Rebuttal Expert Report of Pablo Stewart, M.D.

Parsons v. Ryan, No. 2:12-cv-00601-NVW (MEA) (D. Ariz.)

January 31, 2014

REBUTTAL REPORT OF PABLO STEWART, M.D.

General observations

Dr. Penn did not speak with any prisoners. Penn Rep. at 4. This is a significant methodological flaw, as prisoners may have information about mental health services that is not readily available from other sources. More fundamentally, it is impossible to determine that a patient's mental illness is being adequately treated without speaking to him or her. Such communication is essential because of the information the patient may verbally convey about his or her symptoms, medication efficacy and side effects, and other critical variables. It is also essential because only by talking with the patient can the psychiatrist assess the presence or absence of signs of mental illness such as responding to internal stimuli, flattened affect, and tangential thinking. I am not aware of any psychiatrist in the community who would conclude that a patient's mental illness was being adequately treated without speaking with that patient. Indeed, the American Academy of Psychiatry and the Law Ethics Guidelines for the Practice of Forensic Psychiatry state that "[h]onesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination."[1]

In his review of ADC's mental health services, Dr. Penn places decisive importance on the findings of the National Commission on Correctional Health Care (NCCHC). But NCCHC accreditation does not mean that a prison or jail's health care meets community standards or constitutional minima. A number of prisons and jails have been found by federal courts to provide an unconstitutional level of health care, notwithstanding their accreditation by NCCHC.

[1]American Academy of Psychiatry and the Law Ethics Guidelines for the Practice of Forensic Psychiatry, IV. Honesty and Striving for Objectivity (Commentary), available at http://www.aapl.org/ethics.htm.

Moreover, it appears that the NCCHC has relied on inaccurate information in its review of ADC mental health services. For example, the June 28, 2013 NCCHC report on ASPC-Perryville states that "In the past three years, there have been six suicides. All had death reviews, including psychological autopsies, completed." ADC_P000913 (cited in Penn Rep. at 74). ADC's discovery responses in this case list five suicides at Perryville during that period, on the following dates: July 23, 2010; September 6, 2010; March 25, 2011; January 27, 2012; and February 12, 2013.[2]

However, despite the Court's order to produce all psychological autopsies since January 1, 2011, I have received only one psychological autopsy from ASPC-Perryville (see Stewart Supp. Rep. at 9-10, discussing psychological autopsy of Forrest Day, 258301). Thus, it appears that either ADC has failed to produce the psychological autopsies as ordered by the Court, or NCCHC relied upon erroneous information in its assessment of ADC's suicide prevention program.

Opinion: Inadequate medication system

Dr. Penn appears unconcerned by the fact that prisoners with mental illness miss doses of their psychotropic medication. Penn Rep. at 34-35. But as ADC's suicide prevention training materials correctly recognize, "[f]ailure to receive or take prescribed psychiatric medication" can be a trigger for suicide. ADC_S000523. It can also lead to needless suffering and aggravation of the patient's illness, in some cases making the illness more resistant to treatment.

Dr. Penn believes that requiring prisoners to wait in line outdoors for their medication "increases the opportunity for medication monitoring" and "provides an opportunity to inquire or

[2] Defendants' Response to Plaintiff Wells' First Set of Interrogatories, June 26, 2013, Interrogatory No. 1.

identify side effects." Penn Rep. 39. Based on the sign I saw posted at the medication window at ASPC-Tucson, forbidding prisoners to ask any questions about their medications, I very much doubt that this occurs.[3]

Opinion: Risk of Heat Injury or Death

It is a well-established medical fact that mentally ill individuals are at greater risk of suffering heat-related health problems. The medical literature is replete with references regarding the association between mental illness, psychotropic medication and heat-related health problems.[4] [5] [6] [7] [8] [9] The references I have provided are a very small sample of the articles that appear in the scientific literature about heat-related health problems in the mentally ill. So I find it extremely curious that Dr. Penn, without citing any medical literature, was able to report the absence of any problems in this area. As I noted in my initial report, ADC does not have an overall policy about heat-related health problems. So I am bewildered by his statement "I do not believe that temperature readings measured in this manner above 90 degrees pose an undue risk of harm."[10] I conducted an exhaustive literature search of this topic area and could find no

[3] See photos attached to this report as Exhibit A: ADC 154565.
[4] *Heat-related Death and Mental Illness During the 1999 Cincinnati Heat Wave*; The American Journal of Forensic Medicine and Pathology, 22(3): 303-307, 2001.
[5] *Risk of Death Related to Psychotropic Drug Use in Older People During the European 2003 Heatwave: A Population-Based Case-Control Study*; American Journal of Geriatric Psychiatry 17:12, 1059-1067, December 2009.
[6] *Recurrent Heat-Related Illnesses During Antipsychotic Treatment*; Annals of Pharmacotherapy 2005: 39:1940-1942.
[7] *Heat Intolerance in Patients With Chronic Schizophrenia Maintained With Antipsychotic Drugs*; Am J Psychiatry, 157:8, August 2000.
[8] *Excessive Heat Exposure Can Pose Higher Risks for those on Psychotropic Medication or Other Substances;* Substance Abuse and Mental Health Services Administration, SAMHSA Blog, June 29, 2012, 1-6.
[9] *Heat-Related Illness*; Emerg Med Clin North Am. 2013 Nov; 31 (4) 1097-108.
[10] Confidential Expert Report of Joseph V. Penn, M.D., December 18, 2013, pg. 67.

reference stating temperatures above 90 degrees do not pose an undue risk of harm. I did find a reference published by the Ohio State Department of Mental Health, which defined high temperature as 90 degrees and above. I agree with Dr. Penn that there are limited shaded areas and misters in some of the recreational areas. There are no shaded areas or misters, however, at the Perryville complex where I observed women prisoners having to wait in line outside in the full sun in order to receive their psychotropic medications. And the presence of shade or misters in the recreation areas is irrelevant to the grave risk posed to prisoners by temperatures in the housing units that regularly exceed 85, 90, and sometimes 100 degrees Fahrenheit (see Stewart Rep. at 48).

In his report Dr. Penn stated "I have not identified any medical records or reports of offenders with psychotropic medications or heat related complications or death."[11] In my report I discussed the harm suffered by named plaintiffs Robert Gamez and Sonia Rodriguez. Stewart Rep. at 69-70. In addition, I have reviewed the case of named plaintiff Christina Verduzco, 205576. She is a chronically mentally ill individual whom I evaluated on 7/18/13 at Perryville. I noted her to have auditory and visual hallucinations as well as thought process difficulties. At the time of my evaluation she was being treated with Haldol decanoate, Depakote, Prozac and Cogentin. She had also experienced two very serious bouts of dehydration, one of which required IV therapy. In addition she was noted to be toxic from her Depakote. Her Depakote level was noted to be 123 with the normal range being from 50-100 mcg/ml. Her bouts of dehydration (July 4, 2013) and her very serious medications toxicity problem (June 19, 2013) are dangerous heat-related health problems.

[11] Ibid, pg. 67.

Opinion: Inappropriate use of chemical agents on the mentally ill

Dr. Penn suggests that no prisoners with mental illness have been harmed by being pepper-sprayed or by other use of chemical agents. As noted above, I toured the Perryville facility on July 18, 2013 and had the opportunity to evaluate named plaintiff Christina Verduzco. This evaluation consisted of a face-face interview as well as a review of her medical record. She is a chronically mentally ill individual who presented with prominent auditory and visual hallucinations. She also displayed difficulties with her thought processes that interfered with her ability to express herself in a coherent manner. These psychotic symptoms were confirmed in her medical record in a July 3, 2013 entry that stated "patient is hearing voices, answering questions and asking questions with no one in the room." At the time of my evaluation, Ms. Verduzco was being treated with several psychotropic medications including Haldol decanoate, Depakote, and Prozac. In addition to her psychiatric incapacities, she had experienced at least two bouts of dehydration, one of which required IV therapy. Finally, she was noted to be toxic from her Depakote. Her blood level of Depakote on June 19, 2013 was noted to be 123 mcg/ml with high normal being 100 mcg/ml.

I am aware that Ms. Verduzco was pepper sprayed twice for "refusing directives to come to the cell front for pill call." This action appears to stem from a complete lack of understanding of her clinical situation and is frankly vengeful in nature. Her inability to come to the cell front for pill call was most likely due to a combination of her being psychotic and possibly suffering from medication toxicity and dehydration.

I reviewed a video of the pepper-spraying of Ms. Verduzco on December 22, 2011 (ADC 197317). Ms. Verduzco was first diagnosed as suffering from Schizoaffective Disorder, bipolar type at the Arizona State Hospital in 2004. This is a chronic psychotic condition, which is

characterized by intermittent manic episodes. A review of her medical record reveals that in the 6-8 weeks prior to this use of force incident she was becoming increasingly psychotic and emotionally labile. She began to episodically refuse her psychotropic medications during the run up to this incident. Of note, she was being prescribed four different medications: Depakote delayed release, Geodon, Celexa and Cogentin. On 12/21/11, the day before she was pepper-sprayed, a chart note stated that she was disoriented with deteriorated attention and concentration. Her mood was described as hostile and her affect as labile. The staff noted that she "presented as psychotic" and was "yelling at an object on the floor." The next day she refused all of her morning medications. While she was in this unmedicated, psychotic and manic state, she did not show her face and hands to the guard when requested and was sprayed with a noxious chemical agent.

I do not possess an adequate vocabulary to properly express how egregious it was to pepper spray this extremely ill individual. It is my firm professional opinion that these acts of pepper spraying have worsened her overall mental health condition. ADC's use of chemical agents poses a grave risk of future harm to Ms. Verduzco and other prisoners with serious mental illness.

Opinion: Inadequate suicide prevention

Dr. Penn assumes that there were seven suicides in ADC in 2013. Penn rep. at 69. As I stated in my supplemental report, there were ten suicides in ADC between January 1 and November 28, 2013. Assuming there were no additional suicides during the remainder of the year, this yields a rate of 25 suicides per 100,000 prisoners. Stewart supp. rep. at 5-6. In the

period from 2001 to 2011, only nine state prison systems had a suicide rate higher than 25 per 100,000.[12]

ADC's suicide prevention training materials state that "[f]or a system the size of ADC, an "average" suicide rate would be 4-5 per year." ADC_S000540. Ten suicides in a year – during a period when ADC has allegedly been improving mental health services – is a sign of significant deficiencies in ADC's suicide prevention measures.

There is another, more fundamental flaw in Dr. Penn's analysis. While the number of suicides is one important variable, it is not sufficient to look at raw numbers alone when assessing a prison system's suicide prevention. It is also essential to ascertain whether suicides resulted from poor mental health care or were otherwise preventable. A completed suicide can reveal systemic deficiencies in staffing, in the medication distribution system, in suicide watch practices, and other essential components of a prison mental health system. Dr. Penn apparently made no attempt to review any ADC suicides in this way.

Opinion: Inappropriate Use of Isolated Confinement on the Mentally Ill

Unlike the American Psychiatric Association, Dr. Penn apparently does not believe that housing prisoners with serious mental illness in isolation poses a risk of harm. He writes that "there is no empirical data to suggest any cause and effect psychiatric and/or mental health impact from the limited use of higher custody levels." Penn Rep. at 77. But ADC's own suicide prevention training materials correctly recognize that there is a "[h]igher risk [of suicide] for those in isolation or in higher custody units" ADC_S000521. These materials also note that prisoners "with a history of psychiatric problems or treatment, especially depression" are at

[12] U.S. Department of Justice, Bureau of Justice Statistics, *Mortality in Local Jails and State Prisons, 2000-2011 – Statistical Tables* (August 2013, NCJ 242186), Table 26.

heightened risk of suicide. ADC_S000542. Placing seriously mentally ill prisoners in ADC's isolation units is a recipe for serious harm or death, including aggravation of mental illness, self-mutilation, and suicide.

I have inspected segregation and isolation areas in numerous prisons and jails. I have rarely, if ever, seen anything comparable to the extreme degree of isolation imposed on prisoners in ADC's isolation units. The construction of cells with no windows, the covering of cellfronts with Plexiglas, and other steps taken to maximize isolation pose a grave risk of serious harm to prisoners with mental illness.[13]

Opinion: Lack of Mental Health Programming

ADC training materials state that "[a] significant number of mentally disordered inmates are housed throughout the department, with most inmates in general population rather than in specialized mental health programs." ADC_S000384. As of December 9, 2013, ADC had over 10,000 prisoners classified as MH-3, MH-4, or MH-5. ADC_S000556. Prisoners so classified have "a recognized need, or there exists a routine or current need for mental health treatment and/or supervision." ADC_S000322. According to the report of defendants' expert Richard Seiter, these prisoners have moderate, high, or acute mental health needs. Seiter Rep. at 4. Most if not all of these prisoners require mental health programming.

Dr. Penn focuses on specialized programs like the Women's Treatment Unit (WTU) at ASPC-Perryville and the Behavioral Management Unit (BMU) at ASPC-Eyman. Whatever the

[13] See photos of cells in Florence-CB 1 and Eyman attached to this report as Exhibit A: ADC 153331, 153336, 153339-41, 154497-98.

value of these programs, they serve only a tiny fraction of the thousands of ADC prisoners with mental health needs.[14]

Much of what Dr. Penn describes is not, in fact, mental health programming. Watching television is not mental health programming; nor is working as a groundskeeper or porter, "journaling," going to an exercise enclosure, participating in STG debriefing, or visiting.[15] Many of the activities Dr. Penn describes apparently do not include any interaction with mental health staff. While some or all of these activities may have mental health benefits, they do not constitute the mental health *programming,* provided by qualified mental health staff, that is an essential element of the treatment of prisoners with mental illness.

It is also apparent that many prisoners are excluded from the few mental health programs that do exist because of their custody level. Maximum custody prisoners are excluded from the WTU, Men's Treatment Unit, and Behavioral Health Unit. Penn Rep. at 58-60. Other prisoners may be arbitrarily excluded because of their sentence structure, which bears no relationship to one's need for or ability to benefit from mental health programming. Penn Rep. at 45, 59-60. I am particularly shocked to learn from Dr. Penn's report that 30% of the prisoners ADC itself has identified as suffering from serious mental illness are categorically disqualified from structured mental health programming. Penn Rep. at 45. This is a dangerous and unjustifiable policy that poses a substantial risk of serious harm to these prisoners.

The documents that have been provided to me by plaintiffs' counsel since my last report are listed in Exhibit B. I reserve the right to supplement my opinions if additional information or

[14] At the time of my inspection in July 2013, the WTU program included eight women. Stewart Rep. at 39. According to defendants' expert Richard Seiter, the BMU program currently includes ten men. Seiter Rep. at 2 n. 4.

[15] See photos of prisoners at Phoenix-Baker watching commercial television, attached to this report as Exhibit A: ADC 163939-41.

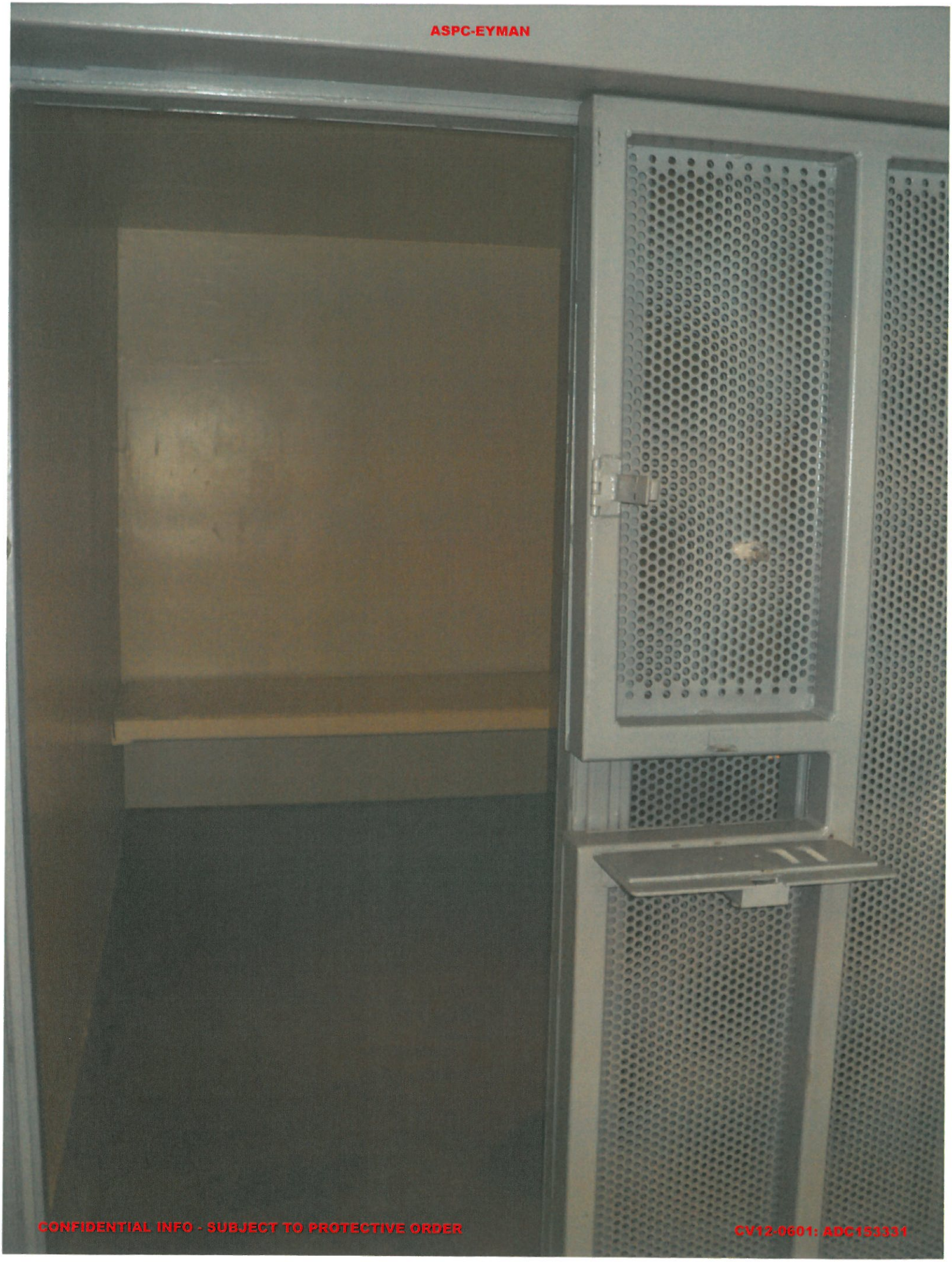
documents are provided in the future.

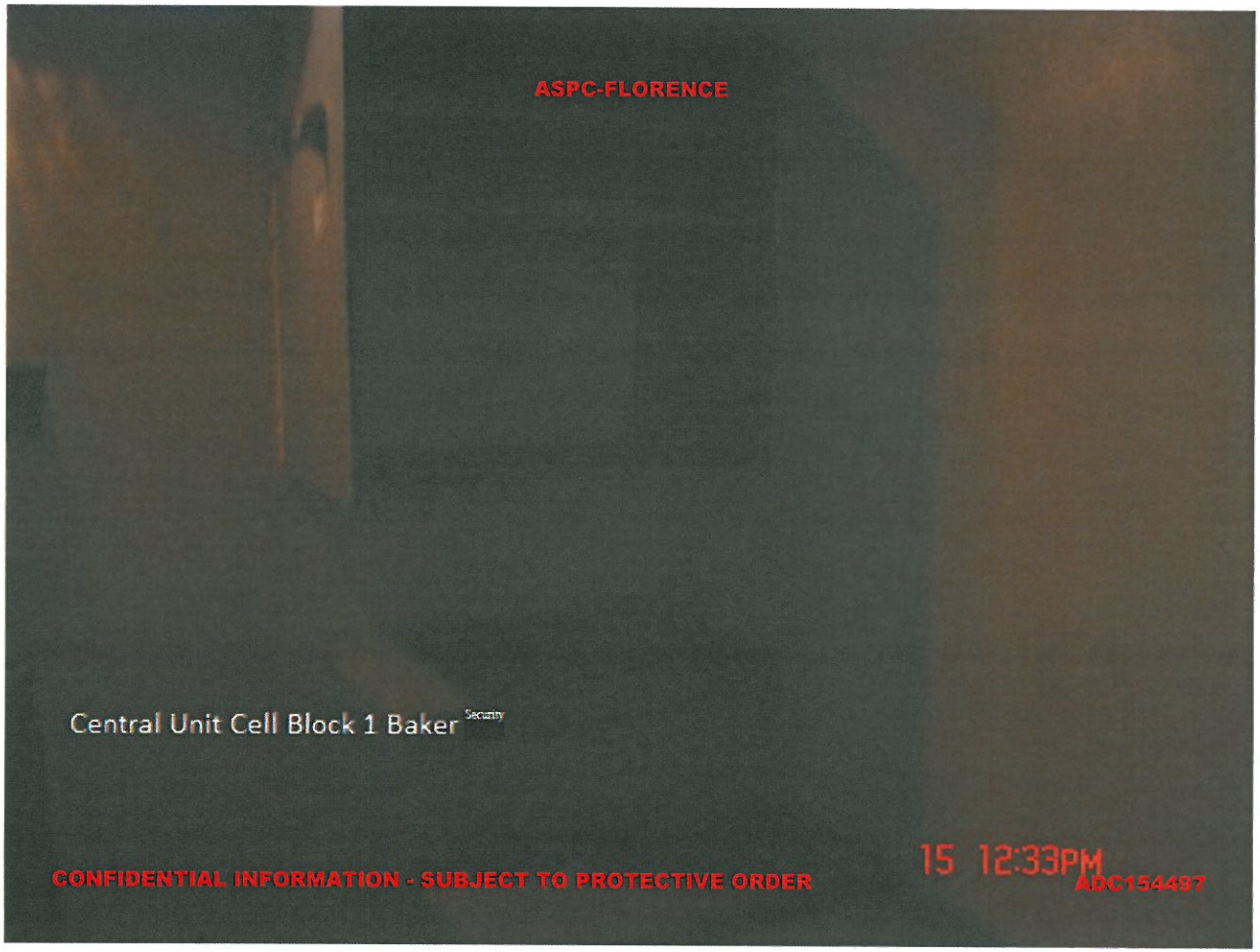
Dated this 30th day of January, 2014, at San Francisco, California.

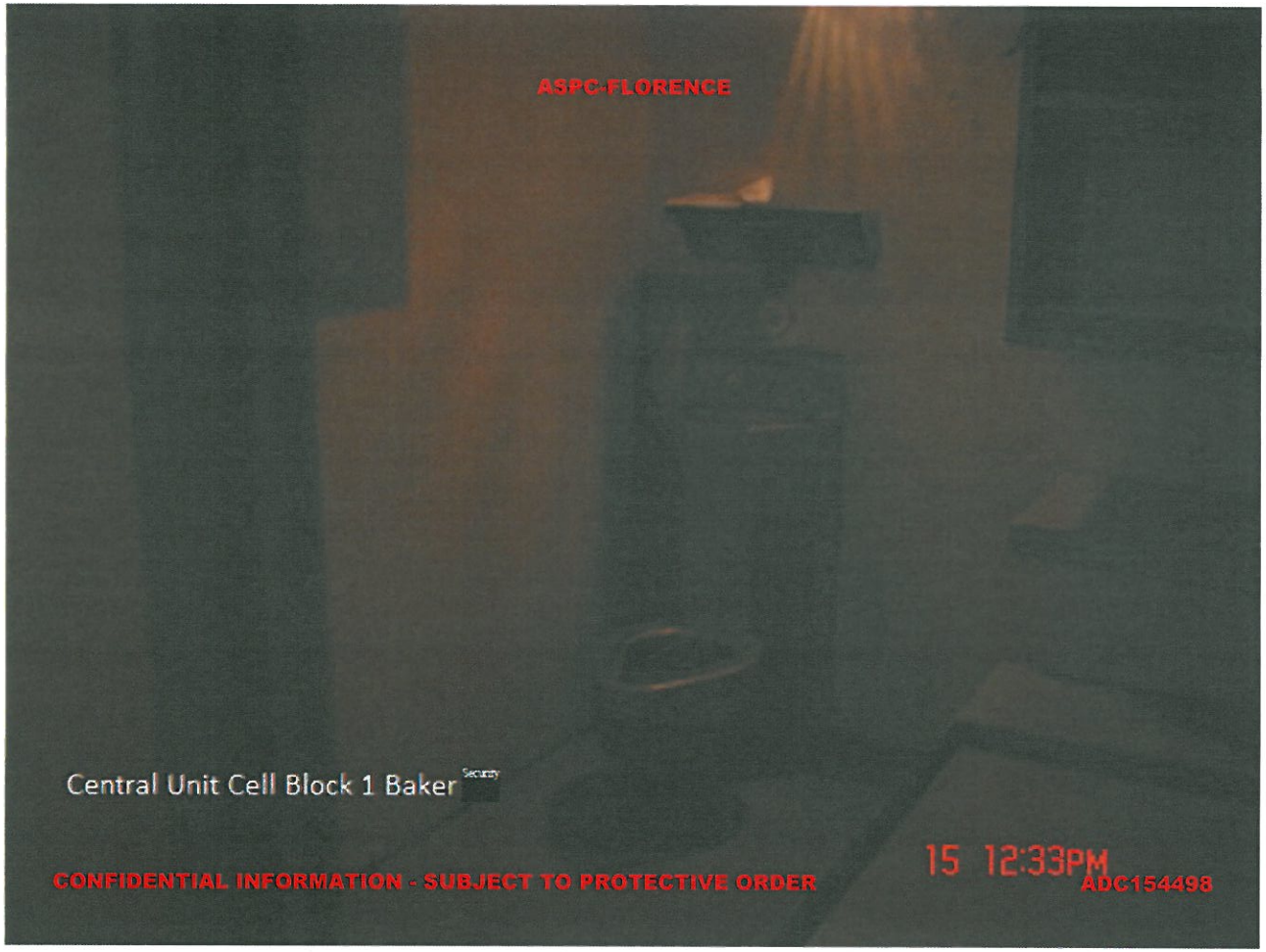
PABLO STEWART, M.D.

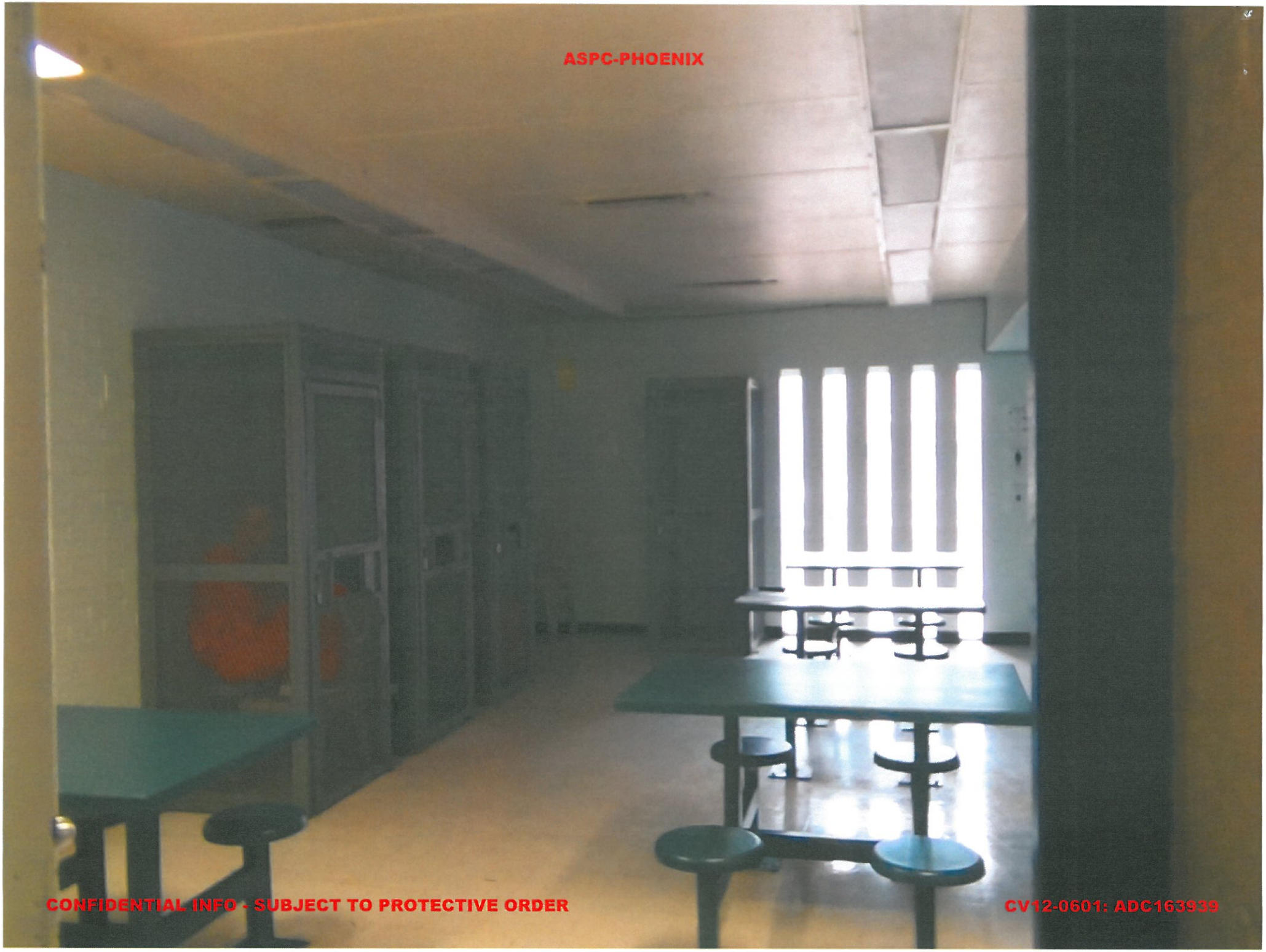
Exhibit A


If you don't want
your Med's sign a
refusal, if not you
will get ticketed
THIS WINDOW IS
FOR MEDICATION
PASS ONLY. NO
QUESTIONS OF
ANY NATURE. IF
YOU HAVE AN
ISSUE OR
QUESTION,




ASPC-FLORENCE
Central Unit Cell Block 1 Baker Security
CONFIDENTIAL INFORMATION - SUBJECT TO PROTECTIVE ORDER
15 12:33PM
ADC154497


ASPC-FLORENCE
Central Unit Cell Block 1 Baker
CONFIDENTIAL INFORMATION - SUBJECT TO PROTECTIVE ORDER
15 12:33PM
ADC154498


ASPC-PHOENIX
CONFIDENTIAL INFO - SUBJECT TO PROTECTIVE ORDER
CV12-0601: ADC163939


ASPC-PHOENIX
CONFIDENTIAL INFO - SUBJECT TO PROTECTIVE ORDER
CV12-0601: ADC163940


ASPC-PHOENIX
Security
CONFIDENTIAL INFO - SUBJECT TO PROTECTIVE ORDER
CV12-0601: ADC163941

Exhibit B

Documents sent from plaintiffs' counsel to plaintiffs' witness Dr. Pablo Stewart after his supplemental expert report was submitted on 12/9/13

ADC Staff Training Materials

- Suicide and Symptoms of Mental Illness
  - In-Service
    - ADC_S000317 2014 - Signs and Symptoms of Mentally Ill Inmates
    - ADC_S000318-000361 - 2014_Signs_and_Symptoms_of_Mentally_Ill_Inmates
  - Pre-Service
    - ADC_S000362-000384 - 9.7a COTA Signs & Symptoms of Mental Disorders
    - ADC_S000385-000439 - 9.7a COTA Signs and Symptoms of Mental Disorders
    - ADC_S000440-000444 - COTA Signs & Symptoms of Mental Disorder
- Suicide Prevention
  - In-Service
    - ADC_S000445 - 2014 Inmate Suicide Prevention
    - ADC_S000446-000515 - 2014_Inmate_Suicide_Prevention
  - Pre-Service
    - ADC_S000516-000517 - 9.7 SP Risk Factor Cards
    - ADC_S000518-000534 - 9.7b Suicide Prevention
    - ADC_S000535-000553 - 9.7b Suicide Prevention LP
    - ADC_S000554-000555 - SP Risk Factor Cards

Corizon Reports

- ADC_M00001 - CONFIDENTIAL SPDR Report
- ADC203028 - CONFIDENTIAL Arizona - Clinical Data Report October 2013
- ADC203029 - CONFIDENTIAL Arizona - Dental Utilization Statistics October 2013
- ADC203030 - CONFIDENTIAL Arizona - Dental Wait Times Report October 2013
- ADC203031 - CONFIDENTIAL Arizona - Formal Grievances by Category October 2013
- ADC203032 - CONFIDENTIAL AZ - Health Needs Requests (HNR) Appt Report October 2013 pivot table
- ADC203033 - CONFIDENTIAL Arizona - Hepatitis C Report October 2013
- ADC203034 - CONFIDENTIAL Arizona - Hospitalization Statistics Report October 2013
- ADC203035 - Arizona - Informal Grievances by Category October 2013
- ADC203036 - Arizona - Inmate Wait Times Report October 2013
- ADC203037 - CONFIDENTIAL Arizona - Intake Report October 2013
- ADC203038 - CONFIDENTIAL Arizona - Med Mal Stats October 2013
- ADC203039 - CONFIDENTIAL AZ - Medical Transports Complex Report October 2013
- ADC203040 - CONFIDENTIAL AZ - Medical Transports Statewide Report October 2013
- ADC203041 - CONFIDENTIAL Arizona - Monthly Staffing Report October 2013
- ADC203042 - CONFIDENTIAL Arizona Statewide Grievances October 2013
- ADC203043 - CONFIDENTIAL CAG FAQ PBMS Report FY14 - October 2013

- ADC203044-203050 - Corizon AZ Emergency Transports by Complex Oct 2013
- ADC203051-203060 - Corizon AZ Medication Report Oct 2013
- ADC203061-203062 - Corizon AZ Inpatient Admits Oct 2013
- ADC203297 - CAG FAQ PBMS Report FY13 - June 2013
- ADC203348 - November 2013 Inmate Wait Times Report
- ADC203349 - CONFIDENTIAL November 2013 Dental Utilization-Statistics
- ADC203350 - CONFIDENTIAL November 2013 Dental Wait Time Reporting
- ADC203351 - November 2013 Hepatitis C Report
- ADC203352 - November 2013 Inmate Intakes by Complex

Defendants' Expert Reports and Associated Productions

- Confidential Expert Report of John Dovgan
- Confidential Expert Report of Lawrence Mendel
- Confidential Expert Report of Joseph Penn
- Confidential Expert Report of Richard Seiter
- Defendants' Expert Materials, Volume 1, January 17, 2014
- Defendants' Expert Materials, Volume 2, January 17, 2014
- Defendants' Expert Materials, Volume 3, January 17, 2014
- Defendants' Expert Materials, Volume 4, January 17, 2014

Disclosure Statements

- Defendants' 11th Supplemental Disclosure Statement

Miscellaneous

- Expert Report of Dr. Pablo Stewart
- ADC203027 - Arizona - Cert and Licensing Monthly Update October 2013
- ADC203063-203258 - Wells 2d Supp Resp - Rog 7
- ADC203259-203296 - Wells 2d Supp Resp - Rog 8
- ADC203353-203359 - Feraci Store Order History
- ADC_P000984 - ADC ID Badge re Suicide Warning Signs
- ADC_S000556 - MHclassificationbyGenderDec9

Named Plaintiffs' Records

- ADC203298-203347 - Licci Updated Medical Records
- ADC_M000195-000206 - Joshua Polson's ENT Records
- ADC_P000580-000858 - AIMS REPORTS - ALL NAMED PLAINTIFFS (CONFIDENTIAL)

NCCHS Accreditation Reports

- ADC_P000888-000901 - Douglas 20130628 Report
- ADC_P000902-000915 - Perryville 20130628 Report.
- ADC_P000916-000919 - Perryville 20131011 Update Report
- ADC_P000920-000933 - Phoenix 20130613 Report
- ADC_P000934-000950 - Tucson 20130628 Report
- ADC_P000951-000959 - Tucson 20131108 Update Report
- ADC_P000960-000964 - Winslow 20131119 Update Report
- ADC_P000965-000973 - Yuma NCCHC - 2011-03-11 - update report
- ADC_P000974-000976 - Douglas 20131119 Update report
- ADC_P000977-000979 - Perryville 20131118 Update report
- ADC_P000980-000983 - Phoenix 20131122 Update report

Photos

- ADC153331 – ASPC-Eyman
- ADC153336 – ASPC-Eyman
- ADC153339-41 – ASPC-Eyman
- ADC154497-98 – ASPC-Florence
- ADC154565 – ASPC-Tucson
- ADC163939-41 – ASPC-Phoenix
- ADC163952 – ASPC-Phoenix
- ADC165980-166048 - Florence - 2013-08-20 (redacted)
- ADC166049-166110 - Lewis - 2013-08-21 (redacted)
- ADC166111-166173 - Perryville - 2013-08-19 (redacted)
- ADC166174-166183 - Perryville-Lumley - 2013-08-19 (redacted)
- ADC166184-166215 - Tucson - 2013-08-22 (redacted)

Programs

- ADC_P000859-000865 - Tucson HU-7 WIPP Time sheets
- ADC_P000866 - Eyman Special Mgmt Unit I Map as of 10-28-13
- ADC_P000867 - Eyman Mental Health Program Schedule
- ADC_P000882 - Eyman Weekend Recreation Schedule
- ADC_P000883-000886 - Phoenix-Baker - Introduction to Baker MH Program
- ADC_S000286-000291 - Central Unit Mental Health Programs & Schedule

Resumes

- ADC203360-203362 - Mark Jansen CV
- ADC203363-203364 - Mark Fleming CV

- ADC203365-203367 - Thomas Buenker CV
- ADC203368-203371 - William Smallwood CV

Videos

- ADC197317-197317 - Verduzco - UOF 11-B02-5191 - 2011-12-22
- ADC197318-197318 - Verduzco - SIR 12-03705 2012-03-25
- ADC197319-197319 - Verduzco - SIR 12-04264 2012-04-14