UNITED STATES DISTRICT COURT
DIVISION OF ST. THOMAS AND ST. JOHN

Carty v Mapp
Civil No. 94-78

THIRD REPORT OF KATHRYN A. BURNS, MD, MPH
ON COMPLIANCE WITH MENTAL HEALTH PROVISIONS OF THE SETTLEMENT AGREEMENT
May 2016

I have completed a third site visit and assessment of the mental health services offered to inmates at the Criminal Justice Complex (CJC), St. Thomas, United States Virgin Islands. I visited both the CJC and Annex during the site visit conducted February 1-3, 2016. All of the female inmates were housed at the Annex at the time of the site visit.[1] I prepared a draft report of the visit and provided it to the parties for review and comment. I received feedback and additional information on some of the case reviews from the BOC and incorporated it into the Appendix where appropriate. Given that there are now quarterly updates and status hearings, this report is relatively brief as the Bureau of Corrections (BOC) is focused on addressing quarterly goals. Reports on progress toward goal attainment are filed quarterly.

As noted during prior status hearings, the BOC drafted and finalized a significant number of medical and mental health policies. The listing has previously been reported to the Court. The policies had not been fully implemented at the time of the site visit. The policies on Suicide Prevention and Therapeutic Restraint/Seclusion had not been finalized. There was no Memorandum of Understanding developed for access to inpatient or intermediate levels of psychiatric care at the time of the site visit. The BOC reported that prisoners had access to acute inpatient care at Schneider Regional Hospital and that they were focusing on developing agreements for intermediate and longer-term care. However,

[1] In a memorandum dated April 8, 2016 the BOC reported that the Annex had been temporarily closed in an effort to "address staffing levels, its impact on operations, and overall compliance with the 2013 Settlement Agreement." Fourteen inmates were transferred to other jails and the female inmates were placed into Cluster 7 at the CJC.

access to acute inpatient care remains extremely limited. Only one inmate was hospitalized at Schneider since the last report: a psychotic pregnant woman who was held in the jail for weeks. She was not eating and did not receive prenatal care. She was held in lockdown[2] status at times for days. She actually delivered the baby while at the Annex. When she was taken to the hospital post-delivery, she was committed to the psychiatric unit for about a week, provided psychotropic medication and her mental condition improved dramatically. (Case is summarized in Appendix; #15) This woman should have been referred to inpatient psychiatric care from the intake screening process or at anytime thereafter when it was clear that the jail was unable to meet her psychiatric and obstetrical needs. BOC reports of inpatient access notwithstanding, inmates with serious mental illness in the jail simply do not have sufficient access to higher levels of mental health care. Many other inmates equally or more psychiatrically ill have not been referred to the hospital for inpatient care. They have remained in jail, often in security lockdown status for days, weeks or months, for behaviors resulting from untreated mental illness, rather than being transferred to Schneider Regional or other psychiatric hospital. The inmate found Not Guilty by Reason of Insanity (NGRI) continues to be held in the jail and remains in nearly continuous lockdown status because of his deteriorated mental state. He has not been transferred for inpatient care. He refuses medication and is psychotic and manic. No petition has been filed to transfer him to inpatient care or get a court order for treatment. (Appendix case summary #7)

An additional psychology intern has been added to co-facilitate treatment groups with the master's prepared psychologist that has been providing services at CJC. This has had a positive impact on making group treatment more available to some of the inmates at the jail. Additionally, it has freed up a small amount of Ms. Warren's time that she uses to focus on individual assessments, supportive sessions with inmates, and communication with inmate families and the court. However, more mental health staffing is required to meet the terms of the Settlement Agreement with respect to the provision

[2] Lockdown status is locking an inmate into his or her cell for unspecified and unregulated periods of time.

of timely psychiatric assessments, individual treatment and psychosocial programming. Insufficient custody staffing levels continue highly problematic and endanger the lives and safety of inmates and staff due to inadequate prisoner supervision. Instances of officer-on-inmate physical abuse have been reported as well.

I have used the same format for this report as in prior reports, focusing primarily on mental health requirements articulated in the Settlement Agreement, Section V. Medical and Mental Health Care and particularly Section V.2.x. Mental Health Care and Treatment. I have again grouped the mental health care requirements into the following larger categories for purposes of reporting.

- Intake screening
- Mental health assessment
- Medication management
- Access to off site consultation and specialty care, including inpatient and emergency care
- Suicide prevention
- Staffing
- Segregation
- Mental health levels of care, access to inpatient or intermediate care, psychotropic medications and special procedures (seclusion and restraint)

There are a number of over-arching provisions more broadly related to the provision of appropriate mental health care as well such as inmate safety and supervision (Agreement Section IV) and the provision of timely medical and mental health care consistent with community standards and the National Commission on Correctional Health Care (Section V.1 and V.2.e.) contained in the Settlement Agreement. Findings related to specific requirement areas are also relevant to these larger concepts/requirements and I have attempted to indicate when there are broader implications for those larger, over-arching Agreement provisions in the specific sections where relevant.

Record reviews and interview information of individual patients are summarized in the Appendix that accompanies this report.

Mental Health components of Settlement Agreement

Intake Screening	
Settlement Agreement Sections: V.2.a.	Not compliant

Intake screening has not been an area of focus in the quarterly goals thus far though it is critically important in ensuring timely identification and access to psychiatric care and initiation of treatment. A policy and procedure was finalized by the BOC though it is not wholly consistent with the terms specified in the Agreement. Correctional officers continue to conduct the initial screening in every instance, even when health care staff are on site. The Agreement requires officers to have had special training to perform this screening but the policy does not reference this requirement and the training materials for COs have not been provided. Nursing assessments are not consistently conducted within 4 hours of booking. The policy does not address physical examinations required by the Agreement. Psychiatric assessments do not consistently occur within three days of admission as required. In fact, significant delays in psychiatric assessment persist leading to lapses in continuity of care with respect to psychotropic medication and delayed initiation of treatment. Further, there were no instances in which acutely psychotic mentally ill inmates were diverted to psychiatric hospitalization as a result of the screening process rather than placement in jail.

Case examples in the Appendix that illustrate the problems with the current intake screening process include delayed referral to mental health from the screening process (cases #5, 14); delayed psychiatric assessment and medication initiation (cases #2, 9, 11, 17, 18, 19, 21, 22) and failures to transfer seriously and acutely ill inmates to emergency services for psychiatric hospitalization from the screening process (case #15, 11 – housed in segregation from intake, not placed in mental health unit.)

Mental health assessments – as follow-up from positive intake screening, conducted by qualified mental health professional within 3 days of admission	
Settlement Agreement Sections: V2b	Not compliant

The BOC Basic Mental Health Services Policy (P-G-04.1) does not address the timeframe for completion of mental health assessments or the qualifications of the assessor as required by the Settlement Agreement. The Agreement requires a mental health assessment conducted by a psychiatrist (or psychiatric nurse practitioner) within three days of admission to the jail.

The jail social worker, Ms. Warren conducts a type of mental health assessment upon receipt of referrals from medical or custody staff and refers cases on to the psychiatrist, Dr. Lu. Ms. Warren's assessments are timely in response to referrals. However, she is not a qualified mental health professional according to the definition in the Agreement, nor is she independently licensed and thus unable to formulate diagnoses.

Dr. Lu's response to referrals for psychiatric assessment and/or intervention is not timely. By contract, psychiatric time is limited to two hours daily during the week. Dr. Lu is not at the jail for two hours daily and uses some of the time that he is at the jail to conduct forensic examinations rather than providing clinical care. Consequently, psychiatric assessments are frequently quite delayed which impacts access to treatment. Inmates with serious psychiatric conditions are untreated and symptoms worsen. This has lead to inmates being placed and held in lockdown status by custody staff for behaviors resulting from untreated mental illness, where conditions further deteriorate. Seriously ill inmates have also been victimized by other inmates and involved in physical altercations with other inmates as well as custody staff.

Cases containing problems with delayed mental health assessments include: #2, 5, 7, 9, 11, 15 and 17.

Medication management - continuity, administration & management of medications that address a number of factors including continuity, timely responses to medication orders and labs, professional medication administration procedures, monitoring for effectiveness and side effects, discharge medications; timely access to a psychiatrist and psychiatric review of medications; and the Agreement's general provisions for timely and appropriate care, including psychiatric care.	
Settlement Agreement Sections: V2f sections i-vi; V2x section iv; V2e; V1	Not compliant

The BOC provided final policies regarding Medication Services (P-D-02), Psychotropic Medications (P-D-02B) and Emergency Psychotropic Medication (P-I-02). Finalization of policies notwithstanding, record reviews continue to demonstrate serious problems: delays in initiation of medication; failure to monitor regularly for side effects, response to medications or blood levels; infrequent, and non-confidential psychiatric follow-up appointments; medications ordered, changed and doses adjusted without face-to-face examination; long acting injectable medication administered over inmate objection; lack of any petitions filed seeking court sanction for on-going involuntary medication administration. Dr. Lu has continued to write medication orders at monthly intervals but still provides no duration of the order. Consequently, when medications are changed, his intent with respect to continuing the former order of medication remains ambiguous as previously reported. (It is unclear whether one or both orders remain in effect if he does not discontinue the first order.) Emergency medication orders are written with no duration so that multiple doses may be administered over periods of days or weeks without any assessment of effectiveness, documentation of need or petitioning the court for on-going permission – practices that contradict the accepted standard of care and the BOC's own written policies.

A serious problem with Medication Administration Record (MAR) documentation was observed at the Annex during the site visits. Doses of medication were recorded as having been administered and ingested by the inmate in *advance* of the scheduled administration time rather than contemporaneously

with the actual administration of the medication. This violates nursing practice standards, the BOC written policy and constitutes falsification of the medical record. (Note that I did address this problem practice with the nurse on duty at the Annex who had filled in the MAR in advance.)

Case reviews that illustrate the areas of serious problems with the medication practices include: # 2, 5, 7, 9, 14, 15, 17 illustrate delays in assessment and medication orders; #2, 11, 12 and 19 illustrate failure to monitor (follow-up examinations, laboratory studies, etc.); #8 – medication ordered without assessment; # 5 and 19 illustrate use of long-acting injectable antipsychotic medication without inmate consent or court order; #14 includes on-going administration of emergency medications without reassessment, petitioning the court or consideration of transfer to a higher level of care.

Off site specialty care and consultation, emergency care and systems to track and monitor inmates with mental health and medical needs	
Settlement Agreement Sections: V2g;V2i section i-vii;V2j; V2p; V2q	Not compliant

No specific agreements related to mental health care were in place at the time of the site visit. Subsequently, the BOC did forward some information that is covered in the May 2016 quarterly goals update report.

Notably, in the interval between site visits, there were no instances of inmates psychiatrically hospitalized with the exception of the pregnant woman who gave birth at the Annex. (Case # 15) Even in this case however, hospitalization did not occur when she was not eating, not speaking and not taking medication. It occurred only after the inmate was transported to the hospital for medical attention after giving birth at the Annex. At the jail, she was not provided adequate medical monitoring, prenatal or psychiatric care. She was untreated and held in lockdown status for days at a time. Her condition improved markedly within a few days of being in the hospital and she returned to the jail.

One inmate (case #14) was released to an intermediate level of mental health care on St. Croix.[3] At the time of his jail booking, he required an inpatient level of care but was not diverted. He was manic and refused medication. No petitions for inpatient transfer or involuntary medication were filed during the course of his 5-month jail stay. The inmate sustained significant closed head injuries in assaults with other inmates and staff. (There are credible allegations of officer misconduct and abuse that require investigation and discipline if found to be true. There was also an incident described as an inmate fall that required transfer to the local emergency room for a head CT scan that also requires thorough investigation.) He was placed in lockdown status on multiple occasions and held there for periods of days to weeks for behaviors resulting from untreated psychiatric illness.

The inmate found NGRI remains in lockdown status at the jail, untreated and psychotic. (Case #7) I found multiple instances of inmates acutely ill and in need of inpatient care at the time of their admission to the jail (cases #2, 5, 7, 9, 14, 15, 19, 22). None of them were diverted to emergency care or psychiatric hospitalization. Dr. Lu and Ms. Warren identified multiple cases of inmates needing long term mental health placement and/or a residential program to transition into the community. (Cases #2, 6, 8, 10, 11, 12, 19, 22) I concur with their recommendation.

Suicide prevention – calls for policy and procedures that include precautions, safety cells, monitoring, communication, treatment, follow-up	
Settlement Agreement Sections: V2l sections i-xii; IVB1d	Not compliant

The Suicide Prevention Policy and Procedure was not completed. As previously reported, there are no safe cells at the institution and correctional staffing levels are not sufficient to provide continuous observation or frequent monitoring. Fortunately, there have been no completed suicides since December 2014. In the absence of a comprehensive policy, safe cells and sufficient staff to monitor watches, inmates assessed at elevated risk of suicide should be transferred to an inpatient facility.

[3] I recently learned that he returned to the CJC.

Case #16 illustrates the problems that persist in current suicide prevention practices that include: no safe cell; no suicide-resistant gowns/blankets; sporadic monitoring by correctional staff; and infrequent mental health risk assessment and poor documentation.

Failure to complete the suicide prevention policy and procedure in spite of its vital importance to inmate health and safety is inexplicable and inexcusable.

Staffing – adequate professional staffing with periodic analysis and plans; adequate correctional staffing to support mental health mission	
Settlement Agreement Sections: V2m section ii,vii,viii; V2n; IVB1d	Not compliant

As reported in prior mental health reports, there is insufficient mental health staff to provide assessments, group and individual treatment, psychosocial interventions, discharge planning and communication with families and the court system. Ms. Warren works very hard to cover all of these tasks, but it simply is too much for one person to do. When Ms. Warren utilized a portion of her earned time off duty, only minimal emergency coverage was available at the jail. No mental health intake assessments were completed and other treatment interventions were suspended. This is not acceptable. As noted, the recent addition of a second part-time psychology intern to co-facilitate groups with the other psychology contractor has been helpful, but does not approach filling the unmet treatment needs.

There is insufficient psychiatric time for the facility leading to delays in initiation of treatment and responses to referrals, even urgent referrals. Dr. Lu continues to split the limited contractual time between providing treatment and conducting forensic evaluations. The logbook located in the main control station continues to serve as the only record of Dr. Lu's time spent at the jail, and it is incomplete and does not record his every entrance or departure from the jail. However, when times listed were reviewed for the weeks of 10/26/15, 11/9/15 and 12/14/15, they demonstrated that Dr. Lu was generally at the jail for an hour or 90 minutes daily rather than the two hours specified in his

contract. (One day, 10/27/15 recorded Dr. Lu as being at the jail for 2 ¼ hours.) No staffing plan or information regarding on-call coverage or coverage in the absence of Dr. Lu have been provided.

Information from prior reports regarding correctional officer staffing was unchanged at the time of the February site visit:

> "Staffing levels of correctional officers remains inadequate to support a mental health mission: suicide watches cannot be conducted appropriately; posts continue to be completely unmanned at times and at other times, officers are called off their posts to assist other officers in routine tasks such as meal distribution (leaving posts completely unmanned) to name just a few examples that highlight the inadequate correctional officer staffing levels…"

Correctional officer staffing levels were inadequate to maintain observations for inmates on watch and logbook entries demonstrated long periods of time (hours to full shifts) without security rounds or inmate supervision. There were multiple instances of inmate-on-inmate assaults in Cluster 1 resulting from inadequate correctional officer staffing levels and supervision. In addition, some incidents noted in the medical and mental health files of inmates with serious mental illness imply inappropriate officer use of force and/or actual abuse of inmates – red flags potentially signaling inadequate staffing, poor training, and problems with supervision of staff. All must be thoroughly investigated and addressed.

Segregation – includes procedures for rounds as surveillance for inmates experiencing difficulty, prohibition against placing mentally ill into segregation, mental health input to disciplinary process, and use of force incidents, minimize segregation time, adequate out of cell time	
Settlement Agreement Sections: IVH1f; V2t, V2u, V2v, V2w	Not compliant

The BOC provided a finalized policy entitled Segregated Inmates/Detainees (P-E-09) but it does not prohibit placing inmates with serious mental illness into segregation as required by the Settlement Agreement. Furthermore, although the policy does require notice of intended placement to medical staff in order to review the inmate and medical record for any contraindications to segregation, and

consultation with mental health staff for inmates on the mental health caseload and/or at risk of suicide, there is no documentation in the records indicating that these procedural policy requirements are in actual practice.

Inmates with serious mental illness are in fact housed in segregation. There is no procedure in place to prohibit placement. There is no documentation that mental health staff are consulted or even notified of inmate placement in segregation. There is no documentation of mental health consultation during the disciplinary process. Inmates, including seriously mentally ill inmates, are moved into segregation (Cluster 6) by custody staff without mental health clearance, notice or opportunity to intervene and diffuse the situation without segregation placement.

Additionally, as discussed in earlier reports, custody staff place and hold inmates on lockdown status in place. This includes inmates displaying active symptoms and behaviors of serious mental illness. Lockdown status is not addressed in the segregation policy provided even though the conditions of confinement (out-of-cell time, property restriction, access to programming, opportunity for appropriate socialization, etc.) are virtually identical to those in segregation.

Cases #11, 14 and 19 illustrate instances of inmates with active symptoms of serious mental illness inappropriately placed into segregation. Cases in which inmates were placed on lockdown status displaying symptoms and behaviors of active mental illness without consultation with mental health staff or referral for treatment include: #5, 7, 9, 14, 15 and 22. Case #7 has been on lockdown status in Cluster 1 for more than a year. His condition continues to deteriorate. He refuses to consider treatment with medication. No petition seeking transfer to inpatient care or involuntary treatment has been filed. He requires immediate transfer to a treatment facility.

Mental health care – includes timely access acute and chronic care, access to inpatient or intermediate care if clinically appropriate, psychotropic medications, staff training, special procedures (seclusion and restraint), appropriate housing, adequate treatment space	
Settlement Agreement Sections: IVB1d; IVIe; IVF7;V2e; V2w; V2x (sections i-xii)	Not compliant

There is no update to report as of the time of the site visit. Mental health staffing levels are insufficient to support a range of mental health services. Ms. Warren continues to provide intake assessments, crisis assessments, supportive contacts, and communication with family and the court system, but the need for these interventions exceeds what one person can do. Dr. Lu provides some measure of psychiatric assessment and prescribes psychotropic medications but his assessments and responses to referrals are not timely and treatment is delayed. Psychiatric follow-up care is not consistent with BOC policy or the accepted standard of care – inmates are not seen at regular intervals, are not always seen in confidential settings and are not routinely monitored with physical examinations and laboratory testing. Psychology contractors co-facilitate some group treatment interventions. However, all of these things combined do not match the level of mental health need present among the inmates at the CJC. Neither is the physical plant appropriate or conducive to providing mental health treatment: there is no safe cell for suicide prevention or sufficient treatment space for group treatment and psychosocial interventions.

The seclusion and restraint policy has not been completed as of the writing of this report although there has been agreement on the principle that physical restraint for mental health reasons will not occur at the CJC due to lack of an infirmary and 24-hour medical staff presence at the facility. The use of therapeutic seclusion must be clearly defined and limited. Both the seclusion and segregation policies require amendment to address the widespread use of security lockdown status for inmates with untreated symptoms of serious mental illness.

As previously reported, Cluster 1, the mental health unit, is not therapeutic and continues to be frankly unsafe at times. Security staff are not always on post to supervise the inmates in Cluster 1.

Mental health staff do not control admissions and discharges to and from Cluster 1. At the time of the site visit, predatory inmates without mental illness were housed on the unit with the vulnerable seriously mentally ill inmates. There were incident reports and medical record documentation of inmate-on-inmate assaults on Cluster 1 as well as credible reports of staff-on-inmate assaults. Some inmates on Cluster 1 are on custody lockdown status with limited access to mental health care at the jail and virtually no access higher levels of mental health care. Other inmates with mental illness were housed in other clusters, including the Annex where access to mental health services was extremely limited.

Inmate record reviews, interviews and staff reports identified many inmates on the mental health caseload in need of a higher level of care than that which could be provided at the jail for all of the aforementioned reasons. These included cases #2, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 19 and 22. However, only two of them were actually sent to a higher level of care. Case #15 was admitted to inpatient care after giving birth at the jail. Her condition improved and she returned to the jail. Case #14 had a tumultuous jail stay, involvement in assaults (victim and perpetrator) and extended periods of time in lockdown status. He went to intermediate care at the end of his jail stay. These are not acceptable outcomes; access to higher levels of care must be more available and timely to those inmates in need.

Conclusions:

I found no areas of compliance or partial compliance with the mental health terms of the Settlement Agreement. Although the BOC has produced many "final" policies, the policies are not consistent with the terms specified in the Settlement Agreement in all instances and require revisions. Even the "final" versions of policies have not been implemented or put into practice as evidenced by the documentation in medical and mental health records. There is no system of quality assurance or

protocol for self-review of compliance with policies. Further, the policies consistently identified as critical, suicide prevention and therapeutic restraint and seclusion, are still in draft form and have not been implemented. There are no safe cells in the jail. Cluster 1 contains a mixed population and is physically unsafe: inmates are not consistently supervised or monitored by correctional staff and some correctional staff are not consistently supervised or corrected for inappropriate practices. Reports of staff abuse and misconduct should be thoroughly investigated and disciplined. There are significant delays in access to treatment at the jail leading to worsening conditions and placement on lockdown status for untreated symptoms of serious mental illness. This amounts to punishment for having a mental illness rather than treatment. It prolongs suffering and subjects inmates to an increased risk of assault, victimization and suicide. There are insufficient mental health staff to meet the needs of the inmate population at the jail and inadequate treatment space. Access to inpatient and intermediate levels of mental health care is so limited as to be nearly unavailable – and it's certainly not readily or easily accessed. There has been no significant improvement to mental health services available and provided at the jail since my initial baseline report.

Respectfully submitted,

/s/
Kathryn A. Burns, MD, MPH
25 May 2016