



American Civil Liberties Union
of Montana Foundation
P.O. Box 9138
Missoula, MT 59807
www.aclumontana.org

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Richard Opper
Director, Montana Department
of Health and Human Services
P.O. Box 4210
Helena, MT 59604-4210
ropper@mt.gov

Mike Batista
Director, Montana Department
of Corrections
P.O. Box 201301
Helena, MT 59620-1301
mbatista@mt.gov

Dear Mr. Opper and Mr. Batista,

We write on behalf of our client, Disability Rights Montana, to inform you of pervasive constitutional violations with respect to the treatment of prisoners with mental illness housed in the Montana State Prison ("MSP") and the Montana State Hospital ("MSH"). Disability Rights Montana is a non-profit organization created pursuant to federal law and charged with protecting and advocating for the rights of individuals with mental illness and other disabilities. Federal law grants Disability Rights Montana standing to bring lawsuits on behalf of persons with mental illness and other disabilities to ensure that their constitutional and statutory rights are protected.

Disability Rights Montana's extensive investigation of the conditions, policies and practices at MSP and MSH has revealed numerous violations of federal law and a pattern of conduct that unquestionably magnifies, instead of reduces, the severity of the mental illnesses afflicting prisoners. The policies and practices of MSP and MSH pose a threat not only to the health and safety of prisoners with mental illness, but also to the corrections officers and health care workers who interact with prisoners, and to the general public when the prisoners are eventually released. In short, Montana's system for dealing with prisoners with mental illness at MSP and MSH is broken, and your agencies must take immediate action to remedy it.



Our conclusions result from more than a year of investigation, including a review of thousands of prison and hospital records, interviews with dozens of prisoners with mental illness, and a December 2013 inspection of MSP by a nationally recognized expert in prison mental health care. The most serious constitutional violations and unjustifiable practices include the following:

- A pattern of deliberately withholding medication from prisoners with mental illness;
- A pattern of deliberately refusing to diagnose prisoners as suffering from mental illness despite clear evidence supporting such diagnoses;
- Keeping prisoners with mental illness locked in solitary confinement 22 to 24 hours a day for months, and in some cases years, which substantially exacerbates their illness;
- Using solitary confinement to punish prisoners with mental illness for inappropriate behavior, in the absence of any legitimate system for determining whether that behavior was the result of their illness;
- Depriving prisoners with mental illness of clothes, bedding, proper food, and human contact as part of so-called “behavior modification plans” that punish prisoners for behavior resulting from their mental illness;
- The absence of any meaningful treatment and therapy for the vast majority of prisoners with mental illness;
- A fragmented administrative system that fails to identify and track individuals with mental illness and fails to take their mental illness into account when classifying and housing prisoners; and
- A mental health treatment unit that contains only 12 beds, despite having more than 275 prisoners on the psychiatrist’s caseload.

MSH is complicit in the systemic mistreatment of prisoners with mental illness. Our investigation has revealed that MSH transfers to MSP prisoners sentenced Guilty But Mentally Ill simply to open up bed space or to avoid treating prisoners who are disliked by the staff. This practice violates both Montana Code § 46-12-312, which governs the transfer of prisoners between MSH and MSP, and the due process protections of the Montana and U.S. Constitutions. In addition, MSH’s forensic unit is not equipped to handle the safety issues posed by some patients who courts have sentenced Guilty But Mentally Ill. As a result, when those patients act out or engage in violent behavior, they are transferred to MSP regardless of whether it is in the best interest of their custody, care and treatment needs. In their present form, MSP and MSH are incapable of remedying the problems that plague the treatment of prisoners with mental illness at those institutions.

Disability Rights Montana will file a lawsuit to stop these ongoing violations, if necessary. However, it is our hope that we can work with the Department of Corrections ("DOC") and the Department of Health and Human Services ("DPHHS") to resolve this matter in a way that avoids the costs of litigation and provides individuals with mental illness the treatment and protections they are guaranteed by our federal and state Constitutions. Given the seriousness of the violations at issue, however, we must insist you give this matter immediate attention. Please contact us by March 14th if you wish to discuss potential resolutions of this matter that do not involve litigation.

Set forth below is a detailed explanation of the numerous constitutional violations by MSP and MSH that were discovered during our investigation. In addition, Exhibit A sets forth the experiences of several prisoners with mental illness who have suffered from the unconstitutional practices at MSP and MSH, as revealed during our investigation.

I. DOC and MSP are Well-Aware of the History of Mental Health Treatment Violations at MSP.

The current violations are particularly disturbing given MSP's history of constitutional violations regarding its treatment of prisoners with mental illness. In its 2003 decision in *Walker v. State*, 2003 MT 134, 316 Mont. 103, 68 P.3d 872 (Mont. 2003), the Montana Supreme Court made it very clear that MSP has a constitutional obligation to provide prisoners with appropriate mental health treatment and to eliminate disciplinary practices that exacerbate prisoners' mental illnesses. The Court stated:

In the case of the mentally ill, basic human needs must be met, along with adequate opportunities to develop capacities, and adequate mental health care must also be provided to treat the illness. . . . Our Constitution forbids correctional practices which permit prisons in the name of behavior modification to disregard the innate dignity of human beings, especially in the context where those persons suffer from serious mental illness. We cannot sanction correctional practices that ignore or exacerbate the plight of mentally ill inmates like Walker, especially when that inmate is forced to rely on the prison for his care and protection. . . . Moreover, if the particular conditions of confinement cause serious mental illness to be greatly exacerbated or if it deprives inmates of their sanity, then prison officials have deprived inmates of the basic necessity for human existence and have crossed into the realm of torture.

Id. at ¶¶81-82 (citations omitted).

The Court concluded that MSP's "behavior modification plans" ("BMPs") and living conditions constitute cruel and unusual punishment when they exacerbate the prisoner's mental health condition and ordered MSP to conform its operations to the Court's requirements. Despite this, prisoners with mental illness are still routinely subjected to BMPs. Our investigation found that four years after the *Walker* decision, MSP's mental health director stated in an email that two individuals found Guilty But Mentally Ill by their sentencing judge would be "good candidates" for a BMP.

In 2009, the DOC faced another lawsuit, *Katka v. State*, challenging MSP's treatment and discipline practices for juveniles with mental illness. DOC resolved *Katka* by entering into a 2012 settlement agreement requiring MSP to implement changes regarding its diagnoses, monitoring, treatment and disciplining of prisoners with mental illness. Throughout that case MSP heard from corrections and mental health experts who described the detrimental effects of MSP's use of isolation and inadequate mental health treatment.

Our investigation found that prisoners with mental illness regularly file grievances regarding the quality of mental health care they receive, including allegations of mental health staff discontinuing needed medications and ignoring previous diagnoses, and the negative impact that solitary confinement has on prisoners' mental state. The overwhelming need for mental health services is obvious; MSP's mental health director publicly stated that mental health staff answered over 2,000 mental health requests by prisoners in 2012 alone. MSP's failure to properly address such requests was recently made clear when it fired a mental health counselor for shredding prisoners' written requests for mental health treatment. In addition, MSP is contacted by family members of prisoners with mental illness pleading for their loved one to be put back on needed medications discontinued by MSP mental health staff.

It is inconceivable that MSP correctional and mental health staff are unaware of these grievances and the recent history of MSP being forced to change its practices with respect to prisoners with mental illness. MSP staff know what the Constitutions require, yet as our investigation has revealed that serious constitutional violations continue to exist. Given that history and knowledge, it is impossible to avoid the conclusion that MSP staff are deliberately indifferent to the harm MSP's practices cause its prisoners with mental illness.

II. MSP Violates the Eighth Amendment's Prohibition Against Cruel and Unusual Punishment By Depriving Its Prisoners of Adequate Mental Health Care.

MSP's obligation to provide adequate mental health treatment to prisoners is well established. As explained by the U.S. Supreme Court, "[t]o incarcerate, society takes from prisoners the means to provide for their own needs. Prisoners are dependent on the State for food, clothing, and necessary medical care. . . . Just as a

prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care.” *Brown v. Plata*, 131 S.Ct. 1910, 1928 (2011). Medical care includes mental health care. See *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995) (“The obligation to provide for the basic human needs of prisoners includes a requirement to provide access to adequate mental health care. . . . If the state fails to meet this obligation, ‘it transgresses the substantive limits on state action set by the Eighth Amendment.’”); *Madrid v. Gomez*, 889 F. Supp. 1146, 1255 (N.D. Cal. 1995) (“There is ‘no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart’”). Our investigation has shown that MSP fails to meet its constitutional obligations at every step of the mental health treatment process.

A. MSP Lacks a Systematic and Comprehensive Mental Health Program.

The constitutional violations begin as soon as prisoners enter MSP. The Constitution requires that prisons maintain a systematic program to screen and evaluate inmates for medical and mental health needs. *Gibson v. County of Washoe, Nev.*, 290 F.3d 1175, 1189 (9th Cir. 2002) (jail’s failure to provide mental health screening on intake could be found deliberately indifferent). “Delivery of adequate mental health care to such inmates requires their identification. For that reason it has been held that correctional systems are required by the Constitution to put in place a ‘systematic program for screening and evaluating inmates in order to identify those who require mental health treatment.’” *Coleman v. Wilson*, 912 F. Supp. at 1305.

MSP has no meaningful system for identifying, classifying, and monitoring prisoners with mental illness. MSP officials do not know the number of prisoners with mental illness. There is no policy or procedure to define or classify prisoners according to their level of mental health need. Initial screening of prisoners with mental illness during intake can occur weeks after admission, which is far too long to identify suicidal prisoners or prisoners in mental crisis. MSP’s level 2 mental health evaluation, which is conducted if a prisoner shows signs of mental illness during the initial screening, can also take weeks. MSP has no clear policy explaining how the information gathered from prisoners at intake should be processed or utilized, whether it should be taken into account when determining housing, custody level, or programming, or who should receive copies of the information.

Even the definition of “serious mental illness” in MSP policy is overly narrow and out of date. It is standard practice that serious mental illness is defined as a function not only of diagnosis, but also of functional impairment and the duration of illness or disability. A prisoner has a serious mental illness if he has a current or recent significant history of DSM-IV-TR Axis I diagnoses, particularly where an individual experiences significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health. In addition, individuals diagnosed with a developmental disability,

dementia, cognitive disorders that result in a significant functional impairment involving acts of self-harm, or other behaviors that have a seriously adverse effect on life or on mental or physical health, also have serious mental illness. Similarly, prisoners diagnosed with a severe personality disorder that is manifested by episodes of psychosis or depression, and results in significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health, also have a serious mental illness. MSP's definition excludes personality disorders, and refers only to Axis I disorders "unless there is certification in the record that the diagnosis has been changed or altered as a result of a subsequent mental health evaluation by a licensed mental health professional." DOC Policy 3.5.5.

Comprehensive treatment plans for prisoners with mental illness are essential in providing constitutionally adequate mental health care. *See Morgan-Mapp v. George W. Hill Corr. Facility*, 2008 WL 4211699 (E.D. Pa. Sept. 12, 2008) (finding that failure to make treatment plans as required by prison policy, combined with failure to ensure medication compliance, could establish psychiatrists' deliberate indifference); *Austin v. Pennsylvania Dept. of Corr.*, 876 F.Supp. 1437 (E.D. Pa 1995) (approving class action settlement after noting that settlement mandated the use of treatment plans). *See also T.R. v. South Carolina Dept. of Corrections*, C/A No.: 2005-CP-40-2925 (5th Judicial Circuit, Jan. 8, 2014), p. 21 (finding constitutional violation for limited involvement of psychiatrists in creating treatment plans for prisoners). The American Correctional Association's standards require prisoners with serious mental health needs to have a written treatment plan based on a comprehensive evaluation by a licensed mental health professional. *See* ACA Standard 4-4350, 4-4372. *See also* NCCHC Standard MH-G-03 ("[m]ental health services are provided according to individual treatment plans").

Despite those legal requirements and national correctional standards, MSP appears to have no system in place for the creation of comprehensive treatment plans for prisoners with mental illness. Instead, MSP's mental health system is an ad hoc system of uncoordinated actions between housing and custody staff, disciplinary staff, medical staff and mental health staff. This lack of coordinated action and planning makes it impossible for MSP to provide the comprehensive, and often complicated, care required for prisoners with mental illness.

B. MSP Mental Health Staff Routinely Misdiagnose Prisoners, Deny Prisoners Necessary Medications, Fail to Review Prior Mental Health Records, and Fail to Adequately Evaluate Prisoners.

Our investigation revealed substantial evidence that MSP's mental health staff engage in a pattern of refusing to acknowledge the long-standing mental illness diagnoses of prisoners and discontinuing medications for those with established mental illness. MSP records show that the prison's chief (and only) psychiatrist regularly changes diagnoses of prisoners with long-standing and well-documented histories of serious and persistent mental illness to less serious mental

health conditions, or no mental illness at all, after only brief meetings with the patient and no meaningful consideration of previously-documented diagnoses. His notes documenting these re-diagnoses fail to account for the vast discrepancies with previous diagnoses formulated by qualified treatment providers. MSP records show that its psychiatrist consistently fails to acknowledge the presence of serious mental illness, and ignores prior history and treatment.

The psychiatrist's notes of his evaluations of prisoners convey disdain and in some cases outright hostility toward prisoners with mental illness. His notes also show a clear pattern of diagnosing prisoners a "malingering" or, in other words, feigning mental illness for secondary gain. The psychiatrist appears to believe that most, if not all, prisoners with mental illness are essentially "faking it." The psychiatrist confirmed his dismissive attitude toward prisoners with mental illness during a panel discussion at MSP for the Children, Families, Health and Human Services Interim Legislative Committee's Study on State-operated public institutions serving individuals with mental illness, intellectual disabilities, and chemical dependency. During this panel he repeatedly stated that the majority of prisoners at MSP, who others on the outside perceive are mentally ill, actually have untreatable personality disorders and "don't want to change." The psychiatrist's well-established practice of refusing to diagnose clearly disturbed prisoners as having mental illness suggests that he does not care how these human beings are treated and, in fact, hopes they receive further punishment.

Those acts are clear violations of prisoners' constitutional rights. *See e.g., Page v. Norvell*, 186 F. Supp. 2d 1134, 1138 (D. Ore. 2000) (allegation that mental health professional downgraded the prisoner's mental health diagnosis after a two-minute meeting with no evidence to support his clinical findings supported Eighth Amendment claim); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 903 (S.D. Tex. 1999) (finding Eighth Amendment violation in part because of over-diagnoses of malingering). *See also T.R. v. DOC, supra*, p. 28 ("the failure to appropriately supervise, evaluate, and dispense psychotropic medications creates a substantial risk of serious harm to inmates with serious mental illness").

MSP mental health staff's disbelief of the existence of mental illness results in the deliberate withholding of necessary medications from prisoners with mental illness. This pattern of behavior is a clear violation of the Eighth Amendment. *See e.g., Steele v. Shah*, 87 F.3d 1266, 1269-70 (11th Cir. 1996). To satisfy the requirements of the Constitution, the administration of medication by prisons must include appropriate supervision and periodic evaluation. *See Coleman*, 912 F. Supp. at 1298, n. 10; *Balla v. Idaho State Board of Corrections*, 595 F. Supp. 1558 (D. Idaho 1984). MSP medical records show that MSP's psychiatrist engages in a pattern of purposefully discontinuing medications, including psychotropic and anti-psychotic medications that prisoners with long-established diagnoses of serious mental health disorders have taken for years. The psychiatrist and MSP's intake staff often discontinue these medications without consulting the patient or after a

cursory meeting that lasts five minutes or less. Patients' medications are discontinued without reference to records from other mental health facilities.

MSP mental health staff also refuse to restart medication if a prisoner decides to temporarily stop taking medication, and discontinue medication where a prisoner misses just a few days of pill pass. The records show a clear bias by MSP mental health staff toward finding any excuse to discontinue providing medications to prisoners with mental illness, which strongly indicates that it is the deliberate, but unstated, policy of MSP mental health staff to deny the existence of mental illness in prisoners and to refuse to treat it.

C. MSP'S Deliberate Use of Solitary Confinement to Punish and Control Prisoners With Mental Illness Violates Both the Eighth Amendment and Numerous National Standards of Care.

Our investigation has uncovered substantial evidence that MSP uses extreme solitary confinement—keeping prisoners isolated in cells for 22 to 24 hours a day for weeks and even months at a time—as a common means for addressing prisoners with mental illness. Courts across the country have repeatedly found that this practice, euphemistically labeled “locked housing” and “segregation,” is effectively a form of torture that has no place in civilized society and is prohibited by the Eighth Amendment.

Over 100 years ago, the U.S. Supreme Court described solitary confinement as an “infamous punishment” and rejected it as follows:

Experience demonstrated that there were serious objections to it. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.

In re Medley, 134 U.S. 160, 168 (1890). More recently, in *Madrid v. Gomez*, a federal court described solitary confinement of prisoners with mental illness as “the mental equivalent of putting an asthmatic in a place with little air to breathe.” *Id.* at 1265-66.

The use of solitary confinement to punish prisoners for behavior that is a product of their mental illness is unconstitutional. *See Johnson v. Beard*, 2008 WL 2594034 (M.D. Penn. 2008) (prisoner stated claim for relief when he asserted that he was placed in “punitive segregation for behavior that is a result of his mental illness”); *Coleman*, 912 F. Supp. at 1320-22 (punitive treatment of prisoners acting out because of their mental illness held unconstitutional); *Arnold on behalf of H.B.*

v. Lewis, 803 F.Supp. 246, 256 (D. Ariz. 1992) (placement in lockdown “as punishment for the symptoms of [the plaintiff’s] mental illness and as an alternative to mental health care” was unconstitutional).

In 2012, a federal court in Indiana concluded that the state’s policy of placing prisoners with mental illness into solitary confinement (labeled “segregated housing units” or “SHU”) violates the Eighth Amendment. The court clearly described the serious harm that such treatment inflicts on prisoners with mental illness:

[T]here are three ways in which segregation is harmful to prisoners with serious mental illness. The first is the lack of social interaction, such that the isolation itself creates problems. The second is that the isolation involves significant sensory deprivation. The third is the enforced idleness, permitting no activities or distractions. These factors can exacerbate the prisoners’ symptoms of serious mental illness. This condition is known as decompensation, an exacerbation or worsening of symptoms and illness.

Indiana Prot. & Advocacy Servs. Comm’n v. Comm’r, Indiana Dep’t of Correction, 1:08-CV-01317-TWP, 2012 WL 6738517, *15 (S.D. Ind. Dec. 31, 2012). The court concluded:

It is inconceivable that any representative portion of our society would put its imprimatur on a plan to subject the mentally ill and other inmates described above to the SHU, knowing that severe psychological consequences will most probably befall those inmates. Thus, with respect to this limited population of the inmate class, plaintiffs have established that continued confinement in the SHU, as it is currently constituted, deprives inmates of a minimal civilized level of one of life’s necessities.

Id. at *23.

Court decisions prohibiting the use of solitary confinement and segregation to control or punish prisoners with mental illness are consistent with the national standards established by numerous correctional, medical and mental health associations. Some of those standards include:

- National Commission on Correctional Health Care (“NCCHC”) Standards for Mental Health Services in Correctional Facilities (2008): MH-E-07: “Inmates who are seriously mentally ill should not be confined under conditions of extreme isolation.”

- American Bar Association Treatment of Prisoners Standards:
 - Standard 23-2.8: “No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing.”
 - Standard 23-4.3 “[Disciplinary] sanctions should never include conditions of extreme isolation . . .”
 - Standard 23-6:11: “Prisoners diagnosed with serious mental illness should not be housed in settings that may exacerbate their mental illness or suicide risk, particularly in settings involving sensory deprivation or isolation.”
- American Correctional Association Standards for Adult Correctional Institutions (4th ed.) Standard 4-4249: “Total isolation as punishment for a rule violation is not an acceptable practice.”
- American Correctional Association Standards require that “inmates in segregation can write and receive letters on the same basis as inmates in the general population.” ACA Standard 4-4266. These standards further require that “inmates in segregation have opportunities for visitation unless there are substantial reasons for withholding such privileges.” ACA Standard 4-4267. These standards mandate that prisoners in segregation receive commissary services, library services, social services, counseling services, religious guidance, recreational programs, and phone privileges. ACA Standards 4-4272, 4-4273.
- American Psychiatric Association Position Statement on Segregation of Prisoners with Mental Illness (2012): “Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (*i.e.* mental health/psychiatric treatment in appropriate programming space and adequate unstructured out-of-cell time) should be permitted.”
- American Public Health Association Policy 201310: “Prisoners with serious mental illnesses should be excluded from placement in solitary confinement.”
- Society of Correctional Physicians’ Position Statement on Restricted Housing of Mentally Ill Inmates: “[P]rolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment. Inmates who are seriously mentally ill should be either excluded from prolonged segregation status (*i.e.* beyond 4 weeks) or the conditions of their confinement should be modified in a manner that allows for adequate out-of-cell structured therapeutic

activities and adequate time in an appropriately designed outdoor exercise area.”

Contrary to these court decisions and national standards, MSP regularly uses extreme forms of solitary confinement to punish prisoners with mental illness, without regard to whether that behavior is a product of their mental illness or the effect that solitary will have on their health. Instead of making legitimate efforts to diagnose and treat the illnesses that may be causing the prisoners’ behavior, MSP in effect locks the prisoners in a steel closet, where they deteriorate, suffer, and engage in self-harm. Some prisoners’ hopelessness manifests in seemingly docile “manageable” behavior, however, prisoners continue to suffer the detrimental effects of solitary confinement, resulting in a decreased ability to reintegrate with others.

1. “Locked Housing”

MSP has approximately 170 solitary confinement cells located in two “Locked Housing” units. There are several categories of custody in locked housing, all of which are solitary confinement, including Restricted Ad Seg, Ad Seg and Max Population. Within these categories are multiple level systems. Prisoners must progress through the most restrictive levels for at least a month with “clear conduct” prior to moving to less restrictive levels. Prisoners in Restricted Ad Seg and Ad Seg are kept in their cell 23 hours per day with one hour of “outside recreation” each day. Depending on the housing unit, outside recreation either occurs in a caged area outside or within a cement block with a grate open to the outside on the top of the block. At the most restrictive levels of Restricted Ad Seg and Ad Seg, prisoners are not allowed phone calls or visits.

Although most cells have a small window, some are frosted or covered with metal resulting in substantially limited natural light, if any. The cell doors are solid doors with a small window and a food slot. Prisoners receive meals through the food slot, and eat all of their meals in isolation in their cells. Many prisoners report hearing screaming, crying or other disturbing noises by prisoners in cells on their block, many of whom have serious mental illness and are actively psychotic or decompensating. The screaming can occur day and night for weeks on end.

Prisoners in locked housing experience little to no human interaction. Prisoners rarely speak to or see others with the exception of corrections officers peering through their cell window during rounds, or during the weekly, very brief, cell door visit by mental health staff. The only human touch prisoners experience is when they are placed in handcuffs or restraints. All prisoners in locked housing are put in restraints whenever they leave their cell.

The *least* restrictive levels of Ad Seg require prisoners to be in their cells 22 hours a day. A prisoner at this level is entitled to one hour per day by himself in the dayroom adjoining his cell and one hour in an outdoor caged area by himself. They may also receive two visits per week from outside visitors. For many, however, their only significant interaction with other human beings occurs during their one hour of dayroom time, when they are permitted to engage in limited conversations with prisoners still locked in their cells, as long as they remain a minimum distance from the cells doors, or during outside recreation if other prisoners are also outside in a separate cage at the same time. Activities in the prisoners' cells are also restricted, being limited to certain hobby arts and in-cell study. Prisoners with mental illness receive no mental health therapy or other programming or activities that might relieve the extraordinary stress that the excessive isolation places on their already fragile condition.

Although there is some paperwork that mental health staff must complete prior to a prisoner being placed in solitary confinement, there appears to be no meaningful inquiry into a prisoner's mental health. We located no instance in which mental health staff determined a prisoner was too mentally ill to be placed in locked housing. On the contrary, mental health staff regularly participate in decisions to place prisoners with mental illness in locked housing, and attribute obvious symptoms of mental illness to volitional behavior that is not the result of mental illness.

2. Disciplinary detention

MSP's use of solitary confinement against prisoners with mental illness can involve even more severe forms of punishment. MSP routinely places prisoners with mental illness in "disciplinary detention," known among prisoners and MSP staff as "the hole," for extended periods of time of up to one month. During this time, the prisoner is in 24-hour isolation in a small single-person cell. Some cells have blacked out windows, resulting in a total absence of natural light. They have no out-of-cell time whatsoever with the exception of three ten-minute showers per week.

Prisoners must maintain five days of good conduct in the hole before they are eligible to receive any property whatsoever, including a book or writing materials. They are prohibited from receiving visits, phone calls, recreation, religious activities or treatment programs for the duration of their 24-hour isolation in the hole. Although on paper MSP policies prohibit a prisoner from being sentenced to more than 30 days of disciplinary detention, MSP staff circumvent that rule by sentencing prisoners to 30 days, followed by one or two days back in Ad Seg, then returning prisoners to another 30 days of 24-hour isolation in disciplinary detention.

3. Behavior Modification Plans

Despite the Montana Supreme Court's admonition in *Walker v. State*, MSP continues to use behavior modification plans ("BMPs") to punish prisoners with mental illness for behavior that is a product of their mental illness. Behavior that can result in a BMP includes attempting self-harm, such as cutting oneself or biting oneself, and spreading feces on one's self or one's cell—behavior that on its face suggests the prisoner is suffering from mental illness. Our investigation has shown that involvement of MSP mental health staff in the BMP process is essentially a sham, with mental health professionals facilitating, rather than regulating, the imposition of BMPs on prisoners with mental illness regardless of the effects that the punishments may have on the prisoners' health.

MSP policy refers to BMPs as "a comprehensive strategy to deal with, and try to end, an inmate's repeated dangerous, disruptive and/or assaultive conduct that isn't associated with serious mental illness." Detention policy informs prisoners "if you do anything to harm yourself or disrupt the safety or security of the unit, you face being placed on a behavior management plan and all items will be restricted."

Prisoners placed on BMPs are either placed in a padded isolation cell or kept in their own cell for the duration of the BMP. A BMP consists of three levels. While on level 1, all prisoner clothing is removed, the prisoner is provided a security mattress, a blanket and suicide smock. The prisoner is allowed no property, and all meals are nutraloaf, a tasteless loaf of food, delivered on a paper towel. The prisoner is not allowed any running water while on a BMP, and must request that staff provide him water to drink or wash his hands. In isolation cells, prisoners on BMPs must go to the bathroom through a grate on the floor, and must request toilet paper, water to wash hands, water to drink, and that staff flush the toilet. Prisoners on BMPs are in 24-hour isolation without even one hour out of their cell. If a prisoner does not "engage in disruptive conduct" for 48 hours, the prisoner is moved to level 2 of the BMP, in which he is given his clothing and a pillow. After 24 hours of non-disruptive behavior, the prisoner can advance to Step 3 in which regular meals and bedding are provided. The BMP is "deactivated" after 24 hours of nondisruptive behavior at level 3.

MSP mental health staff "clear" prisoners for BMPs for six-month intervals based on their "assessment" of the prisoner's current mental health status. During this six-month period, prisoners can be placed on BMPs without input from mental health staff. Despite the fact that prisoners are being cleared for BMPs for future conduct in the six-month period, MSP mental health staff certify that "[t]he inmate's present behavior is not the direct result of an Axis I serious mental disorder"; "the inmate is knowingly, willingly and purposely engaging in the present assaultive and/or dangerous behaviors"; "the inmate does not need a higher level of mental health care or observation"; and "the inmate's mental status is not presently deteriorated or deteriorating." During our expert's inspection of MSP, staff could not identify one case in which mental health staff intervened to discontinue a BMP.

Despite reviewing thousands of pages of records, we located no instances in which mental health staff declined to clear a prisoner to be placed on a BMP. This very important function of clearing prisoners for BMPs is not tracked, monitored or studied in any form of quality improvement activity. There is no information about how many prisoners, if any, are not “cleared” for BMP staff or removed from BMPs as a result of mental illness and/or deterioration.

In a recent investigation, the U.S. Department of Justice (“DOJ”) concluded that the very similar BMP practices at the Pennsylvania State Correctional Institution at Cresson violated the Eighth Amendment because, among other things, prison officials used “punitive behavior modification plans to address behaviors that are derivative of prisoners’ serious mental illness.” Letter from DOJ to Governor Tom Corbett, p. 15.¹ The Department noted that Cresson staff “routinely respond to the prisoner engaging in behaviors associated with serious mental illness (such as shouting, throwing feces, or banging his head against a wall) by further restricting or even eliminating whatever minimal amounts of therapeutic unstructured and structured out-of-cell time a prisoner has.” *Id.* at 16. The Department stated that “[t]his practice punishes the sickest of prisoners by depriving them of adequate treatment and other out-of-cell opportunities when they need it most.” *Id.*

4. MSP’s use of solitary confinement to punish prisoners with mental illness exacerbates their illnesses.

MSP’s use of solitary confinement on prisoners with mental illness prevents those prisoners from obtaining the mental health treatment they need and exacerbates their symptoms, leading to serious harm such as trauma, decompensation, psychosis, physical injuries and death. One prisoner with mental illness explained to us that years in locked housing makes him feel like a young kid locked in a closet with nothing to do. As a result, he spreads feces on the cell wall to keep bad spirits away. Multiple prisoners with auditory or visual hallucinations explained to us that the hallucinations generally become more intense in isolation as there is nothing to distract the prisoner or keep him grounded in reality. Another young prisoner with mental illness in locked housing explained that the only communication keeping him going was phone calls with his family. When that became prohibited, he lost all hope and positivity, making him more frustrated and depressed.

MSP prisoners with mental illness have explained that months in locked housing creates anxiety and paranoia, increased hostility, increased depression and helplessness and increased sensitivity to sensory stimuli. Prisoners in locked housing report a yearning for interaction with others, followed by a fear of other

¹ Available at <http://www.justice.gov/crt/about/spl/findsettle.php>.

people and nervousness around others. While at first isolation is incredibly difficult, prisoners report that after a period of time their inability to interact and hypersensitivity to sensory stimuli renders them incapable of reintegrating into the general prison population. Prisoners grow not to trust themselves and worry that they might explode when around others. As a result, they grow to prefer isolation, often out of fear of hurting others or receiving a longer sentence for a new offense if reintegrated.

A disproportionate amount of the self-harm at MSP is performed by prisoners with mental illness who are misdiagnosed, not properly medicated, or subjected to solitary confinement. This reality comports with the DOJ's observation in its Cresson investigation that "warehousing prisoners in isolation, instead of providing them with the mental health treatment they need, results in serious harm, and the Eighth Amendment prohibits this type of deliberate indifference to prisoners' serious mental health care needs." DOJ Findings Letter Re: Cresson, p. 23.

D. MSP Denies Prisoners With Mental Illness Necessary Therapeutic Treatment.

Prisoners with mental illness have little, if any, meaningful interactions with mental health clinicians. Therapy groups are offered by mental health staff for only a very small number of prisoners, none of whom are in locked housing. Almost no individual therapy or counseling by qualified professionals is provided to prisoners at MSP with mental illness.

The situation is exacerbated for prisoners with mental illness in solitary confinement. *See Coleman*, 912 F.Supp. at 1320-21 (adopting magistrate's conclusion that "inmates are denied access to necessary mental health care while they are housed in [isolation]"); *Plata*, 131 S.Ct. at 1933 (acknowledging concern that prolonged isolation results in inappropriate delays of mental health care); *Griffin v. Vaughn*, 112 F.3d 703, 709 (3d Cir. 1997). In its initial assessment of the Cresson facilities, the DOJ found "providing adequate mental health care to prisoners with serious mental illness requires meaningful out-of-cell activities, such as individual and group therapy, peer and other counseling, or skills building, as well as unstructured activities, such as showers, recreation, or eating out-of-cell." DOJ Findings Letter Re: Cresson, p. 11. The DOJ concluded that isolating prisoners with mental illness for 23 or more hours per day "prevents prisoners with serious mental illness from receiving even a fraction of the out-of-cell activities they need." Just like MSP prisoners in locked housing, Cresson prisoners in isolation received "zero hours of structured out-of-cell therapeutic activity and at most five hours of unstructured out-of-cell activity per week."

MSP prisoners in locked housing receive weekly "cell checks" by mental health technicians, many of whom have very limited mental health education or training. These checks occur at the cell door within earshot of other prisoners and corrections officers. Mental health technicians generally ask a prisoner how they

are doing, and move on if there is no response. If a prisoner expresses a need for mental health services during these rounds, the mental health technician will merely tell the prisoner to submit a written mental health request, which rarely results in a meaningful response. If a prisoner is sleeping, he will miss his chance for the week, and must wait until the following week for another interaction. Not surprising, prisoners report that they are generally uncomfortable sharing personal mental health information in a public setting with an untrained professional who they perceive will not help them regardless of what they say. Some prisoners explained that these perfunctory weekly rounds actually do more harm than good because they create frustration and anger that this is the primary means of addressing their mental health concerns.

MSP has no policy or practice regarding mental health treatment plans or any description of how psychiatric services should integrate with other mental health services. There are no therapeutic groups available to prisoners in locked housing. The only treatment received by prisoners in locked housing is psychotropic medication, which, as discussed above, is routinely discontinued with little or no evaluation and no legitimate consideration of the prisoners' historical records of mental illness.

Non-treatment and under-treatment of prisoners with mental illness has short- and long-term negative impacts. Prisoners with mental illness who go untreated are unable to complete necessary programming and maintain clear conduct, resulting in an increase in their custody level, more time in solitary confinement, further deterioration of mental health, convictions for new offenses, an inability to obtain parole, and longer stays at MSP under the conditions described. Clinical research has demonstrated that the longer treatment is withheld, the longer it takes to affect a response and the treatment response is less robust than had treatment been provided in a more timely manner.

MSP's most common response to suicidal ideations is to put the prisoner on a BMP. Not surprisingly, the result is that MSP prisoners experiencing suicidal ideations refrain from asking for help or sharing their concerns for fear of solitary confinement. Applicable standards require implementation of suicide prevention plans approved by a health authority and reviewed by facility administrators comprehensively trained in identifying, screening, handling and supervising suicide-prone prisoners. *See* ACA Standard 4-4373. The NCCHC has explained:

In determining the most appropriate housing for a suicidal inmate, facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (i.e., segregate) and sometimes restrain the individual. These responses might be more convenient for staff, but they are detrimental to the inmate because the use of isolation escalates the sense of alienation and further removes the individual from proper

staff supervision. . . . Furthermore, removal of the inmates' clothing (excepting belts and shoelaces) and the use of physical restraints . . . should be avoided whenever possible and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

NCHHC 2008 Standards for Mental Health Services in Correctional Facilities, Appendix D, p. 126.

NCCHC states that “[r]esearch consistently reports that approximately two thirds of all suicide victims communicate their intent some time before death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.” *Id.* Despite this, our investigation revealed that MSP’s psychiatrist is shockingly dismissive of prisoners’ claims of previous suicide attempts.

E. MSP Lacks Oversight and Quality Control of the Adequacy of Mental Health Care Its Prisoners Receive.

It is constitutionally suspect for a prison to lack some means of evaluating its mental health care program. *Jones’El v. Berge*, 2001 WL 24379611 (W.D. Wis. Aug. 14, 2001) (supporting its finding of inadequate medical and mental health care by noting there was no continuous “quality improvement program” for health services at the prison); *Cody v. Hillard*, 599 F.Supp. 1025, 1058 (D.S.D. 1984) (holding that prison’s lack of “quality control program” constituted a “deficienc[y] of a constitutional dimension in the health care system”); *Lightfoot v. Walker*, 486 F.Supp. 504, 517-18 (S.D. Ill. 1980) (“[A] primary component of a minimally acceptable correctional health care system is the implementation of procedures to review the quality of medical care being provided. . . . The defendants’ failure in this regard have prevented them from detecting the inadequacies in their health care services.”). *See also T.R. v. DOC*, *supra*, p. 31 (“a major contributing factor to the deficiencies in the SCDC program is the lack of a formal, comprehensive quality management program”).

MSP mental health staff have incredible power over the lives of prisoners with mental illness. Despite this, there is no quality control mechanism in place at MSP to monitor the practices of that staff.

F. MSP Lacks Sufficient Trained Staff to Provide Constitutionally Adequate Health Care.

Prison facilities must have adequate staffing levels to deliver medical and mental health services to prisoners. *See Brown v. Plata*, 131 S.Ct. 1910 (2011); *Madrid*, 889 F.Supp. at 1257. A prison violates the Constitution where gross staffing deficiencies result in prisoners with mental illness not receiving reasonable access to medical personnel qualified to diagnose and treat illness. *See Cabrales v. County of Los Angeles*, 864 F.3d 1454, 1461 (9th Cir. 1989); *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754 (3d. Cir. 1979). *See also T.R. v. DOC*, *supra*, p. 21 (finding constitutional violation where mental health program was “substantially understaffed” resulting in inability to “provide effective services to its mentally ill inmate population”); *Abdollah v. Sacramento*, 405 F.Supp.2d 1194, 1207 (E.D. Cal. 2005) (inadequate staffing does not excuse lack of awareness of a risk, and may lead to a finding that the state was ignoring the risk).

Prison mental health staff must also be adequately trained and qualified. *See Balla v. Idaho State Bd. of Corr.*, 595 F. Supp. 1558, 1577 (D. Idaho 1984) (“treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders”); *Hartman v. Correctional Medical Services*, 960 F.Supp. 1577, 1582-83 (M.D. Fla. 1996). *See also T.R. v. DOC*, *supra*, p. 25 (“[W]hile it is clear that [the department of corrections] does not have enough counselors, it is equally clear that many of the counselors they do employ are underqualified.”).

MSP has 19 mental health staff positions to provide services to over 400 prisoners who receive varying levels of mental health treatment. Many of those positions, however, are perpetually vacant. MSP has had a 75% turnover of mental health staff in the last two years. MSP’s sole psychiatrist has approximately 276 prisoners on his caseload. MSP employs six mental health technicians, who respond to a majority of requests for mental health services by prisoners and conduct weekly “mental health rounds” in locked housing. The only education requirement for mental health technicians is a high school diploma. They generally have very limited experience providing mental health services and little to no formal education in the subject. Yet they are MSP’s primary means of assessing the mental health of its prisoners.

MSP corrections staff receive a mere four-hour mental health class each year, and a two-hour mental health class for new staff. With this negligible mental health training, corrections staff are not equipped to properly handle the large number of prisoners with varying mental illnesses over whom they have custody. The result is an effective denial of mental health services for prisoners with mental illness at MSP, particularly those in solitary confinement.

III. DPHHS Violates the Due Process Rights of Patients Sentenced Guilty But Mentally Ill When Transferring Them From the State Hospital to MSP.

DPHHS has a pattern and practice of transferring MSH patients sentenced Guilty But Mentally Ill ("GBMI") to MSP in disregard of their custody, care and treatment needs. At the end of 2013, MSP housed approximately 16 GBMI patients who were originally sentenced to DPHHS but subsequently transferred to MSP. Transfer of a GBMI prisoner to MSP results in inadequate mental health treatment in a substantially more restrictive environment, often including solitary confinement. Despite this, GBMI prisoners receive no due process whatsoever prior to or following such transfers.

According to DPHHS, MSH staff present GBMI patients to the Forensic Review Board ("FRB") for transfer to MSP. The FRB is comprised of DPHHS and MSP staff. After the FRB recommends transfer to MSP, the DPHHS Director formally orders the GBMI prisoner transferred. We have not seen any instance in which the FRB recommended *against* transferring a patient, nor have we seen any instance in which the DPHHS Director declined to transfer a GBMI patient to MSP. In the case of one GBMI patient transferred to MSP in 2007, arrangements for his transport to MSP from MSH were made prior to the FRB Board meeting regarding his case. In addition, transfer orders sometimes disregard obvious mental illness in an attempt to justify the transfer.

The FRB and director approval processes appear to be nothing more than a rubber stamp of MSH staff's desires to clear bed space or move out undesirable patients, without regard to the transferred patient's custody, care and treatment needs. This was made clear in an email from MSP's mental health director uncovered during our investigation. In that email, the mental health director informs her staff that a number of GBMI patients were being transferred to MSP because "the Director of DPHHS wants to clear out as many GBMI's that they can -- which means they will come here. They heard that we have bed space so they want to fill us up!"

There is a stark contrast between the level of care provided at MSH and MSP. Individuals transferred from MSH to MSP lose inpatient treatment and rehabilitation services in a clinical setting with a low psychiatrist to patient ratio. This transfer effectively renders null and void the judicial finding that a person is mentally ill and thereby entitled to DPHHS's mental health services. At MSH, every GBMI patient is assigned a treatment team, including a psychiatrist or advance practice psychiatric nurse, a social worker and a nurse, and in some cases, a treatment specialist and a recreation therapist. MSH has over seven full-time psychiatrists available at all times for a population of approximately 209 patients, resulting in a psychiatrist-patient ratio of approximately 1 to 28.

At MSP, a GBMI patient transferred from MSH is not assigned a treatment team, and receives a short, quarterly meeting with MSP's lone psychiatrist. MSP's psychiatrist has a caseload of approximately 276 prisoners. Once a GBMI patient is transferred to MSP, there is no continuity of care or follow-up by DPHHS staff regarding him. DPHHS takes no steps to ensure that GBMI patients transferred to MSP are being housed and treated in a clinically appropriate way.

Once a patient is transferred to MSP, there is little chance of returning to MSH. MSP staff can only transfer a GBMI prisoner back to DPHHS custody for a voluntary 10-day transfer or by going through involuntary commitment judicial proceedings. In September 2013, MSP's mental health director stated that in the last five years, MSP staff transferred only one patient to MSH through the involuntary commitment process and two patients for 10-day voluntary transfers.

"The Fourteenth Amendment protects individuals against the deprivation of liberty or property by the government without due process." *Portman v. County of Santa Clara*, 995 F.2d 898, 904 (9th Cir. 1993). DPHHS transfers of GBMI patients from MSH to MSP implicate a substantial number of liberty interests. Pursuant to Mont. Code Ann. § 46-14-312, the DPHHS Director can transfer GBMI patients to correctional facilities only if that facility will "better serve the defendant's custody, care, and treatment needs" and only after "considering the recommendations of the professionals providing treatment to the defendant and recommendations of the professionals who have evaluated the defendant." This creates a liberty interest for GBMI patients to be transferred to a corrections facility only after consideration of recommendations by professionals who have treated and evaluated the patient, and transfer only to facilities that better serve his custody, care and treatment needs.

In addition, Mont. Code Ann. § 53-12-142 guarantees MSH patients the "right to the least restrictive conditions necessary to achieve the purpose of commitment." Individuals remanded to the custody of DPHHS after being found GBMI who reside in MSH enjoy this right equally with individuals who are civilly committed to MSH. *See Baxstrom v. R.E. Herold*, 383 U.S. 107 (1966) (the rights given to those civilly committed cannot be denied to a similarly situated individual simply because that individual is committed in the criminal context). All individuals sentenced GBMI and remanded to DPHHS also retain a liberty interest in receiving adequate mental health treatment and confinement that is not cruel and unusual.

These liberty interests trigger due process requirements prior to transferring GBMI patients from DPHHS custody to MSP. As described by the U.S. Supreme Court in *Mathews v. Eldridge*, 424 U.S. 319, 348 (1976), "[t]he essence of due process is the requirement that 'a person in jeopardy of serious loss (be given) notice of the case against him and opportunity to meet it.'" GBMI patients transferred to MSP are not given an opportunity to speak, to present evidence, or to call witnesses. No independent clinicians are utilized. No family members or previous mental health care providers are consulted. The patient is not even present at the FRB's

deliberations. As such, the transfer process violates GBMI patients' due process rights.


IV. Other States Have Settled Lawsuits Challenging Practices Similar To Those At Issue Here.

Faced with lawsuits challenging such practices, prison systems in other states have entered into settlement agreements that make extensive changes to their treatment of prisoners with mental illness. In one recent settlement, the Massachusetts Department of Correction agreed to "prohibit[] the placement of inmates with serious mental illness in Departmental Disciplinary Units, a form of segregation, and limit[] the use of other forms of segregation of inmates with serious mental illness," "screen inmates both before and during confinement in segregation," "maintain a number of Secured Treatment Units to provide an alternative to segregation for inmates with serious mental illness, and to integrate mental health professionals into the disciplinary process." *Disability Law Ctr. v. Massachusetts Dep't of Correction*, CA 07-10463-MLW, 2012 WL 1237760 (D. Mass. Apr. 12, 2012). See also *State of Connecticut Office of Protection and Advocacy for Persons with Disabilities*, CA 3:03-cv-01352-RNC (D. Conn. Sept. 13, 2006); *Mast, et al. v. Donahue, et al.*, 2:05-cv-00037-LJM-WGH (S.D. Ind. Nov. 26, 2007); *Peoples, et al. v. Fischer, et al.*, 11-CV-2694 (SAS) (S.D.N.Y. Feb. 19, 2014). We hope that DOC and DPHHS are similarly willing to make the extensive changes necessary to correct the constitutional violations described in this letter.

V. Preservation of Evidence

Based on the information gained during our investigation, Disability Rights Montana is prepared to litigate these issues. As you know, this potential future litigation triggers a duty for MSP, MSH, DPHHS and DOC to preserve all relevant, material evidence. See *Silvestri v. Gen. Motors Corp.*, 271 F.3d 583, 591 (4th Cir. 2001) ("[t]he duty to preserve material evidence arises not only during litigation but also extends to that period before the litigation when a party reasonably should know that the evidence may be relevant to anticipated litigation).

Sincerely,



Anna Conley
James Park Taylor
American Civil Liberties Union of Montana
P.O. Box 9138
Missoula, MT 59802
annac@aclumontana.org
(406) 443-8590, ext. 3056

Jeffrey Simmons
Foley & Lardner LLP
Suite 5000
150 East Gilman Street
Madison, WI 53703-1482
jsimmons@foley.com
(608) 258-4267

Kyle Ann Gray
Holland & Hart, LLP
401 North 31st Street
Suite 1500
Billings, MT 59101-1277
kgray@hollandhart.com
(406) 252-2166

ATTORNEYS FOR DISABILITY RIGHTS MONTANA

EXHIBIT A: EXAMPLES OF PRISONERS NEGATIVELY IMPACTED BY THE CONSTITUTIONAL VIOLATIONS OF DOC AND DPHHS¹

"DAN"

Dan was 26 years old when he died after spending much of his sentence in locked housing at MSP. While growing up he never knew his biological father and was eventually placed in group homes and foster care when his mother could no longer care for him. He is believed to have suffered a head injury as a young child and also experienced sexual abuse. He suffered from seizures throughout his life. As a child, he was diagnosed with bipolar disorder, schizophrenia and attention-deficit disorder, and received various medications for those illnesses. He was placed in special education classes until he left school after the 11th grade. Dan attempted suicide numerous times throughout his life.

As a teenager and young adult, Dan was arrested numerous times for non-violent crimes. In 2009, he was convicted of criminal mischief for breaking windows on cars and shops in Billings and received a three-year deferred sentence. In June 2011 his probation was revoked and he was sentenced to DOC custody for two years. At his revocation hearing, the judge recognized Dan's mental health issues and "highly recommend[ed]" that he be considered for placement in the mental health block at MSP "because that seems to me that that's going to be the best place for [him]." The Judge told Dan "I would like to see things get turned around for you. . . [Y]ou need . . . find a person [at MSP] that you can rely on, a person that is an employee of the prison in the mental health block to be the person you look to getting answers as to how you need to act . . . I certainly wish you the very best of luck in the future. I hope you get some help and I hope things work out for you." Dan was never placed on the MHTU.

During his initial screening and placement, DOC noted that Dan had very low academic functioning and "significant mental health issues." DOC sent Dan to the START program because of his mental health needs. START staff recommended that he receive mental health services in the community, which never occurred. Shortly after entering the START program, Dan attempted suicide by hanging and was sent to the Billings Psychiatric Facility. While there he described other previous suicide attempts, including smearing feces on a pencil and inserting it into his penis in the hope that an infection would kill him. A few weeks later, Dan was transferred to MSH for a 10-day evaluation because START staff said he was "delusional stating bugs are crawling all over him and he has been defecating and smearing feces in his cell." Dan stated that he heard voices telling him to hurt himself and he wants to die. Doctors at MSH prescribed him Respiridal for

¹ The names of these individuals have been changed.

“psychosis” and described him as a risk to himself. MSH stated that Dan’s diagnoses included “schizoaffective disorder”.

When Dan returned to the START program, DOC staff recommended that he be placed in the community, but they could not find funding to support the placement. Instead of being returned to the community, Dan was transferred to MSP. Upon arriving at MSP in December 2011, Dan told intake staff that he had numerous suicide attempts over the years, had inserted objects into his body with the hope he might get an infection, and had engaged in cutting himself. He also told them he heard voices telling him to kill himself, harm others, and smear feces on his cell. MSP acknowledged previous reported diagnoses of schizoaffective disorder.

Despite the sentencing judge’s specific recommendation that Dan be placed in MSP’s mental health treatment unit, Dan was never assigned to that unit. Instead, MSP records suggest Dan spent more than half of his time at MSP in locked housing, where his mental health treatment consisted primarily of short cell-side visits by a mental health technician once a week. Despite Dan’s repeated diagnoses of schizophrenia and schizoaffective disorder, MSP mental health staff stated that Dan had “no known history of psychiatric problems or symptoms that would preclude Administrative Segregation for inappropriate behavior.”

Within weeks of being transferred to MSP, Dan told staff that he was hearing voices telling him to do things to himself and he threatened to kill himself. Shortly thereafter, Dan was disciplined for smearing feces on himself, but an MSP therapist concluded that the conduct was not the result of a serious mental illness. A little more than a month later, Dan was disciplined for banging his head against his cell door and again smearing feces on himself. In response, MSP mental health staff authorized placing Dan in a full restraint chair and an isolation cell and initiated a BMP. During his seven months at MSP, Dan met with a psychiatrist just once, more than four months after his arrival.

On June 23, 2011, just seven months after his arrival at MSP, Dan was found dead in his cell as a result of hanging.

“ANDREW”

Andrew is a 50 year old prisoner at MSP. Andrew was raised in an abusive home in Shelby, Montana. He began using drugs at age 12 and dropped out of school in seventh grade. He has spent much of his life in juvenile and adult correctional institutions and psychiatric hospitals, including seven MSH commitments. He previously received disability benefits. Andrew's diagnosis of schizophrenia has remained consistent throughout his life. He has taken multiple medications to treat schizophrenia, including Haldol, Serentil, Prolixin, Stelazine, Trilafon, Risperdal and Clozaril.

On April 26, 2006, Andrew was sentenced Guilty But Mentally Ill by the Lewis and Clark County District Court, and given a 15 year sentence to DPHHS. Andrew was also sentenced GBMI to DPHHS for five years by the Custer County District Court on May 8, 2006. The judge included the following reasons for his sentence: “1. [t]he Defendant has substance and mental health issues and the [DPHHS] is the best facility to address those conditions; 2. To keep the public safe; and 3. To keep the defendant safe.”

Andrew was placed at MSH, diagnosed as schizophrenic and put on antipsychotic medications. While at MSH, Andrew resided on the Residential Care Unit for some time, in which he was described as “polite, friendly, cooperative, and socializing appropriately with staff and peers.” MSH staff's suspicions that Andrew stole another patient's jewelry led to a transfer to MSH's forensic wing with the goal to “work with D-Wing treatment team to prepare for conditional release.”

On July 26, 2007, the Forensic Review Board (“FRB”) voted to transfer Andrew to MSP. The FRB diagnosed Andrew with schizophrenia, paranoid type, but concluded “[Andrew]’s mental disease, [s]chizophrenia, has been stabilized with medications, and that he has achieved maximum hospital benefit.” FRB members voted unanimously to recommend that the DPHHS Director transfer Andrew to MSP. The FRB described its reasons for transferring Andrew as follows: “[I]t is believed his needs will be better served [at MSP]. [Andrew] has continued to engage in prohibited transactions that exploit more vulnerable peers. While at [MSP], [Andrew] would benefit from medication services, as well as chemical dependency and cognitive restructuring groups. [MSP] staff indicated that they would be able to meet [Andrew's] treatment and security needs at this time.” MSH's Administrator approved the recommendation, and DPHHS Acting Director approved the transfer.

MSP's mental health director, however, gave a different reason for Andrew's transfer. She told MSP mental health staff that “the Director of DPHHS wants to clear out as many GBMI's that they can – which means they will come here. They heard we have the bed space so they want to fill us up!”

Upon arrival at MSP, intake staff continued Andrew's schizophrenia diagnosis. In October 2007, MSP transferred Andrew to Crossroads Correctional Center in Shelby, Montana. After four months, however, Crossroads requested that he be transferred back to MSP for "psychiatric stabilization." Andrew was transferred back to MSP in February 2008, and initially placed in general population, then subsequently transferred to the MHTU because he has "schizophrenia with delusions at baseline" and "cannot be maintained in an 'outpatient' treatment setting." He was discharged from MHTU after three weeks.

From 2008 to 2012, Andrew's diagnosis of schizophrenia and medication regime at MSP was fairly stable, including multiple antipsychotic medications. Nevertheless, MSP mental health staff characterized Andrew as "very manipulative and manipulating for placement" with the goal of getting back to MSH. They saw his behavior issues as "attention seeking" and not a result of his mental illness. As a result, custody and discipline staff treated Andrew like any other prisoner. Andrew was put on BMPs for threatening self-harm and placed in Ad Seg. His symptoms worsened in solitary confinement. He reported to mental health staff that he wanted to cry when he was locked down, and that he did not "do hole time well." In his words, in solitary confinement "all I do is suffer unmitigated hell in these cells all the time."

Andrew repeatedly objected to his placement at MSP and requested to return to MSH. Andrew's grievances regarding MSP placement and punishment for behavior that is a product of his mental illness were denied. In one instance, MSP mental health director responded: "Warm Springs said you were fit to come here . . . Mentally ill people can tell right from wrong and we expect that you will make the correct choices, if not, you will receive consequences for your choices." She responded to Andrew's grievance regarding isolation as disciplinary action by telling him, "You did this to you..." An MSP psychologist responded to Andrew's requests to return to MSH as follows: "I recommend you accept your being at prison and try to adjust rather than manipulate and complain of thought and mood disorder." Andrew has been placed on the MHTU several times, generally for a few months each time. Mental health staff concluded that he is "not appropriate" for that unit, that he "is manipulative, narcissistically entitled, and fully capable of conforming his behavior to prison standards, if he chooses to do so."

Andrew began meeting with MSP's current psychiatrist on July 2, 2012, when the psychiatrist diagnosed him as follows: "Axis I: Schizophrenia at least by Hx. Axis II: Probable antisocial personality disorder." During their next meeting on September 26, 2012, the psychiatrist discontinued Andrew's Risperdal, an antipsychotic medication, because "I'm rather skeptical that this man has any kind of chronic disorder. He just has too much insight and doesn't appear to have any negative symptoms to be consistent with schizophrenia. He certainly doesn't need to take the 1 mg of Risperdal along with the Zyprexa which makes me highly suspect that he is probably not mentally ill either."

On December 17, 2012, the psychiatrist decreased Andrew's Zyprexa, an antipsychotic, reasoning "I don't see anything wrong with this man at all and suspect that he has been miss diagnosed [sic]." For the first time in over twenty years, Andrew's Axis I diagnosis changed from schizophrenia to "malingering that is willful exaggeration of symptomology in the absence of objective findings of such" and "schizophrenia by Hx which I question." On March 25, 2013, MSP's psychiatrist noted "I am absolutely convinced that this man is malingering," and decided to taper him off antipsychotic medications with the goal of discontinuing them completely. The psychiatrist concluded, "he will return in three to four months of course it is possible that he will act out in some way to supposedly prove his mental illness but I will alert the whole mental health staff about this at our next meeting."

Andrew exhausted his remedies regarding inadequate mental health treatment. In response to Andrew's appeal, the DOC director stated "my review finds the matter has been given an appropriate level of attention by medical staff. I find no grounds to overturn prior decisions." Andrew currently resides in general population. He reports having a progressively harder time managing his hallucinations and disorganized thoughts without proper medication. He is convinced that MSP's psychiatrist and other mental health staff are torturing him in exchange for large amounts of money.

"BILL"

Bill is a 62 year old prisoner at MSP. Bill has been diagnosed with serious mental illness from the age of 18, including schizophrenia, paranoia schizophrenia, chronic undifferentiated schizophrenia, depression with psychotic features, borderline intellectual functioning, psychotic disorder, borderline personality disorder, and severe (cluster B type) personality disorder. He has taken medications for mental illness almost his entire life, including anti-psychotic medications, and spent time in psychiatric hospitals before being imprisoned. For most of his life, Bill has heard the voice of a dog named Gene who directs him to harm himself when he is unmedicated. Bill has repeatedly attempted to take out his own eyes.

Bill has spent over 20 years at MSP and MSH. Bill spent much of his time at MSP in solitary confinement and in restraints for self-harm and behavior that is a product of his mental illness, such as smearing feces, drinking Ajax, and cutting and swallowing glass. In 1996, MSP's psychiatrist concluded "[a]lthough Bill has a long past psychiatric history, he is not mentally ill, and it appears that his motivation is to avoid a potentially long sentence and harassment from other inmates by gaining admission to the state hospital." In 1997, however, MSP mental health staff concluded that Bill indeed did have "serious mental health problems," and MSP's psychiatrist requested that Judge Mizner transfer Bill to MSH because he "is seriously mental ill and presents a danger to himself." Prior to transferring Bill to MSH, MSP kept Bill in restraints for 10 days.

At MSH, Bill was stabilized on medications and doing relatively well. He participated in therapeutic activities and hobbies, and did not engage in self-harm. In 2000, MSH determined that Bill had met "maximum hospital benefit" and transferred him to MSP with discharge diagnoses of "schizophrenia, paranoid type" and "antisocial personality disorder." Upon returning to MSP, Bill resided on the MHTU for five years, where he remained stable.

In 2005, Bill was transferred out of the MHTU. He subsequently encountered problems receiving his medication and began to decompensate, including hearing voices and "having bad thoughts." Since 2005, Bill has spent considerable time in solitary confinement, in restraints and on BMPs, with occasional stints in the MHTU. Bill has been put on BMPs for self-harm and smearing feces on himself and his cell. MSP mental health staff perceived Bill's decompensation – including threats to take out his eyes – as "malingering." They stated that Bill appeared to "passive-aggressively express his anger and protest by purposely, knowingly and histrionically threatening to harm his eyes." Mental health staff found him to be "in full control of his thoughts and behavior" and "there has been no indication of a serious Axis I mental illness during this period of observation." MSP mental health staff have repeatedly found Bill's attempts to take his own eyes out and swallow objects as "manipulative" and "characterological," rather than symptoms of a mental illness. For example, in 2012 MSP's mental health director dismissed Bill's

statements about suffering from visual hallucinations with the following conclusory assertion: "it was obvious that he was making this stuff up as he went along – he isn't delusional, it was deliberate." As a result, mental health staff have approved standard disciplinary consequences for Bill's behavior for many years. Even when mental health staff have expressed concern that Bill's behavior is actually a result of mental illness, they have continued to approve standard disciplinary sanctions.

In April, 2012, Bill began meeting with MSP's current psychiatrist, who described his first meeting as follows: "He claims to have an imaginary friend that he talks too [sic] and I'm highly skeptical of such complaints as this and would really not see this as being a thought disorder i.e., any kind of psychotic symptomatology. I would rather feel that he is in fact malingering." The psychiatrist diagnosed Bill, in part, as follows: "I was informed that at some point the state hospital thought he was schizophrenic, however he does not appear to me to have anything that would necessarily be consistent with schizophrenia." In subsequent meetings, the psychiatrist questioned Bill's antipsychotics medication regime, and concluded "I did tell him today that as long as he was not acting out and was having good behavior I would go ahead and continue him on these medications even though that's something that I normally don't do."

In December 2012, the psychiatrist discontinued all of Bill's medications because Bill was "noncompliant." The psychiatrist did not meet with Bill or conduct any investigation into possible reasons for noncompliance. Bill's stated reason for refusing medication was "[b]ecause the outerspace people and Gods and I don't need any mental health medication." In the months that followed, Bill received approximately 40 major disciplinary violations, which custody staff attributed to "medication noncompliance." Based on his behavior, and despite the psychiatrist's diagnosis of "malingering," Bill was again placed in the MHTU for a number of months. But he was then transferred to solitary confinement.

Throughout 2013, while in solitary confinement Bill exhibited extreme symptoms of mental illness, including self-harm and behavior that reflects paranoid and delusional beliefs. In April 2013, MSP's psychiatrist decided to put him on Haldol, an antipsychotic, but characterized the medication as treating Bill's behavior, rather than a mental illness. The psychiatrist described Bill as talking "nonsense in an effort to try to fake being psychotic." He noted that while Bill talked about having "13 Gods," Bill could only name 3 of the 13. The psychiatrist concluded, "[i]t is my opinion that this man has a severe personality disorder and has feigned psychotic events in the past probably fooling some people." He continued, "[a]pparently he has a [history] of being on heavy amounts of antipsychotic drugs which would be to his liking now. He also wants to go to the state hospital. He is current in the Max for smearing feces all over his wall that he claims was 'an alien spaceship.' Here again though, if one does not take into account the content of what he says, there is no evidence of a thought disorder. . . . All in all his presentation was of somebody that is extremely histrionic and gamey which would be consistent

with borderline personality disorder with antisocial traits.” With regard to medications, the psychiatrist concluded, “I told him that I would see what his behavior is next week and if he stops threatening suicide, stops being manipulative, stops acting out that I would consider switching him to oral Haldol.” The psychiatrist discontinued Bill’s Haldol in May, 2013, but may have restarted it very recently.

Bill is currently in solitary confinement. He reports feeling like a “young kid locked up in a closet.” He spreads feces in his cell to “keep bad spirits away.” He engages in self-harm such as swallowing pieces of a mirror. He continues to be held accountable for his behavior pursuant to standard disciplinary sanctions with the approval of MSP mental health staff.

"JOHN"

John is a 43-year-old male incarcerated at MSP. His family has a history of mental illness. He had a chaotic and abusive childhood in which he was mentally and physically abused by his parents, who lived a transient lifestyle. John lived in group homes and with extended family. He attended special education until he quit school in fourth grade due to ongoing conduct, disordered behavior and poor academic performance. John has a full IQ of 78, which places him in the borderline range of intellectual functioning (i.e. between the 5th and 7th percentiles). John has been admitted to multiple psychiatric hospitals, attempted suicide multiple times and lived in adult foster homes. Prior to being incarcerated, John received SSDI and was unable to maintain steady employment given his limited cognitive functioning and mental illness.

John has received multiple diagnoses by mental health providers. He has been diagnosed with psychotic disorder NOS, possible substance-induced psychotic disorder, amnesic disorder NOS, immature personality disorder, antisocial personality disorder, and borderline intellectual functioning. Mental health care providers have observed significant depression, problems with reality testing, inadequate psychological coping resources, poor judgment and impulse control, and significant social skills deficits. One provider described John as follows: "This is a man whose life has been like a rudderless ship. Should he be found guilty of sexual abuse, I doubt simple incarceration will remedy the problem."

On June 18, 2002, a Gallatin County district court judge found John Guilty But Mentally Ill of a felony and misdemeanor, and committed John to DPHHS "for placement at Warm Springs for a period of fifteen (15) years." The judge ordered "the defendant shall be returned to the Court upon discharge from the Montana State Hospital for determination of placement." While at MSH, John intermittently required close observation and one-to-one supervision because of suicidal ideations, but was not a danger to other patients or staff. At times, he participated in required groups, and even resided on the less-restrictive Residential Care Unit.

In May 2007, MSH staff unsuccessfully attempted to have John placed in a community group home. On July 23, 2007, a DPHHS employee emailed an MSP employee, informing him that John was being transferred to MSP for "non-complaint [sic] with treatment." Subsequently, on July 26, 2007 the Forensic Review Board, comprised of DPHHS and MSP employees, voted unanimously to recommend to the DPHHS director to transfer John to MSP "where it is believed his needs will be better served" because "he has achieved maximum hospital benefit." On August 2, 2007, the acting DPHHS director issued a memo transferring John to MSP.

While at MSP, John has spent over three years in solitary confinement in administrative segregation. John has been repeatedly classified to administrative segregation because of "bizarre" and "disruptive" behavior. For two months, John was placed on the MHTU, despite previous findings by mental health staff that he was not mentally ill. He was transferred back to administrative segregation because staff concluded that although he had been diagnosed with mental illness in the past, his problems were behavioral stemming from immaturity and other unknown sources, and he would be best served in the disciplinary process in administrative segregation. For years, locked housing staff repeatedly tried to get John moved back to the MHTU, but MHTU staff refused to accept him.

In addition to spending years in administrative segregation, John has been subject to numerous disciplinary sanctions for behavior directly attributable to mental illness and developmental disabilities. John has been put on approximately 25 behavior management plans for many days at a time for actual and threatened self-harm, smearing feces in his cell, banging his head until it bled on his cell door and asking for real food instead of nutraloaf, crying and saying people on the floor were talking to him, attempting suicide, cutting himself with a broken deodorant stick, and hitting his cell door and screaming "help me help me" for 20 minutes.

MSP has also placed John in weeks of 24-hour isolation in disciplinary detention for many of these behaviors. For example, John has been sent to disciplinary detention for cutting himself while on a BMP, shoving a pencil and pen in his stomach, smearing feces in the shower, speaking nonsense to staff regarding a time in the past when (according to John) he was at MSP and families were allowed to live there, and refusing to leave the infirmary after being transported there because he believed his heart was vibrating and he wanted an EKG.

While in locked housing, John was seen by mental health technicians during very short and non-confidential mental health rounds at his cell door, received occasional wellness checks, and had quarterly visits with MSP's psychiatrist. The psychiatrist kept John on multiple antipsychotic medications. John continued to take antipsychotic medications until they were abruptly discontinued after John temporarily refused to take them in March and April 2012. In June 2012, John repeatedly requested that he be prescribed the antipsychotics he had taken for over 15 years. While unmedicated, John was found guilty of multiple rule violations for bizarre behavior and self-harm and subjected to punitive isolation in the form of BMPs, disciplinary detention and administrative segregation.

In July 2012, MSP's current psychiatrist first met with John. The psychiatrist observed that John "was rather argumentative from the beginning of the interview today" and concluded "[i]n my opinion this man is simply malingering." The psychiatrist wrote, "[i]f he is able to articulate in a more appropriate fashion what he thinks is wrong with him it might be appropriate to try him on an

antidepressant. However, today he was bordering on being out of control and so in the end I did not start him on anything at this time.”

Despite John’s IQ of 78, rendering him borderline functioning, MSP’s psychiatrist claimed to observe “no evidence of any cognitive deficits or neurological impairment of any type.” In January 2013, the psychiatrist started John on Celexa, an anti-depressant, despite his finding that “I saw no evidence that he required Celexa anyway. He’s been on all kinds of psych drugs and it right now is really unclear to me why he wants to take them anyway. He may be trying to get a disability check.”

During a June 2013 meeting, MSP’s psychiatrist laughed at John after John voiced negative symptoms from being unmedicated. When John called the psychiatrist a “prick,” the psychiatrist threatened to send John to 24-hour lock down unless he apologized, diagnosed him as malingering, and removed him from his medication caseload. John is currently not taking any mental health medications, and struggles each day to maintain clear conduct and remain on the “high-side” unit of MSP.

"MATTHEW"

Matthew has been a prisoner at MSP for over 12 years. Matthew's childhood was marked by extreme physical and sexual abuse, including repeated sexual assaults by his stepfather, watching his stepfather sexually assault his siblings, and regular beatings with bull whips and other weapons. Matthew has repeatedly been diagnosed with mental illness by a number of providers, including chronic post-traumatic stress disorder, attention deficit disorder, learning disorders, major depression, schizophrenia, and bipolar disorder. His bipolar diagnosis has been confirmed on numerous occasions by mental health providers both outside MSP and within MSP. For many years, Matthew has taken lithium for his bipolar disorder as well as antidepressants and antipsychotic medications.

While at MSP, Matthew has spent more than eight years in solitary confinement, which has drastically exacerbated his existing mental illness. Despite his long history of mental health issues and established diagnoses, MSP mental health staff have repeatedly found he does not have mental health issues that would preclude housing him in ad seg. Mental health staff have placed him in 24-hour isolation on BMPs many times, for behaviors such as threatening to slice his throat, threatening to stab himself with pens, biting his arm and wrist and then smearing the blood on the floor "to make the situation look worse than it actually was," smearing blood on the walls of his cell, and writing a message about wanting to die in blood on his cell wall. MSP staff have repeatedly used force against Matthew for refusing to come out of his cell, including pepper spray and a tazer gun.

Mental health staff perceived many of Matthew's self-harm behaviors to be manipulative acts intended for the purpose of avoiding solitary confinement. In 2012, MSP mental health staff concluded that Matthew's acts of biting and picking at his arm "are for the purpose of manipulating staff and receiving mental health services at his leisure," rather than a result of his mental illness. Similarly, mental health staff concluded that Matthew's act of smearing blood on walls was "malingering his depression to gain attention."

While at MSP, Matthew has spent a number of months on the MHTU, but was always removed from the unit fairly quickly and placed back in solitary confinement for "problematic behavior." In solitary confinement, mental health staff have observed Matthew decompensating. Despite this, he has remained in solitary for years. Matthew has told mental health staff that he would rather die than continue to be placed in solitary confinement, and expressed hopelessness, frustration and depression when placed in solitary.

After years in solitary confinement, Matthew has expressed concern regarding his ability to reintegrate into the general prison population. MSP staff characterize his time in ad seg as a chance to show he can behave himself, ignoring the harmful effect this form of isolation has on Matthew. He reports being afraid to return to

the prison population because he has been in solitary for so long that he does not know how to talk to people, lacks social skills, and gets anxious around others. In a 2011 "Locked Housing Inmate Management Plan," staff's goals for Matthew's placement in ad seg for another year included: "learn to deal with depression," "learn to refrain from this type of behavior by working on his 'people skills' and thinking before he reacts," and finding ways to "occupy his mind." The plan did not explain how it would be possible for Matthew to work on "people skills" and occupying his mind while spending a year in solitary confinement.

The diagnoses Matthew has received from MSP mental health staff are inconsistent. For example, on January 11, 2005, the MSP psychiatrist diagnosed Matthew as having bipolar Type II, which was consistent with some of the psychiatrist's earlier diagnoses of Matthew. That same month, however, an MSP "Mental Health Specialist" wrote a "Mental Health Service Note" stating that Matthew "appears to need a [BMP] rather than psychiatric treatment" because "[w]hile he may have some symptoms of ADHD or Bipolar disorder, it appears unlikely he meets criteria for either diagnosis." Despite being put on the MHTU several times, requests by Matthew to return to the MHTU were denied because, among other reasons, his "mental illness diagnosis does not meet the criteria." On September 5, 2012, MSP's psychiatrist wrote a note setting forth his opinion that Matthew does not have bipolar disorder. On that same day, a mental health technician described Matthew as "currently diagnosed with bi-polar disorder."

Despite multiple previous diagnoses of bipolar disorder by numerous psychiatrists, MSP's psychiatrist concluded that Matthew did not have bipolar disorder and discontinued Matthew's prescription for lithium. The psychiatrist provided no justification for re-diagnosing Matthew, and conducted no tests or meaningful evaluations prior to re-diagnosing him. Despite Matthew's classification as an "atypical" prisoner with limited functioning, MSP's psychiatrist found "no evidence of overt cognitive deficits" after a few minutes meeting with Matthew.

Matthew has repeatedly pleaded to be restarted on lithium, which MSP's psychiatrist characterized as "gamey" manipulation. Meanwhile, Matthew's incidents of self-harm in solitary confinement have escalated. In response to one of Matthew's requests to be placed back on lithium, MSP's psychiatrist wrote – without meeting with Matthew – "Unless you have evidence of mania (and you never have) I will not restart you on lithium" and "I will not restart you on Lithium because you do not have Bipolar disorder." In response, Matthew continued to plead, explaining "I need help not put on a shelf or really put in a cell 24/7 to hurt and feel hopeless and frustrated."

After a subsequent meeting, MSP's psychiatrist described Matthew as "complaining so much that I was having a hard time following what he was complaining about." The psychiatrist wrote, "I think most of his complaints were involving being in locked housing but I explained to him that there wasn't anything I could do about

that.” During a 2012 meeting with the psychiatrist, Matthew stated his frustration that the psychiatrist was not trying to get to know him, to which the psychiatrist responded: “getting to know him is really not my job but rather medication management is what my job is.” With regard to Matthew’s continued requests to be put back on lithium, the psychiatrist opined, “I think this man has too much suicide potential to be placed on something that would kill him anyway.”

“SAMUEL”

Samuel is a 70-year old prisoner at MSP. Samuel was raised in a family with alcoholism and physical abuse, including whippings with switches that his parents forced him to make. He has been in juvenile and adult correctional facilities most of his life. He has been diagnosed with serious mental illness, including schizophrenia and bipolar disorder, major depression, mood disorder (NOS), personality disorder, and borderline personality disorder. Samuel has engaged in extreme self-mutilation, including swallowing such objects as spoons, safety pins, razor blades, paper clips, needles, nails and tacks, and putting objects in his penis, including paper clips, foil and copper wires. These acts resulted in multiple surgeries throughout his life. Some records indicate Samuel had 32 stomach surgeries for swallowing foreign objects by 1995. Samuel commonly will bring his belongings from his cell to correction officers when he feels the urge to engage in self-harm, but he often cannot overcome his urges to harm himself.

MSP staff have repeatedly interpreted Samuel's acts of self-harm as “manipulative” and “not the result of serious mental illness.” Samuel has spent several years in solitary confinement at MSP, and been placed on multiple behavior management plans. In 2005, Samuel was classified to ad seg despite scoring medium custody because he “has mental health issues that are better served at a higher custody level.” In response to Samuel inserting pieces of his catheter bag into his penis, MSP's mental health director explained, “[Samuel]’s self-mutilative history is long and abundant. Years of counseling and mental health care have not helped budge his patterns. In light of this, the mental health team, including [MSP psychiatrists], would like [Samuel] to be placed on a BMP upon completion of his infirmary stay. The mental health team cleared him for a BMP last week.” While he has spent some time on the MHTU, his self-harm behaviors resulted in his being found “not amenable to treatment in the IMHTU” and he was transferred.

From approximately 2005–2012, Samuel took a combination of medications that worked well for him, including Prozac, Lithium, Seroquel and Propranolol. During this time he engaged in almost no self-harm behaviors and worked as a janitor in the prison. Despite Samuel's many years of being diagnosed with major depression, including by MSP mental health staff, in 2012, MSP's new psychiatrist initially diagnosed Samuel as follows: “Axis I: Chart states major depression, but I don't see any evidence for that.” Three months later, the psychiatrist diagnosed Samuel with no Axis I disorder and with “Axis II: Personality disorder NOS with Cluster B traits.”

In December 2012, MSP's psychiatrist continued these changed diagnoses of Samuel, and observed “it's my understanding that he used to be quite a behavioral problem and he has been better behaviorally on this particular med regimen.” Despite this, the following month the psychiatrist discontinued all of Samuel's

medications due to non-compliance without inquiring into Samuel's reasons for non-compliance.

When Samuel subsequently apologized for not going to pill pass and requested to be put back on his needed medications, MSP's psychiatrist restarted Samuel's Prozac and added Risperdal, then subsequently discontinued both of these medications just three weeks later for "noncompliance." The psychiatrist responded to subsequent requests to be put back on his other medications by concluding that Samuel "apparently has severe personality disorder and so I don't think that the Seroquel and Lithium were doing any good for him anyway." The psychiatrist restarted Samuel's Prozac three weeks later, then discontinued it again in two months when Samuel apparently refused to take it.

Without his medications, Samuel began reengaging in acts of self-harm, including swallowing paperclips in 2013. Samuel has tried unsuccessfully for the past year to be put back on the medications that helped him from engaging in self-harm for many years. In response to Samuel swallowing three paper clips after being taken off several medications, MSP's psychiatrist noted "in the past he has been so destructive to himself at this facility that he has cost the taxpayers hundreds of thousands of dollars. It's my understanding that he actually has so much scar tissue that he cannot be operated again so at this point and time they're simply monitoring where the paperclips are in his GI track."

After a subsequent meeting when Samuel requested to be put back on medications, the psychiatrist concluded, "I don't believe that any of these medications he has ever been on have been helpful to him. He clearly is a severe personality disorder with both antisocial and borderline traits. I do not think that any kind of medication is going to be of much benefit and the most benefit that he would get is a placebo effect. Obviously I am not able to stop him from doing mutilation stop [sic] mutilation such as he recently did in regards to swallowing paper clips." When Samuel went to the Deer Lodge Medical Center for abdominal pain from swallowing paper clips, the physician there put him on both antidepressant and antipsychotic medications.

In August 2013, Samuel was denied parole. In the report to the parole board, his case manager stated, "I am unable to support a release at this time without an extensive mental health component and an updated positive psychological report."

“JIM”

Jim was just 23-years old when he was sentenced to life imprisonment and sent to MSP in February 2013. Prior to arriving at MSP, Jim spent two years at Yellowstone County Detention Facility (“YCDF”). While at YCDF, medical and mental health staff repeatedly noted that Jim suffered from anxiety and depression. Jim was prescribed antidepressants throughout his stay at YCDF. While at YCDF, Jim reported seeing visions of hands coming up for him through a hole in the floor.

In June 2011, Jim’s mother died in a house fire. A few days later, Jim attempted to commit suicide by slashing his neck twice with a razor at YCDF. Medical reports indicated that he lost approximately one liter of blood as a result of his wounds. During the months afterward, Jim continued to tell medical staff that he suffered from growing depression and anxiety.

Upon arriving at MSP, Jim informed medical and mental health staff of his suicide attempt, that he suffered from mental illness, and that he believed he had bipolar disorder and schizophrenia. Jim told MSP that he had been prescribed Zoloft for depression, Buspar for his mood, and Doxipen for bipolar disorder and schizophrenia. Nevertheless, MSP mental health staff determined that he had “no significant” mental health needs.

Jim first met with MSP’s psychiatrist in March 2013. In his notes of the meeting, the psychiatrist appeared to dismiss the seriousness of Jim’s suicide attempt. He wrote: “[Jim] reports that he attempted suicide in 2011 by cutting his throat when his mother dies [sic]. However, I actually couldn’t even see a scar so it must not have been very serious.” The psychiatrist diagnosed Jim as “quite likely” having antisocial personality disorder.

In May 2013, just three months after arriving at MSP, Jim was placed in solitary confinement for 90 days for rule violations. In June 2013, MSP’s psychiatrist met with Jim again and stated that a diagnosis of “[a]ntisocial personality disorder is quite likely,” although he gave no basis for that diagnosis. The psychiatrist made no mention of Jim suffering from depression or other mental illnesses. However, he wrote, “I am going to have one of the techs count his meds to make sure he has the right number within the next week or so.”

Jim was released from solitary confinement on August 14, 2013. Nine days later corrections officers found Jim dead in his cell. Although no cause of death has been announced, medical staff who attempted to resuscitate Jim were concerned that he had overdosed on drugs.