

Tolerating Failure: The State of Health Care and Mental Health Care Delivery in the Michigan Department of Corrections

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The People and Organizations Behind Tolerating Failure

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Girard is the author of the Michigan Prison Sentences: A Guide for Defense Attorneys, published by the Michigan Appellate Assigned Council System, and has authored several other articles and publications. She is a founding member of the State Bar Prisons and Corrections Section, a past Chair of the Criminal Law Section, a former member of CDAM's Board of Directors and served on several other State Bar committees.

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The American Friends Service Committee's Michigan Criminal Justice Program has advocated on behalf of women and men in the Michigan prison system since 1986. Through their prisoner-rights advocacy, the AFSC works to monitor the prisons in Michigan and bring about systemic changes that benefit people in prison and the public. The AFSC also works to educate the public on the problems within the criminal justice system and the problems with over-reliance on mass incarceration.

Prison Legal Services of Michigan, Inc. was created to assist prisoners with access to courts and only litigated issues of major importance to a majority of prisoners. In 1996, PLSM was appointed to represent Michigan's male prisoners in *Cain v MDOC*, which was settled in 2003 and addressed issues relating to prisoners' property rights, law library services, clothing provided, the prison mail system, and the administrative grievance process. The Plaintiffs were forced to dismiss without prejudice a count related to the classification of mentally ill prisoners to administrative segregation.

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It is because of the numerous complaints from men and women in prison and their loved ones that we embarked on the development of a report regarding the state of health care and mental health care in Michigan's prisons.

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Executive Summary

In 1976, the United States Supreme Court explained the basis of the Eighth Amendment's requirement that prison officials provide medical care to prisoners: "These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or a lingering death, the evils of most immediate concern to the drafters of the [Eighth] Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose."¹

Article 4, Section 51 of Michigan's Constitution states, "The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health."

The Michigan Department of Corrections (MDOC) has not met its Eighth Amendment obligations with regard to medical care for prisoners; the Legislature has failed to uphold the mandates of the state constitution. Some of these cases have resulted in death:

- In the case of Timothy Joe Souders, a federal court actually found physical torture and a lingering death at the Southern Michigan Correctional Facility in Jackson in August of 2006.²
- In 2002, Jeffery Clark died of dehydration at the Bellamy Creek Correctional Facility in Ionia, when the water to his segregation cell was deliberately shut off, despite the fact that the prison was under a heat alert due to the outside temperature.
- Anthony McManus starved to death in a segregation cell at the Baraga Maximum Security Facility in September 2005. He was 5'7" tall and weighed 75 pounds when he died.

Not every failure to meet medical needs leads to a death, but many of the MDOC's shortcomings in health care have led to the infliction of pain and suffering which serve no penological purpose. Here are a few examples, which are related in greater detail later in this report:

- Andre Davis was subjected to a painful, expensive and completely unnecessary bone marrow biopsy after a prison doctor gave him medication that lowered his blood count, and did not inform Davis' oncologist.
- Dean Creeger is not being treated for Hepatitis C, though treatment was recommended by both the prison doctor and the MDOC regional medical director, because Correctional Medical Services (CMS) and the MDOC medical director will not approve the treatment.
- One woman underwent painful surgeries and lost both legs when her Lupus was allowed to progress through a year of postponed medical appointments and denials of treatment within the MDOC.
- Marc Janness has had over four blood transfusions in the last two years and is receiving injections that cost over \$4,500.00 a year because the MDOC dietician at one MDOC facility refuses to provide the same diet that controlled his blood disorder for the previous 11 years at another MDOC facility.

Timothy Joe Souders died at a prison that has been under federal court oversight in Hadix v. Johnson for the past twenty-seven years. The other prisoners, noted above, serve as examples of the inadequacy of care at the forty-seven other prisons where there is no oversight of health care and the treatment is equally bad, if not worse, than at the three Hadix facilities.

Michigan's prison population has more than tripled in the last 23 years.³ There are now 51,400 people housed in our state prisons. Due to strict parole board policies, people serving long sentences (i.e. long indeterminate sentences and parolable life sentences) are not being released from prison. As a result, there is a growing population of elderly prisoners who develop complicated health conditions and increase the expenditures for health care costs.

As a public we have chosen many legislators who use "tough on crime" rhetoric to drive fear into the populace, which then creates a burden on our prison system as more and more people who have serious medical and mental health problems are incarcerated. Furthermore, the people who are targeted by tough on crime measures are often people who have been neglected by our social service systems, have slipped through the cracks of those services, or have had difficulty gaining access to social services. The poor are less likely to have access to health care while in the free world;⁴ simultaneously, the poor--and specifically poor people of color--are more likely to end up in prison.⁵

Upon entering the prison system, this neglected population brings with it complicated and multi-layered health problems. One article noted, "Most prisoners come from the segment of the American Population that public health researchers have found to possess the poorest health" while simultaneously pointing out that researchers have not "... systematically analyzed prisoner health characteristics at admission."⁶

A literature review and study performed by the National Commission on Correctional Health Care found:

Inmates suffer from higher rates of communicable disease, chronic disease, and several mental illnesses than the U.S. population as a whole. This large concentration of infected and mentally ill persons in prisons and jails provides a unique opportunity to provide needed treatment and prevention services and to help protect the larger public health.⁷

In addition to the neglected health condition of many people before they come into prison and the elderly population, prison in and of itself is not a healthy place to live. The floors are hard concrete, the food is mediocre and meets only the minimal nutritional standards, there is limited access to work (even less access to meaningful work), smokers and non-smokers are housed together, exercise is restricted for long-term segregation prisoners and is extremely limited at some facilities, and educational programming about preventative health care is virtually non-existent.

When men and women enter the world of prison, they bring with them their existing medical conditions and mental health issues. They are put under the care of the state and the state is mandated by the Eighth Amendment to provide them with adequate health and mental health care. This report is a reflection of our findings regarding the systemic failures within Michigan's prison health care system. These systemic failures lead to real human suffering and pain and, at times, to death.

The Michigan Department of Corrections has been under fire in the press over the last year and half for repeated, drastic flaws in its health care and mental health care delivery. As one example, an editorial in the *Grand Rapids Press* raised the issue that “adequate medical care is not just about compassion for sick inmates. It’s also about protecting the public. Inmates not treated for infectious diseases while in prison – such as HIV hepatitis and tuberculosis – can spread those diseases to the public after they are released.”⁸ The publicity included an episode of *60 Minutes* after the death of Timothy Souders – when people die while under the care of a state institution it is the public’s obligation to inquire into the conditions that create potentially life-threatening situations.

The Legislature also has a responsibility to oversee the operation of health care delivery in the MDOC, not least because it appropriates the funds for such services. Why have the problems within the MDOC gotten so bad? More importantly, how has this been allowed to take place? The MDOC’s budget is enormous, and much of that budget is taken up by health care. The total value of the Correctional Medical Services (CMS) contract as of July 2, 2007, was reported by the state Department of Management and Budget to be \$668,944,122.00.⁹ Yet, after all this money is spent, the care provided is often still so inadequate that prisoners are dying, and experiencing rapidly deteriorating health, while the public continues to pay for the for-profit, private corporation responsible for prisoners’ health.

This report has been researched and created by advocates who have spent over twenty years attempting to protect and promote the rights of prisoners. The report itself is in response to the thousands of letters our agencies receive from prisoners describing their unmet medical and mental health care needs, including stories of how CMS and the MDOC have failed to provide even the most basic health care. This report is also in response to the numerous telephone calls we have received from friends and family of prisoners, lobbying on behalf of their incarcerated loved ones to anyone who will listen.

Recently, the MDOC has declined to automatically renew its health care contract with CMS (a private contractor), and has instead been working on developing a new Request for Proposals that would allow new contracts for the first time in almost eleven years. It would surely benefit state officials and the public to pay close attention to the problems and recommended changes that are outlined in this report when considering bidders for these lucrative contracts. However, while CMS contributed distinct problems to a difficult bureaucratic system, it has not been the sole cause of the serious failings of medical and mental health care delivery within the MDOC. Changing providers will not necessarily solve the problems with health and mental health care delivery.

We are cautiously encouraged by the MDOC’s willingness to admit that parts of the prison health care system are flawed. There are both cultural and systemic processes that have created fertile ground for this system to become chronically impaired. In this report we analyze the following:

- The problems created by CMS versus the problems that will likely exist regardless of which vendor provides health care services;
- The problems inherent in MDOC policies and practices affecting health care and mental health care issues (including the kite system¹⁰, call out system, custody issues, transfers and continuity of care, diets, environmental issues, the grievance process, and the culture of care by MDOC and private health care staff);
- The problems caused by using a bifurcated system to treat prisoners’ health and mental health problems;

- The lack of transparency and accountability to the public and elected officials for MDOC and CMS; and
- The MDOC culture of not believing what prisoners say, which leads to a mentality in which treatment professionals disregard potential illness and treatment in favor of disbelief of symptoms and concerns of prisoners often attributing complaints to “manipulative”, “malingering”, or attention-seeking behaviors rather than valid concerns.

The problems with the health care delivered by MDOC and CMS range from the seemingly mundane, such as randomly changing a prisoner’s special accommodations, to the severe, such as failure to treat potentially fatal illnesses like Hepatitis C or Lupus. Shortcomings and failures in the system are both systemic and chronic – prisoners experience delays in getting treated, grievances fail to resolve problems, diagnoses are withheld, treatment is withheld or delayed until it is no longer helpful, and access to medical records is very restricted. Based on the experiences prisoners and their family members have recounted, treatment standards are far below the community standard of care, and at times, amount to inhumane and cruel treatment. The experiences of prisoners, their family members, and loved ones, as members of our community, do matter and must be revealed and addressed with fairness and respect.

This report is an attempt to add the perspective of prisoners, loved ones of prisoners, prisoner advocates, and other concerned citizens to the ongoing discussion concerning health care in Michigan’s prisons.

Through research and advocacy we have compiled the following findings and recommendations (these recommendations are thoroughly explained throughout the report, and the health care reform recommendations are compiled in Appendix A):

- MDOC policies should be amended to reflect that health care must be provided with compassion, dignity, and respect, and MDOC must provide training for employees concerning acceptable conduct and standard of care;
- Funding for the Legislative Corrections Ombudsman should be restored;
- A permanent legislative committee should be created to oversee health care and mental health care within the MDOC;
- Both MDOC policy and legislation should be changed to enhance prisoners’ and advocates’ access to medical records;
- The MDOC should provide patients with medication package insert information on all their medications;
- The MDOC should assure that medication renewals/refills are timely delivered;
- Refusals for treatment should be well documented and submitted to the new committee recommended above and the quality assurance review panel;
- When a specialty referral is refused the patient should be advised of the fact and the reason, and given the opportunity to appeal;
- Blanket denials of treatment protocols should not be permitted;
- When disputes over treatments arise, the Chief Medical Officer of the MDOC should have final say;
- The Department of Management and Budget should incorporate required staffing levels for medical and mental health contractors in all RFPs;
- The MDOC should set and, through a national accreditation association (the National Commission on Correctional Health Care would suffice) follow standards of care for timely and complete follow-up from offsite care and from cancelled appointments;

- The MDOC should follow community standards of care for follow-up from delayed tests and/or diagnostics;
- The MDOC should mandate consistency in treatment of medical and mental health care ailments (including special accommodations) among all facilities;
- The MDOC should provide a copy of its HCV treatment eligibility guidelines to all prisoners diagnosed with HCV, and should not deny HCV treatment to prisoners within the guidelines;
- The Legislature and MDOC should develop meaningful and economical means of redressing problems between prisoners and health care staff, including creation of a health care grievance system separate from the regular prison grievance procedure system, and incorporating many changes to the system as it currently exists;
- The MDOC should end the widespread practice of un-diagnosing and denying treatment to previously diagnosed mentally ill prisoners;
- The MDOC must end the practice of subjecting prisoners to long term confinement in administrative segregation;
- The MDOC should end the practice of allowing staff to use the subjective judgement of symptom exaggeration to deny prisoners access to mental health treatment;
- The MDOC should end the practice of allowing staff to use the subjective judgement of "manipulation" to deny prisoners access to mental health treatment;
- The MDOC should end the practice of allowing staff to use the presence of a personality disorder to deny prisoners access to mental health treatment;
- The MDOC should cease allowing staff to routinely make "cell-side" segregation mental health evaluations, and require these be conducted out-of-cell in a room with auditory privacy;
- The MDOC should require that mental health staff spend at least five minutes with each prisoner in segregation during their rounds of these units;
- The MDOC should require that mental health staff who place prisoners in observation cells/rooms drastically limit the amount of time the prisoner is kept there, and provide meaningful, ongoing access to treatment;
- The MDOC should immediately end the use of in-cell, top-of-bed, 4-point restraint of prisoners in all prisons, statewide, and provide prompt medical/mental health assessment and supervision to prisoners believed in need of temporary restraint;
- The MDOC should immediately cease punitive treatment of self-injurious prisoners and provide appropriate medical, psychiatric and psychological intervention in a mental health treatment setting;
- The MDOC should cease allowing mental health staff to report results of prisoner segregation and other evaluations on checklists, and require a professional-level narrative evaluation with content area guidelines;
- The MDOC should develop and implement an early identification and tracking system for prisoners with pre-existing vulnerabilities that will place them at increased risk for breakdown if they are placed in segregation during their incarceration;
- The MDOC should limit assignment of all staff working in segregation units to a 6-month tour of duty, followed by at least 12 months in general population units before returning to segregation duty;
- All medical, mental health and psychological services in the MDOC should be defragmented and merged under one administrative structure with a single, unified health care delivery system;
- A system of mental health courts, following successful models in other states, should be established by the legislature to divert as many non-violent mentally ill people as possible from incarceration into adequately funded community treatment programs;

- All staff enhancements and service/program improvements agreed to by the MDOC in its December 2006 and June 2007 revised mental health plans submitted to the federal court in the Hadix case, should be implemented statewide in all prisons.

Endnotes Executive Summary

- ¹ Estelle v. Gamble, 429 US 97, 103 (1976) (citations and internal quotations omitted).
- ² Hadix v. Johnson, 461 F.Supp. 2d 574 (W.D. Mich, 2006) (Pacer document 2186, filed November 13, 2006).
- ³ Statistic based on the following information from Citizens Alliance on Prisons and Public Spending, "Michigan's prison population has grown from under 15,000 to nearly 51,500 since 1984." <http://www.capps-mi.org/Causes.htm>.
- ⁴ From J. W. Marquart, D.E. Merianos, J.L. Herbert, and L. Carroll. "Health Condition and Prisoners: A Review of Research and Emerging Areas of Inquiry." The Prison Journal Vol. 77 No. 2 (June 1997): 188-189. Based on findings from J. Feinstein. "The relationship between socioeconomic status and health: A review of the literature." Milbank Quarterly 71 (1993): 279-322.
- ⁵ Mark Mauer. Race to Incarcerate. New York: The New Press, 1999. "The criminal justice system in general and prison in particular have long-served as the principal arena for responding to the crimes of lower-income people. The demographics of the prison population illustrate this well: a 1991 survey of state inmates conducted by the Justice Department found that 65 percent of prisoners had not completed high school, 53 percent earned less than \$10,000 in the year prior to their incarceration, and nearly one half were either unemployed or working only part-time prior to their arrest" (162-163).
- ⁶ J. W. Marquart, D.E. Merianos, J.L. Herbert, and L. Carroll. "Health Condition and Prisoners: A Review of Research and Emerging Areas of Inquiry." The Prison Journal Vol. 77 No. 2 (June 1997): 190.
- ⁷ The National Commission on Correctional Health Care. "The Health Status of Soon-to-be-released Inmates: A Report to Congress—Volume I." 2002: 45. Entire report can be found at http://www.ncchc.org/pubs/pubs_stbr.vol1.html.
- ⁸ Editorial. "In Need of Correction." The Grand Rapids Press, July 24, 2007.
- ⁹ DMB Change Notice No. 27 Contract No. 071B7000384 Between the State of Michigan and Correctional Medical Services, Inc. The contract with CMS began as a contract with United Correctional Managed Care, which held the contract until CMS took it over on March 10, 1998.
- ¹⁰ Throughout this report, the term "kite" is used to describe generic correspondence from a prisoner to any MDOC staff, and the MDOC response to the prisoner.

Speed Bump



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PART ONE

HISTORY AND OVERVIEW

History and Overview: Section One

Why does health care for prisoners matter?

Many people may wonder why they should care about substandard health care for prisoners. Health care is a commodity for all Americans, why should prisoners receive good medical care? There are many reasons why adequate healthcare for prisoners matters to everyone. For one, this neglectful and ineffective medical care costs Michigan citizens millions of dollars – the state’s contract with private companies to provide health care to prisoners is valued at \$669 million for an eleven year period. This money is spent with little or no accountability or oversight by the Legislature or any independent body. The lack of accountability regarding this use of public funds is extremely problematic. What other private contractor for a Michigan state agency is given such a large blank check?

The issues raised in this report are important to citizens, families and loved ones of prisoners, and legislators alike. Governor Jennifer Granholm’s spokeswoman stated in August, 2006, “The governor’s office is very concerned about the issue of prison health care. We want to make certain that prisoners are getting appropriate health care and we want to make sure that taxpayers’ dollars are being spent wisely.”¹

One reason for this concern is that prisoners do not generally stay in prison forever – the vast majority are released.² Ailments that go untreated often worsen due to regular prison conditions (limited exercise, unhealthy diet, exposure to second-hand smoke and countless infections and viruses) and will follow a prisoner out the prison gates and into the community. As an editorial in the *Detroit Free Press* pointed out, “...as any doctor knows, it costs less to keep people well than to treat them when they’re sick. Nearly all prisoners will eventually return to their communities, bringing their health care problems with them.”³

Communicable diseases, such as hepatitis C, MRSA, and HIV, then become greater threats to public health. As just one example, MDOC’s failure to test and notify prisoners found positive for hepatitis C, in addition to the failure to provide treatment (see later case studies in this report), adds to the public health problem created by an unresponsive bureaucracy. The MDOC releases (either through parole or by expiration of sentence) over 13,000 prisoners annually. With an estimated hepatitis C infection rate of 30% of the prisoner population, uninformed prisoners are much more likely to unwittingly infect others, both while incarcerated and when back in the community. Acknowledging the public health factor of this problem, the *Detroit Free Press* also reported, “Contagious and potentially fatal, hepatitis C attacks the liver. The prison epidemic affects everyone. Practically all of those infected - more than 95% - will go home, carrying their infections and health problems with them. As a public health problem, the level of hepatitis C in the prison demands the attention of not only the Department of Corrections but also the Department of Community Health and the Legislature.”⁴

There are less immediate effects as well, such as lost earning capacity when a former prisoner cannot work because he or she is ill. This creates a further drain on the Medicare and public assistance resources for all citizens, and prevents the former prisoner from becoming a productive member of society again. Furthermore, a former prisoner who is ill and unable to work may be more likely to return to prison; this negatively affects the individual and the public. Michigan has embarked on a full-scale Prisoner Re-Entry Initiative, and if this Initiative is to be successful, ex-prisoners must be healthy enough to participate in it and reap the benefits of this program.

Adequate access to mental and physical health care is also a vital civil rights issue for incarcerated persons. The MDOC bears the sole responsibility for maintaining the mental and physical health of prisoners, although it has delegated part of this duty to CMS and the Department of Community Health, Corrections Mental Health Program (CMHP). Prisoners' civil rights are violated when these agencies provide health care that is so deficient that it amounts to cruel and unusual punishment. In addition to providing inadequate and inconsistent health care, at times CMS and MDOC employees take actions (related to health care) that appear to be punitive. The culture of punishment that permeates the MDOC sometimes leaks into the health care field, leading to decisions and actions that appear to punish a prisoner for speaking out, or being sick, or having complicated or unpopular needs.

The lack of humane health care, when prisoners have no other option for obtaining health care because of their imprisonment, is also a violation of basic human rights. Deliberately harmful, deliberately indifferent, or negligent physical and psychological harm at the hands of insensitive decision-makers is not part of a prisoner's sentence. Allowing prisoners to suffer from treatable medical conditions, and allowing physical and mental health to deteriorate for lack of proper care, violate United States and international standards for treatment of incarcerated persons.

Through recent press attention, the public is becoming more aware of these issues. According to a recent editorial in the *Grand Rapids Press*, "...leaving prisoners with life-threatening illnesses and diseases to languish in their cells without treatment or even a doctor's visit is not humane and shouldn't be allowed to occur."⁵

However, recent focus on events in the MDOC has made it apparent that few legislators know details about how physical health and mental health care is delivered in the prison setting. It is likely that the general public knows even less. At a May 1, 2007 state Senate Appropriations Subcommittee on Judiciary and Corrections' hearing, Senator Roger Kahn asked Dr. George Pramstaller, the MDOC Chief Medical Officer, if there was any quality assurance program in place and if so, did this program produce reports. Dr. Pramstaller replied that a Quality Assurance Panel had just been established a couple of months ago, but did not produce reports. Senator Kahn asked him to produce a report and supply it to the Senators.⁶

Legislators should remember that prisoners are their constituents – individuals who they must protect from undue hardship and harm. Prisoners' families and friends are also constituents, and legislators must heed their calls for assistance and protection as well. However, often it seems that these needs and calls for protection and assistance go unanswered. This attitude carelessly opens the door to substandard treatment, with no oversight or recourse for people harmed by the system.

It is also crucial to remember that people in prison are human beings with the capacity to love. Many of the men and women who are incarcerated in this country are working on becoming the best people that they can be. If the public chooses to judge the prison population as bad people who committed bad crimes against good people, then there is a denial on the part of the public that the men and women behind bars are actually our brothers, sisters, mothers, fathers, children, lovers, spouses, friends, who may have made serious mistakes, but who have the capacity to change. Furthermore, by labeling the incarcerated as the bad and the free-world folks as the good, we further ostracize people

who have already found themselves on the outskirts of society. It is critical to remember that the underserved population of people in prison typically came from the underserved population in the free world. "AFSC [American Friends Service Committee] understands justice as a call to do the sustained work over time necessary to foster, where possible, the creation of 'right relationships' among victims, perpetrators, and the larger community. Our concept of right relationship includes affirmation of the human dignity and civil and human rights of all people; concern for the well-being of the entire community, not only yourself or one's own group; and active efforts to live in ways that contribute to the well-being of the whole community and do no harm to oneself or others."⁷

Through this report we hope to shed light on issues of neglectful and flawed health care and mental health care services, and educate the public about the little-known world of prison health care. It is critical for people to know that their state is spending millions of dollars on medical treatment for prisoners that is oftentimes so inadequate as to be inhumane. Furthermore, the legislature needs to know that people are learning about these shortcomings, and they want better services and real oversight of whatever entity is providing these services as well as of the Michigan Department of Corrections. Representative Paul Condino (D-Southfield) commented in November 2006 that he plans to look into the MDOC's health care operations; he stated, "I think it's incumbent on us to do not only the right thing but the compassionate thing and find out what the hell's going on there. The state has an obligation not only to incarcerate folks but to provide compassionate health care."⁸

Prisoners need to know that there are people hearing their legitimate concerns and complaints, and working to make systemic changes to the medical care system that has failed so many of them. Finally, the families of people who have died in prison or suffered because of inadequate treatment should know that their suffering was not in vain, but that it can spur both the legislature and the MDOC to make significant changes to the health care and mental health care delivery system to prevent future suffering.

Endnotes History and Overview: Section One

¹ As quoted by Erik Gable and Andy Rogers News Editors. "Treatment Angers Family." The Daily Telegram, August 22, 2006.

² "The Michigan Department of Corrections paroled over 10,200 offenders to the community in calendar year 2006." Michigan Prisoner ReEntry Initiative: Quarterly Status Report, April 17, 2007. "State prisons admitted about 591,000 people in 1999 and released almost the same number. If Federal prisoners and young people released from secure juvenile facilities are added to that number, nearly 600,000 inmates arrive yearly on the doorsteps of communities nationwide." From Joan Petersilla. "Sentencing and Corrections: Issues for the 21st Century." Papers from the Executive Sessions on Sentencing and Corrections no. 9 (November 2000): 1.

³ Editorial. "Begin Cure of Prison Health Care." The Detroit Free Press, August 22, 2006.

⁴ Jeff Gerritt. "Neglect in Custody: Prisons make unhealthy cuts on hepatitis testing." The Detroit Free Press, November 13, 2006.

⁵ Editorial. "In need of correction." The Grand Rapids Press, July 24, 2007.

⁶ According to Senator Brater's office this report was never provided to the Appropriations Subcommittee on Judiciary and Corrections. Also, according to the Request for Information, Prisoner Health Care, November 2007, Questions received after the RFI Meeting, p.6, "The MDOC has a Health Care Improvement Team that is looking at how we can improve health care with the department. As a part of that, a QA [Quality Assurance] Administrative staff is currently being created." This verifies there is not a functioning QA system that can produce reports at this time.

⁷ Katherine Whitlock. In a Time of Broken Bones: A Call to Dialogue on Hate Violence and the Limitations of Hate Crimes Legislation. Philadelphia: American Friends Service Committee, 2001: 21.

⁸ "Prisoner Advocates Call for Review of Health Care." Gongwers News Service, November 17, 2006.

A Brief Summary of International Standards Concerning the Medical Care of People in Prison

The following excerpts are taken from international documents which cover many conditions of confinement and human rights issues connected to incarceration. Only sections concerning medical and mental health services and the use of restraints are reviewed here. The existence of international standards regarding the health of people in prison indicates that the health care and mental health care of imprisoned people matters to people throughout the world, and monitoring of this care is a natural duty of every government.

A. Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment¹

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

B. Standard Minimum Rules for the Treatment of Prisoners²

Rule 22

(1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

(2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

(3) The services of a qualified dental officer shall be available to every prisoner.

Rule 24

The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

Rule 25

(1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

Rule 26

- (1) The medical officer shall regularly inspect and advise the director upon:
- (a) The quantity, quality, preparation and service of food;
 - (b) The hygiene and cleanliness of the institution and the prisoners;
 - (c) The sanitation, heating, lighting and ventilation of the institution;
 - (d) The suitability and cleanliness of the prisoners' clothing and bedding;
 - (e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

Rule 33

Instruments of restraint, such as handcuffs, chains, irons and strait-jacket, shall never be applied as a punishment. Furthermore, chains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances:

- (a) As a precaution against escape during a transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority;
- (b) On medical grounds by direction of the medical officer;
- (c) By order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority.

Rule 34

The patterns and manner of use of instruments of restraint shall be decided by the central prison administration. Such instruments must not be applied for any longer time than is strictly necessary.

Rule 44

(1) Upon the death or serious illness of, or serious injury to a prisoner, or his removal to an institution for the treatment of mental affections, the director shall at once inform the spouse, if the prisoner is married, or the nearest relative and shall in any event inform any other person previously designated by the prisoner...

Rule 62

The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

C. Basic Principles for the Treatment of Prisoners

In 1990, this text was adopted, without a vote, by the UN General Assembly.³

Principle 9

Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

D. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment

Adopted by the United Nation's General Assembly resolution 43/173 of 9 December 1988.⁴

Principle 24

A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.

Endnotes International Standards Section

¹Adopted by General Assembly resolution 37/194 of 18 December 1982; full text available at <http://www2.unog.ch/intinstr/uninstr.exe?language=en>.

²Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977; full text available at <http://www2.unog.ch/intinstr/uninstr.exe?language=en>.

³ Full text available at <http://www.developmenteducation.ie/humanrights/documents.php>.

⁴ Full text available at <http://www2.unog.ch/intinstr/uninstr.exe?language=en>.

History and Overview: Section Two Paying for Services Not Being Delivered

The value of the Correctional Medical Services (CMS) contract through March 31, 2008 is approximately \$668,944,122.00 million.¹ At least twice during its now eleven year term, the amount of the CMS contract has been increased with no reason given. On July 23, 2004, the contract was increased by \$4,421,784.00,² and two months later, on September 14, 2004, it was increased by another \$79,500,000.00.³ Neither Change Notice gave a reason for the increase; the first simply stated that the increases were done, "per agency request" (MDOC) "and Department of Management and Budget/Acquisition Services approval,"⁴ while the second simply stated, "Per Department of Management and Budget/Acquisition Services approval."⁵ A July 25, 2007 House Fiscal Agency Report noted nearly \$37 million in additional appropriations for Hospital and Specialty care and nearly \$3 million for Prison Clinics for the fiscal year.⁶

CMS Regional Medical Director Craig Hutchinson, M.D., admitted in 2005 that, "there is... some sort of financial incentive--a few hundred thousand dollars one way or the other-- that CMS's fee could go up or down based on whether we come close to that particular net mark, but the overall arrangement is cost-plus."⁷ The most recent Request for Proposals appears to provide similar incentives for providers to deny treatment, adding new language about "risk sharing" when discussing cost structure.⁸

Change on the Horizon?

The State of Michigan posted a Request for Proposals in Summer 2007⁹, it was cancelled and is being researched and will be re-issued sometime in 2008.¹⁰ The state and the MDOC are in a unique position now to make major changes to the health care system when the new health care providers come on board.¹¹ In order to make positive changes, the MDOC must address the systemic failures within the Department that will continue to surface no matter what companies are awarded the health care contracts for prisoner medical services.

This expenditure for substandard and inadequate medical health care is really only the surface part of the cost. Not reflected in that figure is the cost of the MDOC maintaining large and ineffective central and regional office bureaucracies that are not doing a good job of monitoring and enforcing the CMS contract provisions. Also absent from that figure is the hidden cost to taxpayers of having to provide increasingly costly care to paroled prisoners whose illnesses could have been treated earlier and cheaper when discovered during incarceration. It stands to reason that a colon polyp biopsied and removed when discovered will cost much less to treat than one ignored, that later develops into a colon cancer.

This is the outcome when the state hires a for-profit company to handle delivery of health care services – the money rather than the health of prisoners is the bottom line . Perhaps the state should reconsider a return to MDOC-operated health care rather than contracting with an entity that expects to turn a profit in a field where any such profit comes at a human loss.

The state legislature must make changes to ensure sufficient oversight of the delivery of physical and mental health care services. Finally, the MDOC (and the new subcontractors) must address and change the culture and attitude of care, which is derived from a feeling that the medical care is merely an obligation the MDOC must fulfill, rather than a basic human right for prisoners.

Endnotes History and Overview: Section Two

¹ DMB Change Notice Number 27 to Contract No. 071B7000384 Between the State of Michigan and Correctional Medical Services, Inc. The contract with CMS began as a contract with United Correctional Managed Care, which held the contract until CMS took it over on March 10, 1998.

² Id., Change Notice No. 17.

³ Id., Change Notice No. 18.

⁴ Id., Change Notice No. 17.

⁵ Id., Change Notice No. 18.

⁶ July 25, 2007 House Fiscal Agency report "Post Enactment Changes to FY2006-07 MDOC Appropriations" indicated additional appropriations of \$36,976,900 for Hospital and Specialty Care, and \$2,801,800 for Prison Clinics for the fiscal year.

⁷ Deposition of Craig Hutchinson, M.D., page 18, Holmes v. Correctional Medical Services, Inc. and Robert Demasi, M.D., United States District Court for the Western District of Michigan, Case No. 5:03-CV-88, May 11, 2005.

⁸ RFP#071I7200254, "Round 2 questions – Clarification, Note to Bidders" concerning original RFP section 1.601. This RFP was cancelled.

⁹ Michigan Department of Management and Budget RFP#071I7200254.

¹⁰ Request for Information, Prisoner Health Care, November 2007, Questions Received After the RFI Meeting, p.8.

¹¹ The number of providers who may successfully bid for the contracts is not yet known; for purposes of this report, we are assuming there will be more than one sub-contractor, as companies will be submitting bids for the various regions of the MDOC.

History and Overview: Section Three

Reluctant and Obligatory Treatment: An Attitude Problem

We start with a focus on the underlying attitude of MDOC administrators and staff regarding the treatment of prisoners because it is a foundational element of the problems outlined in this report. We use the term “reluctant and obligatory treatment” to describe a kind of care that is set in a foundation of forced obligation rather than a foundation of compassionate care.

The MDOC does not overtly base its health care services on an ethic of compassionate care. Rather, the ethic of the care is reflected by the assertion often made by MDOC Director Patricia Caruso, that “...prisoners are virtually the only people in our society with a constitutional right to health care...”¹

While the constitutional obligation to provide health care is a fact, continually raising this as the basis for providing health care creates an attitude of “*we are doing this because we have to, not because you need it, or because we want to help you heal.*”

However, Director Caruso has also stated, “Your [*Detroit Free Press*] columns on health care have implied that we don’t care, or I don’t care, and that’s not true. ... I think we have good, caring professionals who work in a really difficult environment. I think we do provide good health care and good access to care for prisoners. The governor has called for an independent review, which I’m really welcoming at this point, because I need some partners to help me look at the system.”²

If this ideal is going to be realized, it is essential for the MDOC to make a shift in the language of policy directives, and address the day-to-day staff/prisoner interactions to reflect a culture of compassionate care. A realistic place to start this shift is in the reconfiguration of health care policy directives.

The MDOC’s Policy Directive on Health Services Policy Statement reads, “Prisoners shall be provided with unimpeded access to a continuum of health care services that is timely, humane, and cost efficient. Continuity of care shall be provided from intake until the prisoner is released, including referral to community providers when appropriate.”³ Other policies state, “All prisoners submitted to the jurisdiction of the Department shall be treated humanely and with dignity in matters of health care, personal safety, and general living conditions” and “[h]ealth care shall be available, accessible, and organized for delivery in a humane, cost-effective, and efficient manner.”⁴

While humane care is mentioned in this Directive, there is not an explanation of this standard, or a direct charge to employees to base the health care they provide prisoners on an ethic of compassion. In contrast to the minimalist language that introduces Michigan’s policy concerning health care services, Oregon’s Department of Corrections health care policy directive has compassion as the foundation of the directive; the term is bolstered by the words **respect**, **dignity**, and **non-judgmental**, and the sentiment of compassion is woven throughout the entirety of the detailed directive.

Oregon's Policy Directive reads:

During incarceration, inmates are entitled to responsive, clinically appropriate, and timely diagnosis, treatment and care of health problems. Health Services personnel care for patients with compassion and respect for the patient's privacy and dignity; treatment is provided in an objective and non-judgmental manner; and providers will advocate for the patient's health.

The policy of the Oregon Department of Corrections is to provide those health care services that help preserve and maintain the health status of inmates during incarceration. The health care services provided by the Oregon Department of Corrections will be consistent with the standard for such services in the community. This means that health care procedures will be conducted in a clinically appropriate manner by appropriately credentialed personnel in an appropriate setting.

The following procedure establishes the method and guidelines used to determine whether treatment will or will not be provided by the Oregon Department of Corrections consistent with applicable law and to ensure that sufficient health care resources are available to fulfill the Department's policy of preserving and maintaining inmate's health status during incarceration.⁵

Neither cost efficiency nor the constitutional right to healthcare is the focus of Oregon's policy. By contrast, Michigan's policies are very scant on language about a standard of care, a focus on treatment, or attitude toward delivery of health care. This has fostered a culture of reluctant and obligatory treatment of prisoners.

Recommendations for Change

PROBLEM: Part of the cause of the sub-standard health care provided to prisoners is that staff is not properly trained; attitudes allowing lackadaisical treatment of prisoners prevail, and prisoners suffer.

RECOMMENDED SOLUTION: The MDOC should add language to its policies that indicate that health care must be provided with compassion, dignity, and respect.

The MDOC should also provide training for employees concerning acceptable conduct and standard of care. Current training modules should be reviewed for adequate content pertaining to acceptable conduct and standard of care. It would likely be inexpensive to fix the internal problems and adjust attitudes (through training and implementation of new and revised medical care policy directives) which would prevent such costly expenditures as harm to prisoners and the defense of MDOC employees in recent litigation.

Endnotes History and Overview: Section Three

¹ "A Dose of Hope for Prison Care." The Detroit Free Press, July 18, 2007.

² "Questions and Answers--Patricia Caruso: Pressure on Prisons." The Detroit Free Press, December 14, 2006.

³ MDOC Policy Directive 03.04.100.

⁴ MDOC Policy Directive 03.03.130 policy statement; 03.03.130(G).

⁵ Oregon Department of Corrections, Operations Division, Health Services Section Policy and Procedure #P-A-02.1; "Level of Therapeutic Care Provided by Oregon Department of Corrections, Health Services Division"; Text can be found at http://www.oregon.gov/DOC/OPS/HESVC/policy_procedure.shtml.

History and Overview: Section Four Constitutional Protections Exist for a Reason

MDOC Director Caruso often refers to the constitutional requirement that the MDOC provide health care to prisoners. This requirement exists because, unlike the general public, prisoners are completely dependent on prison officials for their medical and mental health care. This fact led the United States Supreme Court to hold that prison officials' deliberate indifference to prisoners' "serious medical needs" violates the Eighth Amendment's ban on cruel and unusual punishments.¹

MDOC prisoners may seek private health care if they have private health care coverage, but this is very costly (prisoners must pay the transport fees to be taken to and from the visit), and can only be done with the permission of the prison warden.² Furthermore, treatment recommendations or follow-up care may not be approved and/or completed by CMS or the MDOC, which makes outside consultations largely useless. As paragraph E of this policy directive states, "The private practitioner is generally viewed as a consultant only; responsibility for case management lies with the institutional medical director."³ The State of Michigan and the MDOC are solely responsible for the physical and mental health of the more than 51,400 men and women incarcerated here, admittedly no small feat.

Model Jury Instructions on Eighth Amendment Violations-- Sample from the 8th Circuit Court of Appeals

In civil and criminal jury trials, after each litigant presents their case, and before the jury goes to deliberate, the Judge reads the jury a set of instructions. These instructions are intended to guide the jury in making their decision about the case. There are Model Jury Instructions for most causes of action. The following are excerpts of model jury instructions as they relate to Eighth Amendment violation lawsuits (some "Notes on Use" are omitted for ease in reading).⁴

4.31 DENIAL OF MEDICAL CARE - CONVICTED PRISONERS (42 U.S.C. § 1983)

Your verdict must be for the plaintiff on the plaintiff's claim of deliberate indifference to his serious medical need if all of the following elements have been proved by the [(greater weight) or (preponderance)]³ of the evidence:

First, the plaintiff had a serious need for [describe the plaintiff's medical need, such as "treatment for a broken leg" or "pain medication"], and *Second*, the defendant was aware of the plaintiff's serious need for such ["medical care" or "pain medication"], and *Third*, the defendant, with deliberate indifference,⁵ failed to ["provide the medical care" or "direct that the medical care be provided" or "allow the plaintiff to obtain the medical care needed"] [within a reasonable time],⁶ and *Fourth*, as a direct result, the plaintiff was damaged, and [*Fifth*, the defendant was acting under color of state law.]⁸ If any of the above elements has not been proved by the [(greater weight) or (preponderance)] of the evidence, then your verdict must be for the defendant.

Model Jury Instructions on Eighth Amendment Violations-- Sample from the 8th Circuit Court of Appeals

continued

Notes on Use Numbers 3, 5, 6, and 8

3. Select the bracketed language which corresponds to the burden-of-proof instruction given.
5. It is probably best to define "deliberate indifference", although no Eighth Circuit law requires it. See *Howard v. Adkison*, 887 F.2d 134 (8th Cir. 1989); *Duckworth v. Franzen*, 780 F.2d 645, 654 (7th Cir. 1985).
6. Add this phrase if it is alleged the medical care was provided but not at a reasonable time.
8. Use this language if the issue of whether the defendant was acting under color of state law is still in the case. Color of state law will have to be defined. See 42 U.S.C. § 1983 and Model Instruction 4.40, *infra*.

4.43 DEFINITION: SERIOUS MEDICAL NEED - CONVICTED PRISONERS (42 U.S.C. § 1983)

A serious medical need is one that has been diagnosed by a physician as requiring treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.

4.44 DEFINITION: DELIBERATE INDIFFERENCE - CONVICTED PRISONERS (42 U.S.C. § 1983)

Deliberate indifference is established only if there is actual knowledge of a substantial risk that the plaintiff (describe serious medical problem or other serious harm that the defendant is expected to prevent) and if the defendant disregards that risk by intentionally refusing or failing to take reasonable measures to deal with the problem. Mere negligence or inadvertence does not constitute deliberate indifference.

Endnotes History and Overview: Section Four

¹ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976), "We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,' proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under § 1983 ..." (internal quotations, citations, and footnotes omitted).

² MDOC Policy Directive 04.06.150, Prisoners Requesting Outside Health Services At Own Expense; see also, RFP#071I7200254, Round 2 questions, question 116: "Q. Can prisoners be covered under health insurance (such as Medicare or BCBS) while incarcerated? A. No. To our knowledge, prisoners are not eligible for Medicare, Medicaid, or commercial private insurance."

³ MDOC Policy Directive 04.06.150(E).

⁴ 8TH CIR. CIVIL JURY INSTR. § 4.50A (2007), some internal notes omitted.

History and Overview: Section Five Failure to Protect Prisoner Health – A History

Despite the United States Supreme Court's 1976 decision in Estelle, which recognized the constitutional requirement to provide medical care to prisoners, Michigan's prison system has been under fire for deficiencies in its health and mental health care delivery for decades.¹ In the 1970s and 1980s, Michigan's male prisoners challenged unreasonable conditions of confinement, including inadequate medical and mental health care.²

As a result of these cases, the MDOC consented to plans to comply with constitutional requirements.³ During this time, due in part to changes in Michigan statutes concerning the lengths of criminal sentences,⁴ the prison system grew from ten locations in 1978 to the 50 or so that exist today. Despite these class action suits, problems with medical care in the MDOC still abound – between 2001 and 2004, approximately 197 Michigan prisoners filed litigation concerning inadequate health care treatment.⁵

Recognizing the fiscal impact of more and longer sentences and the likelihood of an increase in prisoner lawsuits challenging system failures throughout the country, Congress passed the Prisoner Litigation Reform Act (PLRA) in 1996, putting severe constraints on lawsuits that allege unconstitutional conditions of confinement.⁶ The PLRA also allowed states to terminate existing consent decrees and, thereby, terminate the costs of compliance plans. The only exception was when a court found a need for prospective relief to correct a current or ongoing violation of a federal right.⁷ Michigan also has its own Prison Litigation Reform Act, which, like federal law, requires exhaustion of administrative remedies, forbids a court to grant relief unless it has made certain findings which are not required in other civil cases, and imposes other procedural requirements not present in other civil cases, making it more difficult for an imprisoned plaintiff to obtain judicial relief.⁸

After 1996, Michigan not only took advantage of the opportunity to terminate its compliance plans under federal court consent decrees, but the Michigan Legislature also removed Michigan prisoners from the protections found in the state civil rights law, the Elliott-Larson Civil Rights Act.⁹

At the same time, plagued by a lack of accountability and what appears to have been poor supervision of medical services by MDOC's Bureau of Health Care Services (BHCS) management staff, a major portion of those medical services (non-mental health related) were privatized. Also, a hybrid system for remedying the problems was created. Essentially, direct medical services were to be provided by the contractor, who would be responsible for the hiring and first-line supervision of the physicians. Supervision of the contractor and the whole delivery system would remain with a select few high level MDOC BHCS medical, administrative and nursing managers. Physicians and Physician Assistants would be contracted for privately, while nursing and all other health care staff remained directly under BHCS. Thus, the very people who were unable to solve or correct the medical services problems already in existence were still in charge and were responsible for the overall management of the new, privatized system.

The MDOC continued to complain about the increasing cost of health care in the burgeoning prison system. In 1997, the MDOC attempted to resolve this problem by creating a

contract with United Corrections Managed Care (UCMC). Within a year it became apparent that UCMC was unable to meet its obligations and the contract was awarded to Correctional Medical Services (CMS). When a state audit was done after the transition to CMS, it was discovered that \$9 million was unaccounted for; of the \$26 million UCMC was paid, it could only show that \$17 million was paid out to providers.¹⁰ Additionally, according to a report by Michigan's Auditor General, UCMC's termination was also based on the fact that, "Within a few months, UCMC fell significantly behind in making payments to its subcontracted medical service providers."¹¹

CMS has held the managed care contract since 1998, despite clear evidence that it has not met its contractual obligations and is the defendant in litigation in Michigan and many other states.¹² As reported in the *Grand Rapids Press*, CMS has "...faced allegations of poor care in 11 states, including cases involving a North Carolina prisoner who died from untreated alcohol withdrawal and a mentally ill Alabama inmate who apparently starved to death."¹³

Recent suits against CMS and CMS in the news

At the time that CMS took over the contract for health care in Michigan prisons, it was already facing three lawsuits concerning care for inmates at the Kent County Jail.¹⁴ Since then, CMS has expanded to care for all the prisoners in the state (and still many jail inmates throughout the state), and the lawsuits continue to be filed. Here is a small example of some of the outcomes of successful suits against CMS from around the country:

Stitt v. CMS, Baldwin Co. Sup Ct, Case No. 96-CV-32768E; affirmed at 250 Ga. App. 420 (2001). This is a Georgia case where a jury awarded a prisoner a \$600,000 damages award against CMS; this was upheld on appeal. Prisoner Stephanie Stitt fell and injured her back while playing volleyball; she repeatedly sought medical attention which was delayed and then denied. Because of the delay in treatment, Stitt suffered a herniated disk that left her with no bowel or bladder control. CMS' defense was that they were "providing medical care as practiced in prisons."¹⁵

Woodward v. Correctional Medical Services of Illinois, Inc., 368 F.3d 917 (7th Cir. 2004). A jail inmate with an extensive history of mental health problems repeatedly expressed suicidal ideations, but was not put on suicide watch. He was screened by a CMS employee who was a licensed social worker; a CMS employee who was a nurse; and a CMS employee who was a psychiatrist, who prescribed an anti-depressant and a tranquilizer. After two weeks in jail, he committed suicide by hanging himself. The jury reached verdicts against CMS and its social worker, finding that they acted with deliberate indifference to the inmate's health and safety; they awarded compensatory damages of \$250,000 and punitive damages against CMS totaling \$1.5 million. On appeal, the 7th Circuit Court of Appeals affirmed.

Recent suits against CMS and CMS in the news

continued

In an August, 2006 article, the *Detroit Free Press* reported that in June, 2006 Wyoming paid \$50,000 to settle federal lawsuits filed by a prisoner who blamed CMS and Wyoming's Department of Corrections for the loss of his leg after his diabetes treatment was delayed.¹⁶ That article also cited a confidential settlement over the death of an inmate in Delaware, and hundreds of thousands of dollars in fines against CMS from the Virginia Department of Corrections for failing to fulfill its contract to provide medical care for prisoners.¹⁷

Other successful outcomes can be found at: Turner v. CMS, USDC DE No. 1:03-CV-00048-SLR (HCV case); Szemlpe v. CMS, No. A-3842-02T2 (Sup Ct of NJ App Div, 11/17/04) (delays in authorizing physical therapy; reported in *Prison Legal News* 9/05, p 32); Edens v. Larson, 110 Fed. Appx. 710 (7th Cir. 2004) (treatment of cluster headaches, as reported in *Prison Legal News* 9/05, p 36); Coakley v. Tampa Police Department, Hillsborough County Court no. 98-6042 (broken forearms went untreated for a week, reported in *Prison Legal News* 9/05, p 39).

More insight into CMS can be found in an investigatory article in Harper's Magazine by Wil S. Hylton. Mr. Hylton traveled around the country, talking to prisoners, their family members, prison staff, and prisoner advocates about the poor quality of care provided by CMS, and the retaliation some prisoner advocates faced after public questioning of CMS' capabilities. Near the end of his article, Mr. Hylton notes, "Few lawsuits have managed to expose details of the company's inner mechanisms, and aside from the Michigan hepatitis suit there is no major legal action pending against the company at the moment, only scattered individual lawsuits – the great majority of them, it is safe to say, doomed."¹⁸

Aside from the particular problems caused by CMS, Mr. Hylton comments on the broader solution that is needed to solve the problems with prison health care: "But if the battle over prison health care is beginning to seem lost, littered with the bodies of the wounded, the sick and the sickened alike, with inmates and nurses and journalists by the wayside, if the whole field seems deathly unwell and bordering on hopeless, it may, in the end, have more to do with the way we look at prisons in general than with anything CMS has done."¹⁹

Initially, the contract with CMS focused on organizing and assuring access to necessary specialty services not available within the prison setting (where state employees provided health services to prisoners). But, in 2000, in an attempt to lower costs, the State Administrative Board expanded CMS's contract to include all medical service providers, replacing all MDOC physicians, Physician Assistants, and Nurse Practitioners with CMS employees.²⁰

In addition to changing the nature of providers' employment, the CMS contract was

expected to reduce costs by denying services that “were not clinically indicated” and by using “lower-cost treatment alternatives” to an “expensive request”.²¹

Notwithstanding repeated requests for more money, until May, 2007, the legislature has never questioned the need for more money, or requested any comprehensive report on the quality of the care received or a breakdown of how the money is being spent.²² Would any other request for additional funds receive this carte-blanche?

Instead of inquiring further into why the MDOC and CMS need more money, the legislature has relied upon the annual, one-page reports from the MDOC. These reports include some version of the following summary of health care delivery:

Correctional Medical Services, Inc., (CMS) continues to provide quality services to prisoners and to pay vendors in a timely manner. ...Quality [of prisoner health care] is monitored through several internal mechanisms. The MDOC has an extensive Internal Performance Improvement System in place for health professionals employed by the MDOC. Investigation of prisoner grievances, family complaints and issues brought to the MDOC by Legislators have assured that the quality of services provided by CMS meets MDOC expectations.²³

This summary, nearly verbatim, has been provided annually to the legislature from at least 2002 until 2007. However, reality reflects a radically different picture.

Endnotes History and Overview: Section Five

¹ Hadix v. Johnson, USDC, E.D. Mich No. 80-73581, now Hadix v. Caruso, USDC, W.D. Mich No. 4:92-cv-110; Knop v. Johnson, USDC, W.D. Mich No. G-84-651; USA v. Michigan, USDC, W.D. Mich No. G-84-63; Cain v. MDOC, 30th Circuit Court No. 88-61119-AZ.

² Hadix v. Johnson, USDC, E.D. Mich No. 80-73581, now Hadix v. Caruso, USDC, W.D. Mich No. 4:92-cv-110.

³ USA v. Michigan, Hadix v. Johnson.

⁴ Some factors contributing to this growth were Proposal B, 1978 P.A. 80 (required that prisoners serve minimum sentences without good time); 1978 mandatory drug law changes in, 1978 P.A. 368; an amendment to Proposal B, 1982 P.A. 442 (prohibited reduction of a prisoner’s maximum sentence by applying good time); Governor Engler’s 1992 parole board’s adoption of a policy that “life means life,” Foster-Bey v. Rubitschun, USDC, E.D. Mich. No. 2:05-cv-71318, Hon. Marianne O. Battani, Opinion and Order of October 23, 2007, PACER Document No. 143; and Truth in Sentencing, 1994 P.A. 199, 217, 218.

⁵ Michigan Department of Corrections, 2004 Statistical Report, Page F-11, Section F4, “Litigation Statistics, 2001-2004.”

⁶ Prison Litigation Reform Act of 1995, Pub. L. No. 104-134 (codified as amended 11 U.S.C. 523(b), 28 U.S.C. 1346, 28 U.S.C. 1915, 28 U.S.C. 1915A, 28 U.S.C. 1932, 28 U.S.C. 3626, and 42 U.S.C. 1997(e); see also H.R. 3019, 104th Cong. (1996). The impact of this change was that prisoners must exhaust their administrative remedies before filing suit in court; a court may not grant relief for prisoners unless it has made certain findings not required in other civil cases; it provides for termination of injunctive relief when conditions requiring that relief have been abated.

⁷ In Michigan, an exception was found in the Hadix case with regard to the Southern Michigan Correctional Facility, the Duane Waters Hospital/Egeler Correctional Facility and the Parnall Correctional Facility, which remain in litigation at this time regarding health care at those facilities.

⁸ MCL 600.5501-600.5531, Prison Litigation Reform Act.

⁹ MCLA 37.2101 et seq., compiler’s note, “Enacting section 1. This amendatory act is curative and intended to correct any misinterpretation of legislative intent in the court of appeals decision Neal v Department of Corrections, 232 Mich App 730 (1998). This legislation further expresses the original intent of the legislature that an individual serving a sentence of imprisonment in a state or county

correctional facility is not within the purview of this act."

¹⁰ About the shortfall, the MDOC's spokesman commented that the "...\$9 million discrepancy isn't a concern because the state got what it paid for under the contract – and still saved at least \$12 million last year." Judy Putnam. "\$9 million cannot be accounted for in audit of prison health care." Jackson Citizen Patriot, February 29, 2000: A1.

¹¹ Michigan Auditor General Report 47-305-00, Comment, p.8.

¹² Hadix v. Caruso. We suggest that anyone who is interested in other litigation in other states simply search "Correctional Medical Services" on the Internet to learn more. See also, Wil S. Hylton "Sick on the Inside: Correctional HMOs and the Coming Prison Plague." Harpers Magazine August 2003: 43-54; Andrew A. Skolnick. "Prison Deaths Spotlight How Boards Handle Impaired, Disciplined Physicians." JAMA Medical News & Perspectives JAMA 1998;280:1387-1390 (October 28, 1998); Andrew A. Skolnick "Only the Tip of the Iceberg?" JAMA Medical News & Perspectives JAMA 1998;280:1388-1389 (October 28, 1998); Paul von Zeilbauer. "Harsh medicine: A Company's Troubled Answers for Prisoners with H.I.V. (Prison Health Services in Alabama)." New York Times 1 August 2005. All aforementioned articles available at <http://www.prisonpolicy.org/cms.html>.

¹³ Judy Putnam, "Prisoner medical deal draws fire over cost, care." The Grand Rapids Press, September 10, 2000: A1, A17.

¹⁴ Id.

¹⁵ As reported in Prison Legal News at www.prisonlegalnews.org

¹⁶ Jeff Gerritt. "Unhealthy Confinement: Inmates aren't the only ones who pay for poor medical care in prison." The Detroit Free Press, August 21, 2006.

¹⁷ Id.

¹⁸ Wil S. Hylton. "Sick on the Inside: Correctional HMOs and the Coming Prison Plague." Harper's Magazine August 2003: 43-54.

¹⁹ Id.

²⁰ "During the budget deliberations for the Michigan Department of Corrections (MDOC), questions were raised about prisoner health care and hospital and specialty care services provided under a managed care contract. In the midst of the budget process, the State Administrative Board gave the MDOC permission to extend its contract with Correctional Medical Services (CMS) to include medical service providers, or physicians, physician assistants, and nurse practitioners, displacing civil service positions." Karen Firestone, Fiscal Analyst & Kelly LaRoux, Intern. *Prison Health Care: An Overview*. September 2000:1.

²¹ Karen Firestone, Fiscal Analyst & Kelly LaRoux, Intern. *Prison Health Care: An Overview*. September 2000: 1-2. For these caveats to make sense, one must assume that the services being ordered by state licensed health care providers were not "clinically indicated" and were frequently more expensive than viable low-cost alternatives. As far as this Committee has been able to determine, the MDOC has never published any study to support that assumption.

²² The Committee compiling this report made diligent efforts to track down whether documentation was ever provided to the legislature to support the supplemental budget requests, but no information was located. It was learned that some detail was sought and provided in conjunction with the Fiscal Year 2005-06 supplemental appropriations bill to take care of overspending in that year. As far back as FY 2002-03, there were not any other MDOC health care supplemental requests, but there were funding increases through enacted budgets and legislative transfers. In each of these cases, there was some kind of explanation of why increased funds were being sought, but not necessarily a formal report to the legislature. The subcommittee process typically generates questions that are addressed either through testimony or through memorandum responses, but it is not clear how thorough this process is.

²³ Report to the MI Legislature from the Michigan Department of Corrections. *Health Care Services Contract Payments/Status and Prisoner Health Care Quality Assessment Report*. January 1, 2005.

History and Overview: Section Six More Problems – Less Oversight

Beginning in 1975, the Legislature oversaw the Michigan prison system through its Office of the Legislative Corrections Ombudsman. The Ombudsman's employees had the unique ability to access the prisons, prisoners, and staff at any time. The main role of the Ombudsman's office was to investigate complaints by prisoners, family members, and legislators and investigate "critical incidents" which led to the death or serious injury of a prisoner. The staff had full access to all units, they could interview prisoners, and they could walk through the housing units and communicate with prisoners in their own space. They had the ability to interview staff about critical incidents. Ombudsman's staff had access to all documentation including videotapes of critical incidents, medical and mental health records of prisoners, and records of cell movements of prisoners in segregation and observation units.

The staff had unfettered access to segregation units as well, which was very important because many segregated prisoners have very limited contact with the outside world. Walking through the segregation units allowed the Ombudsman's employees to observe the condition of individual cells and individual prisoners, which is important because segregated prisoners can become psychotic due to conditions of segregation. Having this type of access inside the prison walls allowed the Ombudsman's office employees to "feel" the essence of the MDOC prisons.

In 2003 the Legislative Corrections Ombudsman was de-funded and closed its doors. In the first half of 2007 there were indications that the Legislature was moving towards re-funding and therefore re-instating the Ombudsman's office. House Bill 4348—the Corrections Appropriations Bill for Fiscal year 2007-2008—actually passed through the House with \$1,250,000 "appropriated as an interdepartmental grant to the legislative council for the purpose of reestablishing the office of the legislative corrections ombudsman under 1975 PA 46, MCL 4.351 to 4.364."¹

The appropriated funds did not make it through the Senate's version of the Bill even though a strong voice in corrections politics, Senator Alan Cropsey, had indicated his support of the re-instatement of the Office. In an interview with Free Press writer Jeff Gerritt, Senator Alan Cropsey articulated his support for the reinstatement of the Ombudsman's office:

While talking about prison health care, [Cropsey stated he] would support restoring the Corrections Ombudsman's Office, which legislators closed in 2003 to save the state \$500,000 a year. Cropsey understood that the office provided valuable and independent information for legislators on how the Department of Corrections works.²

The Ombudsman's reports regarding health care reveal that the implementation of the managed care contract in 1996 was followed by increased complaints of unmet medical needs.³ In its last annual report, issued December 15, 2002, the Ombudsman reported serious concerns with regard to the ability of the MDOC and CMS to meet the needs of the ever expanding and aging prison population. Noting prior MDOC reports to the Legislature, the Ombudsman contradicted the MDOC's self-reported and self-assessed achievements:

A DOC report to the Legislature appeared to indicate there were no unresolved complaints concerning medical decisions. The report stated that Correctional Medical Services, Inc. (CMS), its managed care contractor, stated that no denials of access to appropriate care had been logged and stated that no unresolved issues regarding the quality of care provided by CMS contract specialist or hospitals had been identified. The DOC report to the Legislature also stated that the Central Office staff included a position charged with the responsibility of responding to prisoner, family and legislative concerns and to monitor litigation involving health care. It stated that investigations of prisoner grievances, family complaints and issues brought to the DOC by legislators had not revealed any quality problems generated by the CMS referral process or by its providers.

Our investigations indicated this was not true. We found situations where referrals to CMS had not been answered, where referrals were denied without any apparent review of the complete medical record, where services had been delayed due to backlogs in paper processing, where appointments had been cancelled due to lack of transportation and we had frequently had occasion to repeatedly prompt the DOC to answer our inquiries in medical complaints.

The DOC explained that its finding [in the reports to the Legislature] derived from the process that handled disagreements between facility physicians and the managed care provider. The DOC reported that its Medical Advisory Committee (MAC) had been able to reach consensus in each dispute considered. The DOC advised us that the MAC was comprised of DOC health services officials and two representatives from CMS.

While the MAC may have been able to reach consensus on those issues considered, the MAC process did not review all prisoner grievances that were denied through all 3 steps. We also pointed out that there was no medical review at the third level of the appeal process, through which the Chief Medical Officer or the MAC might become aware of conflicts that could warrant their attention.

We also questioned whether the inclusion of CMS officials on the Medical Advisory Committee could unduly influence DOC officials when deciding whether to override CMS denials of requested services.⁴

Questions about the budget were clearly on the horizon. The corrections budget was so big that oversight was eliminated to save money. Despite assurances by the MDOC that these concerns would be effectively addressed, they were not. Instead, the Legislature quit funding the Ombudsman on September 30, 2003, eliminating this critical arena for oversight of the MDOC.

Recommendations for Change

PROBLEM: The office of the Legislative Corrections Ombudsman played a significant role in exercising oversight of the MDOC generally and health care specifically; without this check on the MDOC, problems in health care delivery worsened.

RECOMMENDED SOLUTION: The Office of the Legislative Corrections Ombudsman should be immediately reopened and adequately funded. A medical expert and an economic analyst should be added to the staff of the Office of Legislative Corrections Ombudsman.

Additionally, the Legislature should implement an adequately funded Office of the Legislative Medical Corrections Ombudsman (staff to include medical personnel). This body will report to both Community Mental Health (CMH) and the legislative committee recommended in this report, which will oversee issues including, but not limited to: medical treatment, mental health treatment, health care and mental health care in segregation, and therapeutic programming.

The Legislature should require Senate and House Committee members (with connections to Corrections) to tour the following prisons: Alger, Baraga, Chippewa, Bellamy Creek, Gus Harrison, Duane Waters, Ionia, Marquette Branch, Parnall, Standish, Huron Valley Men's, Lakeland, Scott, and Huron Valley Women's all infirmaries, the dialysis unit at Ryan, and the secure unit of Foote Hospital, accompanied by advocates and the Legislative Ombudsman, to maintain a balance of information provided during these tours. Tours should take place annually.

Reviving and expanding the office and role of the Ombudsman will help keep health care and mental health care delivery effective and productive, while keeping a closer watch on spending.

Endnotes History and Overview: Section Six

¹ HB-4348, as passed by the House on June 28, 2007.

² Jeff Gerritt. "Ombudsman's Return Would Improve Prison Oversight." The Detroit Free Press, November 25, 2006.

³ Office of the Legislative Corrections Ombudsman. "2001-2002 Annual Report to the Legislative Council." December 2002.

⁴ Id.

Another Red Flag

On July 25, 2002, after realizing the failure of the expensive and poorly managed health care delivery by CMS, a group of seven top Bureau of Health Care Services (BHCS) regional level administrators presented a "Leadership Consensus Statement" to the bureau chief concerning CMS' failure to provide even minimally adequate prisoner health care.¹ They noted continuing and severe delays by CMS in providing necessary medical services to prisoners, ongoing violations of the MDOC's own health services policies (which increase the liability risk for the state), and dramatic increases in the volume of health care complaints filed since the service was privatized. They also reported that CMS applied "considerable pressure" on the medical service providers (MSPs) to minimize the number of specialty referrals. This resulted in increased profits for the vendor, and undermined the quality of care by denying many prisoners access to it altogether.

Instead of seriously considering the issues and recommendations raised by these senior regional health care administrators, BCHS Administrator Terry Pitcher responded by attacking and rebuking their efforts in a memorandum.² At the same time, no significant efforts to correct the very serious health care deficits and problems appear to have been implemented by BHCS administrative staff. In fact, many of the problems that were summarized in the July 25, 2002 Leadership Consensus Statement continued on unchanged according to the ongoing assessments by Dr. Robert L. Cohen, Associate Monitor for Medical Care in the Hadix litigation from 2003 to the present.³

Endnotes Another Red Flag

¹ DeVoss, G., Dick, L.A., Fletcher, I.M., Jackson, J., Malloy, T., Naylor, G. & Strachan, C. "Leadership Consensus Statement on Managed Care in the Michigan Department of Corrections Bureau of Health Care Services," July 25, 2002.

² Pitcher, T. Memorandum. "Response to Comments of July 25, 2002," August 13, 2002.

³ In Hadix v. Caruso, W.D. Mich. Case No. 4:92-CV-110, July 7, 2004, First Report of the Associate Monitor Regarding Medical Care Services at the Hadix facilities.

History and Overview: Section Seven Court Ordered Monitoring At Three Prisons

Just as the Ombudsman's work was being halted, the Court in Hadix v. Caruso ordered oversight of health care delivery at three facilities in Jackson. Many sick prisoners ended up at these Jackson area prisons because of its proximity to Duane Waters Hospital, a facility dedicated to serving the needs of MDOC prisoners.¹ There are many other accommodations at these Jackson area prisons that were intended to serve the medical needs of MDOC prisoners. However, as the Hadix experts found in 2003, many of the actual needs of these prisoners were not being met despite the efforts of the MDOC and CMS. To monitor care, the United States District Court appointed its own independent, expert monitor, Dr. Robert Cohen. Dr. Cohen was asked to report back to the Court as to the quality of health care at those facilities.²

Since that time, reports from the independent monitor as well as from Plaintiffs' experts have revealed extremely limited improvement in only a few areas, while serious deprivations in other areas have continued, including shortcomings so egregious as to have contributed to avoidable deaths.³

In fact, the MDOC has consistently failed to meet the medical and mental health care provisions of the Hadix Consent Decree, despite more than 20 years of court monitoring and vast expenditures by the state. Prisoner medical and mental health care are the very last of the consent decree provisions that remain as issues in the suit, all others having long been resolved.⁴ In October, 2002, the U.S. District Court, in a 267 page opinion found that the poor quality and lack of access to medical care provided by the MDOC through its contractual services with CMS resulted in serious harm, unnecessary pain, suffering, loss of function and even death, to some prisoners.⁵ Over 240 cases of negligence resulting in

Current Status and Overview of the Health Care Issues In Hadix v. Caruso¹

Background

The Hadix case was filed pursuant to 42 U.S.C. § 1983 in the Eastern District of Michigan in 1980 to redress a variety of unconstitutional conditions, including inadequate medical and mental health care, at certain designated Jackson, Michigan prison facilities operated by Michigan Department of Corrections. In 1985, a Consent Decree was entered by stipulation of the parties with the approval of United States District Judge John Feikens. Section II of the Consent Decree pertained to health care for prisoners within the Hadix facilities.

Judge Feikens initially transferred enforcement of medical care and mental health care provisions of the Consent Decree to the Western District of Michigan, to Judge Richard Alan Enslin by Order of June 5, 1992 pursuant to 28 U.S.C. § 1404(a).² The case has since been re-named Hadix v. Caruso, to reflect the name of the current MDOC Director, Patricia Caruso. The purpose of the Order was to promote uniformity and effectiveness of remedy in light of Judge Enslin's enforcement of a Consent Decree involving the same issues in a separate suit – United States v. Michigan.

Medical Health

Medical health care at the Hadix facilities has been monitored by Judge Enslin since the 1992 transfer of the issue. Following the most recent full evidentiary hearing on health care on October 11-13, 2006, Judge Enslin issued a permanent injunction that continues previously ordered relief to remedy constitutionally inadequate health care, and ordered the creation of an Office of the

serious injury to sick prisoners were found, as were at least 12 prisoner deaths associated with poor quality medical care. Most of these findings were acknowledged to be true, under oath, by MDOC Bureau of Health Care Services medical staff during the hearing shortly after release of the report.

On July 1, 2002, while court hearings in Hadix were in session, the MDOC released its annual "Prisoner Health Care Quality Assessment Report" stating, "No denials of access to appropriate care have been logged and no unresolved issues have been identified regarding the quality of care provided by CMS contract specialists or hospitals...Investigation of prisoner grievances, family complaints and issues brought to the DOC by Legislators have not revealed any quality problems generated by the CMS referral process or by its providers."⁶ It concluded that "CMS continues to provide quality services to prisoners and to pay vendors in a timely manner."⁷

Yet many administrators in the BHCS of the MDOC knew, as documented in the U.S. District Court report, that many very serious and life threatening problems were not being properly treated, and the CMS health care delivery system was a failure. The July 1, 2003 Prisoner Health Care Quality Assessment Report reached the same conclusion: "CMS continues to provide quality services to prisoners..."⁸ This time, their "Investigation... assured that the quality of services provided by the contractor meets DOC expectations."⁹ These reports were submitted by MDOC staff to legislative budget committees, in support of extending the contract with CMS for prisoner medical services.

As this was occurring, ongoing incidents of extreme and sometimes deadly medical neglect were being discovered by the Plaintiff's medical expert, Dr. Jerry Walden, and the Court's independent monitor, Dr. Robert Cohen, continuing right up to the present. In his August, 2006 report, Dr. Cohen made the following conclusions:¹⁰

Independent Monitor with special powers to take corrective actions regarding patient care.

Mental Health

Mental health care at the facilities was routinely monitored by the Court until 2001. On January 8, 2001, the Court granted Defendants' request to terminate enforcement of the mental health provisions of the Consent Decree effective ten days after the filing of an Updated Continuous Quality Improvement (CQI) Monitoring and Data Validation document. The document was filed by Defendants on January 23, 2001, thus terminating the mental health issues.

Plaintiffs moved on September 8, 2006 to reopen the terminated provisions and for a preliminary injunction pertaining to mental health care. The cause for the Motion was the tragic death of one Michigan prisoner [Timothy Souders] and other fatal cases in which inmates' deaths were attributable to delays or malfeasance in the provision of mental health care.

The Court issued an injunction on November 13, 2006, requiring Defendants to make significant improvements to mental health care and cease the use of in-cell non-medical restraints for punishment.³ The November 13, 2006 order also required Defendants to submit a proposed remedial plan for Court approval.

In July 2007, Plaintiffs' mental health experts toured the Hadix facilities and filed their reports on August 24, 2007. One report is by psychiatrist Terry Kupers, M.D., and the other report is by psychologist Robert Walsh, PhD. There is an evidentiary hearing planned for these issues, but no date has yet been set. Most likely it will be set in the beginning of 2008. To be considered will be the matters raised by Plaintiffs' experts and the adequacy of the MDOC's August 20, 2007 Revised

There are significant problems with the care being provided to the sickest prisoners in the Hadix facilities. This is due to significant weaknesses in the provision of medical services and of specialty services. These problems were identified by the Court in its finding of 2001, and were again documented in my first and second reports. Unfortunately, these problems persist and appear to have gotten worse over the past two years. ...the medical service provider coverage for DWH and C Unit has been extremely deficient. According to nursing staff, and confirmed by review of medical records, nursing requests for urgent physician evaluation of serious and painful medical conditions in the units can be unanswered for days at a time, or never responded to at all. ...During the past two years, there has been essentially no on-site supervision of the medical staff by CMS.

In December 2006, the Hadix court ordered the MDOC to provide space, equipment and funding for an independent monitoring office and staff, on-site at the Hadix facilities.¹¹ These services began in April 2007 and are ordered to continue until the Hadix court allows the monitoring to stop.

Despite many reported incidents of failures in the health care systems at Southern Michigan, Egeler, and Parnall, the MDOC continues to resist the validity of oversight at these Hadix facilities, and has chosen to close these facilities. Remarkably, the MDOC and CMS enjoy virtually no outside or legislative oversight whatsoever at the 47 other prisons throughout the state. And, after a February, 2007 announcement by Governor Jennifer Granholm that she wants to close some prisons and reduce the number of people in prison, the MDOC chose to target the Hadix prisons for closure first.¹² Is this decision related to the Court-ordered monitoring at these facilities? According to MDOC spokesman Russ Marlan, "Hadix was a factor in deciding to close Southern Michigan, one of three Jackson prisons under federal oversight. 'This prison is really the focal point,' said Marlan. 'The court case would continue, but it would not be as significant.'"¹³

Mental Health Plan.

Recent Activity in Hadix v. Caruso

On February 20, 2007, Defendants announced the closing of Southern Michigan Correctional Facility (JMF) and 7 Block of the Charles Egeler Reception and Guidance Center (RGC). Plaintiffs remain concerned about the manner in which the Department of Corrections plans to execute these closures, suspecting that the choice of these particular cellblocks to close – housing a concentrated population of chronically ill prisoners, including about 70 on renal dialysis – is an attempt to move vulnerable prisoners beyond the reach of the Court rather than to fix the constitutional violations that currently place these prisoners in danger. As bad as the medical care is at these facilities with the federal court monitoring it, it appears that health care is just as bad, if not worse, in the rest of the state, as recent public hearings before the Michigan legislature have illustrated.

On February 21, 2007 Plaintiffs requested and were granted a temporary restraining order that was followed by a February 22, 2007 Preliminary Injunction to delay these transfers. On February 28, 2007 Plaintiffs sought modification of the injunction to prevent the most medically vulnerable from transfer without the necessary steps to assure that they will be protected from a precipitous move to an unsafe environment.

New Judge Assigned to the Case on July 23, 2007

The Hadix v. Caruso litigation was reassigned to Judge Robert J. Jonker on July 23, 2007. Judge Jonker was recently appointed as a judge on the Western District Court bench, after Judge Enslin asked that the case be reassigned. At a hearing on August 29, 2007 Judge Jonker heard arguments on several issues, and on September 10, 2007 issued an order and opinion that approved the

Endnotes History and Overview: Section Seven

- ¹ Now known as Duane Waters Health Care Center as it is no longer qualified to operate as a hospital. Hadix v. Caruso, 465 F. Supp. 2d 776, 778 (W.D. Mich. 2006).
- ² Judge Enslin appointed Dr. Robert L. Cohen as Associate Monitor for Medical care in Hadix v. Caruso, W.D. Mich. Case No. 4:92-CV-110, order of April 1, 2003.
- ³ See Current Status and Overview of the Health Care Issues In Hadix v. Caruso textbox above.
- ⁴ See Current Status and Overview of the Health Care Issues In Hadix v. Caruso textbox above.
- ⁵ Hadix v. Johnson, 2002 U.S. Dist. LEXIS 21283 (W.D. Mich. Oct. 29, 2002).
- ⁶ July 1, 2002 Health Care Services Contract Payments/Status and Prisoner Health Care Quality Assessment Report available online on the MDOC website at [http://www.michigan.gov/documents/062602Sec902\(1\)HealthCare_34250_7.pdf](http://www.michigan.gov/documents/062602Sec902(1)HealthCare_34250_7.pdf). See an earlier discussion of these reports to the Legislature on page 24 of this report.
- ⁷ Id.
- ⁸ July 1, 2003 Health Care Services Contract Payments/Status and Prisoner Health Care Quality Assessment Report available online on the MDOC website at http://www.michigan.gov/documents/7-1-03_-_Section_902__1__69022_7.pdf
- ⁹ Id.
- ¹⁰ Hadix v. Caruso, W.D. Mich Case No. 4:92-CV-110, Third Report of the Associate Monitor Robert L. Cohen, MD, August 22, 2006.
- ¹¹ Hadix v. Caruso, 465 F. Supp. 2d 776 (W.D. Mich. 2006).
- ¹² First announced in the *2007 State of the State: Our Moment, Our Choice: Investing in Michigan's People*, Governor Jennifer Granholm, February 6, 2007. <http://www.michigan.gov/gov/0,1607,7-168--161761--,00.html>. A summary of the Governor's 2007-2008 budget, *Governor Granholm's 2008 Budget Invests in Michigan's People* from February 8, 2007, states, "To provide the most cost-effective and safe prison system for the state and its residents, the governor's budget recommends comprehensive policy reforms. ...The reforms include: expanding the successful Michigan Prisoner Re-Entry Initiative; closely examining the need for clemency and parole for the elderly and medically fragile; recommends changing the sentencing guidelines for non-violent offenders; and implementing

MDOC's August Transfer Plan that will allow final closure of JMF (the Southern Michigan Correctional Facility at Jackson).

Appeals Sent Back Without a Decision on September 24, 2007

In a ruling on September 24, 2007 the Court of Appeals remanded six orders entered by Judge Enslin between November 2006 and May 14, 2007.⁴ The appeals were sent back for the new judge to consider the rulings in light of recent changes by the MDOC. The orders involved in the appeal include these two:

November 13, 2006 Ruling on Mental Health and Use of Punitive Restraints⁵

Following an evidentiary hearing, Judge Enslin granted the prisoner plaintiffs a preliminary injunction that reopened mental health care portions of the consent decree that were terminated under the PLRA in several years earlier, in 2000. The Court granted relief pursuant to Federal Rule of Civil Procedure 60(b)(6). Judge Enslin explained that jurisdiction over other aspects of the case has been ongoing because enforcement of the medical health and fire safety provisions of the consent decree continues. The judge explained that under the circumstances it is necessary to reopen the mental health care portions of the consent decree as part of this case because that will impact the Court's ability to oversee the never-terminated portions of the consent decree.

In granting relief, the judge found that the punitive use of in-cell restraints "constitutes torture and violates the Eighth Amendment," and the practice is enjoined.⁶ The Court also held that the psychiatric and psychological staffing levels were constitutionally inadequate, and ordered Defendants to file a staffing plan. The Court also required daily psychologist rounds in the segregation unit and required protocols for medical/mental health staff and interdisciplinary

the Community Placement Program." <http://www.michigan.gov/gov/0,1607,7-168--161937--,00.html>. See also, Gary Heinlein. "Budget Ax Falls on Prison in Jackson." The Detroit News, February 21, 2007.

¹³ David Eggert. "Federal Lawsuit could keep Jackson Prison Open." Michigan Lawyers' Weekly, June 11, 2007: 3.

meetings after finding that patients with medical and mental health problems fall into "the black hole between the disciplines."⁷

December 7, 2006 Ruling on Medical Health⁸

Following an evidentiary hearing, Judge Enslin granted the prisoner plaintiffs partial relief finding Defendants in civil contempt for failing to meet staffing obligations imposed by court order, issued a permanent injunction ordering continuation of the plan to remedy constitutionally inadequate health care provided to prisoners and ordered creation of an Office of the Independent Monitor with special powers to take corrective actions regarding patient care.

Southern Michigan Prison (JMF) Closed on November 2, 2007.

Following the remand of the appeals on November 24, 2007, U.S. District Court Judge Robert J. Jonker permitted the MDOC to proceed with its closure plan, and on November 2, 2007 the facility closed.

Endnotes Current Status of Health Care Issues in Hadix

¹ From http://patstreater.com/html/case_updates.htm, reprinted here with permission.

² Hadix v. Johnson, 792 F. Supp. 527, 528 (E.D.Mich.1992).

³ Hadix v. Caruso, 461 F. Supp. 2d 574 (W.D. Mich. 2006).

⁴ Id.

⁵ Id.

⁶ Id., at 596.

⁷ Id., at 597-598.

⁸ Hadix v. Caruso, 465 F. Supp. 2d 776 (W.D. Mich. 2006) WL 3518260 .

Prison Legal Services of Michigan's Executive Director Sandra Girard gives her opinion on the closure of Hadix prisons

Some officials claim that JMF and part of SMT were the first to be chosen because they are the oldest prisons still in use in Michigan. It is true that the shell of the prison was built in the 1930s. However, the state spent millions of dollars to renovate this prison about 10 years ago. The entire inside of the prison was gutted, and only the exterior brick walls were left standing. Prefabricated cells were dropped in through the top of the building. Instead of maintaining the old *Alcatraz* gallery structure, floors were built across the first and third levels of cells, making common areas for prisoners housed on those floors. On its website, the MDOC even describes JMF as having "opened" in 1997.

I support the State's plan to close prisons but object to closing those prisons that are under the jurisdiction of the federal court in Hadix. The problems that exist in these prisons are not due to the physical plants (except for temperature control and ventilation). Those problems exist at almost all of the prisons. And, if more proof is needed, the part of SMN that the MDOC plans to keep open is the housing unit that has not been renovated. The housing unit which is being closed was renovated, but is a part of the Hadix facilities and is under Judge Enslin's jurisdiction. There are other prisons of roughly the same era that have not been renovated.

Marquette Branch Prison is also old and outdated. It opened in 1889! It is very hard for the MDOC administration to oversee MBP because it is so far away from Lansing. Newberry Correctional Facility (NCF) and Florence Crane Correctional Facility are also old, former mental health hospitals. There are many prisons, like Deerfield Correctional Facility, which are pole barns built as temporary facilities. The buildings have sealed concrete slab floors, weatherized walls covered with plaster board and acoustic-tile ceilings. These temporary pole barns have become permanent prisons, where people live in cubicles which now hold twice the number of prisoners they were built to house.

Judge Enslin once enjoined the MDOC from transferring ill prisoners before a plan for their care is developed and approved. As Judge Enslin pointed out in his March 6, 2007 Opinion in support of the injunction, "In 2002, the Court found that error and omissions in the transfer process perpetuate harm to prisoners by discontinuing medical care. (2002 Findings ¶ 925.) After that time, Defendants were given the opportunity to present evidence that they have cured defects in the transfer assessment process, but failed to do so during the last set of evidentiary hearings. Indeed, prior to those hearings, Plaintiffs' expert, Elizabeth J. Ferguson, studied some 40 prisoner transfer cases to comment on the effectiveness of the assessment process. What she found was that 19 of 40 cases surveyed involved failures to access medical and accommodation issues which resulted in unnecessary suffering and 2 treatment delays. (Ferguson Report, Dkt. No. 2054, Attach. at 20.) Of those cases, the majority did not receive necessary follow-up care following transfer. (*Id.*)"

However, the Sixth Circuit failed to address this issue in its September 24, 2007 opinion, which allowed the Federal District Judge to decide whether the MDOC can go forward with the closure. Judge Jonker, who took over the Hadix case from Judge Enslin, has removed the stay preventing the MDOC from closing the Jackson facilities. According to the MDOC's November 14, 2007 FYI Newsletter, the last prisoner left Southern Michigan Correctional facility on November 2, 2007.

History and Overview: Section Eight The Unmonitored Prisons

Who, then, is watching out for the estimated 47,000-plus prisoners who are **not** housed at the Hadix facilities, and those prisoners moved from the Hadix facilities after they are closed?

Despite recent media attention about the failures in prison health services, implementation of the Governor's August 2006 directive for a review of prison health care¹ is scheduled to be "publicly available after January 1, 2008."² The MDOC is in the process of making changes in the ways in which it delivers Health Care Services. They are developing a new RFP due to lack of bids from outside contractors on the original RFP--this has created a tentative six month contract extension with CMS.³ It is unclear whether the new plan will would exclude CMS from future service within the MDOC.⁴

Notwithstanding their responsibility to represent the interests of prisoners, there has been no legislative oversight of the delivery of health and mental health care for prisoners, with the exception of continued and increased funding for CMS. This ignorance has not escaped the notice of the media; in an August, 2006 article, *Detroit Free Press* reporter Jeff Gerritt noted: "Michigan legislators remain blissfully ignorant about a big and growing part of the state budget, despite widespread evidence of almost criminal incompetence and negligence in how the money is spent. Even State Majority Leader Ken Sikkema, R-Wyoming, one of the state's most capable, experienced and knowledgeable legislators, appeared clueless when I asked him recently about this issue. Practically the only information legislators receive on the CMS contract is a one-page summary twice a year."⁵

Further apathy was demonstrated by the lack of a solid legislative presence at the public hearing held jointly by the American Friends Service Committee and Prison Legal Services of Michigan on November

16, 2006, in spite of invitations to all 148 legislators and their staff. One House Fiscal Agency staffer attended, as well as four legislative aides. At this hearing, forty people gave testimony about health care services in prison, including students who read testimony written by current prisoners, friends and family of prisoners who testified about their experiences dealing with prison health care from the outside, and two former MDOC psychologists who testified about problems with mental health care services.



Approximately 100 people attended the hearing.

Testimony was also heard from Lloyd Byron Martel (pictured on right speaking at public hearing), a former prisoner who was serving a one to four year sentence for fleeing and eluding, who was released on medical parole after he was pronounced terminally ill from colon cancer. Mr. Martel's cancer was detected while he was incarcerated in the MDOC, but he was not diagnosed until 11 months later, at which time he was too ill for treatment. Mr. Martel died within months of his medical parole.



The people affected by these issues are under-represented by their elected officials.

Millions of dollars are paid each year to CMS, a provider that has been sued and found liable for negligent treatment throughout the country, and the only public evidence of oversight by the MDOC itself is a biannual report to the Legislature consisting of a statement that all is well and that no complaints suggest otherwise.⁶ Considering the volume of serious problems uncovered by the Hadix monitors at just three MDOC facilities, these glowing reports seem implausible at best.

It is heartening that the House Appropriations Subcommittee on Corrections held multiple public hearings during their discussions of the 2007 budget regarding the problems with health care and mental health care services. Their interest was prompted, in part, by a *60 Minutes* episode entitled *The Death of Timothy Souders*, which highlighted the deaths of Timothy Souders and other prisoners housed in segregation cells in Michigan prisons.⁷ But the reality is that without the support of its colleagues, this three-member subcommittee has a mountain to climb.

Until then, the work of legislative and departmental change must be cultivated by the public, with the help of the media. The same problems identified by U.S. District Court Monitor Dr. Robert Cohen at the Hadix facilities exist **in equal or greater measure** at the 47 unmonitored facilities. The lack of oversight at 47 unmonitored prisons and the complaints coming out of them prompted this Committee to undertake this medical review project – to receive and report complaints about health care throughout the state and offer recommendations to resolve these issues.

Recommendations for Change

PROBLEM: There is no independent or legislative oversight of prison healthcare or the private, for-profit corporation providing care.

RECOMMENDED SOLUTION: The legislature should create a commission to conduct annual, open, well-advertised hearings concerning medical and mental health care treatment. The commission should consist of representatives from the legislative and executive branch of Michigan government, medical doctors, university medical staff, prisoner advocates, clergy, general public, attorneys, etc. Legislators should allow testimony at these hearings, including that of prisoners through written statements and testimony of the public, including attorneys, families of prisoners, and advocates. This commission should hold bimonthly meetings to discuss issues concerning health care and mental health care within the MDOC, and should have a clear mandate and authority to make recommendations as directed by the legislative committee outlined below.

A permanent legislative committee should be created to oversee health care and mental health care within the MDOC. This committee should be co-chaired by the chairperson of the Senate and House Appropriations Sub-committees on Corrections.

With proper oversight, hopefully the State of Michigan will not repeat the mistakes that have been made in the past, where large sums of money were spent for substandard medical and mental health care.

Endnotes History and Overview: Section Eight

¹ Jeff Gerritt. "Granholm orders review of prison health care systems: Move follows probe of death, longtime troubles." *The Detroit Free Press*, August 22, 2006.

² Request for Information, Prisoner Health Care, November 2007, Questions received after the RFI Meeting, p.9.

³ "The state will have to delay for at least six months its plan to reform prison health care with regional managed-care contracts -- in effect, HMOs for inmates. The Department of Corrections received only three bids for eight contracts that the state had hoped to award next month. Seeking more qualified bidders, Corrections will now rework its proposal with the help of health care providers." Editorial. "Get it right on prison health care." *The Detroit Free Press*, December 6, 2007.

⁴ Editorial. "A dose of hope for prison care." *The Detroit Free Press*, July 18, 2007. Jeff Gerritt. "Get it right on prison health care." *The Detroit Free Press*, December 6, 2007.

⁵ Jeff Gerritt. "Unhealthy confinement: Inmates aren't the only ones who pay for poor medical care in prison." *The Detroit Free Press*, August 21, 2006.

⁶ The following quotes are taken directly from, *REPORT TO THE LEGISLATURE Pursuant to P.A. 331 of 2006 Section 902(1) Health Care Services Contract Payments/Status and Prisoner Health Care Quality Assessment Report, January 1, 2007:*

"Investigation of prisoner grievances, family complaints and issues brought to the MDOC by Legislators have generally found that the quality of services provided by CMS meets MDOC expectations."

"The overall assessment of Prisoner Health Care Quality is that services provided by CMS have generally met MDOC expectations. However the demand for these services has been steadily increasing in the past year as the population served has grown and aged. Overall referrals for Specialty Care Services have increased by 22% for the first 11 months of this year as compared to the same time period in 2005 (11 months). Services are meeting the community standard."

The full bi-annual Health Care Services Contract Payments/Status and Prisoner Health Care Quality Assessment reports from 2000 through 2007 can be found at http://www.michigan.gov/corrections/0,1607,7-119-1441_1513---,00.html.

See also, earlier references to the biannual Health Care Services Contract Payments/Status and Prisoner Health Care Quality Assessment Reports, available on the MDOC website.

⁷ Aired February 14, 2007 on CBS's *60 Minutes*.

History and Overview: Section Nine Cloak of Secrecy – Restricting Prisoner Access to Medical Records

Another systemic problem with medical and mental health care services is the severe limitation on prisoners' access to information about their own health condition, treatment recommendations, and mental and physical health care treatment. Most of the time, prisoners are denied the right to examine their medical files during health care visits, and the MDOC has made it difficult (if not impossible) for them to access their records by charging them for copies of their records.¹ Although it would be a positive contribution to the resolution of legitimate concerns, prisoners are not given copies of relevant medical documents as they are created or even when relied on in response to a kite, question or grievance. Prisoners are not even provided with a synopsis of their visits to the doctor or Medical Service Provider.

In 2004, Michigan's Legislature passed the Medical Records Access Act.² This Act intended to give all patients expanded rights of affordable access to their own medical records by examination, affordable copies (free for the "medically indigent"), or both.³

Unfortunately, this Act has had the reverse effect for prisoners – it made these records *more* expensive for their family, friends, and advocates to obtain. Prisoners are excluded from the definition of "medically indigent" persons who are entitled to one free set of copies of their records.⁴ The only way prisoners can obtain their health care records is if they can pay 25¢ per page for copies.⁵ They must make a "...specific, written request to the appropriate health information manager or designee...", and the MDOC is supposed to respond to this request, but there is no time deadline for responding.⁶ When prisoners cannot afford to purchase copies of their records, they often rely on family members, friends or agency advocates to obtain their records for them.⁷ However, this was recently made more difficult by the passage of this Act because it has been made more expensive. For non-medically indigent people, the Act sets forth a fee structure limiting the charges for copying records. The fees allowed under the Act are discretionary, not mandatory; the Act merely sets a *maximum* that could be charged.

The provision of the Act pertaining to cost structure for obtaining records has actually *harmed* prisoners' access to their records. While prisoners can obtain their records for 25¢ per page, prisoner representatives (such as AFSC, PLSM, families, attorneys, and others) are charged the *maximum* fees allowed by the Act, including a \$20 fee regardless of the number of documents requested plus a per-page charge.⁸ Prior to the Act, prisoner advocates were able to obtain medical records through the Freedom of Information Act at the same 25¢/page cost that prisoners were charged. Now, many advocacy groups or legal aid organizations do not have the funds to make these purchases and cannot strongly advocate for prisoners with regard to medical issues. Thus, some of the low income people that the Act sought to protect are now unable to access their medical records.

If a prisoner lacks sufficient funds to purchase copies, he will never know what his own medical record says.⁹ Denial of access to records due to lack of funds is completely unnecessary and is not allowed under the Act.

The other way the Medical Record Access Act is supposed to protect access to medical records is by instructing health care providers to allow patients and their advocates to freely review their medical records.¹⁰ However, the MDOC does not give prisoners this option of medical file review. One prisoner filed a grievance on the issue, notifying the MDOC its actions were inconsistent with the language of the Medical Records Act.¹¹ The step I respondent denied the prisoner's request to examine his own medical records, citing MDOC policy which does not allow such examination. The grievance respondent failed to consider the provisions of the Act, perhaps because the MDOC has yet to incorporate its requirements into its policy governing prisoner access to their medical records. This must be done to uphold the MDOC's argument that it is indeed meeting the intent of the Act.

In addition to being a violation of this Act, this prohibition is contrary to common sense. It complicates a prisoner's situation because he bases his analysis of his health care status and treatment on memory rather than documentation. If records were more accessible, prisoners would have more insight into their own medical conditions, they would be better, more informed advocates for their own treatment, and they would have a more realistic perception of their own health status and care.

The severe lack of effective communication between patient and health care provider in prisons is nearly equivalent to denying necessary care, to the extent that it prevents the prisoner from being a well-informed partner in his own health management. Furthermore, because prisoners are not allowed to view their medical records, they are further hampered in their ability to purchase copies of their records, as they have no idea what documents to request. The combination of these two factors make prisoners more likely to complain about the treatment they are receiving and it is another way in which the health care delivery system is closed to oversight, even by the individual receiving the care.

Recommendations for Change

PROBLEM: Prisoners have no regular ability to view their medical records; lack of knowledge about their condition and treatment has many ill effects, including confusion and anger, hampered ability to engage in appropriate self-care, and an inability to consult with advocates concerning their condition and care.

RECOMMENDED SOLUTION: Prisoners should receive a print-out report from every health care visit, documenting the nature of the visit and all other pertinent medical information from the visit. This information should be entered into the MDOC's computerized medical information database. If medication is ordered, health care staff should give each prisoner information on the medication. If a diagnosis is determined, the print-out should include an explanation of the diagnosis for the prisoner. All documentation provided to prisoners should be legible, including signatures.

The MDOC should not charge a fee for copies of medical records not originally provided to prisoners, particularly to indigent prisoners and other prisoners who lack sufficient funds because they do not even earn \$20 per month. Current costs of 25¢/page should not be increased unless and until prisoner wages are increased.

The MDOC should immediately make one copy of medical records available to indigent prisoners and their advocates for free, and immediate action should be taken to codify a change in MDOC policy, allowing prisoners the opportunity to examine their medical records.

The Legislature should immediately amend the Medical Records Access Act, Public Act 47 of 2004, so that it includes prisoners as a medically indigent class. The legislature should also immediately make clear that the inspection requirement of the medical records access act (MCL 333.26261) applies to prisoners already. The Legislature should also act to prohibit the MDOC from charging prisoners a fee for the first copy of their medical records.

The Legislature intended to increase availability of medical records when it passed the Medical Records Access Act, and prisoners should also benefit from this intent. There are many reasons to keep prisoners informed of the status of their health care treatment, and the MDOC should allow prisoners to access their records and encourage education about their own condition and treatment.

Endnotes History and Overview: Section Nine

¹ Access to medical records is covered by MDOC Operating Procedure 01.06.110A, Prisoner Access to Medical Records. The MDOC's Operating Procedures are not available on the MDOC website, but can be obtained through the Freedom of Information Act or upon request to the MDOC.

² Medical Records Access Act, MCL 333.26261 et seq.

³ Id.

⁴ Under the Act, the term "medically indigent individual" is defined under section 106 of the public health code, MCL 333.2701.

⁵ MDOC Operating Procedure 01.06.110A, Prisoner Access to Medical Records.

⁶ MDOC Policy Directive 03.04.108(S), "A prisoner may receive copies of documents contained within his/her health record by making a specific, written request to the appropriate health information manager or designee or paying the per-page fee, as set forth in OP 01.06.110-A, Prisoner Access to Medical Records." This policy directive is available on the MDOC's website.

⁷ Many prisoners cannot afford to purchase their records. According to Attachment A to PD 05.02.110, Prisoner Work Assignment Pay and School Stipend, the "Standard Pay Scale" for prisoner work assignments ranges from an entry rate of 74 cents per day for unskilled workers, to a high of \$1.77 per day for skilled workers. Those with advanced education/training in their areas of expertise can earn as much as \$3.34 per day. Furthermore, many prisoners do not even have jobs when the number of prisoners in a facility exceeds the number of available jobs; other prisoners are unable to work due to medical conditions.

⁸ The maximum charge for paper copies of records under the Act, in addition to the initial \$20 fee, is "(i) One dollar per page for the first 20 pages. (ii) Fifty cents per page for pages 21 through 50. (iii) Twenty cents for pages 51 and over." MCLA 333.26269(1)(b). AFSC discovered from a state legislator that all state institutions are charging the maximum fee for copies across the board, which means that the MDOC is simply following suit (although there is no exception for indigent prisoners, like there is for indigent non-prisoners).

⁹ There is an exception to this rule: if a medical care issue is in pending litigation, the MDOC must loan a prisoner the money for copying the records, although it is impractical to expect a prisoner to reach this stage of litigation without having copies of his or her records.

¹⁰ Public Act 47 of 2004, §5; codified at MCL 333.26265(1)-(2).

¹¹ Grievance JCF 05 12 024140 12Z.

History and Overview: Section Ten Furthering the Cloak of Secrecy: MDOC's and CMS' Refusal to Work with Prisoners' Advocates or Representatives

Why Advocacy for Prisoners Matters

Some may wonder why it matters if people in prison have outside advocates who help them with personal and systemic issues. The question is valid and easily answered. The prison system is a closed bureaucracy; it is incredibly difficult to navigate. Many people who end up inside the system have severed family connections, or never had strong ties before going to prison. Some people in prison suffer from mental illness. They must work alone through a system that is complicated, ever changing, and closed to public scrutiny.

Even for those prisoners who have family connections, the system is still complicated and difficult to maneuver. Advocates act as tools to guide people through the MDOC system. Advocates offer a unique, understanding perspective that is not tied to a social system (social services, public welfare system, community mental health, public education system, criminal justice system, etc) that has often failed the men and women who end up locked behind the prison doors.

Advocates can also be useful to the MDOC, as they are in a position to bring neglected problems to the attention of MDOC employees who can resolve the issues. This can in turn prevent small problems from turning into large problems and avoid litigation. Advocates also help the MDOC when they assist prisoners in following the correct procedures to accomplish their goals. Many times, when an advocate takes the time to explain a procedure so that the prisoner can understand, and give the prisoner faith that the procedure will help the problem, orderly resolutions follow. Advocates can also help a prisoner organize and articulate his or her concerns in more concise ways, allowing the MDOC employees to have a clearer picture of what the prisoner's problems are and what issues take priority over other complaints.

Advocates' work with prisoners may also help keep down the level of a prisoner's acting out or misbehaving due to frustration and aggravation, because advocates give an outlet for a prisoner's problems to be voiced, heard, and responded to. Advocates' interactions with prisoners also may alleviate prisoners' sense of hopelessness about the futility of the system or their situation. This hopelessness can lead to more acting out, misbehaving, or depression. Finally, advocates' work with prisoners is key to public accountability for the MDOC, giving employees a sense that someone is watching them and trying to be sure that correct policies are followed. For these reasons, and many more, prisoner advocates are useful to everyone involved in the prison system, and as such, should be welcomed by all parties. Unfortunately, this is not always the case, and the MDOC often fails to recognize the need for advocates.

The MDOC's denials of patients' rights to have their health care information disclosed to and discussed with a patient representative violate the Medical Records Access Act.¹ To date, the provisions of this Act have not been incorporated into MDOC policy that controls access to prisoner health records, although it could easily be done.²

The MDOC often declines to discuss a prisoner's health care with anyone outside the system, even when the prisoner specifically authorizes release of this information.³ For example, for years, the American Friends Service Committee (AFSC) (which regularly attempts to advocate on behalf of prisoners) had prisoners forward a signed release to their medical file. This allowed AFSC to have access to the prisoner's medical history and treatment information. In the last two years, however, the Medical Risk Management Office has refused to accept this practice as a way for AFSC to access a prisoner's records. Instead, AFSC must endure more red tape and bureaucratic obstacles in its efforts to assist prisoners, because they now must send an original release to Central Office, which adds weeks to the time it takes to actually help someone or investigate a case. AFSC has also had experiences where the MDOC has refused to discuss a case or give information to advocates even when they have a signed release.

Recommendations for Change

PROBLEM: In addition to limiting a prisoner's own access to her records, the MDOC further limits advocates' and prisoners' ability to shed light on medical problems.

RECOMMENDED SOLUTION: The MDOC should create a standard policy that allows prisoners' advocates to have access to a prisoner's medical records (upon production of a signed release) and the MDOC should create a policy to facilitate communication between MDOC, the medical care providers, and prisoners' advocates.

Endnotes History and Overview: Section Ten

¹ MCL 333.26263: *As used in this act:(a) "Authorized representative" means either of the following:*
(i) A person empowered by the patient by explicit written authorization to act on the patient's behalf to access, disclose, or consent to the disclosure of the patient's medical record, in accordance with this act.
(ii) If the patient is deceased, his or her personal representative or his or her heirs at law or the beneficiary of the patient's life insurance policy, to the extent provided by section 2157 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2157.

² MDOC Policy Directive 03.04.108(S) governs a prisoner's access to her medical records.

³ MDOC Policy Directive 03.04.108(S), states, "Health information shall be released only upon the prisoner's written authorization or court order, except as follows:..."

Health Care Behind Bars: A Brief Overview

Think of your most recent trip to the doctor. Compare this process with the following process an MDOC prisoner may endure whenever he or she needs medical care:¹

PROCESS FOR RECEIVING HEALTH CARE IN MICHIGAN'S PRISONS

As explained by a prisoner who has spent over 30 years in the MDOC, there are three ways to initiate a health care visit in the Michigan prison system:

1. A prisoner who is experiencing some kind of health care issue may send a Health Care Request form to the medical office.² Depending on the nature of the prisoner's health complaint, health care staff may respond in a day or two, although at times this may take longer.³
 - **NON-URGENT RESPONSES:** The typical response to health care request forms inquiring about a medication refill or a cancelled Medical Service Provider (MSP) appointment is, "Watch the call out." Call out lists are constructed on a daily basis and are the vehicle for granting prisoners permission to move to certain areas of the prison and participate in specific activities (i.e. a visit to health care, time in the library, participation in a volunteer led AA group, etc.).
 - **CHRONIC CARE/NEW ISSUE RESPONSES:** If the health care request form involves a chronic care issue or a new issue, the response will tell you that you are scheduled for a sick call. At sick call, a prisoner reaffirms the content of the health care request form with the nurse and then the nurse makes a decision about how to deal with the issue. For instance, the nurse may decide to refer the prisoner to an MSP, or in more urgent situations, the nurse may get the prisoner in to see the MSP that very day.
2. The second way a prisoner who is experiencing some kind of urgent health care issue to get services is to have a housing unit supervisor or assignment supervisor call Health Services. Often, a prisoner will be evaluated by a nurse that same day, but Health Services will require that the prisoner bring a signed health care request form to the evaluation. Sometimes Health Care Services assigns a co-pay, and sometimes, they do not.⁴
3. The third way a prisoner can get health care services is to fall down, pass out, or have a health emergency. In those situations, on site staff notify health services, a nurse or two are dispatched, the prisoner is evaluated and transported to either Health Services at the prison or transported by outside ambulance to a local hospital.

Endnotes

¹ This is a prisoner's description of the practical application of the MDOC's policy concerning procedures for accessing health care, MDOC Policy Directive 03.04.100.

² The MDOC has complained that prisoners over-use this system, and send health care kites for minor problems. This trend (to the extent that it is true) is likely caused by the prisoners' forced reliance on the MDOC to meet every daily need – part of the institutionalization process is that freedom of movement is very restricted and every action must be requested, approved, and monitored.

³ According to policy, this response must be made within one business day after receipt of the request. MDOC Policy Directive 03.01.100(II).

⁴ This is dictated by MDOC Policy Directive 03.04.101.

PART TWO

CASE STUDIES

Introduction to Part Two: Case Studies

The American Friends Service Committee's Michigan Criminal Justice Program and Prison Legal Services of Michigan, Inc., combined, receive about 300 letters from prisoners per month that complain of problems obtaining medical care, incidents of improper or delayed medical care, and other critical failures of the health care delivery system in the MDOC.

The Hadix case attempted to address these problems at three (two now closed) MDOC facilities, but even after years of litigation and very close monitoring, egregious and widespread shortcomings have been exposed. With this report, the advocates behind this report are attempting to outline the myriad other problems related to health care that plague all of the MDOC's facilities.

The second half of this report highlights case studies as examples of the results of the institutional shortcomings outlined in the first half of the report. The MDOC and medical care system is so huge that anecdotal stories, supported by medical and mental health documentation, are the most feasible way to study the system as a whole. For every example cited here that has been thoroughly researched and vetted, there are countless more that prisoners have complained of, and a vast but unknown quantity of issues that have never been reported to either agency. These examples are just a few of the thousands received from prisoners and their friends and family members.

People who choose to come forward to expose the failings of the system as it exists have taken a grave risk, especially by allowing their names to be part of this report. We are grateful to these prisoners for their bravery, and hope that they will be rewarded by knowing they helped positive change be made. If a thorough look is taken at CMS and health care delivery within the MDOC, we hope that a plan can be created that will address the issues, cure the failures, and stop the money-wasting, neglectful system that governs the current delivery of physical and mental health care behind the bars of our state's prisons. This report provides an external perspective, driven by complaints from the very people that the failing system harms, which is essential in any review and future planning process.

Case Studies: Section One Medication Issues

(A) Failure to Provide Information about Medication

To make informed decisions about their medical treatment, people must have information about the medications they are receiving. In the free world, doctors and pharmacists regularly give patients printed information about their prescriptions. However, the MDOC does not routinely include medication information when it dispenses prescriptions for prisoners.¹ Besides the obvious benefits that would come from providing prisoners with written information about their medications, the United States Supreme Court has ruled that people have the right to refuse unwanted medical treatment,² and a federal court has specifically recognized a prisoner's right to be informed about the medication that is being prescribed.³

This need for education about medication is also highlighted by one of the shortcomings noted in the Third Report of the Hadix Associate Monitor. The report found that the pharmacy program at these facilities "...is also missing drug interaction identification software which includes HIV medications."⁴

The following example demonstrates three separate but related systemic failings. In this instance, medical staff created the first problem by failing to work cooperatively with the prisoner's other treating physician. This mistake was then compounded by medical staff failing to give this prisoner information about the medication he was receiving. The final failing was in the grievance system – had the prisoner's grievance been properly investigated and answered, the underlying problem could have been solved in a timely and comprehensively.

Andre Davis has leukemia. He was housed at the Cotton Correctional Facility while receiving chemotherapy under the management of an off-site oncology specialist at Foote Hospital in Jackson. At the same time, he sought treatment from the prison doctor regarding neuropathy in his feet. He was prescribed carbamazepine (Tegretol), a medication contraindicated in individuals with blood disorders.⁵ The prison doctor never informed the oncologist of the Tegretol prescription. Although Mr. Davis asked in a grievance for an explanation as to why Tegretol had been ordered, because he had been told it was a medication for seizures, the MDOC never answered this question.⁶ When Mr. Davis' blood count was depressed at repeated testing several months later, he underwent a painful bone marrow biopsy. It was only when that procedure failed to explain the depressed blood count that the oncologist discovered that Mr. Davis was prescribed and receiving Tegretol, and ordered him to stop taking it. It took a second grievance, four months after the first one, before the MDOC acknowledged the adverse effects of Tegretol on patients with blood disorders.⁷

Had Mr. Davis received information about Tegretol, including possible side effects and interactions with other drugs or medical conditions, he would have been able to make the informed choice as to whether or not he wanted this treatment. He also would have known to alert his oncologist about the possibility of the Tegretol interfering with his leukemia treatment. The failure of the MDOC in not noting the contraindication of the medication, and the failure to give Mr. Davis informational materials about the drug left the MDOC in jeopardy of litigation. More importantly, this systemic failure left Mr. Davis' health at risk

and made him undergo an painful, expensive, ultimately unnecessary, procedure.

Recommendations for Change

PROBLEM: Prisoners are not given the knowledge that they need, such as information about their prescriptions, so they are not able to make informed decisions about their health care. This can also lead to potentially life-threatening situations for prisoners, and makes them unable to be effective advocates for their own health care treatment.

RECOMMENDED SOLUTION: The MDOC should provide patients the medication package insert information on all their medications upon request. The MDOC should also obtain a prisoner's informed consent for all recommended treatments and prescribed medications, not just surgical or invasive procedures, which is all that is currently required under PD 03.04.105.

(B) Pharmacy Failures

Failing to provide prisoners with the medication they have been prescribed could become an even more pressing problem than the lack of education provided with these prescriptions. Within the MDOC, prisoners often have problems simply *receiving* prescribed medications, and continuing with a consistent treatment regimen upon transfer to another prison.

In response to the Hadix court-ordered review of facilities and delivery of medical and mental health treatment, in 2004, Dr. Robert L. Cohen, MD, the Associate Monitor in Hadix, reported to the court:

Many of the problems with the delivery of medical care at the Hadix facilities derive from failures in the pharmacy system. I have not been provided with evidence of any significant quality assurance or quality improvement activity in the pharmacy....I am not aware of any efforts by Dr. Naylor to evaluate the pharmacy system, identify the sources of the current problems, and work with the pharmacy director, the nursing directors, and the Health Unit Managers to solve them.

Although theoretically the chronic care system provides for automatic renewals of medications it is widely assumed, by prisoners, as well as medical staff, that the automatic renewal system fails on a regular basis. The chronic care system, guaranteeing at least four encounters (two by MSPs and two by RNs) each year for each patient, does not incorporate a mechanism to discover whether chronic medications are being received as ordered. In fact, if there is a delay in the scheduled chronic care clinicmedications may not be reordered, and the pharmacy does not notify the medical staff that chronic medications are about to expire.

There is no functioning system which allows the nursing staff at the facilities to know if ordered medications, both new, and renewal medication, have been received. The system is therefore ultimately, and structurally dependent on the 'medication kite' to determine if ordered medications have been received or not.

...Because there are multiple ways that medications are ordered, there is no system in general use that can provide the nurses and the MSPs with an accurate current list of medications for each patient. There is also no system by which the facilities know what medications they are awaiting, which have been received, and which are being delayed....This system regularly fails, and results in prisoners with serious medical problems not receiving their chronic medications.⁸

Shortcomings like these at a facility which, at the time of the report, had been under federal court scrutiny of its medical care, are inexcusable. From prisoners' reports about pharmacy and prescription problems at other facilities, we believe problems like these exist throughout MDOC facilities, not just at the Hadix prisons.

Although Dr. Cohen reported on the pharmacy shortcomings at Hadix facilities in 2004, the major problems were have not been resolved in any way. For example, in May 2006, the pharmacy system at these three prisons totally failed for at least five days.

When Dr. Cohen visited the Hadix prisons on May 31 and June 1, 2006, prisoners undergoing hemodialysis⁹ at Southern Michigan Correctional (JMF) advised him that they had not been receiving their anti-hypertension medications for five days. The monitor's follow-up with health care staff at JMF revealed that prisoners prescribed ongoing medications for chronic diseases were many days behind in receiving those medications. Prisoners whose medications had run out on May 26, 2006 had not received refills. Exacerbating the situation, the Duane Waters Hospital pharmacy reported that the medication orders were filled, when in fact, they were not.

On June 2, 2006, Dr. Cohen wrote to Judge Richard Enslin outlining his concerns after the visit. His letter included the following excerpt:

Because of these failure[s], a large number of prisoners with chronic medical problems including seizure disorders, HIV infection, hypertension, and diabetes, had not received their medications for approximately five days.

I do not know how long the problem has existed although some serious problems involving transmission of prescriptions to the pharmacy were known to medical staff by May19th....As of the morning of June 1, 2006, when I visited the Duane Waters pharmacy, the staff were making no efforts to address this issue, and informed me that they had no plan to do so. Many prescriptions were being filled in at the local Walgreen's pharmacy, but no rapid effective solution to this critical problem had been formulated or implemented.

This is an extremely dangerous situation, posing a critical risk to the health of many prisoners at the Hadix facilities, and it must be remedied as quickly as possible.¹⁰

Recommendations for Change

PROBLEM: The MDOC creates medical emergencies for prisoners by not providing pharmaceutical refills and MDOC medical staff orders when needed.

RECOMMENDED SOLUTION: The MDOC should assure that medication renewals/refills are made available to prisoners in a timely fashion. Prisoners receiving medications for chronic conditions should be given a one year prescription with automatic monthly refills, so that doctors do not have to sign off monthly on chronic care patients' medications.

It is obvious how disastrous these pharmacy failures are to prisoners and their ongoing health care treatment; this is a basic need that must be met by the MDOC health care providers.

Endnotes Case Studies: Section One

¹ The only policy reference to health care education is contained in MDOC Policy Directive 03.04.100(X), which states, "Health care staff shall schedule an annual health care screening appointment for each prisoner...within 30 calendar days before or after the prisoner's birthday... The screening also shall include the following:...6. Providing health education/disease prevention information, including TB, HIV/AIDS, HCV, smoking cessation, and breast and testicular self exam. 7. Reviewing and updating as necessary chronic disease information."

² Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 278 (1990), where Supreme Court stated a "person has a constitutionally protected liberty interest in refusing unwanted medical treatment." Washington v. Harper, 494 U.S. 210, 221 (1990) (recognizing a prisoner's "significant liberty interest in avoiding the unwanted administration of antipsychotic drugs").

³ White v. Napoleon, 897 F.2d 103 (3d Cir. 1990), where the Third Circuit upheld a prisoner's claim that a prison doctor's refusal to answer his questions about prescribed medication violated the prisoner's Fourteenth Amendment rights.

⁴ Third Report of the Associate Monitor in Hadix v. Johnson, by Robert L. Cohen, MD, August 22, 2006, page 7.

⁵ <http://www.pharma.us.novartis.com/product/pi/pdf/tegretol.pdf>. According to the Novartis ® web site, Tegretol carries the following warning from the manufacturer: "Contraindications Tegretol should not be used in patients with a history of previous bone marrow depression, hepatic porphyrias. According to the Medline Plus web site, a service of the National Library of Medicine and the National Institutes of Health, Carbamazepine [Tegretol] may decrease the number of blood cells produced by the body. In rare cases, the number of blood cells may decrease enough to cause serious or life-threatening health problems. Patients are told to contact their doctor if they have ever had a decreased number of blood cells, especially if it was caused by another medication."

⁶ Grievance No. JCF 2005 05-1133-12F; Step II grievance submitted on 6/25/05; from Step II grievance response, dated 12/8/05: "Summary of Step II investigation: Based on grievant's symptoms, Mr. Davis was prescribed medication by his medical service provider. Conclusion: Appropriate medical treatment was provided for grievant's health care issue."

⁷ Grievance No. JCF 2005 05-1133-12F, from third step response received on 1/14/06: "Grievant alleges that his MSP prescribed medication that was contrary to his chemotherapy. This matter is being reviewed for quality assurance purposes. It is noted that the Step II response was delayed for an inordinate amount of time. That should not have occurred..."

⁸ First Report on Medical Services, Hadix v. Johnson, Robert L. Cohen, MD, July 7, 2004, pages 16

and 17.

⁹ Dialysis is a way to filter the blood artificially, rather than by the kidneys. In hemodialysis, the patient's blood is circulated outside of the body into an artificial kidney machine. The blood is cleansed and returned to the patient's bloodstream. Treatments are usually required several times a week, for 4-8 hours each time. Hemodialysis is usually done in a dialysis center.

¹⁰ Dr. Cohen's letter to Judge Enslin, Hadix v. Caruso, U.S.D.C. W.D. Mich. Case No. 4:92-cv-00110-RAE, Document #2035 on PACER.

Case Studies: Section Two

CMS Denials of Requests for Specialty Services

Denial of treatment recommended after evaluation by a specialty provider is a common complaint throughout all MDOC facilities, even when the institutional Medical Services Provider (MSP) supports the request for treatment.

According to the MDOC's Operating Procedure for the Review and Appeals process for offsite health care, "When the level of care required by a prisoner is beyond the primary level of care provided at his/her institution, the prisoner's MSP is responsible for making referral to the Network Provider [managed care contract company] for such care."¹ If the request is denied by the Network Provider, the MSP can appeal the decision; there are two levels of appeal. The first level of appeal is heard by the "Network Provider's Medical Director of Utilization" who determines whether the case "meets MDOC criteria or an acceptable variance" in order to approve the care.² If the treatment is again denied, the MSP can appeal to the MDOC Regional Medical Officer, who then adds the case to the agenda for the next Medical Services Advisory Committee (MSAC) meeting. At the MSAC meeting, the group tries to reach consensus on approving or denying the treatment; if no consensus is met, the MDOC's Chief Medical Officer has the ultimate authority to decide the outcome.³

Further explanation of this process came from Dr. George Pramstaller in response to Senator Roger Kahn's questioning during a May 2, 2007 hearing before the Senate Committee on Judiciary and Corrections Appropriations Sub-Committee. The following is an excerpt from that transcript:⁴

Q: Wait a minute, wait a minute, the specialist is not going to be able to make that decision until he sees the patient, that ...his conclusion is going to come after the referral. I am asking you about the referral.

A: Maybe I can answer that, the referral for offsite care is made by the primary care provider and generally speaking, they put down a preferred time frame for that. That then goes to CMS, CMS says yea or maybe you ought to handle it this way. O.K.? They notify the Department of Corrections, my regional medical directors, every single case where the care is not approved or the care is in some way changed - what we call a redirection of care - my regional medical directors look at every one of those cases. If they have a problem with any of those, they either take the case back to the primary provider, discuss it with them and resolve it or they bring it to the medical advisory committee which is a committee that meets once a month and we take a look at those cases.

This can be a lengthy process, especially as the MSAC only meets once a month, and prisoners are dependent on their MSPs to make the appeal if treatment is denied. There is also a "pain management committee" that must approve MSP requests for prescriptions of drugs to treat pain. When CMS refuses to authorize treatment recommended by the specialists it has hired, prisoners' medical conditions go untreated and often worsen, causing prisoners to suffer and possibly causing more expensive treatment in later years.

As one example of this phenomenon, an orthopedic surgeon hired by CMS performed arthroscopic surgery on Steven O'Connor while he was housed at the Kinross Correctional

Facility in November 2001, when the surgery failed to resolve his problem. CMS authorized Mr. O'Connor to make a return visit to the specialist, who determined that O'Connor needed a full knee replacement because, "*...there is still a lot of pain and decreased range of motion. He has had multiple arthroscopic procedures and basically no articular cartilage left*" and X-rays demonstrated "*...severe collapse of the medial and lateral compartment*" of the right knee.⁵

CMS refused to approve the surgery, despite Mr. O'Connor's serious and painful condition, the specialist's attempts to resolve the problem first through a less drastic procedure, and the fact that the prison doctor strongly supported the recommended surgery.⁶ No explanation was given for this denial; as policy stands now, no explanation is required.

When Mr. O'Connor grieved the denial, he was told that he had not been denied care, but given alternative care.⁷ The alternate care given was a cane and pain medication, Tylenol up to 4.0 gm/day and Ultramtrate as indicated.⁸ Again, the reason for CMS' action was never shared with Mr. O'Connor. Although the prison doctor appealed CMS' decision to the MDOC's Medical Services Advisory Committee, Mr. O'Connor was told that the decision had been upheld, again without any explanation.

Despite his repeated requests over the years, as of August 2006 Mr. O'Connor had still not received the necessary and recommended surgery. Instead, he was prescribed gradually increasing doses of pain medications.

In the interim, his other knee has been adversely affected and his ambulation has deteriorated. In a 2006 progress note, the delay continued; he was promised resolution if he would lose thirty pounds, because "*surgeries[sic] more successful with weight reduction.*"⁹ O'Connor is 6' 4" tall and weighed about 220 pounds in June 2006, and only had ten more pounds to go to get to the stated goal of 210 lbs. Neither the grievance respondents nor anyone from Health Care ever explained to Mr. O'Connor how those ten pounds would make a difference at this stage.

Recommendations for Change

PROBLEM: When the contractor paying for services, rather than the medical doctors treating the patients, has the power to determine what services will be provided, patient care often gets lower priority than saving money, and bad decisions are made. When a prisoner is not provided with an explanation for why a treatment is denied, he or she has no recourse or ability to obtain outside review or an appeal of the decision.

RECOMMENDED SOLUTION: Refusals of treatment should be well documented and submitted to the new legislative prison health and mental health oversight committee recommended in this report and quality assurance review panel. When a specialty referral is not granted, the MDOC should assure that the patient is advised of the fact in writing, including the reason the request was pended or denied and, if the MSP does not appeal the denial, allow the patient to appeal the decision.

The MDOC should prohibit blanket denials of standard treatments and not allow the contactors to use blanket denials of treatment protocols. When disputes over treatments arise, the Chief Medical Officer should have final say over any HMO opinions.

Part of increasing the accountability of the MDOC, and the contractual entities providing prisoner health care services, is ensuring that there is outside oversight of treatment decisions, and transparency in the decision-making process.

Endnotes Case Studies: Section Two

¹ MDOC Operating Procedure 03.04.100 APA.

² MDOC Operating Procedure 03.04.100 APA paragraphs 14 and 15.

³ MDOC Operating Procedure 03.04.100 APA.

⁴ Partial Transcription of the May 2, 2007 hearing.

⁵ File note December 27, 2001 by Dr. Richard W. Ganzhorn of the Chippewa County War Memorial Hospital. Records obtained from Mr. O'Connor's institutional medical record.

⁶ According to a Memorandum dated November 26, 2002 from MDOC Chief Medical Officer George Pramstaller, D.O. to Dr. Stallman, MSP and Leslie Wright, Health Unit Manager, "The request for knee replacement surgery for Steven O'Connor, #180229, was reviewed by the Medical Services Advisory Committee at its October 29, 2002 meeting. As a result of this review, the request was: NON-APPROVAL UPHeld."

⁷ Grievance KCF 04-12-887-12d3, Step III Response prepared by Nancy Martin on February 28, 2005 and approved by Jim Armstrong on March 4, 2005. At one point another procedure (synvisc injection) was discussed, but another treating physician denied this alternate treatment.

⁸ Memorandum July 22, 2003 from MDOC Chief Medical Officer George Pramstaller, D.O. to Dr. Stallman, MSP and Leslie Wright, Health Unit Manager, re: Recommendations of Pain Management Committee. Special Accommodation Notice May 24, 2004 included the cane.

⁹ MDOC Progress note from Aster Berhane, MD, February 15, 2006.

Case Studies: Section Three

Delayed Access to Medical Service Providers (Doctors, Physician's Assistants and Nurse Practitioners)

There are various systemic reasons for delays in medical services in the MDOC. Many monthly Regional Health Care Reports indicate that there are staff shortages, trouble with burn-out among overworked staff, and difficulties in recruitment of new staff.¹

According to MDOC Health Care Monthly Reports, there are often large backlogs for Medical Service Provider (MSP) appointments. Here are some examples of the wait times:

- From a memo dated October 2006, "The date of the next available MSP appointment at MRF is 1/5/07, ARF is 12/26/06, and ATF is 12/21/06."²
- "RGC [Reception and Guidance Center] MSP appointment cancellations have risen to an all time high. There were 275 MSP cancellations. This compounds their ability to medically clear patients within policy time frames."³
- "Due to psychologist vacancies at various Region II facilities, the number of therapy groups for some of the psychologists has been reduced to below five in order to provide sufficient resources to respond to non-emergency, emergency, and segregation referrals until vacant positions are filled and the new psychologists are functioning independently."⁴
- According to staff meeting minutes dated January 25, 2005, it was reported that, "...the doctor is caught up with chronic cases and appointments are being made for June 2005."⁵

A shortage of MSPs was also a common problem throughout the Hadix litigation and monitoring. In his Third Report, the Associate Monitor Dr. Robert Cohen noted inadequate physician staffing throughout the Hadix facilities, including describing it as "extremely deficient" at two facilities, and commented on the significant turnover for CMS physicians.⁶ He also noted "chronic staffing problems with MSPs" in his First Report in July, 2004.⁷

(A) Delays Due to Position Vacancies

Only Medical Service Providers can prescribe medications, order tests or request CMS approval for specialty services. Accessibility to an MSP is critical, especially for those prisoners with chronic illnesses who need to see MSPs on a regular basis.

Even though policy sets timeframes in which medical appointments must be held,⁸ vacancies in nursing and MSP positions have delayed appointments and plagued facilities throughout the state for several years.

In May, 2006, Rodney Alston filed a grievance at the Ryan Correctional Facility when, after waiting six weeks for a scheduled MSP appointment, the appointment never occurred.⁹ Alston had not been seen by a physician (or any other MSP) for 6 months, even though he is a diabetic chronic care patient.¹⁰

The Step I respondent, acknowledging his chronic care status, advised Alston that "...Ryan Correctional Facility has been without full-time MSP services intermittently for months since 2005. Grievant will be scheduled for chronic care follow up with MSP as permitted by

scheduling concerns. Grievance partially resolved.”¹¹

Similarly, Robert Reynolds sent several requests for urgent health services at the Mound Correctional Facility in 2004, asking for treatment of an eye infection. These requests were not answered until custody staff personally intervened, first by phone call and then by personally delivering one of the kites to health services.

When Reynolds filed a grievance complaining about the delayed response to his urgent needs, he was told by the Respondent, *“Health [sic] is working with the staff to ensure that kites are responded to in a timely and more efficient manner. We regret the delay in seeing you in Health Care. You were [sic] on 8/25/04 and placed on treatment. ...Summary: Delay in scheduling you for assessment is regretted.”*¹²

We do not need to rely solely on prisoner grievances to support the thesis that the system is broken when it comes to getting appointments with MSPs. As further evidence of this problem, the November, 2005 minutes of the Muskegon Correctional Facility Warden’s Forum Health Services Committee provide a concise factual statement about the lack of health care providers at that prison and the adverse effects of that failure, particularly to those prisoners relying on the services for chronic diseases. The MDOC respondent, Health Unit Manager Michael Whalen, RN, answered the questions posed by the Warden’s Forum Health Services Committee about the delays:

You are correct. More than a third of the population have chronic diseases and these clinics are falling behind. We are actually behind more than two months. I have been ordered to schedule only those patients in poor control first. This means that most others that are in fair or good control won’t be seen for a year and in some cases even more than a year. The ambulatory clinic (are [sic] all other doctor appointments) is behind by over 200 appointments. I have made the same complaint to my chain of command for nearly three years. I have recommended and received more (MSP) Medical Service Provider hours....The increase in hours is still not enough to adequately take care of the rather ill population. I have made this known to my superiors through formalized reports.

The lack of appointments for ailing prisoners is the most basic example of the failures of the health care delivery systems at the MDOC. If a private health care facility were 200 appointments behind, this would be unacceptable to the patients waiting to see those doctors; unfortunately, prisoners have no ability to seek treatment or care elsewhere. When a simple doctor’s appointment is impossible to get, this is a symptom of a very broken health care delivery system.

(B) Delayed Access to Medical Service Providers Due to Other Reasons

Prisoners often have trouble getting appointments with MSPs even where these positions are fully staffed. As one example, while Scott Reyst was housed at the Standish Maximum Correctional Facility in January 2006, he was taken to an offsite hospital for a CT scan. During the hospital visit, the technician missed Mr. Reyst’s vein and injected the dye into his hand, causing it to swell and throb. The physician at the hospital ordered treatment consisting of warm and cold compresses, elevation of the hand, and an anti-inflammatory to treat the adverse effects of the technician’s mistake.

Two days after his return to the prison, he had not received *any* of the treatments the hospital had ordered. Mr. Reyst made an emergency call to Prison Legal Services of Michigan (PLSM) seeking help getting proper care for the injuries to his hand. He told PLSM that the nurse who was on duty when Mr. Reyst returned to the prison at 10 pm said he was not going to do the paperwork for the orders that night. The nurse told Mr. Reyst that he would be seen by a doctor the following day.

Mr. Reyst reported that he was seen by a nurse again the next day at 4:30 a.m. and at 5:00 p.m., but he still had not been seen by a physician or received any treatment, although it was two days after the incident. Mr. Reyst said that his hand was so swollen that he could barely move his fingers and had very little use of his hand. He said it was throbbing, and he felt like it was going to burst. He reported that the swelling was moving up his arm and he had developed white blisters. The blisters started on the top of his hand, but then began spreading between his fingers and up his arm. He said he was in serious pain and was very worried about the changes in his hand and arm. Mr. Reyst asked housing unit staff to arrange for a photo of his hand to be taken, but was told this could not be done because his medical issue was not "a security issue." He was indigent and could not pay for a picture himself.

PLSM related this information to Assistant Attorney General A. Peter Govorchin, who contacted the MDOC concerning the problem and replied to PLSM later that day, relaying the information that "*... his arm is swollen; however, the nurses at SMF are aware and he is being monitored. I was just advised by the Health Unit Manager that the prisoner was seen by the doctor, his arm is swollen but improving, it has been elevated and he was given Maalox with a small dosage of anti-inflammatory. The reason he was not given the anti-inflammatory on return from the hospital is because it was contra-indicated due to other medical problems the prisoner has. He will be checked daily but it does appear that he is improving. He was also given a photo of his hand.*"¹³

Another example of an unexplained and unnecessary delay in responding to an emergency request for an appointment and medical care happened to Scott Wolf, who was assaulted in April 2006 while held in the Kalamazoo County Jail.¹⁴ After assessment including x-rays and a CT scan, Wolf was found to have "extensive comminuted fractures involving the left orbit, the left maxillary sinus, and the left nasal bone along with extensive subcutaneous emphysema."¹⁵ Surgery was recommended by a doctor on May 1, 2006 after a consultation.¹⁶ According to Wolf, on the day that corrective surgery was scheduled, it was canceled, and Wolf was moved into the MDOC system at the Egeler Reception and Guidance Center.

While he was housed there, he was given a physical intake exam and x-rays were taken of his face. He was moved to the Boyer Road Correctional facility two weeks later, after the unit manager removed a medical hold.¹⁷ He continued to seek assistance from health care staff regarding his surgery. He was seen by a Physician's Assistant on July 13, 2006; the PA told Mr. Wolf that the fractures had healed, but that the nerve damage he was experiencing was permanent. Mr. Wolf explained that he was still feeling numbness in parts of his face, and pain in other areas and during certain activities. He kited Health Services on July 19, 2006 and was told that "*...Your chart was referred to the Nurse Practitioner by the nurse. You have been scheduled an appointment with the Nurse Practitioner to discuss your issues, however, her schedule is extremely full and you will be worked in. In the meantime, if you have any acute problems or concerns, please send a kite to health*

services.” Despite the evidence from the CT scan and prior x-rays, his next kite to Health Services on August 1, 2006 was answered with the statement, “Your x-rays were normal. You’re scheduled with nursing to evaluate need to refer to MSP.”¹⁸

Mr. Wolf made a request for health care on the same date, which resulted in evaluation by the RN on August 3, 2006 to address his continued facial pain. He was referred for a routine referral to the MSP and was finally examined by an MSP on August 14, 2006, four months after the assault and his entry into the MDOC.

(C) Delays Due to Canceled Appointments

Even after a prisoner has finally gotten an appointment with the MSP, there is no guarantee the appointment will take place. In fact, there is little consistency throughout the system with regard to the scheduling of appointments to see a medical services provider. Sometimes a specific appointment date is designated in the response to the prisoner’s kite, while at other times Health Services directs the prisoner to check the call-out lists. Too often, medical appointments are canceled because there is no provider on site, or because custody staff fails to ensure the prisoner has notice of and necessary transportation to the appointment site. These missed appointments cause great distress to prisoners, unnecessarily burden and upset the MSP appointment system, waste valuable resources, and are completely avoidable.

While he was at Alger Maximum Facility, Steven Montgomery-El had an ongoing problem with his ears. He sent a Health Care Request form on February 15, 2005 and was told that he would be seen by February 21, 2005; when he had still not been seen a week later, he filed a grievance. He was told in the grievance response that a computer glitch caused the appointment to be missed and that it was rescheduled for March 10, 2005.¹⁹ However, when the time came for him to go to the appointment, the housing unit officer refused to allow Mr. Montgomery-El to go to the clinic to see the medical service provider. Mr. Montgomery-El filed a Step II appeal of his grievance to object to custody staff’s unreasonable interference with his access to health care.²⁰ In response to this grievance, Health Services staff told him to send another kite requesting that his appointment be rescheduled. No steps were taken to resolve the interference by custody staff. Rather, the grievance respondent stated “The patient is encouraged to contact his Resident Unit Manager if he has concerns regarding custody staff bringing him out for his scheduled appointments.”²¹

Thomas Potyok missed his MSP appointment while he was housed in protective segregation at the Gus Harrison Correctional Facility in 2005. Mr. Potyok needed a sleep apnea test. A DWH specialist approved and ordered the test in September or October of 2005, but by December 2005 it had still not taken place. Due to Mr. Potyok’s security placement in protective segregation (a non-punitive classification²²), the warden insisted that Potyok be shackled to the bed during the test. The doctor refused to perform the test under these circumstances, so the test was canceled. Mr. Potyok filed a grievance.²³ The grievance respondent acknowledged that the sleep study was scheduled but canceled by custody officials, and informed Mr. Potyok that the sleep study had been rescheduled.²⁴ No reason for cancellation was given. Mr. Potyok appealed the grievance to Step II. The next answer merely reiterated the notice that the test was rescheduled, concluding “Evidence does not support your charge that an unreasonable time has elapsed to complete a sleep apnea test. The test was scheduled, cancelled by Custody and rescheduled. There has been no untoward effects of the delay in the completion of the test...Grievance denied.”²⁵

The MDOC should not allow custody staff to interfere with prisoners' access to health care. The health care delivery system is complicated and defective enough without additional barriers created by other departments. A prisoner's right to health care is fundamental, and is as important as the security needs of the MDOC. Custody and Health Care staff should work together to make access to health care possible; there is no reason these two goals should be at odds with one another.

Alice Amy also experienced delayed services due to canceled appointments, which was exacerbated by untimely responses to her grievances. When her grievance was finally answered *three months* after she filed the grievance, it indicated that her hepatitis C follow-up appointments were canceled a total of three times over a two month period. The grievance response states, "Patient seen by Nurse Practitioner on 2/9/07 and an order was written to schedule appt. w Dr. Hutchinson. Pt. scheduled to see Dr. Hutchinson via Telemed on 3/19/07. Telemed canceled on 3/19/07 and rescheduled for 3/23/07. Telemed conf. for 3/23/07 canceled and rescheduled for 5/3/07. Telemed canceled by CMS on 5/3/07 and rescheduled for 5/31/07."²⁶

It should be noted that Ms. Amy had been receiving treatment for her hepatitis C, but treatment was stopped in October of 2006 because of perceived (but not investigated) complications from the medications. According to Ms. Amy, Dr. Tahi told her that she could not go back on the treatment regimen until she had a consult with Dr. Hutchinson. It took over seven months before she saw Dr. Hutchinson, partly due to canceled appointments. In an August 2007 letter, Ms. Amy gave the following update, "I finally saw Dr. Hutchinson. He ordered the test, and saw me again 5 weeks after he ordered the test. Well when I went back to see him the test had not been done. He was not happy about it, so he said he would handle it his self. The week after I saw him the last time which was July 17 I had the test done."²⁷

By the time all of the tests and consults have finally been performed, Ms. Amy will have been off of the treatment regimen for almost a year. In the grievance response, no reason was given for the canceled appointments and delays in services.

(D) Delayed Diagnostics

A female prisoner, who wishes to remain anonymous, came into the MDOC in 2002 as a first-time offender, completely unfamiliar with the prison environment. She suffered from severe depression and had battled systemic lupus erythematosus (lupus)²⁸ from the age of 10, both of which required treatment and monitoring before coming to prison. She tried to explain the gravity of her condition upon her arrival at the Scott Correctional Facility in August 2002, but was unsuccessful. When the doctor finally saw her in mid-September 2002, he wrote, "Patient has very bad attitude. Talks very badly and requesting everything. I was getting this and that outside."²⁹

By January 2003, a lupus flare-up caused the doctor to conclude it was time to refer her to a rheumatologist; however, this referral was canceled when the next month's lab reports showed normal readings. Subsequent test results were again abnormal and by May 2003, the MSP submitted a request to CMS seeking approval to see an off-site rheumatologist due to failed conservative therapy.³⁰ However, no indication of urgency of the need was included with the request, and the appointment was not scheduled until November 2003, six months after the original request.³¹ By mid-December, her treating MSPs realized that an urgent appointment with a nephrologist was needed.

Furthermore, the paperwork requesting CMS authorization for an appointment with a Nephrologist stated that she had a "probable arterial clot in the left leg."³² Her condition had worsened considerably. Since December 2003, she has required further surgery and has had the lower portions of both legs amputated due to similar blood clots. Until her medical parole on August 7, 2007, she was confined to placement in the prison infirmary at Women's Huron Valley Complex.

Recommendations for Change

PROBLEM: Just as in the free world, undiagnosed illnesses and delays in treatment in prison can cause extreme and permanent harm to individuals. Unfortunately, unlike in the free world, a prisoner cannot obtain the diagnoses he or she needs in order to prevent such harm. These failures cause great harm to prisoners, but also unduly burden the MDOC health care system, because untreated illnesses are allowed to advance into diseases and conditions that are much more complicated and expensive to treat. Many prisoners are so impaired by these problems that they must be housed in special units.

RECOMMENDED SOLUTION:

- (a) **Position Vacancies:** The Department of Management and Budget should incorporate required staffing levels for medical and mental health contractor into the contracts for health care services. The Department of Management and Budget should require the MDOC to report to the legislature immediately when medical or mental health staffing falls below the required levels. When contractors fail to meet the required staffing levels, the Department of Management and Budget must penalize the contractors, including reduction in payments, debarment, and charges for costs incurred in hiring temporary staff to fill the service gaps. The MDOC should work with the contractor/s to establish competitive payment scales for all health care providers. The MDOC should implement an incentive plan; i.e. sign-on bonuses for new staff working in prisons in rural areas.
- (b) **Delayed Access to MSPs:** The MDOC should set and follow standards of care for timely and complete follow-up from offsite care, and must impose these standards upon the contractor providing the care.
- (c) **Cancelled Appointments:** The MDOC should set and follow standards of care for follow-up from canceled appointments to insure timely rescheduling, and should impose these standards upon the contractor providing the care.
- (d) **Delayed Diagnostics:** The MDOC should follow community standards of care for follow-up from delayed tests and/or diagnostics, and should insist the contractor/s follow these standards.

The human and fiscal costs caused by delays in treatment and follow-up can easily be avoided, and greater care must be taken by the MDOC to see that they are eliminated.

Endnotes Case Studies: Section Three

- ¹ See Monthly Report—May 2007—Region III, Submitted to Dr. Pramstaller, Chief Medical Officer, on June 8, 2007, pg.2. Monthly Report—January 2007—Region III, Submitted to Dr. Pramstaller, Chief Medical Officer, on February 8, 2007, pp. 2-5. Monthly Report—December 2006—BCHS Report to CFA, submitted to Deputy Director Straub, on January 19, 2007, pp. 2-3. Monthly Report—December 2006—Region II, Submitted to Richard Russell, Administrator, on January 8, 2007, pg.2.
- ² Monthly Report—October 2006—Region III, Submitted to Richard Russell, Administrator, on November 8, 2006.
- ³ Monthly Report—January 2007—Region III, Submitted to Dr. Pramstaller, Chief Medical Officer, on February 8, 2007. RGC is the initial prison every prisoner must go through when they enter the MDOC.
- ⁴ Monthly Report—December 2006—Region II, Submitted to Richard Russell, Administrator, on January 8, 2007, pg.2.
- ⁵ MDOC Staff Meeting Minutes, January 25, 2005, John Cason, Warden of Muskegon Correctional Facility.
- ⁶ Third Report of the Associate Monitor, Hadix v. Johnson, Robert L. Cohen, MD, August 22, 2006, page 3, 54.
- ⁷ First Report of the Associate Monitor, Hadix v. Johnson, Robert L. Cohen, MD, July 7, 2004, page 7.
- ⁸ MDOC Policy Directive 03.04.100(II): "An appropriate QHP shall triage the information presented on the Health Care Request and either respond in writing to the prisoner's request, or see the prisoner within one business day after receipt of the form....If an appointment is needed the prisoner shall be seen by an appropriate QHP within two business days after the written response is provided and/or, if necessary, by an MSP within seven business days after the written response is provided."
- ⁹ Grievance RRF 06 05 00352 12d1 filed on May 17, 2006.
- ¹⁰ MDOC Policy Directive 03.04.100 (OO) provides, "Chronic care clinics provide continuous health care services as needed to prisoners with chronic diseases or disorders as set forth in chronic care guidelines approved by the CMO."
- ¹¹ Grievance RRF 06 05 0032 12d1.
- ¹² Grievance NRF 04 09 1093 12D3.
- ¹³ PLSM January 24, 2006 fax to AG Govorchin; AG Govorchin January 24, 2006 fax to PLSM.
- ¹⁴ Prosecution against his assailant ensued in State of Michigan v. Lashon Cortney Fischer. The Michigan Constitution, Art 1, Sec 24 guarantees victims of crime the right to restitution, so theoretically Mr. Wolf's treatment should not cost the state anything because his assailant can be billed for the costs.
- ¹⁵ April 28, 2006 CT scan report by Marcio Curvelo, WMRA, to James Hunt, M.D.
- ¹⁶ Report of Dr. Scott Holley, MD, Great Lakes Plastic and Hand Surgery May 4, 2006.
- ¹⁷ Staff can place a hold on a prisoner so that he/she will not be transferred until certain objectives are accomplished; a medical hold forbids the transfer of a prisoner until certain medical treatment is obtained.
- ¹⁸ July 20, 2006 memo from HUM M. Brown to Wolf; Undated answer by unsigned respondent written on Wolf's August 1, 2006 kite to health services.
- ¹⁹ Grievance LMF 05 03 742 12e1, Step I response March 10, 2005.
- ²⁰ Grievance LMF LMF 05 03 742 12e1, step II grievance filed on March 21, 2005, response by Michelle Horton, RN, March 30, 2005.
- ²¹ Id.
- ²² There are different types of segregation. Prisoners in protective segregation are there for protection from harm. They normally have more privileges than prisoners in temporary segregation (such as those held pending a transfer or a hearing on a misconduct charge); punitive segregation (detention) which is punishment for misconduct; or administrative segregation, which can be imposed after a hearing officer or security classification committee has found that a prisoner is unable to be managed with group privileges, is a threat to physical safety of others, is an escape risk, is under investigation by an outside law enforcement agency for a felony, or is HIV positive and found guilty of behavior that could transmit HIV. See MDOC Policy Directive 04.05.120.
- ²³ Grievance ARF 05 12 01689 12Z, step I filed on December 9, 2005.

²⁴ Grievance ARF 05 12 01689 12Z, step I response, December 22, 2005.

²⁵ Grievance ARF 05 12 01689 12Z, step II response byCarolynn DuBuc, RN, dated February 9, 2006.

²⁶ Grievance WHV 07 02 00249 12f1.

²⁷ August 16, 2007 letter from Alice Amy to AFSC.

²⁸ According to the Lupus Foundation of America's website, "Lupus is an autoimmune disease that can affect various parts of the body, including the skin, joints, heart, lungs, blood, kidneys and brain. Normally the body's immune system makes proteins called antibodies, to protect the body against viruses, bacteria, and other foreign materials. These foreign materials are called antigens. In an autoimmune disorder like lupus, the immune system cannot tell the difference between foreign substances and its own cells and tissues. The immune system then makes antibodies directed against itself. These antibodies -- called "auto-antibodies" (auto means 'self') -- cause inflammation, pain and damage in various parts of the body." http://www.lupus.org/webmodules/webarticlesnet/templates/new_aboutintroduction.aspx?articleid=71&zoneid=9s.

²⁹ Medical records progress note September 16, 2002.

³⁰ CHJ-407 CMS Authorization Form, May 8, 2003 requesting initial visit to see rheumatologist. Conservative treatment is "a course of therapeutic action designed to avoid harm, with less possibility of benefit than more risky actions."

<http://cancerweb.ncl.ac.uk/cgi-bin/omd?conservative+treatment>. An example of conservative treatment is the use of inexpensive common drugs to manage chronic pain.

³¹ Medical records progress note November 17, 2003, "Wants to know when she is going to see a specialist for lupus. Offsite coordination of her appointment at U of M on 11-21-03 to see rheumatologist."

³² CHJ-407 CMS Authorization Form, December 16, 2003 urgent request to see Nephrologist.

Case Studies: Section Four

Arbitrary Treatment Change Upon Transfer

Once a prisoner's ailment has been diagnosed and treatment has begun, this treatment may be interrupted by a transfer to another facility. The MDOC maintains 48 prisons and 11 camps, and prisoners are transferred between institutions with great frequency.¹ **There is no policy requiring the different facilities to coordinate medical treatment,** which very often leads to inconsistent and ineffective treatment regimens for prisoners. This may be further complicated when the new health care provider contractors are hired, because there may be different contractors providing the health care services for different institutions, as there are separate contract bids being offered for the different regions of the state. The effects of these inconsistencies are costly to prisoners' health, to the medical care delivery system within the MDOC, and to the taxpayers of Michigan.

Prior to coming to prison, Larry Artibee had been treated for 15 years with a wide array of medical treatments, including a TENS unit² for pain after removal of bone in his hip, Tylenol and Motrin for pain, T-Gel shampoo, Nasarel Nasal Solution, Theroderm Moisture Lotion, and betamethasone dipropionate cream for psoriasis. Mr. Artibee continued to receive these prescriptions while he was housed at the Southern Michigan Correctional Facility, but the prescriptions were stopped without explanation after Artibee was transferred to the Cotton Correctional Facility (across the street from the former prison). Artibee filed a grievance concerning the interruption of his treatments.³ He did not get any relief. Ten months later, the TENS unit and Tylenol were reordered, but none of the other treatments were restored. Artibee was never given an explanation for the abrupt change in treatment nor why some of the decisions were reversed months later.

Another prisoner (who asked to not be named) had been prescribed Vasocon eye drops and blood pressure medication enalapril (Vasotec) while he was housed at West Shoreline Correctional Facility; however, these prescriptions were stopped when he was transferred to Brooks Correctional Facility (LRF)--LRF is an adjoining prison to West Shoreline; they share a warden, business office, and mailroom. When his request for a refill of his eye-drops was denied, he filed a grievance.⁴ In the grievance response, the prisoner was told that after he arrived at Brooks, a Physician's Assistant (PA) decided that he didn't need the eye drops, and that the prisoner had seen the eye doctor after the denial and received a prescription for Vasocon Ophthalmic solution for 30 days.⁵ The grievance response did not explain whether the PA had consulted with the eye doctor before making the change.

This prisoner also filed a grievance over the loss of his blood pressure medicine, which he was told was discontinued by the physician's assistant soon after he was transferred to Brooks. The response to his grievance said, "Patient transferred to LRF 3/12/03. Vasotec was ordered at a different facility prior to his transfer. This was the only current medication order. [The prisoner] did not arrive with Vasotec. The pharmacy wasn't notified to send the Vasotec to LRF nor did health care staff follow up on this."⁶ The grievance response also indicated that an appointment with an MSP would be made to discuss the issue; this appointment was never made, and he appealed the grievance to Step II. At that time, the Step II response indicated that the appointment took place on May 21, 2003, and his medication was started again.⁷ Because the facilities did not coordinate treatment efforts and treating MSPs at the new facility discontinued the prior treatment, this prisoner went without his medications for several months.

Marc Janness is 54 years old has a congenital birth defect with liver damage and abnormal gastrointestinal circulation necessitating several surgeries and he also has Banti's Syndrome--this means his body does not make red blood cells like it is supposed to. From the age of 5 months, he has had seven major operations and has received four blood transfusions. The surgeries he has had left him with only 1/3 of his stomach, no spleen, no gall bladder, and between 12-15 feet of intestines. His esophagus was resected and replaced with a piece of his intestines. As a result, he digests food very quickly and needs extra red meat protein. He cannot eat roughage, bran, fried foods, raw vegetables, or spicy foods, because they cause internal bleeding.

His illness was controlled for 11 years at Riverside Correctional Facility, where he was simply given 4 ounces (after cooking) of ground beef daily along with a bland "low residue, high protein, 6 small feedings" diet. When he was transferred to Muskegon Correctional Facility in November 2003, the dietician and food service supervisor said that providing ground beef every day was special treatment and refused to do it. The MCF dietician ordered Mr. Janness a "low residue, 6 feedings, high protein, no pork, no raw vegetables diet," yet he receives basically the same food as other prisoners on the diet line. This includes fried eggs, fried potatoes, raw vegetables, spicy foods, whole wheat bread, and such things as tuna salad with onions and peppers, none of which he can eat. He has complained several times, and the only change was that he is always given white bread.

Until a better solution could be worked out, on January 19, 2007 Dr. Kim ordered that he be provided double portions of everything at all meals.⁸ The dietician refused to follow this order. Mr. Janness kited health services, and the nurse responded by stating that the dietician said the double portions were not available at this facility.⁹

On February 14, 2007 Mr. Janness again spoke to the dietician about how his dietary needs were met at Riverside Correctional Facility when he was given the extra ground beef. The dietician agreed to increase his red meat portions, but failed to actually change his diet. He kited again on February 18 because he had not received the increase; she responded three days later that she had not had the time to make the change, but would do so when she had time. She made a note in his file on February 28th indicating no changes to his diet, but that she would do a chart review in a month.

Blood tests indicated that Mr. Janness' hemoglobin dropped from 7.1 on February 20, 2007 to 6.6 on March 29, 2007 and to 6.7 on April 17, 2007 (normal levels are between 15 and 18). After this, he was seen by a doctor on April 24, 2007, who ordered a low residue diet with 4 ounces of ground beef or beets daily. According to the dietician's notes, she discussed this order with the doctor and convinced him to rescind it by telling him that food services doesn't have 100% ground beef and that beets are not a rich source of iron. However, a label from a box of hamburger from food services at Muskegon Correctional Facility indicates that Angus Beef Steak Patties were indeed available at the time of this diet recommendation.

On May 1, 2007 Mr. Janness was back in the hospital with a hemoglobin level of 5.9. On May 18, 2007 he met with the dietician again, who again refused to change his diet. On May 21, 2007 he was back in the hospital. On May 31, 2007, his doctor again referred him to the dietician to add "daily hamburger" to his diet. Rather than follow the doctor's instructions, the dietician got the approval of a Physician's Assistant to disregard this order, and instead continue the same diet which resulted in four hospitalizations in the three and

a half years he has been housed at Muskegon. She continues to characterize the foods which aggravate his symptoms as his "dislikes" and continues to include them in his diet. On November 28, 2007, his hemoglobin level was 6.8, and on December 3, 2007, he was hospitalized for yet another transfusion.

Both Mr. Janness and the MDOC are on the losing end of this situation, caused by the dietician's refusal to give Mr. Janness the special diet he was receiving at Riverside Correctional Facility. Since April 2007, Mr. Janness has been receiving 25 mcg injections of Aranesp every two weeks, a very expensive drug used to help cancer patients produce more red blood cells. In his case, it is not working. The four hospitalizations and the expensive (and ineffective) drug treatment prescribed by the MDOC are very costly, especially when compared to the cost of ground beef.¹⁰ Mr. Janness is also losing because his health is being adversely affected; whenever his hemoglobin is low he has no energy and cannot work or engage in other meaningful activities.

Recommendations for Change

PROBLEM: With the frequent movement of prisoners within the MDOC, consistency is lost when information is not conveyed along with the prisoner. Furthermore, each prison's medical staff has the power to completely change a prisoner's course of treatment. Inaccurate or incomplete transfer assessment forms also contribute to the inconsistency in treatment.

RECOMMENDED SOLUTION: The MDOC should mandate consistency in treatment of medical and mental health care ailments (including special accommodations) among all facilities. The MDOC should prohibit the practice of changing a prisoner's treatment simply because she or he has been transferred, unless there is documentation that the treatment prior to transfer is not working. If treatment is changed upon transfer to a different prison, the MSP should be required to explain in writing in the file the reason for the change, and provide a copy of the explanation to the prisoner and the chief medical officer for review.

In addition, a hard copy of the prisoner's "problem list" (also known as the CHJ-160) should be kept in the front of each prisoner's current medical file.

The MDOC should insist on staff accuracy in completing transfer documents, and should more closely monitor these transactions. To maintain consistent treatment, the MDOC should transfer prisoners with medical issues only when absolutely necessary for the good order and security of the institution.

Endnotes Cases Studies: Section Four

¹ Data about the rate of transfers through the MDOC is not freely available, but based on the collective experience of the advocates creating this report, we estimate that the rate of transfer within the MDOC is very high, with individual prisoners being transferred on average once every six to twelve months.

² "TENS stands for Transcutaneous Electrical Nerve Stimulation. It's a drug-free alternative for managing pain. For the past twenty years, doctors have been prescribing it as an effective way to relieve pain. It offers many people safe comforting relief. It reduces and often even eliminates pain. It is FDA approved, and it is reimbursable by most insurance providers" (<http://www.healiohealth.com/tens-unit.html>).

³ Grievance JCF 05 03 00775 12F, grievance JCF 2005 12 2254 12I.

⁴ Grievance LRF 03 06 00904 12F, submitted on June 25, 2003.

⁵ Grievance LRF 03 06 00904 12F, step I response July 13, 2003.

⁶ Grievance LRF 03 04 00591 12F, submitted April 17, 2003, step I response April 24, 2003.

⁷ Grievance LRF 03 04 00591 12F, step II response June 25, 2003.

⁸ Medical Detail January 29, 2007.

⁹ Medical care kite response January 3, 2007.

¹⁰ Michigan State Industries charges \$1.44/lb for ground beef. According to one pharmacy's quote, Mr. Janness' current medical treatment (Aranesp [darbepoetin alfa] in lieu of dietary treatment) costs \$181.00 per 25 mcg vial; Mr. Janness receives two of these injections per month.

Case Studies: Section Five Special Accommodations

Prisoners with identified physical disabilities and special needs may be issued prescriptions or orders for certain services, housing placements or equipment to accommodate that special need. These are called "special accommodations."¹ Unfortunately, having a special accommodation order does not guarantee it will be honored, especially upon transfer to another facility.

Even though it is Health Services staff's responsibility to keep housing unit staff properly informed of a prisoner's special accommodations, Rodney Alston had to file a grievance at the Ryan Correctional Facility in order to enforce his own accommodation. An RN advised Mr. Alston's housing unit staff that he did not have a special accommodation for a bottom bunk, although he did in fact have such an accommodation. Policy Directive 04.06.160 (G) states, "A copy of each...Special Accommodation Notice issued shall be distributed through the institutional mail to the housing unit and records office for placement in the prisoner's files. A copy shall also be distributed to the control center and, as necessary, to the property room." So, in Mr. Alston's case, a copy of the notice should have been in both the counselor's file and the record office file, both of which are transferred with the prisoner.

In response to his grievance about the matter, health care staff finally acknowledged the error, but blamed it on Mr. Alston, stating, "*A review of the grievant's health record reveals that the grievant does have a Special Accommodation Notice ... allowing him to have a bottom bunk. Although the grievant takes issue with the RN in question not giving the Captain this information, it is the grievant's responsibility to retain his copy (pink) of the Special Accommodation Notice so that he may verify his accommodation when necessary. Therefore, the grievance is denied.*"²

This answer directly contradicts the MDOC's Special Accommodations policy, which specifically directs housing unit staff to contact health services when a prisoner reports having an accommodation.³ It was the RN's duty to properly and accurately inform housing unit staff of the lower bunk accommodation upon Mr. Alston's request for the accommodation and housing unit staff's request for the information.

Because of the nurse's failure to follow policy and negligence in denying the existence of his special accommodation, Alston was put into an upper bunk, which was a difficult and painful placement for him, and he also received a major misconduct report for claiming he had a special accommodation when the RN said he did not. While it was later acknowledged he did have special accommodation for a lower bunk, no one saw fit to take corrective action against the nurse.

Similarly, the MDOC impedes access to outside specialist recommendations for specific special accommodations. While housed at Muskegon Correctional Facility, Aaron Ralph was denied his request for transitional prescription sunglasses, which he needed because he has glaucoma and uses prescription eyedrops that made his eyes sensitive to light. It should also be noted that people with glaucoma are subject to severe light sensitivity and the use of tinted lenses is important tool for dealing with this sensitivity for glaucoma patients.⁴ Despite Mr. Ralph's work detail on yard crew, and his sensitivity to light, he still only has clear glasses, not tinted or transitional lenses. According to MDOC policy, prescription eyewear is made by Michigan State Industries, but prisoners may purchase glasses from an outside vendor if the glasses are consistent with policy requirements.⁵

He grieved the denial of his requested lenses.⁶ While the grievance response acknowledged Mr. Ralph's glaucoma, it said that he "did not fit the MDOC criteria for tinted lenses." The MDOC's criteria for tinted lenses were not explained in the grievance response.

After contacting the non-CMS eye specialist he had seen years earlier, Mr. Ralph was told that, based on his current test results and side effects of his medications, he would benefit from transitional (i.e., tinted) lenses. Armed with this additional information, he again sought a prescription for transitional lenses.⁷ He was told his request would be referred to superiors to determine whether a variance was in order. This time the answer had changed to "Transitional lenses are no longer prescribed. If medically necessary one tinted pair and one clear pair are issued. Mr. Ralph does not meet the criteria for medically necessary tinted lenses."⁸ Mr. Ralph also asked for a copy of the memo seeking a variance and was told it was not part of his medical record and he could not obtain a copy of it.⁹

Once again, the criteria for a variance were not explained. Furthermore, nothing in current MDOC policy reflects the "policy change" referred to in the response to Mr. Ralph's request. In fact, under current MDOC policy, transitional lenses shall be issued to a prisoner if the treating MDOC eye care practitioner determines there is a medical need for it and gives examples as albinism or iris defects. The Policy Directive states, "Prescription glasses with glass, tinted or transitional lenses (i.e., lenses that darken when exposed to sunlight) shall be issued to a prisoner only if the treating BHCS eye care practitioner determines there is a medical need for such lenses (e.g., albinism, iris defects). The need and specific medical condition, including diagnosis, shall be documented in the prisoner's health record."¹⁰

There are two problems with Mr. Ralph's case. First, he has a letter from a specialist indicating that the drops he takes make his eyes sensitive to light and recommending that he should use transitional lenses; nonetheless, the MDOC refuses to allow him to have transitional lenses or tinted lenses.

Second, the policy directive has not been changed to reflect a change in medical procedure. This is further complicated by the grievance system's failure to comprehensively explain the reasons behind an answer. Mr. Ralph was told that he does not fit the criteria for tinted lenses, but he was not told the specifics of the criteria. Also, the policy directive does not state the criteria necessary to determine a variance for a special accommodation for tinted lenses.

Recommendations for Change

PROBLEM: Frequent transfer of prisoners has adverse effects on the consistency of recognition of Special Accommodations. Also, Special Accommodations are not always granted when necessary, or followed when they are granted. This complicates prisoners' health care treatment protocols that have been developed by their treating MSPs.

RECOMMENDED SOLUTION: The MDOC should ensure that hard copies of current Special Accommodation notices are transferred with the prisoner and are available in the housing unit files immediately upon transfer. The MDOC should also insure that current Special Accommodation notices are in the current version of the medical file and on the electronic medical records system. Special Accommodations should be granted whenever necessary and the MDOC should be more consistent and open about the decision-making process surrounding Special Accommodations.

Endnotes Case Studies: Section Five

- ¹ MDOC Policy Directive 04.06.160, Medical Details and Special Accommodations.
- ² Grievance RRF 05-01-00009-12I, Step II response by Denise Daniels, MSN, RN, January 26, 2005.
- ³ MDOC Policy Directive 04.06.160, Medical Details and Special Accommodations.
- ⁴ http://www.glaucoma.org/living/daily_life.html.
- ⁵ MDOC Policy Directive 04.06.165, Optometric Services.
- ⁶ Grievance MCF 04 11 00817 12G1.
- ⁷ Letter from doctor Kenyon S. Kendal, D.O. (Grand Rapids Ophthalmology) to Aaron Ralph dated August 16, 2005.
- ⁸ MCF Progress Note September 22, 2005 entered by Collette Perog.
- ⁹ MCF Progress Note September 27, 2005 entered by Collette Perog.
- ¹⁰ MDOC Policy Directive 04.06.165 Optometric Services, Section J.

Case Studies: Section Six Hepatitis C Treatment Denied

Hepatitis C virus (HCV) is a difficult disease for most people to understand, even under normal free-world circumstances. Add the difficulties inherent in any prison system, plus the systemic problems noted throughout this report, and it is no wonder that most prisoners with HCV do not understand the disease, and do not understand why they are not provided with treatment as they believe they should be.

HCV is a virus, and when people initially experience the effects of the virus, it seems like the flu. HCV is contracted through blood. People who have shared IV drug equipment and people who received blood transfusions prior to 1990 are the prime candidates for HCV. Fifteen to twenty years after the initial symptoms appear, new symptoms may appear, including pain in the right side of the abdomen, fatigue, joint aches, headaches, and gastrointestinal complaints.

A treating physician may do a comprehensive blood panel and find several blood levels elevated. The doctor may then do a Hepatitis Panel and find the person to be positive for HCV. The HCV virus has been dormant for many years, but has been slowly damaging the liver, reducing its ability to function. The blood values that are typically monitored are the ALT (alanine aminotransferase), AST (aspartate aminotransferase), and platelet count, among others.

In the free world, hepatitis C patients are normally referred to a gastroenterologist or a hepatologist (a gastroenterologist who specializes in diseases of the liver).¹ Genotype, viral load tests, and a liver biopsy would be done to determine the extent of the liver damage. Most cases are treated with Pegylated Interferon and ribavirin (or generic versions of these drugs) for differing periods of time, depending on the genotype of the disease.

Genotype 1 is usually treated longer than genotypes 2 and 3. To further complicate the general understanding of HCV, some people respond to the treatment and can actually rid their body of the virus. However, some people are not affected by the treatment at all, while in others, some viral loads reduce while on the treatment, but the effect is reversed as soon as the treatment stops. Some people may never get sick or experience any liver damage from the virus.

The treatment of HCV is relatively new and studies are currently being done to find a better treatment regime. Many internal medicine doctors are not well versed in the disease and all the complications that come along with it. As a result, there are many questions about treating HCV that allow the medical staff of the MDOC and CMS to defer treatment. As the disease advances untreated, many other symptoms emerge. The memory can be affected by an increase in blood ammonia levels. The entire blood system can get backed up because the liver is not functioning adequately and swelling can occur in the hands, legs, feet, and around the abdominal area. The skin can itch due to the high bilirubin levels and jaundice. The blood backing up in their systems can also cause blood vessels in the esophagus to burst, which can cause severe bleeding that can lead to death if not controlled in time. As the disease advances further, people lose control of their bowels, experience severe pain and "brain fog", their shoes do not fit, they are continuously tired, and lose their appetite. These symptoms can cause a prisoner to get major misconducts for missing call outs, or other problems caused by a declining mental state.

When a prisoner is diagnosed with HCV, he or she enters into a perpetual maze regarding treatment. Until seven years ago, the MDOC would not always tell a prisoner he or she had HCV because there was not much that was being done to treat the disease. Now,

prisoners who have HCV are put on treatment hold for one year, and their ALT levels are supposed to be drawn every 6 months and monitored. Once a prisoner's ALT level is above "the average of two times the upper limit of normal" consistently for one year, he or she is supposed to be considered for genotyping and biopsy.²

However, when prisoners contact AFSC and PLSM, they report that this is not the reality they experience. Their blood tests are not done on time; the appointments to see the Infectious Disease Doctor ("ID doctor," who makes decisions about progression to treatment and who is also the Chief Medical Officer of CMS) are cancelled, rescheduled and cancelled multiple times. Blood tests which have been ordered are not completed, so that when the ID doctor finally sees the prisoner, he cannot make a decision to treat because tests results are not available. While treatment is delayed, new symptoms may begin and MSPs do not know how to treat them. For instance, if a prisoner reports that his memory is failing or he is confused, an MSP may order lactulose to neutralize the ammonia to reduce these symptoms. However, not all prison MSPs will follow up with an order for the proper medication.

Once the ID doctor orders the biopsy, it can still take months to be completed because of cancelled and rescheduled appointments. There is great latitude in interpreting the biopsy reports and in prescribing treatment. The ID doctor may choose to not treat at one time and recommend a new biopsy be considered in 3-4 years. However, in some of these situations, AFSC has contacted a hepatologist in the community and presented him with the test reports; he reported that the test reports indicated that these patients should have been recommended for treatment and probably would have received treatment if they were not in prison.

For those prisoners who are recommended to begin treatment, it may still take time before the medication is started. If a prisoner is transferred to a different prison during the period of monitoring ALT levels, the wait for treatment can take years because tests are not done often enough, and a "consistent" ALT level of over two times the upper limit of normal cannot be established.

According to the Federal Bureau of Prisons' Clinical Practice Guidelines, "The decision to obtain a liver biopsy should not be strongly based on ALT levels."³ However, the MDOC's Hepatitis C Protocol is based on monitoring ALT levels that must be highly elevated before a referral for a liver biopsy can be ordered. The Federal Bureau of Prisons' Clinical Practice Guidelines also assert, "No laboratory parameters definitively predict which persons infected with HCV will develop cirrhosis or will respond to medical therapy. The presence of moderate to severe fibrosis (Metavir \geq stage 2 or Ishak \geq stage 3) on liver biopsy is currently the best marker for determining who should be offered antiviral therapy for hepatitis C."⁴

Finally, even when treatment has started there is no guarantee it will be appropriate. AFSC has followed numerous cases where medication was missed due to prescriptions not being refilled. Many prisoners have written worrying that the RNs are not drawing up the proper amount of medication or not calculating the proper dose based on the patient's weight.

One such patient who experienced these problems was Dean Creeger, who was diagnosed with hepatitis C in 1993. Since 1998 he has had persistent ALT elevations, which were diagnosed in March 2002 at the Kinross Correctional Facility as in the neighborhood of 1½ times the normal levels; the doctor also found that Mr. Creeger "...has a number of favorable factors for treatment..."⁵ One of these favorable factors was the fact that he was genotyped as type 3a.⁶ The outside specialist recommended treatment with standard Interferon, concluding that it was the less expensive regimen and would probably give "pretty good results, probably comparable to PEG in this setting."⁷ The specialist ordered a

liver biopsy in order to determine if “we would not want to go on towards a year of treatment.”⁸ The biopsy was completed on June 19, 2002.

On July 26, 2002, CMS denied further HCV related consults or workups, stating that the liver biopsy “*show[ed] no need for treatment at this time.*”⁹ The actual biopsy conclusion was not reported along with the denial, and Mr. Creeger was never given a copy of the report. The specialist who ordered the biopsy did not order it to determine if treatment was needed. He had concluded that treatment was necessary and that Mr. Creeger had a number of “favorable factors for treatment, which include the type 3a virus, acquisition of the virus before age 40, and no confounding illness.”¹⁰ CMS decided that Mr. Creeger could be treated solely by being enrolled in the GI chronic care clinic, and counseled on avoidance of alcohol. It was also concluded that Mr. Creeger would be *considered for repeat biopsy in 4-5 yrs.*¹¹

CMS’s treatment refusal based on liver biopsy results that were initiated in order to determine *how to treat, not if treatment should be started*, causes further bafflement when juxtaposed with the Federal Bureau of Prisons’ Clinical Practice Guidelines. These guidelines support deferment of liver biopsies, all together, for prisoners with Genotypes 2 and 3 “due to the high response rates to treatment for these patients,” and they support that prisoners be “offered liver biopsy[ies] to help determine the urgency of therapy.”¹²

Despite appeals for the Interferon treatment regimen by the facility MSP, supported by the MDOC’s Regional Medical Director, CMS continued to refuse to approve this treatment.

Mr. Creeger filed a grievance in an attempt to get the Interferon treatment.¹³ The respondents at Levels I and II could only corroborate their efforts to gain approval for treatment, and CMS’ continued refusal. Eleven months passed from the time treatment was recommended, to the time that Creeger was informed by the Step III grievance respondent that on January 28, 2003 “...the Medical Services Advisory Committee had met and the[y] determined that the denial of treatment by CMS was appropriate.”¹⁴ Mr. Creeger was to continue to be followed by the gastrointestinal chronic care clinic.

As of June 2006, Mr. Creeger reported to PLSM that he had another biopsy on June 1, 2006, and was not feeling well. Despite a diagnosis and documented need for treatment in 2002, Mr. Creeger continued to suffer with untreated HCV for many years. Many cases like this exist among the thousands of prisoners who suffer from HCV within the MDOC.

Recommendations for Change

PROBLEM: While there are continual advances in the world of HCV treatment¹⁵, prisoners with HCV do not often receive the benefits of any consistent or useful treatment. Frequent transfers make this problem even worse. While treatment eligibility guidelines do exist, they are often not followed. Furthermore, these guidelines are essentially designed to narrow the numbers of people who actually “qualify” for treatment. HCV can be a painful disease with many awful consequences, including the possibility of death, and the MDOC must take better care of prisoners with this unfortunately common disease.

RECOMMENDED SOLUTION: The HCV treatment eligibility guidelines should be redesigned to treat as many people who might benefit from treatment as possible. The MDOC must provide a copy of its HCV treatment eligibility guidelines (form CHJ-460) to all prisoners diagnosed with HCV. The MDOC must not deny HCV treatment to prisoners within the guidelines who wish to be treated.

The MDOC and contractual entities providing care must not deny comprehensive treatment solely based on the cost of such treatment. The new Request for Proposals for the health care provider contract must focus on diagnoses of hepatitis C, cutting edge treatment, and protocols that are pro-treatment rather than anti-treatment.

Hepatitis C is a treatable condition, but left untreated it causes multiple health problems and possibly death. CMS commonly denied treatment solely based on cost; this is not appropriate or acceptable.

Endnotes Case Studies: Section Six

¹ <http://www.medicinenet.com/script/main/art.asp?articlekey=77934>.

² “Those prisoners whose liver enzymes (ALT, AST) are elevated on an average of two times the upper limit of normal over the preceding 6 months will be offered further evaluation” (page 3, MDOC, BHCS, Hepatitis C (HCV) Clinical Management Program, Implemented October 1, 2004). It is also critical to note that two times the upper limit of normal fluctuates based on the high normal reflected in lab reports. Various lab reports have stated the high normals on ALTs as 21, 35, 40, and 45.

³ Federal Bureau of Prisons, Prevention and Treatment of Viral Hepatitis: Clinical Practice Guidelines. October 2005, page 28.

⁴ Federal Bureau of Prisons, Prevention and Treatment of Viral Hepatitis: Clinical Practice Guidelines. October 2005, page 27.

⁵ Consultation March 27, 2002, Jeff Gephart, M.D., Specialty Consultant, Kinross Complex.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ Correctional Medical Services Pended or Denied Form, CHJ-408, concerning Mr. Creeger, note by Dr. Hutchinson, July 26, 2002.

- ¹⁰ Consultation March 27, 2002, Jeff Gephart, M.D., Specialty Consultant, Kinross Complex.
- ¹¹ Correctional Medical Services Pended or Denied Form, CHJ-408, concerning Mr. Creeger, note by Dr. Hutchinson, July 26, 2002.
- ¹² Federal Bureau of Prisons, Prevention and Treatment of Viral Hepatitis: Clinical Practice Guidelines. October 2005, page 29.
- ¹³ Grievance KCF 02 12 1248 12F1, step I response dated January 2, 2003; Step II response by Michelle Horton, RN, January 31, 2003.
- ¹⁴ Grievance KCF 02 12 1248 12F1, step III response by Lisa Shedlock, April 4, 2003.
- ¹⁵ See AASLD Practice Guideline: Diagnosis, Management, and Treatment of Hepatitis C at <https://www.aasld.org/eweb/docs/hepatitisc.pdf>.

Case Studies: Section Seven Diabetes Management

Many prisoners within the MDOC suffer from diabetes. While exact figures are not available, the national prevalence of diabetes inside prisons and jails is outlined below. According to the American Diabetes Association:

At any given time, over 2 million people are incarcerated in prisons and jails in the U.S. It is estimated that nearly 80,000 of these inmates have diabetes, a prevalence of 4.8%. The current estimated prevalence of diabetes in correctional institutions is somewhat lower than the overall U.S. prevalence of diabetes, perhaps because the incarcerated population is younger than the general population. The prevalence of diabetes and its related comorbidities and complications, however, will continue to increase in the prison population as current sentencing guidelines continue to increase the number of aging prisoners and the incidence of diabetes in young people continues to increase.¹

In the past year, the American Friends Service Committee (AFSC) has received a tremendous increase in the number of complaints from diabetic prisoners who have trouble controlling their blood sugar levels. Many younger prisoners are being incarcerated, and some of them have Type 1 diabetes. These patients need insulin (usually three to four times a day), blood sugar testing multiple times daily, and a well balanced diet. Older prisoners, who are a growing population within the MDOC, often develop Type 2 diabetes. Initially blood sugar may be controlled with exercise and a balanced diet; however, however, oral medication, and eventually insulin may be needed.

Diabetes can be controlled, but many individuals have difficulty controlling the disease. Prison conditions cause diabetes sufferers to have complications that might not be common for most diabetics. These complications cause increased difficulty in control and the worsening of general health of prisoners, which results in life threatening and expensive health conditions later on.

Diabetes is more difficult for prisoners to manage, as they often do not have the food choices available to maintain a balanced, calorie appropriate diet. This loss of control over the condition can cause uncommon complications, worsening the effects of the disease. Moreover, prison custody issues override medical protocols, causing inconsistent medication regimes. For instance, many insulin dependent diabetics control their blood sugar with three injections per day. The MDOC appears to only give insulin twice a day (AM and PM) causing difficulty in control of the disease.

Various prison conditions complicate diabetic control, including:

- Work details that make meal times uncontrollable
- General control of movement that reduces ability to eat when necessary and/or to receive insulin when necessary
- Frequent change in diet and insulin regimen upon transfer
- Stringent controls over movement if a prisoner is confined to segregation.

The American Diabetes Association points out the importance for incarcerated people to receive diabetic care that meets national standards and is tailored, through policies and procedures, to a correctional environment:

People with diabetes in correctional facilities should receive care that meets national standards. Correctional institutions have unique circumstances that need to be considered so that all standards of care may be achieved. Correctional institutions should have written policies and procedures for the management of diabetes and for training of medical and correctional staff in diabetes care practices. These policies must take into consideration issues such as security needs, transfer from one facility to another, and access to medical personnel and equipment, so that all appropriate levels of care are provided. Ideally, these policies should encourage or at least allow patients to self-manage their diabetes.²

Recently, the MDOC has taken steps toward allowing prisoners to have a little bit more control over treating their diabetes. Insulin-dependent diabetic prisoners are now allowed to possess their own glucometers and other supplies necessary for checking their own blood sugar levels.³ After a pilot study at two prisons, the MDOC determined that giving these prisoners the tools to self-check their blood sugar levels did not present any security concerns, and this medical practice did reduce the number of serious hypoglycemic reactions.⁴ If a prisoner's Medical Service Provider believes that a prisoner is not capable of checking his or her own blood sugar, the MSP can choose not to order a special accommodation for the glucometer and supplies. For prisoners housed in Segregation, their glucometers and supplies must be stored and then retrieved by custody staff whenever the prisoners indicate a need to check their blood sugar.⁵

In summation, there are several problems with the way the MDOC treats Diabetic prisoners. A few changes to procedures and policies within the MDOC could result in far fewer complications for diabetic patients.

Recommendations for Change

PROBLEMS:

- Diets are high in carbohydrates, which are not always appropriate for diabetic patients. Diabetics do need carbohydrates, but their diet should also be rich in protein and fresh fruits and vegetables.
- Insulin schedules are not three or four times a day in the MDOC, but two times a day, which does not provide adequate coverage for Type 1 diabetics.
- Neither the MDOC nor CMS has an endocrinologist working with diabetic patients. It is not always necessary for Type 2 diabetics, but most Type 1 cases should be followed by a specialist. Many of these cases are difficult to control and medical staff who do not specialize in this field have difficulty managing these cases effectively.
- The frequent transfer of prisoners from one prison to another exacerbates the problem of inconsistent treatment. Each time a prisoner is moved from one location to another medical staff follow different theories of how a patient should be managed, and care is not consistent.

Recommendations for Change **continued**

PROBLEMS:

- Custody staff are not properly educated about the side effects of diabetes and the behaviors that commonly occur when a diabetic has low or high blood sugar, or how to respond to a diabetic who is having a reaction. Low blood sugar can cause a prisoner to act aggressively and disoriented. Normal custodial response to this kind of behavior would be to separate the prisoner from other prisoners. For the diabetic, they may only need to provide emergency glucose and the aggressive behavior will stop, but staff are not adequately trained and therefore do not respond safely and appropriately.

- The diabetes formulary is outdated and too limited. Even the Michigan Medicaid formulary is much more inclusive – eight branded insulins, three other brands by prior authorization, and generics of multiple insulin preparations.⁶ The three generic insulins on the MDOC formulary would have been acceptable 10 years ago, but are not adequate if the goal of prisoner care is to meet the community standard.⁷

For instance, the current standard care is to use a 24-hour basal dose insulin (Levemir or Lantus - the latter is on the Medicaid list) once daily (to simulate steady release of insulin from a normal pancreas) with three or four injections of short-acting insulin ("Regular" insulin was used in the past and is probably acceptable, although not ideal) or rapid-acting insulin (Humalog or Novalog, both on the Medicaid list) taken immediately before each meal. Thus the patient can take a bit more rapid-acting insulin if he is going to eat more or be less physically active, or take less rapid-acting insulin if he'll be eating less or activity is planned to burn off more calories.⁸

Oral medication options are likewise too limited within the MDOC - there are currently seven or more classes of oral drugs for diabetes.⁹ Only two classes are represented on the MDOC formulary.¹⁰ The addition of two or three more classes would not be expensive and would decrease the likelihood of developing dangerous and expensive complications of diabetes in the future.

Recommendations for Change **continued**

RECOMMENDED SOLUTIONS:

- The MDOC should make better balanced diets available for diabetic prisoners.
- Insulin injections should be available at least four times a day for diabetic prisoners
- There should be endocrinologists on staff who work closely with diabetic prisoners.
- Prisoners should be transferred only as often as is necessary for custody or security reasons. Upon transfer of a diabetic patient, the treatment regimen should not be changed without a sound medical reason for altering treatment.
- Custody staff should be educated about the side effects of diabetes and the behaviors that are common when a diabetic has low or high blood sugar and how to respond safely and properly to a diabetic who is having a reaction.
- The diabetes formulary should be expanded and brought up to date for both insulin and oral medications. This should be a requirement under any new Request for Proposals that are used in finding new health care companies to treat prisoners.

Endnotes Case Studies: Section Seven

¹ *Diabetes Management in Correctional Institutions*, DIABETES CARE, VOLUME 29, SUPPLEMENT 1, JANUARY 2006, © 2006 by the American Diabetes Association, pg.1. (http://care.diabetesjournals.org/cgi/content/full/29/suppl_1/s59#). Internal citations omitted.

² Id.

³ March 15, 2007 Memo from Dennis M. Straub, Deputy Director, to Wardens and Correctional Facilities Administration, regarding Glucose Meters.

⁴ Id.

⁵ Southern Michigan Correctional Facility Operating Procedure JMF-OP-03.04.100-G, Diabetic Care, pages 3 and 4. This Operating Procedure was attached to the 3/15/07 Straub memo as a resource for each prison to use in developing its own Diabetic Care operating procedure.

⁶ http://www.michigan.fhsc.com/Downloads/PDL_20071008.pdf.

⁷ Michigan Department of Corrections, Bureau of Health Care Services, Clinical Formulary, Revised September 20, 2006.

⁸ http://care.diabetesjournals.org/cgi/reprint/30/suppl_1/S4.

⁹ <http://www.diabetes.org/type-2-diabetes/oral-medications.jsp>

¹⁰ Michigan Department of Corrections, Bureau of Health Care Services, Clinical Formulary, Revised September 20, 2006.

Case Studies: Section Eight Nutrition Services

Within the MDOC, Registered Dietitians (RDs) are responsible for meeting the nutritional needs of prisoners whose health conditions require deviation from the regular institutional diet.¹ The RDs must “conduct nutritional screening and assessment, consultation, and education, as needed and upon referral from appropriate medical staff.”² MDOC policies and procedures also require that prisoners be referred to a registered dietitian to receive education on how to self-select proper foods from the regular meal line.³ If indicated, a therapeutic diabetic diet can be ordered while diabetic self-management education is being completed.

As part of the education process under this procedure, the RD is supposed to evaluate prisoners who refuse to participate in the Diabetes Education self management program, then document the prisoner’s capacity for making appropriate food choices from the regular menu in his/her health record. The prisoner is then referred to a Medical Service Provider (MSP) for a review of the dietitian’s assessment. The MSP is to determine if discontinuation of a therapeutic diet is appropriate and document that decision in the prisoner’s health record, with a corresponding progress note explaining the decision. If there is poor diabetes control, the MSP is supposed to refer the prisoner to the dietitian for follow-up diabetes management education.

However, this system does not always operate the way that it is supposed to. For example, Robert Mousser’s prescription for Prevacid (which he had received since 1999 to control his acid reflux) was stopped without notice or explanation in 2003 while he was housed at Earnest C. Brooks Correctional Facility. When he noticed the discontinuation on July 18, 2003, he immediately submitted an “urgent” Health Care Request. The response to the request was that his chart was given to MSP for review.⁴

On August 5, 2003, Mr. Mousser suffered from several esophageal spasms and became unconscious, which required a trip to the local emergency room. Mr. Mousser filed a grievance in an attempt to get his needed medication reinstated.⁵ The respondent stated that Mousser had been counseled on three occasions on how to reduce his acid reflux symptoms, noting that despite education by the dietitian, he continued to purchase food from the prisoner store that was non-compliant with his suggested treatment. Health Services used this as a justification for the termination of the Prevacid prescription, and the grievance respondent found no problem with this.⁶ This matter was not resolved until Mr. Mousser returned from the emergency room and was seen by the doctor, at which time the acid reflux treatment was reinstated, along with an acid-reflux diet.

Another example of the failure of the nutrition services policies happened to Rodney Alston, who is diabetic and who filed a grievance when his special diet was discontinued in March 2006 by the facility dietician without MSP oversight. Mr. Alston submitted a Health Care Request about this decision on March 2, 2006, but was not seen in a timely matter. In his May grievance, Alston reported that, as a result of the dietician having stopped his special diet detail, “...I now have this problem with acid reflux and was to see the doctor, but never did, now I’m in constant pain!!!”⁷

The step 1 response stated, “*Seen by dietician on 4/24/06 – continues to smoke – alleges items he buys at prisoner store he does not consume. Purchases contraindicated foods in prison store – anti-reflux diet discontinued in April due to non-adherence and lifestyle*”

*practices. Inmate has not kited since March regarding acid reflux although inmate had c.o. call in 5-17 @ 9am c/o 'severe pain' and requesting Maalox..."*⁸ An RN added the following to the grievance response: *"Prisoner has been adequately educated and instructed by the dietician to modify his lifestyle practices as part of recommendation for his treatment plan. Prisoner has refused to adhere to these modifications. Prisoner is challenging the clinical decision of the dietician and does not agree with the dietician's decision."*⁹

According to MDOC policy about therapeutic diets, only physicians, physician's assistants and dentists shall order therapeutic diets based on the prisoner's health needs in accordance with the Diet Manual; diets will be served either through the general population serving line or therapeutic diet serving line or diet tray.¹⁰ In Mr. Alston's case, the dietitian discontinued his acid reflux diet, seemingly as punishment for his failure to "modify his lifestyle choices." While adherence to certain lifestyle choices would certainly have helped control Mr. Alston's condition, there was no real reason to make the problem even worse by refusing to give him a special acid-reflux diet. Physicians do not normally punish their patients for their choices, even when they do not follow the doctor's orders.

Both of these problems were made worse due to long delays in seeing an MSP. The delay in scheduling Mr. Alston for evaluation by an MSP prevented a real medical assessment regarding his dietary needs from happening, and allowed the dietitian to act without the required approval from an MSP. The three week delay in Mr. Mousser's request for an MSP appointment led to an emergency room visit. In both of these cases, staff took it upon themselves to make decisions about patient care that exacerbated medical conditions and caused the MDOC to spend additional funds treating emergency situations, and inflicted unnecessary pain upon the prisoners.

Recommendations for Change

PROBLEM: Special diets are an integral part of maintaining and treating prisoners' health care problems. When these diets are not followed, or capriciously discontinued, this can cause severe problems for prisoners.

RECOMMENDED SOLUTION: When the MSP orders a certain diet, the MDOC should require the institutional dietician to do whatever is necessary to provide it. Dieticians should not be permitted to override the orders from an MSP; MDOC policy should be amended to make this clear. Special diets or other nutritional services should not be withheld or removed as punishment for a prisoner's other lifestyle choices. The MDOC should not transfer prisoners to prisons or camps that are not able to or refuse to provide the diets needed. Where a prisoner is on a special diet, the transfer should not be approved until there is written confirmation by the dietician at the proposed destination facility that the diet is available.

Endnotes Case Studies: Section Eight

- ¹ MCL 333.18351-333.18363.
- ² MDOC Policy Directive 04.07.101, Therapeutic Diet Services, paragraph (E)(1).
- ³ MDOC Policy Directive 04.07.101, Therapeutic Diet Services, paragraph (B).
- ⁴ MDOC Request for Services Medical response by John R. Booth, RN, dated July 20, 2003.
- ⁵ Grievance LRF 03 08 01191 12F, step I filed on August 6, 2003. response by M. Wilkinson, August 13, 2003.
- ⁶ Grievance LRF 03 08 01191 12F, step I response by M. Wilkinson, dated August 13, 2003.
- ⁷ Grievance RRF 06 05 00352 12d1, May 17, 2006.
- ⁸ Grievance RRF 06 05 00352 12d1, response by T. Eshelman, HUM, June 2, 2006.
- ⁹ Grievance RRF 06 05 00352 12d1, response by J. Nzums, RN, dated May 24, 2006.
- ¹⁰ MDOC Policy Directive 04.07.101, Therapeutic Diet Services.

Case Studies: Section Nine Reforming the Grievance Process

Straight from a prisoner: the grievance process

Below, a prisoner at Cotton Correctional Facility (JCF) describes the various steps that should be taken to resolve problems with health care services.

If a new arrival approached me concerning an outstanding and unresolved health care issue, (assuming he had not been taken to intake screening yet), I would suggest that he contact his housing unit officer (HUO), explain his situation to the HUO and ask the HUO to contact Health Care on the matter. This is especially true if someone arrived here, for example, from Reception and Guidance Center (R&GC), with a special accommodation notice for a cane, a wrist brace, diet line, or restricted medications. JCF has a history of not honoring a special accommodation notice issued at another facility so it would be imperative for him to be seen by Health Care to have one issued. If the restricted medication was absolutely necessary and he wasn't called during normal medication line times, I would suggest he address that with the housing unit officer as well. By policy, the HUO can contact Health Care by telephone concerning those issues and others.

If the housing unit officer refused to make the telephone call or if the Health Care staff refused to see him, I would advise him to note the name of the housing unit staff he spoke to, the date and time of the conversation, and, if possible, the name of the health care staff the housing unit officer contacted. All of this should be written on a legal pad or calendar and the prisoner should file a grievance.

If a prisoner's complaint didn't involve a new arrival issue, Health Care issues that go unresolved should always be addressed in the "Health Care Request" form. Responses should be kept on file and monitored. If, for example, the response says he will be seen by an MSP on a certain specified date, and then he is not seen, he should file a grievance and use the Health Care Request form response as an attachment.

In the grievance, he would list the health care issues that prompted him to speak with the housing unit officer. He should list the person/people he spoke with, the date, the time, and if he knows, the name of the Health Care staff member that the housing unit officer spoke to.

When filing a grievance, a prisoner must sign it, retain the goldenrod copy and mail the top copy to the facility grievance coordinator. Normally, within just a day or two, the grievance coordinator will send him a receipt that acknowledges the grievance, shows that it was processed, gives it a unique grievance number, and lists the date by which he can expect a written response. If the grievance coordinator does not send him a response within a day or two, he should kite the grievance coordinator and ask if he filed the grievance.

One of the most important steps in resolving problems with health care is the grievance process, which is the only way for a prisoner to appeal a problem or a bad decision affecting his or her health care. In addition to being an internal review process for the MDOC and CMS, completing the grievance process is required by law before a prisoner can take his or her health care problems to court for resolution. Because of state and federal Prison Litigation Reform Acts, a prisoner must “exhaust administrative remedies” before seeking assistance from a court.¹ In Michigan, the administrative remedy that prisoners must use is the prisoner/parolee grievance procedure.² The grievance procedure has been constructed in an attempt to address prisoners’ problems regarding health and mental health care issues. Unfortunately, the process is full of flaws due to untimely, inappropriate and undocumented responses by staff, by disregard and disrespect for mentally challenged and illiterate prisoners, and by prisoners’ legitimate fear of retaliation.

The grievance process is governed by MDOC Policy Directive 03.02.130, Prisoner/Parolee Grievances. According to this policy, after an incident happens, a prisoner is supposed to spend two days trying to resolve the problem through communication with staff. If these efforts are not successful, the prisoner has five business days within which to file the grievance about the problem; this is “Step I” of the process. The MDOC has 15 business days after receipt of the grievance to respond to Step I, but a 15 business day extension is available (and often utilized). After receiving an unsatisfactory response at Step I, a prisoner has 10 business days to file a Step II response, and the MDOC again has 15 business days to respond (with a possible extension of 15 more business days). After an unsatisfactory Step II response, the prisoner has 10 business days to file a Step III grievance, which is answered by the Administrator of the Bureau of Health Care Services if the grievance involves a medical issue. The deadline for a Step III response is 120 calendar days from the time the Step I grievance was filed (plus a possible 30 business days if extensions were granted for the Step I and II responses). If the MDOC fails to timely respond to a Step I or Step II grievance, the prisoner may proceed to the next level of appeal.

There are certain things that a prisoner cannot file a grievance about – including the content of MDOC policies (except as to how that policy was applied to the prisoner), decisions made in minor misconduct hearings, certain decisions made by the Parole Board, decisions made by hearings officers from the State Office of Administrative Hearings and Rules, and issues that are not within the authority of the Department to resolve. A grievance can also be rejected if it is vague, illegible, contains multiple unrelated issues, or is duplicative of another grievance filed by the prisoner. Grievances will also be rejected if they are untimely; if the prisoner failed to try to resolve the problem first; if the grievant is on modified grievance status and hasn’t gotten permission to file the grievance, or if the grievance contains profanity, threats, or demeaning language.

This Committee is suggesting several changes to the grievance procedure, some about the form of the policy and some about the spirit of the policy. The Oregon Department of Corrections’ (ODOC’s) grievance policies can serve as a model in this respect. The ODOC policy states, “The provision of health care is an interaction between the health care provider and the patient. Therefore, the patient must have avenues to resolve dissatisfaction, misunderstanding, or complaints about service. ...Inmates will not be penalized for seeking resolution of problems experienced with health care during incarceration and health care staff will continue to work with the inmate to achieve an understanding and resolution of complaints about health care.”³ The MDOC’s grievance process policy could benefit from similar guidance and expectations. The ODOC’s policy

reflects an attitude shift that also needs to be made within the MDOC with regard to health care grievances.

Unresolved Prisoner Complaints

Unfortunately, the MDOC's grievance process does not always result in a resolution of or a satisfactory response to a prisoner's complaint. Too often, grievance respondents ignore or gloss over a prisoner's genuine concerns, particularly if the prisoner's description of the problem is unsophisticated or hostile. Although the internal grievance appeal process should resolve this, it rarely does, and the Step II and III responses often merely rubber stamp the original response.

There is no global review or oversight of health care grievances by the MDOC or any outside agency. No audit is performed which might identify systemic shortcomings, problem staff or serious unmet treatment situations. In fact, in its bi-annual electronic report to the Legislature, the MDOC repeatedly denies that any prisoners' or their families' complaints about health care go unresolved.⁴ This is not true, and many of these unresolved grievances concern medical and mental health care issues.

A shortcoming in the grievance process is included in nearly every one of the case studies already addressed. By looking at these cases, it is easy to see the additional damage that can be done by a faulty grievance process.

To revisit some of these issues, Mr. Andre Davis was given a prescription for a medication that was contrary to his chemotherapy, and as a result he had to endure a bone marrow biopsy. Not until the Step III grievance response did anyone actually investigate the problem and provide an appropriate response.⁵ The Step II grievance took nearly *six months* to be answered. For Mr. Davis, the grievance process took far longer than 120 calendar days, and the problem was not actually investigated until the final step in the process.

Another example of grave harm caused in part by delayed grievance responses was in Alice Amy's case. An untimely grievance response at Step I (which took three months) only reiterated the fact that her hepatitis C follow-up appointments had been canceled three times over the previous two months. This did not help her resolve her issue at all. Relief through the grievance process cannot come fast enough if a prisoner must exhaust all three steps, or if grievance responses are so egregiously late.

Another problem with the grievance process is that the responses often fail to have any impact on the root of the problem. One example of this is in Mr. Steven Montgomery-El's case, where after he grieved custody staff for failing to take him to a health care appointment, the grievance respondent advised him to "contact his resident unit manager to complain." This is a serious issue that should have been investigated by the grievance respondent, and if custody staff was violating policy, corrective action should have been taken. Instead, the problem was glossed over and no action was taken, leaving the custody staff unaccountable for this mistake and leaving no room for corrective action to stop similar problems for occurring in the future.

In Jerome Martin's case, health care staff did not ensure that his medical records were confidential. This caused him to be worried that custody staff would have access to his personal medical records. Mr. Martin was housed in segregation at Alger Correctional

Facility when he requested copies of his medical records; some of the records that Health Care said they sent were missing from the packet he received from custody staff. Mr. Martin filed a grievance, objecting to the fact that the envelope containing his copies was not marked confidential, and alleging that the manner in which the records were delivered allowed custody staff to have access to his confidential medical records.⁶

Mr. Martin's claim that health care staff failed to clearly mark the envelope confidential was somewhat acknowledged in the course of the grievance process and caused Step III respondent to notify Mr. Martin the matter was under review for "quality assurance."⁷ However, the respondent did not address Mr. Martin's claim that the envelope was not sealed in a manner that would assure that his confidentiality would not be violated. Worse, his complaint remained unresolved because no grievance investigator or respondent identified which records were missing or checked to see if they had been sent with those originally provided.

One of the purposes of the grievance system is its function as a check and balance on other parts of the system; however, grievance respondents often attempt to deflect any blame for the situation grieved by the prisoner back on to the prisoner, even when he or she is not at fault. This happened in Mr. Rodney Alston's case involving a special accommodation; the Step I grievance response blamed him for not proving that his special accommodation existed when this was clearly not his responsibility in this situation. Again, no corrective action was taken against the incorrect MDOC staff. Another case of misplaced blame is exemplified in the prisoner who filed a grievance after his eye drop prescription was not refilled upon a transfer to a different prison; in that grievance response, rather than resolve the situation, the respondent blamed the prisoner for not bringing the problem up at an earlier health care visit.

Sometimes prisoners are just looking for answers or information in their grievances about health care. In Mr. Steven O'Connor's case, he filed several grievances about CMS' denial of the surgery recommended by the specialist, but was never given any detailed information about why the surgery was denied. Mr. Aaron Ralph also inquired about why his request for tinted lenses was denied, he was told that he did not meet the criteria, but he was not given an explanation of the criteria. When people are denied information about their health care, it is very frustrating, and is fundamentally unfair.

The grievance process needs to be fixed if it is to truly function as a vehicle through which prisoners can resolve the problems they encounter, especially in the area of medical and mental health. Another benefit of revising this process would be that the number of lawsuits filed by prisoners could be reduced because court action will no longer be necessary to receive proper treatment. If the grievance procedure is currently being revised, it would benefit the public and the MDOC to provide a detailed summary of the process and an honest recognition of the systemic flaws within health care and mental health care services.

Recommendations for Change

PROBLEMS: The grievance process does not often provide the internal problem resolutions that were intended by policy. The untimely responses, the lack of accountability in the responses, the lack of explanation, and the lack of real solutions to problems make the process very ineffective. The policy should be altered in several ways to address some of the grievance problems outlined in the many case studies above, as well as others that advocates have noted in the course of years of working with prisoners.

RECOMMENDED SOLUTIONS: The Legislature and MDOC must develop a meaningful and economical means of redressing problems between prisoners and health care staff, including creation of a health care grievance system that is separate from the regular prison grievance procedure system, and which ensures the following:

- Health care grievances should be investigated and answered solely by individuals with medical credentials, who are assigned only for the purpose of investigation;
- Health care grievances should be on a faster track for review and response;

RECOMMENDED SOLUTIONS:

- Health care grievances should be reduced to a two-step process. Health Services staff should answer the Step I grievance, and depending on the urgency, should respond between 24 hours and one calendar week of receipt. After seven days, if the answer is not acceptable or if no answer is received, a prisoner may appeal directly to the office of the Chief Medical Officer at Step II. Step II responses must be received by the prisoner within 10 days; if no response is received within 10 days, the prisoner should have at least one month to exercise an option of settlement through mediation, or else file a case in court;
- When answering a grievance, respondents should document finding(s), requiring the MDOC to meet the same standards prisoners are held to (i.e., the respondent must state who, what, when, how, why, where and dates, times and places and names of those involved);
- The MDOC should create grievance investigation protocols that identify relevant documentation and questions to be asked when responding to a grievance;
- The MDOC should provide the prisoner with copies of documentation that support the grievance answer, including copies of medical records verifying finding(s);
- The MDOC should train grievance investigators, including training in the technical and administrative aspects of answering grievances. This training should incorporate a preliminary statement that defines the relationship between the health care staff and the prisoner patients. Furthermore, the following points regarding grievance responses outlined in the Oregon Department of Correction's Grievance Policy should be adapted by Michigan to create a more effective and respectful medical grievance system:
 1. Responses should be easily understood by the reader. Respond using simple language. Avoid the use of medical terminology that is not easily understood by our patients.
 2. Responses should be courteous. If an apology is due to the patient, include it in the response. The numbers of grievance appeals are more likely to be reduced by an appropriate response.
 3. Direct your response to the writer. The response is not to the supervisor, it is an explanation in writing to the patient.

Recommendations for Change continued

4. Stick to the topic. Do not throw in material that is not relevant to the patient's complaint.
5. If action was taken because of the grievance, let the writer know what steps you took or what you have in mind for future action.
6. A thank you [is] always appreciated. If someone has identified a problem that needs some kind of intervention, let them know you appreciated the information, e.g., Thank you for bringing this problem to my attention...
7. Keep the response short and to the point. Avoid abrupt answers such as: Appointment made. J. Smith, R.N. The patient needs some information and we need to be responsive to their request.
8. Respond in a timely manner.
9. Responses need to be professional and polite regardless of what has been written in the grievance.
10. Offer an opportunity to leave a door open, e.g., if you have any questions please contact...
11. It is recommended that all correspondence be responded to within seven (7) working days.⁸

RECOMMENDED SOLUTIONS:

- The MDOC should create a policy which includes disciplinary action for a grievance respondent's failure to properly investigate, document, and/or answer a grievance at any level;
- Medical Grievances should be reviewed quarterly by the Regional Medical Officer or CMO. These reviews should be based on a system wide method of computerized worksheets connected to whatever medical database is implemented. These worksheets should be written up with every medical grievance at the step I level and reviewed and supplemented at the step II appeal level when necessary. The Oregon department of Corrections Grievance Work Sheet is attached in Appendix C.
- The MDOC and/or the legislature should provide prisoners a route of redress through arbitration or mediation to lower the costs of litigation and increase the accountability on behalf of the MDOC and its contractors.

A revised grievance process with more accountability and greater speed will help the MDOC realize the goals set out by the grievance policy and the internal grievance process generally.

Endnotes Case Studies: Section Nine

¹ Prison Litigation Reform Act of 1995, Pub. L. No. 104-134 codified in 42 U.S.C. §1997e(a); MCL 600.5501-600.5531. see endnotes 6 and 8 in History and Overview: Section Five of this Report.

² MDOC Policy Directive 03.02.130, Prisoner/Parolee Grievances.

³ Oregon Department of Corrections, Operations Division, Health Services Section Policy and Procedure #P-A-11. Revised February 2007, Pg.1

⁴ See endnotes 6 and 8 in Section Six, and endnote 4 in Section Nine of this Report.

⁵ Grievance JCF 05 05 1133 12F, Step III response received on January 14, 2006.

⁶ Grievance LMF 05 09 3203 12z.

⁷ Grievance LMF 05 09 3203 12z, Step III response.

⁸ Oregon Department of Corrections, Operations Division, Health Services Section Policy and Procedure #P-A-11. Revised February 2007, Pg.2

PART THREE

MENTAL HEALTH

Inadequate Mental Health Treatment

Mental health care in the MDOC is a bifurcated system utilizing both the MDOC's Psychological Services Unit (PSU) and the Michigan Department of Community Health (MDCH). Psychologists from PSU provide intake at the Reception and Guidance Center, emergency crisis intervention, segregation unit rounds, segregation psychological evaluations, provide pre-release parole evaluations, conduct assaultive and sex offender programs, and screen referrals to the Corrections Mental Health Program (CMHP). The Michigan Department of Community Health provides psychiatric services through the CMHP, and provides inpatient and outpatient psychiatric services, including acute care, rehabilitative treatment, the residential treatment program, and the secure status outpatient program.

The MDOC's stated intent is to provide a continuum of care ranging from inpatient acute care to outpatient follow-up services.¹ However, CMHP will only provide treatment to prisoners who meet certain criteria. The CMHP's criteria for 'mental illness requiring treatment' includes a prisoner's satisfying the Michigan Mental Health Code (MMHC) definition of mental illness, or the presence of a serious mental illness associated with significant suicide risk, or the presence of a diagnosis of schizophrenia, bipolar disorder, schizoaffective disorder, major depressive disorder or other psychosis. In Chapter 4 of the MMHC, mental illness is defined as "a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life."² The MDCH Program Statement also states "Statutory requirements for admission to the CMHP.. are less stringent than those typically applied in civil psychiatric settings," and that "these are bold guidelines rather than inflexible rules, so that exceptions can be made as needed to best suit the needs of patient/prisoners and resources of the mental health system."³

According to MDOC policy, "A prisoner with a severe mental disorder, serious mental illness, or serious deficiencies in adaptive skills due to mental retardation ordinarily should not be housed in segregation. The Department has more appropriate mental health care settings which are designated for therapeutic management and care of such prisoners; i.e., inpatient psychiatric hospitalization, the Residential Treatment Program (RTP), and the Secure Status Outpatient Treatment Program (SSOTP)."⁴ A small exception to this rule is carved out in the same policy directive: "A small group of prisoners with severe mental disorder, serious mental illness, or serious deficiencies in adaptive skills due to mental retardation cannot be managed outside of a segregation unit without posing a serious threat to the safety of staff and other prisoners. However, while in segregation, all such prisoners must be closely followed by the institution outpatient mental health team (OPMHT) or a Qualified Mental Health Professional (QMHP)."⁵

Unfortunately, MDOC and MDCH practices do not always follow the criteria outlined in policies briefly addressed above. There are lengthy MDOC and MDCH policies concerning mental health treatment of prisoners, which outline practices that appear to adequately address mental health issues that arise in the prison setting. However, in actual practice, the policies and procedures are not followed in a manner that ensures real treatment of mentally ill prisoners; as a result, many prisoners suffer greatly as a result of their untreated mental illnesses.

As part of the litigation in Cain v. MDOC, three of the Plaintiffs' experts investigated cases of prisoners in segregation, who were suspected to have serious mental illnesses. According to these experts, the investigation found a large number of mentally ill and severely psychologically disturbed prisoners in MDOC's segregation units and in most cases, these prisoners were denied mental health treatment. Many of these prisoners, who could be managed in treatment units with proper diagnosis and intervention (as policy dictates), are instead being misdiagnosed and improperly placed in segregation units. There, they languish and further psychologically deteriorate without significant mental health services. A more detailed history and background discussing the evolution and failure of mental health treatment in the MDOC can be found in a separate report by one of our consultants.⁶

The Cain investigation also uncovered many cases where prisoners who had previously been receiving psychiatric treatment for a major mental illness were abruptly un-diagnosed or found suddenly no longer mentally ill. Instead, these prisoners were declared to be 'malingering' or faking a mental illness for the purpose of receiving attention. Almost all of the diagnoses changed were made or approved by psychiatrists, who have the final say on diagnoses; some were supported by the treating psychologists, but some were not. According to Dr. Walsh, subsequent placement in administrative segregation without mental health treatment frequently resulted in further psychological decompensation of these prisoners, usually manifested as increased assaultiveness, self-mutilation, suicide attempts, bizarre behavior, and more rule violations. In other cases, some "at risk" but non-mentally ill prisoners placed in long-term segregation as a consequence of disruptive behavior, actually appear to have developed psychological disturbances and mental illness as a consequence of their ongoing exposure to the severe conditions of solitary confinement.

The end result in both types of cases can be increased psychological deterioration, followed by further isolation in segregation, which may actually increase the assaultiveness and risk of harm to the prisoner and everyone in contact with him.⁷ While MDOC maintains that long term segregation is not punitive, but rather an administrative tool based on security concerns, the effect upon prisoners is universally experienced as punitive and the result of such long term isolation often serves to undermine both security and staff safety.

Long Term Segregation

Segregation in prison means the same thing as the English word – isolation from others. Segregation in prison also means tight restrictions on property, availability of programs, and time spent outside a prison cell. Prisoners in administrative segregation are locked in their cells twenty-three hours a day, take all meals in their cells alone, and are permitted only one hour of exercise on the yard, five days a week.⁸

Long term segregation refers to placement in administrative segregation for more than 90 days. It can only be imposed after a hearing officer or security classification committee has found that the prisoner is unable to be managed with group privileges (the most common reason), poses a threat to the physical safety of others, is an escape risk, is under investigation by an outside law enforcement agency for a felony, or is HIV positive and found guilty of behavior that could transmit HIV.⁹

In July 2005, the MDOC provided the Cain Long Term Segregation Working Group with the following information on the number of prisoners in administrative segregation and the length of time they had been there. Here are the results:

<u>Time in Administrative Segregation</u>	<u>Number of prisoners</u>
Less than 3 months	227
Three to six months	343
6 months to one year	280
One to three years	276
Three to five years	134
Five to ten years	130
Ten to fifteen years	49
Fifteen to twenty years	18
More than twenty years	2

The MDOC implicitly recognizes the psychiatrically toxic effect of long term segregation – it requires a psychological screening of segregation prisoners after the first 30 days, each 90 days thereafter, and annually.¹⁰ However, these evaluations typically take less than one minute, they take place through a closed cell door and in most cases, the screener simply checks boxes on a list rather than writing a narrative report on the individual's condition.¹¹

Background of the Investigation in Cain

As expert witnesses and consultants for Prison Legal Services of Michigan (PLSM) in the Cain v. MDOC lawsuit, psychiatrists Terry Kupers, M.D. and Stuart Grassian, M.D., and psychologist Robert Walsh, Ph.D., interviewed and evaluated a number of pre-selected prisoners in segregation units in various Michigan prisons in 2002. Specifically, prisoners in segregation status at ten prisons were selected on the basis of reports or other indicators suggesting that they may be mentally ill.¹² In 2005, Dr. Walsh performed follow-up evaluations on an additional, smaller sample of long-term segregation prisoners. Despite the policy implication that there would be no (or few) mentally ill prisoners in segregation, these experts found that many of the prisoners in these samples had mental illness.

Together, these two samples present a dire picture of mental health care in Michigan's segregated prisoner population, revealing a critical gap in services for prisoners in segregation. It is likely that these same shortcomings exist for mentally ill prisoners housed in general population as well.

The underlying reason for conducting these evaluations was the strong stance by the MDOC that, with the possibility of rare, isolated exceptions, no mentally ill prisoners were housed in its segregation units. Despite this assertion, the Cain plaintiffs and their counsel found indicators that a significant number of mentally ill prisoners were in fact being so housed. As the investigation progressed, there appeared to be a pattern: prisoners were diagnosed as mentally ill and received major psychotropic medication; then they were suddenly undiagnosed, and re-labeled as "malingers" or having "antisocial personality disorders." Medications were abruptly discontinued, and many of these prisoners were confined to administrative segregation. A large number of these men appeared to be seriously mentally ill and suffering from a variety of conditions, including psychoses and major affective disorders.

It is well established that imprisonment in isolated, solitary confinement for significant lengths of time can have profoundly destructive psychological effects on otherwise healthy people.¹³ Confining actively mentally ill people under these conditions is unusually cruel and dangerous. Similar findings of long-term detrimental effects on mental health have been reported in other jurisdictions that utilize isolation in long-term segregation as a means to control prisoners.¹⁴ The MDOC has been aware of the extremely debilitating effects of isolation as early as 1857, when Michigan's first prison began using solitary confinement and found in 1861 that 9 of the 20 men so placed had become "insane."¹⁵

Removing the mental illness diagnoses from prisoners and then re-diagnosing them as malingerers with personality disorders allows the MDOC to avoid the cost of treating a larger number of mentally ill prisoners, and also allows these prisoners to be housed in segregation. The MDOC has refused to acknowledge the prevalence and incidence data on mental illness found by an extensive epidemiological study of the Michigan prison population in 1987.¹⁶ While this study is several years old, it still compares well with current national data on the prevalence and incidence of mental illness in correctional populations.¹⁷

In fact, because mentally ill prisoners are more likely to have trouble following rules, they consequently receive more major misconducts and spend more time in segregation than healthy prisoners. Because of this, they are less likely to be paroled and thus actually accumulate in the prison population, increasing the percentage of mentally ill prisoners within the entire prison population. However, the actual documented numbers do not reflect this, because when prisoners are un-diagnosed they are no longer tracked or counted as mentally ill prisoners. By ignoring the real prevalence of mental illness among the prisoner population, and redefining these prisoners as not mentally ill, the MDOC actually undermines the very heart of the CMHP commitment, and calls into question the integrity of that program.

The original Cain-related investigation into the mental health care for prisoners in segregation included the initial review of existing mental health records (computer and hard copy) of several hundred prisoners, resulting in Dr. Walsh conducting face-to-face interviews with 37 prisoners, completing written psychological evaluations on 23 of these prisoners, and written reports on 2 prisoners from file reviews only. An additional 48 case reviews were completed by Dr. Kupers. The sample size of prisoners evaluated was limited by court-imposed time constraints, logistics and the MDOC's cooperation with access to selected prisoners. The findings in this section are largely based on the conclusions reached by Dr. Robert Walsh during this investigation and are consistent with the findings of Drs. Kupers and Grassian.

The downplaying of mental illness begins the moment a prisoner enters the MDOC system. In the initial phase of the Cain investigation, Dr. Robert Walsh evaluated 25 prisoners who had spent an average of 49 months in segregation.¹⁸ Of these 25 men, at least 13 had documented, pre-incarceration histories of mental illness (usually psychosis or major mood disorder), and of these, 11 had pre-incarceration histories of having been on anti-psychotic and/or other major psychiatric medication. Another 13 had histories of significant head trauma.¹⁹ Review of Reception and Guidance Center (RGC) and Riverside Reception Center (RRC) intake psychological evaluations revealed that MDOC mental health staff failed to identify at least 15 of these men as having histories of mental illness. Only four were correctly identified as having a major Axis I disorder²⁰ (other than substance abuse or adult antisocial behavior), as indicated by review of later MDOC mental health program diagnoses.

MDOC/DCH mental health staff, at one point, diagnosed these 25 men as follows: 14 with some type of psychosis, 7 with a major mood disorder, one with mild mental retardation, and one with dementia. Eventually, however, they un-diagnosed 19 of these men. Four maintained their diagnoses of mental illness, and two were never diagnosed as having ever had a major mental disorder. Of those who were subsequently un-diagnosed, 13 were labeled as malingerers, and the Axis I diagnoses for five prisoners were changed to either "No Diagnosis" or "Diagnosis Deferred." Many were also labeled as having Antisocial Personality Disorder or Borderline Personality Disorder on Axis II. While some evaluators had originally identified the prisoners' Axis II personality disorders in addition to their major Axis I conditions, the Axis I diagnosis was subsequently removed and then the Axis II diagnosis served as justification to terminate all mental health treatment. Interestingly, at least 17 of these un-diagnosed men had at one time been prescribed significant dosages of anti-psychotic medications, and 16 had been prescribed other psychoactive drugs (e.g., mood stabilizers or anti-depressants). Seventeen of these men had at one time been prescribed drugs from multiple categories, while only four had never been prescribed any psychoactive drugs.

In 2005, three years after the first group of interviews, Dr. Walsh interviewed a second group of ten long-term segregation prisoners in maximum security prisons. These men had spent from one to more than eight years in segregation, the average time being five years. Based on record review and in-person interviews, according to Dr. Walsh, all ten of the men in the follow-up sample showed substantial evidence of a chronic or long-standing major mental disorder. Eight of the men were diagnosable as psychotic, three of which were schizophrenic, two schizoaffective, and two with major affective disorders with psychoses. The remaining two had major affective disorders without psychosis, including one with Bipolar I Disorder and one with Major Depressive Disorder. All appeared to be extremely stressed, anxious and intense in their symptomology. All ten of these men were comorbid²¹ for significant personality disorders, nine of which were Antisocial Personality Disorder, sometimes in combination with Borderline Personality Disorder. The rate of closed head injury history was quite high, and was reported in at least 50% of the cases evaluated. In addition, three of these men had previously been diagnosed as either mildly mentally retarded or significantly learning-disabled.

As was the finding in the original group of prisoners, most of those in the follow-up group had at one time previously been diagnosed as mentally ill by MDOC/DCH clinical staff, only to later be un-diagnosed and declared as personality disordered malingerers. Further, at least eight of them had been previously prescribed major anti-psychotic, anti-depressive, mood stabilizer and/or anti-anxiety medication by DCH psychiatrists. Dr. Walsh found that none of the prisoners in the follow-up sample were considered to be mentally ill by MDOC/MDCH staff at the time he conducted these evaluations; however, at least one prisoner was receiving antipsychotic medication for depression, and his diagnosis kept changing.

Findings and Recommendations for Change

In reviewing and abstracting the massive amounts of data the mental health experts obtained from interviews, evaluations and file reviews on these men, some cases came to light of mentally ill prisoners in segregation units who had actually died while in segregation. Two of these men died from dehydration and two from starvation. These deaths exemplify the urgent need that the recommendations summarized below be implemented as soon as possible, to prevent more unnecessary and preventable suffering and deaths from occurring.

Despite the MDOC's stated policy goals concerning treatment of mentally ill prisoners, its prohibition on housing mentally ill prisoners in segregation, and the required special treatment for the "small group of [mentally ill] prisoners... [who] cannot be managed outside of a segregation unit...", many prisoners who are housed in segregation are indeed suffering from multiple forms of mental illness. These prisoners are not getting the attention, diagnoses, and treatment they desperately need. What follows is a summary of the findings of Dr. Robert Walsh, one of the three Cain mental health experts, after his investigation into the mental health care of segregation prisoners that were conducted as part of the Cain litigation. Following each finding is a recommendation aimed at correcting the problems that currently exist in the mental health care treatment program. Some aim to correct flaws in policy, and others in the attitudes of MDOC/DCH employees and the culture of mistreatment of prisoners that permeates the system.

Finding One: MDOC continues to un-diagnose previously diagnosed mentally ill prisoners as a consequence of their difficult-to-manage behavior. Eighty-four percent of the men in the first sample in Cain had been diagnosed by MDOC mental health staff as having some form of mental illness, but over 90% of them later had that diagnosis removed, and replaced with the label "malingerer" or diagnosis of antisocial personality disorder. This allows the MDOC to place the prisoners in long-term administrative segregation, causing further deterioration in their mental states and exacerbation of their mental illnesses, denial of critical mental health care, increased risk of self-injury, and increased risk of assaults. Once in long-term segregation, the likelihood of further misconduct and behavioral management problems is very high, further ensuring prisoners' continued confinement in isolation. The practice is counterproductive from both a treatment and a management perspective, and endangers staff in addition to prisoners.

Recommendation One: The practice of un-diagnosing a person with a previously established diagnosis should be an isolated occurrence that is severely restricted, and subject to critical supervisory/peer review. Every such occurrence should be well-documented and re-diagnosis should not be used to mask behavior that may be caused by reoccurrence or emergence of mental illness. A well documented justification for the un-diagnosing should be provided with appropriate feedback to the original staff

member who made the incorrect diagnosis, and if necessary, relevant training provided to prevent similar mistakes in the future.

Finding Two: MDOC overuses long-term confinement in administrative segregation as a tool for controlling prisoner behavior, and it is failing. The mental health expert team encountered too many men with hundreds of major misconducts and 50+ staff assaults who are even more dangerous and aggressive as a result of years spent in these units. This practice, which is allegedly used to reduce or stop staff assaults and reduce major misconduct, appears to have the opposite effect.

Recommendation Two: The practice of subjecting prisoners to indefinite, long-term confinement in administrative segregation should be discontinued, as it does nothing to help prisoners bring their disruptive behavior under control. Prisoners should be confined no longer than is minimally necessary to calm them down and bring their behavior back under control. Following this they should be transitioned back into general population at an appropriate security level. After 14 days of in administrative segregation, each prisoner should be interviewed at least weekly by custody and psychological services staff. Each interview should be conducted out of cell and documented in a narrative report. Prisoners who are unable to bring their behavior under control within the first two weeks of segregation confinement should be closely evaluated for the presence of a significant mental disorder, and treated with regularly scheduled individual psychotherapy sessions, for as long as is necessary.

Finding Three: Un-diagnosing prisoners as mentally ill and re-labeling them as malingerers results in that label becoming a filter through which future behavior is viewed as manipulation and symptom feigning. Although it is possible (and common) for mentally ill prisoners to exaggerate and even feign symptoms for secondary gain, these acts are a part of the overarching mental illness, not something separate and different. Instead, these prisoners are being wrongly denied future mental health treatment.

Recommendation Three: Both a major mental illness and an act of symptom-exaggeration or feigning can occur simultaneously in the same person and should not serve as justification to remove a prisoner's mental illness diagnosis. Mental health care staff should carefully examine the motivation for prisoner's behavior, being open to reasons aside from trying to get more "pleasant" housing. Possible explanations for this behavior include using it as a "cry for help," a failure of the prisoner's coping mechanisms, a result of high and traumatic stress levels, etc. Even if he appears to have escaped the deleterious effects of segregated confinement, those effects on the person's current behavior should be explored in detail and constructively addressed.

Finding Four: The reference to "manipulation" as a reason to deny prisoners access to mental health care continues to be a practice among MDOC and DCH mental health staff, who use it as though it is an actual diagnostic condition. Once so labeled, the designation typically sticks with a prisoner and taints future behavior that might have otherwise been seen as symptomatic of a significant mental disturbance, effectively preventing treatment.

Recommendation Four: The characterization “manipulation” is not a valid diagnostic concept and should not be used as such by mental health staff. It is not uncommon for mentally ill and seriously disturbed people to also exaggerate their symptoms in an effort to obtain help from a mental health professional who is not taking their condition seriously. This is especially true in the case of suicidal behavior, which often contains a manipulative component in prisoners and non-prisoners alike. Most suicidal behavior that is unsuccessful is often an attempt to obtain help, made by a very conflicted person in an acute crisis. Labeling and discrediting the behavior (and person) as manipulative and disingenuous is inappropriate and should cease.

Finding Five: MDOC/MDCH mental health staff abuse the personality disorder label, and appear to misunderstand the interaction between major Axis I or mental illness conditions and Axis II personality disorders. According to Dr. Robert Walsh, “Once the prisoner becomes hard to manage, mental health staff often ignore the presence of a prisoner’s mental illness and instead focus on the personality disorder, using it as an excuse to deny previously approved treatment. Many, if not most, mentally ill prisoners have a history of comorbid personality disorders. Sometimes, in response to treatment, the more negative aspects of the personality disorder can emerge, and may temporarily overshadow the Axis I condition. Clinically, it can be very difficult to sort out and isolate these behavioral effects as being based on the personality disorder, as opposed to being caused by the mental illness. It is even harder to separate out when the behavior is the result of an interaction of the two conditions. When this does happen, it may very well be that mental health staff’s frustration in dealing with a multiple diagnosis situation is the basis for the ‘revelation’ that the problem is based not on mental illness but personality disorder.”

MDOC/DCH staff misuse the diagnosis of personality disorder as a reason to remove a legitimate Axis I diagnosis, and/or misdiagnose personality disorders by ignoring the high occurrence of comorbidity for both in this population. MDOC/DCH staff also ignore both the CMHP program statement, which cautions against using only certain Axis I conditions to limit access to treatment, and the DSM-IV warning against misinterpreting Axis II conditions as being of lesser severity and pathogenesis.²² The result is that severely mentally disordered and mentally ill prisoners are submitted to the punitive conditions of segregation and denied much needed mental health treatment.

Recommendation Five: Many MDOC prisoners have personality disorders, and this is particularly true of mentally ill prisoners who end up in segregation. Prison mental health staff should stop using this diagnosis as an excuse to deny treatment to mentally ill prisoners when they become harder to manage because of a comorbid personality disorder. If the behavior is prominent and disruptive, the personality disorder can be simultaneously treated with psychotherapy as an adjunct to the pharmaceutical treatment of the mental illness. The MDOC should provide specific training to prison mental health staff in recognizing and therapeutically managing the all too common comorbidity of mentally ill prisoners with significant personality disorders, and break the cycle of placing them in segregation. This is critical, because many mental health staff come to the MDOC with little prior training in correctional mental health care, and can develop bad habits when the models and concepts learned in school and the

community are not easily adapted to prisoners. Severe personality disorders are major mental disorders as much in need of treatment as the Axis I disorders commonly identified with mental illness, and it is inappropriate to treat them otherwise.

Finding Six: In MDOC segregation units, cell-side or cell door “mental health evaluations” continue to be the standard method of documenting the mental status of those prisoners. However, prisoners have reported a habit of refraining from talking openly to psychologists doing these evaluations because there is no privacy, and there is a reasonable danger of being overheard by other prisoners and custody staff. It is naive to dismiss this as inconsequential, as personal information in this type of prison environment is both a commodity to be exchanged and a source of potential physical harm to the prisoner making the revelation. Psychologists can miss significant signs and symptoms of mental illness during these superficial “screenings,” and thus many problems go unnoticed until too late. This practice is a major flaw in the mental health care service delivery system for segregated prisoners, and undermines both the effectiveness of the whole process and the stated policy goals of the MDOC. The potential violation of patient confidentiality may also be a violation of professional ethics and is an inexcusable, unprofessional practice.

Recommendation Six: The MDOC/MDCH should immediately cease the practice of conducting segregation psychological evaluations and/or screenings at cell fronts, including the policy-required 30 and 90 day screenings. Such evaluations should be conducted in the privacy of a room with at least auditory confidentiality. Regular housing unit rounds can still be done cell-side as long as every effort is made to engage the prisoner in enough non-confidential small talk so the practitioner can evaluate whether any major disturbance is present. If there is any indication that the person may be experiencing significant psychological decompensation, custody staff should escort the prisoner to an enclosed room so a confidential and thorough evaluation of the prisoner’s condition can be done. The only exceptions should be when the prisoner refuses to leave the cell, or where removal of the prisoner from the cell poses a real danger of serious injury to either staff or the prisoner. In such circumstances the clinician should make every effort to determine the reason for the prisoner’s behavior, and give serious consideration to a referral for more intensive mental health care.

Finding Seven: When the Cain experts toured segregation units and perused unit log books, it appeared that mental health staff making policy-required segregation rounds actually spend very little time interacting with the prisoners. In fact, it was not uncommon to find that staff spent an average of one minute or less with each prisoner, hardly sufficient time to ascertain the mental status of prisoners in general population, let alone one subjected to the extreme stresses of isolation in a segregation cell.

Recommendation Seven: Mental health staff making segregation screening rounds should spend a minimum of 5 minutes with each prisoner to get a valid impression of each prisoner’s general mental state, and more time if symptoms of psychological decompensation are detected. If a prisoner refuses to cooperate with the interview/screening, mental health staff should spend a minimum of three minutes observing the prisoner, and then follow up with custody staff about their impressions of the prisoner’s

recent behavior in order to get a valid impression of the prisoner's mental state. This investigation will also take more time if symptoms of psychological decompensation are detected. Hopefully this will avoid major mental problems from going undetected until they reach extreme and sometimes tragic levels.

Finding Eight: In the opinion of the Cain mental health care experts, the placement of a suicidal or seriously self-injurious prisoner into a so-called "observation" cell is actually punitive and non-therapeutic at best.²³ This was found to be especially true of prisoners already housed in administrative segregation, who reported that the conditions in these cells were far more restrictive and punishing than they experienced in their regular administrative segregation cell. According to Dr. Robert Walsh, "All too often, we encountered segregation prisoners, some with clear signs of major mental illness, who stated that they would deny or fail to report suicidal thoughts and preoccupation to staff out of intense fear of being placed in one of these observation cells." It is inherently wrong for a suicide prevention policy to include a practice that actually puts higher levels of stress and trauma on people already contemplating taking their own lives, and punishes them for asking for help.

Recommendation Eight: The MDOC's "Suicide Prevention" policy should be re-examined and revised to create more safeguards to prevent these harmful practices from occurring. If there is any reason to believe that a prisoner's suicidal behavior is anything but extremely superficial, the person, regardless of segregation status, should be referred to an appropriate treatment unit to receive mental health services, not more punitive detention. Further, clinical supervisors should more closely supervise and monitor the behavior and practices of staff's use of observation cells to avoid punitive use of these cells. Any prisoner placed in such a cell as a result of possibly suicidal or self-injurious behavior should automatically be afforded intensive, short-term individual psychotherapy sessions several times a week until the crisis is resolved.

Finding Nine: The MDOC's use of in-cell, top of bed, 4-point restraints is excessive and serves more for the convenience of staff than for actual protection of (or from) the prisoner. It is also commonly used for suicidal and self-injurious prisoners when they are placed in an "observation cell" where their hands and feet are shackled to a concrete or metal "bed" for long hours. The recent deaths of two mentally ill prisoners while under top of bed, 4-point restraints underscores the danger of this practice except under extremely rare conditions, and then only with onsite direct medical supervision. When the Cain experts interviewed prisoners who had undergone such "self-protection" measures, they universally reported experiencing these restraints as extremely punishing.

Recommendation Nine: All MDOC facilities, not just those under the jurisdiction of Hadix, should immediately cease use of in-cell, top of bed, 4-point restraints. This practice is dangerous and has been found by a United States District Court judge to constitute torture and violate the Eighth Amendment of the United States Constitution.²⁴ This determination was made after a hearing during which four physicians testified about the use of these restraints. Three of the witnesses indicated that a doctor cannot ethically monitor use of the restraints. Judge Enslin stated in his opinion, "Further, the fact that physicians regard such treatment as torture

and will not facilitate it means that the process could only be continued by either forsaking medically necessary examinations or commissioning medical officers to violate their professional ethical rules. The Court will do neither.”²⁵ The opinion goes on to outline what legitimate uses of mechanical restraints continue to be permitted at Hadix facilities, which is limited to restraints being used only during transportation or movement of prisoners, for the safe provision of services to prisoners, and for temporary emergency reasons (such as to quell a riot). All MDOC facilities should adopt similar guidelines regarding these restraints.

Finding Ten: Upon interviewing prisoners as part of the Cain case, the mental health experts found that prisoners who engage in self-injurious behavior (SIB) are often treated punitively, and are rarely provided with meaningful mental health treatment. Self-mutilative behavior (SMB), a subset of SIB, is known to have multiple causes and neurochemical components. Research has demonstrated that much of this behavior is maintained by the release and binding of dopamine and endogenous opiates/opioids, or both, to receptors in the tegmentum and nucleus accumbens (receptors in the brainstem).²⁶ People in highly stressful situations naturally release large amounts of dopamine, triggering a cycle of excessive arousal, release, and re-arousal, a pattern seen in long term segregation prisoners, who repeatedly self-mutilate during the arousal state. Research has also demonstrated that some medications that block serotonin reuptake²⁷ can break the cycle and reduce the SIB/SMB. Administered conjointly with psychotherapy, this behavior can be successfully treated in many people with SIB, bringing the anxiety/panic attacks and high stress levels experienced back under control.²⁸

This stress, along with isolation, loss of meaningful social contacts and the sleep deprivation or disruption that occurs in segregation serve to act negatively on the serotonergic neurons in the brain, triggering and recycling many of these behaviors that are improperly viewed as volitional acts of defiance, and punished accordingly. The initial triggers for SIB seen in segregation units appear to be environmental, but once initiated, the behavior is maintained and recycled by neurochemical changes.

Recommendation Ten: MDOC staff should cease treating SIB/SMB behavior as volitional defiance and stop punishing people who, because of the environmentally induced trauma and stress, deteriorate to that level of extreme desperation. Significant staff training in the multiple causes of this behavior is critical, as well as implementing a major change in staff attitudes towards prisoners who engage in SIB/SMB. Treating staff should consider the biochemical, psychological, and environmental components that trigger this behavior, and provide appropriate therapeutic interventions that address all of the contributing factors.

Finding Eleven: When doing mental health screenings, mental health services staff increasingly rely on checklists and pre-printed forms, rather than completing narrative evaluations. This is apparently a cost saving and streamlining measure. As applied to segregation psychological screening, the manner in which the CHJ-551 (Segregation Psychological Screening Form) is being used actually undermines the purpose and integrity of the screening process it was created to enhance. If one were to accept the results recorded on the majority of these forms, one could only conclude that long-term

segregation has no significant negative effects on these prisoners. The facts are clearly otherwise.

According to Dr. Robert Walsh, "We reviewed form after form on the men in our samples and usually found there was no indication of signs of mental illness in people who often had documented histories of psychoses and/or major mood disorders. Yet when we spent some time actually evaluating these same prisoners in a private room without other prisoners and custody staff overhearing our conversation, we found widespread depression, anxiety, suicidal preoccupation, and psychotic symptoms, including delusions and hallucinations. But many of the forms were completed time after time with the same brief comments and an indication that no symptoms were observed. In at least several cases we found forms that appeared to have been pre-filled out, using the same identical comments in the same identical handwriting, except for the dates of the screening, which were different. These appear to have been mass photocopied and then dated and put in the prisoner's health record on the date the cell-side screening was required. In another case the forms were also blank in the spaces for the prisoner's name and number, suggesting that the same pre-filled form without significant findings may have been used for more than one prisoner."

This is not the practice that was intended when these screening forms were created; it is inappropriate and unethical, and contributes to the negligence in the way mental health services are provided that was found by the Cain experts.

Recommendation Eleven: These screenings were originally implemented as part of consent decrees in two Michigan cases, Hadix v. Johnson, and USA v Michigan. The parties accepted that periodic psychological screening of these prisoners was a necessary safeguard to ensure prompt identification and referral for treatment of these patients when such symptoms began to emerge. The current dilution of this screening into little more than a "paper chase" undermines the integrity of the process, rendering it indistinguishable from the wholly inadequate processes that existed prior to the consent decrees. The checklists should be discontinued and replaced with a narrative format, with strict content guidelines requiring some documentation of the clinician's conclusions. More supervision should be put in place, including supervisory review of the quality of the narrative report, and review of a random sample of prisoner health records which includes a brief supervisory interview of the prisoners in this sample.²⁹

Finding Twelve: In the cases reviewed by the Cain mental health experts, mental health staff did not identify or flag conditions that could make prisoners vulnerable for breakdowns if subjected to the intense stress of long term segregation. There is an extensive body of research documenting the extremely detrimental psychiatric effects of incarceration in general and isolation in particular.³⁰ This reality should be considered by prison mental health and administrative staff when making decisions about placement of prisoners in long term segregation. From this and other research it is known that individuals with developmental disabilities, prior histories of mental illness, past suicide attempts, histories of brain injuries, are at increased risk of breakdowns under the harsh stimulus deprivation of segregation. There is very little effort to identify these prisoners with psychological vulnerabilities that place them at increased

risk of decompensation if placed in segregation.

Recommendation Twelve: The MDOC should develop and implement an early identification and tracking system for prisoners with significant, pre-existing conditions that make them vulnerable to breakdowns if placed in segregation. This would alert mental health and custody staff to more carefully monitor these people for early warning signs that might otherwise be ignored, and to intervene early to prevent the emergence of more severe conditions under such intensive and prolonged stress.

Finding Thirteen: MDOC employees who spend long periods of time working in segregation units become anesthetized to the extreme conditions prisoners endure there. As a result, these employees no longer recognize the growing symptoms of mental illness or breakdown exhibited by prisoners. Circumstances that the average citizen would find abhorrent have become normalized (and therefore unremarkable) for the MDOC/MDCH employees working solely in segregation units. This normalization opens the door to tragic events, such as deaths in segregation units, and leaves the MDOC employees open to liability and prisoners open to cruel and unusual punishment. Many of the serious problems in segregation units are due to the culture that exists among staff in those units.

Recommendation Thirteen: The MDOC should immediately ensure that all staff working in segregation units (including mental health, medical and custody staff) be placed on mandatory rotation schedules limiting the time assigned to those units before being transferred to non-segregation assignments. This could be a 6 month segregation assignment followed by 12 months on a non-segregation assignment, before another segregation assignment is allowed. This is critical to prevent staff burnout and desensitization to the conditions and the suffering of people confined to these units.

Awareness training should also be provided to staff preceding assignment to segregation units, and Traumatic Incident Stress Management (TISM) debriefing should be provided to staff and prisoners in these units following any death, near death, or very serious suicide attempt or self-injurious behavior occurrence. Taking steps to address the culture and attitude of employees in segregation units would make the mental health care system more effective, regardless of what company, department, or organization is providing the services.

Finding Fourteen: The bifurcated health care delivery system in the MDOC is a poorly managed, dysfunctional and confusing operation that has caused unnecessary and avoidable suffering of hundreds of prisoners. As the recent deaths of prisoners Timothy Souders, Jeffery Clark, Phillip Hayes and Anthony McManus demonstrate, there is little coordination between medical and mental health services. Some of these deaths are never brought to public attention. The mental health system has a wide service gap that too many severely mentally disturbed prisoners fall into, many inappropriately placed in segregation units, where they deteriorate further.

Recommendation Fourteen: Mental health services should be merged under a single department. An independent study committee, without any ties to special interests, should be appointed to study the best way to organize, manage, deliver and supervise

a single, unified prisoner medical and mental health delivery system, and promptly submit its findings and recommendations to the legislature and the MDOC. This department should stay under the direction of the state and not be privatized – the Hadix case demonstrated that MDOC’s experience with privatization of medical services has resulted in many of the problems and failures described in this report. Whatever system emerges as best for our state should be open to public scrutiny and accountability, which has not occurred under the current system.

Finding Fifteen: Numerous problems and shortcomings that are described in this report have also come to the attention of the Federal District Court in the Hadix case. As a consequence, the MDOC issued two revised mental health services plans, dated December 28, 2006 and June 7, 2007, in an effort to correct some of these problems. However, these changes have been only applied to the Hadix facilities, several of which are now closed. While these plans are still far from addressing all of the problems that exist in mental health care delivery, many of the changes proposed by the MDOC are important ones that could significantly improve mental health services at any MDOC facility.

Recommendation Fifteen: The MDOC should implement the changes to mental health services contained in the above referenced mental health services plans statewide, to include all MDOC staff and prisoners, as an important first step to correcting the many problems identified in the provision of mental health services.

Finding Sixteen: Finally, the failure of the Michigan Community Mental Health systems to provide a meaningful safety net for people with significant mental health problems has led to a large increase in the number of mentally ill prisoners within the MDOC. It is a large scale, community-wide tragedy that grew out of the closing of state mental hospitals in Michigan and the subsequent failure to provide mentally ill citizens with the necessarily treatment or follow-up care.

Recommendation Sixteen: While this is beyond the power of MDOC to change, there is a need for the statewide establishment of mental health courts, similar to drug courts, which would promote the diversion of non-violent mentally ill offenders away from jails and prisons, and into treatment programs.

Endnotes Part Three: Inadequate Mental Health Treatment

¹ MDOC Policy Directive 04.06.180(J), Mental Health Services.

² Michigan Mental Health Code, Act 258 of 1974, Chapter 4, MCL 330.1400(g), “Mental Illness” Defined; MDOC Policy Directive 04.06.183(E), Voluntary and Involuntary Treatment of Mentally Ill Prisoners.

³ MDCH Corrections Mental Health Program Statement and Admissions and Discharge Criteria and Guidelines; MDOC Policy Directive 04.06.180 (D), Mental Health Services, which states that “Serious mental illness/severe mental disorder is not limited to specific diagnosis.”

⁴ MDOC Policy Directive 04.06.182(F), Mentally Ill Prisoners In Segregation.

⁵ MDOC Policy Directive 04.06.182(G), Mentally Ill Prisoners In Segregation.

⁶ Walsh, R. R., The Mentally Ill in Michigan Prisons: An Out of Control Crisis. *Prisons and Corrections Forum of the State Bar of Michigan*, Vol. VI, No.1, Summer, 2004.

⁷ The majority of prisoners in long term segregation are men.

⁸ MDOC Policy Directive 04.05.120, Segregation Standards

⁹ MDOC Policy Directive 04.05.120, Segregation Standards

¹⁰ MDOC Policy Directive 04.05.120, Segregation Standards

¹¹ See findings 6 and 7 on page 97 of this report and finding 11 on pages 99-100 of this report.

¹² The ten prisons were: Marquette Branch Prison, Ionia Maximum Correctional Facility, Standish Maximum Correctional Facility, Southern Michigan Correctional Facility, Kinross Correctional Facility, Alger Maximum Correctional Facility, Chippewa Correctional Facility, Baraga Maximum Correctional Facility, Huron Valley Complex – Men, and Michigan Youth Correctional Facility. All prisoners interviewed were men because the class of plaintiffs in *Cain v. MDOC* only included male prisoners within the MDOC. In addition to considering information submitted by corrections staff and other prisoners, and disjointed, bizarre correspondence with PLSM, selection criteria included whether the prisoner had a history of mental health treatment prior to prison, mental health treatment in prison, prescriptions for psychotropic medications in prison, history of suicide attempts or ideation in prison, housing in a mental health setting while in prison, and the number of major misconduct guilty findings while in prison.

¹³ Grassian, S., 1983, *Psychopathological effects of solitary confinement*, American Journal of Psychiatry, 140, 1450-1454; Haney, C., Banks, W. & Zimbardo, P., 1973, *Interpersonal dynamics in a simulated prison*, International Journal of Criminology and Penology, 1, 69-97; Kupers, T., 1999, *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, San Francisco: Jossey-Bass; Toch, H., 1992, *Mosaic of Despair: Human Breakdowns in Prison*, Washington, DC: American Psychological Association; Toch, H. & Adams, K., 2002, *Acting Out: Maladaptive Behavior in Confinement*, Washington, DC: American Psychological Association.

¹⁴ Human Rights Watch, 1997, *Cold Storage: Super-Maximum Security Confinement in Indiana*, New York: Author.

¹⁵ *Michigan Department of Corrections turns 50*, FYI: A News Bulletin for Employees of the Michigan Department of Corrections, Vol. 14 No. 3 (March 2003); also available at http://www.michigan.gov/corrections/0,1607,7-119-1441_1476_22382---,00.html.

¹⁶ Neighbors, H.W., Williams, D.A., Gunnings, T.S., Lipscomb, W.D., Broman, C. & Lepkowski, J., 1987, *The Prevalence of Mental Disorder in Michigan Prisons*, Ann Arbor and East Lansing: University of Michigan and Michigan State University.

¹⁷ Bureau of Justice Statistics. (2001) *Mental Health Treatment in State Prisons*. Washington, DC: U.S. Department of Justice; Bureau of Justice Statistics. (2001). *Sourcebook of Criminal Justice Statistics*. Washington, DC: U.S. Department of Justice.

¹⁸ The range of time spent in segregation was 1 month to more than 120 months.

¹⁹ Examples of head trauma include closed head injury (CHI), traumatic brain injury (TBI), and depressed skull fracture.

²⁰ According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), and the American Psychiatric Association, clinicians should use a multi-axial assessment system when diagnosing mental illness. There are five axes: Axis I describes clinical disorders, Axis II personality disorders and mental retardation, Axis III general medical conditions, Axis IV psychosocial and environmental factors affecting the disorders, and Axis V the clinician's judgment of the patient's level of functioning. Diagnoses from any and all axes may exist together. The diagnoses commonly regarded as "serious mental illnesses" are almost exclusively contained in Axis I. Although it is contrary to MDOC policy, general practice within the MDOC is that only Axis I diagnoses receive treatment. According to Dr. Walsh, who practiced within the MDOC for 24½ years, this practice may be due to over-reliance on traditional schooling and training, traditional interpretation and application of the definition of mental illness in the Michigan Mental Health Code, insufficient staffing, an absence of meaningful clinical supervision or psychiatrists (who determine which prisoners are admitted to mental health treatment programs) and a failure of leadership at the MDOC Central Office level and MDCH CMHP managers.

²¹ Comorbid is defined as "existing simultaneously with and usually independently of another medical condition." Merriam-Webster's Medical Desk Dictionary, Revised Edition, 2002.

²² American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), 1994, p. 26.

²³ See MDOC Policy Directive 04.06.115(P), Suicide Prevention, for a description of "observation

room" conditions.

²⁴ On November 13, 2006 Judge Enslin issued an order in the Hadix case enjoining the use of in-cell restraints at the four Jackson area MDOC facilities covered by his jurisdiction in that case. In the order, Judge Enslin found that the punitive use of these restraints "constituted torture and violates the Eighth Amendment." Hadix v. Caruso, 461 F. Supp 2d 574, 596 2006 (W.D. Mich. 2006).

²⁵ Hadix v. Caruso, 461 F.Supp.2d 574, 596 (W.D. Mich 2006).

²⁶ Sandman, C.A. & Touchette, P. (2002). Opioids and the maintenance of self-injurious behavior. In Schroeder, S.R., et al., (eds.) *Self-Injurious Behavior: Gene-Brain-Behavior Relationships*. 191-204; Thompson, T., Symons, F., Delaney, D. & England, C. (1995). Self-injurious behavior as endogenous neurochemical self administration. *Mental Retardation and developmental Disabilities Research Reviews*, 1, 137-148.

²⁷ E.g., the tricyclic anti-depressant Clomipramine, a SSRI and dopamine receptor antagonist.

²⁸ Schroeder, S.R., Oster-Granite, M.L. & Thompson, T., eds., 2002, *Self-Injurious Behavior: Gene-Brain-Behavior Relationships*, Washington, DC: American Psychological Association.

²⁹ We recommend that the random sample size be 10% of the total number of narrative evaluations done in long term segregation, and a record review/interview random sample of 3-5% of the prisoners in long term segregation.

³⁰ Haney, C. (1997). Psychology and the limits to prison pain: confronting the coming crisis in eighth amendment law. *Psychology, Public Policy and Law*. 3, 499-588; Haney, C., 1998, *The past and future of U.S. prison policy. Twenty-five years after the Stanford prison experiment*. *American Psychologist*, 53, 709-727; Haney, C., Banks, W. & Zimbardo, P., 1973, *Interpersonal dynamics in a simulated prison*, *International Journal of Criminology and Penology*, 1, 69-97; Grassian, S., 1983, *Psychopathological effects of solitary confinement*, *American Journal of Psychiatry*, 140, 1450-1454; Human Rights Watch, 1997, *Cold Storage: Super-Maximum Security Confinement in Indiana*, New York: Author; Kupers, T., 1999, *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, San Francisco: Jossey-Bass; Toch, H., 1992, *Mosaic of Despair: Human Breakdowns in Prison*, Washington, DC: American Psychological Association; Toch, H. & Adams, K., 2002, *Acting Out: Maladaptive Behavior in Confinement*, Washington, DC: American Psychological Association.

Conclusion

The MDOC health care delivery system is broken, and creates barriers for those needing health care and mental health care, instead of just providing timely and adequate health care and mental health care. Individual employees are not necessarily the problem; rather, the system and attitudes combine to create an atmosphere in which inadequate treatment is prevalent and acceptable. Simply changing the company that holds the health care contract will not fix the problems outlined in this report; an overhaul of the procedures, the attitudes of the people delivering health and mental health care, and an external mechanism of professional oversight of the quality and cost of care must be established to ensure adequate health care for prisoners and reduce costs at the same time.

This report has outlined the systemic defects and illustrated these defects with case studies to show the effects of these failures. The second half of the report focused on prisoners who have experienced delays in obtaining their medication and information about the medication they receive, CMS denial of specialty services recommended by off-site specialists, prisoners experiencing preventable delays in seeing health care professionals, prisoners' necessary special accommodations being denied, and many accommodations and other health care treatment being arbitrarily changed when a prisoner is transferred to another institution. Prisoners with chronic illnesses, such as Hepatitis C and diabetes, have a great deal of trouble getting the treatment they need, often because it costs too much, resulting in additional costs later because of the delayed treatment. The grievance process, which is supposed to act as a "check" on medical care, fails in every respect. There are many, very wide gaps in treatment to prisoners with mental illness, and this too often results in prisoners being locked up in long term segregation, where their mental health further declines. The result of housing prisoners with severe mental illness in segregation, where physical health care needs are not always met, has led to tragic deaths. In fact, preventable death can be the long-term result of *all* of the shortcomings listed in this report.

Prisoners do not have the ability to seek alternatives if access to their medical care providers is delayed or ineffective, if their problems are ignored, or if they receive wholly inappropriate treatment. There is no reliable method for prisoners to obtain oversight of their providers, and even when they can, it is typically not available quickly enough to prevent damage. Even prisoner advocates, who have access to telephones, outside expert advice and opinions, and an ability to communicate directly with MDOC administrative staff, are rarely able to make a positive difference in the care of individual prisoners. Health care for prisoners is a very different universe from what people in the free world experience -- even those people who rely on public benefit programs such as Medicaid and Medicare for their medical treatment. Prisoners are wholly reliant on the MDOC and the sub-contracted companies for assurance of their well-being, and no one is watching to make sure appropriate measures to create well-being for prisoners is accomplished.

A distinction must be made between the system and the individuals who work for it. Of prison mental health care, Terry Kupers wrote that a large number of people "seem very conscientious, competent, and caring, and work very hard to provide adequate mental health services."¹ The same is true of prison health care. Overcrowding, understaffing, and a subcontracted provider driven by corporate profit motive can, in combination, erode the efforts of the most competent, caring, and hard working people.

This report has outlined some of the more serious shortcomings in the delivery of health care and mental health care services to Michigan's prisoners. These problems range from the seemingly innocuous, such as problems with special accommodations, to serious issues that have resulted in the death of prisoners. While these problems seem different, they exist on a continuum and are inherently closely related. A person's physical and mental health is a dynamic thing; all the damage and healing along the way contribute to a person's physical and mental health state on any given day. There are problems that cut through all levels of health care delivery within the MDOC. The state and the institution are in a unique position right now to make positive changes, as they are on the cusp of opening the contract to private bidders. In addition to changing the contract provision, the MDOC needs to make major changes in the culture and work ethic of its employees. Staff of MDOC, CMS, and other for-profit, private entities' employees need to get out of the mindset of discrediting prisoners and viewing provision of health and mental health care services as an unseemly burden, rather than seeing their role as serving the legitimate health care needs of a particular population.

As outlined in the first half of the report, the MDOC and CMS have a long history of failing to meet the medical and mental health needs of prisoners, and the state legislature has been lax in its duty to provide oversight of the monies spent on prisoner health care and to ensure that prisoners are well cared for. The legislature must bear some of the responsibility for fixing this broken system, including more oversight of MDOC policies, expenditures, and quality of care.

While a Request for Proposals (RFP) for new health care providers was released in mid-2007, the MDOC has recently decided to extend its contract with CMS for approximately another year, and begin the bidding/RFP process anew sometime in late 2008. The Request for Proposals for prison health care that was released in 2007 had a number of positive attributes. It required that services conform to nationally accepted standards of care; it required that the contractor monitor waiting times for appointments to see medical services providers; it required that the contractor maintain a pool to fill in for employee absences; and it set specified time frames for standard and expedited authorization decisions by the contractor.

Other provisions of the 2007 RFP were that the contractor must disclose provider incentive plans to the MDOC on request, disclose all owners of a 25% or greater interest in the company, disclose all subcontractors who are paid \$25,000 or more, and disclose all former state employees involved in the performance of the contract.

The 2007 RFP divided the state into eight regions and allowed authorized HMOs to bid on one or more regions. It set a ceiling and a floor for the per-prisoner cost of care for each region, and dictated that all bids must fall within these ranges. The RFP provided for a three-year contract with only two additional one-year extensions. However, there was still no provision for any kind of oversight by any body besides the MDOC.

No matter which contractors win the new contract, many of the flaws inherent in this system will remain because the system itself is flawed. In Appendix B, we have suggested an alternate model for health care delivery. This model is based on the university model.

While the 2007 RFP looked promising, now that it is off the table it is unclear what the next RFP will contain. This is a golden opportunity for the MDOC and the state legislature

to effect the changes that need to be made in order to correct the failures of the current medical and mental health care delivery system. The legislature and the MDOC now have

three sources from which to draw recommendations for future change: this report, the NCCHC report slated to be released after January 1, 2008, and the many recommendations made by the monitors in the Hadix case.

The recommendations that have been made in this report (which are compiled in Appendix A, and also included in each relevant section within the body of the report) are closely tailored to the problems that have been reported by prisoners and observed by prisoner advocates. Unfortunately, there are many other systemic failures that were not mentioned in this report, which also need to be addressed.²

Prisoners are a vulnerable population in our society because very few agencies have oversight on how they are being treated. It is our responsibility as a public, and the state legislature's responsibility as a governing body, to pay attention to how the medical and mental health care needs of prisoners are being met. The current system of giving large sums of money to a private, for-profit contractor and hoping for the best is not working. It is not working for the prisoners, for the state budget, for the MDOC, or for the people who live in the state of Michigan. It has led to preventable human suffering, lawsuits against the MDOC, poor use of state funds, and prisoners being released to the free world with dangerous medical and mental health conditions. It is time to make all of these agencies and companies involved in providing medical care to prisoners accountable for providing appropriate and compassionate care.

Endnotes Conclusion

¹ Kupers, T., *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, Jossey-Bass: San Francisco (1999).

² Issues that could have been contained in this report, given endless time and printing space, would have included: difficulties experienced by prisoners' friends and families in getting correct and timely information about their prisoner loved ones in emergency health care situations; the policy provision that prevents a prisoner's family and loved ones from visiting him or her for the first thirty days he or she is in the hospital (even if the prisoner is expected to die before the thirty days are over); the parole board's hesitation and/or refusal to grant medical paroles to prisoners when appropriate; the problems in the pain management system and the excessive restrictions on the drug formulary used by CMS; shortcomings in aftercare and ancillary care after a major medical procedure; and the problems caused by MDOC staff paraphrasing prisoner kites when entering them into the computerized database rather than entering them verbatim.

APPENDIX A

Health Care Recommendations

ONE

PROBLEM: Part of the cause of the sub-standard health care provided to prisoners is that staff is not properly trained; attitudes allowing lackadaisical treatment of prisoners prevail, and prisoners suffer.

RECOMMENDED SOLUTION: The MDOC should add language to its policies that indicate that health care must be provided with compassion, dignity, and respect.

The MDOC should also provide training for employees concerning acceptable conduct and standard of care. Current training modules should be reviewed for adequate content pertaining to acceptable conduct and standard of care. It would likely be inexpensive to fix the internal problems and adjust attitudes (through training and implementation of new and revised medical care policy directives) which would prevent such costly expenditures as harm to prisoners and the defense of MDOC employees in recent litigation.

TWO

PROBLEM: The office of the Legislative Corrections Ombudsman played a significant role in exercising oversight of the MDOC generally and health care specifically; without this check on the MDOC, problems in health care delivery worsened.

RECOMMENDED SOLUTION: The Office of the Legislative Corrections Ombudsman should be immediately reopened and adequately funded. A medical expert and an economic analyst should be added to the staff of the Office of Legislative Corrections Ombudsman.

Additionally, the Legislature should implement an adequately funded Office of the Legislative Medical Corrections Ombudsman (staff to include medical personnel). This body will report to both Community Mental Health (CMH) and the legislative committee recommended in this report, which will oversee issues including, but not limited to: medical treatment, mental health treatment, health care and mental health care in segregation, and therapeutic programming.

The Legislature should require Senate and House Committee members (with connections to Corrections) to tour the following prisons: Alger, Baraga, Chippewa, Bellamy Creek, Gus Harrison, Duane Waters, Ionia, Marquette Branch, Parnall, Standish, Huron Valley Men's, Lakeland, Scott, and Huron Valley Women's all infirmaries, the dialysis unit at Ryan, and the secure unit of Foote Hospital, accompanied by advocates and the Legislative Ombudsman, to maintain a balance of information provided during these tours. Tours should take place annually.

Reviving and expanding the office and role of the Ombudsman will help keep health care and mental health care delivery effective and productive, while keeping a closer watch on spending.

THREE

PROBLEM: There is no independent or legislative oversight of prison healthcare or the private, for-profit corporation providing care.

RECOMMENDED SOLUTION: The legislature should create a commission to conduct annual, open, well-advertised hearings concerning medical and mental health care treatment. The commission should consist of representatives from the legislative and executive branch of Michigan government, medical doctors, university medical staff, prisoner advocates, clergy, general public, attorneys, etc. Legislators should allow testimony at these hearings, including that of prisoners through written statements and testimony of the public, including attorneys, families of prisoners, and advocates. This commission will hold bimonthly meetings to discuss issues concerning health care and mental health care within the MDOC, and will have a clear mandate and authority to make recommendations as directed by the legislative committee outlined below.

A permanent legislative committee should be created to oversee health care and mental health care within the MDOC. This committee should be co-chaired by the chairperson of the Senate and House Appropriations Sub-committees on Corrections.

With proper oversight, hopefully the State of Michigan will not repeat the mistakes that have been made in the past, where large sums of money were spent for substandard medical and mental health care.

FOUR

PROBLEM: Prisoners have no regular ability to view their medical records; lack of knowledge about their condition and treatment has many ill effects, including confusion and anger; hampered ability to engage in appropriate self-care, and an inability to consult with advocates concerning their condition and care.

RECOMMENDED SOLUTION: Prisoners should receive a print-out report from every health care visit, documenting the nature of the visit and all other pertinent medical information from the visit. This information should be entered into the MDOC's computerized medical information database. If medication is ordered, health care staff should give each prisoner information on the medication. If a diagnosis is determined, the print-out should include an explanation of the diagnosis for the prisoner. All documentation provided to prisoners should be legible, including signatures.

The MDOC should not charge a fee for copies of medical records not originally provided to prisoners, particularly to indigent prisoners and other prisoners who lack sufficient funds because they do not work enough to earn even \$20 per month. Current costs of 25¢/page should not be increased unless and until prisoner wages are increased.

The MDOC should immediately make one copy of medical records available to indigent prisoners and their advocates for free, and immediate action shall be taken to quickly codify a change in MDOC policy, allowing prisoners the opportunity to examine their medical records.

The Legislature should immediately amend the Medical Records Access Act, Public Act 47 of 2004, so that it includes prisoners as a medically indigent class. The legislature should also immediately make clear that the inspection requirement of the medical records access act (MCL 333.26261) applies to prisoners already. The Legislature should also act to prohibit the MDOC from charging prisoners a fee for the first copy of their medical records.

The legislature intended to increase availability of medical records when it passed the Medical Records Access Act, and prisoners should also benefit from this intent. There are many reasons to keep prisoners informed of the status of their health care treatment, and the

MDOC should allow prisoners to access their records and encourage education about their own condition and treatment.

FIVE

PROBLEM: In addition to limiting a prisoner's own access to her records, the MDOC further limits advocates' and prisoners' ability to shed light on medical problems.

RECOMMENDED SOLUTION: The MDOC should create a standard policy that allows prisoners' advocates to have access to a prisoner's medical records (upon production of a signed release) and the MDOC should create a policy to facilitate communication between MDOC, the medical care providers, and prisoners' advocates.

SIX

PROBLEM: Prisoners are not given the knowledge that they need, such as information about their prescriptions, so they are not able to make informed decisions about their health care. This can also lead to potentially life-threatening situations for prisoners, and makes them unable to be effective advocates for their own health care treatment.

RECOMMENDED SOLUTION: The MDOC should provide medication package insert information on all their medications upon request. The MDOC should also obtain a prisoner's informed consent for all recommended treatments and prescribed medications, not just surgical or invasive procedures, which is all that is currently required under PD 03.04.105.

SEVEN

PROBLEM: The MDOC creates medical emergencies for prisoners by not providing pharmaceutical refills and MDOC medical staff orders when needed.

RECOMMENDED SOLUTION: The MDOC should assure that medication renewals/refills are made available to prisoners in a timely fashion. Prisoners receiving medications for chronic conditions should be given a one year prescription with automatic monthly refills, so that doctors do not have to sign off monthly on chronic care patients' medications.

It is obvious how disastrous these pharmacy failures are to prisoners and their ongoing health care treatment; this is a basic need that must be met by the MDOC health care providers.

EIGHT

PROBLEM: When the contractor paying for services, rather than the medical doctors treating the patients, has the power to determine what services will be provided, patient care often gets lower priority than saving money, and bad decisions are made. Secondly, when a prisoner is not provided with an explanation for why a treatment is denied, he or she has no recourse or ability to obtain outside review or an appeal of the decision.

RECOMMENDED SOLUTION: Refusals of treatment should be well documented and submitted to the new legislative prison health and mental health oversight committee recommended in this report and quality assurance review panel. When a specialty referral is not granted, the MDOC should assure that the patient is advised of the fact in writing, including the reason the request was pended or denied and, if the MSP does not appeal the denial, allow the patient to appeal the decision.

The MDOC should prohibit blanket denials of standard treatments and not allow the contactors to use blanket denials of treatment protocols. When disputes over treatments arise, the Chief Medical Officer should have final say over any HMO opinions.

Part of increasing the accountability of the MDOC, and the contractual entities providing prisoner health care services, is ensuring that there is outside oversight of treatment decisions, and transparency in the decision-making process.

NINE

PROBLEM: Just as in the free world, undiagnosed illnesses and delays in treatment in prison can cause extreme and permanent harm to individuals. Unfortunately, unlike in the free world, a prisoner cannot obtain the diagnoses he or she needs in order to prevent such harm. These failures cause great harm to prisoners, but also unduly burden the MDOC health care system, because untreated illnesses are allowed to advance into diseases and conditions that are much more complicated and expensive to treat. Many prisoners are so impaired by these problems that they must be housed in special units.

RECOMMENDED SOLUTION:

- (a) **Position Vacancies:** The Department of Management and Budget should incorporate required staffing levels for medical and mental health contractor into the contracts for health care services. The Department of Management and Budget should require the MDOC to report to the legislature immediately when medical or mental health staffing falls below the required levels. When contractors fail to meet the required staffing levels, the Department of Management and Budget must penalize the contractors, including reduction in payments, debarment, and charges for costs incurred in hiring temporary staff to fill the service gaps. The MDOC should work with the contractor/s to establish competitive payment scales for all health care providers. The MDOC should implement an incentive plan; i.e. sign-on bonuses for new staff working in prisons in rural areas.
- (b) **Delayed Access to MSPs:** The MDOC should set and follow standards of care for timely and complete follow-up from offsite care, and must impose these standards upon the contractor providing the care.
- (c) **Cancelled Appointments:** The MDOC should set and follow standards of care for follow-up from canceled appointments to insure timely rescheduling, and should impose these standards upon the contractor providing the care.
- (d) **Delayed Diagnostics:** The MDOC should follow community standards of care for follow-up from delayed tests and/or diagnostics, and should insist the contractor/s follow these standards.

The human and fiscal costs caused by delays in treatment and follow-up can easily be avoided, and greater care must be taken by the MDOC to see that they are eliminated.

TEN

PROBLEM: With the frequent movement of prisoners within the MDOC, consistency is lost when information is not conveyed along with the prisoner. Furthermore, each prison's medical staff has the power to completely change a prisoner's course of treatment. Inaccurate or incomplete transfer assessment forms also contribute to the inconsistency in treatment.

RECOMMENDED SOLUTION: The MDOC should mandate consistency in treatment of medical and mental health care ailments (including special accommodations) among all facilities.

The MDOC should prohibit the practice of changing a prisoner's treatment simply because she or he has been transferred, unless there is documentation that the treatment prior to transfer is not working. If treatment is changed upon transfer to a different prison, the MSP should be required to explain in writing in the file the reason for the change, and provide a copy of the explanation to the prisoner and the chief medical officer for review.

In addition, a hard copy of the prisoner's "problem list" (also known as the CHJ-160) should be kept in the front of each prisoner's current medical file.

The MDOC should insist on staff accuracy in completing transfer documents, and should more closely monitor these transactions. To maintain consistent treatment, the MDOC should transfer prisoners with medical issues only when absolutely necessary for the good order and security of the institution.

ELEVEN

PROBLEM: Frequent transfer of prisoners has adverse effects on the consistency of recognition of Special Accommodations. Also, Special Accommodations are not always granted when necessary, or followed when they are granted. This complicates prisoners' health care treatment protocols that have been developed by their treating MSPs.

RECOMMENDED SOLUTION: The MDOC should ensure that hard copies of current Special Accommodation notices are transferred with the prisoner and are available in the housing unit files immediately upon transfer. The MDOC should also insure that current Special Accommodation notices are in the current version of the medical file and on the electronic medical records system. Special Accommodations should be granted whenever necessary and the MDOC should be more consistent and open about the decision making process surrounding Special Accommodations.

TWELVE

PROBLEM: While there are continual advances in the world of HCV treatment¹⁵, prisoners with HCV do not often receive the benefits of any consistent or useful treatment. Frequent transfers make this problem even worse. While treatment eligibility guidelines do exist, they are often not followed. Furthermore, these guidelines are essentially designed to narrow the numbers of people who actually "qualify" for treatment. HCV can be a painful disease with many awful consequences, including the possibility of death, and the MDOC must take better care of prisoners with this unfortunately common disease.

RECOMMENDED SOLUTION: The HCV treatment eligibility guidelines should be redesigned to treat as many people who might benefit from treatment as possible. The MDOC must provide a copy of its HCV treatment eligibility guidelines (form CHJ-460) to all prisoners diagnosed with HCV. The MDOC must not deny HCV treatment to prisoners within the guidelines who wish to be treated.

The MDOC and contractual entities providing care must not deny comprehensive treatment solely based on the cost of such treatment. The new Request for Proposals for the health care provider contract must focus on diagnoses of hepatitis C, cutting edge treatment, and protocols that are pro-treatment rather than anti-treatment.

Hepatitis C is a treatable condition, but left untreated it causes multiple health problems

and possibly death. CMS commonly denied treatment solely based on cost; this is not appropriate or acceptable.

THIRTEEN

PROBLEMS:

- Diets are high in carbohydrates, which are not always appropriate for diabetic patients. Diabetics do need carbohydrates, but their diet should also be rich in protein and fresh fruits and vegetables.
- Insulin schedules are not three or four times a day in the MDOC, but two times a day, which does not provide adequate coverage for Type 2 diabetics.
- Neither the MDOC nor CMS has an Endocrinologist working with diabetic patients. It is not always necessary for Type 2 diabetics, but most Type 1 cases should be followed by a specialist. Many of these cases are difficult to control and medical staff who do not specialize in this field have difficulty managing these cases effectively.
- The frequent transfer of prisoners from one prison to another exacerbates the problem of inconsistent treatment. Each time a prisoner is moved from one location to another medical staff follow different theories of how a patient should be managed, and care is not consistent.
- Custody staff are not properly educated about the side effects of diabetes and the behaviors that commonly occur when a diabetic has low or high blood sugar, or how to respond to a diabetic who is having a reaction. Low blood sugar can cause a prisoner to act aggressively and disoriented. Normal custodial response to this kind of behavior would be to separate the prisoner from other prisoners. For the diabetic, they may only need to provide emergency glucose and the aggressive behavior will stop, but staff are not adequately trained and therefore do not respond safely and appropriately.
- The diabetes formulary is outdated and too limited. Even the Michigan Medicaid formulary is much more inclusive – eight branded insulins, three other brands by prior authorization, and generics of multiple insulin preparations.⁶ The three generic insulins on the MDOC formulary would have been acceptable 10 years ago, but are not adequate if the goal of prisoner care is to meet the community standard.⁷

For instance, the current standard care is to use a 24-hour basal dose insulin (Levemir or Lantus - the latter is on the Medicaid list) once daily (to simulate steady release of insulin from a normal pancreas) with three or four injections of short-acting insulin ("Regular" insulin was used in the past and is probably acceptable, although not ideal) or rapid-acting insulin (Humalog or Novalog, both on the Medicaid list) taken immediately before each meal. Thus the patient can take a bit more rapid-acting insulin if he is going to eat more or be less physically active, or take less rapid-acting insulin if he'll be eating less or activity is planned to burn off more calories.⁸

Oral medication options are likewise too limited within the MDOC - there are currently seven or more classes of oral drugs for diabetes.⁹ Only two classes are represented on the MDOC formulary.¹⁰ The addition of two or three more classes would not be expensive and would decrease the likelihood of developing dangerous and expensive complications of diabetes in the future.

RECOMMENDED SOLUTIONS:

- The MDOC should make better balanced diets available for diabetic prisoners.
- Insulin injections should be available at least four times a day for diabetic prisoners.

- There should be endocrinologists on staff who work closely with diabetic prisoners.
- Prisoners should be transferred only as often as is necessary for custody or security reasons. Upon transfer of a diabetic patient, the treatment regimen should not be changed without a sound medical reason for altering treatment.
- Custody staff should be educated about the side effects of diabetes and the behaviors that are common when a diabetic has low or high blood sugar and how to respond safely and properly to a diabetic who is having a reaction.
- The diabetes formulary should be expanded and brought up to date for both insulin and oral medications. This should be a requirement under any new Request for Proposals that are used in finding new health care companies to treat prisoners.

FOURTEEN

PROBLEM: Special diets are an integral part of maintaining and treating prisoners' health care problems. When these diets are not followed, or capriciously discontinued, this can cause severe problems for prisoners.

RECOMMENDED SOLUTION: When the MSP orders a certain diet, the MDOC should require the institutional dietician to do whatever is necessary to provide it. Dieticians should not be permitted to override the orders from an MSP; MDOC policy should be amended to make this clear. Special diets or other nutritional services should not be withheld or removed as punishment for a prisoner's other lifestyle choices. The MDOC should not transfer prisoners to prisons or camps that are not able to or refuse to provide the diets needed. Where a prisoner is on a special diet, the transfer should not be approved until there is written confirmation by the dietician at the proposed destination facility that the diet is available.

FIFTEEN

PROBLEMS: The grievance process does not often provide the internal problem resolutions that were intended by policy. The untimely responses, the lack of accountability in the responses, the lack of explanation, and the lack of real solutions to problems make the process very ineffective. The policy should be altered in several ways to address some of the grievance problems outlined in the many case studies above, as well as others that advocates have noted in the course of years of working with prisoners.

RECOMMENDED SOLUTIONS: The Legislature and MDOC must develop a meaningful and economical means of redressing problems between prisoners and health care staff, including creation of a health care grievance system that is separate from the regular prison grievance procedure system, and which ensures the following:

- Health care grievances should be investigated and answered solely by individuals with medical credentials, who are assigned only for the purpose of investigation;
- Health care grievances should be on a faster track for review and response;
- Health care grievances should be reduced to a two-step process. Health Care staff should answer the Step I grievance, and depending on the urgency, shall respond between 24 hours and one calendar week of receipt. After seven days, if the answer is not acceptable or if no answer is received, a prisoner may appeal directly to the office of the Chief Medical Officer at Step II. Step II responses must be received by the prisoner within 10 days; if no response is received within 10 days, the prisoner should have at least one month to exercise an option of settlement through mediation, or else file a case in court;
- When answering a grievance, respondents should document finding(s), requiring the MDOC to meet the same standards prisoners are held to (i.e., the respondent must state who, what, when, how, why, where and dates, times and places and

- names of those involved);
- The MDOC should create grievance investigation protocols that identify relevant documentation and questions to be asked when responding to a grievance;
 - The MDOC should provide the prisoner with copies of documentation that support the grievance answer, including copies of medical records verifying finding(s);
 - The MDOC should train grievance investigators, including training in the technical and administrative aspects of answering grievances. This training should incorporate a preliminary statement that defines the relationship between the health care staff and the prisoner patients. Furthermore, the following points regarding grievance responses outlined in the Oregon Department of Correction's Grievance Policy should be adapted by Michigan to create a more effective and respectful medical grievance system:
 1. Responses should be easily understood by the reader.

Respond using simple language. Avoid the use of medical terminology that is not easily understood by our patients.
 2. Responses should be courteous. If an apology is due to the patient, include it in the response. The numbers of grievance appeals are more likely to be reduced by an appropriate response.
 3. Direct your response to the writer. The response is not to the supervisor, it is an explanation in writing to the patient.
 4. Stick to the topic. Do not throw in material that is not relevant to the patient's complaint.
 5. If action was taken because of the grievance, let the writer know what steps you took or what you have in mind for future action.
 6. A thank you [is] always appreciated. If someone has identified a problem that needs some kind of intervention, let them know you appreciated the information, e.g., Thank you for bringing this problem to my attention...
 7. Keep the response short and to the point. Avoid abrupt answers such as: Appointment made. J. Smith, R.N. The patient needs some information and we need to be responsive to their request.
 8. Respond in a timely manner.
 9. Responses need to be professional and polite regardless of what has been written in the grievance.
 10. Offer an opportunity to leave a door open, e.g., if you have any questions please contact...
 11. It is recommended that all correspondence be responded to within seven (7) working days.
 - The MDOC should create a policy which includes disciplinary action for a grievance respondent's failure to properly investigate, document, and/or answer a grievance at any level;
 - Medical Grievances should be reviewed quarterly by the regional Medical Officer or CMO. These reviews should be based on a system wide method of computerized worksheets connected to whatever medical database is implemented (currently HMIS). These worksheets should be written up with every medical grievance at the step I level and reviewed and supplemented at the step II appeal level when necessary. The Oregon department of Corrections Grievance Work Sheet is attached in Appendix C.
 - The MDOC and/or the legislature should provide prisoners a route of redress

through arbitration or mediation to lower the costs of litigation and increase the accountability on behalf of the MDOC and its contractors.

A revised grievance process with more accountability and greater speed will help the MDOC realize the goals set out by the grievance policy and the internal grievance process generally.

APPENDIX B

Proposed Alternative Corrections Health Care Delivery System

In the late 1990's, Michigan experimented with partial privatization of health care in its prisons. It is time to acknowledge this effort has been a dismal failure. The result too often has been increasingly severe cases of medical neglect and unnecessary suffering, disability and even death for prisoners. This has been well documented in this report. Finally, after ten years of employing an expensive and dysfunctional prisoner health care system, the state has in effect finally acknowledged this failure by deciding to open the health care contract for bids in 2008. What happens next will be critical to MDOC and the State of Michigan extricating itself from this quagmire in which it has created.

The first step toward creating a competent, responsive and cost effective prisoner health care delivery system is to clearly understand the problems corrections has historically faced in trying to meet these needs. This has included long-standing recruitment problems in most, if not all, of its health care provider professions and, retention of the competent staff it is able to recruit. Apart from nationwide shortages in many health care professions, recruitment efforts in corrections have consistently fallen far below their targeted needs. This may be because corrections departments have a reputation for being punitive and anti-therapeutic. The most promising candidates – newly graduating physicians, psychologists and nurses – look for work elsewhere.

This problem has been exacerbated by utilization of a "management by crisis" style, which over time has given rise to the fragmented and disconnected MDOC health care system that exists today. A new, lean, accountable health care delivery system needs to be created, and a new program for recruiting, training, and professionally supervising qualified health care staff initiated. A transition plan, involving assistance from Michigan medical schools in recruiting replacement medical personnel could be developed and implemented. Competent, primary care medical staff now working for the private contractor should be allowed to stay on so that medical services to prisoners can be spared further disruption.

During this transition, all competent-appearing primary care medical services providers (MSPs) could be converted to state civil service positions, but as one year probationary employees. During this time they could be evaluated and those who are competent and dedicated should be allowed to become regular employees, while those found to be unfit would be terminated. The Governor has the authority to waive the regular hiring process in a situation like the one now approaching crisis levels. The Department of Civil Service (MDCS) may also have such authority. In fact, during severe staffing shortages in 1979 of physicians, psychiatrists and psychologists, the power to make on-the-spot hiring decisions was granted by MDCS to four MDOC managers. This happened again in 1985 with three managers authorized to hire up to 50 psychologists to fill newly created state-wide outpatient mental health team positions. Such authorization can be granted again, until minimally necessary MSP positions have been filled.

The next step is to merge the bifurcated mental health care system into a single, unified whole, under a reorganized and accountable bureau within the Michigan Department of Community Health (MDCH). The current system is antiquated and dysfunctional, actually widening the service gap between MDCH mental health staff and MDOC psychological services. It allows increasingly large numbers of mentally ill prisoners to go untreated because each service sees many of these people as being outside their area of responsibility. Managers and supervisors are not doing their jobs and too many mentally

ill prisoners are left to suffer in prison segregation units. Excess managerial staff left over from the merger could be re-assigned to fill primary patient care duties consistent with their level of training and competence. The same sort of problems with competent staff recruitment, training and retention also plague mental health services, and the solution proposed below will substantially improve both services.

Through a joint cooperative effort of the governor and state legislature, special professional correctional health care specialty programs in medicine and in clinical and counseling psychology could be established at all major Michigan tax-supported universities with medical schools, schools of nursing, and schools granting doctoral degrees in psychology. Each of these programs could establish graduate level internship programs placing students under appropriate supervision in correctional facilities, where they will provide timely, competent, direct patient care to prisoners in need. D.L. Waters hospital, at Jackson, with assistance from the state medical schools, could be reopened and can regain JCAHO accreditation, with a long term goal of establishing residencies in emergency medicine and possibly other specialties.

The former Huron Valley Center at Ypsilanti could be re-opened and accredited as an inpatient psychiatric facility, with assistance from university psychiatry and psychology departments, and could offer psychiatric residencies and psychology internships. Students electing to pursue study and involvement in these correctional health care programs can be provided with educational loans that, upon completion of their degrees and a to-be-determined length of post-doctoral employment in corrections, could have their educational loans forgiven.

The population served by corrections health care is demographically similar to those in the community living in poverty and in inner cities. Thus a career track in correctional medicine, psychology and nursing is readily transferable to society at large, where health care needs and problems are similar to that of incarcerated prisoners. Significant university involvement, with its potential for generating research grants, would go a long way toward overcoming the negative stigma of association with corrections that has been a major recruiting and retention obstacle.

The final step is to then merge all prisoner medical and mental health care into one interrelated management structure, in one department, and that should be the department most qualified to do so, the MDCH. The MDOC's expertise is in custody and security, not medical and mental health treatment. Such a merger could do much to help solve the long-standing problems of correctional health staff recruiting, training and retention. Competence and accountability can likewise be enhanced, as well as interdisciplinary communication and cooperation, something lost in the current fragmented system.

The MDOC can and must stop interfering with medical/psychological treatment. A special correctional health care arbitrator can be appointed, subject to executive and legislative branch approval, with the power to promptly resolve treatment/custody conflicts involving critical prisoner health care. Critical health care could be provided in a timely fashion without compromising necessary security by managers willing to work together and to give up past bad practices that have often been extremely costly and harmful to everyone.