreement between the United States Department of Justice and the State of Georgia designed to improve the quality of care in its juvenile detention facilities. The Agreement encompassed mental health care, medical care, educational services, and treatment programs. Also, as part of the case, Georgia created significant new mental

health treatment programs with dedicated staffing and capacity limitations, including most significantly a new inpatient treatment facility for boys and a second new inpatient treatment facility for girls. The Agreement also included a provision forbidding the prior practice of housing suicidal youths in administrative segregation units, and required "mainstream" housing and suicide watch monitoring of such youths. The youths would go to school and work during the day, and would continue their suicide watch in their housing units overnight. This provision was introduced because it had become clear under the prior practices that suicidal youths frequently would not come forward with their suicidal feelings because they did not want to be locked down in administrative segregation for suicide watch. This further demonstrated to me the dangerous and damaging nature of isolation in locked units for suicidal individuals. It also demonstrated to me the dangerous nature of punitive suicide watch conditions when they discourage suicidal individuals from coming forward and seeking treatment.

12. Between June of 2003 and December of 2004, I was hired by the State of New Mexico as a defense expert for the implementation phase of the psychiatric sections of the "Ayer's Agreement" covering the New Mexico Corrections Department ("NMCD"). The Agreement was a settlement between a class of New Mexico prisoners and the NMCD concerning the provision of psychiatric care for inmates in New Mexico's highest security facility. The Ayers Agreement concerned a mental health treatment program in a disciplinary detention unit. The treatment program implemented in the unit was based in part on the treatment standards for the Psychiatric Security Unit mental health care programs in California. New Mexico implemented the new treatment program

with an acknowledgement that they needed to maintain minimum clinical staff-to-inmate ratios given the severe nature of the housing conditions in the locked-down unit, and the potential for mental decompensation.

13. Between March of 2003 and the summer of 2006, I worked as an expert for the United States Department of Justice in connection with inspections to identify and remedy various problems at the Maxey Training School, a youth facility with large medical and mental health treatment programs in Whitmore Lake, Michigan. The case involved the adequacy of medical and mental health care provided at the facility. The case included an investigation of excessive lock-downs of suicidal youths.

14. In 2007 and 2008, I prepared expert statements and testified before the court and the three-judge panel in the Coleman/Plata overcrowding litigation. My expert report in that case was cited twice in the United States Supreme Court decision upholding the three-judge court's imposition of an order requiring California to reduce overcrowding.

15. In 2008, I served as an expert and testified before the United States District Court for the District of Arizona in Graves v. Arpaio, No. CV 77-479, in support of Plaintiffs' opposition to the Defendants' Motion to Terminate the relief related to mental health care at Maricopa County Jail. I concluded at the time that Defendants failed to provide mental health care to seriously mentally ill prisoners at Maricopa County Jail, and those in need of mental health treatment. As a result, mentally ill prisoners at Maricopa County Jail unnecessarily suffered, and were put at risk of harm through the deficiencies in Maricopa County Jail's mental health care system. In some cases, the risk

of harm mentally ill prisoners endured was exacerbated by their harsh living conditions, particularly for those housed in the segregation/closed custody units throughout the Jail. My conclusions were based upon a multiple-day site visit to Maricopa County Jail facilities, interviews, discussions with staff, and a review of medical records and other documents relevant to mental health care then being offered at Maricopa County Jail.

16. In 2013, I was retained by counsel for the plaintiff class in Parsons v. Ryan, D. Az. Case No. CV 12-00601, to offer my opinion of the mental health care provided to prisoners at the Arizona Department of Corrections. During my inspection tours, I viewed cells and other housing areas, mental health treatment spaces, mental health programming areas, and other areas to which prisoners have access. I also conducted cell-front interviews with prisoners and reviewed prisoner records.

17. I have held numerous positions with responsibility for ensuring the quality of clinical services provided by inpatient and community-based programs. From 1997 to 1998, I was Director of Clinical Services for San Francisco Target Cities Project. I also served as (1) Medical Director of the Comprehensive Homeless Center, Department of Veterans Affairs Medical Center in San Francisco, where I had overall responsibility for the medical and psychiatric services at the Homeless Center; (2) Chief of the Intensive Psychiatric Community Care Program, Department of Veterans Affairs Medical Center in San Francisco, a community-based case management program; (3) Chief of the Substance Abuse Inpatient Unit, Department of Veterans Affairs Medical Center in San Francisco, where I had overall clinical and administrative responsibilities for the unit; and (4) Psychiatrist, Substance Abuse Inpatient Unit, where I provided consultation to the

Medical/Surgical Units regarding patients with substance abuse problems. Between 2006 and 2009, I served as a member of the Board of Directors of the Physician Foundation at the California Pacific Medical Center.

18. I also served as a Physician Specialist to the Westside Crisis Center, San Francisco, from 1984 to 1987, and to the Mission Mental Health Crisis Center from 1983 to 1984. I was the Chief of Psychiatric Services at the Haight Ashbury Free Clinic from 1991 until February 2006. I also worked as a Technical Assistance Consultant to the Center for Substance Abuse Treatment, which is part of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services.

19. Beginning in May 2016, and continuing in the present, I am serving as the court-appointed monitor in *Ashoor Rasho, et al. v. Director John R. Baldwin, et al.,* No. 1:07-CV-1298 MMM-JEH (C.D. Illinois), a case about mental health care in the state correctional system in Illinois. In the *Rasho* monitoring, I have conducted numerous tours of the Illinois state prisons, interviewed hundreds of prisoners, and provided detailed reports to the parties and the Court on the status of the prison mental health system.

II. OPINIONS AND FACTUAL BASES

20. I have been asked to render an opinion as to the policies and practices of the Nebraska Department of Correctional Services ("NDCS") and its agents with regard to the provision of mental health care to NDCS prisoners.

21. I have reviewed numerous NDCS policies, documents within the named Plaintiffs' medical files as produced by NDCS to counsel for the Plaintiffs, deposition transcripts of NDCS officials, and other medical files as produced by NDCS to counsel

for Plaintiffs. A complete list of the materials I have reviewed is attached to this declaration as **Exhibit 2**.

22. I toured six NDCS facilities during the last week of October and the first week of November in 2018. During my tour, I visited the Tecumseh State Correctional Institution ("TSCI"), the Nebraska State Penitentiary ("NSP"), the Lincoln Correctional Center ("LCC"), the Nebraska Correctional Center for Women ("NCCW"), the Diagnostic and Evaluation Center ("DEC"), and the Nebraska Correctional Youth Facility ("NCYF"). During the tours I was able to randomly select individual files of prisoners receiving psychiatric care at each facility and had the opportunity to speak with individual prisoners and NDCS staff about the provision of mental health services at NDCS facilities.

23. My opinions at this early stage of the case are necessarily constrained by the limited amount of information I have. Although I had the opportunity to make site visits to NDCS facilities, speak with prisoners and staff, and review a limited set of prisoner records, I have not yet had the opportunity to conduct confidential interviews with prisoners or to review a more robust sample of medical records of the prisoner population. Nevertheless, based upon the documents listed in **Exhibit 2,** I am able to reach the following preliminary opinions. These should not be taken as an exhaustive list of the opinions I will reach in this case, and I reserve the right to supplement or modify these opinions as more information becomes available.

24. Based upon my review, I have formed the opinion that NDCS lacks the systems and resources needed to ensure that prisoners with mental illness are identified

and treated in the manner necessary to prevent serious harm or death. The problems fall into the following specific areas, discussed in more detail in the body of this declaration:

a. Staffing. Mental health care services at NDCS are dangerously understaffed, and are lacking in the basic components needed to prevent needless suffering, bodily injury and death. NDCS employs too few clinicians—particularly at the psychiatrist level—for the number of prisoners it houses.

b. Identification and Screening. The most dangerous times for prisoners are the first few weeks after arrival at an institution or housing unit. A disproportionate number of attempted and completed suicides occur within hours or days of arrival. Prison systems must develop and employ screening mechanisms to ensure that prisoners with serious mental illness are identified promptly and assigned to the correct levels of care.

c. Levels of Care. NDCS lacks a system for ensuring that prisoners receive the necessary level of mental health care for their current conditions. Mental illness is not static. Persons with mental illness experience varying levels of acuity over time, especially in stressful and rapidly changing prison and jail environments. By operating without defined levels of care, NDCS cannot promptly provide prisoner patients with the necessary increases in mental health treatment when their conditions change, creating substantial risks of harm for such patients.

d. Access to Care. NDCS relies on an all-purpose Inmate Interview Request (known as a "kite") for prisoners to request mental health care. This system

seriously impedes access to care, adding to the already dangerous delays in treatment caused by understaffing.

e. Records. The medical records system does not function properly. A non-functioning medical record systems creates substantial risks of injury and death because it prevents mental health clinicians from properly diagnosing the patients' conditions, and from safely prescribing medication.

f. Medication. The systems for prescribing and adjusting medication, and for detecting and treating dangerous side effects of powerful psychotropic medication are not functioning at the level needed to prevent serious harm and death.

g. Isolation. Aggravating all of these problems with the NDCS mental health care system is an overreliance by custody on restrictive housing, in which regimes of isolation and sensory deprivation make already sick people sicker, and cause previously healthy people to develop mental illness.

h. Suicide Prevention. Prisoners are at high risk of suicide. This applies both to prisoners who come into to the system without any mental health diagnosis, and those already diagnosed. The problems identified above make it impossible for NDCS to implement an effective suicide prevention program.

25. As I detail below, the shortage of mental health staff, structural deficiencies in the provision of mental health treatment and medications are statewide systemic problems. Prisoners who need mental health care have already experienced, or will experience, a serious risk of injury to their health if these problems are not addressed. Additionally, the problems that Plaintiffs experienced and continue to experience with

NDCS' mental health system are typical of the problems one would expect to see as a result of these systemic failures. In my experience in correctional mental health care, these types of systemic problems have most commonly been addressed through an injunction directed against directors and administrators of the prison system.

A. STAFFING SHORTAGES

26. Qualified mental health staff are the foundation of any prison mental health care system. Based on my site visits to NDCS facilities, conversations with NDCS staff, my review of prisoners' mental health and medical files, my review of NDCS policies, my review of investigatory documents compiled or authored by Nebraska's Inspector General, and my review of deposition testimony given in this case it is my opinion that it is apparent that there have been and continue to be severe systemwide shortages of mental health staff in NDCS.

27. NDCS' has mental health staffing shortages that are both longstanding and chronic. I have not yet fully evaluated the NDCS mental health staffing plans to determine whether NDCS has properly assessed its treatment workloads to set its targets for mental health staffing. But, even assuming its staffing targets are correct, NDCS is not meeting them. Persistent vacancies in allocated positions are mentioned in each of the annual reports issued by the Office of the Inspector General. As of June 14, 2016, 34 of the 161 behavioral and mental health positions were vacant (2016 OIG Report, pg. 17). One year later, the most recent information on staffing shortages showed almost no change from the year before and noted at that time there were no psychiatrists within NDCS (2017 OIG report, pg. 57). As of July 4, 2018, NDCS had 29 Behavioral Health clinical vacancies (2018 OIG Report, pg. 23). Some facilities are facing worse shortages

than others. For example, OCC had two total behavioral health clinical vacancies as of the end of FY 2017, and that number grew to ten vacancies by July of 2018. (2018 OIG Report, pg. 24).

28. In his December 2018 deposition, NDCS's statewide medical director, Dr. Deol testified that there were two vacancies for on-site psychiatrists within NDCS facilities, one being a chief of psychiatry, a position that was vacant for seven months at the time of his deposition. (DEOL 230:3-18.) NDCS currently utilizes two on-site psychiatrists to treat patients at LCC, DEC, and NCCW. NDCS utilizes telepsychiatry at every other facility, as well as partial coverage at NCCW. (DEOL 235:3-.237:25) Also, according to Dr. Deol, psychiatry services are provided by two part-time psychiatrists at NSP.

(DEOL 240:1-12.) This provides NDCS with one additional full-time employee in terms of psychiatry time. (DEOL 235-236.) According to Dr. Deol, the telepsychiatry services are provided by three individuals, one psychiatrist and two psychiatric nurse practitioners. (DEOL 237-238.)

29. By Dr. Deol's own estimate, between 70 and 80 percent of NDCS prisoners are receiving psychiatric medication. This would be an extraordinarily high percentage, and I question the reliability of Dr. Deol's recollection on this point. In a 2015 report prepared for NDCS by Dr. Bruce Gage, former Chief of Psychiatry for the Washington Department of Corrections, Dr. Gage estimated that approximately 82% of NDCS's 5.225 prisoners in April 2015 were diagnosed with mental illnesses, including those with only a substance abuse diagnosis. (Nebraska Department of Correctional Services, Behavioral Health Needs Assessment, December 2015 at 11.) Dr. Gage estimated that

approximately 52% of NDCS prisoners were diagnosed with a mental illness other than just substance abuse. Dr. Gage estimated that 25% of male and 50% of female prisoners were on psychotropic medications. These figures seem more plausible than Dr. Deol's recollection of 70% to 80% of prisoners receiving psychiatric medications. Even using Dr. Gage's figures, however, it is my opinion having the equivalency of three or four full-time psychiatrists, two being on-site and full time, the remainder being through telepsychiatry and part-time staffing, is insufficient to meet the needs of this population. It is my opinion at this stage of the case that such a psychiatrist staffing ratio places all prisoners needing mental health services at risk for serious harm.

30. One result of having insufficient mental health staffing is delay in accessing appropriate care. For example, I reviewed the Critical Incident Report of Prisoner A[1] in TSCI, an individual diagnosed with Adjustment Disorder with a Mixture of Depressed and Anxious Mood and Major Depressive Disorder three months prior to his suicide. In the three months prior to this individual's suicide he requested psychiatric care twice indicating that he needed mental health interventions, that his prescribed medication was not working, and he could "not stand it anymore." After his first plea for assistance, this individual was informed that he would be seen in one to two months. Moreover, the Critical Incident Report indicated that the prisoner's new diagnoses were not uploaded to NICAMS and that mental health and medical staff were not apprised of this individual's

[1] For medical privacy reasons, I refer to prisoner/patients here by a letter code. A guide to the codes with the actual patient names is attached as **Exhibit 3**.

acute situation because the psychiatry provider, "does not consistently enter mental health diagnoses into NICAMS or consistently inform mental health of changes to an inmate's psychiatric medications; nor do these three entities meet on a consistent basis to share information." This is unacceptable. The delay in providing this prisoner mental health treatment lead to serious and deadly consequences, and had this individual been provided with timely access to the services he desperately was requesting, he may still be alive.

B. IDENTIFICATION AND SCREENING.

31. NDCS policies and practices for identification of screening of prisoners at arrival in the system, and after transfers within the system are dangerously lacking. Initial screenings are performed by custody staff with no medical qualifications. (DEOL 167-168.) Although the policies are unclear, Dr. Deol testified that an incoming prisoner is not screened by medical staff until 14 or even up to 30 days later. (DEOL 83-85.) In this scheme, inmates do not routinely see a mental health professional until weeks after arrival. This system is indifferent to the fact that the riskiest time for prisoners is the first few days after arrival, when prisoners are often suffering the worst effects of dislocation from society to an institution, and facing the realities of a long prison sentence. Many attempted and complete suicides occur in these first few days and hours. A functioning correctional mental health system requires screening by mental health professionals within hours or days or arrival, not within weeks.

C. LEVELS OF CARE

32. Prisoners with mental illness need to be assessed, treated, and monitored on a timely and regular basis by qualified mental health staff.

33. A correctional mental health care system must include discreetly defined, and available, levels of care sufficient to meet the needs of its population. In the context of mental health in corrections, this means that there must be an outpatient level of care, an inpatient level of care, a residential level of care, crisis care or acute care, and suicide watch protocols in place.

34. When I toured NDCS facilities I asked mental health providers and other NDCS staff at each facility about their understanding of the NDCS levels of mental health care. I received a variety of answers from each individual that I spoke with, however, there was not one person that was able to answer this question fully, and many mental health providers were not even familiar with the concept of differing "levels of care" within the provision of mental health services.

35. The concept of having differing levels of mental health care is not new. One of the chief purposes of having discrete levels of care is to ensure that patients are accessing mental health services that are appropriate in intensity, scope, and duration, and based upon clinically accepted standards. Due to the waxing and waning aspect of mental illness that manifests in fluctuating clinical presentations of symptoms on a day-to-day, week-to-week, or even month-to-month basis, the lack of policy here will impact all prisoners with mental health issues.

36. For instance, it is foreseeable and likely that a prisoner with mental illness that has been maintaining an acceptable level of behavior, at what would be an outpatient level of care, can have an acute mental decompensation for a variety of reasons and immediately require a higher level of care which necessitates additional staffing,

monitoring, and modifications to their treatment plan. The fact that NDCS would not have a defined level of care, or uniform standards of practice available to treat such an individual, places them at an unreasonable risk of harm, and unnecessarily delays the stabilization of the prisoner's condition.

37. Similarly, prisoners needing a heightened level of care, such as a residential level of care, may be able to safely transition to less intensive services, but the lack of any uniform criteria on which to base such a decision could foreseeably cause a prisoner to unnecessarily languish in more restrictive treatment modalities than is medically necessary or beneficial. Moreover, the lack of criteria upon which to base such a decision places patient needing a heightened level of care at an unnecessary risk of harm in that they will foreseeably be inappropriately discharged to a lower level of care.

38. NDCS's statewide medical director, Dr. Deol, testified that when male prisoners of any security level cannot function in the general population due to mental illness, the system responds by sending them to the Secure Mental Health Unit, ("SMHU") at LCC. (DEOL 249:15-17.) This unit, however, operates simply as an extension of the Restrictive Housing, or segregation units, and lacks the resources and programs necessary for an inpatient or residential mental health treatment unit. Even to the extent that this SMHU serves as a substitute for a higher level of mental health care, its use is dangerously haphazard due to the lack of defined levels of care and protocols for moving inmates into and out of levels of care. The result is the prisoners are admitted to and discharged from the SMHU without necessary clinical resources, especially on discharge to housing units with no mental health mission. Prisoner B, was placed in the mental

health unit at LCC in response to his severe and increased manifestations of his PTSD and Bipolar Disorder. Whether he received any clinical benefit from the SMHU is highly questionable, but in any event, he was discharged to an even less clinical setting without proper planning, and subsequently engaged in serious self-injurious behavior that necessitated his hospitalization. This lack of defined levels of care creates a substantial risk of harms to all NDCS prisoners, both those currently without mental illness who may develop mental illness, and those with mental illness whose conditions can worsen at any time.

39. During my site visits, I encountered at least four individuals whose mental health needs were so acute that it is not possible for NDCS, given their current staffing, resources, and facilities, to meet the treatment needs of these patients. Dr. Deol testified that in very acute cases it is possible to transfer a prisoner to the Lincoln Regional Center ("LRC"), or the University of Nebraska Medical Center ("UNMC"), but NDCS has not transferred any prisoner to those facilities during his tenure as NDCS Medical Director (which started in January 2017). (DEOL 247-248.) Moreover, Dr. Deol testified that there are no written NDCS policies regarding how to handle prisoners that are having an acute psychotic episode and that prisoners suffering these episodes are frequently are taken to the secured nursing facility ("SNF"). (DEOL 245.) I have personally visited and spoken with NDCS staff employed in each SNF within NDCS. The SNF functions essentially as a prison infirmary without a specific mental health mission. Prison infirmaries are not mental health units, and a policy of employing them as such exposes prisoners with mental illness to serious risks of injury and death.

40. The housing units that Dr. Deol identified as having a mental health mission are the SMHU at LCC and the Strategic Treatment and Reintegration ("STAR") unit at NCCW for women. As noted above, the SMHU functions more as an extension of Restrictive Housing than as mental health units. Dr. Deol testified that there are currently 32 beds within the SMHU at LCC, and 12 beds within the STAR unit at NCCW and that the admission criteria for admittance to these units is, "any decompensation mental illness." (DEOL 250.) Dr. Deol testified that if a male prisoner has an acute mental health crisis at any other facility, NDCS will potentially temporarily treat them at a SNF, then seek to transfer the patient to the SMHU. (DEOL 249-250.) As I have stated above, the SNF, or infirmary, setting is not a safe place to treat persons in mental health crisis. Nor are the SMHU or STAR units.

41. For example, one prisoner with whom I spoke personally and had an opportunity to review their medical file, Prisoner C, at DEC was diagnosed with Schizoaffective Disorder and was so mentally ill that he required an in-patient level of care. I did not observe any facility within NDCS that could even be considered remotely adequate in light of this individual's behavioral manifestations and symptoms. In my opinion this individual would meet the criteria for admission into an in-patient psychiatric facility, and NDCS' failure to either provide or transfer this prisoner to such a level of care places him and others at DEC at an unreasonable risk for harm.

42. A correctional mental health system need not maintain every possible level of care "in-house," but must at least ensure prisoners have real and meaningful access to appropriate levels of mental health care. Based upon my review of NDCS inmate medical

files, and my initial impressions from conversations with these individuals, the needs of inmates with the most serious mental health needs exceed what NDCS is able to provide internally and these individuals are not transitioning to an acceptable acute level of care.

43. The lack of uniform practices and policies in this area pose a substantial risk of serious harm to prisoners.

D. ACCESS TO CARE

44. NDCS does not have an effective means for prisoners to make their mental health needs known to qualified staff in a timely manner. Upon speaking with prisoners, NDCS staff, and mental health providers, I learned that the Inmate Interview Request Form (also known as a "kite") is the primary means by which prisoners request and eventually access mental health care.

45. While there may be other means of making mental health needs known to NDCS staff, such as requesting care from NDCS staff or medical professionals directly, the kite appears to be the primary vehicle of which to initiate mental health care within NDCS. Even in the instances in which mental health professionals directly interact with prisoners, there are issues with accessing care. For example, I reviewed the Critical Incident Report of Prisoner D, an individual residing at TSCI with a known history of depression and suicidal ideations, and at least one incidence of TSCI not completing a mental health appointment because of a "custody" issue. In this case, a PLMHP working at TSCI conducted a "mental health status examination" of Prisoner D not long before his suicide and she indicated that the prisoner "waived her off" and that he knew how to reach mental health if he wanted to. However, there is no indication that anything further

was done. This inmate's lack of access to care had grave consequences, shortly thereafter, Prisoner D committed suicide.

46. Moreover, kites are not triaged by mental health staff, but by custody staff. Putting mental health triage in the hands of custody staff is dangerous. During my tour of NDCS facilities I reviewed 68 medical files of prisoners across six different facilities. Upon review of these medical files I have noted at least eleven separate prisoners, across all facilities, that have faced an unnecessary barrier in requesting or accessing mental health care due to the fact that unqualified NDCS staff control access to mental health care. I have reviewed files at each of the NDCS facilities that I visited and found clear examples of NDCS staff receiving a request for mental health services and not facilitating the provision of services in a timely manner, such as described herein by the tragic consequences suffered by Prisoner A.

47. Another method of requesting mental health care or alerting staff to mental health needs is through filing an official grievance. Inmates with mental health issues who may need assistance obtaining and filing grievance forms are not provided assistance or accommodations. In fact, the most common way for an inmate with a mental health issue who needs assistance with filing a grievance receives any assistance is through asking another inmate for it. (FORGEY 28.) Staff do not receive training on how to assist inmates with mental illnesses in filing grievances. (FORGEY 29.) The grievance process should provide all inmates the opportunity to communicate mental health concerns and grievances to NDCS. Due to NDCS' failure to provide assistance to people with mental illnesses who need help navigating the grievance process, some

inmates are functionally locked out of the grievance process and unable to use it as a means of communicating concerns related to their mental health. The grievance process is utilized system-wide, so this deficiency affects all inmates with mental health issues who need assistance.

48. NDCS staff, including mental health professionals, routinely respond to requests for medical services by making needless requests to the prisoner for follow-up information, by diverting the request to irrelevant departments, and in some cases by outright refusing to see a patient or informing them when they will be seen. This back and forth written correspondence between prisoners and NDCS staff unnecessarily and frequently impede the process of connecting the prisoner to the services they are requesting within a timely manner.

49. For example, I reviewed the medical file of and spoke with Prisoner E at NSP. He is diagnosed with Bipolar Disorder Type II, Attention-Deficit Hyperactivity Disorder, Polysubstance Abuse Disorder, and Antisocial Personality Disorder and has received a variety of psychotropic medications. This individual has serious mental health issues and has experienced decompensation while placed in restrictive housing. However, this individual faced a variety of barriers in accessing appropriate mental health care—including long back-and-forth dialogs via the kite system that simply delayed care. Prisoner D's requests should have been properly triaged so that he would have been visited by a qualified mental health professional based on his symptomology and behavioral manifestations. The kite system's failures directly caused this individual to

miss medical appointments and placed him at an unnecessary risk for harm through the delay in his access to care.

50. Similarly, I have reviewed the medical files of, and spoken with Prisoner F, an individual that resides at LCC, a man that is so acutely ill that he requires a residential or inpatient level of mental care immediately. Prisoner F has a diagnosis of Schizoaffective Disorder and Anti-Social Personality Disorder and has debilitating auditory command hallucinations which direct him to harm himself and others. During this individual's treatment at LCC he has been repeatedly screened away from proper mental health care through unqualified staff responding to his kites and not directing him to mental health care. Moreover, this individual has been prescribed Haldol Decanoate, a powerful psychotropic medication, but his side effects are not being managed appropriately and his hallucinations have not improved. This prisoner has been vacillating between a variety of different medications for years, but he requires a level of treatment which exceeds the capacity of NDCS.

E. MEDICAL RECORDS

51. A properly functioning medical records system is necessary for safe prison mental health care. Prison mental health treatment involves the use of powerful psychotropic drugs, which can only be used safely in a coordinated system of care, in which prescribers have access to up-to-date records. In addition, records systems are essential to prevent suicide and self-harm, as clinicians must be able to access a prisoner's history in order to fully access current risks.

52. During my review of NDCS medical files I frequently noted issues relating to the lack of internal consistency and organization in the medical files. While I am aware

that NDCS is employing a partially electronic medical record system, I saw no evidence that an electronic system as deployed has remedied the problems.

53. For example, many of the Medical Administration Records ("MARS") contradicted the contemporaneous psychiatric recommendations and notes kept in the same file.

54. The risks of a poor medical record system are aggravated when the mental health system relies heavily on remote providers seeing patients through video links, as NDCS does. Such “telepsychiatry” providers have no ability to review the patient’s on-site files or consistently talk to on-site clinicians, and must rely on whatever records can be faxed, emailed or made available over a network. I have observed many telepsychiatry sessions in many prison and jail systems where providers attempt to use electronic medical records to make up for lack of on-site information, and the results are consistently poor and often dangerous for the prisoner patient.

55. Dr. Deol testified that NDCS does not provide access to anything but a prisoner's NICAMS and MARS to telepsychiatry providers as a matter of course (DEOL 240-241.) According to Dr. Deol, the information contained in NICAMS only includes behavioral health progress notes, recent psychiatric notes, diagnostic information, and chronic care information. Moreover, some NDCS health staff, including medical doctors, do not have access to NICAMS. (DEOL 174-176.) Dr. Deol testified that there were roughly 5,000 telepsychiatry visits last year, which made up about half of the psychiatry encounters. (DEOL 237.) Furthermore, Dr. Deol testified that telepsychiatry providers are only provided access to a prisoner's requests for psychiatric care, or kites, if they are

directed to them via electronic mail. (DEOL 240.) Finally, Dr. Deol testified that telepsychiatry providers have their own electronic records which are supposed to be faxed to NDCS and uploaded into NICAMS. (DEOL 241.) This kind of Rube-Goldberg system of workarounds is typical of the failed telepsychiatry schemes I have observed around the country.

56. Some of the dangers in this system of documentation and coordination of care are exemplified by Prisoner G at NSP. This individual has chronic physical health issues and severe mental health issues. However, upon reviewing this prisoner's file I noted inconsistent diagnoses between the individual's physical health and mental health files. The disorganization, and structural deficiencies of NDCS recordkeeping all but ensure that that physical health professionals and mental health professionals will not have access to the same information. This fact that this individual's providers are apparently not aware of this individual's full treatment history unnecessarily places him at risk for harm. This is also exemplified by NDCS' admitted failures to coordinate a cohesive system of record keeping between psychiatric care, mental health providers, and medical staff as discussed herein as related to Prisoner A.

57. Based on this information, I believe NDCS prisoners are placed at an unreasonable risk of harm in that NDCS has failed to maintain a system of documentation necessary to coordinate their physical, mental, and psychiatric needs. Based on the system as described by Dr. Deol, it is foreseeable and likely that a telepsychiatry provider will not possess the necessary medical information about a patient to formulate a sufficient psychiatric treatment plan.

F. MEDICATION

58. According to Dr. Deol, between 70 and 80 percent of NDCS prisoners are currently receiving medication for mental health illnesses. (DEOL 225.) As I have stated above, this estimate appears too high, and I would credit Dr. Gage's estimate that 25 percent of men and 50 percent of women are receiving psychotropic medications. This is still a substantial percentage of the Nebraska prisoners, and medication management for this population is a major undertaking that is beyond NDCS's current capabilities.

59. The administration of psychotropic medications needs to be supervised by a psychiatrist and prisoners need to be able to make their mental health needs known and have those needs promptly assessed by qualified staff.

60. Based on my site visits to NDCS facilities, my conversations with NDCS staff, my review of prisoners' mental health and medical files, my review of NDCS policies, my review of investigatory documents compiled by Nebraska's Inspector General, and my review of deposition testimony in this case I have reached several preliminary conclusions regarding the provision of psychiatric medication to NDCS prisoners.

61. NDCS has not deployed the resources necessary to safely provide psychiatric medication to the incarcerated population. The systemic deficiencies I have observed so far in this area includes the inappropriate use of psychotropic medications, including inadequate utilization of laboratory monitoring, and the absence of any policy or practice regarding proactive measures to protect prisoners on psychotropic medication from heat injury.

62. The practices and policies of NDCS and its agents in this area pose a substantial risk of serious harm to prisoners.

1. Inappropriate Use of Psychotropic Medications

63. Psychotropic medications can, and should be, utilized as part of a patient's mental health treatment for a variety of serious mental illnesses. Indeed, while psychotropic medications can be effective in treating these illnesses, the powerful nature of many of these medications cannot be overstated. The formulation of psychotropic medications has improved a great deal over the last several decades, yet even modern psychotropic medications still have serious side effects for patients which must be closely monitored by a licensed psychiatrist. Moreover, due to the powerful nature of psychotropic medication, the prescription and formulation of a patient's medication must be precise, suitable to treat the patient's condition and active behavioral manifestations, and consider the patient's physical condition and other prescribed medications.

64. The failure to closely follow the accepted standards of practice in utilizing psychotropic medications leads to serious negative consequences for patients. During my site visits to NDCS facilities I reviewed 68 medical files of prisoners across six different facilities, and found that that in at least 34 of these cases the medically accepted standard of care had not been met, had been entirely disregarded, or NDCS had failed to document clinically appropriate provision of psychotropic medication.

65. In these 34 cases, the medical files indicate that NDCS has failed to meet the applicable standards of psychiatric care in a variety of ways including having an inadequate formulary of psychotropic medication, utilizing improper dosages and types of psychotropic medication, utilizing an inappropriate number of different psychotropic

medications within a distinct time period, prescribing antipsychotic medication for patients with no diagnosis or symptoms of psychosis, and failing to treat the side effects caused by psychotropic medications.

66. For example, one of the prisoners with whom I met, and whose medical files I reviewed, Prisoner H, had been prescribed Haldol Decanoate. However, this individual had been immediately prescribed the long acting version of this psychotropic medication, as opposed to first establishing that the medication would be effective through prescription of the short acting version, which is the clinically accepted practice. This ensures the medication interacts with the patient appropriately and reduces the patient's symptoms. It is only appropriate to prescribe the long acting version of the medication after the short acting medication is shown to be efficacious, to avoid unnecessary decompensation, or in the event the medication is not effective in allowing the provider to alter the treatment modality to avoid further harm to the patient. In practice, this means the patient was not stabilized as quickly as she should have been, and the patient was placed at an unnecessary risk of harm should the medication have proven to be ineffective.

67. Due to NDCS' failure to abide by the accepted clinical practice, this individual has been repeatedly placed in solitary confinement, has had episodes of smearing feces on the wall, and continues to suffer from command hallucinations. Furthermore, this patient suffers from chronic constipation, which is one of the well-known side effects of this particular psychotropic medication. Despite this, NDCS failed

to prescribe any medication to alleviate this side effect. The patient's only option is to purchase over the counter medication from the canteen.

68. I also reviewed the file of Prisoner I, an inmate at NCCW diagnosed with a mood disorder. NDCS was treating this patient with Ziprasidone and Sertraline during my tours, but the auditory hallucinations and depression she experienced were not being ameliorated by the treatment modality in the slightest. Her medications had the effect of making her more docile, but she is not currently receiving effective psychiatric treatment that could reduce her symptoms and the suffering they cause. Moreover, this individual requires a level of care that is not currently offered to her at NCCW, or anywhere within NDCS. As such, this individual has been placed at an unnecessary risk for harm.

69. In my experience, the issues detailed above can be mitigated or entirely avoided in the correctional setting by maintaining a medically adequate formulary and not having to rely upon outdated and ineffective medications to treat patients. Furthermore, these issues can be mitigated or prevented by having a sufficient number of qualified mental health staff available and employed in each facility to prescribe and monitor the use of psychotropic medications, as well as through employing a qualified director of psychiatry that can implement uniform standards of practice and care across different facilities and with different providers.

70. As noted herein, and in the deposition of Dr. Deol, NDCS does not have an acting chief of psychiatry, a position that I have found to be critical in the provision of a mental health system in the correctional setting. (DEOL 230-231.)

71. The safe provision of many types of psychotropic medications requires extensive and thorough laboratory monitoring to ensure the health and safety of the patient. For example, the standard of practice for a patient receiving Olanzapine would be to perform a comprehensive metabolic analysis prior to the prescription of the medication and every three months thereafter, unless a specific clinical situation demands otherwise.

72. Laboratory monitoring is necessary for patients receiving these medications for two primary reasons. First, to ensure the patient is receiving the proper dosage of the medication. Second, to ensure the psychotropic medication is not causing the patient's physical health to fail. Many psychotropic medications are known to cause potentially catastrophic health consequences for certain patients. Lab monitoring allows psychiatrists to monitor certain health markers on an ongoing basis to ensure this is not happening, and to intervene if it is.

73. For example, I reviewed the file Prisoner J that was taking Carbamazepine, Cetirizine, Doxepin, Gabapentin, Venlafaxine, and Prazosin but according to his medical files he had not had the necessary blood work done for a span of six consecutive months in 2018. Based upon the information in this individual's file, he should have had blood work completed prior to the initiation of his medication and then every three months thereafter. I found this type of issue to be common at each facility that I visited.

74. In addition to laboratory monitoring, the safe use of psychotropic medications also requires timely evaluation for side effects, including timely regular evaluations by a psychiatrist. Such timely evaluations are impossible in an understaffed system like NDCS. The side effects of powerful psychotropic medications can cause

permanent injury. For example, some medications can interfere with the body's regulation of motion, leading to Parkinson's like symptoms such as facial tics and twitches, known as tardive dyskinesia. If these symptoms are not caught early and medication dosages are not adjusted to alleviate them, the symptoms often become permanent and irreversible.

2. Protection of Prisoners on Psychotropic Medications from Heat Injury

75. All psychotropic medications change the body's ability to manage temperature, and can lead to a runaway increase in body temperature that can result in organ failure or death. Patients on such medications can be permanently injured or killed if exposed to temperatures that would not be harmful to persons not on such medication. In prison systems, where prisoners do not have control over their environment and where prisons are often located in hot climates, it is essential to identify the patients who are on heat sensitive medications and to employ a protocol to address such patients' exposure to excessive heat. I have reviewed the NDCS policies contained in **Exhibit 2**, and the deposition testimony of Dr. Deol, and believe that NDCS' failure to adopt any policy regarding this issue to be relevant for several reasons.

76. First, the lack of any existing policy indicates NDCS would likely fail to take proper prophylactic action to protect prisoners from heat injury. Heat sensitivity is a predictable side effect of all commonly-used psychotropic medications, and prisoners prescribed those medications should be uniformly and proactively protected from heat, without first requiring that they exhibit dangerous clinical signs such as hyperthermia, hypotension, or confusion before NDCS staff refer a prisoner to medical staff.

77. During hotter months in Nebraska, which consistently bring high temperatures and high levels of humidity, there is a significant risk that prisoners on psychotropic medications will be exposed to dangerous levels of heat unless NDCS takes proactive measures to prevent it. An effective policy would consider this risk and ensure that prisoners on psychotropic medications are protected from dangerous heat levels in both their housing units and in other areas within NDCS facilities in which they spend any significant amount of time. It is my understanding that NDCS has no policy specifying temperature limits for areas housing these prisoners, despite the fact that NDCS is aware of and keeps a master list of every individual receiving these medications. (DEOL 174; 262.) NDCS' indifference to the well-being of these inmates exposes them to an unnecessary risk of significant harm.

G. ISOLATED CONFINEMENT

78. NDCS uses the term "Restrictive Housing" to refer to housing units in which prisoners' access to out of cell time, social contact, and environmental stimuli are limited. Under the NDCS definition, "Restrictive Housing" refers to "conditions of confinement that provide limited contact with other offenders, strictly controlled movement while out of cell, and out of cell time of less than twenty-four hours per week." Neb. Rev. Stat. § 83-170(13). This definition tracks the type of conditions usually considered "solitary confinement" in the literature and in other jurisdictions with which I am familiar in that it allows for very limited social interaction and environmental stimuli. Such settings are profoundly damaging to one's mental health even for prisoners with no known pre-existing mental illness. For persons who already have serious mental illness, such as psychotic disorders and major mood disorders, isolation can be devastating,

leading to severe deterioration to their mental health, and leading to their self-injurious behavior, or suicide. These facts appear to be well known to NDCS given that NDCS leadership received a report written by the Vera Institute of Justice recommending that, "no one with serious mental illness is placed in any form of restrictive housing that limits meaningful access to social interaction, physical exercise, environmental stimulation and therapeutic programming, in particular do not place these individuals in longer term restrictive housing." (The Safe Alternatives to Segregation Initiative, Findings and Recommendations for the NDCS dated November 1, 2016).

79. During my tours, I visited with, and reviewed medical files of, NDCS inmates at NCCW, LCC, TSCI, and NSP that have a serious mental illness and who resided in restrictive housing. I have also spoken with and reviewed the medical files of Plaintiffs who suffer from serious mental illness and who have resided in restrictive housing. The experiences these individuals have described and displayed — including exacerbation of psychotic symptoms such as paranoia and hallucinations as well as worsening cognitive functioning — are typical of the reactions I would expect from seriously mentally ill persons exposed to these conditions. Moreover, in speaking with NDCS employees within each of these facilities, inmates kept in restrictive housing do not have the same access to mental health programming as their peers in general population. As noted above, Prisoners E and H, exemplify how an inappropriately restrictive housing assignment can directly cause mental decompensation through his worsening mood swings, mania, and mental decompensation.

H. SUICIDE PREVENTION

80. All of the problems described above increase the risks of self-harm and suicide. During the period from 2001 to 2014, NDCS had a suicide rate of 21 to 100,000 according to a US Department of Justice report.[2] This compares to a nationwide rate of 16 per 100,000 for the same period across all state prison systems. According to the Nebraska Inspector General, there were two suicides in 2018, both at TSCI, one of which was in restrictive housing. (OIG Report 2017-2018 at 80-81.) In both of the 2018 suicides, the OIG noted problems with the frequency and completeness of safety checks in the housing units where the prisoners died. Prison systems that rely heavily on restrictive housing, or on cell lockdowns in general population, create unreasonable risks that prisoners confined to their cells for most of the day will decompensate and engage in self-harm or suicide. This is a risk for all prisoners in such systems, both those who have already developed mental illness, and those who have not yet been identified as mentally ill. While NDCS has written suicide prevention policies, the lack of staffing and treatment resources described above make it impossible for such policies to be implemented effectively.

III. CONCLUSION

81. Based on the information summarized above, it is my opinion that the current state of mental health care services in NDCS poses a substantial risk of serious harm to prisoners who require mental health care. I have reviewed the declarations and

[2] https://www.bjs.gov/content/pub/pdf/msp0114st.pdf

medical files of Plaintiffs who have raised mental health claims in this case. In their declarations Plaintiffs describe problems such as delayed access to care, unnecessary decompensation, indifference to their mental health or diagnoses as it relates to restrictive housing assignments, and the lack of timely psychiatric care. These problems are typical and predictable outcomes of the deficiencies I have described above. Given that there is a waxing and waning aspect of mental illness, prisoners with mental illness are likely to intersect with many of these deficiencies throughout their incarceration.

82. While not all NDCS prisoners will be harmed by these deficiencies in exactly the same way, these systemic problems are susceptible to common systemic solutions, including better staffing, development of new policies and procedures, deployment of more treatment space and other resources and a re-evaluation of segregation practices. The problems described above are systemic in nature and require systemic solutions.

83. The NDCS mental health care system appears to be highly centralized on its face, governed by policies of statewide application. However, equally important in understanding the deficiencies within NDCS mental health care system is the disturbing lack of policy, systems, procedures or practice in a variety of areas described herein. This absence of direction given to frontline NDCS employees in these areas, that may have only been on the job for several months, without receiving sufficient training on how to

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identify, intersect with, and triage mental health symptoms and manifestations, poses a grave risk to the entire inmate population.

84. In my experience as a court expert in other class action lawsuits challenging mental health services in prisons, court orders directed at prison administrators who oversee the entire system can bring about the needed changes to provide relief to the class as a whole, by reducing the risk of harm faced by all prisoners.

I declare under penalty of perjury under the laws of the State of HAWAII that the foregoing is true and correct, and that this declaration is executed at HONOLULU, HAWAII this 14TH day of February, 2019.

Pablo Stewart, M.D.