Disability Law Center, Inc. vs Massachusetts Department of Correction, et al.
Civil Action No. 07-10463 (MLW)

Fifth Report of Designated Expert Kathryn A. Burns, MD, MPH

Dates of Site Visit: November 3-4, 2014
Date of Report: December 2, 2014

Sites visited:
MCI-Cedar Junction (MCI-CJ)

- Departmental Disciplinary Unit (DDU)
- Special Management Unit – 10 Block (SMU)

Additional Information reviewed:

- Data submission required in Settlement Agreement
- Medical Records of selected inmates
- Response to 4th report
- Supplemental reviews

Concerns were raised and recommendations offered on site during the exit interview. Additional summary detail is provided here. A synopsis of the inmate interviews is attached.

MCI-Cedar Junction

MCI-Cedar Junction was toured on November 3-4, 2014. As in past visits, interviews with individual inmates were held with prisoners in DDU and SMU. The BMU was not visited this tour.

In the interim between site visits, MPCH conducted an analysis of the location in which mental health contacts occur (i.e., cell front vs. out of cell) in the DDU and plan to continue to monitor it regularly. Additionally, inmates were given a survey asking them about the reasons they refuse out of cell contacts. MPCH should also analyze why clinicians are not complying with the provision of the settlement agreement requiring documentation in a progress note of all attempts made to engage the inmate in a private interview.

MPCH also reported reinforcing the importance of rounds in segregation and implemented a procedure in which rounds are observed by the Mental Health Director, or designee, on a monthly basis to enhancing clinical supervision and provide feedback to the rounding clinicians. Both of these actions are important quality improvement activities and should yield important clinical information upon which more reliable/accurate assessments of inmates' functional capacities can be made as well as improve inmate engagement in treatment activities. It will take some time however, for these important steps to actually bear the intended positive results.

Extensive clinical reviews were conducted on a number of inmates identified as potentially seriously mentally ill during the last site visit by MHM Clinical Operations, primarily, Dr. John Wilson. In addition to Dr. Wilson's review and examination, Dr. Mays conducted some supplemental telepsychiatry

interviews. Thereafter, there was documentation in many of the inmate charts that a large case conference meeting was held between Clinical Operations and on-site clinicians to discuss the case and findings. Since these activities were completed relatively recently, it was not yet apparent how or whether the results of the extensive reviews will be incorporated into the subsequent treatment and treatment plans of all of the reviewed inmates. (See for example, &) In other cases, recommendations for psychological testing had been acted upon and referrals made.

Unfortunately, inmate committed suicide 9/4/14. A comprehensive review of this death is not possible because the chart was not available to me. However, MPCH reviewed the case as did MHM Clinical Operations. There are some discrepancies between those reviews, which I will not detail as beyond the scope of this report. Briefly, though a number of previously identified concerns are apparent: Mr. was not seen outside of his cell in the period of time between medication discontinuation and his suicide; medications were discontinued without face-to-face contact by the prescriber; all outside treatment records were not received/reviewed (unknown as to whether they were requested); and 's treatment and diagnostic history within MDOC and the House of Correction were re-interpreted as related to substance abuse and not SMI with virtually no additional data points except brief cell front contacts upon which to make this sweeping diagnostic reclassification.

Assessment:

I continue to believe that a number of problems exist which are not simply matters of differing clinical judgment:

1. Lack of out of cell contact. All parties agree that cell front visits are not treatment and steps have been taken to monitor and potentially address this issue. Nevertheless, the issue persists and the data being gleaned from these types of contacts is being used as the basis upon which to arrive at diagnoses and re-interpret past diagnoses. There were instances in the records in which the monthly contact was at the cell front and lasted two minutes though the progress note detailed findings about orientation, thought form and organization, affect range and reactivity and other components of a mental status examination. Brief cell front contacts simply do not permit appropriately detailed and accurate functional assessment. To use them as the sole basis upon which to reinterpret past internal and external diagnoses is reckless.

2. Request and then review of outside treatment records is not clearly documented. The information is important to gain a longitudinal view of the inmate patient's illness and course. (See above and)

3. Inmates with "minor" diagnoses sometimes require two or more medications in the same class for treatment-resistant symptoms. It is not illogical or irrational to conclude that the illness is more severe than labeled since augmentation or supplementation is generally not pursued unless there is a clinical reason to do so. This should continue to be a "red flag" to MPCH: Either the doctors are not prescribing according to currently accepted clinical practice guidelines

which is a problem; OR the inmates are very sick but it is not being acknowledged diagnostically – either categorically or via an accurate and thorough functional assessment. Other medication practices are also concerning: Continued use of low dose (or larger doses) of antipsychotic medications without clinical justification. Psychotropic medications discontinued WITHOUT a face to face examination of the inmate; no medication counseling or education; no compliance monitoring; no discussion of considering seeking involuntary treatment order.

Finally, I feel compelled to address the Mr. Saltzman's allegation that my suggestion to review discontinuation of treatment and subsequent behavioral issues was in any way implying that a "criminal responsibility" concept be injected into the prison disciplinary process. Frankly, this is the type of hyperbolic thinking that has permeated MDOC's responses to site visit findings and sabotaged attempts to approach issues in a consultative and collegial fashion. There has never been the scintilla of suggestion advocating insertion of a criminal responsibility concept into the MDOC disciplinary process. However, several cases have been identified in which mental health treatment was discontinued, perhaps with the best of intentions and then, nevertheless, inappropriate behaviors emerged and the inmate faced segregation and potential DDU placement. This certainly has implications for CLINICAL policy makers and continuous quality improvement activities and offered in that vein.