UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

DENNIS E. JONES 'EL, MICHA'EL JOHNSON, DE'ONDRE CONQUEST, LUIS NIEVES, SCOTT SEAL, ALEX FIGUEROA, ROBERT SALLIE, CHAD GOETSCH, EDWARD PISCITELLO, QUINTON L'MINGGIO, LORENZO BALLI, DONALD BROWN, CHRISTOPHER SCARVER, BENJAMIN BIESE, LASHAWN LOGAN, JASON PAGLIARINI, and all others similarly situated,

Plaintiffs, **Case No. 00-C-421-C**

v.

JON LITSCHER, in his official capacity; GERALD BERGE, in his official and individual capacities; and DOES 1-100, in their official and individual capacities,

Defendants.

DECLARATION OF DR. TERRY A. KUPERS

1. Background and Qualifications. My name is Terry A. Kupers, M.D., M.S.P. (See curriculum vitae, Appendix A). I am a Professor in the Graduate School of Psychology of the Wright Institute in Berkeley and maintain a clinical practice in Oakland, California. I am a Diplomate of the American Board of Psychiatry & Neurology (Psychiatry, 1974, for life). I recently finished a one-year term as President of the East Bay Psychiatric Association; I am a Fellow of the American Psychiatric Association; I am Co-Chair of the Committee on the Mentally Ill Behind Bars of the American Association of Community Psychiatrists; and I am a Fellow of the American Orthopsychiatric Association. I am on the staff of the Alta Bates Medical Center in Berkeley, and serve as consultant to several public mental health agencies.

2. I received a B.A. in Psychology from Stanford University in 1964, with Distinction; an M.D. from UCLA School of Medicine in 1968 where I was elected to Alpha Omega Alpha Honor Society; I have been licensed to practice medicine in the State of California since 1968; I completed Internship at Kings County Hospital/ Downstate Medical Center in Brooklyn in 1969; I completed residency training in Psychiatry at UCLA Neuropsychiatric Institute (NPI), with a year elective at Tavistock Institute in London, in 1972; I did a fellowship in Social and Community Psychiatry (including Forensic Psychiatry) at UCLA NPI from 1972 to 1974; and I received a Masters Degree in Social Psychiatry from UCLA at the conclusion of that fellowship. Between 1974 and 1977 I was an Assistant Professor in the Department of Psychiatry and Co-Director of the Psychiatry Resident Training Program of the Charles Drew Postgraduate Medical School in Los Angeles, and I was a staff psychiatrist and Co-Director of the Outpatient Clinic at Martin

Luther King, Jr. Hospital. From 1977 to 1981 I was staff psychiatrist and Co-Director of the Partial Hospital Program at the Richmond (California) Community Mental Health Center (Contra Costa County Mental Health Services). I have conducted a private practice of psychiatry since 1974, and have been on the faculty of the Wright Institute since 1981.

3. I have written four books, including: Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (Jossey-Bass, 1999); Revisioning Men's Lives: Gender, Intimacy and Power (Guilford Press, 1993); and Public Therapy: The Practice of Psychotherapy in the Public Mental Health Clinic (Free Press, 1981). I am a co-editor of Prison Masculinities (Temple University Press, 2001). I have written over two dozen articles, including "The Mental Health Crisis Behind Bars," Harvard Mental Health Letter, July, 2000; "The SHU Syndrome and Community Mental Health," The Community Psychiatrist, Summer, 1998; "Trauma and Its Sequelae in Male Prisoners," American Journal of Orthopsychiatry, 66,2,1996, pp. 189-196; "Jail and Prison Rape," TIE-Lines, February, 1995; and "Contact Between the Bars: A Rationale for Consultation in Prisons," Urban Health, Vol. 5, No. 1, February, 1976. I wrote a book chapter, "Psychotherapy with Men in Prison," In A New Handbook of Counseling & Psychotherapy Approaches for Men, eds. Gary Brooks and Glenn Good, (Jossey-Bass, 2001). I am on the Editorial Advisory Board of The Correctional Mental Health Report, as well as The Juvenile Correctional Mental Health Report.

4. I have testified in over twenty criminal and civil proceedings, including state and federal courts, regarding jail and prison conditions, their effects on prisoners, and the quality of mental health services. Cases concerning jails include Rutherford v. Pitchess (1977); Hudler v. Duffie (1979); and Branson v. Winter (1981). Cases concerning prisons include Toussaint/Wright/Thompson v. Enomoto, 1983; Gates v. Deukmejian, 1989; Coleman v. Wilson, 1993; Cain v. Michigan Dept. of Corrections, 1998; Bazetta v. McGinnis, 2000; and Everson v. MDOC (ongoing). I have served as a consultant regarding prison conditions and the quality of correctional mental health care to the U.S. Dept. of Justice, Civil Rights Division, and to Human Rights Watch and Amnesty International. I consulted to Amnesty International during their investigations and compilation of the report, "Cold Storage: Super-Maximum Security Confinement In Indiana" (1997).

5. I have been retained by attorneys David Fathi, Ed Garvey, Pamela McGillivray et al. in this matter. My fees are $150 per hour for research, document preparation, meetings and tours, and $300 per hour for depositions and court appearances.

6. I base this Declaration on my training in general psychiatry, social and community psychiatry and forensic psychiatry; my clinical and research experience in all of these fields; my experience as an expert in other cases; my experience as a clinician who has visited correctional facilities and interviewed many administrators, staff and prisoners; my familiarity with the literature of psychiatry and the social sciences; my training as a trainer and consultant in correctional settings; and my extensive clinical practice in my office and in public agencies where I have treated and trained others to treat patients who have been imprisoned, and/or have family members in jail or prison.

7. I toured the Supermax Correctional Institution (SMCI) on July 26, 27 and 28, 2001, in the company of attorneys and Mr. Vincent Nathan. We toured the entire physical plant, including the administration building (B), and entered cells, recreation areas, libraries, dayrooms, visiting rooms, control booths and related areas on A, C, D and E units. I conducted in-depth interviews with Prisoner 1, Prisoner 2, Prisoner 3, Prisoner 4, Prisoner 5, Prisoner 6, Prisoner 7, Prisoner 8, Prisoner 9, Prisoner 10, Prisoner 11, Prisoner 12, Prisoner 13, Prisoner 14, Prisoner 15, Prisoner 16, Prisoner 17, Prisoner 18, Prisoner 19, and Prisoner 20. I also briefly interviewed several additional prisoners during the course of my tour. I spoke with Dr. Apple, clinical psychologist. I returned to SMCI at 10 P.M., walked through the physical plant and entered a cell on A Unit. I reviewed Clinical, Classification, Social Service, Medical and Legal Charts for the prisoners I interviewed plus several others. I reviewed a large number of documents, including the Legislative Fiscal Bureau, Prison Staffing, Supermax, Paper #332; Rules of Department of

Corrections; Wisconsin Legislative Audit Bureau Audit Summary, Report 01-9, May, 2001; Administrative Directive, AD-39.1, Mental Health Screening of Inmate Candidates for Supermax; and Mental Illness Screening Tool for SMCI (DOC-2056, 4/00).

> 8. Based on the tours and interviews I conducted and the files and
> documents I reviewed, I have formed the opinion that many of the prisoners
> confined in the SMCI currently suffer from serious mental illnesses and are
> not receiving the mental health treatment their psychiatric condition
> requires. I have further concluded that confinement at SMCI of prisoners
> suffering from serious mental illnesses, prone to serious mental illness
> and/or prone to suicide is an extreme hazard to their mental health and
> well-being, and causes irreparable emotional damage and psychiatric
> disability as well as extreme mental anguish and suffering, and in some
> cases presents a risk of death by suicide. I have identified seven
> prisoners who should be transferred out of the SMCI on an urgent basis and
> undergo thorough psychiatric examination in a less stressful mental health
> treatment setting. In addition, all prisoners in the SMCI should undergo
> rigorous psychiatric examination and psychological assessment within the
> next one to two months, and those exhibiting significant signs and symptoms
> of serious mental illness and/or suicide risk should be transferred
> immediately to a correctional or secure psychiatric setting where their
> psychiatric condition can be adequately evaluated and they can receive
> competent psychiatric treatment. Monthly re-assessments of all prisoners in
> the SMCI should be conducted to determine which prisoners develop
> psychopathological conditions, and any that do should be transferred to a
> secure psychiatric setting for assessment and treatment.
>
> 9. Confinement in a supermaximum security prison such as the SMCI is well
> known to cause severe psychiatric morbidity, disability, suffering and
> mortality. The prisoners are confined to their cells 23 or 24 hours per day,
> there is very limited social interaction, very sparse possessions are
> permitted, there are very few if any contacts between prisoners, staff
> contact with prisoners is limited mainly to the handing out and collection
> of food trays and disciplinary activities, prisoners eat alone in their
> cells, programming is extremely minimal, discipline is very strict and
> punishments are frequent. Prisoners are left alone to their own devices in
> cells that are often extremely hot and humid. The incidence of suicide
> attempts is quite high. And the prisoners might spend years in this kind of
> near-solitary confinement and enforced inactivity. Sheilagh Hudgins and
> Gilles Cote performed a research evaluation of penitentiary inmates in a
> Supermaximim Security Housing Unit and discovered that 29% suffered from
> severe mental disorders, notably schizophrenia. ("The Mental Health of
> Penitentiary Inmates in Isolation," Canadian Journal of Criminology,
> 177-182, April, 1991.)
>
> 10. Psychiatrist Stuart Grassian examined a large number of prisoners
> during their stay in segregated, near-solitary confinement units and
> concluded that these units, like the sensory deprivation environments that
> were studied by psychologists in the 1960's, often induce psychosis,
> especially in prisoners who have histories of mental illness or a
> predisposition to psychiatric breakdown. Even prisoners who do not become
> frankly psychotic frequently report a number of serious psychiatric
> symptoms, including but not limited to: a. Massive free-floating anxiety;
> b. Hyper-responsiveness to external stimuli, including a startle response;
> c. Perceptual distortions and hallucinations in multiple spheres (auditory,
> visual, olfactory); d. Derealization experiences; e. Difficulty with

> concentration and memory; f. Acute confusional states, at times associated
> with dissociative features, mutism, and subsequent partial amnesia for those
> events; g. The emergence of primitive, ego-dystonic aggressive fantasies;
> h. Ideas of reference (paranoia) and persecutory ideation, at times
> reaching delusional proportions; i. Motor excitement, often associated
> with sudden, violent destructive or self-mutilatory outbursts; and j. Rapid
> reduction of symptoms upon termination of isolation. (Stuart Grassian,
> "Psychopathological Effects of Solitary Confinement," American Journal of
> Psychiatry, 140:1450-1454, 1983.
>
> 11. This constellation of symptoms in prisoners who have been confined for a
> significant period in punitive segregation or supermaximum security units
> has been unofficially termed "The SHU Syndrome" ("SHU" is an acronym for
> Security Housing Unit, the name by which many supermaximum security units
> are known). While this syndrome has not yet been granted official
> recognition as a diagnostic category in the Diagnostic and Statistical
> Manual of the American Psychiatric Association (official diagnoses such as
> paranoid delusional disorder, dissociative disorder, schizophrenia, panic
> disorder and so forth are employed to describe the equivalent clinical
> picture), it is widely recognized by correctional medical and mental health
> professionals as an omnipresent hazard of supermaximum security confinement
> with very serious sequelae.
>
> 12. If many prisoners who have no history of serious mental illness and who
> are not especially prone to psychiatric decompensation (breakdown) develop
> this degree of symptomatology and disability, the experience of prisoners
> who do have a history of serious mental illness or suicide potential is far
> worse. Indeed, it has been my experience, from tours and clinical
> interviews in supermaximum security units in five states, that the
> conditions that cause SHU Syndrome in relatively healthy prisoners cause
> psychotic breakdowns, severe affective disorders and suicide crises in
> prisoners who have histories of serious mental illness, as well as in
> prisoners who never suffered a breakdown in the past but are prone to break
> down when the stress and trauma become exceptionally severe. Indeed, there
> are striking similarities between textbook descriptions of Schizophrenia,
> Bipolar Disorder, and other major mental illnesses and the list of symptoms
> described by Grassian and others in prisoners confined in supermaximum
> security units. Many prisoners are not capable of maintaining their sanity
> in such an extreme and stressful environment, and a frighteningly high
> number attempt suicide.
>
> 13. The Wisconsin DOC is well aware of the expectable psychiatric effects
> of longterm supermaximum security confinement. The Wisconsin Legislative
> Audit Bureau Summary on Prison Health Care (Report 01-9, May, 2001) states:
> "Based on the number of inmates for whom psychotropic medications have been
> prescribed, 2,642 inmates have a diagnosed mental illness. Approximately 15
> percent of inmates currently at Supermax are receiving psychotropic
> medications." The Joint Committee on Finance, Paper #332, Prison Staffing –
> Supermax (DOC – Adult Correctional Facility) Budget Summary, May 17, 1999,
> contains a summary of some National Institute of Corrections observations
> about the operation of supermax facilities: "Minimization of human contact
> may result from the use of technologies such as cameras; remote listening
> devices; and remote control devices for televisions, water, and lights…..
> Inmates displaying self-destructive, assaultive, or aberrant behavior often
> end up being treated solely as disciplinary cases and, in some corrections
> systems, become prime candidates for extended control. Other inmates

> become mentally ill while in the extended control environment…. Insofar as
> possible, mentally ill inmates should be excluded from extended control
> facilities. Each inmate being considered for such a facility should have a
> mental health evaluation. Although some mentally ill offenders are
> assaultive and require control measures, much of the regime common to
> extended control facilities may be unnecessary, and even counterproductive,
> for this population" (p. 4)
>
> 14. WDOC Administrative Directive AD-39.1, May 8, 2000, requires "The
> Division of Adult Institutions (DAI) will conduct a mental health review of
> each inmate that is being considered for a transfer to the Supermax
> Correctional Institution (SMCI) to monitor the movement of inmates with a
> severe mental illness to such a controlled environment." The "Mental
> Illness Screening Tool for SMCI" (DOC-2056, 4/00), which must be filled out
> and signed by a psychiatrist prior to the transfer of a prisoner to SMCI,
> includes several questions about the prisoner's mental health history and
> status. The form includes a tripartite list of conditions, the first part
> entitled "General Clearance for SMCI," the second "Restricted Movement to
> SMCI" and the third "Conditional Transfer to SMCI." Listed under
> "Restricted Movement to SMCI" are "Major Depressive Disorders," "Bipolar
> Disorders," "Borderline Personality Disorders," "Dissociative Disorders,"
> "Schizophrenic/Psychotic Disorders," "Mental Disorders due to a medical
> condition," and "History of severe self-abusive behaviors." The list is
> followed by this qualification: "This list is not exhaustive. This is to
> provide direction to clinicians to assure appropriate placement for the
> mentally ill at the Supermax." When I spoke to Dr. Apple, a clinical
> psychologist at SMCI, she assured me that she and other members of the
> mental health staff make every effort to transfer prisoners exhibiting signs
> and symptoms of serious mental illness out of the SMCI.
>
> 15. Some features of supermaximum security units are typical of the genre.
> For example, there is extremely limited social interaction, almost total
> idleness, the prisoners are cell-fed, almost every aspect of daily life is
> controlled and monitored, remote controlled doors minimize human contact
> even further, there very limited out-of-cell activities and there is little
> if any natural light and access to the outdoors. There are also features
> unique to each supermaximum security unit and each Department of
> Corrections, and some of these unique features serve to mitigate the
> negative psychiatric effects of the near-solitary confinement and idleness,
> whereas others of these unique features serve to aggravate the psychiatric
> damage and suffering. Several features of the SMCI, by structural design as
> well as functional program, make life within the unit especially difficult
> to bear and greatly enhance the psychiatric damage as well as the general
> suffering of prisoners. I will list a few features of the SMCI that are
> uniquely damaging to the mental health of its residents, particularly those
> suffering from serious mental illness. I emphasize that this is not nearly
> a complete list:
>
> 16. At the SCMI the exercise yard is so unappealing to prisoners that on the
> four or five units I toured well over ninety percent of prisoners "refused"
> to go to the yard, even when they were given permission to do so. A glance
> at the logs kept by officers confirms that at least ninety percent of the
> prisoners routinely refuse their time on the yard. I have never seen this
> extent of refusal. In most supermaximum security units the prisoners crave
> to go to the yard, since it is almost the only time they are able to leave
> their cell. Even in supermax facilities, prisoners are permitted

> out-of-cell exercise, the rationale being that the need to get out of their
> cells and exercise is an important prerequisite to sound physical and mental
> health. Men who are confined in prison need access to a yard and an
> opportunity to run or play with a ball. This is not merely a matter of
> exercise, though that is certainly important. It also has to do with the
> fact that these men, on average, express themselves mainly through their
> body and maintain a sense of well-being by exerting and challenging
> themselves physically. A man who does not opt to make use of his time on
> the yard is likely a depressed man – the depression is reflected in the
> absence of physical activity, but then secondarily the physical somnolence
> actually causes lethargy and depression (as well as hypertension, diabetes,
> heart disease and so forth.) If the prisoner was only going to be in the
> SMCI for a few weeks or a month the inactivity might be tolerable. But with
> many of these prisoners spending many months alone in a cell, the physical
> and mental health effects are very detrimental.
>
> 17. I found the yards in each unit that I toured at the SMCI entirely
> unappealing. They are little more than a large cell, constructed of
> concrete (walls, floor and ceiling), with no real windows, even though there
> is a space high up on the external wall where, on some but not on all of the
> units' yards, one can catch a small glimpse of the sky. But in the summer
> the yards are suffocatingly hot, humid and uncomfortable (I am told they are
> freezing in the winter, and no more likely to be utilized then). Most
> prisoners are only permitted on the yard alone (some prisoners at the
> highest level are permitted to be on the yard with another prisoner, but
> almost all of the prisoners who suffer from serious mental illness fail to
> attain that level). The athletic equipment is extremely inadequate. When I
> ask prisoners why they do not utilize the yard more, they explain that
> besides the unbearable heat and humidity and the fact there is nothing to do
> on the yard, they are subjected to humiliating searches each time they go to
> the yard and return, and their cells are often "torn up" and searched when
> they leave. For these and other reasons, they tell me "it's not worth it,"
> and most prisoners spend 24 hours per day in cell-confinement. In other
> words, for most it would be all the same were there no yard at all. I have
> never toured a supermaximum security unit where the yards are so
> infrequently employed, and the effect is especially harmful to prisoners
> with serious mental illness.
>
> 18. The architectural design of the SMCI, including the "boxcar doors,"
> creates a greater degree of forced isolation than exists in any other
> supermaximum security units I have toured. "Boxcar doors" have a solid
> metal construction and slide on tracks. There are no windows, not even
> grating, except a small metal slot in the middle of the door, a food slot,
> and a small slot near the bottom of the door through which leg irons or
> shackles are affixed. The door is entirely constructed of metal. There are
> no windows in the cells (there is a small glass slot at the very top of the
> outer wall of the cells where the prisoner can get a glimpse of a small
> sealed skylight through a translucent outer ceiling cover). The effect is
> that the prisoner is essentially encased in metal and concrete just about 24
> hours per day. In addition, in the Alpha Unit, where the lowest level of
> the Level program is housed, the architectural construction is even more
> damaging psychologically. The prisoners' cells do not even open onto a
> hallway traversed by officers. Instead, pairs of cells are located on a
> small hallway, once removed from the traversable hallway, and each of the
> pair of cells is separated from the other by the small side-passage. So the
> officers do not even walk past the prisoner's cell unless they have a

> specific reason to do so. The effect again is to isolate the prisoner even
> further, and cut off his contact with all other prisoners and with the
> staff. It is impossible for the prisoners to see what is occurring in areas
> adjacent to their cells, and the sound is either muffled by the heavy walls
> and boxcar doors, or at another moment the sounds swell into a cacaphony of
> loud yells and slamming gates. I have never seen this degree of purposely
> designed isolation interspersed with maddening noise. The prisoners tell me
> they feel like they are entombed. Obviously this is one important reason so
> many prisoners describe to me the intense panic, claustrophobia and
> inability to breathe that they feel in this unit. Any prisoner who is prone
> to emotional instability of any kind will be more likely to fall apart in
> this kind of extreme setting. Other prisoners tell me they have great
> difficulty containing their rage in such a setting. One does not have to be
> a psychiatrist to see why so many prisoners decompensate or suffer nervous
> breakdowns in this setting. In the Maximum Control Facility at Westville,
> Indiana, in the Indiana Department of Corrections, the cells also have
> "boxcar doors;" but in recognition of and partial compensation for the
> near-total isolation and deadening quiet created by the doors, prisoners in
> that section of the prison are permitted more hours out of their cells than
> are prisoners in units without the boxcar doors. No such compensation is
> offered at SMCI.
>
> 19. In Prison Madness (1999), I explored the importance of quality family
> visitation in terms of the prisoner's mental health. The most striking
> feature of the literature about the benefits of visits for prisoners,
> especially prisoners suffering from serious mental illness, is that all the
> research demonstrates that the better the quality of visitation throughout a
> prisoner's incarceration, the better the effects on the prisoner and his or
> her mental health. Conversely, the denial of visitation has a devastating
> effect on prisoners' mental health, particularly if the prisoner is already
> seriously mentally ill.
>
> 20. At SMCI visiting is by video monitoring only. Most prisoners I
> interviewed told me they never receive visitors. Either their visitors live
> too far away (Milwaukee is over three hours drive), or they refuse to permit
> their family and friends to come to the facility when they are unable to
> even be in the same area of the prison (the visitors enter video booths near
> the entrance of the prison, whereas the prisoner is taken to a booth with
> video monitors in close proximity to his cell area). I observed one of
> these "video visits" during my tour of SMCI. A fairly representative
> prisoner with a serious mental illness told me he can't actually see his
> family through the video screen anyway, and without literally seeing them
> (not on a video monitor) he cannot know how they are. The families of SMCI
> prisoners likewise tell me they do not visit often or at all because they
> cannot get a close enough glimpse of their loved one to know if he is OK.
> Prisoners tell me that the reception through the monitors is unpredictable
> and often poor, and prisoners and visitors with poor eyesight cannot even
> see each other through the small monitor that is placed on the far side of a
> visiting booth. Prisoners I interviewed who suffer from paranoid delusions
> presented more idiosyncratic and bizarre reasons for refusing visits, for
> example more than one told me that since they cannot actually see their
> visitors, not even on the other side of a breakproof glass, they cannot be
> certain it is really their family member and not an altered image. In a
> psychiatric hospital, when an acutely disturbed patient creates a commotion,
> the staff attempts to bring the family to visit the patient, perhaps to do a
> family session or social work interview to determine what might be the

> matter. In other words, we try to encourage the family to visit the
> disturbed patient and maintain close contact. At SMCI, the very opposite
> occurs. Far from the family visiting the disturbed prisoner often, the
> location of the prison and the arrangements for video visitation actively
> discourage prisoners' families from visiting. On some days visits are
> permitted only in the morning, and for a family that lives over three hours
> away in Milwaukee, and cannot afford to stay in a hotel, it is nearly
> impossible to arrive at the prison at 8:00 or 9:00 A.M. to see their son.
> For these and other reasons, there were only a very few visits occurring
> while I passed through the visiting room on each of the three days I visited
> SMCI. Whether or not this is the intent of the visiting policies, the
> effect is that prisoners whose mental health depends on regular quality
> visits with their families receive very few visits, if any.
>
> 21. A large proportion of the prisoners I interviewed could not give me a
> good explanation of the reasons they were transferred to SMCI. Many could
> not tell me when they would be released, and most could not tell me what
> they would have to do in order to gain their release from SMCI. In
> addition, I found a disturbingly high proportion of prisoners at Level 1 in
> Alpha Unit who had been there for many months – in other words they were
> not progressing along the expected levels – and these are the very prisoners
> who exhibit the most severe signs and symptoms of serious mental illness.
> The problem is that prisoners with serious mental illnesses need to have
> clear expectations what to expect, and need to have realizable goals they
> can attain in an incremental way. If they are left in the lowest level of a
> step level program, they despair of ever moving on and soon their
> frustration turns to rage and destructive behavior follows. I met quite a
> few prisoners suffering from serious mental illnesses who had been in the
> Alpha Unit for much longer than expected, sometimes many months. The
> prisoner with a serious mental illness has too short an attention span or
> too little capacity to behave appropriately for a sufficient time to
> graduate from the program, and then the repeated failures and the absence of
> attainable goals cause him to despair and eventually destroy his own
> progress and act out in destructive and/or self-destructive ways. Prisoners
> who have this kind of emotional problem need to be moved to more humane
> conditions and helped to accomplish realistic program and treatment goals,
> no matter what security level they require.
>
> 20. Meaningful activities are a requirement for the maintenance of mental
> health. Prisoners in the SMCI are almost absolutely inactive all day long.
> The ones who can read do so, but I met many who are either too agitated to
> concentrate (instead they pace constantly or clean their cells incessantly)
> or they are illiterate and would not be able to read even if their agitation
> calmed sufficiently for them to concentrate. One of the reasons prisoners
> with mental illnesses do as poorly as they do in the SMCI is that they often
> lack the emotional resources to calm down, read and write to loved ones.
> For these and related reasons, the psychiatric condition of prisoners with
> mental illness tends to deteriorate in supermaximum confinement, and that is
> why so many of them remain at the lowest level of the level system. Quite a
> few told me during my tour that they did not think they would ever get out
> of Alpha Unit.
>
> 21. The lights are a huge problem in the SMCI. The lights in prisoners'
> cells are kept on all night long. The prisoner can adjust the light to one
> of two intensities, but he cannot turn the light entirely off. He is also
> not permitted to cover his face while sleeping. I conducted a tour of Alpha

> Unit at 10:00 P.M. to assess the effect of the lights on the prisoners'
> sleep. I was surprised to see that even the lower light setting put out
> sufficient light to read by -- all night long -- and there was nowhere to
> hide from the glaring light. I definitely would not be able to sleep in a
> cell with that degree of light on all night. And officers make rounds
> regularly and wake prisoners who have covered their faces or are not
> sleeping in the prescribed position. Many prisoners report they cannot
> sleep because of the constant lights, because there are frequent orders for
> a prisoner to change his position in bed, or because doors are slammed open
> and shut all night. In addition, the lighting causing a constant confusion
> of day and time, and this adds to the disorienting effect - a further
> serious hazard for people prone to mental illness. The net effect is that
> many prisoners barely sleep, if at all. A large majority of prisoners I
> spoke to complained of sleeplessness and chronic headaches (very likely
> linked with the lights being on all of the time). It is well known that
> sleep deprivation greatly exacerbates psychosis, depression and other forms
> of mental illness.
>
> 22. I have mentioned these five aspects of confinement in the SMCI – low
> utilization of the yards, isolating features of the architecture including
> "boxcar doors," visiting by video monitors, confusion about reasons for
> being confined in SMCI and what needs to happen for a prisoner to win his
> release, and lights that are on all night – as illustrations of uniquely
> hazardous aspects of confinement in the SMCI for prisoners who suffer from
> serious mental illnesses or are prone to psychiatric decompensation
> (breakdown) or suicide. A lack of meaningful exercise and activity, a lack
> of quality visitation, a lack of meaningful social interactions, sleep
> deprivation caused by lights that are always on, and uncertainty about one's
> fate are all known exacerbating factors in the etiology and continuation of
> a state of psychosis or disorientation.
>
> 23. I should mention one other special risk factor at SMCI: heat
> prostration. There have been several heat-related deaths in Wisconsin
> already this summer, and one is reported to be the death of a mental patient
> who was taking psychiatric medications. Psychiatric medications are known
> to be associated with heat-related deaths, probably because psychiatric
> medications interfere with the body's ability to regulate temperature.
> There have been many heat-related deaths around the country in patients,
> including prisoners, who have been taking psychiatric medications. The
> temperature in the SMCI, particularly inside the cells, was very hot in when
> I visited in July. There is real danger confining prisoners with mental
> illness who are taking psychiatric medications during the hottest part of
> the summer, in a facility in which the temperature is not adequately
> regulated.
>
> 24. At this point, instead of detailing further the design and program
> features of the SMCI that cause an inordinate amount of emotional pain,
> suffering and breakdown, I will proceed with brief descriptions of
> illustrative cases of prisoners who suffer from serious mental illnesses and
> should not be confined at SMCI.
>
> 25. There is much discussion in the clinical mental health charts I read at
> SMCI about "manipulation" and "malingering." For example, several of the
> cases I reviewed for this declaration involve prisoners who have been
> repeatedly admitted to psychiatric hospitals, prescribed strong
> antipsychotic and mood-regulating medications, and been treated for years

> for a serious mental illness. Yet one or another psychiatrist or
> psychologist continues to doubt in the chart that the individual is truly
> disturbed - the notion is advanced that the individual is "merely
> manipulating." In order to help with this discussion, I will cite a
> research criterion David Lovell, Kristin Cloyes and their team ("Who Lives
> in Super-Maximum Custody? A Washington State Study," Federal Probation,
> 64-2, December, 2000. p. 33) proposed as an operational definition of a
> prisoner with a serious mental illness in a supermaximum security prison.
> They propose five indicators, any one of which provides reasonably strong
> evidence of a serious mental disorder: Confirmed serious mental illness by
> evaluation of a mental health professional with the assessment recorded
> electronically; multiple acute care admissions (at least three) to an acute
> care facility at the state penitentiary; case management notes with mention
> of hallucinations, delusions, and psychotropic medications in the chart;
> mental health residency, 30 or more days, in one of the department's
> residential mental health units; or an electronically recorded diagnosis of
> a psychotic disorder, bipolar disorder, major depression, dementia, or
> borderline personality. These research criteria can be helpful in
> determining when to finally classify a prisoner's longterm emotional problem
> as qualifying as a serious mental illness.
>
> 26. Manipulation and malingering are definitely problems in a correctional
> mental health program. We need to be wary of manipulations. On the other
> hand, when we are too wary, we miss prisoners who are in serious need of
> psychiatric help. In fact, when a correctional system does not have
> sufficient staff for them to spend enough time with each patient - for
> example a hurried clinician might have to visit prisoners at the cell doors
> even though it is not a confidential setting - then prisoners discover that
> they have to manipulate to a certain extent in order to get the attention
> they really need. A truly suicidal prisoner quite often feels he has to
> manipulate in order to make a staff member pay attention to his call for
> help. There have been many cases where staff who are overly wary about
> letting themselves be manipulated ignore the cry of a prisoner for help and
> the prisoner goes ahead and commits suicide.
>
> 27. When I toured the Supermax Correctional Institution July 26 through
> July 28, 2001, I interviewed twenty prisoners in some depth and a half dozen
> others is less detail, and administered a modified version of the Brief
> Symptom Checklist (SCL-90-R). The SCL-90-R is a standard structured
> psychological assessment instrument containing ninety (90) questions. I
> modified it by adding seven (7) additional questions that extend the utility
> of the instrument in the assessment of prisoners confined for lengthy
> periods in supermaximum security units. Almost all of the prisoners I
> interviewed exhibited signs of severe stress and emotional disturbance as
> evinced by my interview, a mental status examination, a review of clinical
> and disciplinary charts, and the administration of the SCL-90-R Brief
> Symptom Checklist. A large number of the symptoms they endorsed fit the
> picture of "The SHU Syndrome," with varying levels of intensity and
> disability. But at least seven of the prisoners I interviewed were
> suffering from serious mental illnesses, including psychotic disorders and
> severe affective disorders. I will proceed to summarize those clinical
> presentations.
>
> Prisoner 1
>
> 28. This 25 year-old Latino man has been at SMCI since February 28, 2001.

> He reports he hears voices constantly in spite of taking his prescribed
> medication, Thorazine 300 mg. twice per day (this is a very strong daily
> dose of an antipsychotic medication). He has a history of serious mental
> illness for at least six years, with a note on his DOC clinical chart from
> December 14, 1995 by Dr. Jay Hartz at Green Bay Correctional Institution,
> assigning him a diagnosis of Paranoid Schizophrenia. Dr. Hartz prescribed
> Haldol (a powerful antipsychotic medication), 10 mg., Elavil 100 mg., and
> Cogentin 1 mg. – all at bedtime. On the Screening Tool for SMCI, he was
> assigned a diagnosis of "Chronic Paranoid Schizophrenia vs. Major Depression
> with Psychotic Features." A review of his chart on April 3, 2001, lists
> medication orders dating back to 1995 that include the antipsychotic
> medications Thorazine, Haldol, Quetiapine, Seroquel, Loxitane, Risperdal,
> and Olanzapine. Dr. Maier, the psychiatrist at SMCI, has been prescribing
> increasing doses of Thorazine since April 24, 2001, until he reached the
> current dose of 300 mg. twice a day. Prisoner 1 reports to me that he
> cannot sleep because he "sees things," including "demons moving around the
> floor and climbing up my bed" all night. He hears voices commanding him to
> kill himself or hurt others. He reports his most recent suicide attempt
> occurred a couple of years ago, prior to his transfer to SMCI, when he tried
> to hang himself with his bedsheet. He paces in his cell constantly. He
> tells me he has paranoid thoughts that the guards are out to get him. He is
> very anxious and distrustful. He has spent almost all of his time in the
> SMCI in Alpha Unit, on a very restricted program, and was only moved to
> Level Two 35 days prior to our interview. He endorses strongly (#4 on the
> SCL-90-R): perceptual distortions, and hearing voices that other people do
> not hear. He tells me that all of these symptoms have worsened
> progressively since his transfer to SMCI. On mental status examination he
> exhibits flat and angry affect, some tangential thinking, auditory
> hallucinations, internal pre-occupation, bizarre gaze, concreteness and
> several of Schneider's First Rank Symptoms of Schizophrenia, including
> thought insertion and the belief others are reading his mind. Thus Prisoner
> 1 exhibits a clear clinical picture of Paranoid Schizophrenia that has been
> diagnosed and treated with powerful antipsychotic medications in the
> Wisconsin DOC since at least 1995. Still he was transferred to the SMCI in
> February, 2001; and since being transferred the psychotic symptoms have
> worsened. He continues to suffer from auditory hallucinations in spite of
> being prescribed a relatively high dose of Thorazine. He is obviously quite
> disturbed and very dysfunctional. The failure of his auditory
> hallucinations and massive anxiety to respond better to relatively high
> dosages of psychotropic medications is probably due to the continuing stress
> of confinement in SMCI and the absence of an adequate mental health
> treatment program.
>
> Prisoner 2
> 29. Prisoner 2 is a 23 year-old White male who has been admitted to the
> SMCI twice, in February, 2000 and again in February, 2001. He says he had
> been committed to the Mendota Mental Health Institute (MMHI) as
> Not-Guilty-By-Reason-of-Insanity. By his own report, he has been diagnosed
> at various times as Schizoaffective, Bipolar, Obssessive-Compulsive
> Disorder, Borderline Character Disorder, Antisocial Personality Disorder and
> Histrionic Personality Disorder. He has attempted suicide on multiple
> occasions. He is currently prescribed the tranquilizer, Librium, the
> antidepressant, Paxil, and the mood regulating medication, Depacote.
> Prisoner 2 tells me he has not been given a good explanation why he is at
> SMCI, he has not been convicted of a violent crime, and he believes he
> should be in a mental hospital. He claims most of his infractions have been

> for spitting, cutting himself, and threatening. Most of his psychiatric
> signs and symptoms have become progressively aggravated by confinement in
> SMCI. He feels his mood cycles are getting worse, as is his despair. He is
> thinking quite a lot about ending his life. After one suicide attempt
> inside SMCI, he tells me he was punished for misuse of property. He has
> never reached Level 3, and is often returned to Level 1 in Alpha Unit for
> minor infractions or for attempts on his own life. He is unable to sleep
> because of the lights being on all night, and he is quite agitated. He
> describes constant paranoid ideas, worsened by lack of sleep. He has
> suffered cell extractions, and he fears he will be in SMCI forever because
> his psychotic symptoms prevent him from advancing in the level system. On
> May 1 he was extracted from his cell, and he alleges a stun gun was utilized
> in the process, even though he was taking psychiatric medications at the
> time. He claims he was lying on the floor, unresponsive, because he was
> experiencing a panic attack, when they used the stun shield on him. He says
> he has also been placed in the restraint chair and held in the observation
> cell – he describes these experiences as terrifying.
>
> 30. Prisoner 2 describes the mental health care in SMCI as quite
> inadequate. If he puts in a request to see a mental health worker, they
> will come to see him after 4 or 5 days, and then only for a few minutes. If
> he complains of a crisis, a crisis worker comes to see him, but only to ask
> if he is suicidal. He does not report when he is suicidal because he is
> afraid he will be punished or strapped down. He talks to other prisoners
> through a vent. He daydreams all day. He tries to read, but cannot because
> he is unable to concentrate, so he paces constantly and cleans his cell
> repetitively. He is always terrified the doors will open and he will be
> attacked by officers. He believes he is decompensating, and his mental
> illness is made worse by the fact he gets no answers to his questions about
> when he can get out of the SMCI. His family never visits because they live
> 4 1/2 hours away. And he would prefer they not visit because visits by
> video are so alienating. He does not go to the recreation yard, even if he
> is permitted, because it is so hot and humid that he feels like he is going
> to suffocate. In Alpha unit, where he spends most of his time because his
> symptoms prevent him from gaining a higher level, he feels the officers are
> mean, for example throwing his food tray on the floor when they become
> impatient with him. He tells me the compulsive symptoms are getting worse.
> He fills in his calendar over and over, runs the water in his sink and
> flushes the toilet repetitively. He tells me the symptoms were much
> improved when he was at MMHI, he believes largely because cell confinement
> at SMCI drives him crazy whereas he was permitted out of his cell at
> Mendota.
>
> 31. In the clinical chart, there are notes opining that Prisoner 2 suffers
> from Borderline Personality Disorder and is manipulative (May 17, 1999 – Dr.
> Andrew Heritch); interspersed with orders for Lithium. A February 5, 1998
> psychiatric examination by Dr. Rubin contains a diagnosis of Schizophrenia,
> the antipsychotic medication Haldol and the mood regulator Valproic Acid
> are prescribed; and an 8/03/97 Psychiatric Evaluation at Wisconsin Resource
> Center contains a report of psychological assessment stating that the MMPI
> profile is consistent with a thought disorder with paranoid features. While
> there are several clinical opinions that Prisoner 2 does not suffer from a
> serious mental illness, this is not a credible diagnostic impression. Not
> only has he been diagnosed too many times with a very serious mental
> illness, but also his psychiatric condition has improved when he was in
> treatment while his condition and behavior have deteriorated when he has

> been in SMCI. This man suffers from very severe mental illness, and has met
> all criteria for the diagnosis of serious mental illness for quite a few
> years, including treatment with antispsychotic and mood regulating
> medications with good therapeutic effect. In the SMCI, his condition has
> deteriorated significantly, he has suffered terribly, he is clearly unable
> to advance in the level system because of his psychiatric disability, and
> then he tells me he is repeatedly subjected to harsh punishments for
> self-destructive acts and rule violations he is incapable of avoiding.
>
> Prisoner 3
> 32. Prisoner 3 is a White seventeen year-old young man who entered SMCI on
> April 9, 2001, allegedly for biting during a cell extraction. He tells me
> he has attempted self-hanging with serious suicide intention on three
> occasions. He reports the diagnoses he has been given include Bipolar
> Disorder, Multiple Personality, Depression, and Schizophrenia. He has had
> behavior problems and has had to be extracted from his cell at Prairie Du
> Chien for covering his window. He has been prescribed the anti-depressant
> Celexa, but could not tolerate the side effects. He was disruptive and on
> July 4, he tells me, he set fire to his cell. It is very interesting that
> he had almost no infractions at Prairie Du Chien prior to the fire, but
> since arriving at SMCI he has been written up fifteen times and I found him
> clad in a protective vest. He tells me it is very difficult to have the
> psychologist come to see him. He refuses to tell staff how suicidal he
> feels because he is convinced they will not spend any time talking to him
> but will rather place him in a strip cell. He strongly endorses on the
> SCL-90-L: headaches; trouble concentrating, feeling lonely and blue,
> worrying too much about things; trouble falling asleep; feeling tense or
> keyed up; thoughts of death or dying; awakening in the early morning;
> getting into frequent arguments; and feelings of guilt.
>
> 33. Prisoner 3's clinical chart documents chronic, severe mental illness,
> dating at least to 1997 with Attention Deficit Disorder. His mother was
> schizophrenic, his father alcoholic, and his childhood was chaotic. A
> psychiatric evaluation at Mendota Mental Health Institute dated May 20,
> 1997, reveals that he had been admitted to Charter Hospital in California at
> age nine, assigned a diagnosis of depression, and was prescribed an
> antidepressant. He was also prescribed the antipsychotic agent, Serentil,
> at approximately the same time. He was subsequently treated again for
> depression. There are notes in the chart claiming he is manipulative, and
> then there are other signs of serious depression. There is at least one
> very serious suicide attempt by hanging on 9/2/00. Two or three years ago
> he was reported to have been hearing voices, with no follow-up in the chart.
> He was also diagnosed as psychopathic by Dr. Caton Roberts in 1996, but on
> the other hand he was diagnosed as early as 9 years of age as possibly
> suffering from Bipolar Disorder. In any case, his chart is thick and there
> are many diagnoses of serious mental illness, especially depression. There
> is much description of suicidal ruminations, he has been repeatedly placed
> on clinical observation or monitoring by the mental health staff, and
> psychological assessment on September 22, 2000, and at other times,
> indicates strong signs of depression. On mental status examination I
> discovered very flat affect, psychomotor retardation, hopelessness,
> anhedonia, worthlessness and other signs and symptoms of serious affective
> disorder. The harsh conditions in the SMCI and the lack of meaningful
> activities are greatly exacerbating this young man's chronic and serious
> mental illness, making his prognosis very grave.
>

> Prisoner 4
> 34. Prisoner 4 is a 22 year-old White man who began his first period of
> adult incarceration at age 17, and entered the SMCI in November, 1999. He
> has been confined in the Alpha Unit, Level 1, for that entire time, failing
> to raise his Level. He is considered assaultive, and is currently taking no
> psychiatric medications. He is not certain why he was sent to SMCI, but
> fears he was sent there because he won a lawsuit wherein he successfully
> claimed excessive force. He believes the officers do not want him to get
> out of the most restrictive Level 1, and they send officers to "mess" with
> him to make certain he will be given further infractions. He never receives
> visits. He sees mental health workers occasionally. He experiences
> auditory hallucinations off and on, but not currently. He says he is very
> depressed. The light being on all the time causes him to be angry and
> causes headaches. He does not sleep well, and the lack of sleep makes him
> lose control all the more. He feels entirely incapable of controlling his
> anger, and he complains he is always anxious and pacing. He cleans his cell
> compulsively and constantly. He was at MMHI, where he reports he was much
> less anxious and he feels he was better behaved, but he believes the staff
> there thought he was too ill-behaved to keep in the unit. In the past he
> was prescribed Imipramine (an anti-depressant), Lithium (a mood regulator),
> Risperdal (a powerful antipsychotic) and Valium (a minor tranquilizer). He
> believes the combination of psychoactive medications helped him quite a bit
> and he was less anxious and much better able to control his anger and
> behavior; but the psychiatrist discontinued the medications. Immediately
> after the psychiatric medications were discontinued he tells me he became
> more assaultive and anxious, and experienced much more intense pacing and
> anxiety. He feels he is caught in a never-ending cycle of no-wins, whereby
> his anxiety and lack of control cause him to misbehave, he suffers cell
> extractions and becomes even angrier, and he is never released from the
> unbearable situation that causes him to misbehave. He believes the staff
> want to kill him, and he will never get out of the SMCI. He says he has
> nothing to look forward to, and no motivation to improve his behavior.
>
> 35. On the SCL-90-R Brief Symptom Checklist, Prisoner 4's endorsements
> include at the level "extremely:" losing ability to feel or react
> emotionally or care about things; feeling easily annoyed or irritated;
> feeling that most people cannot be trusted; feeling that you are watched or
> talked about by others; awakening in the early morning; sleep that is
> restless or disturbed; having urges to break or smash things; getting into
> frequent arguments; feeling so restless you couldn't sit still; and the
> feeling that something bad is going to happen to you. In Prisoner 4's
> clinical chart there is some disagreement among clinicians about his
> diagnosis. He is described as impulsive and out of control. Yet he is also
> described as having racing thoughts and being hyperactive – signs of Bipolar
> Disorder. He is considered a good candidate for mental health treatment, he
> is diagnosed psychotic and Bipolar and he is prescribed antipsychotic
> (Loxitane, Risperdal) and mood regulating medications. And at another time
> he is approved for transfer to SMCI. He reports he was considered for a Not
> Guilty by Reason for Insanity determination in 1998, and then he was
> prescribed Risperdal and Depacote by Dr. Maier at SMCI in August, 2000. He
> has received many disciplinary infractions. He has attempted to harm
> himself many times. Clearly he suffers from a serious mental illness and
> should not be in SMCI where he repeatedly gets into trouble and says he
> never advances in the Level system beyond the first level. He has undergone
> a large number of cell extractions and been restrained and/or kept in
> observation many times. It is clear that he improves with mental health

> treatment and psychotropic medications, whereas when he is left untreated
> and confined in SMCI his mental condition deteriorates markedly and he
> accumulates many disciplinary infractions. I believe Prisoner 4 suffers
> from a Bipolar Disorder and should be tried on mood regulating and
> antipsychotic medications in a mental health treatment unit. It would be
> cruel and unconscionable to maintain him at SMCI, where the stressful
> conditions are known to precipitate further bouts of serious mental illness.
>
> Prisoner 5
> 36. This 42 year-old Mexican-American man was transferred to SMCI in
> November, 1999, when the facility was opened. He had no history of
> psychiatric illness nor mental health treatment prior to entering SMCI.
> Currently he complains of severe depression, acute suicidality, and
> generalized anxiety with episodes of severe panic. He tells me he has not
> eaten for a week, he denies that he is on a hunger strike, and while he does
> suffer from moderately severe gastritis, he denies that his physical malady
> prevents him from eating. He admits to severe depression, and with a little
> probing tells me he is not interested in eating because he wants to die. I
> ask if he is suicidal and his eyes display tears and sadness. He states he
> has been contemplating suicide for some time and is currently intent on
> ending his life. He says he has spent an inordinate amount of time in Alpha
> Unit on Level 1, being promoted to Level 2 only one month ago. When he
> reported panic attacks and insomnia to psychiatrist Dr. Fulton a year ago,
> Dr. Fulton prescribed Diazepam (Valium), a minor tranquilizer of the
> benzodiazepine type, and he says the insomnia and panic improved. However,
> Dr. Fulton left SMCI approximately one year ago, and the new psychiatrist,
> Dr. Maier, discontinued his medications. He has had many disciplinary
> tickets. He links some of the infractions to his psychiatric condition.
> For example, he experiences the walls closing in on him, he experiences
> severe anxiety, panic, palpitations, trouble breathing, etc. (He says he
> has great difficulty at times breathing in the hot, humid cell.) He decides
> he has to get out of his cell no matter what the consequences, and he covers
> his window with something, knowing the officers will come and perform a cell
> extraction. He says he feels such a desperate need to get out of the cell
> so he can breathe that he ignores the disciplinary ramifications. The items
> he very strongly endorses on the SCL-90-R include the following: Perceptual
> distortion such as feeling the walls are closing in; confusion and
> disorientation; the idea that someone else can control your thoughts; pains
> in heart or chest; suddenly scared for no reason; temper outbursts that you
> could not control; heart pounding or racing; trouble falling asleep; trouble
> getting your breath; feeling hopeless about the future; thoughts of death or
> dying; having to repeat the same actions such as touching, counting, washing
> (he reports washing his hands 20 to 30 times per day); spells of terror or
> panic; and the idea that something is wrong with your mind.
>
> 37. Prisoner 5 tells me that all of these symptoms have been building since
> he was placed in SMCI. On mental status examination, he is very sad,
> exhibits psychomotor retardation typical of severe depression, earnestly
> expresses the wish to die, exhibits hopelessness, helplessness and
> powerlessness, and gives this observer the strong impression he is a serious
> risk of suicide. There are also signs of a thought disorder, and he needs a
> thorough psychological assessment to rule out psychosis. I asked if he has
> any plan to utilize a method of self-destruction other than starvation and
> he assured me he has no immediate plan to cut himself or commit suicide by
> other means. I encouraged him to speak to the psychologist on an urgent
> basis. In Prisoner 5's clinical chart there many notes about his smearing

> feces, being a danger to himself, yelling and refusing to eat. He reports a
> period around April 2000, when he was frequently or continuously confined in
> an observation room or restraints and observed. He alleges he was naked much
> of that time. He tells me he does not want a repeat of that traumatic
> event, so he does not seek mental health treatment in spite of feeling
> suicidal. Immediately after one such episode he was released from
> restraints only to smear feces again and be considered a danger to himself.
> On a few occasions he was evaluated by mental staff and determined not to be
> suffering from a thought disorder nor to be suicidal. But no thorough
> mental status exam was completed. His agitated and chronically disordered
> behavior requires a thorough psychiatric examination. He needs to be
> assessed for suicide and panic disorder, and it is quite likely the
> stressful conditions in SMCI are keeping in him in a perpetual state of
> panic, suicidality and agitation.
>
> Prisoner 6
> 38. This 32 year-old African American man has been in SMCI since April,
> 2000. He was transferred from the federal prison in Florence, Colorado. He
> has a long history of serious mental illness, first reported in 1991 in the
> course of competency evaluations and NGI deliberations for the court. He
> was given a diagnosis of Depression with Psychotic Features and prescribed
> the antipsychotic medication Haldol along with the antidepressant medication
> Elavil. In 1994 he was accused of murdering two other prisoners. There is
> a note about his being prescribed Haldol in 1995 as well. He reports he
> underwent mental health treatment and was in general population in the
> federal penitentiary in Florence. On an 11/2/2000 admission mental health
> questionnaire at the SMCI he reported feeling confused and paranoid and
> suffering from hallucinations. Currently, he complains he sees dead people
> lying on the floor. He will not permit visits with his family via video
> monitors because "they could be faking the images." He has a history of
> multiple suicide attempts, including cutting all over his body and overdose
> with pills. He tells me that the very earnest suicide attempt in December,
> 2000, involved cutting his head with a broken piece of glass "because I
> wanted to see what was inside my head." (This kind of bizarre and extreme
> suicidal act is usually a sign of schizophrenia). He complains he does not
> know what time of day it is (no watches or clocks are permitted in the
> cells, some prisoners have the time displayed on their television, but not
> Prisoner 6). When I ask him if the officers know he is actively
> hallucinating he tells me "The Doctor told them I hear voices, but still
> they punch me and spray me (with mace)." His mental health chart is very
> thick, with many diagnoses, admissions to hospitals and anti-psychotic
> medication prescriptions.
>
> 39. Prisoner 6 reports that even prior to his transfer to SMCI, and
> certainly for all the time he has been in the SMCI, whenever he is confined
> to his cell the voices become more intense and he experiences severe anxiety
> and paranoia. He tells me he is not permitted to advance beyond Level 2
> because at Level 3 he would be permitted to have a television, but the staff
> are concerned he might break it and use the glass to cut himself. He tells
> me he paces in his cell and occasionally goes to the yard, but he does not
> read because he cannot concentrate sufficiently. Prisoner 6 is clearly
> suffering from a serious mental illness, his disciplinary infractions result
> from his psychotic ideation, and yet he is kept in the extremely restrictive
> and psychosis-inducing environment of the lowest level within the SMCI,
> where he suffers constantly. He needs to be transferred on an urgent basis
> to a mental health treatment setting.

>
> Prisoner 7
> 40. Prisoner 7 is a 29 year old White male who has been in the SMCI since
> 3/22/2001. He is HIV+, and quite depressed about his medical condition.
> His family has essentially cut off contact with him, which worsens his
> depression. Another aggravating factor in his depression is a lack of
> contact with his child. He is actively hallucinating, he sees dead people
> walking around and hears someone (a voice others do not hear) talking to
> him. He had no psychiatric history prior to entering prison, and never took
> psychiatric medications prior to incarceration. He is prescribed Remeron,
> an antidepressant medication. He complains of severe depression and is
> chronically suicidal. I found him in the Observation Unit of Alpha Unit,
> with a deep gash in the middle of his forehead where he had been banging his
> head against a metal door. He was on observation when I met him, and told
> me he had been in restraints a few days earlier.
>
> 41. On the SCL-90-R Brief Symptom Checklist, Prisoner 7 endorses at the
> level "extremely": perspiring or sweaty hands; oversensitivity to
> stimulation; perceptual distortions; wide swings in emotion; confusion,
> disorientation; headaches; nervousness or shakiness inside; trouble
> remembering things; thoughts of ending your life; hearing voices that other
> people do not; crying easily; suddenly scared for no reason; temper
> outbursts that you could not control; feeling blue; heart pounding or
> racing; feeling inferior to others; soreness of your muscles; feeling that
> you are watched or talked about by others; trouble falling asleep; having to
> check and doublecheck what you do; difficulty making decisions; feeling
> hopeless about the future; trouble concentrating; awakening in the early
> morning; having to repeat the same actions such as touching, counting,
> washing; sleep that is restless or disturbed; getting into frequent
> arguments; the idea that something is wrong with your mind.
>
> 42. Prisoner 7 suffers from a severe, chronic depression with imminent
> suicide potential and possible psychotic features and Borderline Character
> Disorder. Confinement in the SMCI has greatly exacerbated his mental illness
> and made his long-term prognosis more grave. There is a serious risk of
> suicide. For a couple of months he was reported as self-destructive, and
> then the next note reported he was feeling better. But he was sent to
> observation repeatedly and reported feeling very depressed. He should not
> be confined in the SMCI, and should be transferred to a mental health
> facility for the intensive evaluation and treatment his condition warrants.
>
> 43. These seven men suffer from severe morbidity and disability on account
> of mental illness. Clinicians might disagree about the fine points of
> diagnostic assessment – it is often difficult to be certain whether the
> diagnosis that best describes a patient's condition would be Schizophrenia,
> or Bipolar Disorder, or even Borderline Character Disorder in some cases.
> More thorough assessment and trials of specific treatments might be needed.
> But the seven prisoners I have identified suffer from serious and long-term
> mental illnesses. They are suffering on account of the morbid psychiatric
> reactions to the conditions of confinement in the SMCI. And they require
> much more intensive psychiatric assessment and treatment than it is possible
> for the staff to provide in the SMCI. (I will explain in great detail in my
> final report why I believe that the mental health services are vastly
> understaffed and the resources are not adequate relative to the need for
> professional mental health services at SMCI.)
>

> 44. Clearly the assessment of a person's capacity to function is relative
> to the setting. A man who might obviously appear psychotic and unable to
> care for his basic needs in a community setting nonetheless could be housed
> in a prison cell 24 hours per day and not be noticed -- especially in a unit
> like Alpha Unit where there is little or no contact between staff and
> prisoners. As long as he is quiet and eats his meals, he may seem on
> cursory examination to be coping, even if he is silently listening to voices
> or withdrawing into a depressive, autistic stupor. In other words, unless
> he screams, hurls feces or attempts to kill himself, he does not become a
> "management problem" and can be essentially ignored by staff. Meanwhile, it
> is likely that his condition is deteriorating, in large part because of his
> social isolation and lack of meaningful activities. And it is well
> established in the case of people who are suffering from psychotic
> decompensations that the sooner the gross symptomatology is controlled by an
> appropriate medication regimen and other mental health treatment modalities,
> the better the eventual prognosis. Thus, leaving psychotic or seriously
> depressed prisoners alone in a cell to suffer for long periods of time from
> the kinds of symptoms I discovered in prisoners in the SMCI is likely to
> cause significant deterioration in their mental condition over time.
>
> 45. The population in the SMCI at the time of my tour was approximately 330.
> I only had an opportunity to interview and administer a brief symptom
> checklist to twenty prisoners. Yet I discovered a shocking degree of
> psychopathology. Seven prisoners I interviewed are suffering from serious
> mental illnesses, including various forms of psychosis, Bipolar Disorder,
> Major Affective Disorder, Panic Disorder, and suicide crisis. Besides the
> fact that these prisoners are in urgent need of mental health treatment and
> their psychiatric condition is being jeopardized by their continuing
> confinement in the SMCI, there are related questions about the fairness and
> appropriateness of SMCI's treatment of these prisoners, who are rendered
> incapable on account of mental illness of accomplishing the steps required
> to improve their level of programming, and avoid harsh punishments that are
> in many cases brought on by the symptoms of their mental illness. The seven
> prisoners I have identified need to be transferred to a secure mental health
> unit outside the SMCI where they can receive the assessment their conditions
> warrant and then be assigned to more appropriate housing and treatment
> settings.
>
> 46. Given the level of psychopathology I found among the twenty prisoners I
> interviewed, I have no doubt that there are many more prisoners at SMCI who
> suffer from serious mental illness. However, there does not seem to be any
> systematic, ongoing assessment of the psychiatric condition of all prisoners
> in the SMCI. (Each prisoner is supposed to receive an initial mental health
> screening upon transfer to SMCI, but I reviewed several of those screening
> forms and found them deficient in major ways). An emergency assessment of
> all prisoners within the SMCI needs to be conducted to ascertain how many
> more seriously mentally ill prisoners require mental health services and/or
> transfer to a less stressful setting where they can receive the treatment
> they require. Further, ongoing monitoring of all prisoners in the SMCI
> should be conducted on a monthly basis to identify cases of impending
> psychiatric breakdown. Needless to say, these mental health assessments
> must be conducted in an environment that allows privacy for the prisoner and
> the clinician; it is not sufficient to conduct "cell front" interviews,
> where the conversation can be overheard by others.
>

> I VERIFY AND DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS IN THIS
> DECLARATION ARE TRUE AND CORRECT AND BASED UPON MY PERSONAL KNOWLEDGE.
>
> Executed on August ____, _____
> TERRY A. KUPERS, M.D., M.S.P.