REPORT ON MENTAL HEALTH ISSUES AT SMCI

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I. INTRODUCTION

I incorporate by reference into this report my declaration of August 9, 2001 (Exhibit A) and my testimony at the preliminary injunction hearing on September 20, 2001 (Exhibit B). My biographical information and qualifications are outlined in my August 9 Declaration and in my curriculum vitae (Exhibit C). Before I make this report final, I will need to review additional documents as well as depositions of defendants' staff, including mental health staff I was not permitted to speak to during my tour of SMCI in July, 2001. Since there is insufficient time to gather this additional information prior to the deadline for this report, this report is necessarily preliminary.

Since writing my declaration I have reviewed the following additional documents: Report on Conditions in the Supermax Correctional Institution in Boscobel, Wisconsin, by Vincent M. Nathan (September 28, 2001); the clinical and social service files of Prisoner 22; recent notes from the files of other prisoners; use of force incident reports; Defendants' Exhibits from the preliminary injunction hearing; "Level One Handbook" (11/27/00); the affidavits of Twila Hagan, Ph.D., Gary Boughton, and John W. Stoner, Ph.D.; the Report of Joe Goldenson, M.D. and Jackie Clark, R.N.; declarations of Daniel Feldt and Richard Levine, Ph.D.; the deposition of Rodney K. Miller, Ph.D.; Psychotropic Medications List, Revised: August 22, 2001; and various manuals and self-study guides. I also interviewed Prisoner 22 by phone for approximately one hour on October 11, 2001.

II. THE SHU SYNDROME

As noted in my declaration (pp. 6 – 8), isolated confinement and severe restrictions on social interactions and activities cause emotional pain, mental illness, and longterm suffering and disability, generally referred to as "the SHU Syndrome."

A. Effects of Isolated Confinement

Human beings require social interaction and productive activities to establish and sustain a sense of identity, self-worth, and well-being, as well as to maintain a grasp on reality. In the absence of social interactions, unrealistic ruminations and beliefs cannot be tested in conversation with others, so they build up inside and are transformed into unfocused and irrational thoughts. Disorganized behaviors emerge. Internal impulses linked with anger, fear and other strong emotions grow to overwhelming proportions. This is why psychiatrists around the country have been cautioning citizens against isolating themselves, and recommending they go on with their usual activities, in the wake of the tragic September 11th attacks on the Pentagon and World Trade Center and the October 7th outbreak of war.

In sensory deprivation experiments conducted in the 1960's, subjects were immersed in water at body temperature in total darkness and their hearing was blocked. Eventually even the sanest subject began to experience hallucinations and delusions. While it took approximately six hours for the most stable subjects to begin hallucinating, subjects with less ego strength began hallucinating within minutes. SMCI is designed to foster isolation and idleness. Sensory deprivation at SMCI is not total – there is the intermittent slamming of doors and loud yelling – but this kind of noise does not constitute meaningful human communication.

Prisoners at SMCI are locked alone in their windowless cells all but four hours per week (most prisoners elect not to go to the recreation room, so they do not leave their cells for the four hours). On the lower levels, prisoners do not participate in programs, are allowed no television or books, and are allowed to have very little property in their cells. The environment is totally controlled by the staff, meaning that the prisoners have almost no control of their daily living. Officers bring their food trays, turn the water in their cells on and off, permit them to go to the exercise cell or law library, etc. Officers give orders, refuse many of the prisoners' requests, and sometimes use force against the prisoners. Anxiety and anger mount in the prisoners. The almost total lack of social interaction and meaningful activities means the prisoner has little or no opportunity to test the reality of his worst fears, nor direct the emotional intensity provoked by the harsh environment into productive activities.

Prisoners do what they can to cope. Many at SMCI pace relentlessly, as if this non-productive action will relieve the emotional tension. Those who can read books and write letters do so, but prisoners on Level One are not permitted to have books. Moreover, at least 40% of prisoners nationwide are functionally illiterate, and evidence is accruing that illiterate prisoners fare less well than others in supermaximum prisons. Other prisoners clean their cells many times each day.

Under these extreme conditions, symptoms begin to emerge. For example, the walls may seem to be moving in on the prisoner. He may begin to suffer from panic attacks wherein he cannot breathe and thinks his heart is beating so fast he is going to die. He may find himself disobeying an order or inexplicably screaming at an officer, when really all he wants is for the officer to stop and interact with him a little longer than it takes for a food tray to be slid through the slot in his solid metal cell door. It is in this context of near-total isolation and idleness that symptoms of the SHU Syndrome emerge in previously healthy prisoners. In less healthy ones, there is psychosis, mania or compulsive acts of self-abuse or suicide.

In my Declaration and testimony I described the toxic effects of isolated confinement on prisoners with severe mental illness. Here I will focus in greater detail on the effects on prisoners who have not previously been known to suffer from diagnosable serious mental illness. It is important to note that even a person who has not been diagnosed with a "major mental illness" such as schizophrenia or major depression may still have a mental health condition, such as posttraumatic stress disorder or anxiety disorder, that makes him more likely to deteriorate and develop the symptoms of SHU Syndrome if he is exposed to conditions of extreme isolation and sensory deprivation. As a group, prisoners are far more likely than persons in the general population to suffer from such pre-existing conditions.

Dr. Stuart Grassian and others who have studied the negative effects of isolated confinement or "reduced environmental stimulation" report the symptoms that most often evolve in prisoners who were not previously diagnosed as mentally ill (see Grassian, Psychopathological Effects of Solitary Confinement, Amer. J. of Psychiatry, 140, 1450, 1983). It should be noted that not all prisoners are affected. For various reasons, some prisoners prefer isolated confinement to being placed in a general population situation. For example, there are prisoners who fear for their safety, and

because there is no protective custody unit at their security level, they purposely violate rules or get into a fight so they will be sent to punitive segregation and remain isolated from the prisoners they fear. Also, there are prisoners who prefer to be by themselves, and are willing to give up activities in order to have a cell by themselves. In my experience, the prisoners who adjust well to the conditions in supermaximum security units for any reason make up approximately ten to fifteen percent of the prisoners confined in these units. Among the 22 prisoners I interviewed, I found one prisoner who says he does not mind being at SMCI – and even he had a list of complaints, including the long delays it takes to see a mental health clinician and the short time the clinician spends with him. But the vast majority of prisoners object to their confinement in supermax facilities, and find the experience extremely traumatic and painful. (Even prisoners who say they want to remain in supermax can experience many of the signs and symptoms of the SHU Syndrome.)

B. The Brief Symptom Checklist

Of the twenty-two SMCI prisoners I interviewed at any length, I conducted the Brief Symptom Checklist (SCL-90-R) with nineteen. (One prisoner was not responsive to the questions.) This is a list of ninety questions that is often utilized to screen individuals for symptoms of mental illness. I have added seven additional questions to make the checklist more relevant to prisoners confined in segregation units. I interviewed Prisoners 21 and 22 by phone, and though I asked them about symptoms, I did not administer the entire symptom checklist. (A copy of the SCL-90-R Brief Symptom Checklist and the supplemental questions I added in order to better identify the SHU Syndrome are attached to this report as Exhibit D.) I matched the symptoms the nineteen prisoners endorsed strongly on the SCL-90-R checklist with the symptoms Dr. Grassian lists for the SHU Syndrome. In order to make clear my methodology, I will list the nine categories of SHU Syndrome symptoms (I am leaving out the tenth, “rapid reduction of symptoms upon termination of isolation,” because it is not relevant here), followed by a colon, and then I will list questions from the SCL-90-R Brief Symptom Checklist that most closely match each of them (some of the SCL-90-R checklist questions are matched to more than a single category of SHU Syndrome symptoms):

1. Massive free-floating anxiety, as expressed by responses to the following questions: nervousness or shakiness inside?, suddenly scared for no reason?, feeling fearful?, feeling tense or keyed up?, spells of terror or panic?, perspiring or sweaty hands?

2. Hyper-responsiveness to stimuli, or startle, as expressed by responses to the following question: oversensitivity to stimulation (e.g. jump at noises, angered by sounds, light painful to eyes, sensitive to smells)?

3. Perceptual distortions, including hallucinations, as expressed by responses to the following questions: hearing voices that other people do not hear?, perceptual distortions (e.g. eyes playing tricks, feeling walls closing in or things around you changing shape)?

4. Derealization, as expressed by responses to the following question: losing ability to feel or react emotionally or care about things?

5. Difficulty with concentration and memory, as expressed by responses to the following questions: trouble remembering things?, feeling blocked in getting things done?

6. Acute confusional states, as expressed by responses to the following questions: having to do things very slowly to insure correctness?, trouble concentrating?, the idea that something is wrong with your mind?, confusion?, disorientation?

7. Primitive aggressive fantasies, as expressed by responses to the following questions: feeling easily annoyed or irritated?, temper outbursts that you could not control?, fantasies or daydreams about violence?

8. Paranoia, as expressed by responses to the following questions: feeling that most people cannot be trusted?, feeling that people are unfriendly or dislike you?, feeling that you are watched or talked about by others?, feeling uneasy when people are watching or talking about you?

9. Motor excitement, with or without violent and self-mutilatory outbursts, as expressed by responses to the following questions: temper outbursts that you could not control?, having urges to beat, injure, or harm someone?, getting into frequent arguments?, shouting or throwing things?, fantasies or daydreams about violence?

These questions are randomly distributed among 97 questions in the modified brief symptom checklist I administered to 19 prisoners at SMCI. By using randomly distributed questions in an instrument that includes many other questions, I avoided asking directly about the nine symptoms of the SHU Syndrome, thereby preventing prisoners from giving me what they thought was "the right answer." Since in administering the SCL-90-R Brief Symptom Checklist I requested the prisoners to respond to each question on a scale of zero to four (zero=not at all, one=a little bit, two=moderately, three=quite a bit, and four=extremely), I was able to measure the relative severity of each symptom of the SHU Syndrome. The numerical averages reflect the degree to which each prisoner experiences each symptom of the SHU Syndrome. For example, Prisoner 2, a 23 year old Caucasian male who suffers from a severe and persistent mental illness, responded with a 4 (extremely) to 19 out of 26 questions that match symptoms of the SHU Syndrome. Prisoner 8, who has not been diagnosed with a mental illness, responded with a 4 (extremely) to 7 of the 26 matching questions, and with a 3 (quite a bit) to 13 more of the matched questions. Different prisoners responded differently to the questions. Thus prisoner 8 responded that he experiences very little motor excitement associated with violent outbursts (0, 1 and 2 responses to the matched questions), but he responded with three 4's (extremely) and a 3 (quite a bit) to the four questions matched with paranoia. Some suffer more from one symptom while others suffer from other symptoms. But in general, I found an unusually large number of 3's (quite a bit) and 4's (extremely) among the responses all 19 prisoners gave to the items on the checklist that match the symptoms of the SHU Syndrome – unusually high even in comparison to prisoners in other supermaximum facilities where I have asked about these symptoms.

C. Statements by Prisoners

Then, in my interview with each prisoner, I heard from the prisoners themselves narrative accounts of the same or similar symptoms. Prisoners 1 through 7 responded strongly to very many of the checklist questions matched with the symptoms of the SHU Syndrome. Because I presented many of their symptoms and

complaints in my declaration and courtroom testimony, I will not review their responses here. I will quote a few of the symptoms the remaining prisoners report:

Prisoner 8, who has not been diagnosed with a mental illness, reports "I walk around for hours in my cell talking to myself… I wake up crying and afraid…. I see someone standing in the corner of my cell, I saw the devil come up out of the toilet, I couldn't sleep all night."

Prisoner 9 reports that after an officer threw his food tray through the slot in his door onto the floor, he worried incessantly "what if they threw you (him) on the ground and smashed your head."

Prisoner 10, a 35 year old African American man, told me that "since I've been here, I've fallen into a rage that lasts for months, and then I get depressed for months."

Prisoner 11, a 32 year old Caucasian man on level 3 who has been in SMCI practically since it opened in late 1999, tells me that during the first year he was confined at SMCI "my rage was out of control, I had a lot of violent feelings, I had crying fits, I hallucinated, I couldn't sleep, I couldn't concentrate – it was horrible!" Since then, he believes he has learned to adjust, but he does not think he will ever get out of SMCI.

Prisoner 12, a 29 year old Caucasian man who has been diagnosed with Bipolar Disorder and is prescribed Lithium for his rapid cycling mood swings, actually thinks being in SMCI has helped him in some ways (he is the one prisoner who speaks in somewhat positive terms about his experience at SMCI). Still, he reports, "I have sensory deprivation – since being here I don't see them (people, including family members) as living, breathing human beings."

Prisoner 17, a 29 year old African American man who has damaged his cell several times since entering SMCI in November, 1999, reports: "I always feel paranoid because you never know when the door will open and they (officers) will pop in and beat you. I'm sleep deprived because I'm afraid they'll come in on me. I've been up for three days. I get paranoid – up all night, watching the door."

Prisoner 18, a 35 year old African American man who seems very paranoid to me on mental status examination, shows me a copy of a letter he wrote to the Bureau of Health Services about the way the officers poison his food, poison the water,

poison the air, and poison his clothing. He tells me “the poison attacks your brain like tiny bombs.”

Prisoner 19, a 17 year old African American youth who has been at SMCI since July, 2000, tells me he smells strong scents (olfactory hallucinations), he hears cars all the time, he hears voices of people talking about him, he is always anxious, he has a strong startle reaction especially when he hears a door open, he feels like he is in a daydream most of the time, and he believes the officers are not real – they are corpses that are already dead.

Prisoner 20, a 35 year old Caucasian man, told me he gets agitated and argues all the time over trivial things, something he never did before coming to SMCI. He is extremely anxious and paces all the time in his cell.

Prisoner 21 came to my attention only after I wrote my declaration, but I testified about him on September 20 in court. He has a long history of depression, auditory hallucinations and very serious suicide attempts. He reported to me that he hears voices quite a lot, there are actually “thousands of different me’s, some of whom explain to others how I should cut myself.” He reports that the voices have been a lot louder and more vulgar since he has been at SMCI. He believes the television broadcasts messages from his enemies. He believes his thoughts can be picked up by others without his speaking if those others have an “extra sense.” He believes others control his movements. He has a very strong startle response. He feels “surreal.” He is always anxious and experiences frequent heart palpitations and an inability to breathe.

These quotes from prisoners describe the SHU Syndrome more poignantly than I could by listing clinical signs and symptoms. Often these kinds of subjective symptoms are not corroborated by entries in the clinical chart, because clinicians at SMCI rarely interview the prisoners in enough depth and in a setting where these symptoms might come to light. But I did a mental status examination on each of these prisoners and found them to be forthright historians and their responses to be consistent with what I know of the various psychiatric disorders. In addition, where possible, I checked the prisoners’ narrative responses against their responses to the questions on the SCL-90-R Brief Symptom Checklist, and found a high degree of consistency. For example, Prisoner 17 reports he always feels paranoid, he is sleep

deprived because he is afraid "they'll come in on me," and he has been up for three days watching the door. On the Brief Symptom Checklist, which I administered quite a few minutes before he said these things to me, he responded with a 4 (extremely) to the following questions: feeling that most people cannot be trusted?; feeling that you are watched or talked about by others?; feeling uneasy when people are watching or talking about you?; trouble falling asleep?; awakening in the early morning?; sleep that is restless or disturbed?; the feeling that something bad is about to happen to you?

The tenth symptom Dr. Grassian lists for the SHU Syndrome, "rapid reduction of symptoms upon termination of isolation," is not turning out to be very accurate. If someone is placed in isolation for a limited amount of time and then released, and if he or she has not suffered a psychiatric decompensation or breakdown during that time, it is true that the other nine symptoms will be mostly alleviated. But we are discovering with further research that if a prisoner is left in isolated confinement for many months or years, especially if the conditions are very harsh and the idleness and isolation very severe, there will be permanent psychiatric damage. If a mental illness has emerged or become more severe, there will often be longterm destructive effects, including a more severe mental illness, greater disability, more chronicity and more disability. If a diagnosable mental illness has not emerged, but the symptoms of the SHU Syndrome have lasted during a long term of isolated confinement, then these symptoms will often become chronic and unremitting and cause poor adjustment outside of isolated confinement as well as longterm pain and suffering.

It is my opinion that the harsh conditions of confinement at SMCI, particularly the extreme sensory deprivation, social isolation and enforced idleness, pose a grave risk of serious psychiatric harm even to prisoners who have no history of mental illness.

III. THE MENTAL HEALTH PROGRAM AT SMCI

I have not had an opportunity to complete an entirely comprehensive assessment of the quality of mental health care at SMCI, in part because I was denied access to the psychiatrist and was not permitted to talk candidly and in depth with other mental health staff. I have reviewed the Accreditation Report by the

National Commission on Correctional Health Care (October 27, 2000), reports of Mental Health Audits by the State of Wisconsin Department of Corrections, "An Evaluation of Prison Health Care in the Department of Corrections" by the Joint Legislative Audit Committee (May, 2001), descriptions and policies regarding treatment programs at the Wisconsin Resource Center, Mendota Mental Health Institute, Oshkosh Correctional Institution (Mental Illness-Chemical Abuse Program), and Winnebago Mental Health Institute, and I have reviewed various manuals that are provided to prisoners by mental health staff. These documents shed light on many aspects of the mental health resources at SMCI and within the DOC.

A. Minimal Requirements for a Mental Health Program

The adequacy of mental health services cannot be measured solely in terms of staffing levels or the number of prisoners who receive mental health treatment, with or without medications. Adequate mental health treatment requires the availability of a trained clinician to develop a trusting relationship with a patient in a setting that permits privacy, where confidentiality is respected so that very personal themes can be explored and worked through. Adequate mental health treatment requires a variety of treatment modalities, including but not limited to crisis intervention; psychotropic medications as needed; the availability of a certain number of group activities such as group therapy, psychoeducational groups, facilitated socialization or recreational activities, and psychiatric rehabilitation groups that involve psychoeducational programs, training in the skills of daily living and medication compliance; admission to an acute psychiatric hospital as needed; social work outreach to family members as needed; and after-care planning so that the disturbed individual is not returned to the environment that caused a breakdown but rather is provided with the ongoing care and social supports needed to sustain his mental health.

Not all of these modalities need to be available in any particular setting, and not all of them need to be utilized with any particular prisoner. But they need to be available, and a major problem with the mental health services at SMCI is that very few are available within the institution, and the mental health staff do not transfer many prisoners in acute crises to other institutions where they can receive the

treatment they need. Of course, if a prisoner is not yet capable of participating in a group, a treatment program that includes incremental steps to help the prisoner get along with others must precede his attendance at a group activity. Otherwise, the prisoner is likely to spend all of his sentence at SMCI, with no meaningful social interactions, not even visits (for reasons I discussed in my declaration), for several years, and then be released into the community with a much worse mental illness and no preparation to relate to others in an appropriate way.

In short, confinement in a cell 23 or more hours each day, even with the prescription of psychotropic medications, does not constitute adequate mental health treatment. Dr. Jeffrey Metzner, a recognized expert on correctional mental health care and the current chair of the American Psychiatric Association's (APA) Council on Psychiatry and Law, was quoted in the APA's publication, Psychiatric News (September 21, 2001): "If the conditions of confinement involve being locked in a 70-square-foot cell 23 hours a day for months at a time, it is unlikely that patients with mental illness could receive adequate mental health services" (p. 6).

B. Problems with the Mental Health Program at SMCI

My own observations during my tour of SMCI, my interviews with prisoners and with one psychologist, and my review of many documents and clinical and social service charts do provide me with an accurate picture of many, but not all aspects of the mental health services offered at SMCI. For example, many prisoners informed me that they have given up requesting mental health treatment because their prior requests were not met with visits by a psychologist or psychiatrist for a very long time, and then the contact was limited to an interview lasting only a few minutes at cell front. By contrast, Dr. Apple, a psychologist, told me she and the other mental health staff respond to requests promptly and conduct interviews and psychotherapies as needed. Because of discrepancies like this, I cannot yet make final conclusions about the time mental health staff spend with individual prisoners. But I can match the prisoners' complaints with the clinical charts and determine that a significant proportion of mental health interviews are conducted at cell front. This is because many prisoners tell me this is the case, and many notes in the clinical charts begin with phrases like "I spoke to (prisoner) at cell front." In other words, while I will avoid

conclusions on matters where I cannot find enough evidence, I can offer with confidence some opinions I have arrived at from the tour I made, the interviews I conducted and the documents I reviewed. (As mentioned above, I will be gathering additional information from documents, depositions, and other sources.) My conclusions are as follows:

1. There is inadequate screening for mental illness at the point of entry to SMCI, and then there is inadequate monitoring of prisoners to detect mental illness emerging during their stay at SMCI. I base this conclusion on the fact that the files of Prisoners 5, 6 and 7 contain no Mental Illness Screening Tool; the screening tool for Prisoner 4 is dated almost a year after he entered SMCI; the mental illness screening tool for Prisoner 2 says he had no prior psychiatric hospitalizations, yet his DOC clinical chart documents two; and the Mental Illness Screening Tools in other prisoners' charts are incompletely filled out or inconsistent in their content. I see almost no sign of organized ongoing monitoring of prisoners' mental status in the files I reviewed. Since most prisoners enter prison in their late teens and early twenties, and this is precisely the age range in which severe mental illness usually first appears, it often happens that a prisoner will suffer from a psychiatric breakdown after entering prison, especially if he is subjected to harsh conditions such as those that prevail at SMCI. Therefore a periodic mental health assessment by a qualified clinician needs to be conducted to identify prisoners who first experience severe psychiatric symptomatology only after being confined at SMCI. Cell front "rounds" by crisis workers who have no advanced degree in a mental health field are certainly no substitute for periodic thorough assessments by a well-trained professional clinician who talks to the prisoners in private in an interview room.

In addition, in the eight cases I presented in court on September 20 as well as in many of the clinical and social service files I have reviewed, prior histories of mental illness and prior clinical notes are not sufficiently considered, or, indeed, not considered at all, in the psychiatric assessment of prisoners. I gave many examples of this problem in my testimony on September 20. I will mention one more here. Prisoner 21 had a history of severe mental illness and multiple serious suicide attempts for many years prior to his admission to SMCI. Subsequently, he made several serious suicide attempts at SMCI. Besides notes about his serious mental

illness and suicide potential, his prior clinical chart contains a psychiatric assessment from Mendota Mental Health Institute, where Dr. Karen Bauman, Ph.D. and Unit Chief, and Dr. James Killpack, M.D. (5/3/93), write: "Furthermore, (Prisoner 21) has a pattern of escalation in terms of inappropriate behaviors and deterioration in terms of mental status which are associated with the use of isolation as a management strategy. Isolation strategies have been markedly unsuccessful with him in the past when he was a resident at Lincoln Hills School and ended in two instances with serious suicide attempts. At LHS (Prisoner 21's) behavior in isolation became severely regressive."

Mental health practitioners must be very aware of the tendency for suicidal patients to repeat patterns of the past, and when a pattern this ominous is spelled out in a previous clinical note, it must be taken very seriously. Instead, this prisoner was confined at SMCI, and even though he had attempted suicide on more than one occasion in segregation at another institution, and then at SMCI he cut himself badly with broken glass, the pattern described by Drs. Bauman and Killpack was not mentioned in the clinical notes and he was retained at SMCI. He attempted suicide again on 12/10/00, a hanging that resulted in his face turning purple before he could be cut down by staff, and again he was retained at SMCI in isolation. Finally, this prisoner made a serious enough suicide attempt for the mental health staff to transfer him to Wisconsin Resource Center for intensive psychiatric treatment in late August, 2001, and still there is no notation in the chart that the note by Drs. Bauman and Killpack had even been noticed.

2. There is a tendency on the part of mental health clinicians at SMCI to underdiagnose mental illness and downplay emotional distress. The number of prisoners with severe mental illness who are confined at SMCI is unknown. In my opinion, a major reason for this is an unfortunate tendency for the mental health staff at SMCI to minimize the seriousness of the mental illnesses afflicting prisoners. I base this opinion on my review of the clinical/social services files of 22 prisoners. As I testified in the hearing on September 20, the SMCI mental health staff failed to diagnose severe mental illness in the eight prisoners I determined are suffering from severe mental illness. Prisoner 22 is also an example of someone suffering from a serious mental illness, depression with serious suicide potential, where the diagnoses

placed in the chart by SMCI mental health staff do not reflect the severity of the mental illness nor the suicide danger.

I found many chart notes that are self-contradictory. For example, with Prisoner 21, there is a note on the chart by psychiatrist, Dr. Maier, on February 6, 2001 (two months after the serious suicide attempt by hanging), “He had so many overt paranoid thoughts I wondered whether a neuroleptic was actually useful.” The diagnosis Dr. Maier made was “Adjustment Disorder with Depressed Mood,” and the medications he prescribed were Loxitane and Depakene. Loxitane is a powerful anti-psychotic medication, and Depakene is a form of valproic acid, utilized in psychiatry as a substitute for Lithium, i.e. as a mood stabilizer. Loxitane is usually prescribed for psychosis, and Depakene is usually prescribed for Bipolar Disorder or Schizoaffective Disorder. Thus it makes no sense that these medications are being prescribed for a prisoner who suffers from a much less severe diagnosis, “adjustment disorder.” This is not an isolated case. In my opinion, there is a pattern of skepticism on the part of the mental health staff about prisoners’ symptoms and diagnoses, as well as their pain and suffering, that results in the underdiagnosing of severe mental illness, inadequate mental health treatment at SMCI, the substitution of punishment where there should be more intensive therapeutic intervention, and too little consideration being given to the possibility the prisoner needs to be transferred out of the stressful SMCI setting if his psychotic or depressive symptoms or his suicidal tendencies are to be controlled.

It is interesting in this regard that one of the Defendants’ experts, Dr. John W. Stoner (see Affidavit, Sept. 19, 2001), echoes the insensitivity to prisoners’ pain and suffering that is reflected in the mental health staff’s underdiagnosing of mental illness and downplaying of emotional distress. Dr. Stoner says that “Inmates at SMCI are confined to their cells for 23 hours a day” (p. 9). He has failed to notice that most inmates at SMCI, especially on Alpha Unit, do not take advantage of the out-of-cell time they are permitted (and that is four hours per week, not the seven that his statement assumes), and thus spend 24 hours a day in their cells. After offering other opinions that reflect an inadequate attention to the facts, he goes on to opine: “The records of the clinical services at SMCI, instead, suggest that most inmates are psychiatrically very stable, that those who are seen with problems typically have a

long history of such problems, and that the problems developed are most often of a form which can be well managed at the facility" (p. 13). Since the facts that Dr. Stoner takes for granted (e.g., that the clinical records at SMCI reflect the true incidence of mental illness or the actual mental state of prisoners) are the very facts at issue in this case, and he has not examined prisoners at SMCI, his opinion is based on something other than an objective assessment of all available evidence. After making many more generalizations of this sort, he proceeds to opine about the clinical status of Prisoners 1 through 7. But he has not examined, or even spoken to, Prisoners 1 through 7.

3. A Note About Staffing Levels. Standards for Health Services in Prison, published by the National Commission on Correctional Health Care (1997), do not designate a precise ratio of mental health staff to prisoners in correctional settings. Psychiatric Services in Jails and Prisons, published by the American Psychiatric Association (2000), specify a minimum standard of one full time psychiatrist for 150 prisoners receiving psychotropic medications (p. 7-8). The Wisconsin Legislature and the Wisconsin Department of Corrections seem to accept the ratio of one F.T.E. (full time equivalent) psychiatrist per 150 prisoners who are being prescribed psychotropic medications as a standard for their mental health staffing policies. The "Supermax Correctional Institution Psychotropic Medication List, Revised: August 22, 2001," includes the names of 70 prisoners. That would require approximately 20 hours per week of a psychiatrist's time according to the ratio of 1 F.T.E. per 150 prisoners taking psychotropic medications. Currently the psychiatrist's hours are far fewer than 20 per week.

Moreover, the psychiatric staffing provided by the contract with Prison Health Services is premised on the assumption that there will be no prisoners with Axis I psychiatric disorders at SMCI (see PHS contract, p. 2). Since there are, in fact, many prisoners at SMCI with Axis I disorders, it is doubtful that this staffing is adequate to care for the serious mental health needs of SMCI prisoners. In addition, the contract requires mental health staff to participate in "post traumatic incident debriefings and counseling services for both PHS and security staff" (PHS contract, p. 8). These duties presumably divert already limited mental health staff time away from direct patient care.

According to Defendants' Answer to Plaintiff's First Amended Complaint (#33), "Defendants ALLEGE that the (legislative) audit based its conclusion that 15% of the inmates at SMCI were mentally ill on the number of inmates who were prescribed 'psychotropic medication.' Defendants further ALLEGE that this number is unreliable because up to 70% of these inmates are actually prescribed medications like Benadryl, which are technically defined as psychotropic but are not being prescribed due to mental illness" (p. 11). There is a gross miscalculation and some false logic in the State's allegation here. By my count, there are only 8 prisoners being prescribed Benadryl on August 22, 2001 (see Psychotropic Medication List) . This is hardly 70% of the 70 prisoners receiving psychotropic medications. In terms of the false logic, I mentioned that I believe the mental health staff at SMCI tend to underdiagnose serious mental illness. As a result of this underdiagnosis, prisoners who have been prescribed psychotropic medications in the past have had their medications discontinued. Also, I do not agree with the Defendants' claim that the prescription of Benadryl for a sleep disorder does not constitute prescribing a psychotropic medication for a mental illness. Sleep disorders are listed among mental illnesses in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association (1994), and sedatives (i.e., sleeping pills – Benadryl is an antihistamine that can be substituted for a sleeping pill) are generally included by psychiatrists and other physicians on their list of psychotropic medications. From the sample of prisoners I interviewed, it seems clear that far more than 15% of prisoners at SMCI suffer from mental illness. The discrepancy between my estimate and the State's must be due, in large part, to the underdiagnosing at SMCI that I have described, and the consequent underprescribing of psychotropic medications. Even if one accepts the State's method for calculating the prevalence of mental illness, the 70 prisoners on psychotropic medications make up more than 20% of the SMCI population.

In other words, if a prisoner's diagnosis is changed from Schizophrenia to Adjustment Disorder, and his medications are discontinued, then the number of prisoners considered by the mental health staff at SMCI to be suffering from mental illness is reduced by one. But I have encountered several cases in which a prisoner's medication has been discontinued and yet he clearly suffers from a mental disorder.

For example, Prisoner 22 told me he has a history of depression with multiple suicide attempts. His report is corroborated by Ms. Cullen's chart notes and the incident reports describing suicide attempts he has made recently at SMCI. Yet Dr. Maier discontinued the antidepressant medication he had been taking and prescribed Benadryl at a relatively high dose to help him sleep (subsequently this prisoner has refused to take antidepressants when Dr. Maier has recommended them). Here is a prisoner with significant mental illness who is taking Benadryl for sleep. He would be included in the count of prisoners with mental illness according to the standards utilized by the Legislature and the American Psychiatric Association, but would not be included if the Defendants' method of excluding prisoners at SMCI taking Benadryl for sleep were to be adopted. It is my opinion that there are many more prisoners who suffer from severe mental illness at SMCI than the number who are diagnosed with a severe mental illness and are prescribed psychotropic medications.

4. There is a tendency for the mental health treatment offered prisoners in emotional distress to be sparse and erratic. In many cases, contact with a mental health clinician seems to be almost random. Crisis workers make rounds and ask at cell front if the prisoner has a problem, but crisis workers are not highly trained, and a cell front interview is not likely to uncover much emotional disturbance or suicide intention. The reason is that prisoners do not want to appear weak in front of other prisoners or officers. I spoke to several prisoners through the port in their solid metal doors, and found I had to raise my voice to be heard, and they had to raise theirs. Prisoner 22 explained to me that following each suicide attempt on his part, a crisis worker would come to his door and ask if he is feeling suicidal. There are prisoners in neighboring cells and officers walking by who can hear the conversation. He reports that on several occasions when a crisis worker questioned him like this, a prisoner in a neighboring cell yelled out "What, are you suicidal?!" He felt horrified and refused to even respond to the crisis worker's question. There are many chart notes that end with the statement that the prisoner can request a mental health visit when he feels a need. But there are many conditions wherein it is the clinician's responsibility to make follow-up visits even if the prisoner does not initiate the contact. With certain exceptions, such as prisoners placed in Observation, I saw little or no evidence that this is being done at SMCI.

5. The prisoner has a right to privacy during a clinical interview, and confidentiality to the extent that is practical in a prison setting. The 1990 Code of Ethics of the American Correctional Health Services Association (ACHSA) state that the correctional health professional must "provide sound privacy during health services in all cases and sight privacy whenever possible" (cited in Psychiatric Services in Jails and Prisons, a publication of the American Psychiatric Association, 2000). The problem with cell front interviews is that a prisoner is unlikely to be candid about psychiatric symptoms in such a setting. Besides, talking through the port hole in the metal boxcar doors does not provide a context in which sufficient trust can be engendered for the clinician to find out what the prisoner is feeling and whether he is planning self-harm. The National Commission on Correctional Health Care, in an Accreditation Report of SMCI dated October 27, 2000, found: "Officers are with the inmates during all examinations. Many of the PA and physician sick call visits are done through the cell door. The officers do step back from the door; however, other inmates on that range can hear the exchange of information. Neither auditory or visual privacy is maintained. The Standard is Not Met" (p. 6, P-09).

6. Mental health staff seem to view very many of prisoners' complaints as signs of manipulation, malingering or antisocial personality disorder, instead of crediting the prisoner's report of emotional distress and intent to harm himself until proven otherwise. I testified about this issue in great detail in court on September 20.

7. There is a reluctance to transfer prisoners who do exhibit signs and symptoms of psychiatric decompensation (breakdown) and those who seem intent on harming themselves to another setting, such as the Wisconsin Resource Center or Mendota Mental Health Institute, where they might receive the treatment their condition warrants and requires. Again, I testified about this issue in great detail in court on September 20.

8. Too little credence is given to the possibility that rule-breaking and tensions between prisoners and staff might reflect an underlying mental illness or emotional symptom. Consequently, there is a tendency for staff (security and mental health staff) to respond to rule-breaking and misbehavior on the part of prisoners suffering from mental illness with punitive interventions, disciplinary write-ups that can result in a return of the prisoner to the Alpha Unit, cell extractions and other uses of force (I

believe staff burnout is a big factor here). Even when a prisoner is placed in observation for self-destructive acts, the conditions are punitive (for example, he might be restrained naked on a concrete slab with no bedding in a cell with windows facing the hall and left to feel physical pain as well as the humiliation of being observed by staff passing by). The practice of requiring a prisoner to stand in the middle of his cell with his light on and his pants on if he is to receive his medications (see Level One Handbook, 11/27/00, and Mr. Nathan's Report, p. 24) is another reflection of a punitive attitude where a therapeutic attitude is required. According to all medical standards as well as human decency, a prisoner receiving psychotropic medications must not be denied those medications on account of unsatisfactory behavior that may well result from the very mental illness for which the medication is prescribed.

9. The mental health staff's general approach to suicide underscores many of the inadequacies of the mental health treatment program at SMCI. Generally, there are well-established clinical guidelines for the assessment and treatment of individuals who have attempted suicide or seem intent upon taking their own life. First, a thorough assessment is indicated. There are indicators of very serious suicide risk, for example severe depression, a past history of suicide attempts, a note indicating sincere intent to commit suicide, command hallucinations (voices) ordering the individual to take his own life, and so forth. Then, the individual who seems to be at risk of suicide needs to be placed in a safe setting. This usually means a psychiatric hospital, but in a prison setting an observation room might be adequate for a prisoner who does not pose a very serious risk, if the approach of staff is therapeutic rather than punitive, and if the mental health staff are able to take the time to gain the suicidal prisoner's trust and offer the intensity of treatment that is required in such an emergency. But the main component of treatment with a suicidal individual is one-on-one personal therapeutic contact. A trusting relationship must be established in order to foster disclosure on the suicidal individual's part about the inner sense of despair and hopelessness that is driving him to seek death. Psychotropic medications might play an important part in the treatment of a suicidal individual, but there are many problems and complexities in their prescription. For example, a suicidal individual might utilize the medications in the next suicide attempt,

and the most often prescribed type of medication in suicidal crises – i.e., antidepressants – take between two and three weeks to reach full effect, so they are not very useful in the acute situation. Another crucial part of the treatment of individuals intent on taking their own life is for the clinician to figure out what stressors are driving them to this level of despair, and then to make every possible attempt to change their situation so that those stressors will not drive them to another attempt on their life after the immediate treatment for the current suicide attempt or crisis has passed.

From my interviews with prisoners who have attempted suicide (Prisoners 2, 3, 6, 7, 21 and 22) and a review of their clinical and social service charts, it is clear that the staff's usual response to a suicide attempt is to remove the prisoner from his cell, often by a use of force called a cell extraction, and to move the individual to an observation room (a cell with large windows along one wall with a concrete bed and little else in the way of amenities) or a restraint chair, then to restrain the individual on a concrete slab in the observation room or a restraint chair. Then, the prisoner is observed every fifteen minutes, the mental health staff visit the prisoner at least once per day, but from the prisoners' reports as well as notes in their chart, most of these visits are at cell front or inside the observation room if the prisoner is restrained (there are a few instances, but definitely a small minority, where the prisoner is moved to an attorney visiting room for an interview of up to 30 minutes). These contacts often last only a few minutes, and judging from the notes in the charts and the prisoners' reports, in most cases the discussion is limited to whether the prisoner is going to try to kill himself again.

The problem with restraints and disciplinary write-ups for prisoners who attempt suicide is that these measures do not get to the prisoner's despair, and as soon as he is released from restraint, he is very likely to plan an even more lethal attempt. Meanwhile, the already suicidal prisoner is very likely to turn on himself the anger he feels on account of what he considers unfair and brutal treatment, for example a cell extraction that occurred in the process of moving him to the observation room and then the humiliation and pain of being restrained on a concrete slab or a restraint chair.

You cannot punish someone into transcending their despair. In fact, the prisoner knows that in order to get out of observation he needs to convince the mental health staff that he is no longer suicidal, so when the mental health staff member makes rounds and asks him at cell front if he still wants to take his own life, he is inclined to answer that he is no longer planning or desiring to kill himself. Then, back in his cell, he can make another attempt. Several prisoners told me that they do not tell the staff when they feel suicidal, because they know they will be placed in observation, possibly naked, and punished even more severely. For example, Prisoner 2 said: "I don't report when I am suicidal because I'm afraid I will be punished or strapped down." It is my opinion that the mental health treatment offered at SMCI is not adequate to deal with the imminent suicide risk posed by many prisoners there.

C. Conditions of Confinement and Mental Health Programming

My assessment of mental health services at SMCI should not be taken primarily as a criticism of any particular staff member's competence, ethics or commitment to alleviate the suffering of prisoners they treat. Rather, as I testified on September 20, it is my opinion that mental health treatment cannot compensate for the extreme and psychiatrically destructive conditions that prevail at SMCI. However, increased staffing would help to ameliorate to some extent some of the problems I have identified. For example, if an increase in hours for the psychiatrist permitted him or her to take time to have more prisoners removed from their cells so they can be examined in a private and confidential setting, or if the increased hours permitted him or her to see prisoners suffering from emotional distress more frequently than once a month or once every few months, that would constitute an improvement in mental health services. But since the conditions of confinement and the policies in effect at SMCI have such a powerful and ongoing negative effect on the prisoners confined therein, improvements in the level of staffing cannot entirely compensate for the damage done by the institution to prisoners' psychiatric condition, disability and prognosis.

It is as if a very highly trained heart surgeon were backpacking in a very remote wilderness area, his backpacking partner experienced sudden and intense chest pain,

the surgeon was able to diagnose dissecting aneurysm of the aorta, but there was absolutely no way to reach anyone and arrange transportation to a hospital where the kind of open heart surgery that would be required to save the man's life could be performed. All of the heart surgeon's training would do no good in this situation, and he would be forced to watch his partner bleed to death without being able to prevent his demise. The surgeon's frustration is analogous to the mental health clinician's frustration at SMCI, even if more extreme. While the clinician might know that the environment and policies at SMCI are worsening the patient's condition, the clinician cannot order that a disturbed prisoner on Alpha Unit, Level 1, be allowed family visits, be given extra reading material, or be let out of his cell at other times than the four hours per week prescribed for recreation, even though the clinician might believe that the claustrophobic prisoner must be let out of his cell if his anxiety is to be reduced. Also, there is very limited opportunity to transfer the patient to a mental health treatment setting where he can take part in the kind of group treatments and out-of-cell activities that should be a critical part of his treatment. So the frustrated clinician is limited to cell front visits and the prescription of psychotropic medications.

Because of the inadequacies in the mental health system, including poor screening, underdiagnosing and sparse treatment, many prisoners who do not suffer from Schizophrenia, Major Depression or Bipolar Disorder, yet suffer from significant pain and emotional distress, are neither diagnosed nor treated. This category includes many suffering from the SHU Syndrome who do not break down and become psychotic or suicidal; it also includes prisoners suffering from anxiety disorder, panic disorder, posttraumatic stress disorder, obsessive-compulsive disorder, and so forth. These conditions are not considered "major mental illnesses," even though they can cause much pain, and when they are left untreated they can become chronic and disabling. With the mental health staff concentrating on severe psychiatric breakdowns and suicide attempts, prisoners who have serious mental health needs but do not fit the description of acute psychosis or suicide crisis often go unnoticed and suffer alone in their cells.

There are areas where I do believe the mental health clinicians fail in their clinical responsibilities. For example, the mental health screening is inadequate, prisoners are underdiagnosed, and the mental health staff do not try hard enough to

transfer the prisoners who suffer from psychoses or repeatedly attempt suicide to an appropriate setting where they might receive the kind of treatment their condition requires. But ultimately, the bottom line problem with mental health services at SMCI is more about the fact that the setting causes or exacerbates more psychiatric distress than mental health clinicians can ameliorate or even treat properly in that same setting. This does not mean the mental health services could not be improved greatly by increasing the staffing and developing some of the much needed programs that are currently lacking or deficient.

For all these reasons, it is my opinion that the mental health program at SMCI falls below community standards and is inadequate to provide for the serious mental health needs of the prisoners confined there.

IV. THE EFFECTS OF USE OF FORCE ON PRISONERS WITH SERIOUS MENTAL ILLNESS

At SMCI, too little attention is given to the way a use of force is woven into a prisoner's psychological make-up and symptomatology, even into his delusional system.

A. Use of Force and Trauma

Cell extractions and other uses of force constitute major traumas, and each prisoner has his own, idiosyncratic reactions to the trauma, often including a worsening of his mental illness, disability and prognosis. The ensuing psychological damage often goes unrecognized because the prisoner is in a cell by himself and often elects to suffer in silence, and the staff are too angry, on account of the recent incident, to interact with him. There is also a gender issue here: male prisoners, like most men on the outside, tend to believe that displaying emotions or expressing neediness is unmanly. This male trait is exaggerated in a prison setting where any sign of weakness is considered unmanly and may lead to attack. Thus, a use of force, with or without the use of an incapacitating agent such as CN gas, and with or without the use of an electronic incapacitating device such as an Ultron II, can cause a prisoner to suffer nightmares and flashbacks while becoming severely depressed and withdrawing into himself. But at SMCI, for all the reasons I outlined in my

discussion of the mental health care at SMCI, a prisoner who becomes silent and withdrawn in his cell after a use of force, and refuses out of fear or out of pride to share with staff the major psychological symptoms he is experiencing, is not likely to come to the attention of a mental health clinician. This is especially the case if the mental health staff merely ask the prisoner at cell front how he is feeling, and the officers conclude that the prisoner has been successfully shocked into acting more appropriately (i.e. remaining silent). Meanwhile, in large part because of the lack of social contact and opportunity to talk about and work through the trauma of the use of force, the prisoner's mental condition deteriorates as he sits frozen and alone in his cell. Only when the symptoms become severe enough for him to cut his wrists or refuse to eat for weeks or smear feces will the staff recognize that there is a problem. From my review of records for 22 prisoners, I am concerned that the staff's response will likely be repeated uses of force, which will constitute for the prisoner further traumas, and then there will be another period of withdrawal with worsening mental status, until the prisoner's mental deterioration worsens to the point that he acts out in a destructive or self-destructive way, and the whole cycle repeats itself.

B. Predictable Ramifications of the Use of Force

When a prisoner who is suffering from mental illness is subject to the use of force, there are these predictable ramifications:

1. There is an exacerbation of fear and anxiety. For example, Prisoner 4, who seemed very anxious to me on mental status exam, told me he has become much more agitated since being confined at SMCI, he is afraid of officers barging into his cell and using force, and he tries to cope with his mounting anxiety by pacing constantly in his cell and cleaning his cell repeatedly.

2. In a prisoner prone to paranoia, there is intensified paranoia. For example, Prisoner 18, whom I found to be very paranoid on mental status examination, has been the object of cell extractions on multiple occasions. He says, "Since I've been here, I feel people think I'm crazy…. I feel like they're trying to murder me; they put poison, or urine, or feces in my food…." Similarly, Prisoner 17, who has also been the object of cell extractions, explained: "I always feel paranoid, because you never know when the door will open and they (officers performing a cell extraction) will pop

in and beat you. I'm sleep deprived because I'm afraid they'll come in on me. I've been up for three days. I get paranoid - up all night, watching the door…." The use of force is woven into the delusions that plague the already paranoid prisoner.

3. In a prisoner prone to depression and self-harm, there is an intensification of the depression and increased likelihood of suicide. Prisoner 3, who has a history of severe depression and has been the object of cell extractions, reports feeling much more severe sadness and loneliness since entering SMCI, his hopelessness has turned to despair, he awakes early each morning, and he is afraid he will never get out of SMCI – these are all symptoms of depression, and he tells me every one of these symptoms has become worse since he has been at SMCI and he has been the object of multiple uses of force. He has made suicide attempts while at SMCI.
In a prisoner prone to extreme mood swings, there is an increase in the extremity of their depressive and manic swings, or in their frequency.

4. Posttraumatic Stress Disorder, where the trauma is cell extraction or an incident involving an electrical incapacitating device, is a frequent repercussion of the use of force, especially in a prisoner with previous trauma (studies show that most prisoners have a background that includes multiple traumas) and a mental illness.

5. In a prisoner suffering from severe mental illness who is prone to act out his anxiety and other psychiatric symptoms by resorting to hyper-masculine bravado, there is an exaggeration of that tendency. For example, the prisoner feels disrespected by staff and decides he needs to prove his manliness by not backing down. The staff in turn feel disrespected by the prisoner, and proceed quickly to a cell extraction when he misbehaves. He views the cell extraction as another test of his manliness and is willing to suffer a large amount of pain in order to prove he is tough. The staff regard this as further evidence of his disrespect and escalate the confrontation. The vicious cycle proceeds, and many incident reports of cell extractions accumulate in his file. Prisoner 4, who has spent almost his entire time at SMCI in the most restrictive setting, Alpha Unit, on Control status, and has been subject to multiple uses of force, exhibits this tendency. He confided to me that: "They put me in Observation buck naked. Do they talk to you? - only token visits that last a few minutes. I am always angry here. I was already angry before I came here, but I'm much angrier in here…. This is a never-ending cycle of no-wins – more

disciplinaries, more extractions. The violence is much worse since I've been in SMCI. There's nothing to look forward to, no way out."

C. Problems with Alpha Unit

Alpha Unit presents a huge problem for prisoners with serious mental illness as well as those prone to the SHU Syndrome and those prone to act out their anxiety by becoming embattled with staff. The unit is the most isolating unit at SMCI, and also the most restrictive in terms of possessions and activities. But Alpha Unit is the point of entry into SMCI for prisoners who have been sent there on account of being out of control and possibly acting in a very regressed manner. In short, the prisoners with the most severe behavior problems and mental illness are confined in Alpha Unit just when their behaviors and symptoms are most out of control and they are least able to interact appropriately with staff. This arrangement leads many of these prisoners to get into conflicts with officers, and then they are likely to become the object of a use of force such as a cell extraction, often on account of behaviors that are driven by mental illness. For example, I found disciplinary write-ups in the charts of prisoners who had made serious suicide attempts for violating the rule against "disfigurement." In fact, suicide attempts and other sequelae of mental illness are often punished many times over at SMCI: The prisoner is moved from his cell to an observation cell in Alpha Unit; this cell change involves a "cell extraction" in many cases, with or without the use of immobilizing gas or an electrical device; he is charged with a violation for "disfigurement"; and then he is likely to remain in Alpha Unit with all its deprivations for some time after the attempt. Thus the prisoners who are the least capable of coping with the situation are forced to spend many months in this most isolating and restrictive of environments. This is one major reason why so many prisoners with mental illness spend a disproportionate amount of their time at SMCI in Alpha Unit. A cycle occurs, wherein the prisoners most vulnerable to decompensation in isolated confinement, because they are unable to control their behavior, either remain in Alpha Unit for extended periods or recycle back to Alpha Unit repeatedly, and spend more time than most prisoners do in the very circumstances that most intensify their mental illness.

D. A Pattern of Failure and Return to Level 1

Alpha Unit is not the only site of a vicious cycle. The Level System at SMCI involves 5 levels. The time it takes to progress through the five levels is approximately 17 months. SMCI opened in November, 1999. Yet only 6 prisoners have graduated and been transferred out of SMCI. Others have left the facility because their release date arrived, and still others have been transferred to medical or psychiatric facilities. Fewer than 200 prisoners were confined at SMCI during its first few months of operation. But still, 6 graduates after almost two years constitutes a very low success rate. These numbers corroborate what many prisoners told me: as soon as one plays by the rules and moves up a few levels, he is quite likely to be written up for a disciplinary infraction and sent back down to a lower level. Or, the conditions of confinement cause them to lose control and express anger or behave inappropriately at the wrong time, and they are sent back to a lower level. Whatever the case, there seems to be a vicious cycle in that prisoners work hard to raise their level, are sent back to a lower level, accumulate bad feelings about the demotion or hopelessness about ever getting out of SMCI, and then they act out and are sent down to a lower level again.

A step system can work if the prisoners are encouraged to succeed at the tasks they must complete to move forward, the goals are attainable, and the fact that a significant proportion of participants do not advance through the level system in the expected time makes the administration and staff review their policies and procedures to see if there is something that needs to be changed. I did not find evidence of a general attitude of encouragement on the part of staff at SMCI. Rather, I found a punitive attitude that tends to cause prisoners to either rebel against the authority they consider unfair, or begin to despair of ever getting out of SMCI and consequently stop trying. In the latter case, a kind of passivity sets in and the prisoner becomes depressed and hopeless. I found many prisoners at SMCI, especially prisoners suffering from mental illness, and especially prisoners in the Alpha Unit, fit this pattern.

E. Use of Force and Prisoners with Mental Illness

I concur with Mr. Vince Nathan's conclusion in his Report (9/28/01) that "there is a pattern or practice of using numerous forms of force, including electronic weapons, against seriously mentally ill prisoners at SMCI" (p. 49). The reasons for this tendency, which of course seriously worsens the pain and disorder of prisoners with serious mental illness, are complicated. I can say with a reasonable degree of certainty that the tendency for staff to use force against prisoners with serious mental illness occurs because of a combination of these factors: 1. The architecture and sparseness of both social interactions and activities at SMCI, especially on Alpha Unit where many prisoners with serious mental illness spend much time, causes a worsening of symptoms and a tendency to become irrational, to act out, to decompensate or to attempt suicide; 2. There is a tendency for staff to employ punitive rather than therapeutic interventions when, on account of a mental illness or emotional distress, these prisoners act inappropriately and/or break rules (this tendency indicates a lack of adequate training and supervision); 3. Because of the inadequacies in the mental health services at SMCI that I outlined above, many prisoners in need of urgent and ongoing clinical attention do not receive it; 4. A level of desperation builds in these prisoners and they are driven by their inner voices and other symptoms to act out even more.

In regard to the employment of electronic weapons as the use of force proceeds, there is an additional danger that prisoners suffering from mental illness will suffer severe physical injuries or death. This is especially true when the prisoner is prescribed psychotropic medications. The mechanism for sudden death when an electronic weapon is used on a prisoner taking psychotropic medication is not entirely clear, but probably has to do with alterations the medicine effects in the electrical conduction systems of the central nervous system and the heart. We know that psychotropic medications lower the seizure threshold, in other words on the medication an individual is prone to suffer from a seizure after experiencing a lower level of stress than it takes to set off a seizure in the average person who is not taking the medication. A similar alteration is effected by psychotropic medications on the heart's electrical conduction system, the system that accounts for the timing and frequency of heartbeats. The application of an electronic weapon, for example the

Ultron II or a taser, during a use of force such as a cell extraction, disturbs the electrical activity in the heart and brain of the prisoner taking psychotropic medications much more than it is likely to do in a person who is not on such medications. The empirical finding has been that prisoners who were taking psychotropic medications have died when electronic weapons were used on them.

In California, two cases in federal court (Gates v. Deukmejian, CIV S-87-1636 LKK JFM P {E.D. Cal.} and Coleman v. Wilson, CIV S-90-0520 LKK JFM {E.D. Cal.}) addressed the use of tasers with prisoners suffering from mental illness who are receiving psychotropic medications. A taser is a weapon that fires a needle-like dart attached to a wire through which the victim receives an electric shock. There was at least one death of a California prisoner that was likely caused by the use of a taser while the Gates case was in process. As a result, under supervision of the federal court in the Gates case, the California Department of Corrections adopted a policy in 1992 whereby officers cannot utilize a taser gun to immobilize a prisoner until they have consulted with the Chief Medical Officer and determined that that prisoner does not have a medical condition (including the prescription of a psychotropic medication) that would make the use of an electrical immobilization device, such as a taser, dangerous. In Coleman, the court determined that, in violation of that policy, tasers were still being utilized with prisoners receiving psychotropic medication (see Coleman v. Wilson, Order, pp. 76-78, and Coleman v. Wilson, Findings and Recommendations, pp. 54-56). The court ordered that tasers no longer be utilized in the immobilization of prisoners receiving psychotropic medications. I am not aware of equivalent safeguards being employed by the staff at SMCI, and therefore I have to conclude there is grave risk of injury or death when prisoners with serious mental illness are the object of a use of force and electronic weapons are employed.

F. Some Case Examples

In his report, Vince Nathan provides a brief description of seven uses of force where Prisoner 7 was the object (p. 41). Prisoner 7 suffers from a serious mental illness, attempted suicide on more than one occasion while at SMCI, and was transferred to Wisconsin Resource Center only after I interviewed him on July 27, 2001. The sequence of events illustrates serious problems in the way suicide

attempts are managed at SMCI. Prisoner 7 had notes in his clinical file from Dodge Correctional Institution identifying him as suicidal, stating that he had ongoing suicidal thoughts that were worse when he is in segregation because there is no one to talk to, and that he acted self-destructively by banging his head. Still, he was transferred to SMCI, and no Mental Illness Screening Tool was placed in his chart. Four days after arriving at SMCI he made a serious enough suicide attempt by hanging, using his sheet as a noose, that his face was turning blue by the time he was found. He made more suicide attempts at SMCI. A sequence of suicide attempts and uses of force is noteworthy. He was the subject of a forced cell extraction on several occasions, and then after each cell extraction he again attempted suicide. He caused a wound on his forehead on 7/17/01 by slamming his head into his cell door. He was the subject of a cell extraction where he cooperated with officers. He was the subject of a forced cell extraction on 7/19/01, and then on 7/22/01 he was discovered with a towel around his neck and his head turning dark. While officers prepared for another cell extraction, he “stepped back from his door and then lunged forward, slamming his forehead in to the door.”

My interview with Prisoner 7 confirmed that he was serious about taking his own life on both occasions when he slammed his head into the door. Thus, he attempted suicide on 7/17, he was the subject of a cell extraction; he smeared what appeared to be “diet loaf” on his windows and was subsequently the subject of a forced cell extraction on 7/19; and on 7/22 he made another serious suicide attempt and then was the subject of another forced cell extraction; and then on 7/25 he made another attempt to harm himself and he was again the subject of a forced cell extraction.

The question to ask is whether forced cell extractions are an appropriate intervention for what seems to be a severe suicidal crisis. Or are the cell extractions exacerbating the pain and despair and fostering the next suicide attempt? I believe the latter is the case, and Prisoner 7’s cycle of suicide attempts and cell extractions demonstrates the staff’s punitive approach to mental health problems, as well as the ineffectiveness of punishment and restraint in the management of the seriously suicidal prisoner. Prisoner 7 should never have been transferred to SMCI (his chart contained the information that segregation increased his suicide risk); and once he

attempted suicide four days after being transferred on March 22, 2001, the mental health staff should have noticed they had failed to complete the Mental Illness Screening Tool, and upon examining him and his past records should have realized the mistake and transferred him immediately to a less harsh setting where he could receive the mental health treatment he urgently needed. Moreover, it is my opinion that the repeated use of force on Prisoner 7 exacerbated his mental illness and suicidal crisis, and caused him significant pain and suffering.

Prisoner 3 suffers from depression and has made many suicide attempts, before and after being admitted to SMCI. He has been confined on Alpha Unit for just about the entirety of his confinement at SMCI. At SMCI, Prisoner 3 cut his wrists (see incident report, May 9, 2001). On May 20,2001, staff sprayed Prisoner 3 with incapacitating gas. On May 22, he tied a sheet around the showerhead in his cell and threatened to harm himself. Later that evening he cut his wrists and smeared the blood on his cell wall (see incident reports, May 22,2001). On June 6, 2001, he refused to return his razor and talked about "ending it all." That same day, according to Vince Nathan's report, "staff sprayed him with three bursts of CN chemical agent… to induce him to uncover his range window and to hand over a broken disposable razor" (p.42). On July 2, 2001, he was removed from his cell, strip searched and placed on control status after starting a fire in his cell (see Nathan Report, p. 43). On July 5, 2001, he was placed on "Behavior Management Plan," and was permitted to wear only briefs (see July 5, 2001 memo from Mr. Hompe). On July 10, 2001, Prisoner 3 was the subject of a forced cell extraction (see Nathan report, p. 42). On August 6, 2001, he cut his arms (see incident report, August 6, 2001).

I have listed chronologically several suicide attempts and uses of force involving Prisoner 3. I have left out entries in the clinical/social service notes about mental health treatment provided during the same time period. Certainly mental health staff saw Prisoner 3 during this time period, but I am not commenting here on the adequacy of the mental health staff's interventions (see III-B, above). Rather, what is astonishing is the sequence of alternating uses of force and suicide attempts. For example, on May 20 Prisoner 3 was sprayed with incapacitating gas and on May 22 he threatened to hang himself and then cut his wrists. Again, on July 10 he was the subject of a forced cell extraction, and then on August 6 he cut his arms. In other

words, Prisoner 3, who was known to be depressed and suicidal when he arrived at SMCI, attempted to harm himself on several occasions, and interspersed between the suicide attempts were uses of force that would have been traumatic and humiliating for anyone. There are two important points illustrated by this case: 1. Use of force constitutes a significant trauma, and trauma is known to increase the despair and suicide risk of a depressed individual (I am not counting the fire-setting as a clear suicidal act, but it does seem symptomatic and very dangerous); 2. Even after making more than one suicide attempt serious enough to warrant Observation, Prisoner 3 was not viewed as enough of a suicide risk to be transferred to a facility where he might receive more intensive mental health treatment.

G. Problems that Reflect Insufficient Training and Supervision of Staff

In my opinion, the rapidity and frequency with which officers resort to the use of force against prisoners suffering from mental illness is a clear reflection of insufficient training and supervision of correctional staff both in alternatives to the use of force in managing the difficult prisoner, and in working with prisoners who suffer from serious mental illness or are suicidal. The number of cell extractions that occur in a supermaximum prison can be greatly reduced by training and supervising staff better. For example, in the Intensive Management Unit at Shelton, Washington, the administration has put into place a set of standards that emphasize mutual respect between officers and prisoners, and trainings have been conducted to teach the officers how to develop this kind of mutual respect. In the short time that these standards have been enforced, the number of cell extractions per month has greatly diminished. This is not the only approach that works, and the Washington DOC is not the only system that has adopted policies to reduce the number of times officers in a supermaximum facility have to resort to use of force with prisoners. But the fact that corrections officers and prisoners with severe mental illness clash so often at SMCI indicates that adequate training and supervision are lacking.

H. Equivalent Trauma for Prisoners who have not been Diagnosed Mentally Ill

The experience of prisoners with diagnosed mental illness sheds some light on the ramifications of the use of force on other prisoners who have not necessarily

been diagnosed with a mental illness, even though many of them are suffering from the SHU Syndrome and other forms of emotional distress on account of the harsh conditions at SMCI.

It is my opinion that the use of force on mentally ill prisoners at SMCI results in unnecessary pain and suffering, exacerbates their mental illness, and in some cases increases their risk of death by suicide.

V. MALINGERING AND RELIABILITY

A correctional mental health clinician, like any mental health clinician, is constantly faced with the issue of reliability. The clinician must always take into account the possibility that the person being examined is exaggerating, distorting the truth to improve his situation, malingering, faking, misleading the examiner, and so forth. At the same time, if mental health clinicians become too wary about the possibility of being manipulated, then the prisoners who are urgently in need of care do not receive the treatment they need. The mental health staff at SMCI definitely err on the side of excluding possible fakers from their caseloads, in fact I think it is fair to say they are, on average, obsessed with the idea they might be manipulated.

The rate of suicide in prison is at least twice as high as in the population at large. In a majority of prison suicides I have reviewed, there were inadequate mental health services prior to the deaths, and there are notes in the chart such as "manipulating to get attention," or "malingering," or "no Axis I diagnosis, antisocial personality disorder on Axis II"; and then the diagnosis leads the clinician to ignore obvious signs of lethality on the part of a prisoner who is actually quite depressed, or is hearing voices telling him to kill himself. In one case that I report in my book, Prison Madness, the officer on rounds passed a prisoner standing on his bunk with a noose around his neck, and instead of ringing the alarm, he calmly completed his rounds. After rounds he returned to that prisoner's cell to check on the man and found him hanging and dead. There were several notes in the prisoner's clinical chart from several days earlier indicating that he was inappropriately seeking psychiatric help and did not really suffer from any mental illness.

Unfortunately, this is not an uncommon scenario. Research shows that in a "total institution" (prison, asylum, large group home), when mental health services are

inadequate, people with bona fide psychiatric problems essentially have to create a ruckus to get the minimum level of care they need. People with Schizophrenia or serious suicidality have to exaggerate or "fake" symptoms to get the attention of the overstretched mental health staff. In other words, they both suffer from psychosis (and/or suicidality) and they manipulate – it is not a case of either/or. In fact, the tendency to manipulate or exaggerate symptoms may actually be a symptom of the mental illness. But when the mental health staff react only to the manipulation and look no further, the prisoner's condition is likely to deteriorate further, or he or she may successfully commit suicide. This tragic reality is especially prevalent in supermaximum security units, because of all the reasons I have enumerated in my declaration and in this report. The staff at SMCI seem obsessed with the notion that prisoners might manipulate them or malinger, and this is a major part of the reason why so many prisoners are underdiagnosed and there are so many cases where a prisoner repeatedly attempts to take his own life. It is very fortunate that there has not been a death by suicide at SMCI, and the staff's alertness is to be credited here, but this does not mean that the status quo is satisfactory. The problem with the staff's obsession about being manipulated, and the punitive approach that is built into what seems to be the suicide protocol at SMCI, is that the harsh, punitive treatment, and lack of real a opportunity for the prisoner to develop a trusting relationship with a clinician or get out of his cell, leads to repeated suicide attempts.

There are many ways to assess the reliability of an interviewee. Wherever possible, information provided by the interviewee is corroborated by documents and information from others. Exaggeration of symptoms usually results in a clinical picture that does not fit any known disease or syndrome. The internal consistency of the interviewee's story can be evaluated, and where there are inconsistencies, there may be distortions of the truth. The story an interviewee tells in the present can be checked against the story he has told others in the past. The secondary gain (benefit of having more severe symptoms) can be assessed. The interviewee's intelligence can be taken into consideration – i.e., a very intelligent person is more capable of reading about a disease or syndrome and mimicking its signs and symptoms, whereas a less intelligent person is likely to make obvious mistakes in the process. And probably the most useful test of reliability is the clinician's examination. The

clinician is trained to assess the match between a person's story and their facial expressions, affect, body language, and so forth.

The clinician knows the signs and symptoms of diseases, and can determine whether a person is faking or exaggerating symptoms by the way the report of symptoms matches what is known about the way the disease presents. A psychiatrist's examination is composed of two parts, broadly speaking: the history or "subjective" part, and the mental status examination or "objective" part. When an interviewee claims he is hearing voices, that is a subjective report of a symptom. But the psychiatrist can note that he seems preoccupied with internal ruminations, and that is an objective finding or a sign. The objective and subjective material can be matched to see if there are inconsistencies, and whether the interviewee presents information and symptoms in a reliable fashion. For example, if the interviewee says he hears voices but does not appear to be internally preoccupied or upset about it, there may be some question about the reliability of his story. If he seems anxious, believes his thoughts are being broadcast, or presents other known symptoms of a specific mental illness, his story is more reliable.

I followed all of these procedures in assessing the reliability of information provided to me by prisoners at SMCI. I checked their stories about their background, previous history of mental illness and current symptoms and treatment against the clinical and social service charts, and found great consistency. For example, Prisoner 4 told me he has been in Alpha Unit almost the entire time he has been at SMCI, except for a brief period in December, 1999, when he reached Level II. In fact, his file substantiates that fact. Similarly, almost all of the facts other prisoners gave me were confirmed by a review of their files, where it was possible for me to find that data. I checked their accounts of events at SMCI with the incident reports, policies and other documents I reviewed, and again found great consistency. In general, my mental status examination of these prisoners tended to be consistent with the symptoms they reported (e.g. prisoners who reported auditory hallucinations also seemed to me to have flat affect, to be incapable of abstracting and to exhibit a certain degree of thought disorder – and this is a consistent picture of a particular mental illness, paranoid schizophrenia).

I checked some of their stories about not taking advantage of the exercise area against the logs that showed they had, in fact, refused their time in the exercise area. I checked their complaints about their environment by touring and observing the environment – e.g., I returned at 10 P.M. to check the claim by prisoners that having the lights on all night caused them to have problems sleeping. There is also a consistency to the prisoners' responses to the questions I asked. For example, almost all of the prisoners responded to the question on the SCL-90-R about headaches with a 3 (quite a bit) or a 4 (extremely). This was true on all the units I entered. These prisoners do not know all the others I interviewed. The fact that so many of them answered in strong terms to the question about headaches, compared to what an average group of people randomly assembled would say about the presence and severity of headaches, confirms the fact that the prisoners are being straightforward in their reports of severe headaches, and that there is something about the SMCI environment that causes an unusually high incidence of headaches. In general, with a few exceptions, I found the prisoners I interviewed to be quite frank, truthful and forthcoming. As I testified on September 20 regarding the 8 prisoners I identified as suffering from severe mental illness, I found great consistency between the prisoners' reports of symptoms and past history (subjective) and my mental status examinations (objective).

CONCLUSION

The conditions of confinement at SMCI are the most harsh and restrictive I have seen in a prison, even compared with supermaximum facilities in other states. The architecture, especially in Alpha Unit, guarantees a level of isolation and reduced environmental stimulation that poses a grave risk of psychiatric damage to prisoners confined at SMCI. Even though we know from research that visitation is important to maintaining prisoners' mental health, visitation at SMCI is made so difficult and so unappealing that most prisoners receive few if any visits. Even though exercise is a critical part of maintaining sound health and psychological stability, the recreation cells at SMCI are so unappealing that very few prisoners take advantage of the four hours a week they are permitted to leave their cell and go to recreation. Lights are on around the clock, and this fosters insomnia and disorientation as to the diurnal rhythm

of night and day. Most prisoners, except at Level 5, remain in their cells virtually 24 hours a day. The programs for prisoners are so minimal (and for those on Level One, nonexistent) that most are idle in their cells, except those who can manage to do the study programs and engage in some kind of reading and writing pursuits. But a significant proportion of prisoners are illiterate, or are too disturbed to concentrate in their cells on written lessons. All of these factors increase the likelihood of psychiatric breakdown.

Under these extreme conditions, many prisoners develop symptoms of the SHU Syndrome. Those who are prone to mental illness or have a past history of mental illness suffer psychiatric breakdown or attempt suicide. The response by staff is mainly punitive, which creates a cycle of acting out, punitive responses by staff, and more acting out. The vicious cycle continues while the prisoners' mental health, disability and prognosis worsen. The mental health program provides a certain amount of relief, but for all the reasons I have enumerated, it is grossly lacking and does not meet the standard of care in the community. In any case, even a much more comprehensive mental health program would not be able to entirely compensate for the very toxic environment, policies and practices at SMCI, as well as the inadequacies in terms of staff training and supervision.

The officers lack the training and supervision necessary to interact with prisoners in a non-punitive way, especially prisoners suffering from mental illness, so when they see a prisoner get out of line, they quickly resort to harsh punishments, including writing a disciplinary infraction, or using force such as a cell extraction or a chemical or electrical incapacitating device. This further aggravates the prisoner's mental illness.

The result of these conditions is that prisoners at SMCI suffer a great deal. A significant proportion of prisoners develop psychiatric conditions that interfere with their ability to cope with life in prison, have a devastating effect on their emotional life far into the future, and many suffer breakdowns that become chronic and chronically disabling.

Respectfully submitted,

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