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ISOLATED CONFINEMENT IN MICHIGAN:
MAPPING THE CIRCLES OF HELL

Elizabeth Alexander
Patricia Streeter*

INTRODUCTION

For the past twelve months, there has been a burgeoning campaign to abolish, or greatly reduce, the use of segregated confinement in prisons.1 Advocates for the campaign call such classifications “solitary confinement” despite the fact that in some states, like New York, prisoners in these cells are often double-celled.2 The Michigan Department of Corrections, as well as other prison systems, uses labels such as “segregation,” “special management,” “special housing,” and “observation” for these classifications.3 Prisoners ordinarily use traditional terms, such as “the

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3. “Solitary confinement” is a general term. In Wilkinson v. Austin, 545 U.S. 209, 214 (2005), the Supreme Court described confinement at the Ohio State Prison that involved prisoners spending twenty-three hours a day in cells with solid metal doors, taking their meals in their cells, exercising alone, and lacking the ability to control cell lighting as more restrictive than other forms of solitary confinement in Ohio.
hole.”

In this Essay we will refer to such restrictive classifications as “segregation” or “segregated confinement.” Our perspective on the problems with such classifications comes from serving as counsel for plaintiffs in Hadix v. Caruso. Hadix is a long-running class action regarding what was once called the State Prison of Southern Michigan; in this case, we are attempting to enforce remaining portions of a 1984 consent decree to which the Michigan Department of Corrections (MDOC) is subject.

Part of what we describe in this Essay is the harm that segregated confinement has inflicted on mentally ill members of the Hadix class. The evidence of harm to mentally ill prisoners from segregated confinement that we found was entirely predictable. It has long been known that segregated confinement results in the deterioration of the mental health status of many prisoners so confined and the related deterioration of their ability to interact safely with other persons once released from segregation.

This Essay, however, will not focus particularly on the harms caused by the propensity of segregated confinement to engender or exacerbate mental illness.

We will describe examples drawn from our own experiences and other litigation in Michigan documenting the potential for lethality from assigning medically vulnerable prisoners to segregated confinement—an issue that has received less attention in the national campaign against the use of solitary confinement. We will also suggest explanations for why assigning such prisoners to segregated confinement is so predictably dangerous, as well as why the MDOC has been so slow to recognize these dangers.

We will argue that many of the harms flowing from segregation in Michigan arise from the fact that such confinement, to a much greater extent than confinement in the prison general population, renders prisoners with disabilities and other medical needs at special risk from such confinement. The physical barriers imposed by segregated confinement make it far more difficult for prisoners to communicate emergency needs to staff, and far more difficult for staff to recognize those needs. In addition, segregated confinement promotes a culture in which staff become particularly inattentive to information suggesting that a prisoner is at serious risk. These particular features of segregation in Michigan (as well as other states)

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4. This observation is based on our experience representing prisoners in a variety of facilities.


have had deadly consequences, yet the MDOC has repeatedly failed to adjust policy and practice in light of the demonstrated risks to prisoners.

The standard features of segregation cells in Michigan, as well as elsewhere, include doors that are solid rather than barred, with small or non-existent windows in the door. This serves to isolate the prisoner and interfere with the prisoner’s ability to communicate with staff, as well as the ability of staff to observe the behavior and physical condition of the prisoner. This danger arises precisely from the intended architectural function of segregation cells to isolate the occupants from communication with others.

Moreover, the personal characteristics of prisoners placed in segregation tend to exacerbate the risks from such confinement. While much of the literature regarding segregated confinement has focused on the risk that rules violations triggered by mental illness will result in isolation rather than treatment, segregation in Michigan is not restricted to rules violators. The risks from segregated confinement are substantially exacerbated because the MDOC does not restrict its use to the punishment of misbehaving prisoners. In fact, the MDOC has also assigned prisoners to segregation because of their mental or physical illnesses. As discussed below, these uses of segregation result in precisely those prisoners at most risk for experiencing emergency medical and mental health needs having the least access to treatment in the event of a life-threatening emergency. Some of the prisoners placed in segregated confinement because of their medical and mental health problems have been subjected to conditions that entailed physical and mental suffering that, had it been ordered as punishment, would have clearly been classified as torture. Moreover, the MDOC’s use of segregation to confine persons with severe medical problems and physical disabilities exposes them to an unreasonably high risk of harm, regardless of whether the prisoners deserve punishment for the violation of prison rules.

I. THE LETHAL HISTORY OF MICHIGAN SEGREGATION CELLS

MDOC policy allows prisoners to be assigned to segregation because they are considered suicidal or otherwise mentally unstable. Indeed, the MDOC has a particularly tragic history of deaths related to assigning men-

7. This description of typical segregation cell features is based on our personal observations at various Michigan prisons and is similar to segregation cells in other prisons that we have observed. See also Wilkinson, 545 U.S. at 214 (describing cell conditions in Ohio’s supermax, Ohio State Penitentiary).
8. As many of the cases we discuss below illustrate, prisoners who die while confined in segregation frequently suffer from serious medical conditions, including serious mental disorders.
tally ill prisoners to segregated housing. We found several such cases simply by looking at reported opinions from the federal courts. For example, a Sixth Circuit opinion describes the death of Ozy Vaughn, a mentally disabled prisoner, after he became dehydrated in an observation room in the Riverside Correctional Facility in Ionia, Michigan. The temperature in that room exceeded ninety degrees in January 2002.\textsuperscript{11} It is unclear why the observation room was so hot.\textsuperscript{12} Prison officials placed Mr. Vaughn in the observation room after he engaged in bizarre behavior, such as standing naked over his cellmate while preaching, as well as stating that outside forces were controlling his actions.\textsuperscript{13} Following that placement, a staff psychiatrist prescribed a psychotropic medication for Mr. Vaughn that interferes with the brain's ability to regulate body temperature.\textsuperscript{14} After Mr. Vaughn spent a weekend in the observation room, the staff psychiatrist noted that his condition was worsening. Nonetheless, the psychiatrist, who was aware of the excessive heat, decided to give the medication more time to work.\textsuperscript{15} Days later, Mr. Vaughn was vomiting after attempting to drink a large amount of water.\textsuperscript{16} The temperature in the room had reached ninety-six degrees.\textsuperscript{17} As Mr. Vaughn's condition continued to deteriorate that day, the psychiatrist decided to continue his observation, with a plan to move Mr. Vaughn to a cooler room and eventually to a psychiatric hospital.\textsuperscript{18} However, Mr. Vaughn, still in the observation room, continued to vomit and dry heave.\textsuperscript{19} He died from dehydration early the next morning.\textsuperscript{20}

The court does not discuss the physical characteristics of the room; however, it appears that the room had a solid door rather than a standard-cell grill opening because the opinion refers to the plaintiff having been moved from a prison cell to the room.\textsuperscript{21} "Rooms" in prison generally refer to housing with solid rather than grill doors.\textsuperscript{22} In addition, the court describes the temperature problems only in relation to problems within the cell, suggesting that a solid door (probably with a viewing window) was

\begin{thebibliography}{99}
\bibitem{11} See Gibson v. Moskowitz, 523 F.3d 657, 660–61 (6th Cir. 2008). The degree of risk was probably heightened by high humidity. See discussion of Timothy Souders and heat indices, infra note 87.
\bibitem{12} Gibson, 523 F. 3d at 660.
\bibitem{13} Id. at 661–62.
\bibitem{14} Id. at 661–63.
\bibitem{15} Id. at 661.
\bibitem{16} Id.
\bibitem{17} Id.
\bibitem{18} Id.
\bibitem{19} Id.
\bibitem{20} Id.
\bibitem{21} Id. at 660.
\bibitem{22} This observation is based on the authors' experiences.
\end{thebibliography}
involved.\textsuperscript{23} Thus, it is likely that the observation cell met our definition of a segregation cell.\textsuperscript{24}

Also in 2002, Jeffrey Clark was a prisoner at the Bellamy Creek Correctional Facility while the prison was in the grip of high temperatures.\textsuperscript{25} On June 29, 2002, Mr. Clark collapsed while he was outside on the prison yard.\textsuperscript{26} Staff noticed that, after the collapse, Mr. Clark was crying, talking about dying, and not making sense.\textsuperscript{27} A correctional officer believed that Mr. Clark was suffering from mental problems and transported him to an observation cell.\textsuperscript{28} Although the observation cell was purportedly used so that behavior could be monitored more closely, the cell had a solid door with a small window and a food slot.\textsuperscript{29} Functionally, it was a segregation cell.\textsuperscript{30} Correctional staff described Mr. Clark as “barking like a dog” and screaming after being placed in the cell.\textsuperscript{31}

When officers attempted to move Mr. Clark back to a regular cell, his legs went limp, and he stiffened up.\textsuperscript{32} This behavior led staff to decide to leave him in the observation cell.\textsuperscript{33} By June 30, Mr. Clark’s water had been turned off.\textsuperscript{34} The next day, a staff psychologist diagnosed Mr. Clark as suffering from psychosis.\textsuperscript{35} The psychologist asked that Mr. Clark’s water be turned back on, but the correctional officer in charge denied that request.\textsuperscript{36} Later that day, Mr. Clark was observed drinking from the toilet.\textsuperscript{37} The next day, July 2, the water in Mr. Clark’s cell was off again, and the head of outpatient mental health services at the prison stated that Mr. Clark was psychotic and in need of intensive services.\textsuperscript{38} On July 3, mental health staff observed that Mr. Clark was “virtually non-responsive,” although several prisoners described him as asking for water.\textsuperscript{39} The officer in charge informed the Resident Unit Manager of the housing unit that Mr.

\begin{itemize}
\item \textsuperscript{23} See Gibson, 523 F.3d at 661.
\item \textsuperscript{24} See supra text accompanying notes 1–5.
\item \textsuperscript{25} See Clark-Murphy v. Forebeck, 439 F.3d 280, 283 (6th Cir. 2006) (noting that the events that led to Mr. Clark’s death occurred during a heat alert period at the prison, meaning that the temperature outside was at least eighty-five degrees).
\item \textsuperscript{26} Id.
\item \textsuperscript{27} Id.
\item \textsuperscript{28} Id.
\item \textsuperscript{29} Id.
\item \textsuperscript{30} See supra text accompanying note 3.
\item \textsuperscript{31} See Clark-Murphy, 439 F.3d at 283.
\item \textsuperscript{32} Id.
\item \textsuperscript{33} Id.
\item \textsuperscript{34} Id.
\item \textsuperscript{35} Id. at 284.
\item \textsuperscript{36} Id.
\item \textsuperscript{37} Id.
\item \textsuperscript{38} Id.
\item \textsuperscript{39} Id. at 285.
\end{itemize}
Clark's water was turned off. The Resident Unit Manager responded that the water could not be left off. The following day, July 4th, 2002, Mr. Clark was discovered in rigor mortis in his "observation" cell. When staff entered Mr. Clark's cell that day, it was the first time the cell door had been opened since the attempted move to regular housing on June 29th.

In January 2005, Anthony McManus was at the Baraga Correctional Facility, a maximum security facility where most, if not all, prisoners are held in cells that are essentially the equivalent of segregation. According to evidence submitted by the estate of the deceased prisoner, Mr. McManus suffered from several psychological problems that the prison staff failed to treat. The facility lacked a psychiatric department, and a nurse on staff testified that prisoners with psychiatric illnesses should not be kept in the facility. In late January 2005, Mr. McManus was placed on a finger-food diet. By July 2005, Mr. McManus, whose height was 5'7", was reported to weigh ninety pounds. A staff member reported that Mr. McManus looked like someone from a concentration camp. "[D]uring the final weeks of Mr. McManus's life, various [staff] turned off the water in his cell and restricted his access to food" in an attempt to control his behavior. Mr. McManus often refused to eat, and he often smeared the food he received on the walls of the cell. On September 5, 2005, Mr. McManus flooded his cell, and a staff nurse determined that there were no health reasons why a chemical agent could not be used in order to remove Mr. McManus from his cell. Mr. McManus was then moved, naked, to another housing unit. The nurse, who observed the move, saw that Mr. McManus was breathing but did not perform a hands-on medical exami-

40. Id.
41. Id.
42. Id.
43. Id. at 283.
44. See Baraga Correctional Facility, MICH. DEPARTMENT CORRECTIONS, www.michigan.gov/corrections/0,4551,7-119-5325-00.html (last visited Apr. 2, 2013) (stating that seven of the prison's eight housing units house maximum security prisoners within the secure perimeter). The doors of the cells in which Mr. McManus was held had narrow windows and food slots and staff found it difficult to observe Mr. McManus in the cells due to a combination of the cell door design and his behavior. See Valarie v. Mich. Dep't of Corr., No. 2:07-cv-5, 2009 WL 2232684, at *4-*5 (W.D. Mich. July 22, 2009).
46. See id. at *1.
47. Id. at *2.
48. Id.
49. See id. at *2. Presumably the finger food diet was ordered in response to Mr. McManus' habit of smearing food on the walls of his cell. See id. at *3.
50. Id. at *3.
51. See id.
52. Id. at *4.
53. Id.
nation. The nurse did note that his speech was nonsensical. A videotape of the move shows a “very emaciated, naked individual” who is speaking incoherently but “eventually makes clear requests for water and help.” Two days later, a correctional officer suggested that Mr. McManus should be examined by medical staff. The next morning, staff noticed that Mr. McManus was not breathing.

A report on Mr. Manus’s death by the Chief of Clinical Affairs of the Corrections Mental Health Program notes the following:

[U]ntreated mental illness probably explains the weight loss that made McManus vulnerable to changes in hydration. Absent behavior arising from mental illness, it is likely that water restriction would not have been imposed. Failure by staff to appreciate the significance of extreme weight loss, whether attributed to mental illness or not, and imposition of water restriction in a nutritionally compromised prisoner without adequate monitoring appear to be the most immediate contributors to death.

II. MENTALLY ILL HADIX CLASS MEMBERS HAVE SUFFERED SEVERE HARM FROM CONFINEMENT IN SEGREGATION

Sadly, all three of these deaths bear substantial similarities to the later death of Timothy Souders, a member of the Hadix class. We had long been concerned that class members with certain health characteristics could be at high risk of heat injury in the conditions prevailing in the Hadix cellblocks during hot, humid weather. In 2000 and 2002, we sought orders that such prisoners, including prisoners prescribed psychotropic medications that interfered with their ability to regulate body temperature, be assigned to temperature-controlled housing. In the course of preparing for the 2002 evidentiary hearing on that and other issues, we developed evidence
regarding a sixty-seven-year-old man who had suffered a fatal heart attack. This *Hadix* class member had been excused from work for several days because of the heat.\(^6\) He was then required to return to work.\(^6\) He collapsed and died after being forced to walk a quarter mile in direct sun on a day in which the National Weather Service reported that the heat index was 107 degrees.\(^6\) After various proceedings, the district court issued an interim order requiring the defendants to implement their own plan that did not require the Department of Corrections to place high risk prisoners in temperature-controlled housing.\(^6\)

The district court then scheduled a hearing to consider the MDOC request to terminate injunctive relief regarding medical care, and the plaintiffs' request for additional relief on various issues, including protection from heat injury. While the parties were preparing for the hearing, Timothy Souders arrived at the *Hadix* facilities in March 2006.\(^6\) Prior to Mr. Souders' incarceration, he had been diagnosed with bipolar disorder and depression; he also had a history of suicide attempts.\(^6\) Although he was a young man, he also was prescribed medication for a thyroid disorder and had risk factors for cardiovascular disease.\(^6\) Because of Mr. Souders' medical and mental health problems, it was known that he would be subject to a high risk of injury from exposure to excessive heat.\(^6\) About two months after Mr. Souders arrived at the Southern Michigan Correctional Facility, the only psychiatrist for the approximately 1,400 prisoners there went on leave.\(^6\)

The following month (June 2006), Mr. Souders received a disciplinary charge for fighting with another prisoner.\(^7\) As a result, he was ordered to undergo thirty days of punitive detention in "Top 6," a notorious segregation unit within the prison.\(^7\) Top 6 had previously been the site of

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62. *Id.* at 229.
63. *See id.* at 229–30. Heat indices are important in determining the healthfulness of a particular temperature, combining temperature, ventilation and humidity, and allows comparison of the heat effects on health. For example, a 90 degree temperature could have a heat index equivalent of 119 degrees, well beyond acceptable standards for personal health and environmental concerns.
67. *Id.* at 577, 579.
70. *Id.*
a death. After Mr. Souders served his disciplinary time, he was again classified to general population but was returned to Top 6 for taking an unauthorized shower on a hot day. The Top 6 cells lacked the standard open grilled front of most prison cells. Instead, prisoners were confined in cells without a window or any ventilation. When the solid metal door was closed, the only way to communicate with the prisoner inside was through the slot in the door that correctional officers used to insert food trays. Top 6 was particularly oppressive on hot days because the cells were essentially locked metal and cement boxes. A staff psychologist testified that, on such days, when he opened the food slot of a prisoner on the unit in order to counsel prisoners, he would feel a blast of hot air coming out of the cell.

Once in the segregation unit, Mr. Souders’s behavior deteriorated. On August 2, 2006, he damaged a metal stool in his cell. Staff responded by putting him in standing restraints. While he was in restraints, he tried to flood his cell. This act resulted in a supervisory nurse giving approval to turn off the water in his cell, although that order was later countermanded by custody because the entire prison was experiencing a heat alert condition. At that point, staff responded by placing Mr. Souders on a concrete slab, with metal restraints on his wrists and ankles. A mental health worker who saw Mr. Souders that day characterized him as “floridly psychotic,” and by that time he was screaming incoherently. Despite Mr. Souders’s apparent need for emergency intervention by mental health staff, that intervention did not come. Moreover, presumably as a result of Mr. Souders’s mental deterioration, he rarely accepted water from staff at a time when conditions in the unit were oppressively hot. The videotape

72. See, e.g., Comstock v. McCrary, 273 F.3d 693, 699 (6th Cir. 2001) (in a case involving the suicide of a prisoner confined in observation status on Top 6, affirming the denial of qualified immunity to a prison psychologist).
74. The characterization of most prison cells is based on our experience.
75. See 2006 Hearing, supra note 68, at Pl.’s Ex. 106B (videotape on file with authors) (showing Mr. Souders’ cell).
76. Id.
77. Id.
78. Id. at Pl.’s Ex. 103 at 73.
79. Id.
80. Id.
82. Id.
83. 2006 Hearing, supra note 68, at Pl.’s Ex. 42 at 320844, 320904, 320906.
84. Hadix I, 461 F. Supp. 2d at 577.
85. Id. at 578.
86. Id.
87. 2006 Hearing, supra note 68 at 320844, 320904, 320906, 320952–62, 320964, 320966, 320969.
unit recording events in Mr. Souders's cell shows that on August 2nd and 3rd, the first two days that he was restrained, custody staff were complaining of the heat and humidity in his cell. At times, the video image is obscured because the camera has fogged up.

Mr. Souders repeatedly urinated on himself while in restraints and eventually was left naked. His skin developed sores from lying in urine without an opportunity to change his position. At one point, Mr. Souders was taken out of his cell for a medical examination. The physician declined to examine Mr. Souders, apparently because he had urinated on the examining table. Despite all this, at no point did any staff member demand that he receive an examination to determine his mental state. On August 6th, Mr. Souders' fourth consecutive day of confinement in four-point restraints, correctional officers took him to the unit showers. The videotape shows him staggering as he walked, unable to stand in the shower, and requiring the use of a wheelchair to return to his cell. He was moved to another cell in the unit, and shortly thereafter, the restraints were removed. He fell to the floor and did not get up. Correctional officers returned him to the concrete slab. A nurse then entered the cell. In response to a question from Mr. Souders, the nurse told him that his pulse was faint, indicating that Mr. Souders needed emergency care. Notwithstanding this finding, the nurse left Mr. Souders' cell without taking any steps to respond to the emergency, and Mr. Souders was discovered to have died when staff reentered his cell about an hour later. The subsequent autopsy listed the cause of death as hyperthermia with dehydration as a contributing cause.

The death of Mr. Souders is the most well-known tragedy resulting from the MDOC's use of segregation as a housing location for seriously mentally ill prisoners, but it stands out merely in the degree of harm inflicted. The only mental health beds in the Hadix complex currently are

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88. See id. at Pls.' Ex. 42, 106B (videotapes on file with authors).
89. See id.
91. Id. at 578.
92. Id.
93. Id.
94. Id. at 579.
95. Id.
96. Id.; see also 2006 Hearing, supra note 68, at Pls.' Ex. 106B (on file with authors).
98. Id.
99. Id.
100. Id. at 579–80.
101. Id.
five observation cells. At the time of the last hearing on mental health in 2008, when those observation cells were full, staff was instructed to use the Special Management Housing Unit (SMHU)—a disciplinary segregation unit—instead. Mentally ill prisoners were frequently placed in the SMHU. As experts in the Hadix case have documented, prisoners suffering from serious mental illness find it difficult to conform to the rules of prison staff and the norms of prison culture. Thus, confinement of mentally ill prisoners can start a downward spiral. In the stressful atmosphere of segregation, the mental status of many prisoners deteriorates, and they become entangled in escalating conflict with staff. This deterioration results in new disciplinary charges, including lengthening the stay in segregation leading to further deterioration.

The problem of the assignment of mentally ill prisoners to the SMHU is complicated by the fact that it has been common for prisoners undergoing intake procedures at the Hadix facilities to have their mental illness "undiagnosed." Psychiatrists were prone to consider inappropriate behaviors as deliberate malingering rather than as symptoms of mental illness. The state psychologists complained in their staff meetings that the psychiatrists were failing to identify prisoners who suffered from mental illness or who were at risk of committing suicide. Only 57 percent of prisoners who reported that they had been taking psychotropic medications prior to coming to prison had those medications continued upon arrival. There was a several-fold difference between the rate of mental

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103. Personal observation at Duane Waters Health Care during discovery inspection.
106. See generally, Terry A. Kupers, How to Create Madness in Prisons, in Human Prisons (David Jones ed., 2006) (Dr. Kupers served as the psychiatric expert for the Hadix class).
108. Id. at Defs.' Ex. BB at 18.
109. For example, a psychiatrist at the MDOC's in-patient mental health facility diagnosed a patient as bipolar with psychotic features. He was transferred to Duane Waters Hospital, given anti-psychotic medications, and placed in mechanical restraints. He was neither eating nor drinking, and was unresponsive. The psychiatrist who examined him there decided that the patient was a "maligner." As a result, the patient was force fed and almost died. Subsequently, the MDOC was forced to begin guardianship proceedings. Fourth Report of the Office of the Independent Medical Monitor, supra note 105, at 14–17.
110. 2008 Hearing, supra note 104, PIs.' Ex. 102 at 328378.
111. In 2007, 12.5 percent of newly-admitted prisoners arrived with a prescription for psychotropic medications, but only 7.1 percent were admitted to the mental health treatment caseload. Id. at PIs.' Ex. 45 at 37.
illness diagnosed by one staff psychiatrist and others. As a result, less
than one-quarter of the prisoners eventually determined to need mental
health treatment while in prison were identified during the intake pro-
cess. Although MDOC policy limits the placement of severely mentally ill
prisoners in segregation, the policy cannot be effective when the seri-
ously mentally ill are not properly diagnosed.

Finally, the harm from these failings of the MDOC continues un-
abated. Currently, policy severely limits the prescription on non-gen-
eric psychotropic medications for prisoners. As a result, Hadix class
members who were receiving prescription psychotropic medications prior
to intake have these medications stopped or tapered and switched to older
medications. In one case we became aware of during an October in-
spection of the Hadix facilities, a prisoner undergoing intake had his
psychotropic medications abruptly discontinued. In a matter of days, as
his psychological state deteriorated, staff placed him in an observation cell
but still did not provide the medication he needed. Shortly thereafter,
his condition deteriorated profoundly to the point that he experienced
episodes of incontinence. At that point, staff realized that he needed
effective medication and that he required in-patient mental health treat-
ment. Staff noted in his record the medication failures and the bad effect
of isolated confinement on his condition.

112. During one six-month period, one psychiatrist approved fewer than half of incoming
prisoners screened by psychologists for admission to the mental health caseload. Id. at Defs.' Ex.
Z at 11. The other two full-time psychiatrists refused admission to the prisoners screened by the
psychologists at rates of 10.9 percent and 11.8 percent, respectively. Id. at 5-6. There were no
differences in the assignments of the psychiatrists that could have explained these discrepancies.
Id. at Tr. at 234.

113. Id. at Pls.' Ex. 45 at 39.

114. See Mich. Dep't of Corr., Policy 04.06.182—Mentally Disabled Prisoners
in Segregation (2010).

115. See Change Notice No. 2 to Contract 07B9200147 between the State of Michigan
and Prison Health Service, Inc., at §1.031, ¶ Q (requiring physicians providing service on behalf
of private medical contractor for prison system to refrain from prescribing non-generic medica-
tions for more than 15 percent of all prescriptions).

116. See infra text accompanying note 117 for a particularly unfortunate example of this
widespread practice.


118. Id.

119. Id.

120. Id.

121. Id.

122. Id.
Michigan policy allows a prisoner to be assigned to segregated confinement because of his medical status. A number of prisoners who are members of the Hadix class have been placed on segregated status because of a diagnosis of methicillin-resistant Staphylococcus aureus,\(^{123}\) commonly known as MRSA, or drug-resistant “staph.” A person who has been exposed to the bacteria causing MRSA can spread it to others, even if the carrier does not develop an infection.\(^{124}\) While most MRSA infections involve the skin, under certain conditions such infections can become life-threatening by spreading to the blood, lungs, or other organs.\(^{125}\) MRSA is most common in facilities where large numbers of persons live together in close quarters, such as hospitals and prisons. Under MDOC policy, the determination of where to house a person with a MRSA infection is left to the warden of the prison.\(^{126}\) In our experience, this delegation of a medical decision to the warden results in prisoners with MRSA being assigned to the regular segregation unit designated for prisoners who have been found to have committed disciplinary violations in prison, or to a holding cell located within a regular housing unit.\(^{127}\) In either case, the prisoners are effectively in segregated confinement.\(^{128}\) When we inspected the Hadix facilities prior to the mental health hearings in July 2008, we talked to several prisoners who were being held in these holding cells because of a diagnosis of MRSA. In 2012, during a discovery inspection, we reconfirmed that the SMHU cells in the Hadix facility are still used to confine prisoners with contagious MRSA infections.\(^{129}\)

In a case unconnected with the Hadix litigation, we are counsel for Martinique Stoudemire, a former prisoner.\(^{130}\) Plaintiff’s evidence in the


\(^{124}\) \textit{Id.}


\(^{127}\) \textit{See Pramstaller Dep., supra note 126, at 47–48; Russell Mem., supra note 126, at 6022.}

\(^{128}\) \textit{See Pramstaller Dep., supra note 126, at 47–48; Russell Mem., supra note 126, at 6022.}

\(^{129}\) Personal communication with Heidi Washington, Warden, MDOC Reception and Guidance Center, at discovery inspection (Oct. 2012).

\(^{130}\) \textit{See Stoudemire}, 2011 WL 1303418, at *1 (denying various defendants’ motions for dismissal or summary judgment on claims under 42 U.S.C. § 1983 and the Americans with Disabilities Act, and specifically denying summary judgment to the warden regarding Ms. Stoudemire’s Eighth Amendment claims based on her placement in segregation). The defendants
case indicates that Ms. Stoudemire was assigned to segregation solely because she was infected with MRSA, and she suffered immensely as a result.\footnote{See R. 86, Ex. 31, Stoudemire Medical Records Excerpt 004420 (Jan. 18, 2005), Stoudemire, 2011 WL 1303418 (noting diagnosis of MRSA and movement to segregation) (on file with authors).} As a child, Ms. Stoudemire was diagnosed with systemic lupus erythematosus,\footnote{Id. at 004419, 004387–88.} a chronic inflammatory disease of the immune system that can affect many organs, including the heart, lungs, kidneys, and circulatory system.\footnote{Id. at 004412.} Prior to Ms. Stoudemire’s incarceration, she experienced kidney disease and circulatory problems that required leg surgery; however, at the time that she entered prison in 2002 at the age of twenty-two, all of her organs were functioning and all of her limbs were intact.\footnote{Id. at 004387–88.} Unfortunately, after Ms. Stoudemire arrived in the Huron Valley Women’s Facility, her health status declined markedly.\footnote{Russell Memorandum, supra note 126, at 6025, Stoudemire Decl., supra note 136, ¶ 14.} By the end of 2005, she had just undergone her second below-the-knee leg amputation.\footnote{Walden Decl., supra note 137, at 21.} In January 2006, on the day that she returned from the hospital to the prison, laboratory tests indicated that she had acquired a MRSA infection in the stump of her leg.\footnote{Id. at 004412, 004378–79, 004357.}

As a result of the MDOC policy mandating that the warden determine where MRSA quarantine should take place, Ms. Stoudemire was moved from the prison infirmary to the segregation unit.\footnote{Exhibits to Plaintiff’s Response in Opposition to Defendants’ Motion to Dismiss and/or Motion for Summary Judgment and Plaintiff’s Response in Opposition to Michigan Dep’t of Corr. Motion for Dismissal; R. 89-5, Declaration of Jerry S. Walden, M.D., Attach. 3, at 21, Stoudemire, 2011 WL 1303418 (No. 07-15387) [hereinafter Walden Decl.].} Unfortunately, medical staff had little contact with the segregation unit.\footnote{R. 93, MDOC Medical Rec. at 004348, Stoudemire, 2011 WL 1303418.} The prison physician did not see Ms. Stoudemire at any point during the two weeks she was in segregated confinement.\footnote{Id. at 004419, 004387–88.} At the time Ms. Stoudemire was assigned to segregation, she still needed daily dressing changes for her actively-draining stump infection.\footnote{Id. at 004412, 004378–79, 004417–18, 004357.} She was weak, in great pain, and her heart rate was significantly elevated at 120.\footnote{Id. at 004387–88.} She was also experiencing severe psychological trauma from the loss of her remaining leg.\footnote{Id. at 004419, 004387–88.} Ms.
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Stoudemire was crying and undergoing abrupt withdrawal from narcotics prescribed by the hospital to control the pain from the amputation.\footnote{144} The segregation cell was unsanitary and unequipped for the special needs of a person without legs.\footnote{145} Ms. Stoudemire found that the cell did not allow her to transfer safely between the wheelchair, bed, and toilet, or to use the shower facilities because the locked cell contained no grab bars or bed trapeze for her use.\footnote{146} Similarly, the toilet lacked a commode chair to assist in transfer.\footnote{147} Ms. Stoudemire’s inability to contact staff when she needed help exacerbated these problems.\footnote{148} Ms. Stoudemire’s cell was located at a distance from the desk of the officer’s desk, which was at the other end of the segregation unit,\footnote{149} and the cell lacked an emergency call button.\footnote{150} As a result, Ms. Stoudemire experienced great difficulties in summoning staff when she needed their assistance.\footnote{151}

Two days after arriving in the segregation unit, Ms. Stoudemire had to be sent to an outside hospital, where she stayed five days.\footnote{152} When she returned to the prison, she was again immediately sent to another segregation unit cell that lacked grab bars, a bed trapeze, or a commode chair.\footnote{153} At this point, however, she had even more medical issues. The hospital had installed an intravenous tube in her chest to facilitate delivery of the medications for the MRSA infection.\footnote{154} Despite the unsanitary conditions in her cell, the nurses required Ms. Stoudemire to change her own dressings.\footnote{155} She defecated on herself when she could not get to the toilet on time because of her physical limitations, and she was scolded by staff for using a wastebasket when she did not have time to get to the toilet.\footnote{156}

The day after Ms. Stoudemire returned from the outside hospital, a mental health worker at the prison spoke to her through the food slot in her door.\footnote{157} Ms. Stoudemire reported that she had been crying and that she felt like “giving up.”\footnote{158} She thought that staff wanted her to die.\footnote{159} When Ms. Stoudemire reported to health care staff that she was experiencing chest pain and shortness of breath, a nurse recorded “B.S.” on a health-
One day later, Ms. Stoudemire returned to the hospital where the amputation had been performed for a follow-up appointment. While there, she experienced breathing and heart problems that led to two additional weeks of hospitalization.

IV. THE STAFF CULTURE OF SEGREGATION REMAINS UNCHANGED

Many different failures of policy and practice contributed to the death of Timothy Souders and the ordeal of Martinique Stoudemire, as should be apparent from even these brief accounts of their experiences. We have asked ourselves, regarding both cases, how it could be that so many staff observed the situations of these prisoners yet did nothing to stop their suffering. We have also considered what changes would be necessary to ensure that future MDOC prisoners with comparable physical or mental disabilities avoid exposure to similar harm. First, and critically, these events illustrate the dangers from the use of closed cells in segregation units, even for short periods of time, to confine prisoners with severe medical or mental health problems. As many mental health experts have repeatedly explained, isolated cell confinement can be extraordinarily stressful, triggering new mental illness or exacerbating existing illness, so that confinement in segregation initiates a downward spiral in behavior that staff treat as misconduct rather than symptoms of mental illness. As we and others have observed, the standard physical features that mark cells in segregation units, such as the solid rather than barred doors, interfere with communication with staff, and limit staff opportunities to detect deteriorating mental or physical status. These features make it particularly likely that prisoners with physical disabilities will suffer harm. Indeed, the leading case in the Supreme Court regarding the applicability of the Americans with Disability Act to prisons, United States v. Georgia, involved a prisoner with paraplegia who alleged that he suffered injuries as a result of his confinement in a segregation cell.

We believe that both health care and custody staff assigned to segregation units become accustomed to food slot communication and observation, and thus lose perspective on its dangers. In our experience, asking that a cell door be unlocked and opened in a segregation unit, or that a prisoner be escorted to an area that allows an appropriate examination,

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163. See Hadix I, 461 F. Supp. 2d at 597 (concluding that the psychiatric needs of prisoners in segregation were not being met in significant part due to prisoners' inability to request care and ordering daily psychologist rounds as part of remedy).
164. Id. (providing that needs of mentally ill prisoners will often not be met in segregation because of prisoner's inability to request care).
166. Id. at 154–55.
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tends to take significant time. Further, regardless of the reason that a particular prisoner is confined in a segregation unit or in an observation cell, the staff culture of segregation units emphasizes the unpredictability of prisoner behavior. Prisoners in segregation are regarded as particularly dangerous and not to be trusted. Thus, for example, when prisoners complain of medical problems, both medical staff and custody staff are likely to dismiss the complaints as merely attempts to obtain some illegitimate advantage from the system. The failure of the MDOC to develop or enforce policies counteracting this culture produces the willful blindness to risk by custody and medical staff that marked both the Souders and Stoudemire cases. As a result, staff ignore the risks of segregated confinement for prisoners with known medical and mental health problems. There is no systematic check to avoid obvious risks from placement in segregation for a prisoner based on physical disabilities or other medical issues. For example, the door to Ms. Stoudemire's segregation cells was only one-inch wider than Ms. Stoudemire's hand-operated wheelchair. Attempting to leave the cell was accordingly fraught with risk because of the possibility of injuries to her hands, which were already compromised by her damaged circulation.

Of course, a system that ignores the predictable consequences of placing a woman with no legs in a cell with no disabilities accommodations is also likely to ignore this risk.

If a prisoner with mental health and medical problems similar to those of Mr. Souders was charged with misconduct today, he or she could still end up in segregated confinement. Under current policy, a prisoner who is on the out-patient mental health services active caseload can be placed in segregation if custody staff, after consultation with mental health staff, determine that the prisoner's mental health needs can be met in segregation. Similarly, the policy for release from segregation lists as one of four factors for custody staff to consider whether the prisoner needs mental health services, including in-patient treatment. Custody staff, however, are not required to release a prisoner who needs mental health treatment that cannot be provided in segregation. Thus, MDOC policy gives the final decision to custody rather than mental health staff. The dangers that prisoners with untreated mental illness will be assigned to segregation, and suffer harm as a result, have also been significantly increased

167. A few months ago, in a jail in another state, one of the authors asked that a door be opened to a cell used to confine detainees on suicide observation to allow an inspection of physical plant changes in the cell. There was a substantial delay because staff could not locate the key.


169. See Mich. Dep't of Corr., Policy 04.05.120—Segregation Standards 3 (2010) (on file with the authors).

170. Id. at 11–12.

171. Id.
because the MDOC has implemented policies that have drastically reduced the number of prisoners receiving psychotropic medications.\textsuperscript{172}

Nor has the potential for heat injury been effectively addressed. After Mr. Souders’ death, the MDOC closed JMF, the facility where he had been housed in segregation. However, prisoners throughout the state who are assigned to segregated statuses remain in cells that lack air-conditioning and that are unsafe for prisoners at high risk of heat injury. Although prisoners in \textit{Hadix} facilities at high risk of heat injury are eligible to move to a large air-conditioned tent during periods of hot weather,\textsuperscript{173} the MDOC has not implemented this policy in any other prison.\textsuperscript{174}

Further, despite the number of deaths in segregation related to dehydration and exposure to excessive heat, current MDOC policy does not require that health care staff be notified if a prisoner in segregation whose access to water is restricted unless the prisoner is known not to have been drinking for twenty-four hours.\textsuperscript{175} It is not obvious that custody staff would even know whether the prisoner has been drinking water. Although the policy requires documentation of when water was offered or provided, the policy does not require that any staff member monitor whether the prisoner actually drinks it.\textsuperscript{176}

Today, a Michigan prisoner diagnosed with MRSA with disabilities similar to those of Ms. Stoudemire could find herself subjected to similar torture by placement in segregation. The policy directive governing segregation provides that segregation cells may be used to house any prisoner with a communicable disease who has been ordered to medical quarantine.\textsuperscript{177} The policy directive regarding communicable diseases indicates that the Regional Medical Officer or designee is to convey “recommendations...
tions” regarding the control of an outbreak of a communicable disease, including recommendations to isolate the prisoner, “to the Regional Health Administrator (RHA), [the MDOC Bureau of Health Care Administrator], and, as appropriate, the [w]arden.” It does not indicate who must make the ultimate decision to utilize segregation for a prisoner with a communicable disease like MRSA. Additionally, the policy directive regarding medical orders and accommodations for disabilities, which is cross-referenced in the segregation Policy Directive, gives to the Director of the MDOC the ultimate authority to deprive a prisoner assigned to segregation of accommodations, such as a wheelchair or hearing aid ordered by medical staff as a result of a prisoner’s disability or medical need. Until the MDOC provides safe housing for prisoners with the entire range of medical needs that require special accommodations, such prisoners remain at risk of suffering a disastrous outcome as punishment for the offense of illness or disability.

V. THE SAME BARRIERS THAT THREATEN ACCESS TO HEALTH CARE FOR MICHIGAN PRISONERS IN SEGREGATED CONFINEMENT ALSO IMPAIR ACCESS TO THE COURTS

We have argued that prisoners who suffer from mental or physical illness are particularly at risk when placed in isolated confinement, among other reasons, because of the barriers to communications and to responses to emergency needs that such confinement creates. Aside from all the inherent barriers that are likely to impede a mentally ill prisoner or physically-disabled prisoner from pursuing a civil rights claim related to isolated confinement, such a prisoner will face extraordinary barriers from the legal system. While a detailed exposition of these barriers is beyond the

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178. MICH. DEP’T OF CORR., POLICY 03.04.110—CONTROL OF COMMUNICABLE DISEASES 1–2 (2010).
179. See id.; see also MICH. DEP’T OF CORR., supra note 169, at 6–7.
180. See MICH. DEP’T OF CORR., POLICY 04.06.160—MEDICAL DETAILS AND SPECIAL ACCOMMODATIONS 2 (2008) (providing that if the warden and a medical practitioner disagree on whether to remove an accommodation such as a wheelchair from a prisoner, the disagreement shall be resolved by referral to “the chain of command”). In the MDOC chain of command, the Chief Medical Officer of the Bureau of Health Care reports to the Director of the MDOC. See MICH. DEP’T OF CORR., supra note 169, at 4.
181. The vast majority of prisoners who attempt to pursue litigation regarding their conditions of confinement must do so without a lawyer and must generally do so through preparing her own pleadings or gaining the assistance of another prisoner. Prisoners with severe disabilities, even if not held in segregation, will be held in a specialized unit where they lack opportunities to interact with more than a few other prisoners. A prisoner with significant limitations in mobility is likely to face particular impairments such as problems in assembling the necessary information for a filing and transportation problems because of the difficulties that disabled prisoners face in being transported. Ms. Stoudemire, for example, dreaded medical appointments outside the prison because many of the transportation vans were not appropriately equipped and staff were sometimes unhelpful. On one occasion, she had to crawl into the van because staff would not assist her. See Stoudemire Decl., supra note 136, ¶ 2–11.
scope of this Essay, we will sketch out some of the obvious issues. For example, if a prisoner files a civil rights claim while still in prison, he or she will be required to demonstrate compliance with the Prison Litigation Reform Act (PLRA). The Act requires that prisoners, unlike most civil rights plaintiffs, demonstrate that they have exhausted available administrative remedies before filing suit. Yet as a practical matter, neither Timothy Souders nor Martinique Stoudemire would have had a reasonable opportunity to initiate their requests for administrative remedies within the seven days that the MDOC grievance system mandates. The videotape of Mr. Souders strongly suggests that he was neither mentally nor physically capable of obtaining the proper form and writing or filing a grievance in the days before his death. Ironically, the only reason that a civil rights action was available in his case was that the event was fatal; the restrictions of the PLRA did not apply to his case because the plaintiff was technically his estate, and the Act applies only to “prisoner” plaintiffs.

Ms. Stoudemire was also incapable of exhausting her civil rights claims after her ordeal in the segregation unit, followed by two weeks at University of Michigan hospitals. Indeed, if Ms. Stoudemire had thought of exhausting her civil rights claims at all, she could have reasonably assumed that, because she had not filed grievances while she was locked in the segregation cell and could not get attention for her urgent needs, any grievance that she could have filed would have been rejected by the MDOC as untimely. Ms. Stoudemire could have similarly anticipated that, unless she had attempted informal resolution of her grievance with staff within two days, and thereafter had filed a formal grievance within five

182. 42 U.S.C. § 1997e(a) (2006) (providing that no “action shall be brought with respect to prison conditions under [42 U.S.C. § 1983], or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.”).


184. 2006 Hearing, supra note 68, at Pls.’ Ex. 106A at 1, (log describing Mr. Souders’ last few days, in restraints and incoherent; on Aug. 3, 2006 he was “yelling and making strange screaming sounds” (10:10); “talking incoherently and rolling his head from side to side” (11:30); screaming unintelligible ramblings (14:05); “sitting up, yelling” (14:48, 14:56, 15:01)). The case law is split regarding whether a prisoner’s mental condition can make the prison grievance system “unavailable” to that particular prisoner. Compare Days v. Johnson, 322 F.3d 863, 867 (5th Cir. 2003) (indicating that a personal inability to utilize a grievance system could mean that the grievance system was unavailable and therefore a prisoner was not required to exhaust it prior to filing a claim subject to PLRA) with Ferrington v. La. Dep’t of Corr., 315 F.3d 529, 532 (5th Cir. 2002) (holding that prisoner plaintiff’s severe visual impairments did not relieve prisoner of the obligation of exhaustion of grievance system before filing case subject to PLRA).

days, the grievance would have been rejected as untimely under MDOC policy.\textsuperscript{186} Ms. Stoudemire was ultimately able to file a civil rights lawsuit in federal court only because she was eventually released from prison so that PLRA no longer applied to block her litigation.\textsuperscript{187} Unfortunately, the necessary consequence of waiting until after release was that Ms. Stoudemire had to forego challenges to her treatment by staff during the earlier part of her incarceration, which precluded challenges to the care she received related to the events that led to her first leg amputation.\textsuperscript{188}

The substantive law of the Eighth Amendment can also have particularly pernicious effects in the context of solitary confinement. In order to prove an Eighth Amendment violation related to prison conditions of confinement, prisoners must meet a difficult test: they must demonstrate that a defendant had actual knowledge of a substantial risk to prisoner health or safety but disregarded that risk.\textsuperscript{189} The features of segregation that interfere with prisoners' ability to communicate their needs, as well as staff observation of those needs, thus have the potential of preventing prisoners from demonstrating a constitutional violation in precisely the circumstances in which high-risk prisoners are most vulnerable to harm.

The facts from a recent case decided by the Supreme Court illustrate the predictable nature of these emergencies, even among prisoners not obviously at risk of a crisis related to placement in isolation. In \textit{Ortiz v. Jordan}, the Supreme Court decided a procedural question regarding the necessity after a jury verdict of renewing a motion for judgment as a matter of law pursuant to Rule 50 of the Federal Rules of Civil Procedure.\textsuperscript{190} The case involved a prisoner in Ohio who had filed a civil rights claim charging that, after she reported that a staff member had sexually assaulted her, other staff members violated the Eighth Amendment by allowing her to be sexually assaulted again, as well as subsequently by transferring her to isolation.\textsuperscript{191} The staff's announced reason for transferring her to isolation was to prevent her from continuing to discuss the assaults with other prisoners, conversations which were alleged to interfere with the ongoing in-

\begin{itemize}
\item \textsuperscript{186} See \textit{Mich. Dep't of Corr.}, \textit{supra} note 183, ¶ P.
\item \textsuperscript{187} See, e.g., Norton \textit{v. City of Marietta}, 432 F.3d 1145, 1150 (10th Cir. 2005); Nerness \textit{v. Johnson}, 401 F.3d 874, 876 (8th Cir. 2005); Ahmed \textit{v. Dragovich}, 297 F.3d 201, 210 (3d Cir. 2002).
\item \textsuperscript{188} While Ms. Stoudemire's complaint included a discussion of the first amputation, when defendants argued that events relating to that amputation were barred by the statute of limitations, she responded by disavowing any intent to seek recovery for the actions of defendants related to events more than three years before filing. Rather, she argued, the allegations about earlier events were relevant as background and for various evidentiary purposes, such as defendants' knowledge of the risk to her. The district court accepted this construction of the complaint. Amended Order at 12, Stoudemire \textit{v. Mich. Dept. of Corr.}, No. 07-15387, 2011 WL 1303418 (E.D. Mich. March 31, 2011).
\item \textsuperscript{189} Farmer \textit{v. Brennan}, 511 U.S. 825, 837 (1994).
\item \textsuperscript{190} 131 S. Ct. 884 (2011).
\item \textsuperscript{191} Id. at 890.
\end{itemize}
vestigation. After a few days in isolation, the plaintiff, who had been strong enough to pursue a claim of sexual assault despite substantial obstacles, was described as ill and vomiting. A psychologist recommended that she be moved to the prison infirmary, where she stayed a week.

Ms. Ortiz's ordeal suggests that, when a prisoner is experiencing a crisis—a common circumstance when a prisoner is sent to segregation—the additional stress of segregated confinement is particularly likely to give rise to urgent health needs. Further, because the point of segregating prisoners is to reduce their ability to interact and communicate with others, proving a constitutional violation becomes more difficult precisely because of that isolation. There is not much one can observe through a solid door, and very little more that can be observed through an occasional view through a food slot. Thus, the requirement that a particular defendant be shown to have actual knowledge of a "substantial risk of serious harm" often poses an insurmountable legal obstacle to the plaintiff when the events at issue in the litigation took place in physical surroundings that were designed to cut the prisoner off from others. The combination of the physical barriers of segregation with the cultural barriers to staff perception of risk that are endemic to segregation are deadly—too often to the prisoner, but also, routinely to the prisoner's legal claim.

VI. CAN WE IMAGINE AN APPROACH THAT MIGHT WORK?

We believe that it is helpful to focus attention on the potential risk of harm to all prisoners posed by the isolation and loss of ability to obtain assistance from staff in emergencies that flows from segregation confinement. Indeed, given the current energy in the movement challenging segregated confinement, there is perhaps a chance that prison officials may pay more attention to these risks. If so, staff training materials and policies could begin to reflect more recognition of the generic risks in segregation, as well as special risks of prisoners with particular physical or mental vulnerabilities.

For prisoners with medical and mental health problems, the risks of placement in segregated housing, with its resulting restrictions on their ability to community with staff and staff's ability to monitor their needs may well be best analyzed according to the admonition in Farmer v. Brennan that, "[I]t does not matter whether the risk comes from a single source or multiple sources, any more than it matters whether a prisoner faces an excessive risk of attack for reasons personal to him or because all

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193. Id. The plaintiff's only obvious high risks of mental or physical harm from confinement in isolation were the recent trauma of sexual assault and a history of domestic violence incidents. See id.
194. See Farmer, 511 U.S. at 837.
prisoners in his situation face such a risk.”195 Although official MDOC policy now restricts the assignment of seriously mentally ill prisoners to segregation,196 actual practice, as the case of Timothy Souders demonstrates, has been considerably less enlightened, and formal MDOC policy needs more clarity.197 In contrast, some other prisons have been forced by court orders, or have agreed following litigation, to adopt more effective screening policies.198 In addition, the MDOC already recognizes that it must screen prisoners with physical disabilities to avoid assignment to facilities that lack appropriate accommodations.199 However, the MDOC’s policies regarding accommodations for physical disabilities are deeply flawed on their face, because they allow other institutional needs such security to trump a prisoner’s needs for accommodations for disabilities.200 These same flaws played a central role in the ordeal of Martinique Stoudemire.

As an interim step to reduce the risks from segregated confinement, the MDOC needs to promulgate and implement policy imposing a rigorous exclusion from segregation of the seriously mentally ill and those whose medical needs cannot be met in segregation. A more effective solution would be to eliminate the confinement of prisoners in segregation. Most effectively, the solution is to eliminate such confinement and mas-

195. Id. at 843.
197. See supra text accompanying note 60.
200. See id. at 2 (providing that if a warden disagrees with a decision by a medical provider to order a medical accommodation for a prisoner, the disagreement is to be “referred through the appropriate chain of command until it is resolved”). Medical staff within the MDOC ultimately report to the Director of the MDOC. See Mich. Dep’t of Corr., Policy 01.01.101—Department Organization and Responsibility 4 (2012) (providing that the Chief Medical Officer of the MDOC reports to the Director of the Department for medical policy purposes) (on file with the authors).
sively reduce the nation's massive over-incarceration rate that has led us into the disastrous reliance on this dangerous and discredited practice.