Expert Report
Mental Health Care in the Alabama Department of Corrections
Bradley v. Hightower

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Introduction and Overview

Kathryn Burns, M.D., M.P.H. and Jane Haddad, Psy.D. were retained as experts by plaintiffs' counsel in the above captioned matter. Although complete resumes are provided in Appendix A, brief overviews of our experience with correctional mental health follow.

Dr. Kathryn Burns is a Medical Doctor licensed to practice medicine in the state of Ohio. She is Board Certified in the practice of general psychiatry and has added qualifications in Forensic Psychiatry. Dr. Burns was the Chief Psychiatrist for the Ohio Department of Rehabilitation and Correction from May 1995 until August, 1999, and as such, provided clinical direction to correctional mental health staff by developing a comprehensive mental health care system within Ohio's prisons and implementing policies and procedures. She served as a member of the Task Force appointed by the President of the American Psychiatric Association to revise the national guidelines for the delivery of psychiatric services in jails and prisons. She has served or been retained as an expert in the field of correctional mental health care in Illinois, New Mexico and Ohio.

Dr. Jane Haddad is a clinical psychologist with extensive experience in correctional and forensic mental health. Prior to assuming administrative and program development responsibilities for correctional mental health systems, she provided clinical services for both jails and state prisons. As Director of Mental Health Services for the Kansas Department of Corrections, Dr. Haddad developed a day treatment program for inmates with serious mental illness that achieved national recognition. She also developed a statewide mental health system achieving 100% compliance with the standards of the National Commission on Correctional Health Care. In the private sector, Dr. Haddad was responsible for mental health program development, implementation and the monitoring of services provided by Correctional Medical Systems throughout the country. She also served as the

Director of the Forensic Unit and Adolescent Unit for the Commonwealth of Virginia. Dr. Haddad currently provides consultation to state and county agencies regarding adult and juvenile correctional mental health programs. She provides legal and clinical consultation in system issues and in individual inmate cases. She recently completed a five-year involvement in the monitoring of the Ohio Department of Rehabilitation and Correction's compliance with the *Dunn* Consent Decree.

In forming our opinions in this case, we studied the documents listed in Appendix B and conducted site visits of the following seven Alabama prisons:

- March 13, 2000 – Kilby Correctional Facility
- March 14, 2000 – St. Clair Correctional Facility
- March 15, 2000 – Donaldson Correctional Facility
- March 16, 2000 – Holman Correctional Facility
- March 17, 2000 and June 21, 2000 – Bullock Correctional Facility (Dr. Burns not present for second visit)
- June 21, 2000 – Easterling Correctional Facility (Dr. Burns not present)
- June 22, 2000 – Limestone Correctional Facility

During the site reviews, we were accompanied by class counsel, two or three lawyers representing the defendants, and Fred Cohen, an expert in the area of Correctional Mental Health who was serving at the time as an expert for the plaintiffs. Counsel for the defendants remained in close proximity throughout the visits, providing auditory privacy when requested. We were unable to engage in lengthy discussions with staff of the Alabama Department of Corrections (ADOC) or staff of the medical and mental health contract provider, Correctional Medical Services (CMS), some because they had been advised by their counsel not to speak with us. We were able to ask specific questions through defendants' counsel.

Three fundamental factors must be analyzed when assessing the quality of a correctional mental health care system:

- Bed and treatment space
- Quantity and quality of mental health care staff
- Inmate access to these physical and human resources

To some extent the first two factors may be assessed by a "paper" review, although simply listing and characterizing something as a "mental health bed" or providing the formal credentials of a doctor is not the end of the inquiry. Site visits are essential for determining the inmates' awareness of how to obtain mental health assistance as well as for ascertaining whether adequate treatment is provided.

During the site visits, we reviewed the ADOC mental health units and the areas designated at each institution for mental health treatment. We met with numerous inmates in small groups or individually to gain an understanding of current practices and to gauge the level of inmate satisfaction with mental health treatment. We visited the segregation units of each institution we toured and conducted cell-front interviews with inmates housed there. We observed medication administration practices and also reviewed the medical records of selected inmates.

As a very general introduction to our detailed findings, summary statements of our overall findings are provided. In our judgment, the ADOC fails to provide even minimally adequate mental health care for its inmates with serious mental illness, and the record provides evidence that ADOC administration either knew or ignored the serious shortcomings of the system.

We uncovered no evidence of meaningful oversight of mental health treatment either by ADOC officials or by CMS. Indeed, high-ranking ADOC officials appeared to have little information about mental health services and either had not actually visited these facilities or could not recall their last visit. Since Merle Freisen's departure about two years ago, there has been no replacement for the position of Director of Treatment. This has seriously compromised ADOC's ability to monitor mental health care. Further, the deposition of Dr. Feldman indicated that the oversight of mental health services by Alabama's Medical Advisory Committee (MAC) is limited to review of deaths related to suicide; acceptance of information provided by Dr. Gail Williams, the chief psychiatrist for CMS; and very brief tours of mental health areas by Dr. Feldman during quarterly MAC meetings held at various

prisons. This is totally inadequate oversight of a large mental health system.

The ADOC mental health system is deficient as to staff; including numbers and quality; as to bed/treatment space; and as to access to the limited care that is available. As stated previously, these three factors are essential for any correctional system. We believe current practices result in the prolonged and needless suffering of many inmates with serious mental illness.

To be somewhat more specific, it is our opinion that:

1. There is no practical access to needed hospital-level treatment, and the care that is given this designation at Kilby Mental Health Unit does not approximate hospital care.
2. Inmates with serious mental illness report that they frequently must violate rules, hurt themselves or cause property damage to gain the attention of staff. Often even this destructive behavior does not eventuate in treatment; only further disciplinary action and segregation result.
3. The medical records do not reflect adequate treatment planning or interventions and there is simply no way to determine continuity of care.
4. Acutely psychotic inmates are locked-down for long periods of time with little or no treatment. For example, in the case of the Donaldson inmate (125433) who committed suicide on January 11, 2000, the medical records document diagnostic swings from "psychosis" to "never saw evidence of psychosis"; from "clearly paranoid ideation" to "doing fine"; and from pleas for help that go unanswered to a response which is unduly delayed to his completed suicide.
5. Medications are administered in a dangerous and unprofessional manner.
6. Therapeutic programs and counseling are wholly inadequate. Some claims as to providing psychotherapy, both in terms of frequency and what this clinical activity entails, are transparently false.
7. Conditions of confinement in some areas housing inmates experiencing serious

mental illness are totally unfit for these very vulnerable inmates.

8. Based on inmate reports and medical record documentation, some mental health staff have demonstrated a general distrust of and contempt for individual inmate-patients.
9. The only treatment consistently available is psychotropic medication, but the medication is administered improperly; required monitoring often is not done; and medication is sometimes prescribed without the physician ever seeing the inmate. Medication is not supplemented anywhere we visited by adequate therapy or therapeutic programming. We believe that a prison system which, in practical effect, provides only medication to inmates with mental illness, is grossly inadequate. Treatment for inmates with serious mental illnesses encompasses more than medication.
10. There is little or no evidence of effective training of staff on the rudiments of mental illness and medication.

The section entitled "Individual Prisons", which immediately follows, provides our findings and opinions as to each of the prisons we visited. General conclusions as to certain aspects of each prison also are included. The final section, "Conclusion", summarizes our findings.

Individual Prisons

KILBY CORRECTIONAL FACILITY

The site review of Kilby Correctional Facility was conducted on Monday, March 13, 2000. Kilby is the ADOC male reception center and houses approximately 1200 inmates. Kilby has been designated as the primary site within ADOC for the treatment of inmates with acute serious mental illness. These services are provided on P-I, the Mental Health Unit (MHU) and South Ward. Kilby is the only ADOC facility in which non-emergency involuntary medication orders may be initiated.

Kilby mental health staff are responsible for the completion of reception mental health evaluations, the treatment of inmates on P-I, the MHU and South Ward, as well as the treatment of inmates on the outpatient caseload who are housed either in segregation or in general population.

Documentation provided by ADOC reported the Kilby mental health staffing as of May 15, 2000 follows. (Note: The May 15th staffing report reflects an increase in psychiatric coverage from twenty-four hours per week in February 2000 to forty hours per week in May 2000.)

Psychiatrists (CMS)	Sanders - 16 hours per week Williams – Approx. 8 hours per week Bell – 16 hours per week
Licensed Pschologists (CMS)	Woodley – 40 hours per week Campbell – 8 hours per week Van Wyck – 8 hours per week
Social Workrs (CMS)	Moody – 40 hours per week Wilson – 40 hours per week
Psychiatric Nurse (CMS)	Schofield – 40 hours per week
Mental Health Technicians (ADOC)	Crenshaw – 40 hours per week Barnett – 40 hours per week Cannon – 40 hours per week

The ADOC psychological associates, listed below, perform the reception mental health evaluations and conduct what are termed rounds of segregation:

Psychologist Associates (ADOC)	Smith – 40 hours per week Brantley – 40 hours per week Goltry – 40 hours per week Johnson – 40 hours per week

The CMS psychiatrists provide all psychiatric services, including the psychiatric evaluation of inmates referred at reception.

According to Dr. Woodley's deposition, the mental health technicians provide a supportive function for inmates on P-I, the MHU and South Ward, as well as conduct rounds of the segregation units. The responsibilities of a mental health technician, as outlined in the Kilby Standard Operating Procedure: Mental Health Unit, effective July 10, 1998, are as follows:

- The cleanliness of the unit; which entails light duty housekeeping
- The inmate's personal hygiene. Unit inmates will be allowed to shower/shave every day.
- Insuring that clean clothing (pressed whites) are issued Monday through Friday or as needed.
- Coordinate/supervise recreational activities of the Mental Health inmates
- Coordinating and participating in the treatment programs by monitoring behavior of Mental Health inmates.
- Recording daily activities of the Mental Health inmates on DOC forms and logs.

The deposition of Roberta Crenshaw, a Kilby mental health technician, indicated that she spends the majority of her time on correctional tasks (providing inmate clothing, coordinating commissary orders, serving meal trays, completing forms related to inmate movement) and not in clinical treatment.

Only one correctional officer, Officer Woodard, is consistently assigned to the mental health areas. Additional coverage is provided by officers on a rotating basis, a practice found to be disruptive to staff and inmates as well as general operations in other correctional mental health units with which we are familiar.

P-I UNIT

The site review of Kilby began with a visit to P-I, the six-cell unit designated for the treatment of inmates who are unable to be safely managed within the MHU due to clinical or security concerns. Although P-I remains a dark, dreary isolation unit, it was evident that ADOC had attempted to improve the conditions. All cells, except one, have been enlarged

to provide the inmate with additional space, and the cell-fronts have been covered with plexiglass to reduce the risk of suicide attempts by hanging.

Even with these modest modifications, P-I is not an acceptable place to provide mental health interventions for more than a few days. It is dark and inmates are isolated from adequate mental health contact. Reportedly, rounds of P-I are completed weekly by the psychiatrist, psychologist and nurse and daily by the psychologist and mental health technicians. There are also five to twenty minute evaluations completed by the psychiatrist on an irregular basis. Other than these minimal contacts, the inmates in crisis see nurses only during medication administration and correctional officers when rounds are conducted.

P-I inmates are permitted out-of-cell time in shackles forty-five minutes per day.

ADOC has acknowledged the restrictive and insular conditions in P-I by requiring mental health review of any inmate's placement on this unit for more than seven days. The most recent data available (Third Quarter 1999) indicated that the average length of stay of the forty-five inmates placed on P-I was 8.14 days. The longest length of stay was forty-four days.

During the site visit, five of the six P-I cells were occupied. All the inmates were termed "psych hold" inmates, although P-I rosters from other dates indicate that ADOC sometimes places segregation overflow and other Kilby inmates in P-I. An institutional procedure, issued on July 10, 1998, indicated that the Psychological Isolation (P-I) Ward is " a series of six cells located in the hospital, designated to house mental health, medical and/or high-risk security inmates." Thus, the P-I cells are not dedicated solely for mental health interventions.

Dr. Woodley stated in his deposition that P-I is the initial placement for many inmates referred to Kilby for acute care. An inmate is placed on the MHU directly only if there is a single cell available or the inmate is sufficiently stable. According to the Woodley

deposition, death row inmates with mental illness are confined to P-I throughout their treatment at Kilby.

Brief interviews during the site review with all of the five P-I inmates suggested that their placements were related primarily to security concerns. None appeared obviously psychotic, and none was on a precautionary watch related to suicide prevention.

Placement on P-I for longer than a few days is not therapeutic. If an inmate is on P-I, rather than the MHU, he receives less out-of-cell time, less staff involvement, no programming, and is maintained in an environment without even a television for sensory stimulation. The institutional procedure for the P-I security officer, issued July 10, 1998, indicates that department-provided radios could be tuned to an "easy listening" station and played at the lowest volume level upon inmate request, but for no longer than one hour on each shift. This is not currently done.

Dr. Bell stated in his deposition that P-I is also used as a time-out area for MHU inmates who request such placement and also is used when an MHU inmate acts out. Since the majority of the MHU cells are single cells, it is not clear why placement on P-I (also single cells) is used as a response to hostile or assaultive behavior. That some inmates may request P-I placement does not justify its utilization, since the inmate's rationale for requesting this isolation may be indicative of his mental status. There is also evidence from inmates, supported in mental health records, that P-I is used for inmate placement as a more restrictive setting when an inmate refuses psychotropic medication, regardless of his clinical condition. Confinement to this highly restrictive setting, then, may serve several purposes, including use as a mechanism to coerce medication compliance.

P-I could be marginally adequate for the provision of brief psychiatric stabilization of acutely psychotic inmates, but only if adequate staff interaction were provided daily. The medical records confirmed very limited mental health interaction other than the previously discussed brief evaluations of continued need for placement.

MENTAL HEALTH UNIT

The MHU is a nineteen-bed unit composed of eleven single cells, one two-man cell and two three-man cells. Although there is a room serving as a nursing station on the unit, there were no other enclosed areas for individual interviews and programming. Inmates reported that while they may be permitted to go to mental health staff offices off the unit for individual interactions, this is rare and typically only for appointments with a psychiatrist. Individual interventions by mental health staff are routinely conducted at cell-fronts or on the dayhall.

The little group programming that exists is provided on the unit's dayhall and outdoor patio. Dr. Woodley's deposition suggests that ADOC has recently agreed to soundproof a holding cell to provide a small group room for mental health programming. This is indicative of the staff's knowledge of inadequacies as well as a possible affirmative development.

While the lack of office and programming space severely compromises the ability of the MHU to provide services, the unit seemed otherwise nominally acceptable for the treatment of inmates with serious mental illness. Whether it is an acceptable substitute for hospital care, however, is an entirely different issue that will be discussed later in this report.

The placement of a restraint chair on the dayhall certainly does not contribute to a therapeutic environment. Since we were advised by security staff that the restraint chair is used infrequently, the placement of the chair on the dayhall is questionable.

During the site review, six of the nineteen beds of the MHU were unoccupied. This appeared to be related to the utilization of the three cells able to accommodate more than one inmate being used to house only a single inmate. Dr. Woodley's deposition indicated that this occurs when an inmate is unable to handle placement with others based on clinical presentation. Given this completely justifiable practice, the capacity for the MHU is more

often fourteen beds than the nineteen beds regularly reported as being available for "inpatient" care.

Out-of-cell time for the MHU inmates varies based on their security and clinical status. Inmates who are maximum or close security, or who are medium security with pending disciplinaries, are considered to be on "walk alone" status. When on "walk alone" status, an inmate is permitted only forty-five minutes daily out-of-cell time daily with their hands cuffed behind their backs and their feet shackled. Mental health staff may designate other inmates on "walk alone" status based on clinical status and potential for disruptive behavior.

During the site review, most MHU inmates were on "walk alone" status. The MHU roster from the previous week indicated that ten of the sixteen inmates at that time were on "walk alone" status. Dr. Woodley stated in his deposition that the number of MHU inmates on "walk alone" status had been increasing, presumably due to increased number of inmates on close security. The Warden's approval is required to remove these restrictions from a close security or segregation inmate to facilitate treatment while on the MHU.

When we entered the MHU, there were numerous shackled inmates walking through the unit and on the outside patio. Three of the inmates on the patio were actually attempting to play horseshoes while shackled. Brief interviews with the "walk alone" inmates did not reveal acute psychosis. Review of their records confirmed higher security levels and histories of disruptive behavior.

While the "walk alone" inmates confirmed receipt of at least forty-five minutes of out-of-cell time daily, they reported only limited treatment. They stated that "treatment" is primarily restricted to cell-front contacts during mental health rounds. Consistent with the deposition of Officer Woodard, the "walk alone" inmates reported that the mental health technicians will at times conduct limited group activities with these cuffed inmates.

After the "walk alone" inmates were returned to their cells, two inmates were released from their cells unshackled. These inmates reported that they are permitted to be out-of-cell for a maximum of four hours a day (starting about 9:45 AM and ending at 1:45 PM) but this time is reduced when the number of "walk alone" inmates requires their recreation in two groups. These inmate reports were confirmed by the depositions of Dr. Woodley and Officer Woodard.

Officer Woodard, the only correctional officer regularly assigned to the MHU, stated that the inmates are allowed out-of-cell time only when two officers are present and two officers are assigned to the MHU only during the dayshift which ends at 2:00 PM. Dr. Woodley's deposition suggested that the regular presence of a second correctional officer on the second shift would permit additional inmate treatment. The inmates reported that there are times on the second and third shift when there is not even one officer present on the MHU because the assigned officer must cover multiple posts.

Although there were nursing staff present in the nursing office during our visit, and Dr. Woodley's deposition indicated that there are nursing staff assigned to mental health each shift, the inmates reported that nurses are not consistently present on the MHU. While nursing staff, comprised primarily of licensed practical nurses -- not qualified psychiatric nurses -- may be present periodically on the unit to administer medication, these nurses also have medical responsibilities. The ADOC-CMS contract does not require the provision of twenty-four hour nursing coverage for mental health services, and Dr. Woodley's deposition indicated that the available nurses have other duties outside the MHU, P-I and South Ward. Thus, the required twenty-four hour, seven day a week coverage essential to an acute psychiatric treatment setting is neither contractually required nor consistently provided.

The MHU inmates who were not on "walk alone" status reported that they typically participate in one or two groups a week conducted by the social workers or mental health technicians. These groups are however, unstructured and not clinically driven. Other mental health staff interaction is limited to staff rounds or brief interactions at the inmate's

cell-front. The staff rounds include those completed daily by Dr. Woodley that, according to the deposition of Officer Woodard, take from ten to thirty minutes for Dr. Woodley to complete for the entire month. The weekly "grand rounds" conducted by Dr. Woodley, the psychiatrists, and a registered nurse, according to the inmates, is sometimes the only time that an inmate regularly sees a psychiatrist. If the inmate reports are accurate, treatment planning and discharge decisions are primarily based on the "grand rounds."

Brief clinical interviews with the inmates who were permitted access to the dayhall, whether shackled or unshackled, confirmed their serious mental illness but at least marginal stability. Four inmates (185110, 209212, 181582 and 174212) who remained in their cells demonstrated obvious symptoms of acute psychosis. One of these inmates (181582) may have been transferred to P-I during our visit.

A cursory review was conducted of the current treatment documentation for the MHU inmates. The review of the MHU records uncovered virtually no documentation evidencing continuity of care:

- no admission or discharge orders for placement in the MHU;
- no admission summary of condition or rationale for admission;
- no multidisciplinary assessments;
- inadequate treatment plans;
- no evidence of informed consent for medication treatment;
- no evidence of coordination with the "main" medical record;
- no notes reflecting the treatment efforts of mental health technicians; and
- nursing notes that did not address mental health issues at all, but rather spoke to inmate vital signs and overall medical condition or activity.

While many of the inmates on the MHU were able to name the medication they were taking, only a few were able to provide the dosage they were receiving or the anticipated benefits of the specific medication.

In his deposition, Dr. Bell, the psychiatrist now providing weekly psychiatric monitoring for the MHU inmates, indicated that he believed each inmate had a treatment plan but that he was not routinely involved in the plan's development. His report was consistent with those of the mental health technician, Ms. Crenshaw, who stated that while she may or may not be provided a treatment plan for a specific inmate, those that she receives are completed by the social workers or Dr. Woodley. Thus, there is no coordinated multidisciplinary approach to treatment.

Dr. Bell acknowledged that inmates for whom he has been providing weekly psychiatric services may be discharged from the MHU or transferred to P-I without his knowledge or consultation. Dr. Bell's deposition indicates that he does not consider himself to be the primary psychiatrist for these patients, even though his notes are the only documentation of psychiatric care in the medical record.

Review of the medical records of inmates who had previously received treatment on the MHU confirmed that a Release Summary is provided at discharge. These summaries provide a minimally adequate description of the treatment provided, the inmate's response to treatment, and a plan for follow-up that is typically limited simply to a recommended placement and continued medication. The release summary diagnosis frequently differs from the diagnosis the inmate carried at the time of admission, yet there is no supporting rationale to explain the discrepancy (behavioral observations, longitudinal course, review of outside records, psychological testing, etc.) This lack of congruity provides no guidance to mental health staff subsequently responsible for coordinating and providing follow-up mental health care upon the inmate's discharge from the MHU.

Although the MHU plainly does not provide treatment or a treatment milieu consistent with inpatient psychiatric treatment standards, there are inmates who appear to have benefited from the placement. The unit is now providing some acute stabilization and maintenance but, to repeat the point, it does not approximate a hospital level of care.

Psychotropic medication is the primary treatment modality. Based on the inmate reports and documentation in the medical records, efforts to improve the inmates' understanding of their mental illness and the need for treatment compliance, as well as efforts to improve inmate coping skills, are seriously limited. The most recent information available to us (April 1999) indicated an average length of stay on the MHU of thirty-two days; which is adequate time to provide this type of basic psychoeducational treatment.

SOUTH WARD

South Ward is a twenty-two bed dormitory described as providing transitional mental health care for inmates whose clinical condition or security status no longer requires the single cell placement of the MHU. This dormitory was clean, well lit and physically appropriate for the extended care of inmates with serious mental illness. However, there was severely limited space for any active treatment. The inmates reported that any individual and group treatment is usually provided at the picnic table on the outside patio.

During the site review, five of the twenty-two South Ward beds were unoccupied. While Dr. Woodley's deposition indicated that South Ward typically has two or fewer unoccupied beds, the South Ward roster for March 9, 2000, reported nine unassigned beds. It is a curiosity that in a system so desperate for mental health space, the limited space there is not fully used.

When we entered South Ward, the inmates were sitting or lying in their beds, walking through the dormitory or sitting at the picnic tables on the outdoor patio. These inmates have access only to a few games and a television at specified times. Several inmates reported that they do nothing but watch TV all day.

No overt symptoms of acute psychosis were detected among the South Ward inmates, although the majority appeared seriously compromised by chronic serious mental illness. Several inmates reported that they would be able to manage placement in general population if accompanied with ongoing outpatient services. Brief clinical interviews and

review of the records of the inmates supported their views. These inmates were awaiting transfer to another institution or were being maintained on South Ward until their release from ADOC at the end of their sentence. Dr. Woodley's deposition confirmed that inmates may be retained on South Ward simply because there are no available beds at the designated parent institution. A printout dated October 28, 1999, indicated twenty-five inmates from South Ward and the MHU were awaiting transfer. Analysis of the list indicated that fifteen of the twenty-five inmates had been waiting a transfer for more than thirty days. It is perplexing that transfers out of South Ward and the MHU would be so delayed given the scarcity of mental health resources within the system and the pervasiveness of the unmet mental health needs of the inmates.

Consistent with the MHU, the South Ward inmates reported extremely limited active treatment and programming. The inmates did not confirm the consistent provision of one weekly group by each of the two social workers and three mental health technicians, as reported in Dr. Woodley's deposition. Officer Williams' deposition indicated that the mental health technicians conduct groups as security and time permits. Ms. Crenshaw's deposition also suggested that the conduct of group activities is determined by the availability of sufficient security and time. Ms. Crenshaw's description of the activities provided indicated that the groups are unstructured and not clinically-driven. She commented that arts and crafts activities had ceased after January of 2000 because supplies were no longer available.

The effectiveness of the South Ward program would begin to move toward minimal acceptability with additional attention to individual and group treatment focused on skill building for these dysfunctional inmates. The provision of psychotropic medication alone does not qualify as acceptable treatment. While Alabama is free to elect individual or group counseling, therapeutic communities, behavior modification, therapeutically driven programming (and more), Alabama does have to make such an election and then provide access to that aspect of treatment. If that election has been made, we found little or no operational evidence to support any such election.

One of the major complaints of the South Ward inmates was their inability to smoke cigarettes, even while outside, when placed on South Ward or the MHU. Because inmates on the MHU's at Bullock and Donaldson have access to cigarettes, it is unclear why those at Kilby would be so denied. The inmates reported that the restriction causes them distress and frequently results in disciplinary infractions since general population inmates are able to pass cigarettes to the South Ward inmates through the outside fencing. Informal discussion with the ADOC lawyers during the site review suggested that Kilby might reconsider the current practice.

There are no clear admission or discharge criteria for each of these purported levels of care. Inmate placement in P-I, the MHU and South Ward appears driven primarily by security or bed availability rather than mental health clinical condition. Further, as indicated, if an inmate refuses medication, he may be moved from one setting to a more restrictive setting to coerce medication compliance.

MEDICATION PRACTICES AT KILBY

Four of five inmates confined to P-I were prescribed antipsychotic psychotropic medication, with two of the four receiving the long-acting injectable antipsychotic medication, Prolixin Decanoate, all with no evidence of informed consent. Treatment of acute mental health problems with a long-acting medication is contraindicated because medication adjustments can be made only infrequently. In the MHU, ten inmates were prescribed antipsychotic medication, with eight of the ten prescribed the long-acting injectable. Four of the ten were also receiving Risperdal – a newer atypical antipsychotic medication – but none were prescribed the other newer medications: Clozaril, Zyprexa or Seroquel. In South Ward, eleven of the thirteen inmates prescribed antipsychotic medication were receiving Prolixin Decanoate injections.

None of the medical records reviewed had evidence that the forced, involuntary medication procedure had been invoked or that the inmate had given informed consent to

treatment with the prescribed medication. These factors, coupled with an over-reliance on long-acting injectable antipsychotic medication in an acute care setting where nurses are available to administer oral medications, are indicative that the forced medication policy is being circumvented in the only institution where the policy may be implemented.

ADMINSTRATIVE SEGREGATION

Review of the ninety-six Kilby administrative segregation cells found seven inmates (151575, 181185, 203277, 175612, 207710, 177547, 116878) who were least as, or even more, acutely mentally ill as any of those inmates located on P-I and the majority of inmates on the MHU. These inmates were being provided seriously deficient mental health attention and treatment. While the inmates were readily identified even by their peers as requiring more intensive treatment, they remained on the segregation units with only cursory mental health rounds and nominal psychiatric follow-up. Since only brief clinical interviews could be conducted at the cell-fronts, it is highly likely that there are other inmates with less obvious mental illness who were not identified.

The records indicated that several of the seven inmates identified with acute psychosis had received treatment on the MHU or at Taylor Hardin and were discharged after reaching "maximum benefit" from treatment (151575, 177547). While at least three of the inmates identified as psychotic were prescribed medication, either the inmate was not taking the medication or the medication was ineffective. In either case, the inmates required a clinical intervention and a period of stabilization. Continued placement on a segregation unit is clinically unacceptable for these inmates, disruptive for the other inmates housed on the unit and, in many instances, will contribute to the suffering and mental deterioration of the inmates with mental illness.

The inmates with serious mental illnesses who appeared currently stabilized on medication (208080, 136634, 132708) reported delays in access to care and inadequate answers to questions regarding their mental health treatment

The presence of inmates demonstrating acute psychosis on the segregation units during the site visit suggests that the mental health staff may consider segregation to be an acceptable placement for such inmates, since staff routinely review the segregation units. Dr. Bell, in his deposition, reported that he goes cell-to-cell in each of the four Kilby segregation units monthly to assess all inmates and determine the need for psychiatric assistance. Dr. Bell added that when he conducts these rounds, he has the medical charts of the inmates and notes the contact. Ms. Crenshaw reported that the mental health technicians rotate providing rounds of mental health inmates in segregation twice a week.

Observation of medication administration in segregation indicated the following: medications are pre-poured by one nurse into small envelopes labeled with the inmate's name and the names of the medications prescribed to him. A different nurse, accompanied by correctional officers, walks along the segregation range, stops at cell-fronts, and pours the envelope contents into the out-stretched hand of the inmate. The inmate is told to get some water with which to swallow his medication(s). The ingestion of medication is not observed, and their mouths are not checked to ascertain whether or not the inmate actually swallowed his medications. Documentation that the medication was delivered to the inmate occurs after the fact, a practice that likely jeopardizes the nurses' licenses.

GENERAL POPULATION

We were not permitted by ADOC counsel to move freely among the general population inmates to assess the possible presence of inmates whose serious mental illness was unidentified. We were permitted to interview approximately fifteen general population inmates whom we selected from the medication administration records. Four of these inmates reported problems with mental health services. Two of these inmates (209119, 209078) reported that the medications they had been prescribed and taken when in the community, Risperdal and Wellbutrin, had been summarily changed to Thorazine and Sinequan upon their arrival at Kilby. Another inmate (209078) reported the non-renewal of Sinequan and Artane, and the non-renewal may well have clinical justification. However, in such a case the inmate must be monitored to assess the impact of such change. This inmate

stated he had not been scheduled for follow-up and there was no evidence in the record of monitoring. The most troublesome report was from an inmate (154941) who stated he had been prescribed Haldol while at Taylor Hardin but he had not received the medication for the three weeks he had been at Kilby.

It is disturbing that four of fifteen of the inmates receiving psychotropic medication in general population credibly reported problems with mental health services. If we had been permitted access during the visit to speak with mental health staff, it is possible that these reported problems would have been explained by staff.

Two of the fifteen general population inmates interviewed also reported there were inmates in their dormitories who appeared to have serious mental illness. The inmates described the inmate bed locations but were unable to provide the inmate names. Thus, we were unable to interview these inmates.

INFIRMARY MENTAL HEALTH CELLS

Kilby has twelve single cell infirmary cells located in the South, East and West Ward Isolation areas. These cells are not dedicated for mental health treatment and plainly should not be part of any count of mental health beds. While there are also forty-one infirmary dormitory beds, dormitory beds are inappropriate for the treatment of inmates requiring mental health crisis stabilization.

ST. CLAIR CORRECTIONAL FACILITY

Our site visit of St. Clair Correctional Facility was conducted on Tuesday, March 14, 2000. St. Clair is a male, maximum-security institution with an inmate census of approximately 1330. General population inmates are housed in dormitories. There are 216 segregation cells used interchangeably for administrative and disciplinary placements. There are three cells in the infirmary designated for mental health crises. One additional single cell and a sixteen-bed dormitory are reportedly available for some mental health care as well as medical treatment.

St Clair mental health staffing as of May 2000 was as follows:

Psychiatrist (CMS)	Sanders/Williams (rotated) - 8 hours per week
Licensed Psychologist (CMS)	Leonard – 8 hours per week
Licensed Practical Nurse (CMS)	Noell – 16 hours per week
Psychologist (ADOC)	Sandefer – 40 hours per week

St. Clair inmates who receive psychotropic medication participated in a group discussion with us and reported that they have no interaction with the licensed practical nurse except during medication administration and when she assists the psychiatrist during his inmate reviews.

The ADOC psychologist, Dr. Sandefer, provides services to general population inmates and conducts rounds of segregation inmates. When an inmate reports a psychiatric problem, Dr. Sandefer reportedly refers the inmate to CMS staff. In his deposition, Dr. Sandefer agreed that he spends about 40% of his time providing clinical services to inmates, with the remaining 60% of his time spent on such administrative functions as participating on the Institutional Segregation Board and Progress Review Committees or completing evaluations for the Parole Board and individuals seeking employment at the institution.

SEGREGATION

It was in this facility that we became aware of Alabama's use of what we would estimate to be one-half inch thick rubber or plastic mats used for sleeping in lieu of a regular mattress. While it appeared that at most ADOC institutions these mats were used only in the mental health cells, they were used in many of the St. Clair segregation cells. In three of the St. Clair segregation cells, a white foam was escaping from the pad and oozing onto the concrete block, which serves as the firm portion of the bed. When lifted, the surface in each case was blackened, resembling some type of fungus or mildew. Inmates could actually scoop-up the white foam and display it in their hands. When asked, the inmates said they had no access to any cleaning materials and claimed that they were being medically affected by the foam and fungus. One inmate displayed a rash over much of his body and said it came from the pad and the fresh mortar used to construct his new bed.

The generally terrible condition of the St. Clair segregation cells suggests that for the five inmates who told us they asked to be placed there, it was better than living in the vast dormitories. Two of these five inmates described themselves as paranoid and, in accord with the other inmates who spoke to us, they indicated that mental health treatment was virtually nonexistent.

Review of the list of inmates on psychotropic medication indicated that twenty-six of the segregation inmates were prescribed such medication. Brief cell-front interviews with the inmates on the segregation units identified at least fifteen inmates with serious mental illness. Dr. Sandefer's deposition confirmed our observation of the presence of acutely psychotic inmates on the St. Clair segregation units.

One severely regressed inmate (100116) reported that he had been on SSDI (Social Security Disability Income) and prescribed Prolixin (an antipsychotic medication) while in the community, but had been prescribed only Benadryl (an antihistamine with some sedative effect) in the prison.

The segregation inmates reported that since the psychiatrist sees them only very briefly, they have very limited opportunity to ask questions or discuss their problems. The inmates who are prescribed injectable medications reported that at times the psychiatrist sees them only when they are lined up to receive their injections. This cannot reasonably be considered "treatment" or "therapy" by any standard. The St. Clair inmates also reported that if a psychotropic medication injection is refused, it may be forced, apparently without a hearing.

The segregation inmates reported little follow-up by the CMS or ADOC psychologist. While the inmates acknowledged that Dr. Sandefer does conduct weekly rounds, they claimed that his rounds of the twenty-four cells in one of the segregation units can take less than ten minutes. In his deposition, Dr. Sandefer stated that he spends from one

to three hours completing the segregation rounds of 216 segregation cells. The inmates described the rounds as more like a "drive through." This theme -- rounds as a "drive through" -- was repeated in most of the facilities visited, giving rise to our overall conclusion that rounds exist primarily in name only.

The segregation inmates reported that there is little staff observation of medication ingestion. Indeed, several inmates volunteered that they routinely "cheek" their medication to save it for when they feel they need it or to pass the medication on to other inmates.

GENERAL POPULATION

We were not permitted to move freely among the general population dormitories because of security concerns expressed by ADOC counsel. As a consequence, we conducted two groups with general population inmates. The inmates provided a description of mental health services that was consistent with that of the segregation inmates, emphasizing the lack of contact with mental health staff and inattention to their medication needs.

Medication administration for general population inmates is scheduled for 4 AM, 11 AM and 4 PM. Observation of 11 AM medication administration disclosed that the administering nurse made no attempt to verify that an inmate had in fact ingested the medication. The inmates also reported that their medications are not always available and they may appear for their medication only to be told to return the following day because the medications had not yet arrived.

With regard to accessing care, inmates consistently reported that for immediate mental health attention, it was necessary to beat on your cell door or bed, flood the cell, start a fire, or "to act out - like mutilate yourself." (In fact, inmates at several institutions gave the same report.) Written requests for care took several days for any response or, more likely, were never answered.

Review of the mental health records of St. Clair inmates indicated consistently inadequate documentation by the psychiatrist, with no recorded evidence of treatment efforts other than medication. There were no treatment plans found in the records. There was no evidence of an informed consent process; no documentation of whether or not the inmate had ever undergone the involuntary medication procedure; and there was inappropriate, or simply no, monitoring of laboratory work.

There was evidence that inmates had been started on medications without ever having been seen by the prescribing psychiatrist and then continued on medication without appropriate follow-up to determine the medication's effectiveness or side effects.

Again, overutilization of long-acting injectable antipsychotic medication was apparent with no supporting rationale in the medical records. Medications commonly prescribed in other correctional systems with which we are familiar, and in the free world, for the treatment of bipolar disorder, impulse control problems and aggression (e.g., lithium, Tegretol and Depakote) were rarely being utilized. This is very surprising given a maximum security setting where inmates are routinely described as having problems with impulsivity and aggression.

Although Dr. Sandefer reported that he was able to review an inmate's medical record, he has not been permitted to document in the medical record since some time in 1999. Dr. Sandefer retains his own inmate files and also documents certain information in the inmate's Institutional File but never in the medical file. Since Dr. Sandefer provides monitoring and counseling to inmates also receiving psychiatric care, the omission of Dr. Sandefer's notes from the medical record precludes the sharing of important information. Confidential mental health information maintained by Dr. Sandefer in a file separate from the medical record also poses serious problems relating to continuity of care whenever an inmate is transferred.

The paucity of documentation in the mental health record makes it impossible to ascertain whether there is any continuity of care and whether even the most basic of medical requirements (informed consent for psychotropic medication) are being observed. Inmates are at-risk because of these omissions since medications appear to be prescribed absent personal contact with a psychiatrist and because medications which are routine in other correctional systems are not utilized here.

INFIRMARY MENTAL HEALTH CELLS

During the site review, one of the three mental health cells was occupied by an inmate on suicide watch; another was occupied by a medical patient; and the third was unoccupied. Although the inmate on watch had been provided a suicide blanket and tunic, the St. Clair inmates in the outpatient group chuckled at this news. They unanimously reported that inmates on watch consistently are left nude with only the thin rubber mat to sleep on.

The small windows of the mental health cell doors do not permit the total observation of the cell required for the regular monitoring of the inmate without staff opening the door. One window actually was painted over and the paint then attempted to be scratched out, further reducing visibility. The inmates unanimously reported that the cell door is not opened except for meals and when nursing staff checks vital signs.

An inmate may be placed in a mental health cell by security staff but is discharged by a psychiatrist. Since a psychiatrist is on-site only one day a week, the inmate may remain nude in the Spartan cell for six days without a psychiatric evaluation. There is no documentation of active treatment of the inmate during the interim. Although CMS staff are present only two days a week, Dr. Sandefer, the ADOC psychologist who is present 5 days a week, reported that he no longer has the authority to admit or discharge an inmate from a mental health cell, nor is he expected to provide monitoring of inmates placed in these cells. Indeed, Dr. Sandefer stated that Dr. Williams told him "to stay the hell away from his patients."

The delay in the treatment of inmates experiencing a crisis is totally unacceptable by any professional standard of which we are aware for an inmate whose behavior or verbalizations resulted in placement in this restrictive setting. Indeed, if it is a mental health crisis that precipitates the move (*vis a vis* overt punishment), then the inmate suffers needlessly in this cell and there is a strong likelihood of preventable deterioration in the inmate's mental health.

In his deposition, Dr. Woodley noted one inmate who had been transferred to Kilby after spending three weeks in the St. Clair infirmary for having voiced suicidal ideation. This report contradicts any claims to using these mental health cells only for short periods of time.

Because St. Clair staff reported that they do not maintain logs for the use of restraints, it was not possible to determine the frequency or duration of such use. The security staff indicated that restraints were used infrequently and that they do not use a restraint chair.

DONALDSON CORRECTIONAL FACILITY

The site visit of Donaldson Correctional Facility was conducted on Wednesday, March 15, 2000. Donaldson is a male maximum-security institution with a census of approximately 1450 inmates. The institution has eight segregation blocks with a total of 212 segregation cells. One of the segregation blocks of twenty-four cells is known as the Donaldson Mental Health Unit (MHU). The remaining general population inmates are housed in dormitories and cell blocks containing two-man cells that are open during the day. There are two cells in the infirmary designated for mental health treatment.

Donaldson mental health staffing as of May, 2000 was as follows:

Psychiatrist (CMS)	Murbach - 24 hours per week
Licensed Psychologist (CMS)	Vacant

Licensed Practical Nurse (CMS)	Hendrix – 40 hours per week
Psychologist (ADOC)	Vacant

(Dr. Rankart, the CMS psychologist who had provided 16 hours per week at Donaldson, resigned prior to our visit and CMS was said to be recruiting for a replacement.)

Warden Mitchem stated in his deposition that Donaldson had approval to recruit for the vacant ADOC psychological associate position and was seeking approval to hire an additional psychological associate. The duties of the ADOC psychological associate include: services for general population inmates; crisis intervention; rounds of the administrative segregation units including the MHU; and referrals to CMS for psychiatric assistance.

Warden Mitchem also indicated that CMS had recruited for a mental health technician on numerous occasions without success.

MENTAL HEALTH UNIT

The Donaldson MHU is characterized in CMS/ADOC documents as a transitional unit for inmates with serious mental health problems who would have difficulty managing in the large maximum-security dormitories. Dr. Woodley's deposition indicated that maximum-security inmates who received mental health treatment at Kilby may be transferred from the South Ward dormitory to the Donaldson MHU as a "step-down" from Kilby. There is no indication in the CMS/ADOC documentation that the Donaldson MHU would maintain inmates with serious mental illness who do not respond to treatment.

The MHU is located on the 3 Side of Seg 5 Block and has twenty-four single cells in a two-story cell-block. There is no protective covering on the second-floor railing or on the stairwell as a suicide, self-injury protective measure. A central dayhall with tables and chairs for inmate dining included a plexiglass shower that permitted total observation of the inmates during bathing. The showers leak water onto the concrete floor, forming puddles

that constantly need to be mopped, adding humidity to an already physically uncomfortable environment.

While some acoustical dampening material has been installed to reduce the noise within the unit and some wall murals were added in an attempt to provide a therapeutic milieu, the environment remains dark, dreary and stark. The inmates reported that the unit may become very warm or very cold depending on the weather. Several inmates reported that the unit is infested with rodents and insects. The unit has an outside recreation area, but there are no staff offices or group areas for confidential treatment or group activity. Thus, the environment is physically unacceptable as a therapeutic setting.

While some documents suggest that the Donaldson MHU began functioning in 1995, Warden Mitchem's deposition indicated that the full time correctional officer presence on the MHU on the dayshift required for treatment activities may not have been effectuated until early in 1997. At that same time, a CMS licensed practical nurse was assigned to the unit on the day shift.

The MHU is fortunate that the correctional officer assigned to the unit, Officer Evans, received some mental health training while in the military. Officer Evans' deposition reflected his appreciation for providing the "eyes and ears" for mental health staff. On the other hand, the licensed practical nurse, Mr. Hendrix, reported that his only preparation for mental health responsibilities were two weeks of mental health training while in nursing (LPN) school in 1990 and the on-the-job training provided by CMS staff.

Depositions indicated that the MHU inmates are permitted to be out-of-cell approximately three hours a day as a group unless contraindicated by security or clinical concerns. The depositions of Officer Evans and Mr. Hendrix indicated that they jointly make the decision of whether or not an inmate receives out-of-cell time. Inmates who are not permitted group out-of-cell time are given the forty-five minutes of shackled out-of-cell time consistent with "walk alone" status.

The inmates reported receiving less out-of-cell time than three hours a day, particularly when the need to exercise inmates on "walk alone" status decreases the time available for groups of inmates. No inmate is permitted out-of-cell after the day shift ends at 4 PM.

A typical day on the MHU was described by the inmates as follows:

3 AM	Breakfast.
8 AM until 9:30 AM	Showers, cell cleaning and medication administration.
9:30 AM until 12:30 PM	One group of approximately 10 inmates is permitted out-of-cell for lunch and then activities and outdoor recreation.
12:30 PM until 3:30 PM	A second group of inmates is permitted out-of-cell for activities and outdoor recreation and then dinner.
3:30 PM	A few inmates remain out-of-cell to complete cleaning chores.
4 PM	All inmates locked down.

The inmate reports of a typical day were consistent with the depositions of Officer Evans and Mr. Hendrix, as were the reports of the treatment that is provided.

Dr. Rankart, the CMS psychologist who recently resigned his position and has not yet been replaced, reportedly spent from two to three hours on the MHU two days a week. On Mondays, he would arrive about 11 AM and the inmates would be returned to their cells so that Dr. Rankart might complete cell-to-cell rounds. During the rounds, he reportedly entered the cell of most inmates, had a five to ten minute interaction, and assessed the cleanliness of the cell. His assessment was conducted through the cell-front for unstable or hostile inmates. After completing the rounds, Dr. Rankart participated in watching the

weekly movie provided as a reward for inmates who demonstrated acceptable hygiene. He then left the unit at the end of the movie. While the inmates reported no discussion of the movie, depositions suggest that at times the content of the movie may have been discussed.

On Tuesdays, Dr. Rankart arrived at the unit at about 11 AM and conducted a "community meeting" for inmates electing to participate. Dr. Rankart was then available to speak with inmates and in some fashion engage in outdoor sports with them until approximately 2 PM.

The activities available to inmates when out-of-cell on Wednesday, Thursday and Friday mornings, and during all weekday afternoons, are primarily limited to simple board games and outdoor recreation. Inexplicably, there is no television available to the inmates. A local religious leader may come to the unit on Wednesday mornings for about an hour to conduct religious programming for interested inmates.

In his deposition, Mr. Hendrix reported that while he conducts some group programming he has had no formal training in psychoeducational or supportive groups. He indicated that he has no lesson plans for the groups but will present such topics as anger management and personal hygiene based on some unspecified material he has read.

Dr. Murbach began providing three days of psychiatric coverage at Donaldson shortly before our visit. He is the only psychiatrist available at Donaldson. (Previously, he provided only two days per week.) According to his recent deposition, his time may soon increase to four days per week.

According to Officer Evans' deposition, Dr. Murbach arrives about 3 PM and spends approximately ninety minutes on the unit. Mr. Hendrix reported that Dr. Murbach may remain on the unit from two to two and half hours. Dr. Murbach has a list of ten to fifteen inmates that he interviews. The individual inmate interviews reportedly last from five to ten minutes.

Inmates are seen approximately once a month by the psychiatrist for the individual five or ten minute sessions noted above. Inmates are handcuffed when brought to see Dr. Murbach at the desk in the dayhall, even when inmates are not required to wear cuffs at any other time when out of their cells. This practice obviously further inhibits the development of a positive or trusting relationship with the psychiatrist. Curiously, we were permitted to assemble an inmate group outside and there were no cuffs used. The inmates said they had never before been in a group where they could sit outside, talk, and be treated like people.

The type and level of individual and group treatment available to the MHU inmates is seriously deficient. The psychiatrist and psychologist provide only cursory individual reviews of the inmates. Individual treatment plans are developed but they are generic and provide very limited information about the inmate. A typical treatment plan, for example, lists the following goals: optimize psychopharmacotherapy (medication); participate in group therapy (156007).

As noted previously, everything denominated as treatment must be provided on the dayhall of the unit or at the inmate's cell, without apparent attention to confidentiality.

The only group programming that the psychologist offered was to provide a weekly movie and a "community" meeting; each a potentially valid activity but totally inadequate and certainly not requiring the skill of a psychologist. The licensed practical nurse, although plainly well intentioned, is not trained to conduct psychoeducational groups. An essential component of treatment with this population is medication education designed to foster an informal basis for treatment compliance. Mr. Hendrix continues to learn the basics about psychotropic medications, but his deposition indicates that he does not yet know what constitutes an atypical antipsychotic medication.

It is perplexing why MHU inmates capable of group interaction are not given the opportunity to be out-of-cell routinely both in the morning and afternoon. Mr. Hendrix's

deposition indicated that there was no limit on the number of inmates permitted to attend the Monday movie or Wednesday religious programming.

While we were not present for the "morning" (12:30 AM) or "mid-day" medication administration times (8:00 AM), Mr. Hendrix's deposition indicated that he and Officer Evans go cell-to-cell and request the inmate to step out of his cell so that medication ingestion may be observed. Observation of the "evening," that is, last medication pass of the day at 3:00 PM, revealed unacceptable medication administration practices. Mr. Hendrix provided the inmates with medications from small envelopes that he took from his pocket as the inmates sat around the dayhall tables. Documentation of the administration is not completed at the time of administration. Although the process supported the seeming rapport the nurse has with the inmates, it is inconsistent with nurse practice standards.

While treatment practices on the MHU fall well below acceptable standards of care, the majority of the inmates observed on the dayhall appeared to have somehow achieved at least marginal functioning. However, several of these inmates demonstrated the tremors often associated as a side effect from psychotropic medication.

The major complaints voiced by the inmates concerned delays in pending transfers and the monotony and total boredom of the unit.

The medical records suggest that while mental health staff may request a reduction in an inmate's security to permit treatment in a less restrictive environment, the institution's approval of the modification is often denied or delayed (156007).

Cell-front interviews with MHU inmates who either were restricted to their cells or refused to participate in unit activities revealed the inmates with the most serious problems. Brief interactions quickly identified eight inmates (109970, 124298, 135129, 108809, 113878, 111156, 137113, 150579) suffering with acute psychosis. The inmates evidenced delusional and tangential thinking and in our presence appeared to be responding to

hallucinations. Their personal hygiene and cell cleanliness were generally poor. The body odor emanating from three of the cells was overwhelming. Several of the inmates confined to their cells also appeared to experience profound side effects from prescribed antipsychotic medications in the form of severe tremors of the musculature of the arms and neck. Record reviews indicated that these inmates had not recently become psychotic but had been experiencing symptoms of serious mental illness over extended periods of time. One record, for example, (124298) indicated that the inmate had been deteriorating for months and that for weeks the psychiatrist had contemplated a transfer to the acute care supposedly available at Kilby.

What we saw and read contradicted Dr. Woodley's deposition testimony that when Donaldson MHU inmates exhibit symptomatology of acute mental illness, stabilization through psychiatric evaluation and medication on-site are the first interventions. According to Dr. Woodley, if an inmate did not respond within twenty four to forty eight hours, he was to be transferred for more intensive treatment at Kilby. Our visit simply did not confirm this practice.

Warden Mitchem's deposition indicated that Dr. Williams and Dr. Woodley coordinate with the Donaldson classification staff in arranging transfers in and out of the MHU. He gave testimony that mental health staff assigns priority for placement of inmates on the MHU and that inmates may be retained in administrative segregation while awaiting transfer to the Unit. While there is no doubt that there is a waiting list of inmates awaiting transfer in or out of the MHU, we were unable to determine how many inmates were on the list or the duration of time spent waiting for transfer.

Our review of the Donaldson MHU found a physical environment and treatment practices that seriously contradict Dr. Feldman's description in the MAC minutes of March 12, 1998 of the unit as "one of the most therapeutic mental health units one could get." In our opinion the absence of regular clinically-driven activities combined with the bleak

environment and restricted movement results in grossly inadequate care and leads to needless suffering.

ADMINISTRATIVE SEGREGATION

Review of medication administration records during the site visit indicated that thirty-two of the inmates in the 192 administrative segregation cells (approximately 17%) had psychotropic medication ordered on their behalf. Mental health follow-up of these inmates was provided by Dr. Murbach and by Dr. Rankart previous to his departure. In his deposition, Dr. Rankart indicated he maintained a caseload of approximately twenty segregation inmates and, in addition, he reviewed inmates referred to him. These interventions were usually conducted at the inmate's cell-front.

Brief cell-front interviews conducted with inmates on the administrative segregation unit quickly identified four inmates with serious mental illness (including inmates 108804, 135129, 109315). Inmates who may be just as sick but with less overt symptoms would likely be identified with a more intensive review. One inmate (109315) reported that he chose to be on the administrative segregation unit for his "paranoia." He reported that he has received Prolixin at times but often refuses the medication because the psychiatrist will not order medications for his side effects. Another inmate reported that while he was treated for "hearing voices" in the free world and in the county jail, he receives no treatment at Donaldson in spite of experiencing the same symptoms. A review of his record demonstrated that he earlier had in fact been prescribed both Haldol and Prolixin but that his diagnosis had been amended while in ADOC custody to "personality disorder and malingered psychosis." His medications were discontinued.

While we did not observe medication distribution on the segregation units, discussion with the nurse completing the process (with the approval of ADOC lawyers) indicated a process inconsistent with nursing practice standards. The nurse provided the medication from envelopes labeled with the inmate's name and medication. These envelopes were prepared by a different nurse. The distributing nurse stated that she would

document the inmates' acceptance or refusal of medication on the medication administration records while preparing the envelopes for the next shift of nurses. This process violates the chain of responsibility required by nursing practice, which requires the same nurse to prepare, administer and document the medications.

Although the nurse confirmed that she observed the inmates' ingestion of medication, the quality of the observation is questionable. When one inmate was asked about his medication shortly after the administration process, the inmate replied that he did not know the name of his medication but could show us the pills and he did.

GENERAL POPULATION

Review of medication administration records during the site visit indicated that thirty-two of the general population inmates were prescribed psychotropic medication.

Since there were security concerns expressed about our moving freely among the general population dormitories, our review of these inmates was restricted to individual meetings with six selected inmates. The individual inmates were selected either because they were receiving psychotropic medication or because they were identified by other inmates as experiencing serious mental health problems.

Mental health follow-up of general population inmates is completed by Dr. Murbach and Dr. Rankart. In his deposition, Dr. Rankart indicated that he saw from six to seven inmates in his office on Mondays and Tuesdays from 8:30 AM until approximately 11 AM. He reported that the individual interviews with general population inmates might last from ten minutes to an hour.

Interviews with the general population inmates uncovered no signs of acute mental illness. The inmates identified by other inmates as behaving in unusual ways did demonstrate some idiosyncratic and paranoid thinking, but there was no obvious evidence of acute psychosis.

INFIRMARY MENTAL HEALTH CELLS

Review of one of the mental health crisis cells revealed a bare room with a rubber pad on the floor. While nurses and correctional officers are to maintain "watches" in these cells, there were areas of the room that could not be seen through the small door window. Inmates consistently reported that staff do not open the doors to conduct the required observations, and we have no contradictory evidence.

Inmate reports that they are typically placed in the mental health cells nude and for extended periods of time were confirmed by the medical records. The records indicate that an inmate may be placed in a mental health cell by security staff for risk of self-harm or disruptive behavior possibly related to mental illness. The on-call psychiatrist is contacted for "watch orders" to govern the placement and possibly also for medication orders. The inmate is then maintained in the cell until the CMS psychiatrist or psychologist is next on site. Thus, there can be a period of several days before an inmate receives a face-to-face mental health evaluation. While the inmates reported that nursing staff check vital signs each shift, many found this disturbing since they had no clothing or even a sheet with which to cover themselves in the presence of female staff.

The inmates reported, and one correctional officer confirmed, that when inmates are restrained at Donaldson, they are restrained on their stomachs; a dangerous, unprofessional practice which may have serious medical implications, including positional asphyxia and death. Constant observation by staff with the inmate in the supine position is the acceptable practice.

HOLMAN CORRECTIONAL FACILITY

The site visit of Holman Correctional Facility was conducted on Thursday, March 16, 2000. Holman is a male, maximum-security institution with an inmate census of approximately 750. The facility has 160 cells for death row inmates and eighty-nine segregation cells. General population inmates live in large dormitories. There are no

infirmary mental health beds at Holman. Holman inmates experiencing a mental health crisis are transferred to mental health cells at nearby Fountain Correctional Facility.

Holman's mental health staffing as of May 2000 was as follows:

Psychiatrist (CMS)	Passman - 4 hours per week
Licensed Psychologist (CMS)	Crum – 8 hours per week
Psychiatric Technician (CMS)	Pearson – 40 hours per week
Psychological Associate (ADOC)	Holbrook - 40 hours per week

(At the time of the site review Dr. Williams, rather than Dr. Passman, was providing the four hours per week of psychiatric service at Holman.)

Ms. Pearson's deposition indicated that her duties as the mental health technician include reviewing referrals to schedule inmates for the CMS psychologist and psychiatrist; interviewing inmates for possible inclusion in groups; counseling inmates "who need to talk to someone;" and evaluating inmates who threaten or inflict self-injury.

Dr. Crum's deposition indicated that the ADOC psychologist provides general follow-up and group treatment for general population inmates as well as conducts rounds of the segregation areas. Inmates presenting with psychiatric problems are referred to CMS staff.

RECEIVING UNIT

The site review began with a visit to the Holman Receiving Unit. While we are unable to determine exactly why an inmate is held in this medieval five cell unit, the placement must be related to security or discipline since it is the most restrictive, isolated placement in the institution, perhaps the entire state. The double-door cells were dungeon-like and filthy. Even with both doors open, there was little illumination within a cell. Opportunities for inmate interaction are limited to yelling between cells and infrequent correctional officer's rounds. While these inmates are provided forty-five minutes of out-of-

cell time daily, many refuse because the out-of-cell time reportedly is offered extremely early in the morning.

At the time of the site review, two of the five Receiving Unit inmates were receiving psychiatric follow-up. One (186652) appeared stable on his medication and the other (181334) reported that he had discontinued his medication. Review of the records of the inmate refusing medication indicated that the inmate had numerous placements on the Kilby MHU and had been maintained in the Fountain mental health cell ("the padded cell") for more than a month in July of 1999. His receiving unit cell was filthy, which is a sign of acute mental illness.

In his deposition, Dr. Crum reported that he visits the inmates in the Receiving Unit to "keep an eye on them." We agree with his evaluation that no inmate with mental health problems should be placed on this unit. Placing such inmates in this type of environment enhances the chances for suicide, reduces the opportunity to prevent or even react to it, and is likely to exacerbate serious mental illness. It is our further opinion that no person - whether mentally ill or not - should be required to live in the conditions of the receiving unit.

SEGREGATION UNIT AND DEATH ROW

Brief interviews were conducted with those segregation unit inmates who were not sleeping. Those interviews were very difficult to conduct because of the high noise level and limited meshed cell window areas. However, even under these conditions, at least four inmates with overt signs of acute psychosis were identified (116798, 129721, 121152, 143399). Others appeared to be regressed and functioning at a marginal level. Several of the segregation inmates expressed concern with the limited attention paid to a segregation unit inmate who is deaf and unable to speak. We were unable to communicate with this inmate who appeared to be utterly frustrated by our unavailing efforts.

Review of the medication administration records indicated that twenty-one segregation inmates were prescribed psychotropic medication. Three other inmates reported at one time that they had received medication at one time but that the psychiatrist had discontinued the medication reportedly because the inmate did not need medication.

One inmate (129721), who we believe was psychotic, reported that he had received medication but it had been discontinued in 1998 because he was non-compliant. Although the inmate said that he had requested to see the psychiatrist three weeks earlier, his records revealed no documentation of the request. The records did contain a psychiatric order on 12/3/99 indicating "May give Haldol 10 mgm IM q. 4 hours as needed PRN agitation. May use 4-point restraints PRN indicated for uncontrolled behavior." PRN orders to use injectable antipsychotic medications for agitation, rather than psychotic thought processes, is a highly suspect practice. PRN orders for four-point restraint are a violation of accepted psychiatric practice and specifically prohibited by health care regulatory bodies of which we are aware.

Dr. Crum's deposition indicated that he spends about one hour, twice a week, monitoring inmates of the segregation units who are on his caseload or have been referred to him. He stated that he sees from six to seven inmates in an hour and characterized his interactions as "bam-bam." It is doubtful that the psychiatrist could do any more since he is only at the institution four hours per week.

The records provide limited information and provide no evidence of meaningful treatment other than medication.

Segregation pill call is conducted in as unacceptable a manner at Holman as the other facilities described thus far. Medications are prepared by one person and placed in small envelopes labeled with the inmate's name, cell location and medication. Medication envelopes are then distributed by a different nurse by placing them into the inmate's outstretched hand. Ingestion is not observed. Documentation that the medication was

delivered does not occur until after the entire process has been completed. Once again, this violates acceptable nursing practices.

GENERAL POPULATION

Review of the medication administration records indicated that twenty-six general population inmates were prescribed psychotropic medication. A group meeting with nine inmates selected from the medication roster revealed general dissatisfaction with the services but no evidence of acute psychosis. The inmates identified other inmates they believed had serious mental health problems. Individual interviews with these identified inmates confirmed marginal functioning and idiosyncratic thinking but no acute psychosis.

Dr. Crum's deposition indicates that he has limited time to follow-up on the general population inmates. His report suggests that he spends less than two hours each week monitoring the general population inmates, which is consistent with his reports that he spends from five to ten minutes with twelve to thirteen inmates. Dr. Crum stated that he conducts a weekly group for fifteen to twenty inmates. Since only three or four of these inmates receive psychotropic medication, it appears that most of the inmates receiving group psychotherapy do not have a serious mental illness.

INFIRMARY MENTAL HEALTH CELLS

As noted previously, Holman inmates requiring precautionary mental health placements are transferred to nearby Fountain Correctional Facility. The inmates report, and the records confirm, that the inmates are placed in the cells nude with only the rubber mat favored by the ADOC. They spend extended periods under these restrictive measures because discharge requires a psychiatric order and a psychiatrist is in the area only one day per week. This must challenge Holman operations because Dr. Crum reported that if an inmate is a death row or life without parole inmate, Holman must provide the correctional officer observation while the inmate is at Fountain.

Documentation that Holman inmates have been maintained in the Fountain mental health cells for weeks at a time demonstrates an unacceptable and grossly deficient practice. An inmate requiring more than a few days to stabilize clinically requires a transfer for more intensive treatment. In his deposition, Dr. Crum stated that when a transfer to Kilby is approved by Dr. Woodley, the transfer typically occurs within three or four days.

The presence of a CMS psychologist and psychiatrist only 12 hours per week compromises the ability to provide timely crisis intervention. Ms. Pearson's deposition indicated that she may provide the initial assessment of an inmate potentially at risk for self harm and then shares her assessment with the on-call psychiatrist. Ms. Pearson defined decompensation as "to lose – their muscles and stuff start deteriorating. Start looking a lot older than what they are, just totally." She also stated that decompensation is related to lack of exercise or sunlight. Given her obviously complete lack of knowledge about acute psychosis, her ability to effectively evaluate inmates in crisis is dubious at best.

BULLOCK CORRECTIONAL FACILITY

The initial site visit of Bullock Correctional Facility was conducted on Friday, March 17, 2000 with a follow-up visit conducted the morning of June 21, 2000, by Dr. Haddad. Bullock is a male, medium security institution with an inmate census of approximately 1125. The institution was opened in 1987 to specifically treat inmates with intermediate mental health problems. The inmates are housed in dormitories ranging in size from eight to forty-four beds. Two 44-bed dormitories are managed by CMS staff and named the Transitional Mental Health Unit. Five 38-bed and three 8-bed dormitories are managed by ADOC staff as the Intermediate Mental Health Unit. Recently, a four-bed dormitory was designated as a "time out" room. We observed four single cells of the infirmary available for mental health treatment. Bullock has twenty cells that are used interchangeably for disciplinary and administrative segregation.

The CMS mental health staffing at Bullock as of May 2000 was:

Psychiatrists (CMS)	Sanders - 16 hours per week Downs – 40 hours per week
Licensed Psychologists (CMS)	Gilbert – 16 hours per week Van Wyck – 8 hours per week
Licensed Practical Nurse (CMS)	Penn – 40 hours per week
Mental Health Technician (CMS)	Goodwin – 40 hours per week

(Note: Psychiatric coverage at Bullock increased from forty to fifty-six hours per week from the time of our initial visit in March.)

TRANSITIONAL MENTAL HEALTH UNIT

The two dormitories of the Transitional Mental Health Unit provide a total of eighty-eight beds. During the initial site review, only a few beds were unoccupied, but at least seven of the forty-four beds of one dormitory were filled with "overflow" inmates without any mental health needs. These did not appear to be temporary placements since two of the inmates (including 194108) had been maintained on the unit for more than thirty days. Dr. Gilbert's deposition confirmed that ADOC uses mental health beds for other inmates when needed. Again, this is an odd use of specialized beds in a system where decent bed/treatment space is so limited.

The environment of these units generally was acceptable for the long-term housing of inmates with non-acute mental illness. The dormitories were well lit, clean, orderly and provided access to outdoors. However, the space available for staff office and group treatment was limited to dayhall space and one office. The inmates have limited space to sit other than their bunk beds. They are permitted to have meals in the institutional dining room.

Brief interviews with the inmates identified only two inmates who were experiencing symptoms of acute psychosis. In fact, some of the inmates demonstrated

functioning that might permit general population placement with adequate outpatient support. Four of the inmates were functioning well enough to have jobs off of the unit. The major complaint of the inmates in this unit was the non-stop boredom.

Interviews of the two inmates identified by their peers as having difficulty functioning (141037, 143814) confirmed auditory hallucinations and sleep disturbance. It is troublesome that while the inmates noticed the signs of decompensation, staff apparently had not brought the situation to the psychiatrist's attention. An interview with one of these inmates (141037) during the second Bullock visit found the inmate remained psychotic. The inmate demonstrated poverty of speech and appeared to be attending to auditory hallucinations. In his deposition on May 10, 2000, the mental health technician Charles Goodwin identified this inmate as talking to himself and displaying shifting eye movements. Mr. Goodwin also stated that the psychiatrist knew that the inmate had been talking to himself. Review of the inmate's medical record revealed the most recent psychiatric review on March 20, 2000 indicated "no change" in treatment. There were no progress notes reflecting staff assessment or intervention with an inmate who had been demonstrating overt signs of psychosis for several months.

The inmates reported adequate, if brief, monitoring by the psychiatrists and acknowledged that Dr. Sanders spends a couple of hours in the dorm office twice a week and is available for inmates who wish to speak with him. The inmates on medications requiring periodic laboratory testing reported, and records confirmed, that laboratory testing had been sporadic in the past but, presently, Dr. Downs routinely orders such testing for inmates on his caseload. The inmates suggested that the nurses do not always follow through on Dr. Downs' orders but continue to follow old orders. We could not confirm or disprove this report. In his deposition, Dr. Downs acknowledged that he had also received such inmate reports.

Programming seems limited to three thirty minute psychoeducational sessions conducted weekly by the mental health technicians. All forty-four inmates of each

dormitory are required to sit on their beds while the technician conducts the group. Although the most recent topics of the sessions, problem solving and the pursuit of happiness, may have value, smaller groups with increased inmate involvement would likely have more benefit.

A few inmates stated that they leave the unit to attend programming by the ADOC psychologist associate held in the general population. Inmates reported that while a staff person may initiate these group sessions, it also was routine for an untrained fellow inmate to actually conduct the groups.

Review of the records found limited, if any, treatment planning and did not provide any evidence of continuity of care. In many cases, the only treatment modality referenced was psychotropic medication. For many of the inmates, the medication was a decanoate (the long-acting injectable antipsychotic medication) with no evidence of informed consent**.**

Inmates of the Transitional Mental Health Unit receive medication at the medical infirmary. Observation of the process revealed that the inmates were not required to supply verification of their identification prior to be given the medication. Two inmates advised the nurse that they were given the wrong medication, suggesting that nursing practices to minimize such occurrences are not consistently followed. A correctional officer was present to monitor the inmates' ingestion of medication. The routine manner with which the inmates responded to the process suggested that monitoring of ingestion is an established practice at this institution.

A problematic, humiliating practice which appears unique to Bullock was observed during medication administration. Inmates prescribed Artane (a medication to control side effects of older antipsychotic medication with some abuse potential in correctional settings) is administered in crushed form onto the inmate's outstretched palm. Inmates are told to swallow the medication crumbs with water. However, if any residue remains on their hand, the officer instructs them to lick it off. If the inmate refuses, the Artane will be summarily

discontinued whether or not the inmate has side effects. This development is very curious given that 1) there are many alternatives to the prescription of Artane for side effects with much lower abuse potential; 2) the utilization of the newer, readily available antipsychotic medications would likely permit the discontinuation of side effect medication altogether as the newer medications do not have the same side effect profile; and 3) Artane is available in a liquid preparation.

INTERMEDIATE MENTAL HEALTH UNIT

Inspection of several large thirty-eight-bed Intermediate Mental Health Unit dormitories confirmed an environment similar to the Transitional Mental Health Unit. Brief interviews and group discussion revealed that while many of these inmates had mental health problems, not all experienced serious mental illness. While these inmates were among the most functional interviewed during all four prior site reviews, they were also among the most vocal in expressing their dissatisfaction with mental health services. Some of the inmate allegations appear related to their personality disorders, but it is clear that treatment other than medication is severely limited. Mr. Jones, an ADOC social worker, was said to conduct groups related to anger management, life skills, parenting and the Bible. Indeed, Mr. Jones was consistently praised for his work and attitude toward the inmates. During both site reviews, we never saw a single therapeutic activity. The inmates were on their beds or milling around, and we saw nothing that would suggest a treatment milieu.

When the inmates of the large dormitories were asked where the inmates with serious mental illness were housed, they directed us to the smaller eight-bed dormitories. The inmates were accurate. Most of the inmates in the smaller dormitories were significantly compromised by serious mental illness and were receiving inadequate treatment. The personal hygiene and sanitation of these dormitories was dramatically lower than the other dormitories and reflected the level of the inmates' dysfunction. Several of these inmates reported that they had "chosen" the smaller dormitories to minimize their contact with others. However, these inmates were existing in a non-therapeutic environment that does not offer the opportunity for improved functioning. In our opinion,

several of these inmates (156422, 133328, 104205) required acute mental health treatment, if not psychiatric hospitalization.

The second site visit of Bullock, conducted by Dr. Haddad, focused on the inmates within the smaller eight-man dormitories. While these areas continue to house the inmates most seriously impaired by mental illness, the areas and inmates were cleaner than during the first visit. Over 75% of the inmates in the smaller dorms were prescribed Prolixin Decanoate (long-acting medication). The number of inmates demonstrating negative side effects that were ineffectively managed by a side effect medication was significantly higher that that typically seen in current mental health settings. The inmates reported that psychiatric appointments continue to last no more than ten minutes.

One inmate (133328) in the smaller dormitories identified in April as potentially in need of inpatient treatment appeared improved by the change in medication to Zyprexa. There was no noticeable change in the mental health of the other inmates except that one (156422) demonstrated increased agitation and nervousness. This inmate reported that his requests for medication had been denied.

The inmates' identification of the most ill inmate in the smaller dorms confirmed their ability to assess level of functioning. This inmate (107711) was very regressed and likely in need of more intensive treatment. The inmate's medical records indicated no treatment other than infrequent psychiatric reviews.

The Intermediate MHU inmates continued to report programming limited to that which is provided to all Bullock inmates. Some of these groups are conducted by inmates. Others are conducted by Mr. Jones. Inmate participation in these groups apparently depends upon the inmate signing up for the group. Thus, participation is not clinically-driven by the specific needs of the inmate but likely related to the inmate's desire to gain a certificate for the Parole Board.

The inmates were appreciative of the one hour on the recreation yard offered twice weekly for mental health inmates only. The inmates reported that the mental health technicians conduct multiple sports activities during these times. These activities are important but are inadequate programming for inmates with serious mental illness.

Three of the inmates in the smaller dormitories reported that they had third shift custodial work assignments. They were pleased to have meaningful work but reported that it was difficult to complete the nighttime work when receiving psychotropic medication, which is sedating, at evening pill call rather than in the morning when these inmates would be trying to sleep after having worked the nightshift.

The inmates uniformly complained about the institutional requirement that all inmates leave the housing areas from approximately 7 AM until 9 AM every day (assuming that it is not raining, snowing or extremely cold) to permit the mopping of the housing areas. They recommended that we return one morning to see the number of inmates on psychotropic medication sleeping on the ground during these periods.

During the second review of Bullock, the inmates continued to report that they are forced to accept their Prolixin Decanoate shots. In some cases, the "force" is reportedly the summoning of correctional officers to demonstrate that force will be used if the inmate does not comply. This does not constitute voluntary acceptance of medication. In other cases, inmates reported they were locked down in segregation cells if they refused the shot. The inmates identified one inmate (191537) who they stated was placed in segregation because he refused his shot. Indeed, the inmate was on a "mental health hold" in segregation. A cell-front interview with the inmate confirmed the prior reports. The inmate was upset that he had not yet been released from segregation even though he had accepted the shot three days ago. During a brief interview, Dr. Sanders denied that the inmate had been placed in segregation for non-compliance but reported that the inmate had made threats requiring him to be locked-up. The limited and poorly legible documentation in the inmate's medical record made it difficult to substantiate either the inmate's allegation or Dr. Sanders' report.

TIME OUT UNIT

The implementation of a four-bed time-out dormitory appeared to be a recent development at Bullock. There were two inmates in the unit during our initial review. One (154285) was covered with a blanket and would not respond to us. His medical record indicated that he had been seen by Dr. Sanders on March 13, 2000, and he was described as being in "stable remission" from "chronic schizophrenia." There were no subsequent chart entries to explain his placement in the time-out dorm or describing the condition or behavior which led to the placement. The other inmate (140675) stated that he had been placed there because his Dilantin had "made his heart pound."

Since there were no staff in the time-out unit, the purpose of the inmates' placement in the room could not be determined. Apparently, the area is used for inmate stabilization without a staff observation requirement. Oddly enough, this "time-out" unit was one of the most brightly lit units used for inmates with serious mental illness that we encountered. Where a darkened area would have been helpful, there was light; at Donaldson, where light would help, it was dark.

During the second review of Bullock, the inmates reported that they could request placement in the time-out area when they were feeling stressed. The inmates said that generally they are permitted to stay in the small unit until they request to leave. It is possible that the time-out unit reduces the practice of transferring an inmate who is unable to handle the large dormitories to an infirmary or segregation cell.

An interview of the one inmate (136966) in the time-out area during the June review suggested agitation but no acute psychosis. The inmate was thankful for the environment, claiming he was afraid he was going to be hurt in the dormitories.

SEGREGATION UNIT

Of the eighteen inmates in the segregation unit during the site review, only two were receiving psychotropic medication and they appeared stable. One inmate reported that he received weekly therapy from the psychologist. He was pleased with the psychologist but dissatisfied with the psychiatrists who allegedly refuse him medication for his mood swings. The inmate added that he had signed a release while at Kilby for records of his prior psychiatric treatment but no one had acknowledged their receipt or discussed his treatment history with him.

Review of the records of inmates on the Bullock mental health units suggests that mental health staff may place an inmate in segregation, apparently as a step-down to the dormitories, after an inmate has required a crisis placement due to decompensation or suicidal ideation. The records of one inmate (183213) indicated that after he decompensated he spent a month in either an infirmary mental health cell or segregation cell before he was considered appropriate for return to the Transitional MHU. This is grossly inadequate treatment. Transfer to the Kilby Mental Health Unit would have been a clinically appropriate option.

In his deposition, Dr. Downs reported that an inmate may be placed under mental health observation in a segregation cell when the infirmary mental health cells are not available and the inmate is not considered at risk for suicide or self harm. Dr. Downs stated that inmates appropriate for mental health observation in the segregation cells would be "Someone who is psychotic, agitated, potentially violent, having auditory hallucinations telling them to hurt others." While these inmates would appear to qualify for Kilby transfer, Dr. Downs stated that such transfer is considered when " They would have gotten to the point that I simply could not control them here or, I suppose, that they were requiring single cell placement for some unusually long period of time." Dr. Downs could remember only one inmate that had been transferred to Kilby since he began providing services at Bullock in December of 1999.

INFIRMARY MENTAL HEALTH CELLS

The four single rooms designated for mental health crisis intervention at Bullock were superior to those observed at the other institutions reviewed in terms of cell visibility and lighting. The one cell that was being utilized for placement of a "suicidal" inmate during our visit, however, did contain exposed electrical wires in an easily accessible portion of the wall. It appeared that a plate of some sort which would ordinarily cover the wiring was missing. One of the four cells was not available for mental health crises since it was occupied by a very elderly infirm inmate (141464). A memo on the wall dated 1998 that provided staff information on the management of this elderly inmate's meals and incontinence suggested that this inmate was a long-term resident, limiting the number of cells available for mental health care to a maximum of three. (Dr. Downs identifies only two mental health cells in the Bullock infirmary, contradicting earlier reports of four cells dedicated to mental health care.)

The inmates reported, and the records confirmed, that inmates are routinely placed in the mental health cells nude with only a rubber mat.

INMATE IDENTIFICATION & HOUSING DECISIONS

Inmates are provided with various colored plastic bracelets that we initially assumed had some housing or clinical significance. The inmates we talked with during our initial Bullock review professed not to know their meaning, saying you get whatever bracelet is available. During the second review, the inmates confirmed the statements in the deposition of Charles Goodwin that the bracelets are based on an inmate's housing assignment. Orange bracelets indicate placement on the Transitional MHU; green bracelets indicate placement on the Intermediate MHU; and red bracelets indicate general population placement. However, the inmates suggested that at times bracelets are not assigned as intended. For example, one general population inmate who was housed in the Intermediate MHU due to bed space issues was give a green bracelet to permit his attendance at meals and recreation periods with the other inmates of his dormitory.

It is unclear why a given inmate is placed on Transitional MHU rather than the Intermediate MHU. Indeed, even Dr. Downs could not distinguish the differences in programming or inmate illness severity between the two. Bed availability may well be the determinant as to unit placement rather than the exercise of any sort of clinical judgment.

EASTERLING CORRECTIONAL FACILITY

The site visit of Easterling Correctional Facility was conducted the afternoon of June 21, 2000. Easterling is a male, medium-security institution with an inmate census of approximately 1200 inmates. The facility has two segregation units, each with twenty-six cells. Each segregation cell can be double-bunked, creating a total of 104 segregation beds. General population inmates live in large dormitories. There are four placements designated for mental health crisis intervention: one room in the infirmary; another behind the Control Center; and two cells in the segregation units.

The CMS Alabama Psychotropic Report – April 2000 indicated that seventy Easterling inmates were prescribed psychotropic medication. Of the fifteen inmates prescribed antipsychotic medications, five were prescribed injectable medications. No inmate was prescribed a newer, so-called atypical antipsychotic medication.

Sixteen of the inmates prescribed psychotropic medication were selected for review during the Easterling visit. Five of those selected were not available since they had been transferred from Easterling or did not appear for the group meeting.

The site review of Easterling occurred after an extended period of inmate lock-down related to an institutional disturbance at the end of May. The inmates had not had visitation or regularly scheduled out-of-cell time for over three weeks. The Warden has reintroduced outdoor recreation in a scheduled manner and planned to reinstate visitation the following weekend.

Easterling's mental health staffing as of May 2000 was as follows:

Psychiatrists (CMS)	Sanders & Williams - 4 hours per week (rotate weekly coverage)
Licensed Psychologist (CMS)	Gilbert – 8 hours per week
Psychiatric LPN (CMS)	Vacant – 40 hours per week
Psychological Associate (ADOC)	Croy - 40 hours per week

In his deposition, Mr. Croy explained that his duties included: assessment of inmates as needed; inmate referral to the CMS psychologist and psychiatrists; rounds of the segregation unit twice weekly; participation in institutional Progress Reviews; inmate counseling; mental health updates for the Parole Board; and supervision of the substance abuse treatment units.

The Easterling inmates were disappointed that the former LPN assigned to mental health duties had resigned since this staff member was described as "caring."

SEGREGATION UNITS

The institutional disturbance that occurred at the end of May resulted in the over-crowding of the segregation units. Fifteen of the twenty-six segregation cells of one unit held three inmates. The calm and cleanliness of the segregation areas was notable in light of the presumably temporary over-crowding. The inmates confirmed adequate access to mental health services through the regular conduct of mental health rounds where Mr. Croy knocks on each cell-door and asks how the inmates are doing.

Brief interviews of two selected inmates found that one (162177) was functioning adequately with no signs of acute psychosis. This inmate reported acceptable follow-up by the psychologist but that psychiatric follow-up consisted of only five to ten minute interactions.

The second inmate (130625) appeared to be only marginally stable and in acute distress. This inmate had been identified by Dr. Gilbert in his deposition as one that he had repeatedly requested transfer to Bullock due to marginal functioning. The inmate's report that his prescription for Navane had been discontinued by the psychiatrist the day of the site

visit was confirmed by the medical record. The inmate's medical record indicated that a psychiatric review on May 31st found the inmate in "remission" with a plan to continue medications with a follow-up appointment in three months. A referral from Dr. Gilbert on June 12th resulted in a follow-up review by a different psychiatrist on June 21st. Notes of this review indicated: "Patient no longer psychotic but (illegible). Discontinue meds. Discontinue Navane/Artane." Neither the inmate's presentation nor the medical record provided adequate clinical justification for the change in treatment.

GENERAL POPULATION

A group meeting was conducted with eight general population inmates who were prescribed psychotropic medication. Although none of the inmates demonstrated symptoms of acute psychosis, one (199151) displayed signs of significant side effects to the medication and three denied any knowledge of why the medication was prescribed. Their only rationale for accepting medication was that the "shots" would be forced or they would be locked-up if they refused.

The inmate reports that they had little access to programming was confirmed in the depositions of Mr. Croy and Dr. Gilbert. Mr. Croy reported that there were no groups conducted since there were insufficient staff to provide them. Dr. Gilbert also reported that additional mental health staff time was necessary to meet the needs of Easterling inmates.

While general population inmates reported several problems with medication administration, correctional officer observation of medication ingestion reportedly was consistent. Inmates said that medication administration times are inconsistent and that they must wait in pill lines for over an hour. They also reported that medication administration had been suspended at least three times in the last month, but these claims were denied by Easterling medical staff. It was not possible at the time to reconcile the discrepancies.

MENTAL HEALTH PLACEMENTS

The two segregation cells designated for mental health treatment were not reviewed during the site visit. The cell behind the Control Center is acceptable for crisis care, but the location does not facilitate clinical staff observation. The mental health cell of the infirmary appeared to be undergoing renovation since the ceiling vents were exposed.

The inmates reported that they are placed in the mental health cells nude or wearing only underwear. Since a CMS psychiatrist is at Easterling only four hours per week, inmate reports that they could spend up to five days in the mental health cells without a psychiatric assessment seemed credible. However, these reports were disputed by Dr. Sanders, who said that when an inmate is known to him, he may change medications and/or discontinue precautionary watches based on a telephone call from Easterling staff. This practice is not consistent with community treatment standards.

Easterling medical staff reported an infrequent use of restraints for mental health reasons. Staff descriptions of how restraints were applied indicated acceptable procedures.

LIMESTONE CORRECTIONAL FACILITY

The site visit of Limestone Correctional Facility was conducted on June 22, 2000. Limestone is a male, medium-security institution for approximately 1900 inmates. The facility also provides the housing for 200 male inmates of all security levels who have been diagnosed as HIV+ (Human immunodeficiency virus infection). The HIV unit has a capacity of 240 dormitory beds, a separate dining room, nursing station and recreational areas. Limestone has several segregation units, one of which is designated for HIV+ inmates. Three rooms in the infirmary are designated for mental health crisis interventions.

The visit to Limestone suggested that this is a well-run institution. The facility was clean and orderly with many landscaped outdoor areas. The inmates were calm and reacted positively to interactions with the Assistant Warden and the Lieutenant providing our escort.

The CMS Alabama Psychotropic Report – April, 2000 indicated that sixty-nine Limestone inmates were prescribed psychotropic medication. Of the nineteen inmates prescribed antipsychotic medications, nine were prescribed the long-acting injectable form. No inmate was prescribed an atypical psychotropic medication.

Limestone's mental health staffing as of May 2000 follows:

Psychiatrist (CMS)	Murbach - 8 hours per week
Licensed Psychologist (CMS)	Leonard – 16 hours per week
Psychological Associate (ADOC)	Day - 40 hours per week

SEGREGATION UNITS

Brief cell-front interviews with approximately fifteen randomly selected inmates in the Limestone administrative segregation units disclosed no inmates with acute psychosis. One inmate (193709) who was prescribed psychotropic medication without side effect medication displayed involuntary tongue movement. The administrative segregation inmates confirmed that the ADOC psychologist associate, Ms. Day, conducts cell-to-cell rounds and is available for individual sessions when requested.

Review of two inmates housed on the segregation unit for HIV+ inmates, and also prescribed psychotropic medication (153125, 171201), found the placements were appropriate. The inmates confirmed that their mental illnesses made functioning in the large dormitory extremely difficult so that they had requested and been approved for placement on the segregation unit. Since the inmates were placed on protective custody rather than administrative segregation status, they had access to general population property and out-of-cell time. There was no programming offered for these inmates, but they had created a garden next to the unit. Both inmates reported monthly follow-up by the psychiatrist. Although one inmate (171201) was prescribed Cogentin, he displayed the hand tremors and "pill-rolling" related to side effects of antipsychotic medications.

GENERAL POPULATION

A group meeting was conducted with seven general population inmates who were prescribed psychotropic medication. These inmates were very dissatisfied with psychiatric services. They stated that they are summoned to the infirmary for a psychiatric appointment and then routinely wait up to four hours for a session with the psychiatrist.

The inmates also reported that while in the past, psychiatric sessions lasted no longer than five to ten minutes, they have been able to spend more time with a psychiatrist now that Dr. Murbach is providing services for Limestone.

The general population inmates reported that if they refuse prescribed injectable medications, they may be stripped and placed on watch. One inmate (164200) reported that when he requested discontinuing lithium because he no longer wanted to attend the lengthy pill lines, he had been placed in a mental health cell for fourteen days. This practice, which was identified repeatedly at ADOC facilities, is coercive, punitive and unacceptable.

One inmate (139950) displayed significant akathesia, a side effect from his Prolixin Decanoate. He said he did not want medication for the side-effects because he did not want to wait in the pill line.

Another inmate (124198) reported that he had not seen a psychiatrist since his transfer to Limestone on December 17, 1999, but he had continued to receive his lithium. Review of the inmate's medical record confirmed that lithium had been consistently provided but there were no physician orders for the medication since December of 1999 when the inmate was transferred from Kilby. Limestone nursing staff assisted in the medical record review to validate the presence of no notes of mental health assessment or medication orders since the inmate's arrival at Limestone. This gap in care is particularly problematic since the use of lithium requires periodic laboratory testing to monitor the effectiveness of the medication and to ensure that current dosages do not create a life-threatening situation. The inmate had not requested an appointment with the psychiatrist to discuss the problem because of the inmate's perception that he would be charged a medical

co-payment fee. His belief that mental health follow-up should be scheduled automatically when an inmate prescribed medication is transferred from one prison to another is valid.

The Limestone general population inmates reported that they have access to groups conducted by the CMS psychologist and the ADOC psychologist associate. While these groups may be helpful, they are not clinically-driven or related to the treatment needs of a specific inmate. Reportedly, Dr. Leonard's groups discuss a variety of issues ranging from the Bible to football and DNA testing.

Observation of medication administration for general population inmates revealed a process involving two nurses. One nurse identified the inmate and administered the medication to the inmate after the second nurse read off the inmate's medication from the medication administration record. The second nurse then documented the process on the medication administration record. The fact that the first nurse repeatedly reminded inmates that they had to provide their identification badge before receiving medication suggests that this requirement is not consistently followed.

Observation of the correctional officer's monitoring of medication ingestion indicated that this is a routine practice. Each inmate receiving medication had to acknowledge the receipt by signing a medication log. While not required by medical standards, the practice may assist the institution in ensuring medication compliance.

According to a memo from the Psychology Associate, Linda Day, to Harry Lenach dated March 26, 1999, Limestone experienced frequent lapses in medication availability. She reported that inmates could be without prescribed psychotropic medication from one to nine days. The fact that these lapses were reported to present the security staff with significant problems and increased use of the infirmary single cells suggests that inmates deteriorated while awaiting medication.

DORM 16: INMATES DIAGNOSED HIV+

Dorm 16 housed 197 inmates at the time of the site review. We were permitted to move freely within the Dorm 16 and interact with all interested inmates. Although the inmates were very discouraged about the lack of programming and vocational training provided for them, the inmates seemed proud of their dormitory and their efforts to improve the quality of life.

The nursing station added to Dorm 16 was extremely positive and indicated the commitment of the assigned nurse to the HIV+ inmate population. The station was painted in pleasant pastels paid for by the nurse and completed by the inmates. The nursing station walls include designs signed by individual inmates.

Dr. Leonard reportedly conducts a weekly group for Dorm 16 inmates. The inmates, with ADOC approval, have also developed a peer-support group COPE (Committee on the Prevention and Education of HIV/AIDS) to assist the inmates in "meeting their own needs with HIV and AIDS." Inmate leadership of the COPE program provided a program description that confirmed the program's benefits.

Three inmates of Dorm 16 (176000, 173858, 207018) reported that their antidepressant medications had been discontinued because the psychiatrist judged that they "didn't need it" in spite of their reports that the medication was beneficial and their requests that it be continued.

When the Dorm 16 inmates were asked to identify fellow inmates in their unit with serious mental illness, they immediately identified one inmate (143324). An interview with this inmate confirmed the presence of acute psychosis in an extremely vulnerable inmate. The inmate is prescribed Prolixin but continues to experience such psychotic symptoms as auditory hallucinations, thought blocking, and beliefs that the television/radio is speaking directly to him. The inmate described his daily schedule of walking around, listening to voices and doing "odd jobs" for his peers in exchange for cigarettes and coffee. Since he cannot read, write or watch television due to his psychosis, he has limited options. The

inmate stated that he had not told the psychiatrist about his continuing "voices" because he did not yet trust him and he was afraid that he would "spook" the doctor. He also indicated that the "voices," even though derogatory, were important to him. This inmate's severe psychological distress was evident during the interview. He acknowledged that he had been given the option of protective custody placement but refused after trying protective custody placement for several months. His refusal is likely related to his perception of reduced access to bartered cigarettes and coffee. This inmate, having served only 13 years of a 99 year sentence, requires enhanced psychiatric intervention and trials of atypical medication in an effort to address the intense suffering he experiences.

MENTAL HEALTH PLACEMENTS

Our review of the three infirmary mental health cells found them to be acceptable placements for crisis intervention. They were equipped with hospital beds and bedside tables. However, the inmates reported that when placed on watch, they are nude and not provided even a rubber mat for bedding. Limestone staff confirmed that furniture is removed from the mental health cells when necessary.

Since a CMS psychiatrist is at Limestone only one day per week, an inmate may be placed on watch status for many days in the mental health cells without a psychiatric assessment. According to a memo from DOC psychologist associate Linda Day to Harry Lensch dated March 26, 1999, a review of the use of mental health cells for the preceding quarter indicated twelve inmates were admitted one or more times for acute mental health problems. The average length of stay for the acute admissions was nine days with one inmate remaining in the mental health cell for thirty-nine days. Such lengths of stay far exceed what would be anticipated for treatment in an infirmary mental health cell.

Limestone staff reported limited use of restraints for mental health reasons, but stated that restraints are applied by restraining the inmate's extremities to the closest corner of the bed, a practice which may lead to inmate shoulder joint injury and which also inappropriately permits some upper extremity mobility which can lead to staff injury. (The

proper restraint position is to have the elbows extended and arms positioned down at the sides.)

Conclusion

The System as a Whole is Grossly Inadequate

In our judgment, the ADOC system for identifying, housing, and treating inmates with serious mental illness is grossly inadequate and riddled with systemic deficiencies. This is not to say that all aspects of the system and every facility are equally deficient. For example, the Donaldson MHU, with some renovations, could be physically acceptable as a mental health unit. Bullock, as another example, with the provision of far greater treatment and programming, could be acceptable as the placement for certain inmates with mental illness in need of transitional-type housing and care. Pockets of minimal acceptability, however, cannot lift an entire system to the level of acceptability. As experts, we look at physical space and the mental health tasks to which it is devoted, and we ask whether the practice fits the label. Beyond the labels and actual practices, we also consider the services which correctional mental health care must provide, - - for example, crisis care and hospital-like care - - and ask if it is reasonably available regardless of nomenclature.

Staffing Levels Are Seriously Deficient

ADOC mental health staffing levels do not permit the provision of timely or minimally adequate treatment of inmates with mental illness. Without sufficient staff, inmates identified with mental illness receive grossly inadequate care and follow-up, while other inmates with mental illness remain unidentified. Further, those inmates who are placed on mental health units for treatment receive little more than a protected environment. The high number of very ill inmates found locked-down in segregation is undoubtedly a further artifact of inadequate staffing.

Psychiatrists are essential to any treatment system for inmates with serious mental illness. Until July 1999, CMS was authorized to provide two full-time psychiatrists for

more than 20,000 inmates. CMS subsequently was authorized to increase the psychiatric staffing to seven full-time positions. This increase in psychiatric hours may facilitate more frequent psychiatric intervention and medication management but it will not permit regular psychiatric presence for multidisciplinary treatment planning, another keystone to mental health treatment.

Outpatient services for inmates identified as experiencing serious mental illness are provided by CMS mental health staff who may be present in a particular facility only one or two days per week. The ADOC psychologists are not responsible for the monitoring and treatment of inmates with serious mental illness. Inmates who experience emergencies on days when a CMS mental health staff member is not present are routinely placed on watch in isolation until the CMS staff member's next scheduled day. Isolation alone, particularly under the conditions previously described, is inadequate treatment for mental health emergencies and exacerbates the inmate's distress and suffering.

On days when a CMS mental health staff member is on-site, the number of outpatient inmates requiring just routine monitoring is so great that it results in these inmates receiving little more than a brisk, "How are you doing?" Any hope of facilitating an inmate's adjustment to correctional living and enhancing treatment compliance through education is not achieved.

Mental health staff may be present on the designated mental health units, but there is insufficient staff to provide even the most basic care necessary for inmates whose illness requires a specialized mental health placement. Further, not all mental health staff are qualified or trained to conduct the requisite programming. Others have their time for clinical interventions diverted to either medical or correctional duties. The title "mental health technician" is itself misleading given that many of the duties of these staff relate to such correctional issues as visitor lists, commissary orders, and inmate clothing. These are important duties but do not constitute mental health treatment.

The mental health nursing staff, which is primarily licensed practical nurses -- not trained psychiatric nurses -- provide no inmate treatment or medication education, which are essential functions for psychiatric nurses. The primary duties of the mental health nurses are administrative functions related to medication ordering, monitoring the medical conditions of inmates on watch status, and assisting psychiatrists during scheduled appointments. Since the mental health nurses also complete medical duties, their ability to provide mental health treatment is further compromised.

Inadequate mental health staffing impacts all aspects of treatment. Therapeutic programming is either severely limited or non-existent. As a result, individual monitoring is brief and typically does not provide staff the opportunity to "work" with an inmate on identified issues. Medication is an essential component of mental health treatment but medication alone is not clinically sufficient. Finally, limited staffing contributes to limited record documentation that does not reflect or permit continuity of care.

Treatment for inmates assigned to the mental health units is limited by the lack of appropriately trained mental health staff and also by the lack of correctional officer presence required for inmates to be out-of-cell in a safe manner. Inmates on the Kilby and Donaldson units, for example, are completely locked-down except for a few hours during the day shift due to limited security coverage. Extended periods of cramped isolation are contraindicated for those inmates with serious mental illness who already experience significant social skill deficits.

Staff Recruitment and Retention Is Compromised

The shortage in qualified mental health staff is dramatic. In order to attract and retain high caliber staff, especially with regard to psychiatrists, the reputation, character, and credentials of current staff are very important. In Alabama, this situation is compromised, in our view, and represents a significant hurdle to professional staff recruitment and retention.

Staff Training in Mental Health Issues Is Wholly Inadequate

An essential standard of the National Commission on Correctional Health Care (NCCHC), used here as a benchmark, requires that correctional officers receive on-going training (at least every two years) in the following mental health areas:

- Recognizing acute manifestation of certain chronic illnesses (e.g., seizures, intoxication and withdrawal, and adverse reaction to medication)
- Recognizing signs and symptoms of mental illness
- Suicide prevention

Correctional officers serve as gatekeepers, assisting inmates to gain access to needed mental health care. The officers' importance magnifies in relation to how well staffed a prison system is with qualified mental health professionals and how often and effectively rounds are conducted. As noted elsewhere, staffing levels in the ADOC are unacceptably low and rounds exist primarily in name only.

According to the documentation provided by ADOC and depositions of ADOC and CMS staff, NCCHC's recommended training does not occur in the Alabama system. Dr. Woodley stated that he coordinates pre-service mental health training for new correctional officers three or four times a year. This training was reported to be a five to six hour presentation that covers the essential NCCHC requirements. However, periodic refreshers

on these issues are not routinely provided. Officer Woodard and Officer Williams, two correctional officers often assigned to the Kilby MHU, reported no training in suicide prevention for at least five years.

Dr. Williams reported that he had provided staff with an "800 number" for accessing literature about suicide prevention and Dr. Woodley stated that he had sent the major institutions handbooks about suicide prevention prepared by the CMS corporate office. The mental health staff also reported that they share information about mental illness with the correctional officers during informal discussions. These efforts, while positive, do not constitute adequate training. Without concentrated training in the identification of inmates demonstrating signs of mental illness or suicidal risk, it is not possible for the security staff to consistently refer inmates for clinical intervention prior to the development of a crisis. Without training, behavior associated with serious mental illness is likely to be treated as willful misconduct and such behavior associated with an illness becomes an occasion for a disciplinary proceeding.

The need for additional staff training in mental health issues was identified in a 1998 study by CMS staff concerning the satisfaction of ADOC wardens and correctional officers with the mental health services provided at their institutions. The specific training requested by ADOC staff during the 1998 study included:

- Dealing with real or secondary gain based threats of self-injury
- Differentiation between symptoms of mental illness and simple behavioral problems
- Basic techniques of behavior modification for mentally ill and normal inmates
- Effects and side effects of psychotropic medications
- Nature of treatment plans and role of the correctional officer

According to the depositions of numerous DOC officers and wardens, no system-wide training has ever been conducted to address the above-mentioned systemic deficiencies identified by CMS.

While all correctional officers require at least basic mental health training, systems with effective mental health programs provide enhanced training for staff assigned to mental health or segregation units, the areas most likely to experience mental health problems. CMS staff reported that five-hour enhanced, voluntary mental health training sessions are conducted each quarter for approximately fifty staff. Since half of the training participants are mental health or supervisory staff, less than 100 correctional officers have access to one of the training sessions each year. Further, review of the content of these training sessions revealed the inclusion of many topics not related to the identification, treatment and management of serious mental illness.

Correctional officers are not the only staff inadequately trained to handle the problems that occur when persons with mental illness are incarcerated. The depositions of the "mental health nurses" and the mental health technicians revealed their seriously limited knowledge about basic issues concerning mental illness, medication and suicide prevention.

Bed/Treatment Space Is Grossly Deficient

ADOC has designated numerous beds as "mental health beds," but the configuration and utilization of these beds does not allow adequate treatment. Given that numerous inmates with serious mental illness were found untreated in the ADOC segregation units, the sheer number of mental health beds, to say nothing of their quality, is clearly not adequate to meet the system's needs. Additional bed space is particularly needed for inmates unable to be housed in dormitories either due to security or mental health considerations. There is a waiting list of inmates for the Donaldson MHU single cells, with some of these inmates "waiting" in a segregation cell for months for treatment.

* **Kilby MHU and P-I** The MHU and P-I units at Kilby reportedly provide acute and in-patient hospital-like psychiatric treatment. (Kilby's inadequacy as an in-patient hospital facility is discussed in further detail below.) While the MHU provides appropriate bed space for inmates experiencing an acute episode of mental illness, there is no space for

programming or mental health staff interventions in a confidential manner. The dayhall and outdoor space for recreation is also limited. The mental health beds in P-I are basically enlarged isolation cells that do not have direct access to treatment space. P-I treatment is typically conducted at the inmate's cell-front.

* **Kilby South Ward and Bullock** Kilby's South Ward and Bullock's mental health units offer dormitory housing for inmates with serious mental illness. Although the dormitories are crowded, most offer physically adequate living areas. Again, the space available for individual interventions or group programming is totally inadequate. Offering "programming" to forty or more inmates while they are forced to remain seated on their bunk beds hardly qualifies as meaningful programming. In addition, the actual content of the programming is also inadequate.

* **Donaldson MHU** Donaldson's MHU provides single cell placement for inmates with serious mental illness whose security level does not permit placement in the Bullock dormitories. While the physical environment of this unit is dreary, the actual physical bed space area is adequate. As with the other units, there are no areas for confidential individual interventions or group programming.

The utilization of the ADOC's mental health beds is a seriously problematic. While there were vacant beds on the Kilby MHU during our site review, there were acutely psychotic inmates in Kilby's segregation units, on the Donaldson MHU, and in the segregation units at Donaldson, Holman, and St. Clair. Housing acutely psychotic inmates in segregation cells while supposedly acute care beds on Kilby's MHU go unoccupied is appalling and results in needless pain and suffering. There were also inmates in the smaller mental health dormitories at Bullock obviously in need of more intensive treatment.

ADOC reports of the number of beds available for mental health crisis care at each of the institutions (except Holman, which has no infirmary beds), include even the infirmary

dormitory beds as back-up mental health beds. Treating inmates with a mental health crisis in a dormitory alongside inmates experiencing medical problems is inconceivable.

Inspection of the rooms designated as the primary sites for mental health crisis care revealed restricted visibility into the rooms unless the door was opened. This does not facilitate the routine fifteen-minute monitoring by correctional officers required when an inmate is placed on watch. The rooms have no beds and an inmate is typically placed in the room naked with only a rubber mat on which to rest. While this type of placement may be necessary for very brief periods of time to minimize the risk for self-harm (based on an individual clinical decision), inmates report, and medical records confirm, that inmates may be retained under these conditions for days or weeks with infrequent mental health staff contact. This level of treatment is seriously deficient and appears humiliating and punitive on its face.

While the use of restraints for mental health reasons may be infrequent, institutional practices in this high risk/low frequency event are inconsistent. The Standard Operating Procedures of St. Clair, Kilby and Donaldson defined "four point restraints" as the method of restraining a inmate by securing each arm and leg to the nearest corner of the bed. This suggests a spread-eagle positioning of the inmate. This position is inconsistent with CMS policies and was reported to be the actual practice only at Limestone. Staff at Donaldson reported that their inmates are restrained face-down. Inconsistencies in restraint application practices present risks of serious harm to the inmate and staff.

Kilby As Inpatient/Hospital-Type Care

Clinical necessity dictates that every prison mental health system either provides its own hospital-type care or provides reasonable access thereto. While Taylor Hardin Secure Medical Facility is a psychiatric hospital that is theoretically available to the ADOC, in practical effect its use for treatment of ADOC inmates with serious mental illness is extremely limited. The prior history of objectionable delays in gaining admission to Taylor Hardin has been "solved" in practical effect by not using it for treatment. This resource is

being denied to acutely ill inmates who would clearly benefit from such a transfer. In light of the systemic deficiencies in the system, removing Taylor-Hardin as a treatment option is tantamount to denying life-saving treatment.

(To the extent that Taylor Hardin might again be viewed as the appropriate hospital placement, one would have to address the Alabama law on prison-to-hospital transfers. The requirement of executive approval may take six to ten weeks; an unacceptable period of delay when an inmate requires inpatient treatment and particularly so in light of the inadequate care provided within ADOC.)

A hospital level of care requires that a comprehensive multidisciplinary assessment occur within a short time of admission. The assessment includes the reason for psychiatric hospitalization; a history of the mental illness and past response to treatment; a medical assessment; personal, social, family and legal histories; a description of functioning; and a comprehensive mental status examination which leads to a psychiatric diagnosis, and finally, culminates in the development of a treatment plan. Inpatient psychiatric hospitals perform psychiatric assessments at least weekly, generally more often. In addition, other professional disciplines interact with the patient – psychology, social work, adjunctive therapists, nursing, education and substance abuse counselors. Efforts are made to secure past treatment records and family members are contacted to provide information about the illness – longitudinal course, response to treatment, level of functioning possible, and so on.

Patients in psychiatric hospitals are engaged in numerous activities including medication education, group and individual therapy and other activities aimed at symptom reduction/symptom management while permitting trained mental health assessment of functioning. The therapeutic milieu (hospital environment) is designed to foster positive socialization through socially appropriate interactions with staff and other patients; reinforcing acceptable behavior, and similar socialization arrangements. Treatment is intense and aimed at rapid resolution or reduction of symptoms to permit a return to previous level of functioning.

There is no evidence that any of the aspects of hospital-level care identified above are provided by the Kilby MHU. There is no assessment (admission or otherwise) by a multidisciplinary team, and no multidisciplinary treatment plan which defines the inmate's problems, the planned interventions, the staff responsible, or the goals to be achieved. Treatment consists of brief, non-confidential interactions with the psychologist, irregular participation in limited group sessions, and infrequent psychiatric interaction.

The primary mode of treatment is medication – for which consent is neither sought nor granted. Inmates are very often prescribed long-acting injectable antipsychotic medications. These types of medications are contraindicated for management of acute psychiatric illness due to their long duration of action. With long-lasting medications, adjustments in dosage, increases or decreases, may be made only infrequently and one must wait several days to determine whether the medication has any effect and several weeks to determine whether or not the dosage is adequate.

There are no clear admission or discharge criteria for Kilby's P-I unit and MHU. Subsequently, mental health staff working in other institutions appear not to understand which inmates are appropriate for transfer to the facility or when to access admission in a timely fashion. When inmates are transferred to that level of care, they are transferred without being provided appropriate notice or the opportunity to challenge the transfer or placement.

The involuntary, forced medication procedure appears dramatically underutilized. We uncovered no evidence of any inmate being on involuntary medications during the site visit. However, inmates reported being transferred from South Ward to the MHU or from the MHU to P-I routinely if they refused the prescribed long-acting medication. In other words, they were transferred to a more restrictive setting if they refused medications which they had never consented to receive. Thus, the forced medication process appears circumvented through the utilization of long acting, involuntarily injected, coerced

medication without granting the inmate a hearing or the rights associated with it.

Nursing notes in the MHU chart are best described as medical/surgical in nature rather than psychiatric. Notations about vital signs and notes such as "resting comfortably" are the most common types of nursing documentation. The nursing notes do not address mental health issues, medication compliance or education, or inmate response to administered medications.

Programming is minimal, abysmally poor, and is not clinically-driven. It consists primarily of ping-pong games among inmates, television, walking around outside with a radio playing, and some group discussions with a mental health technician or a social worker.

Inmates are granted extremely limited out-of-cell time. The vast majority of MHU inmates are only allowed out of their cells for forty-five minutes each day in hand cuffs and leg shackles. Even the few that are not shackled are only out-of-cell about two hours per day. After 2:00 p.m., when the second shift begins, inmates are locked down until the following morning. According to the depositions of Drs. Woodley and Bell, mental health staff have very little input into these security and housing decisions. The ADOC's failure to consider the mental health needs of inmates in making security level and housing decisions seriously compromises the ability of the mental health clinicians to effectively and adequately treat their patients. This is true not only at Kilby, but at all the institutions we visited.

Discharge summaries frequently contain diagnoses that differ substantially from previous diagnoses and without appropriate documentation in the summary itself or in the progress notes which describe or explain the discrepancy.

The end result is that the ADOC effectively denies access to inpatient treatment for inmates with acute and serious mental illness. Kilby is not staffed with twenty four-

hour/seven-day a week psychiatric nursing - - a benchmark for hospital care. There is no multidisciplinary assessment; no comprehensive mental health evaluation; no real treatment plan; and no intensive mental health treatment provided at Kilby. Although frequently diagnosed, substance abuse disorders are not addressed in treatment. There is no more (and, ironically, perhaps less) out-of-cell time in the supposed therapeutic environment than that permitted inmates of similar security levels.

In sum, the "treatment" provided on the Kilby MHU consists of little more that seclusion, increased correctional supervision, and coerced psychotropic medication. The consequences of failing to provide access to inpatient treatment causes inmates with mental illness to greatly and needlessly suffer from treatable symptoms of serious mental illness. Persistent symptoms without relief raises the risk of suicide or attempts at self-harm. Inmates may also be at increased risk of assaulting other inmates or staff.

Access to Care Is Grossly Deficient

Access to care is a critical component of a minimally adequate correctional mental health system. It is our opinion that many ADOC inmates with serious mental illness have little access to minimally acceptable mental health care. The only consistent strategy reported by inmates to access care is to violate prison rules and cause a disturbance, damage property, or inflict self-injury. Thus, on the most fundamental of the dynamics of prison mental health care, Alabama does not provide reasonable ready access to required mental health care.

Inmate Screening and Evaluation Is Deficient

Screening and evaluation for potential signs of mental illness when an inmate is received is a critical element for ensuring access to care. According to ADOC documentation and staff depositions, this process at Kilby is marginal at best.

Medical nurses screen new inmates for mental health and psychotropic medication issues. ADOC psychology associates then interview the inmates to complete a three-page assessment questionnaire. Inmates also receive an intelligence screening (BETA), educational evaluation (WRAT) and complete a personality inventory (MMPI-II). It is not clear if the information gained through the psychology associate's assessment process is utilized in later treatment planning.

If a medical nurse or psychology associate identifies an inmate as requiring psychiatric assistance, the inmate is referred for a psychiatric evaluation. In Dr. Sanders' deposition, he reported that evaluating new inmates who had been referred for psychiatric evaluation was his primary responsibility during his two days per week at Kilby. However, during that time he also is scheduled to see inmates from the MHU and P-1. Dr. Sanders stated that he sees about five inmates an hour and may spend up to thirty minutes with an individual inmate. While thirty minutes may be sufficient to conduct psychiatric medication management, it is inadequate to complete an initial psychiatric assessment and develop a treatment regimen for a previously unknown patient.

Medication Practices Are Seriously Deficient and Dangerous

* **The Psychotropic Medications Administered by the ADOC** The CMS formulary (choices of psychotropic medications available to psychiatrists to prescribe for their patients) is limited. The newer atypical antipsychotic medications (Clozaril, Zyprexa, Seroquel and Risperdal) are available only if the prescribing psychiatrist makes a special request for Dr. Williams' approval.

Clozaril is the only medication demonstrated in the scientific literature to provide symptomatic relief for patients with psychotic symptoms who have not responded to treatment with the older antipsychotic medications. However, other atypical medications have been demonstrated superior to the older antipsychotic medications in their side effect profiles. That is, they are much less likely to cause problems with movement disorders, including the development of tardive dyskinesia - a potentially irreversible, disfiguring

involuntary movement disorder. Consequently, the atypical medications do not require the co-administration of such medications as Artane and Cogentin to prevent the development of side effects. Both Cogentin and Artane have abuse potential in correctional settings, while none of the antipsychotic medications have black market value. Artane may be crushed and smoked for the "high" that may be obtained. Cogentin may also create an altered state or "high" when ingested. In a correctional system which purports to have a great deal of difficulty with inmates "manipulating" to obtain Artane prescriptions, it is remarkable that the newer medications are not used to curtail this problem.

In addition, the evolving community standard of care is to utilize the atypical medications as "first line" medications in the treatment of psychotic disorders (that is, the first medication to try rather than a medication of last resort.) Cost containment is an issue but it can be successfully managed through utilization of mechanisms to ensure appropriate prescription based on diagnosis, utilization of the lowest effective dose, and monitoring of response to treatment.

Review of the CMS Alabama Psychotropic Report - April of 2000 indicates the following:

- 1,145 male inmates were prescribed psychotropic medication.
- Of the 475 male inmates prescribed neuroleptic medications, only 53 (11.2%) were prescribed atypical psychotropic medications. Recently, the percentage of inmates on atypical medications has dramatically increased.
- Of the 475 male inmates prescribed neuroleptic medications, 252 (53%) are prescribed injectable medications. A significant number of these inmates demonstrate side effects from these medications not adequately controlled by side effect medication.

The analysis of the prescribing patterns prevalent throughout the Alabama system demonstrates a profound under-utilization of the atypical antipsychotic medications and a remarkable over-utilization of long-acting injectable decanoate preparations of the older medications. Many inmates that we observed demonstrated serious side effects to these

medications (tremors of the extremities, tremors of the muscles involving the neck, etc.). Inmate requests for relief from these side effects tend to be viewed as manipulative and drug seeking with the consequence that medication side effects are not treated or are under-treated. As a result, seriously mentally ill inmates suffer needlessly with such conditions.

Of almost equal importance is the failure of the formulary to contain newer types of antidepressant medications known as the selective serotonin reuptake inhibitors (SSRIs), so named for their chemical mechanism of action. Older antidepressants (tricyclics) are available on the formulary. However, the tricyclic antidepressants are potentially fatal in overdose; the SSRIs are not. In a system which does not routinely observe or monitor inmates for medication ingestion, utilization of medications which are potentially fatal in overdose rather than the safer, readily available alternative medications is extremely risky and a professionally dubious practice.

Review of the CMS Alabama Psychotropic Report (April 2000) indicated the following:

- 487 male inmates are prescribed antidepressant medications.
- Of the 487 male inmates prescribed antidepressant, only 98 (20%) are prescribed SSRIs.

Many inmates with a documented history of response to treatment with an SSRI in the free world are often immediately discontinued from that medication upon reception at an Alabama prison. This increases the likelihood of a depressive relapse, which not only causes needless pain and suffering, but also elevates the risk of suicide - with the mechanism (antidepressant overdose) placed into the hands of the depressed inmate.

*** Medication Administration Practices**

Medication administration, or "pill call," is not in accordance with accepted professional standards and is dangerous to the health and safety of the inmates. Medication administration is the act in which a single dose of an identified drug is given to the proper

inmate. It requires the same nurse to provide the right dose of the right medication to the right inmate at the right time. A record is to be made of this transaction on the medication administration record (MAR) by the nurse who has prepared and delivered the medication contemporaneously with its dispensing.

The ADOC nursing practices observed by the experts violated every aspect of proper medication administration. Medications are prepared by one nurse and placed into small envelopes for delivery to inmates in segregation. A different nurse takes the envelopes to segregation. He/she does not check inmate identity by requesting to see his identification tag. He/she cannot truly verify that the medications in the envelope are in fact the medications that the psychiatrist prescribed.

Medications are poured from the envelope into the inmate's outstretched hand. Inmates are not observed to take their medication – the nurse moves on to the next outstretched hand. Documentation of the delivery of medication is not made contemporaneously with pill call. In fact, it is sometimes done by yet a third nurse on a different shift. The end result of these practices is a system in which there can be no confirmation that a given inmate received the appropriately ordered medication at the proper time. This could have harmful, even life threatening, consequences: a given inmate could receive too much medication, too little medication or even the wrong medication and something to which he is allergic or interacts negatively with another medication he is prescribed. We heard frequent complaints from inmates about actually receiving the wrong medication.

*** Monitoring Response to Medications and Lab Testing**

Anyone receiving prescription medication must be assessed by the prescribing psychiatrist on a regular basis to determine the effectiveness or lack thereof and potential side effects. There are numerous instances throughout the Alabama prison system in which psychiatrists prescribe medications for periods of up to three months without any face-to-face contact with the recipient. The nursing staff are medical/surgical type nurses and do not

document inmate response to prescribed psychotropic medications.

In addition, there are several psychotropic medications which require periodic blood level monitoring and laboratory studies to check on liver, kidney and thyroid functioning to ensure the medications are not causing damage to those organs. Blood work is not routinely ordered on ADOC inmates. Serum levels are not checked to ensure the inmate is receiving an appropriate dosage of medication. Subsequently, behaviors are attributed as being willful or manipulative rather than understood as symptomatic of untreated or improperly treated mental illness.

One example of this type of problem would be an inmate prescribed lithium to treat bipolar or manic-depressive disorder. The therapeutic window for a serum lithium level is well established. Lithium controls mania if prescribed in the proper manner. A level which is too low will not treat mania. Inmates may be loud, irritable and aggressive as symptomatic of manic depressive illness. These types of behavior are considered disciplinary infractions and inmates are written up and sent to segregation rather than treated appropriately for mental illness.

Failure to appropriately monitor serum levels of lithium can lead to toxic levels causing coma, kidney failure and death. Failure to periodically test the blood to ensure that other prescribed medications are not having an adverse effect on thyroid, liver, kidney and bone marrow functioning can lead to permanent damage to those organs, and in some instances, death.

There are numerous examples of delays of up to several weeks duration between the time a medication is ordered for an inmate and when it is actually available for administration. In his deposition, Dr. Murbach conceded delays but not of this extended duration. Inmates are made to suffer untreated mental illness needlessly and are at risk for violent behavior directed at themselves and others during these delays. The problems associated with such delay are enhanced by the failure to medically reassess the patient's

needs in light of the delay.

The ADOC mental health records reveal instances in which inmates experiencing psychiatric difficulties are prescribed psychotropic medication by a psychiatrist in a remote location who has never seen the inmate. A nurse, with no experience or training in the signs or symptoms of mental illness, relays the information on which the psychiatrist bases his prescription decision. There is no documentation as to the effectiveness of the prescribed medication, and no planned follow-up.

The consequences of failing to provide medication or to monitor its effectiveness leads to needless suffering and subsequent worsening of symptoms. For example, inmates who attempt suicide are often given disciplinary write-ups for possession of contraband or destruction of property if they use some object from their cell to inflict self-injury or tear a bed sheet to construct a noose. Initially, they are stripped of all clothing and placed on a watch status in a cell with only a rubber mat on the floor in place of a bed. They are maintained in this setting until they deny feeling suicidal in order to earn back their property. (It is ironic that in a system where mental health staff are quick to label behavior and reports of symptoms as "manipulative" and malingering, there also are simultaneous demands to "fake being good" in order to be permitted clothing and a mattress.) Finally, the inmate may be punished by being placed in segregation for the disciplinaries they received while the symptoms of their illness remain untreated and access to care is further compromised by placement in segregation.

There are several additional prescribing practices that fall significantly below the accepted standard of care that are worthy of note. The over-utilization of long-acting injectable medications absent informed consent and without benefit of an involuntary medication hearing has already been mentioned. There were other cases found in a randomly studied sample of inmates wherein inmates with well-established diagnoses of serious mental illnesses such as schizophrenia were tapered off antipsychotic medication completely without planned follow-up. They experienced a recurrence of psychotic

symptoms including auditory hallucinations, paranoid delusions and disorganized thinking which is then either not discovered until correctional staff refer the inmate to mental health care, discounted by mental health staff as being false, or re-treated with a medication that now takes weeks to have an effect. That schizophrenia is a life-long psychiatric illness characterized by exacerbations and remissions is well established in the psychiatric literature. Inmates with these disorders require life-long, uninterrupted treatment. Thus, the total absence of treatment is not an option, although mental health professionals may well have reasonable disagreements as to the precise nature of that treatment.

Medications commonly prescribed in other correctional settings and the free world for the treatment of bipolar disorder, aggression and impulsivity are seriously under-utilized in the Alabama system. These medications include lithium, Depakote, and Tegretol -- medications that require baseline and periodic laboratory testing. As noted previously, improperly treated mania (irritability, hyperactivity, insomnia) and impulsivity lead not only to inmate psychological suffering, but also lead to behavior that leads to rule infractions and subsequent placement into segregation settings -- making it even more difficult for inmates to access mental health care.

Medications to which an inmate has had a good response in the past are often automatically discontinued if they are not on the Alabama formulary when the inmate is received into the system. A medication of the same general class (such as Prolixin instead of Risperdal in the general class of antipsychotic medication) is typically prescribed. The inmate is likely to experience an exacerbation of his illness when his medication is changed, leading to needless suffering and deterioration. We observed instances of inmates who had been psychiatrically stable prior to admission but relapsed when their medication was discontinued and replaced by a medication of lower efficacy for them. They experienced recurrent depression and had to be placed on suicide watch status to prevent the likelihood of serious self-inflicted harm. If the inmate continues to request his previously prescribed medication and offers his consent to have previous treatment records forwarded to mental health staff, his actions may be viewed as manipulative. Little effort appears expended by

the Alabama system in securing outside treatment records.

In sum, the ADOC's medication policies lead to needless pain and suffering, and pose a substantial risk of serious harm and even death.

Inmates With Serious Mental Illnesses Confined to Segregation

In some of the prisons reviewed, we found a very high proportion of inmates with serious mental illness confined to segregation. Some inmates in segregation appeared to be experiencing even more acute episodes of serious mental illness than their counterparts in the mental health treatment units. (ADOC's Administrative Regulation #433, issued January 10, 2000, indicates that placement of inmates with acute mental illness in administrative segregation is authorized).

Despite the fact that the mental condition of inmates segregation were often worse than those on the mental health units, they had even fewer contacts with mental health treatment staff, were assessed even less frequently by the psychiatrist, and received only psychotropic medication and intensive correctional supervision. When the psychiatrist is available to segregation inmates, interviews are conducted at the open cell front where there is no confidentiality from other inmates or in an open correctional office where there is no privacy from correctional staff. Some inmates reported being confined to segregation as a result of behavior flowing from untreated mental illness. Confinement in segregation often greatly exacerbates an inmate's mental illness, and tragically results in needless pain, suffering, and deterioration.

The Mental Health Medical Records Are Inadequate, Inaccurate, and Unprofessional

The medical records maintained for mental health inmates are inadequate, inaccurate, incomplete, and unprofessionally maintained. There is no standardized mental health evaluation or assessment. Inmate diagnoses are not readily available in most records. When the record's "problem list" acknowledges an inmate's mental illness, it is listed as

"MENTAL," with no diagnosis or symptom description for other health care staff to reference. There is no documented evidence of attempts to secure past treatment records and many of the inmates provided confirmation that they were not asked to sign a release of information.

There is no attempt to incorporate historical information into inmate management. For example, inmates who have had a previous positive response to treatment of paranoia with a given antipsychotic medication at a particular dosage are tapered and then weaned off the medication. When they experience an exacerbation of their paranoia, it takes weeks for them to come to the attention of mental health staff, generally after the inmate has been returned to segregation as a result of a rule infraction. When the inmate is finally granted a psychiatric assessment, oftentimes a different medication is prescribed or the dosage is so low as to be ineffective thus prolonging the course of their illnesses.

Psychiatric progress notes fall significantly below the professional standard of care. The notes are frequently completely illegible – often to the author of the notes, much less other mental health and health care staff. Progress notes are not reflective of the inmate's condition or symptoms, often stating only vague generalizations ("same," "stable," "unchanged") which essentially provide no information to other staff. Dr. Sander's notes, for example, often consist merely of a date and his initials, reflecting only that the inmate had been seen. The rationale underlying psychotropic medication prescription choice is almost never elaborated upon and frequently there is no apparent concordance between the doctor's conclusion: "manipulative" or "malingering" and the choice of medication; an antipsychotic, generally prescribed for bona fide mental illness.

Some psychiatric progress notes include derogatory and negative remarks about an inmate, rather than focusing on his illness. For example, inmates are called "losers" and "bull shitters". Orders for psychotropic medications are sometimes properly written on the physician order sheet, other times in the progress notes themselves, further complicating any medical or mental health care provider's ability to ascertain a comprehensive knowledge of

medications prescribed, start dates, stop dates, medical and psychiatric conditions.

ADOC psychologists and psychological associates provide services to inmates with serious mental illness but their interventions are not reflected in the medical record since they are no longer permitted to document in the medical record. ADOC mental health staff document their work in the inmate's Institutional Files (which are totally separate from the medical files) or in personally maintained files which cannot be readily accessed by other clinicians. Further, the practice of documenting mental health information in the institutional files represents a violation of inmate confidentiality.

The consequences of inaccurate and incomplete record keeping are devastating for even basic continuity of care. Inmates with serious mental illness who are receiving mental health care and psychotropic medications at one institution and are then transferred to another, fall through the cracks. Health care staff at the receiving institution cannot readily ascertain diagnosis, current psychiatric condition, scheduled follow-up time, or even a comprehensive listing of prescribed medications necessary to continue treatment. The end result is that treatment is delayed or withheld altogether, causing inmates to unnecessarily suffer.

Summary

As we stated at the outset, it is our opinion that the ADOC system for providing mental health care is grossly inadequate and riddled with systemic deficiencies. Pockets of acceptability cannot alone lift this system to the level of minimal acceptability. In practical effect, there is no hospital level care available to inmates with serious mental illness, given our judgment about Kilby's inadequacy. Even at Bullock, inmates with mental illness are assigned bed/treatment space on the basis of bed availability and not clinical judgment. The entire system's clinical staff is hopelessly thin and often under-qualified. The correctional staff assigned to mental health is also inadequate and untrained about mental illness.

Every type of what goes by the name "treatment" or "treatment unit" is seriously

deficient in some critical aspect. Rounds that are designed to assess inmates and provide inmates with access are rapid "drive-throughs." Brief encounters at the cell or in a "pill line" are termed "psychotherapy." Inmates with serious mental illness are locked-down under primitive conditions, and, if thought suicidal, stripped and made to sleep on the floor on a thin plastic mat. Medications are distributed in an unprofessional and dangerous fashion. Psychotropic medications are administered without prior consent and the policy and procedures for the forcible administration of medications are not followed.
The "treatment plans" that exist do not meet the most basic requirements for such plans and the medical records as a whole are professionally unacceptable.

The ADOC's system for providing care to the seriously mentally ill requires substantial change if it is to become even minimally adequate. We have observed many inmates with mental illness greatly suffering needless pain and offer this report in the hopes that it can assist the court to fashion a solution that will ameliorate this suffering.