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March 20, 2009

National Prison Project
Attn: Eric Balaban
915 15th St, NW
7th Floor
Washington, DC 20005-2112

Re: *Carty v. DeJongh*, No. 94-78

Dear Mr. Balaban:

I have completed my assessment of mental health services offered to inmates at the Criminal Justice Complex (CJC) and the CJC Annex, St. Thomas, United States Virgin Islands (USVI).

I visited the CJC and the CJC Annex from February 2 to February 4, 2009. I have made similar site visits in 1994, 2005, 2006 and 2007. In preparing this assessment, I reviewed my August 2007 site visit report, as well as the following documents:

1. The Settlement Agreement,
2. Defendants' progress report (exact date unknown but written after June 2, 2008),
3. July 2 and 15, 2008 correspondence from Richard Schrader, Jr., Esq. to Denese Marshall, Psy.D. re: the five persons adjudged not guilty by reason of insanity (NGRI) who had been housed at the Golden Grove Adult Correctional Facility (ACF),
4. medical records relevant to Jonathan Ramos from the Hollywood Pavilion as well pertinent correspondence from Vincent Frazier, Esq. to Commissioner Ebbesen-Fludd,
5. transcript of my November 30, 2007 testimony in this case,
6. the June 2, 2008 Hearing on Motions transcript,
7. a January 11, 2008 letter from you to Mr. Schrader re: Aljahra Francis,
8. various CJC logbooks, and

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9. the classification, medical and/or mental health records of 23 inmates.

At CJC, I briefly interviewed the nine male mental health caseload inmates housed in Cluster 3 in a group setting, and then briefly interviewed three of these inmates individually.

During the morning of February 2, 2009, I interviewed Leighman Lu, M.D., Lisa LaPlace, RN, and correctional officers in Clusters 1, 2, 3, 4, 5, & 6.

During the morning of February 3, 2009, I had the opportunity to meet with acting Assistant BOC Director Hilary Herman, CJC Warden Everett Hansen, and the new BOC medical director, Linda Callwood, M.D. On February 4, 2009, I met with Dr. Marshall.

Introduction

Elwood York, who was the BOC's director at the time of the November 2007 hearing, resigned in December 2007. The BOC had no director for close to a year. Julius Wilson became the acting BOC Director in October 2008 along with acting Assistant BOC Director Hilary Herman. Everett Hansen has been the acting CJC Warden since August 2008.

As described in my previous reports, the CJC is located on the third floor of a building in the Alexander Farrelly Justice Complex. The first two floors are occupied by the Virgin Islands Police Department. The jail has a rated capacity of 97 prisoners, which is the total number of fixed beds, and the Agreement caps the population at this total. At any one time, about 80% of the prisoners at the CJC are pre-trial detainees.

The prisoners in the CJC (also referred to as inmates in this report) are housed in seven housing clusters. The capacity of each cluster ranges from 10-20 prisoners. Three of the clusters have special designations: Cluster 7 houses female prisoners; Cluster 6 houses new admissions and prisoners in administrative or disciplinary segregation, although all clusters can also house segregation prisoners; and Cluster 3 houses mentally ill prisoners and protective custody inmates who cannot safely be housed with the general population. However, mental health caseload prisoners also are housed in other Clusters throughout the jail. All of the cells are double-bunked. There are no single cells at the jail, although there are occasional inmates who have been single-bunked for safety reasons. There are no cells are specifically designated for mental health observation or suicide watch.

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There reportedly have been no significant changes relevant to the statistics concerning the average daily census, monthly admissions, and percentage of inmates on the mental health caseload since my April 2005 visit. The average daily population remains at about 89 inmates. The average monthly admissions over the past year has been 102 inmates.

Inmates who cannot be treated at the CJC theoretically can be transferred to the Roy L. Schneider (RLS) Hospital in St. Thomas, which is about a mile from the jail. The hospital has a small Behavioral Treatment Unit (BTU) for acutely mentally ill persons. However, there have been no such transfers for treatment purposes for at least the past 18 months; the absence of any such transfers is the result of obstacles to transfers, and not a lack of clinical need for transfers.

The CJC Annex opened shortly after my May 2006 site visit. The facility has an 80-bed capacity, but the average daily population at the Annex since it opened has been 18 inmates. With few exceptions, the CJC Annex houses sentenced inmates, who typically have less than a year remaining on their sentences.. It also occasionally houses a limited number of federal and/or immigration detainees. Galen Hall, M.D. provides up to 10 hours per week of physician services to the inmates at the Annex.

In my May 2006 report, I recommended that policies be developed for the Annex that describe the screening process to be used to identify and exclude mentally ill inmates from the Annex, and that describe the process to be implemented to identify and transfer inmates who were appropriately admitted to the Annex, but later demonstrate symptoms of a mental illness. This recommendation is now court-ordered.

During the morning of February 4, 2009, I briefly visited Unit B at the CJC Annex, which had about 8 double man cells. This unit has been used to house inmates with mental illnesses who were transferred from ACF.

The BOC has not developed policies and procedures to assess, identify, and exclude mentally ill inmates from the CJC Annex. Instead, Lisa LaPlace, RN, the Territorial Nursing Coordinator and functional CJC head nurse, acts as an informal gatekeeper. Ms. LaPlace reported that on a monthly basis about 1-2 inmates with mental illnesses were transferred to the CJC Annex, which was usually brought to her attention within 24 hours. Such inmates were generally transferred to the CJC within 24 hours, although it could take several weeks due to security concerns. At the time of my site visit, Ms. LaPlace could identify at least two mentally ill prisoners who were currently housed at the Annex. One of these prisoners was refusing medications.

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The lack of policies and procedures for screening mentally ill inmates at the Annex has resulted in their receiving inadequate care. I briefly interviewed one ACF prisoner in his cell in B Unit (Appendix II, Inmate 58). At the time of our interview, he had been housed at the Annex for approximately one month. This prisoner had a history of mental illness, and had been hospitalized at the BTU in 2008. During our interview, he exhibited symptoms of mental illness. Currently he was refusing medications, and denied his illness. This prisoner did not have a medical record until I spoke with Ms. LaPlace about him, and she created a record during my site visit. He had not received an intake screening, and had not been seen by either healthcare staff or by Dr. Lu during his incarceration.

Dr. Lu, the jail's lone psychiatrist, still does not provide treatment at the Annex. Rather, he only sees mentally ill prisoners at the CJC.

Security staff has refused to follow physician's orders to move prisoners in need of mental health treatment from the Annex to the CJC. Ms. LaPlace told me that in the past year, security chief Dale Donovan overrode a medical order by Dr. Hall to move one prisoner from the Annex to the CJC for purposes of receiving mental health treatment.

Recommendations: As per my May 2006 report, policies and procedures need to be developed that describe the screening process to be used to identify and exclude mentally ill inmates from the Annex. In addition, these policies and procedures need to describe the process to be implemented to identify and transfer inmates who were appropriately admitted to the Annex but later demonstrate symptoms of a mental illness. These policies and procedures would be a subset of the previously recommended mental health system policies and procedures (see my May 2006 report) that would address the subject areas summarized in Appendix II. Of note, the BOC still has not developed relevant mental health policies and procedures related in large part to leadership and staffing issues that will be further described later in this report.

In addition, Ms. LaPlace needs a full-time head nurse at CJC in order to allow her to relinquish these duties so she can assume her role as Territorial Nurse Coordinator, which would facilitate implementation of the above recommended policies and procedures.

Staffing

Physician staffing

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There is no change in the healthcare staffing since my August 2007 site visit.

The jail's physician remains Garfield Less, M.D. and the psychiatrist is Leighman Lu, M.D. Both are contracted to provide 10 hours of service weekly. Galen Hall, M.D. provides physician coverage when Dr. Less is unavailable. There is no designated psychiatrist to cover on site for Dr. Lu during his absences from the jail. There appears to be limited psychiatric coverage during his absences via the local psychiatric hospital by telephone for inmates known to the covering psychiatrist.

The absence of a relief psychiatrist contributed to significant problems late last year when the BOC decided to transfer a groups of seriously mentally ill ACF prisoners to the CJC so they could get renewed medication orders and treatment plans. The decision to transfer the prisoners was made without consulting Dr. Lu, who had planned a vacation to begin just days after the prisoners were scheduled to arrive. As a result, a number of these mentally ill prisoners remained in the CJC and CJC Annex for several weeks without seeing Dr. Lu or receiving current medication orders. Some of these prisoners apparently continued to receive medications on expired orders.

Nursing staffing

As I have reported previously, Ms. LaPlace was hired as the Territorial Nursing Coordinator in April 2005. There is still no approved job description for the coordinator position. Ms. LaPlace submitted for approval a draft job description to the BOC's personnel department during April 2007. She has not heard back from personnel about her draft description.

In addition to Ms. LaPlace, there is a full time LPN at CJC (Ms. Smith) and two part-time LPNs (each working 10 hours per week). Ms. Smith, who was hired during 2006, has duties that include scheduling appointments, assisting Dr. Less with examinations, and distributing medications. She cannot under her license assess prisoners for sick call.

The head nurse position at CJC remains vacant, but is functionally filled by Ms. LaPlace. She has also taken on additional duties (~ 6-12 hours per week) as the treating nurse at the Annex since Ms. Anderson resigned last fall. As a result, Ms. LaPlace has limited time available to fulfill her duties as Territorial Nursing Coordinator. Ms. LaPlace told me she thought that the head nurse position had been transferred to ACF (and another one not yet created/approved for CJC), and, therefore, had not been actively recruiting to fill this position. Ms. LaPlace reported that she had identified candidates to work at the CJC

during the past eighteen months, but that these candidates took other positions because the CJC head nurse position was not an approved vacancy she was authorized to fill. Ms. LaPlace indicated that she would like to move the FTE LPN position from the CJC to the Annex, and hire an additional FTE RN for the CJC.

Recommendation: The confusion re: the nursing positions should be resolved and the needed positions created, if not already created, and filled.

Healthcare Staffing Plan

In 2006, the Court ordered the Defendants to submit a staffing plan for the CJC and the Annex. To date, the BOC has failed to produce a comprehensive staffing plan that notes hours, vacancies, and NOPA status. Director Wilson told Ms. LaPlace in November 2008 he had ordered Ms. Joshua in personnel to produce a complete staffing vacancy list. Ms. LaPlace had not yet received this list.

Staffing allocations at the CJC and Annex remain unclear. Ms. LaPlace described the current staffing at the CJC and Annex as follows:

Annex

Physician (10 hrs-filled)
RN (20 hrs-vacant)
Social worker (20 hrs, status unknown)

Ms. LaPlace still has not heard back from the personnel department on the status (e.g., has the position been created?) of the unfilled social worker position at the Annex.

CJC

Physician (10 hrs, filled)
Psychiatrist (10 hrs, filled)
Head nurse (FTE-NOPA requested)
Mental health specialist (10 hrs, vacant)
NP/PA (no NOPA requested)
RN (20 hrs, NOPA requested)
LPN (FTE, filled)
2 LPNs (10 hrs each, filled)
Social worker (10 hrs, filled but no one working)
Psychologist (10 hrs, NOPA requested)

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Beverly Latimer, M.S. was the jail's mental health specialist, and had contracted for 10 hours of service weekly. Ms. Latimer resigned in June 2006. Ms. LaPlace had identified a candidate (Ms. Mann) to replace her around April 2007, but the BOC has not approved the hire to date.

The status of the CJC social worker position is unclear. In June 2008, Ms. LaPlace testified that Bentley Thomas had a NOPA for the social worker position since before she began working at the jail in 1999. In the subsequent nine years, Ms. LaPlace had never seen Mr. Thomas work at the jail until around November 2008, when she did see Mr. Thomas at the CJC but has no idea why he was there or what he did. Ms. LaPlace does not know what his job duties are and reported that there was not any type of service collaboration with him.

Ms. LaPlace drafted a job description for the Medical Director position at the request of Mr. Schrader and Ms. Joshua (DOJ department of personnel). She consulted with colleagues at the RLS Hospital for models. Ms. LaPlace did not know if her draft job description was approved.

Recommendation: The creation of positions via the NOPA process and the hiring process remain broken and have resulted in both vacancies and probably loss of previously established positions. This issue needs to be addressed by senior administrators.

The next section of this report will be organized by general subject headings relevant to mental health services at the CJC and the forensic facility at Anna's Hope, St. Croix, USVI. I have noted below the applicable provisions and the Court's remedial orders. An "SA" denotes the Settlement Agreement headings, and the headings from the remedial orders are denoted by "Order." This section will use my April 2005 report as a template.

MEDICAL LEADERSHIP AND POLICIES & PROCEDURES

The Settlement Agreement requires the BOC to hire a Health Care Coordinator who will oversee the health care system at the CJC and Annex. [SA ¶¶ IV.A.1., IV.M.4.] The coordinator is required to conduct bi-weekly meetings with CJC health care staff. The coordinator also is responsible for producing and implementing a complete set of medical policies and procedures that are consistent with National Commission on Correctional Health Care (NCCHC) Guidelines. On March 22, 2006, the Court also ordered the

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Defendants to hold monthly management team meetings with BOC leadership where health care is a permanent agenda item. [Mar. 22, 2006 Order ¶4].

In my May 2006 Report, I also recommended that the BOC develop a budget specific to mental health services. My recommendation is now court-ordered. *Carty v. DeJongh*, Civil No. 94-78, Order (D.V.I. Nov. 20, 2006) ¶1.

BOC still has not produced and implemented medical/mental health policies and procedures consistent with the NCCHC Guidelines, nor has it developed a budget specific to mental health services.

Privatization Plans

Shortly before the November 2007 contempt hearing, the Government announced that it planned to privatize health care services territory-wide. The proposed Scope of Services contract the Government introduced at the hearing did not mention the Criminal Justice Complex and CJC Annex. The sole and entire focus of the proposal was health care services at ACF. There was nothing about staffing for the CJC and Annex, about services at these facilities, and the specific requirements of the Settlement Agreement and the Court's health care orders are not mentioned once in the proposal.

It was my understanding, based on my interview with Assistant Director Herman, that the privatization plan for the CJC and Annex is no longer being pursued.

The Role of DOH

At a June 2008 status hearing, the parties discussed the privatization issue and the status of any discussions between DOH and Defendants. Dwayne Benjamin, the BOC's compliance coordinator, testified at the hearing that as of June, 2008, DOH was assessing health care services in the BOC. However, DOH was not going to produce a proposed scope of services for the Defendants describing the services it would provide to BOC prisoners. Mr. Benjamin also testified that the Department of Justice knew how much it spent on health care for BOC prisoners, that the amount would be set out in the budget it submitted to the Legislature, and that Justice would " earmark" its BOC health care funding to the DOH to provide all health care services if the departments entered into an agreement.

Ms. LaPlace also testified at the June 2, 2008 hearing. She said that she had not

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participated in any discussions with DOH, and that she first heard about this planned DOH takeover at that hearing. Since the June 2, 2008 status conference hearing, Ms. LaPlace has been involved in at least one meeting about the proposed DOH takeover. She reported that Attorney General Frazier hired Mr. Wilbur Smith as a consultant to determine how DOH could assist BOC in running health care services.

There had been earlier discussions between DOH and Justice about prisoner health care services. Before the November 2007 hearing, the BOC submitted a draft memorandum of understanding (MOU) for the Department of Health to become involved in providing mental health services in the BOC. Ms. Fern Clarke, the Territorial Assistant Commissioner, testified at the hearing about the relationship between the two departments. She testified that she, Director of Health Vivian Fludd, and Attorney General Frazier had been meeting bi-weekly for months regarding the role the DOH would play in administering health services within the BOC.

Ms. Clark testified that the departments were “working collaboratively... to alleviate the many challenges that have come before this Court over the past few years.” Ms. Clark admitted that she had not read the remedial orders, contempt decisions, or hospitalization orders in this case.

Ms. Clark testified that she expected their draft MOU to be completed “within the next couple of weeks.”

I reviewed the draft MOU. It is vague, does not obligate the DOH to provide any direct services to most of the seriously mentally ill prisoners in the BOC, and its pledge for continued cooperation between the departments is unconvincing in the context of the historical relationships between the two departments.

Assistant Director Herman indicated to me during this site visit that the two departments would not be entering into an agreement that involved DOH providing the health care to inmates in the BOC.

Assessment: It appears clear that DOH will not be providing health care services to inmates in the BOC.

Mental Health Leadership Issues

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Five weeks before the November 2007 hearing, the Defendants hired Denese Marshall, Psy.D. Dr. Marshall's job description included being the director of the planned forensic facility at Anna's Hope, St. Croix. At the November 30, 2007 hearing, she described her duties as follows: "I am responsible for bringing the Forensic Unit to fruition in addition to assisting with the mental health program in the prisons territory wide." However, her job description was directed towards her duties as the forensic unit director.

I interviewed Dr. Marshall, on the morning of February 4, 2009. She indicated that she was initially hired to oversee the Forensic Unit. However, it was now clear that the building of this unit was not going to occur any time in the near future. She thought the long range plan for the forensic unit was to build an addition to the Eldra Schulerbrandt facility using joint funds from DOH and BOC. Such a plan was not consistent with the information obtained from Mr. Herman.

Dr. Marshall described her role as "overseeing the mental health programs" in both districts. She reported providing mental status examinations of inmates upon referral from custody or healthcare staffs as well as suicide risk assessments and parole evaluations. She said her clinical work at CJC is based on referrals from staff because she is based in St. Croix. Dr. Marshall indicated that correctional and healthcare staff members use a behavioral checklist form to refer inmates to her, and this referral process through this form to her is well-known to staff. She also said that Warden Hansen had referred several prisoners to her for evaluation. The information I obtained by speaking with healthcare staff and reviewing records was not consistent with Dr. Marshall's description of the referral process. Warden Hansen told me that behavioral checklists were used by corrections staff to document unusual behavior by prisoners, and were given to nursing staff at the CJC, not to Dr. Marshall. He said that he did not complete behavioral checklists, and that he could recall only two prisoners whom he had referred to Dr. Marshall for treatment. Warden Hansen said he did not review behavioral checklists, which went directly from corrections staff to shift supervisors and health care staff. Ms. LaPlace told me she did not send all behavioral checklists to Dr. Marshall, nor did she schedule Dr. Marshall to see all prisoners who were the subject of a checklist. I reviewed several records that had behavioral checklists, but did not have a corresponding assessment by Dr. Marshall. I only found two documented assessments by Dr. Marshall in the records I reviewed.

Dr. Marshall perceived Ms. LaPlace to have a minor role in the mental health system at the CJC. She essentially perceived the system to be functioning reasonably well due to the services provided by Dr. Lu. She said that Warden Hansen was Dr. Lu's supervisor.

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She acknowledged the need for therapeutic programming for inmates with serious mental illnesses.

Dr. Marshall does not have a set schedule at the CJC, and infrequently visits the facilities on St. Thomas. Ms. LaPlace and Dr. Lu indicated that there was no formal referral process for CJC prisoners to see Dr. Marshall. Dr. Marshall does not inform Ms. LaPlace when she will be at the jail. Dr. Marshall does not meet with or speak to Ms. LaPlace about mental health services. There have been no case conferences or management team meetings involving Dr. Marshall at the CJC. Dr. Marshall had not seen either the Mental Health Services Proposed Plan or the Medical Assessment Team Report, which are both discussed elsewhere in this report.

Dr. Lu knew who Dr. Marshall is, but did not know her job title, and had not formally met with her. Dr. Lu was not sure who his supervisor was.

Dr. Marshall stated that she was in the final stages of drafting a suicide prevention policy.

Mr. Bentley Thomas and Ms. Jennifer Charles report to Dr. Marshall. Dr. Marshall has met once with Mr. Thomas, but was unclear as to what services he provided to inmates other than refer them to counseling and bible studies. Dr. Marshall reports to Director Wilson.

Mr. Herman told me that the BOC was considering hiring Olaf Hendricks, M.D. as a treating psychiatrist for ACF, and that he may have additional territory-wide responsibilities. Mr. Herman told me that Dr. Hendricks and Dr. Marshall had had a difficult working relationship while he was working at ACF, based in part on some restrictions Dr. Marshall had placed on ACF staff being able to refer patients to Dr. Hendricks. Based on my conversation with Mr. Herman, I asked Dr. Marshall whether she and Dr. Hendricks were experiencing conflicts with each other. She reported that she has never met Dr. Hendricks nor had any professional dealings with him. She indicated some bewilderment concerning this perception, but a willingness to work with Dr. Hendricks.

Dr. Marshall is the point person for overseeing the off-island placements for the five persons found NGRI and for two persons found incompetent to proceed. Four of these persons were transferred to the Sylmar Rehabilitation Center in California. Dr. Marshall has visited this facility four times during the past year and receives quarterly reports from the facility re: the treatment of these inmates.

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Another inmate (Inmate 6-see key to Appendix II) was transferred to The Pavilion in Hollywood, Florida. Dr. Marshall indicated this inmate was subsequently discharged to a step-down unit, Home Sweet Home II. At that point, she essentially notified the DOH that they were now responsible for monitoring his care. She said she did not confirm that DOH agreed to assume responsibility for Inmate 6, and had had no further contact with DOH about this patient. DOH reportedly did not monitor his care and Inmate 6 was subsequently picked up by the police and noted to be grossly psychotic. He was psychiatrically hospitalized at Jackson Memorial Hospital for three months and is currently hospitalized at a Florida state hospital.

The Defendants have yet to produce a budget for health care services in the BOC. I reiterate my recommendation from previous reports that the Defendants develop such a budget, so healthcare expenditures can be tracked, vacant positions timely filled, and financial accountability introduced to the BOC's health care system.

Assessment: Dr. Marshall did not appear to have an accurate understanding how the mental health system was structured and functioning at the CJC. Based on my assessment of the mental health system at the CJC, Dr. Marshall clearly has not functioned as the mental health director for the facility. The lack of adequate mental health leadership has contributed to the broken mental health care system at the jail, which has resulted in seriously mentally ill prisoners needlessly suffering. The reported interpersonal issues between Dr. Hendricks and Dr. Marshall are very disconcerting to the extent that they will be in leadership positions and will need to work closely with one another. If the plan is to have them working together in some manner, any problems that exist between the two of them will need to be further clarified and/or resolved.

Medical Director Issues

Just before the November 2007 hearing, the BOC submitted a contract proposal for Dr. Hall to serve as medical director for a six-month term. Dr. Hall's duties were to include providing direct medical services at both ACF and the jail. The proposal called for her to provide 15 hours a week of services, split between ACF and the CJC. This proposal was never approved or implemented.

In April 2008, Attorney General Frazier wrote to Commissioner of Health Vivian Fludd, asking for permission to "continue negotiations" with Dr. Hall to have her serve as the temporary medical director, while the Department "conclude[s] the process of selecting a medical provider for the Bureau of Correction." Attorney General Frazier wrote that

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negotiations had stalled with Dr. Hall “due to [her] reservations... [about her] availability as a result of her many responsibilities in the Department of Health.” The Attorney General wrote:

Right now, we do not have a Medical director, which results in a major leadership vacuum in our health services to the inmates and detainees. We desperately need a medical director to take on the immediate process of preparing policies and procedures for our health care services unit.

The medical director position remained vacant until February 2, 2009, when Linda Callwood, M.D. started her first day as the medical director. There was not yet a job description for the position of medical director.

I briefly interviewed Dr. Callwood during the afternoon of February 3, 2009. Understandably, since it was her second day of employment, the interview was essentially an introduction and not substantive in content. She had not yet had time to review the consent decree and was not familiar with the relevant court orders.

Assessment: It is encouraging that a fulltime medical director has finally been hired. However, it is very clear that Dr. Callwood will not be able to “hit the ground running” due to longstanding and significant system problems, which include lack of an adequate infrastructure (e.g., policies and procedures) and staffing allocation shortages.

As described in my October 2007 report, Attorney General Frazier had appointed Ms. LaPlace to head the Medical Assessment Team (MAT), which was charged with submitting a report to Attorney General Frazier on “the condition and needs of the medical care units... and a recommended staffing list.” Ms. LaPlace reported that the MAT had not met since it submitted its report in June 2007. She has still heard nothing from Attorney General Frazier about the MAT report. Hopefully, the MAT report will assist Dr. Callwood in her efforts to establish an adequate healthcare system for the CJC and CJC-Annex.

Territorial Nursing Coordinator Issues

Despite her title as Territorial Nursing Coordinator, Lisa LaPlace, RN has continued to function as the head nurse at the CJC. Ms. LaPlace estimates that she has been spending about 60% of her time on her territorial duties since October 2008.

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Ms. LaPlace reported being unable to hire her replacement (i.e., head nurse position at CJC) because the BOC transferred the head nurse position to ACF. It was her understanding that the BOC must either create a new head nurse position and/or complete a new NOPA before hiring a new head nurse at CJC. Ms. LaPlace has continued to have significant problems communicating with the Department of Justice's personnel department and has had similar problems communicating with the Department of Finance. For example, Ms. LaPlace testified that she submitted a request in November 2007 to Ms. Joshua to hire Ms. Mann to replace Ms. Latimer, the jail's former mental health specialist, who resigned in June 2006. As of June 2008, Ms. LaPlace had not received a response from Ms. Joshua, despite following-up with her numerous times. Director Wilson told Ms. LaPlace in November 2008 he had ordered Ms. Joshua in personnel to produce a complete staffing vacancy list. As of February 2009, Ms. LaPlace had not received this list

Assessment: Ms. LaPlace needs a full-time head nurse at CJC in order to allow her to relinquish these duties so she can assume her role as Territorial Nurse Coordinator, which would facilitate development and implementation of the previously referenced policies and procedures.

It is obvious there remain serious problems with the working relationship between the BOC health care staff, the budget and personnel departments at the Department of Justice, and custodial management at the BOC and the CJC. Patient care in the BOC has suffered as a result. Resolution of the above communication issues will require intervention from officials with more administrative authority than Ms. LaPlace.

Other Information

Director Wilson recently began to institute regular management team meetings. These meetings began in November 2008 and involve all management staff. Ms. LaPlace, Dr. Marshall, and Mr. Herman described these meetings as being very useful. Meeting minutes are kept.

But despite Director Wilson's recent efforts to organize the system, there remain serious problems of miscommunication regarding health services. The recent transfer of seriously mentally ill ACF inmates to CJC is illustrative.

At the end of October 2008, Director Wilson decided to move seriously mentally ill prisoners from ACF to the CJC so they could receive updated medication orders and

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treatment from Dr. Lu, who is the only psychiatrist providing services to the BOC. Director Wilson made Dr. Marshall the point person to determine which ACF prisoners would be moved.

Dr. Marshall told me that she did not set the criteria for deciding who would be transferred to CJC. Rather, Jennifer Charles, LCSW, ACF's lone mental health worker, established the criteria.

In the end, 30 ACF prisoners were placed on the move list, with 6-7 prisoners to be moved to CJC at a time to be stabilized.

Ms. LaPlace told me there were no discussions with CJC health care staff about the timing of these moves, or special security and housing measures that would be necessary for the transferred prisoners. This lack of coordination caused a host of problems.

The first group of seven ACF prisoners was moved on November 8 and 9, 2008. This was just days before Dr. Lu was set to begin a previously announced scheduled vacation. As a result, a number of these prisoners remained warehoused at the CJC and Annex. They were not seen by Dr. Lu, and did not receive mental health treatment or updated medication orders. Also, several ACF prisoners had single-cell designations, but CJC security staff was not notified in advance of these housing restrictions.

Some ACF prisoners were transferred to the Annex. Currently, there is no mental health or nursing staff at the Annex. However, a number of these seriously ill men were housed in Unit B, a dark, isolated housing area in the back of the Annex, where the cells are not directly observable by corrections staff.

Other ACF prisoners were moved to the CJC. Some of them were placed in Cluster 3, which required staff to move some Cluster 3 prisoners out to general population units. Neither Dr. Lu nor Ms. LaPlace was involved in these housing decisions.

BOC Assistant Director Herman also told me the following:

1. There was no plan in place for the mental health system in the BOC.
2. Dr. Marshall's role in the BOC mental health system was unclear.
3. BOC was unable to produce a valid list of funded mental health positions.
4. Bentley Thomas's role in the BOC mental health system was unclear.

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5. The creation of positions and the hiring process were both very problematic and need to be fixed.
6. No budget exists for healthcare services in the BOC.
7. No healthcare organizational chart exists.
8. The MAT recommendations and the mental health system draft proposal from Ms. LaPlace have been forwarded to Dr. Callwood.
9. Dr. Callwood, the new medical director who was recruited by Mr. Wilbur Smith, is expected to develop a model for the healthcare delivery system within the BOC that will include a mental health component. She will be assisted by Olaf Hendricks, M.D. in this endeavor when he begins full time employment with the BOC in June 2009.

Mr. Herman indicated that he believed the monitoring and treatment of persons found NGRI are within the jurisdiction of the Department of Health, and not the DOC. He had a similar opinion about the proposed forensic facility.

Mr. Herman reported Dr. Hendricks was reviewing a contract with the BOC that would result in him providing treatment services to inmates at ACF. Dr. Hendricks had stopped providing such services due to reported difficulties with Dr. Marshall.

Dr. Marshall told me she did not know how many funded and unfunded mental health positions there were at the CJC and Annex. She said she had “been going in circles for a year” with the Department of Personnel over her request for a list of all mental health positions.

There were significant discrepancies in what Warden Hansen thought was occurring with regard to mental health services and the actual practices based on record review and information obtained from staff. For example, Warden Hansen stated that custody staff, Ms. LaPlace, and Dr. Lu all were regularly involved in the decision to admit and discharge prisoners from Cluster 3. He also told me that Ms. LaPlace and Dr. Lu were notified when prisoners were placed on suicide watch, if they did not order it themselves, and that they decided when prisoners were removed from suicide watch. However, Dr. Lu reported no involvement in Cluster 3 housing decisions, and Ms. LaPlace described infrequent involvement. Ms. LaPlace, who was usually notified about inmates being placed on suicide watch, would arrange for an assessment of these inmates by Dr. Lu. However, Dr. Lu acknowledged he was not always told if a prisoner had been placed on suicide watch, and he was not necessarily the person who ordered suicide precautions discontinued. This was confirmed by my review of medical records.

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Warden Hansen provided information about the behavioral checklist, which is a form that was developed for use by the correctional officers to notify their supervisor about unusual behaviors being exhibited by inmates. The supervisors can then forward this form to the healthcare staff, which should then initiate a health or mental health assessment.

Monthly management meetings between healthcare and CJC administrative custodial staff have not been scheduled although informal brief meetings occur. However, such informal meetings have not been very productive as evidenced by findings summarized in this report.

Assessment: There remain serious problems with inadequate health care leadership, and a lack of communication between health care and custodial staff as well as BOC leadership and personnel, particularly those in Department of Justice's personnel department as well as the Department of Justice's financial section. These problems have contributed to inadequate health care services being provided to seriously mentally ill prisoners, as described throughout this report.

Policies and Procedures

The BOC still has not developed relevant mental health policies and procedures related in large part to leadership and staffing issues.

Recommendations: The infrastructure of the mental health system is lacking and, aside from the recent hiring of Dr. Callwood, is basically unchanged from my May 2006 findings. By infrastructure I include the following elements:

1. Key administrative staff and medical leadership as per the submitted organizational chart.
2. Mental health policies and procedures as previously recommended and currently court ordered. They should include those areas summarized in Appendix I.
3. A reasonable working relationship between custody and healthcare management staffs.
4. A hiring process (i.e. personnel department) that is able to create and fill needed mental health care positions in a timely manner.
5. Timely access to adequate assessment and programming space for mental health purposes.
6. A discrete and adequate healthcare (which includes mental health services) budget.

There needs to be a designated director of mental health services with a budget specific to mental health services. Although there are a variety of acceptable administrative structures for correctional healthcare services, having the mental health services closely integrated with medical services would be the most cost-effective, and would be my recommendation. It remains my recommendation that the Territorial Nurse Coordinator position include significant healthcare administrative responsibilities over both medical and mental health services. Unfortunately, the current organizational chart is not consistent with this recommendation.

Based on site visits at CJC since 2005 and experience with similar class action litigation in many other states, it is my opinion that more drastic intervention is necessary to implement the desperately needed changes and remedy the significant mental health system problems that have been summarized in each of my site visit reports. Despite numerous contempt findings and specific court orders instructing the Government what steps it must take to bring its health care system up to constitutional standards, the mental health care system in the BOC is very deficient. As a result, seriously mentally ill prisoners have suffered—and continue to suffer—needlessly.

MENTAL HEALTH STAFFING & TREATMENT

Intake Screening

Screening Form

Defendants have been ordered to implement a revised intake evaluation form. All officers responsible for administering the form are required to receive training by health care staff in the use of the form and all officers are required to receive training in identifying prisoners exhibiting signs of mental illness, suicide ideation, or potential for self-harm behavior. [SA ¶IV.G.1., Jan. 18, 2001 Order ¶ 5].

My October 2007 report included the following:

Ms. LaPlace revised the intake screening form in November 2006 consistent with my prior recommendations, and the new form began to be used in December 2006.

However, my review of medical records indicated that the form was not consistently completed. Ms. LaPlace said that no formal training has been

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provided to the correctional officers on this screening form, but she has periodically trained correctional officers in the intake area about using this form. However, correctional officers in the intake area are not permanently assigned there, which makes training an ongoing issue.

The jail has not implemented a computerized management information system (MIS), which means that it remains very difficult to assess a variety of issues relevant to the mental health screening process due to data gathering problems. All intake screening forms are still completed by hand. I had recommended that the jail develop an MIS in my previous two reports.

The situation remains unchanged. Ms. LaPlace told us that regular management team meetings are not held at the jail.

During the February site visit, it was clear that the findings from August 2007 were unchanged from previous reports based on medical record review (see Appendix II) and information obtained from correctional officers.

On June 2, 2008, Mr. Benjamin testified that the BOC would implement a computerized record system by the end of July 2008. However, this has not occurred.

Screening Process

My assessment of the CJC's screening process remains unchanged from my April 2005 report. The current mental health screening process remains flawed. The only mental health screening provided to all inmates involving a health care clinician occurs during the intake history and physical examination. Unfortunately, this examination does not include an adequate mental status examination.

As reported during October 2007, Ms. Latimer, the jail's last mental health specialist, no longer works at the CJC. She has not been replaced. Therefore, the jail has lost the capacity even for the limited intake mental health assessments she performed at the time of my 2005 visit.

My October 2007 report included the following:

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In May 2007, Ms. LaPlace submitted a “Mental Health Services Proposed Plan” which includes proposed changes to intake procedures for mental health assessment. Under the proposed plan, a deputy would continue to complete the revised screening form. Any positive answers to mental health screening questions would trigger an assessment within 12-24 hours. All inmates without positive mental health indicators upon intake would receive a mental health screening within 14 days. The plan does not specify who will perform these evaluations, but does recommend the hiring of two psychologists and two social workers to serve on the team. Furthermore, “a request for Mental Health Services form may be filled out at any time and given to the Mental Health RN,” a position which does not exist. The plan proposes that the team train a specified RN to function as the “triage person” for mental health services. The plan also specifies that all mental health caseload inmates “involved in any altercation will receive an assessment to evaluate if the psychiatrist needs to adjust medications.”

As during the previous site visit, Ms. LaPlace told me that she had not received a response from either the BOC or the Attorney General’s office regarding the proposal. This proposed screening process has not been implemented, in part because the jail does not have adequate staff. As a result of problems with the screening process, there are still seriously mentally ill prisoners who are not identified at intake as needing mental health services. These prisoners do not receive timely mental health care, and their serious health care needs go unmet.

Ms. LaPlace gave the Proposed Plan to Assistant Director Herman during late November 2008, but has not received feedback about the plan from him.

Psychiatric Services

The Agreement requires the BOC to retain mental health staff to establish a mental health referral system, and to provide evaluations and follow-up care to prisoners in need of mental health services. [SA ¶¶IV.V.2-3].

I interviewed Leighman Lu, M.D. during the morning of February 2, 2009. Dr. Lu reported averaging five days per week of coverage at the CJC, which he said generally involves 8-10 hours per week. The contractual rate of \$80 per hour that he is paid has not changed since my May 2006 site visit. He again indicated that he is likely to retire soon if the pay issue has not been resolved.

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Should he leave, the BOC would have significant problems recruiting a replacement psychiatrist for Dr. Lu. This is because of the low financial compensation and the shortage of psychiatrists in the Virgin Islands.

As reported during October 2007, it appeared that Dr. Lu was working significantly less than the number of hours he is contracted to work at the jail. My review of the Main Control CJC logbook indicated that for selected weeks in July 2006, August 2006, and January 2007, Dr. Lu's actual time at the CJC was averaging around 4 hours per week. This is similar to the findings I made regarding Dr. Lu's actual hours of direct services in my May 2006 Report. Based on my review of the relevant logbook over the past year, the work hours of Dr. Lu do not appear to have changed since my August 2007 site visit.

Dr. Lu continues to perform court-ordered evaluations. A review of his appointment log shows that a significant amount of his time is taken up with forensic assessments and court testimony.¹

In April 2005, I reported the following:

Mental health services were limited to initial assessments, psychopharmacological management, and some discharge planning. There did not appear to be any meaningful psychosocial interventions or psychotherapy available to inmates with serious mental illnesses. I found no evidence of discharge planning documented in the mental health records.

There has been essentially no change in the nature of the direct treatment services provided by Dr. Lu since my April 2005 site visit.

Dr. Lu reported no involvement in the decision whether to admit and/or discharge inmates from Cluster 3. Dr. Lu reported he usually did not go to Cluster 3, which was confirmed by my review of that unit's log book.

As in the past, Dr. Lu made it very clear that he is not in charge of the mental health program at CJC. Dr. Lu estimated that the mental health caseload since 2006 has averaged 14 to 20 inmates.

¹ For example, according to the log, Dr. Lu was in court no fewer than 5 work days during July-August 2008.

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Dr. Lu reported that he did not receive information relevant to inmates being discharged, which meant that he was unable to provide adequate discharge services for mental health caseload inmates.

As I have previously reported, there still is no process in place to trigger a mental health assessment for inmates with serious mental illnesses after they are involved in disciplinary infractions. Based on my review of records and incident reports (see Appendix II), inmates with serious mental illnesses continue to get involved in assaults at the jail. However, Ms. LaPlace estimated that she receives information from custody staff concerning approximately 40% of those incidents, and Dr. Lu reported not being notified as a matter of course about such incidents. I confirmed Dr. Lu's statement by reviewing the relevant records.

As a result, inmates with serious mental illnesses may be punished, instead of receiving appropriate treatment, for behaviors that are directly related to their mental illness. In addition, staff and other inmates are at risk of being injured due to behaviors related to inadequately treated mental illnesses of various inmates.

Other mentally ill prisoners apparently have not been appropriately identified and referred to Dr. Lu at intake, or while housed in general population clusters. I also found instances where mentally ill prisoners refused their medications and were not timely seen by Dr. Lu. There have also been instances where prisoners have been referred to Dr. Lu, but not timely seen by him. Examples are listed in Appendix II to this report.

Assessment: As I have previously reported, there are significant problems related to the mental health assessment process and with provision of timely psychiatric follow-up care. In addition, needed psychosocial interventions for inmates with serious mental illnesses are essentially not available at the CJC. These problems are primarily related to lack of policies and procedures, inadequate mental health staffing allocations, and physical plant limitations (see "Mental Health Housing" section later in this report).

I reiterate my finding from my last two reports that it is also likely that more than 10 hours per week of direct psychiatric services are required, based on the average monthly admission numbers and the average mental health caseload figures. The jail will also need additional services once the Annex is fully re-opened, and the total prisoner population on St. Thomas doubles.

Mental Health Specialist

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Under the Agreement, the jail also must hire a master's level mental health specialist to conduct initial mental health evaluations, develop treatment plans, ensure follow-up, and provide individual and group counseling. [SA ¶¶ IV.A.2., V.; Dec. 10, 2002 Order ¶ 2]. In December 2002, the Court ordered the Defendants to conduct a study on the feasibility of using the rooftop recreation area for group therapy, and to increase the hours of the mental health specialist to provide expanded substance abuse and counseling services.

In 2006, the Court also ordered Defendants to implement the following recommendation:

The BOC must develop a comprehensive staffing plan for both the CJC and the Annex so that it can improve the inadequate level of mental health services it currently provides to prisoners. The department should strongly consider hiring a social worker to develop discharge plans through relationships with the courts, public defender's office, probation and parole offices, and the Department of Health.

Excerpts from my October 2007 report included the following:

The mental health specialist, Ms. Latimer, no longer works at the CJC, and the jail has not hired her replacement. In October 2006, Nurse LaPlace identified a candidate for the position, but that candidate has not been hired.

Except for the medication management services provided by Dr. Lu and the attempted discharge planning efforts by Ms. LaPlace, there are no other mental health services that CJC offers to inmates. There are not any meaningful psychosocial interventions or psychotherapy available to inmates with serious mental illnesses.

Ms. LaPlace described an expanded mental health program in the Mental Health Services Proposed Plan (see Appendix III, Ex. C). It states that Dr. Lu has contacted two local psychologists, and Ms. LaPlace has contacted two local social workers, all with an interest in working part-time on the mental health team "to develop a new approach to Mental Health Care within BOC." The psychologists each requested a fee of \$180 an hour, and the proposal calls for them to each work five hours a week, during which time they will evaluate and test individuals and offer individual counseling services. The social workers "will see clients that require referrals to

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substance abuse, outpatient mental health services, and family contacts.” Ms. LaPlace proposed that this team would train a registered nurse to perform mental health triage. The entire team would meet bi-weekly “and as needed” to develop plans of care and to evaluate progress or changes in conditions. Some of the meetings would include the classification officer “to coordinate the inmates housed in the designated Mental Health Area.”

Ms. LaPlace has not received a response from the BOC to her proposal. None of the new positions listed in her plan have a finalized NOPA, and none of the positions has been filled.

February 2009 Assessment: There is no change in my current findings as compared to the findings from my 2006 site visit as reflected in my October 2007 report. Dr. Lu’s work is still limited mostly to medication management, and he is still contracted to provide 10 hours of mental health services, although he provides less than 10 hours per week of direct treatment services to CJC inmates.

As described earlier in this report, the BOC has not developed the comprehensive staffing plan for both the CJC and the Annex that is needed to improve upon the inadequate level of mental health services it currently provides to prisoners.

The Department also has failed to hire a social worker to develop discharge plans through relationships with the courts, public defender’s office, probation and parole offices, and the Department of Health.

As during past site assessments, my review of medical records (see Appendix II) revealed the following significant problems in the mental health service delivery system at CJC:

1. The current mental health screening process is flawed due to the nature of the healthcare screening process and lack of mental health training for correctional officers.
2. The absence of a sufficient number of health care staff creates significant problems with the mental health assessment process. A timely and comprehensive initial mental health assessment is usually not present in the healthcare records.
3. There are significant problems related to the provision of timely psychiatric services.
4. Needed psychosocial interventions for inmates with serious mental illnesses are not available at the CJC.

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5. Group counseling is not available for inmates with serious mental illnesses.
6. Treatment plans are not developed. This is most likely related to the lack of available psychosocial interventions due to inadequate programming spaces and inadequate mental health staff.
7. There is inadequate access to psychiatric hospitalization for inmates in need of such a level of care.
8. I again found that there was no process to trigger a mental health assessment for inmates with serious mental illnesses after they are involved in disciplinary infractions.
9. Communication between correctional staff and healthcare staff is problematic, especially regarding behavioral problems being exhibited by inmates with serious mental illnesses. This communication problem often results in missed opportunities to re-assess an inmate's clinical condition and make appropriate medication adjustments and/or provide needed counseling. Mental health staff also is not involved in the disciplinary process for mentally ill inmates.
10. There is inadequate clinical intervention for prisoners who are noncompliant with their medication orders.
11. There is inadequate discharge planning.

These problems are primarily related to lack of policies and procedures, inadequate mental health staffing allocations, leadership issues, and physical plant limitations. As a result of these problems, seriously mentally ill prisoners continue needlessly to suffer at the CJC.

MEDICAL CHARTS

The Agreement requires the jail to adopt standardized charting practices so that prisoners' medical records are complete and usable. [SA ¶IV.N.1-4.]. On March 22, 2006, the Court ordered the BOC to hire a records clerk to assist health care staff in maintaining prisoners' medical records. [Mar. 22, 2006 Order ¶ 5].

On June 2, 2008, Mr. Benjamin testified that the BOC would implement a computerized medical record system by the end of July 2008.

As previously reported in an earlier section of this report, a computerized medical record system has not been implemented.

Medical records filing continues to be problematic due to inadequate staffing for medical

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records purposes. Ms. Horsford, the civilian records clerk, does not have a set schedule to file health care records. As a result, her work on these records is haphazard, and the burden of filing and maintaining medical records remains on nursing staff. I reviewed a number of medical charts that were disorganized. As a result, it was difficult to follow a patient's clinical course. This poses a risk of disrupting these patients' quality and continuity of care.

MENTAL HEALTH HOUSING

The Agreement requires the jail to set aside a housing area for prisoners requiring mental observation, who are on suicide watch, or who need to be secluded or restrained. [SA ¶IV.V.4-5.]

The Court has also ordered (*Carty v. DeJongh*, Civil No. 94-78, Order (D.V.I. Nov. 20, 2006)) ¶1) the following:

Dr. Lu should be involved with the decision to admit or discharge prisoners into cluster 3. Corrections and mental health staff need to develop a working relationship over the operation of this unit, where there is regular and open communication between staff about the condition of the prisoners housed there. To this end, the jail should institute treatment team meetings between Dr. Lu., Ms. Latimer, the warden, and correctional personnel to discuss the operation of the cluster, and mentally ill prisoners who have exhibited behavioral/psychological changes. The goal of the treatment team is to come up with interventions that may help the inmates clinically improve.

Corrections staff monitoring of cluster 3 prisoners is significantly compromised due to custody staffing patterns in this unit, which at times requires lockdown status due to the custody staffing shortage. This unit should be staffed by adequate numbers of specially trained correctional officers, who are assigned to this unit on at least a six-month basis in contrast to the current practice of staffing this unit with different officers on a very frequent basis.

The need for chronic care programs (often known as a residential treatment unit, intermediate care unit, supportive living unit, special needs unit, psychiatric services unit, or protective environment) for the seriously mentally ill in a correctional setting is now widely recognized. Inmates

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appropriate for these units generally have had significant difficulty functioning in a general population environment due to symptoms related to their serious mental disorders. Establishment of a psychosocial rehabilitation model for inmates in need of such a level of care should be a priority at the CJC, which will require additional mental health staff and adequate programming space.

February 2009 findings: Nothing with regard to mental health housing has changed since my May 2006 report. Cluster 3 remains the designated mental health unit. Deputies assigned to the cluster have not received specialized training or any in-service training on mental health issues.

I interviewed the correctional officer who was staffing Clusters 3 & 4 during the first day of this site visit, and he indicated that the usual staffing pattern around-the-clock was one correctional officer for both of these units. He indicated that the assignment of the correctional officer to these clusters, like all other clusters, was based on a rotating schedule.

The correctional officer stated that the other inmates were generally observed about every 30 minutes. As reported during prior site visits, the assigned officer has duties that require him to leave the control office, leaving the Cluster 3 prisoners periodically unsupervised and unobserved. During my site visit, I observed several cluster control offices unattended by corrections staff, while prisoners remained housed in the cluster.

At the time of my previous site visits, the Cluster 3 officer recorded his 15-minute checks of Cluster 3 prisoners in a separate log book. The jail discontinued this practice in the past year. Now, all 15-minute checks are recorded in the unit log. Although the Cluster 3 log indicated that inmates were seen exactly every 15 minutes, the log's accuracy was very questionable due to understaffing at this post. The quality of the documentation of the checks in the unit logbook ranged from poor to good. Some officers do not record the condition and behavior of the inmates, or the condition of their cells, and instead repeatedly write "all appears O.K.," throughout their shifts.

The Cluster 3 correctional officer reported that the decision to admit and/or discharge inmates from Cluster 3 was made by a classification officer. Dr. Lu confirmed that he has no role in this housing decision.

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The jail is significantly understaffed. As a result, officers often must work double shifts, which negatively impact the ability of correctional officers to adequately provide supervision to the inmates due to fatigue. For example, I reviewed log books that showed that officers worked at least eight double (i.e., 16-hour shifts) in a one week period from June 4-12, 2008. During a previous site visit, I observed an officer sleeping during his watch. This understaffing poses a particular risk of harm to the seriously mentally ill prisoners housed in Cluster 3, who by reason of their illness require enhanced supervision.

Cluster 3 has continued to be plagued by overcrowding in the past year. For example, one cell in the cluster had held three prisoners for at least the first three weeks of January 2008. This triple-celling was documented on daily custody lists. Triple bunking increases the risk of assaultive behaviors by these inmates.

I interviewed all of the Cluster 3 inmates in a group setting in the dayroom. As during past site assessments, inmates in Cluster 3 demonstrated obvious symptoms of a serious mental disorder, which included agitation, responding to internal stimuli, gross thought disorder, and withdrawn behaviors. One of these inmates was single-celled and on suicide watch during this site visit.

Inmates acknowledged access to the dayroom during most of the day except during lockdowns. Inmates provided varying accounts regarding their access to Dr. Lu. None of the inmates knew who Dr. Marshall was, and none reported being seen by her.

Assessment: My opinion regarding Cluster 3 remains unchanged from my prior site visits because there have not been any significant changes re: the mental health services offered to inmates, the physical plant, or the correctional officer staffing pattern. Cluster 3 does provide a safer environment, as compared to other housing clusters, for inmates with serious mental disorders. Cluster 3 does not provide enhanced mental health programming or even adequate mental health programming. The CJC is not equipped to house and treat the most seriously mentally ill prisoners who are in Cluster 3. Some of these prisoners require inpatient psychiatric hospitalization.

The lack of psychosocial interventions has contributed to CJC inmates with serious mental disorders (often associated with active psychotic features) either clinically deteriorating or not improving. Problems persist as a result, which include periodic assaults among these mentally ill inmates, as has been repeatedly documented in my site assessment reports. The absence of adequate psychosocial services can also lead to

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longer stays in the jail for seriously ill prisoners who have ongoing problems being restored to and maintaining competency to proceed in their criminal cases.

Recommendations: My recommendations remain the same from previous reports. Corrections and mental health staff need to develop a working relationship regarding the operation of this unit, where there is regular and open communication between staff about the condition of the prisoners housed there, which would help decrease, but not eliminate, the resulting harm to many of these inmates with serious mental disorders who are receiving inadequate psychiatric treatment. To this end, the jail should institute treatment team meetings between Dr. Lu, Ms. LaPlace, Warden George, and correctional personnel to discuss the operation of the cluster, and mentally ill prisoners who have exhibited behavioral/psychological changes. The goal of the treatment team is to come up with interventions that may help the inmates clinically improve.

Correctional staff monitoring of cluster 3 prisoners is significantly compromised due to custody staffing patterns in this unit, which at times requires lockdown status due to custody staff shortages. This unit should be staffed by adequate numbers of specially trained correctional officers, who are assigned to this unit on at least a six-month basis in contrast to the current practice of staffing this unit with different officers on a very frequent basis.

Establishment of a psychosocial rehabilitation model for inmates in need of such a level of care should be a priority at the CJC, which will require additional mental health staff and adequate programming space.

Dr. Lu should be involved with the decision to admit or discharge prisoners into Cluster 3.

Seclusion, Restraint & Suicide Precautions

My October 2007 report included the following:

In April 2005, I reported that Dr. Lu did not initiate mental health observation or suicide precaution measures. Rather, most orders for suicide watch or close observation came from the correctional supervisors. There were no specially designated cells for prisoners on suicide watch. I was also told that some prisoners are moved for suicide watch. These prisoners are usually transferred to Cluster 6. I toured that cluster. The inside of the

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cells were not directly observable by correctional staff assigned there. There were also no specially designated cells for secluding or restraining mentally ill prisoners.

I again recommend that correctional officers receive at least annual training relevant to suicide prevention policies, procedures, and practices. Cut down tools and mouth guards/ambu bags should be available in all of the housing units for CPR purposes.

It is my understanding the BOC has been ordered to implement the above recommendation. However, suicide prevention policies and procedures have not been finalized, training has not been provided to correctional officers, and emergency cardiopulmonary resuscitation (CPR) equipment is not uniformly available in all of the housing units. It was my understanding from Warden Hansen that such equipment has been ordered.

There has been no change in suicide precautions or the use of restraints/seclusion since my previous site visits. There continues to be no specially designated cells for prisoners on suicide watch. I spoke with several deputies assigned to general population clusters, who told me that suicide precautions could be initiated in any general population housing cluster. The deputies record their checks of these prisoners in the cluster logbook.

The correctional officer assigned to Cluster 3 on February 1, 2009, stated that inmates on suicide watch in Cluster 3 were supposed to be observed by the correctional officer every 15 minutes. However, as in the past, such a procedure was likely not possible due to the officer's other job responsibilities in staffing both clusters 3 & 4.

When an inmate is placed on suicide watch, Ms. LaPlace reportedly was generally given notice by custody staff so that she could schedule an assessment by Dr. Lu. Ms. LaPlace told me Dr. Lu is then supposed to determine when the suicide watch can be discontinued. However, during our site visit we identified we identified an inmate in Cluster 4, who had been on suicide watch for at least several days, and yet healthcare staff had not been notified by custody staff. As a result, no mental health evaluation had been performed.

The CJC does not maintain statistics on suicide attempts or self-harm incidents. The only way to determine how many prisoners have been placed on suicide watch is to review all incident reports, cluster logs, and medical records.

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As reported in my October 2007 report, it was estimated that three inmates per month are placed in restraints in their cells for mental health purposes. The decision to use restraints was made by a supervisor. Dr. Lu had very little knowledge regarding the use of restraints for mental health purposes at CJC and he was not involved in the decision either to put someone in restraints or remove them from restraints.

A female detainee (a.k.a., Jane Doe) did commit suicide at the CJC in early February 2008. The Department of Justice conducted an internal investigation of this incident, which reportedly took over ten months to complete. Plaintiffs' counsel informed me that the detainee's medical record, all relevant unit records, as well as all documents that were part of the internal investigation of this incident have not yet been received by the National Prison Project.

I reviewed the CJC records of Jane Doe that have been made available to Plaintiffs' counsel, who committed suicide by hanging during the early morning hours of February 11, 2008. The mental health questions contained in the intake health screening form were apparently not asked based on review of this form. She did appear to be under the influence of drugs or alcohol at the time of booking at 10:57 pm during February 10, 2008. CO Francis reported making periodic checks on inmate Doe prior to her suicide.

Assessment: The suicide prevention program at the CJC and CJC Annex is inadequate and almost non-existent. The absence of a completed intake health screening form with specific reference to the mental health screening questions regarding Jane Doe is an example of this inadequate program. The lack of specially designated cells for secluding or restraining prisoners, or for prisoners who are on suicide watch, is very problematic, especially from the perspective of developing an adequate suicide prevention program. Prisoners on suicide watch should be under constant observation. However, officers cannot directly observe prisoners housed in many cells at the jail, including all of the cells in Clusters 3 and 6. Moreover, Dr. Lu's limited involvement with suicide precautions and the use of restraints for mental health purposes is very problematic. It reflects an absence of necessary communication between Dr. Lu and the custodial staff concerning issues relevant to suicide prevention and the use of restraints as well as the inadequate mental health staffing allocations at the CJC.

Fifteen minute checks are very difficult to perform due to custody staffing issues. Mental health training for correctional officers has not been provided and is needed.

All correctional staff, as well as medical and mental health personnel, should receive at

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least eight (8) hours of initial suicide prevention training, followed by two (2) hours of refresher training each year. Training should include why correctional environments are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identification of suicide risk despite the denial of risk, liability issues, critical incident stress debriefing, recent suicides and/or serious suicides attempts within the facility/agency, and details of the facility/agency's suicide prevention policy. In addition, all staff who has routine contact with inmates should receive standard first aid and CPR training. All staff also should be trained in the use of the emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training.

ACUTE REFERRALS & HOSPITALIZATION

Under the Agreement, Defendants must transfer all prisoners in need of emergency mental health intervention or hospitalization to either the RLS Hospital or a community mental health center (CMC). [SA ¶¶IV.V.2-3, 6]. The BOC is also required to develop a memorandum of understanding regarding admissions to the RLS Hospital's BTU that describes inpatient care as well as the procedure for admitting and discharging CJC inmates that should include the criteria for admission and discharge.

My October 2007 report included the following:

In April 2005, I found that inmates in need of inpatient psychiatric hospitalization rarely were transferred to the Roy L. Schneider Hospital due to significant access problems. I recommended that the BOC and RLS Hospital develop a memorandum of understanding (MOU) regarding admissions to the BTU. On March 22, 2006, the Court ordered the Defendants to produce this memorandum in thirty (30) days. [Mar 22, 2006 Order ¶12].—Essentially, there have been no changes since my 2005 site visit. An MOU still does not exist between CJC and the Roy L. Schneider Hospital. It was very clear that access to psychiatric treatment for inmates with chronic psychiatric symptoms was very poor. Staff could only remember one prisoner being transferred to the BTU at the Roy L. Schneider Hospital, but his transfer was court-ordered.

The CJC still does not have an MOU with the RLS Hospital for admission and treatment of mentally ill prisoners. Over the past year, Dr. Lu could not recall a single prisoner

who had been transferred to the BTU for treatment.

Review of medical records of inmates assessed to be mentally ill (see Appendix II) revealed the need for an inpatient psychiatric setting for various inmates incarcerated at CJC within the past several years.

I again recommend that the CJC develop an MOU with a hospital that provides inpatient psychiatric care that describes the procedure for admitting and discharging CJC inmates and that includes the criteria for admission and discharge.

FORENSIC FACILITY

The July 19, 2004 Order required Defendants to submit a progress report documenting their efforts to construct, staff, and open a forensic facility in the territory that could safely house and treat chronically and acutely mental ill prisoners. [July 19, 2004 Order ¶ 2]. The September 8, 2004 Order required Defendants to complete construction of the forensic unit by November 30, 2004. In November 2006, the Court also ordered the BOC to implement the following steps:

The Bureau must strongly consider executing a contract with the Department of Health to operate this facility. Under a contract, the BOC along with the Department of Health should then develop a staffing plan for the facility. The facility's medical leadership must be hired well in advance of the unit's opening, so that they can develop policies and procedures and hire key staff. The BOC must develop a budget and a time line for the construction project, and hire either a construction firm with experience building forensic facilities, or a consultant to help oversee the project.

As previously summarized, Denese Marshall, Psy.D. reported that it was now clear that the building of this unit was not going to occur any time in the near future. She thought the long range plan for the forensic unit was to build an addition to the Eldra Schulerbrandt facility using joint funds from DOH and BOH. Such a plan was not consistent with the information obtained from Mr. Herman. Dr. Marshall could not recall a single BOC prisoner who had been transferred to the Schulerbrandt facility absent a court order.

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Assessment: The plan described by Dr. Marshall does not appear to be realistic based on the information obtained from Mr. Herman. Access to needed inpatient psychiatric care for a select group of CJC inmates continues to be lacking.

QUALITY IMPROVEMENT PROGRAM

My October 2007 report included the following:

A quality improvement (QI) program is the process by which BOC leadership can measure staff performance in delivering mental health services. It involves a multidisciplinary quality improvement committee of health care providers who meet regularly with correctional administrators to design QI monitoring activities and to review the results.

As reported after my 2005 and 2006 site visits, Defendants did not conduct any QI activities, and there is no meaningful oversight of mental health services at the CJC, and the lack of a comprehensive QI program contributed to the continuation of an inadequate mental health system.

There has been no change since my tour last year. The CJC still has no MIS, nor the equipment needed to install a MIS, which is needed to facilitate the QI process. There is currently no QI program at the jail.

There has been no change since my August 2007 site visit.

MEDICATIONS

The jail has no formulary. The jail's medications vendor is Henry Schein, Inc. On October 12, 2006, Ms. LaPlace wrote to Attorney General Drue asking for authority to pursue a new medication vendor. At the time, the BOC had been experiencing difficulties obtaining medications in a timely manner from its vendor. Ms. LaPlace still has not received a response to her request. Currently, Ms. LaPlace purchases from local pharmacies medications that she cannot obtain from Schein.

The CJC's medical office has no working fax machine, so staff cannot fax medication orders to the vendor or to local pharmacies.

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In general, discharge medications are provided on a planned basis only to sentenced inmates. There remains a need for a medical social worker to better coordinate discharge planning.

Related to the lack of policies and procedures, there are still no policies and procedures relevant to the use of emergency and/or involuntary medications.

Staff confirmed that corrections officers distribute psychotropic medications to inmates, particularly at the Annex. This is a very serious problem that should cease.

Informed consent is central to ensuring that patients knowingly and voluntarily consent to treatment with medications. I did not find informed consent forms in any of the medical records reviewed.

Very few of the medication orders had expiration dates. This practice is problematic and contributes to inmates receiving medications without appropriate monitoring for side effects and efficacy.

Patients on certain psychotropic medications can develop side effects that can be very debilitating and/or cause other medical problems. The side effects include various metabolic disorders, extrapyramidal symptoms (EPS) (which are involuntary and sometimes painful), and movement disorders that include tardive dyskinesia, a potentially permanent, debilitating condition. Patients receiving these medications must be timely monitored for these side effects, including in some instances appropriate diagnostic tests. Patients receiving other medications, such as lithium and Depakote, must have periodic blood tests to ensure that they are receiving an adequate dosage of their medications. My review of medical records (Appendix II) shows that prisoners are not being timely and appropriately monitored to ensure their medications are working. As a result, these prisoners are at risk of developing serious side effects, and of receiving sub-therapeutic dosages of needed medications.

NGRI Inmates

In my last report, I made the following findings regarding the treatment of the five NGRI prisoners housed at ACF:

These inmates, who all experienced significant symptoms of serious mental illness, were receiving inadequate psychiatric treatment that was also dangerous

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due to lack of adequate monitoring related to both their clinical conditions and prescriptions of psychotropic medications.

Denese Marshall, Psy.D. is the point person for overseeing the off-island placements for the five persons found NGRI and for two persons found incompetent to proceed. Four of these persons were transferred to the Sylmar Rehabilitation Center in California. Dr. Marshall has visited this facility four times during the past year and receives quarterly reports from the facility re: the treatment of these inmates.

The Court has ordered Defendants to produce by February 2, 2009, the medical records of all NGRI patients who have been transferred stateside. The ACLU had not yet received these records.

Another inmate (Inmate 6-see key to Appendix II) was transferred to The Pavilion in Florida on January 28, 2008. I have reviewed Inmate 6's records from this facility that were forwarded to Plaintiffs' counsel. These records end on May 23, 2008. As of that date, Inmate 6 was still responding to internal stimuli, his participation in groups and structured activity was minimal, he still required 1:1 supervision, he was at times sexually inappropriate, and he spent most of his time in his room.

Despite his acuity, the Pavilion nonetheless recommended that Inmate 6 be discharged to an assisted living facility (ALF). On May 23, 2008, a social worker at the Pavilion wrote to Dr. Marshall, stating that staff concluded that Inmate 6 "has been stabilized and has made sufficient progress towards meeting his inpatient goals, "and recommended he be housed at an ALF, and transported daily to a partial hospitalization program for treatment." On June 18, 2008, Dr. Marshall wrote to Dr. Fludd (DOH), requesting that the Department of Health pay the one-month housing advance for Inmate 6 to be transferred to the ALF.

At some point, Inmate 6 walked away from the ALF. He was picked up by police in Miami, Florida on July 4, 2008 for sleeping in a public park, and brought to Jackson Memorial Hospital. According to his August 11, 2008 involuntary commitment order, Inmate 6 refused to identify himself when he was found by police officers sleeping in a Miami public park. He was mute when first examined by a physician at Jackson Memorial Hospital. The second time the physician attempted to examine him, he ran through the Crisis Unit holding his crotch. As of August 11, 2008, he had been involuntarily medicated twice, he still "would provide no information about himself or where he came from," and he was not bathing. The Court determined that Inmate 6 was manifestly incapable of surviving alone, and without treatment posed a threat of

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substantial harm to himself. As result, the Court appointed a guardian for Inmate 6, and involuntarily committed him to Jackson Hospital Intensive Treatment Unit for a period of no more than three months. Inmate 6 is currently housed at a Florida State Hospital.

Plaintiffs' counsel reports that he learned of Inmate 6's plight from a social worker at Jackson Memorial, who called the ACLU in October 2008, soon after Inmate 6 finally told staff there his name, three months after his admission. She found Plaintiffs' counsel by googling Inmate 6's name, which led to a link to the National Public Radio story on Inmate 6 that aired last year.

On October 7, 2008, Plaintiffs contacted Defendants, who apparently were unaware that Inmate 6 had walked away from the ALF and had been missing for three months. I spoke with Dr. Marshall about Inmate 6. She indicated this inmate was subsequently discharged from the Pavilion to a step-down unit, Home Sweet Home II. At that point, she essentially notified the DOH that they were now responsible for monitoring his care. I have asked for, but not received, the notification Dr. Marshall says she sent to DOH regarding Inmate 6. Dr. Marshall did not follow-up with DOH to determine if the department accepted responsibility for this patient, and she did not conduct any further oversight of his care.

One NGRI patient remained housed at ACF at the time of my site visit. Dr. Marshall told me that his transfer was imminent. I renew my recommendation from my previous reports that this inmate needs immediate assessment by a psychiatrist relevant to his current psychotropic medications as well as ongoing monitoring. He should also be transferred to an appropriate mental health treatment setting.

Assessment: Based on the information summarized re: Inmate 6, it is clear that the treatment being provided to Inmate 6 has not been adequately monitored by BOC, which clearly has been harmful to Mr. Ramos. Regarding the other NGRI inmates receiving treatment at the Sylmar facility, I cannot adequately assess either their care or the monitoring of their care without reviewing their medical records, a program description (including whether there is confirmation of JCHAO accreditation for Sylmar), and all documents from or to Government personnel about their care.

Review of Medical Records

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During this site visit, I reviewed the medical records of 23 inmates along with selected classification records and logbook entries (see Appendix II). I identified the following mental health system problems:

1. Although clearly improved from earlier site visits, the records were frequently not chronologically organized and, at times, the psychiatrist's progress notes were in the nursing section of the progress notes.
2. I rarely found any recent laboratory test results pertinent to the use of atypical antipsychotic medications and/or mood stabilizing medications. When present, the results had not been reviewed by the psychiatrist.
3. I only found two assessments completed by Dr. Marshall in the records reviewed. One of these assessments was a mental status examination. The reason for the consultation was unclear as was its usefulness.
4. The intake health screen frequently was only partially completed by the booking correctional officer. Even when there were positive responses, the "notify RN" section was usually left blank. There were mentally ill prisoners who were not identified at intake as needing treatment, and their subsequent treatment was delayed.
5. It was common to not find a behavioral checklist in the medical records of inmates who were clearly psychotic.
6. It was common for healthcare staff to not be notified by correctional staff re: significant incidents involving inmates with serious mental illnesses.
7. Treatment plans were not present in any of the medical records reviewed.
8. Informed consent forms were not present in the chart regarding the prescription of psychotropic medications.
9. Psychotropic medication orders did not specify how long the orders were good for (e.g., 7 days, 30 days, 90 days?), which is not consistent with the standard of care.
10. Medication noncompliance was frequently not adequately addressed.
11. Mental health treatment lacked psychosocial interventions and consisted almost exclusively of the use of psychotropic medications.
12. It was not uncommon for psychiatric follow-up to be untimely.

As a result of these deficiencies, and others identified throughout this report, seriously mentally ill prisoners have been denied adequate mental health treatment, and have suffered unnecessarily as a result.

2009 Summary

There is very little change from my 2006 or 2007 assessments. Although I identified some positive findings, significant problems with the CJC and CJC Annex mental health system continue to exist.

Positive findings include the following:

1. Lisa LaPlace, RN, continues to provide the glue for the very fragile healthcare system at CJC. She has filled the position of Territorial Nursing Coordinator. However, due to staffing vacancies and allocation issues, she remains functionally the head nurse at CJC and is unable to devote enough time in the role of Territorial Nursing Coordinator.
2. Cluster 3 appears to provide a better environment for inmates with serious mental illnesses as compared to the other clusters. However, Cluster 3 is not designed or staffed to provide adequate psychiatric care to inmates with serious mental illnesses.
3. A medical director, Linda Callwood, M.D. had just been hired.
4. There was new leadership in the BOC and at the CJC.
5. Four of the five NGRI inmates have been transferred off-island to a psychiatric facility.

Negative findings included the following:

1. The mental health system continues to be lack critical leadership.
2. There is no established budget for healthcare services at the jail.
3. The continued lack of relevant mental health policies and procedures and established healthcare leadership has contributed to an inadequate mental health system at the CJC.
4. The current mental health screening process remains flawed due to the content of the medical screening intake form, nature of the healthcare screening process, and lack of training for correctional officers on mental health issues.
5. There are significant problems related to the mental health assessment process due primarily to the inadequate number of mental health staff employed and the lack of relevant policies and procedures.
6. None of the medical records I reviewed contained a formal treatment plan.
7. There are significant problems related to the provision of timely psychiatric services.
8. Needed psychosocial interventions for inmates with serious mental illnesses are rarely available at the CJC.
9. Group counseling was not available for inmates with serious mental illnesses.
10. Despite providing a better environment for inmates with serious mental

illnesses, as compared to the other clusters, Cluster 3 does not provide adequate mental health programming, let alone enhanced mental health programming.

11. The lack of specially designated cells for secluding or restraining prisoners, or for prisoners who are on suicide watch, is very problematic, especially from the perspective of developing an adequate suicide prevention program.
12. Inmates in need of inpatient psychiatric hospitalization are not transferred to the RLS Hospital due to significant access problems.
13. The forensic facility construction project has essentially been cancelled.
14. No effective discharge planning process for mentally ill inmates exists at CJC.

The following recommendations, with some minor modifications, were included in my October 2007 report. None of them have been implemented except when noted otherwise.

1. As per my May 2006 report, policies and procedures need to be developed that describe the screening process to be used to identify and exclude mentally ill inmates from the Annex. In addition, these policies and procedures need to describe the process to be implemented to identify and transfer inmates who were appropriately admitted to the Annex but later demonstrate symptoms of a mental illness. These policies and procedures would be a subset of the previously recommended mental health system policies and procedures (see my May 2006 report) that would address the subject areas summarized in Appendix I. Of note, the BOC still has not developed relevant mental health policies and procedures related in large part to leadership and staffing issues that are described throughout this report.

In addition, Ms. LaPlace needs a full-time head nurse at CJC in order to allow her to relinquish these nursing duties so she can assume her role as territorial nurse coordinator, which would facilitate implementation of the above recommended policies and procedures.

2. The infrastructure of the mental health system is lacking and basically unchanged from my May 2006 findings except for the recent hiring of a medical director. By infrastructure I include the following elements:

- Key administrative staff and medical leadership with a clear organizational chart.
- Mental health policies and procedures as previously recommended and currently court ordered. They should include those areas summarized in Appendix I.

- A reasonable working relationship between custody and healthcare management staffs.
- A hiring process (i.e., personnel department) that is able to create and fill needed mental health care positions in a timely manner.
- Timely access to adequate assessment and programming space for mental health purposes.
- A discrete and adequate healthcare (which includes mental health services) budget.

3. Corrections and mental health staff need to develop a working relationship regarding the operation of Cluster 3, where there is regular and open communication between staff about the condition of the prisoners housed there, which would help decrease, but not eliminate, the resulting harm to many of these inmates with serious mental disorders who are receiving inadequate psychiatric treatment. To this end, the jail should institute treatment team meetings between Dr. Lu, Ms. LaPlace, the Warden, and correctional personnel to discuss the operation of the cluster, and mentally ill prisoners who have exhibited behavioral/psychological changes. The goal of the treatment team is to come up with interventions that may help the inmates clinically improve.

Correctional staff monitoring of Cluster 3 prisoners is significantly compromised due to custodial staffing patterns in this unit, which at times requires lockdown status due to the custodial staff shortages. This unit should be staffed by adequate numbers of specially trained correctional officers, who are assigned to this unit on at least a six-month basis in contrast to the current practice of staffing this unit with different officers on a very frequent basis.

Establishment of a psychosocial rehabilitation model for inmates in need of such a level of care should be a priority at the CJC, which will require additional mental health staff and adequate programming space.

Dr. Lu should be involved with the decision to admit or discharge prisoners into Cluster 3.

4. I again recommend that correctional officers receive at least annual training relevant to suicide prevention policies, procedures, and practices. Cut down tools and mouth guards/ambu bags should be available in all of the housing units for CPR purposes. Separate CPR training also needs to be provided.

5. CJC should develop an MOU with a hospital that provides inpatient psychiatric

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care that describes the procedure for admitting and discharging CJC inmates and that includes the criteria for admission and discharge.

6. A management information system should be developed, which should include data points relevant to the intake screening process, in addition to other important data elements such as mental health caseload inmate names, diagnoses, medications, scheduled appointment dates, etc.

7. The BOC should strongly consider increasing Dr. Lu's fee structure rate to bring it more in line with his rate with the Department of Health. Along with increasing the rate structure, the BOC should periodically review Dr. Lu's hours to ensure that he is providing a level of services that is consistent with his contract.

Please contact me if I can answer any further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "J. L. Metzner, M.D.", with a stylized flourish at the end.

Jeffrey L. Metzner, M.D.
Clinical Professor of Psychiatry
University of Colorado School of Medicine

Appendix I

Appendix II