ATTACHMENT 1

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October 31, 2007

National Prison Project
Attn: Eric Balaban
915 15th St, NW
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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), St. Thomas, United States Virgin Islands (USVI), and to five persons adjudged not guilty by reason of insanity (NGRI) who are now housed at the Golden Grove Adult Correctional Facility (ACF), St. Croix, USVI.

I site visited the CJC and ACF during August 6, 7, 8, 2007. I had previously made similar site visits during 1994, 2005 and 2006. In addition to reviewing my May 2006 site visit report, I reviewed the following documents as part of this assessment:

1. The Settlement Agreement,
2. Findings of Fact and Conclusions of Law (February 2007),
3. documents produced by Defendants in responses to the February 2007 court order, as well as documents included in Appendix III to this report
4. various CJC logbooks, and
5. the classification, medical and mental health records of 19 inmates.

During the morning of August 6, 2007 I interviewed Leighman Lu, M.D., Lisa LaPlace, R.N. and correctional officers in Clusters 1, 2, 3, 4, 5, & 6. I also

interviewed Agnes George (Warden–CJC) and Jennifer Charles, MSW (mental health coordinator at ACF).

At CJC, I briefly interviewed in two group settings seven male mental health caseload inmates housed in Cluster 3. I also interviewed the five persons at ACF found NGRI.

Appendix I provides a summary of these interviews and my review of selected healthcare records.

Introduction

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. Sentenced inmates, with few exceptions, who typically have less than a year remaining on their sentences, are transferred to the CJC Annex, which also houses a limited number of federal and/or immigration detainees.

The prisoners (also referred to as inmates in this report) are housed in seven housing clusters. The capacity of these clusters 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. Cluster 3 houses mentally ill prisoners, and some protective custody inmates, who cannot safely be housed with the general population. All of the cells are double-bunked. There are no single cells at the jail (although there are inmates who have been single bunked due to safety reasons, including one inmate in Cluster 3 who has been singled bunked for over two years), and no cells are specifically designated for mental health observation or suicide watch.

There 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 about 89 inmates. The average monthly admissions over the past year have been 102 inmates. See Appendix III, Ex. T.

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. There are occasional federal detainees at the Annex. There is currently one registered nurse (Odulia Anderson) who works at the facility 20 hours per week (five days per week). Galen Hall, M.D. provides physician services up to 10 hours per week.

The Bureau of Correction (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 CJC head nurse, acts as an informal gatekeeper. Ms. LaPlace was aware of four inmates with mental illnesses being transferred to the CJC Annex during different weekend days, which was brought to her attention on the first Monday following their transfer.

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, due to obstacles to transfers rather than a lack of clinical need for transfers.

Agnes George remains the CJC's warden. Rosaldo Horsford (ACF warden) is no longer the acting head of the BOC. He was recently replaced by Alvin York, who was the BOC's acting director in 1996-97. Vincent Frazier was confirmed as Attorney General in mid-2007, and John DeJongh was sworn in as Governor in early 2007.

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.

The next section of this report will provide my updated findings based on this site visit.

Staffing

Physician staffing

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. Dr Less has announced his intention to retire by the end of the year. 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.

Nursing staff

During April 2005 Ms. LaPlace was hired as the Territorial Nursing Coordinator. 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. See Appendix III, Ex. D (2007Progress Report) at Ex. B. 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 last year, has duties that include scheduling appointments, assisting Dr. Less with examinations, and distributing medications. She cannot under her license assess prisoners for sick call. One of the part time LPNs has announced her plan to retire at the end of October 2007.

The head nurse position at CJC remains vacant, but is functionally filled by Ms. LaPlace. As a result, Ms. LaPlace has little time available to fulfill her duties as Territorial Nursing Coordinator. Ms LaPlace 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

did tell me that she had identified candidates to replace her over the past year, but that these candidates took other positions because the CJC head nurse position was not an approved vacancy she was authorized to fill.

Warden George, however, indicated that a head nurse position was still open at CJC, but vacant due to recruitment difficulties.

Mental health staffing

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.

Both Dr. Less and Dr. Lu are on-call 24 hours per day.

During March 22, 2006, the Court ordered the Defendants to submit a staffing plan for the CJC and the Annex. To date, the BOC has not produced a comprehensive staffing plan, noting hours, vacancies and Notice of Personnel Action (NOPA) status. Ms. LaPlace did create a list of vacant health care positions for the CJC and Annex in May 2007. See Appendix III, Ex. C, memo dated May 7, 2007. That list does not include filled positions, does not list the hours of service for the vacant positions, and does not indicate whether the positions have NOPAs and budget control numbers.

Ms. LaPlace provided the following information about the current (and requested) staffing at the CJC and Annex:

Annex

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

Ms. LaPlace identified candidates for the unfilled positions at the Annex and submitted applications to the Department of Justice's department of personnel about four months ago. Ms. LaPlace was unclear whether these positions have

been created. She also said she was confused about the process for creating these positions as well as the NOPA process.
CJC
Physician (10 hrs-filled)
Psychiatrist (10 hrs - filled)
Head nurse (FTE position-vacant)
Mental health specialist (10 hrs, created but vacant)
NP/PA (FTE position requested but not created)
RN (20 hrs- position requested but not created)
LPN (FTE-filled)
2 LPNs (10 hrs each-filled)
Social worker (10 hrs, filled but not functional—essentially vacant for the past 7 years)
Psychologist (10 hrs, position requested but not created)

Ms. LaPlace drafted a job description for the Medical Director position at the request of Richard Schrader, Jr. and Eliza Joshua (Department of Justice personnel department). See Appendix III, Ex. D. She consulted with colleagues at the RLS Hospital for models. Ms. LaPlace did not know if her draft job description was approved.

On June 19, 2007, the personnel department sent to Ms. LaPlace, at her request, a memorandum listing all BOC heath care vacancies that have existing NOPAs and budget control numbers. See Appendix III, Ex. F. However, the vacancy list did not include positions for which a NOPA is pending, or positions with a NOPA but no budget control number. Also, the memo does not list vacancies by facility (e.g., CJC, ACF, Annex, Forensic Facility). Therefore, it is very difficult to know what this document means in terms of staffing for the CJC.

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 Defendants to hold monthly management team meetings with BOC leadership where health care is a permanent agenda item. [Mar. 22, 2006 Order ¶4]. The Court also ordered the Government to provide a laptop computer to Mr. LaPlace so she could carry out her duties as a territorial nursing coordinator. [Mar. 22, 2006 Order ¶8].

I previously reported that during November 2005 Dr. Olaf Hendricks resigned from his positions as the BOC's medical director and as the lone treating psychiatrist at ACF. I was told last year that a NOPA was in process to replace Dr. Hendricks, although it was unclear when the NOPA process would be completed.

Last year, Ms. LaPlace had proposed that Dr. Less' hours be doubled to 20 hours per week in order to have him serve as an interim medical director. This proposal included changing Dr. Hendricks' NOPA to create two separate NOPA's—one NOPA for a medical director position and one NOPA for a psychiatrist's position at ACF. The BOC never determined the number of hours for each of these proposed positions, nor had it decided whether it would split Dr. Hendricks' NOPA.

The medical director's position remains vacant, and Dr. Less has told the BOC he is not interested in being interim director. The NOPAs were reportedly never processed by the Department of Justice's personnel department.

In fact, as of May 2007, the BOC did not have a budget control number for the position, although there is a budget control number for a health services administrator. See Appendix III, Ex. F, June 19, 2007 memorandum to Ms. LaPlace from Eliza Joshua. This position is funded at an annual salary of $60,000. However, the approved job description of the health services administrator position is apparently lacking. In other words, there appear to be major obstacles to filling the vacant medical director's position originating from the department of personnel

In May 2007, Ms. LaPlace proposed that the BOC sign a contract with Charles Braslow, M.D., who is now in private practice in St. Croix, to "assist the BOC in developing and implementing Medical Policies and Procedures, the Organizational

Chart, Continuous Quality Improvement Program and Infection Control Program." See Appendix III, Ex. D at Ex. A. Dr. Braslow would be responsible for recruiting and interviewing candidates for the Medical Director of Health Services for BOC. Dr. Braslow told Ms. LaPlace he also was willing to negotiate memoranda of understanding (MOUs) with outside agencies and vendors to obtain lower-cost medications, medical services, and supplies. Ms. LaPlace suggested a one-year contract for Dr. Braslow. Ms. LaPlace has not received a response from the BOC to her proposal. Since making the proposal last May, she has not spoken with Dr. Braslow to determine if he remains interested.

Dr. Lu, as in the past, said that he did not consider himself to be in charge of mental health services at the jail.

The BOC has also produced a health care organizational chart. See Appendix III, Ex. D at Ex. C. Essentially all the key positions (medical director, mental health director, and territorial nursing coordinator) are vacant. Despite her title as Territorial Nursing Coordinator, Ms. LaPlace continues to work full-time as the head nurse at the CJC. She reported being unable to hire her replacement 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.

Warden George told me, however, that there is a vacant head nurse position at the CJC, and that it had not been filled because of recruitment difficulties. If Warden George is correct, then Ms. LaPlace has been unable to hire her replacement because she does not know there is a vacant position. Again, the BOC must establish reliable communications between custodial management, its office of personnel, and health care staff. This cannot be done without strong health care leadership.

The mental health director position is vacant. Jennifer Charles, MSW was recently hired as a mental health coordinator for ACF. I briefly interviewed Ms. Charles, who returned to work at ACF on June 20, 2007 after a prolonged stress leave that began during 2006. Ms. Charles stated that there is a written job description for her position, although it was not relevant to her actual job. I reviewed the mental health coordinator job description, approved on July 25, 2006, which appears to be more consistent with a director job description than a coordinator description. It was clear that Ms. Charles does not perceive her job to be the BOC director of mental health. Her job is appropriately restricted to coordinating mental health services for inmates at ACF, given her qualifications.

In my May 2006 Report, I found that Ms. LaPlace had taken part in two meetings with BOC leadership, although minutes were not kept, and that there were no regularly scheduled meetings regarding health care services. I recommended that management team meetings be held at least monthly, and minutes should be distributed to all attendees. As I understand it, my recommendation is now court-ordered. Carty v. DeJongh, Civil No. 94-78, Order (D.V.I. Nov. 20, 2006) ¶1.

Ms. LaPlace has met with Attorney General Frazier once since he took office, in April 2007. One month later, Attorney General Frazier appointed Ms. LaPlace to head the Medical Assessment Team (MAT). See Appendix III, Ex. D at Ex. I. The MAT was charged with providing the Attorney General with a report on the condition and needs of the medical care units, including an inventory of needed supplies and equipment to bring the facilities "up to constitutional standards;" and a recommended staffing list. In addition to Ms. LaPlace, Attorney General Frazier appointed Dr. Park (ACF physician) Dr. Less, RN Qualey (ACF), LPN Moise (ACF-Detention) Dwayne Benjamin (prison compliance coordinator), and Jennifer Charles (mental health coordinator) to the MAT.

The MAT completed its report on June 10, 2007. Ms. LaPlace told me that she had not spoken with the Attorney General since the MAT gave him the report, and she knows of no actions that have been taken as a result of the report. The MAT has not scheduled any more meetings until it hears back from the Attorney General.

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. In August 2006, Ms. LaPlace asked then-Director Horsford to arrange monthly meetings between health care and custodial staff regarding operations at the Annex. See Appendix III , Ex. H, November 6, 2006 Memorandum from Lisa LaPlace Knight, R.N. to Director Horsford. Ms. LaPlace was prompted to ask for these meetings after a series of snafus plagued the opening of the health care office at the facility.[1]There have been no such meetings to date.

[1] The Annex began accepting prisoners in May 2006. Three months later, Ms. LaPlace described the conditions in the health care office as follows, "Ms. Anderson hired part-time 20 hours week RN . . . . Awaiting access to Medical office. Equipment arrived but not set up. Then when set up not as requested by Territorial Coordinator. Privacy compensated. No garbage can, no privacy screen, no water source, fire hydra[nt] hung where inmate may use as a weapon, exam table

On August 8, 2007, I spoke with Warden George. She acknowledged that she does not meet formally with either Dr. Lu or Ms. LaPlace about mental health issues at the jail. Information obtained from Ms. George concerning the mental health services at the CJC was, at times, inconsistent with my findings. For example, she described Dr. Lu as being involved in the decision process to place inmates on, or remove them from, suicide watch. Dr. Lu was generally not involved with such decisions. Warden George also said that either Dr. Lu or Ms. LaPlace was involved in the decision to admit and discharge prisoners from Cluster 3. However, Ms. LaPlace and Dr. Lu described little, if any involvement, in such decisions. Other examples can be found in this report.

Ms. LaPlace described significant problems in communicating with the Department of Justice's personnel department as well as the Department of Justice's financial section. The department has failed to provide Ms. LaPlace with requested job descriptions, and has not answered her requests for updates on the status of personnel decisions. For example, Ms. Josiah failed to show up at a scheduled meeting she had with Ms. LaPlace to discuss the status of health care positions and vacancies. See Appendix III, Ex. C, June 10, 2007 Medical Assessment Team Rpt. at 2. Because of her poor working relationship with the personnel department, Ms. LaPlace was very unclear how the hiring process worked and what positions have been created and/or are ready to be filled.

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

In February 2007, Acting Director Horsford asked Ms. LaPlace to develop a budget for BOC health services. On February 8, 2007, she spoke with BOC Director Horsford's secretary, and proposed estimated costs for one year. See Appendix III, Ex. C, Feb. 14, 2007 memorandum from Lisa LaPlace-Knight. Ms. LaPlace does not know if the BOC has developed a health care budget, and has had no further conversations with either the BOC Director or the Attorney General about developing a budget.

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missing part and torn fabric to cover. Build-in cabinet not where requested and no consultation with Territorial Coordinator as to reason for the need to change from requested placement. Improved communication between Health Services and Security Staff would be recommended. Suggest monthly meetings to develop policies for Annex. It is not clear as to what type of client will be housed at [the Annex] and the procedure to have patients seen at CJC by Dr. Less." See Ex. H.

According to a newspaper article, on June 29, 2007, Attorney General Frazier appeared at a hearing before the Virgin Islands Senate Finance Committee on the proposed budget for the Department of Justice. The proposed budget had a single line item for $5,201,970 to cover "professional services, inpatient and outpatient services, repairs, and travel." See Appendix III, Ex. J. The Government failed to provide the budget documents it submitted to the legislature by the time of my site visit, as requested by class counsel

A laptop computer has been provided to Ms. LaPlace.

Mental health policies and procedures have not been completed, let alone implemented. This is primarily related to the absence of a medical director, a director of mental health, and a shortage of mental health staff positions. Ms. LaPlace told me that there has been no work done on the draft policies I reviewed in May 2006 because the BOC has not hired a medical director to replace Dr. Hendricks.

Assessment: My assessment from my April 2005 report remains essentially unchanged. A reliable mental health system is based on a set of appropriate policies and procedures, which guides staff in delivering services. Policies and procedures will not be successfully developed and implemented without strong leadership. The BOC has not had a medical director for close to two years, and there are no concrete plans to hire Dr. Hendricks' replacement. It is clear that no one is in charge of mental health services in the BOC, and the Bureau has not established a clear health care management structure. The absence of established mental health care leadership and healthcare policies for the BOC have resulted in serious deficiencies in the mental health services at the CJC. Many inmates with serious mental illness have received inadequate mental health treatment.

As I stated in my May 2006 report, Defendants cannot devise a reasonable quality improvement (QI) program until a complete set of health care policies is developed. CJC currently conducts no QI activities, and there is little, if any, oversight of mental health services.

There is a very problematic working relationship between health care staff and several key offices in the Bureau of Correction, including the personnel and finance departments. Ms. LaPlace's requests for the authority and/or assistance to hire staff for key health care positions have often gone unanswered by the BOC. As a result, key health care positions remain vacant, with no concrete action by the

Bureau to fill them. If Warden George is correct, Ms. LaPlace has not been told that there is a vacant head nurse position available for her to hire her replacement. Also, the BOC continues to operate without a specified health care budget, even though it provides services to over a 1000 prisoners in the territory.

Recommendations: The infrastructure of the mental health system is lacking and 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 II.
3. A reasonable working relationship between custody and healthcare management staffs.
4. A hiring process 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 budget, which includes mental health services.

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. See Appendix III, Ex. D at Ex. C.

Although I think that hiring Dr. Braslow would potentially have been very helpful in the development of a healthcare system within CJC, I am very pessimistic how much Dr. Braslow could have accomplished without controlling an adequate healthcare budget, and receiving direct and ongoing support from the Attorney General and the Governor, while also having the independence and power to build a health care system from the ground up. Even if his proposed contract had been approved, Dr. Braslow would not have acted as an interim medical director. He

would not have had the power to hire, fire, or discipline personnel. He would not have supervised the physicians or health care staff, and he would not have provided any direct services.

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 needlessly suffered. Most striking is that fact that Jonathan Ramos and prisoners adjudged NGRI continue to languish in BOC facilities, despite court orders entered over two years ago requiring that they be hospitalized. Absent more action by the Court, I can see no realistic prospects for the kind of systemic improvements in the BOC's health care system that are long overdue.

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 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].

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. See Appendix I. Ms. LaPlace said that no formal training has been 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.

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 physician's intake history and physical examination. Unfortunately, this examination does not include an adequate mental status examination.

Most of the active health care records have been combined although Dr. Lu has continued to have a small number of patients who have separate medical and mental health charts (see Appendix I).

Ms. Latimer, the jail's 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 did perform at the time of my last visit.

In May 2007, Ms. LaPlace submitted a "Mental Health Services Proposed Plan" which includes proposed changes to intake procedures for mental health assessment. See Appendix III, Ex. C. 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."

Ms. LaPlace told me that she had not received a response from either the BOC or from 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 were not identified at intake as needing mental health services.

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 August 6, 2007. Dr. Lu reported averaging five days per week of coverage at the CJC, which he said generally involve 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 indicated that he is likely to retire at the end of September 2007 if the pay issue has not been resolved. However, he reported being open to remaining in his role at CJC if his contract was increased to the equivalent Department of Health per diem rate of $214 per hour.

Ms. Laplace proposed raising Dr. Lu's salary to $200 in her Mental Health Services Proposed Plan. Appendix III, Ex. C. Ms. LaPlace told me that she had submitted the plan to the BOC and Attorney General's Office, but had not received a response to it.

The BOC would have significant problems recruiting a replacement psychiatrist for Dr. Lu should he leave. Dr. Lu told me that there are currently a total of four psychiatrists on the Island, one of whom does not have license to practice medicine in the Virgin Islands.

It appears that Dr. Lu is 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.

In April 2005, I found that 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 no change in the nature of the direct treatment services provided by Dr. Lu since my April 2005 site visit.

In early 2006, Dr. Lu informed the territorial court the he would no longer perform court-ordered forensic evaluations. However, Dr. Lu resumed performing court ordered forensic evaluations shortly after my May 2006 site visit. It is unclear to me how much of his time at the CJC involves these assessments; however, court ordered forensic evaluations often involved multiple interviews in order to obtain the needed minimum database for them.

Dr. Lu reported very little involvement in the decision whether to admit and/or discharge inmates from Cluster 3. This was confirmed by my review of medical records. See Appendix I. However, correctional officers told me that all such decisions were made by Dr. Lu.

Mental health referrals from Ms. LaPlace and custody staff generated a significant proportion of Dr. Lu's daily schedule. There was not a systematic way of scheduling patients to be seen by Dr. Lu.

Dr. Lu indicated that he infrequently uses atypical antipsychotic medication because the high costs of these medications are raised with him when he prescribes them. He stated that laboratory studies relevant to drug screening have become problematic because they are not available.

Dr Lu said that the combining of the medical and mental health records of active mental health patients had decreased his access to medical records in a timely fashion due to the absence of medical records staff. Dr. Lu stated that it was common for him to see patients without the medical record. During the past three to four months he has not been documenting his meetings with patients when the medical record is not available, which has caused obvious documentation issues.

Dr. Lu made it very clear that he is not in charge of the mental health program at CJC. He has had some contact with Jennifer Charles, MSW in the context of temporary transfers of inmates from ACF for psychiatric consultation. However,

he does not know information relevant to her job description or her responsibilities.

Dr. Lu estimated that the mental health caseload during 2006 averaged 18 to 20 inmates. He thought the mental health caseload during 2007 averaged about 14 inmates at any given time. On August 6, 2007 there were 11 inmates on the mental health caseload.

Dr Lu said he rarely went to Cluster 3.

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.

Dr. Lu said that he is not involved with the decision whether or not to transfer an inmate to the CJC Annex. In addition, he does not provide any treatment to inmates at the CJC Annex.

As I have previously reported, there still is not a process in place that triggers a mental health assessment for inmates with serious mental illnesses after they are involved in disciplinary infractions. In my review of records and incident reports, I continued to document assaults that involved inmates with serious mental illnesses. See Appendix I. Ms. LaPlace estimated that she receives information from custody staff concerning approximately 20% of such incidents. Dr. Lu reported not being notified as a matter of course about such incidents, which was confirmed by my review of records.

As a result, inmates with serious mental illnesses may be punished, instead of receiving appropriate treatment, for behaviors that directly relate 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.

Warden George said that either Ms. LaPlace or Dr. Lu would be notified every time a mental health caseload prisoner was involved in a disciplinary or violent incident at the jail. This was inconsistent with my own record review.

Warden George also said that deputies record in incident reports all violent or unusual behavior by mentally ill prisoners, and that the shift supervisors review all daily logs and incident reports to ensure that deputies do prepare appropriate reports. Again, I reviewed a number of logs documenting mentally ill prisoners

exhibiting violent or unusual behavior, but there was no corresponding incident report, and these prisoners were not referred to Dr. Lu for an 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 last year 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

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.

The mental health specialist, Ms. Latimer, no longer works at the CJC, and the jail has not hired her replacement. In October 2006, Ms. 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. I reviewed the healthcare records of 14 inmates who are or were receiving mental health services at CJC. Refer to Appendix I which documents my assessments, which are also summarized in the next section entitled "Assessment."

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 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. In October 2006, Ms. LaPlace did identify a candidate (Bentley Thomas) who was willing to return to the CJC to fill the social worker position at a higher rate of pay. See Appendix III, Ex. C, Oct. 12, 2006 memorandum from Lisa LaPlace-Knight, RN. That candidate was not hired by the BOC, and Ms. LaPlace has not heard from the personnel department about her request to hire him.

Assessment: There is no change in my current findings as compared to my 2006 site visit. 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. Dr. Lu estimated that there were generally 13-14 inmates being prescribed psychotropic medications at CJC at any given time during the past year. Review of records indicated that many of his contacts with mental health caseload prisoners occurred in the nurse's office during pill pass.

My review of medical records 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.
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 not a process in place that triggered 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 issues 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 is also not involved in the disciplinary process for mentally ill inmates.
10. There is inadequate clinical intervention for prisoners who are non-compliant with their medication orders.
11. Mental health records are still not yet fully integrated with the medical record.
12. There is inadequate discharge planning.

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 Defendants to hire a medical records clerk to maintain health care files at the jail. [Mar. 22, 2006 Order ¶5].

During my April 2006 site visit, I noted significant problems with the current health care record system that were caused by jail's maintaining multiple health care records for the same inmate, and by not having medical records staff to organize and maintain the files. It was extremely difficult to document and assess a specific inmate's course of treatment with the disorganized records system. This had current and future treatment implications. Specifically, it is much more difficult to determine the adequacy of treatment when clear documentation relevant to an inmate's treatment program is lacking or difficult to obtain.

Since my 2006 site visit, the Defendants have hired a civilian, Latoya Horsford, on a temporary basis to assist health care and classification staff to file and maintain records at CJC. As of June 2007, 75% of records had been integrated. She has been providing these services for four hours per week for the past several months.

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.]

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, who 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. He stated that inmates in Cluster 3 were supposed to be observed by the correctional officer every 15 minutes, which was not possible due to the officer's other job responsibilities in staffing both of these clusters. He thought that such inmates were generally observed about every 30 minutes. This correctional officer indicated that inmates placed on suicide watch were supposed to be seen every 15 minutes, which was difficult to accomplish for similar reasons. The assigned officer has duties that require him to leave the control office, leaving the Cluster 3 prisoners periodically unsupervised and unobserved. I reviewed the record of one seriously mentally ill prisoner who was able to open his cell door after lockdown while the Cluster 3 & 4 officer was out of the control office. See

Appendix I, Inmate 10. This prisoner was very agitated on the night he freed himself from his cell, and posed a risk to himself and other prisoners.

The Cluster 3 correctional officer thought that the decision to admit and/or discharge inmates from Cluster 3 was made by Dr. Lu, which turned out to be inaccurate. These decisions are made by custody staff with little or no input from Dr. Lu.

The Cluster 3 correctional officer estimated that three inmates per month are placed in in-cell restraints for mental health purposes. The decision to use restraints was made by a supervisor. The correctional officer reported that, at times, Dr. Lu was notified by the custody staff that restraints had been used.

Inmates in this cluster have periodically been triple bunked. For example, as of June 23, 2007, one cell in the cluster had held three prisoners for at least two weeks. The Cluster 3 deputy also acknowledged that mentally ill prisoners have been triple-celled in Cluster 3.

When prisoners are triple-celled in Cluster 3, one mentally ill prisoner must sleep on the cell floor. This poses substantial security risks, particularly given that the cluster is manned by a single deputy who is responsible for both Clusters 3 & 4. As summarized in my record reviews, mentally ill prisoners housed in Cluster 3 have been involved in multiple violent altercations with both deputies and fellow prisoners.

The overcrowding in Cluster 3 has been exacerbated in recent months because the cluster has also been used as a protective custody unit. In the past year, a protective custody prisoner (N. Parker) was single-celled in Cluster 3 for several months, even though he was not on Dr. Lu's roster, and did not receive mental health treatment. As a result of his being single-celled, and of Jonathan Ramos being single-celled, the Cluster only had 8 beds available for mental health caseload prisoners.

We also smelled marijuana smoke prior to entering the custody station for Clusters 3 & 4. We observed the cells in Cluster 3, which had just been cleaned. Despite the cleaning, the smell from several of the cells related to hygienic issues was obvious. Review of the daily custody sheet had indicated that the cell conditions in Cluster 3 were very poor at times.

I interviewed all the inmates in Cluster 3 in two separate small group settings within the law library, which was problematic. The supervisor did not allow us to use the day room within Cluster 3, as I had on my previous site visit, due to reported security concerns.

Inmates in group 1 (see key to Appendix I) all demonstrated obvious symptoms of a serious mental disorder, which included agitation, responding to internal stimuli, gross thought disorder and withdrawn behaviors. Inmate 10 was periodically agitated and Inmate 6 was very withdrawn. Inmate 21 was disorganized in his speech.

Inmates in group 2 were generally very reluctant to discuss issues related to mental illness problems. Inmate 22 denied having any mental health problems but complained about behaviors demonstrated by his cellmate. He acknowledged receiving psychotropic medications. Inmate 2, who appeared disorganized, was unwilling to state his name and was withdrawn throughout the interview. Inmate 23 was withdrawn throughout the interview. Inmate 11 appeared disorganized and was very sparse in his speech.

Inmates from both groups acknowledged access to the dayroom during most of the day except during lockdowns. They also stated they had access to the outdoor recreational area about one hour per day. Information provided by the inmates relevant to access to Dr. Lu was variable.

Several inmates reported having had periods of time when they were restrained although the information provided by them relevant to these episodes was rather vague.

Inmate 10 reported lack of access to phone calls to his mother related to financial issues. He reported that he wanted to talk to his mother in order to arrange for a custodian in order to be bailed out.

Assessment: My opinion regarding this housing unit remains unchanged from my prior site visits. Cluster 3 does appear, based on inmate interviews, to provide a safer environment 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 in-patient 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 documented in my review of records section. See Appendix I. The absence of adequate psychosocial services can also lead to 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.

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 appropriate for these units generally have had significant difficulty functioning in a general population environment due to symptoms related to their serious mental disorders.

Recommendations: 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 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.

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

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

There has been no change in suicide precautions or the use of restraints/seclusion since my previous site visits.

Ms. George said that all prisoners who were placed on suicide watch were referred to Dr. Lu for an assessment, that Dr. Lu generally made the determination whether to initiate and discontinue suicide precautions, and that the only time that prisoners would be put on suicide watch absent an order from Dr. Lu was when Dr. Lu was not on-site. This was inconsistent with Dr. Lu's description of his role in suicide prevention practices.

Dr. Lu reported minimal involvement in the decision leading to inmates being placed on or taken off suicide watch precautions. Dr. Lu thought that all such inmates would be placed in Cluster 3. However, correctional officers indicated that the suicide watch precautions could be initiated anywhere in the CJC, although inmates on such watch were frequently housed in either Cluster 6 (the intake unit) or Cluster 3.

There are 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. As during prior site visits, I was also told that some prisoners are moved for suicide watch. These prisoners are usually transferred to Cluster 6, where deputies cannot directly observe prisoners inside their cells. Deputies generally receive an order to initiate suicide watch from the shift supervisor. The deputies record their checks of these prisoners in the cluster logbook.

During the morning of August 6, 2007 I visited Cluster 1, where inmates reported that the dayroom phones and television were not functioning. There were two correctional officers for Clusters 1 & 2, with one of the officers sleeping and/or

very drowsy and rather incoherent during our attempted interview with him. The other correctional officer in the office, who had been working in the system for 18 years, reported not having ever received training relevant to mental health issues or use of emergency equipment or suicide attempts (e.g., cutdown tools, Ambu bags). Such equipment was not available to the correctional officers.

The alert correctional officer in Cluster 1 indicated that inmates were placed on suicide precautions by the Warden, who conveyed the information to the supervisor, who then conveyed the information to the line staff. Inmates placed on suicide watch were reportedly observed every 30 minutes by correctional staff. There were no special cells used for suicide watch precautions. The correctional officer indicated that generally suicide watch precautions occurred in Clusters 3 & 6.

I also visited Clusters 5 & 6 during the morning of August 6, 2007. The correctional officer reported that they were currently about four inmates on 15 minute watch related to the nature of their crime in contrast to suicide precautions. This information, which appeared to be accurate, was not consistent with information obtained from the correctional officer from Clusters 1 & 2. This correctional officer confirmed that inmates could be placed on suicide watch in any of the housing units within CJC.

Cluster 5 had much better, although still limited, observation of the cells from the correctional officers' perspective in contrast to Cluster 6.

The correctional officer in Cluster 5 & 6, who had been working at CJC for eight years, confirmed that he had not received any training relevant to mental health or training relevant to cardiopulmonary resuscitation (CPR). Cutdown tools and Ambu bags were not present in the control office. The first aid kits within the unit were inadequately stocked.

Cut down tools were not available in any of the housing units nor were mouth guards/ambu bags which could be used for CPR.

Dr. Lu appeared to have very little knowledge regarding the use of restraints for mental health purposes at CJC and aid he was not involved in the decision either to put someone in restraints or remove them from restraints.

I reiterate my assessment of suicide precautions from my last report. 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. Dr. Lu's lack of involvement with suicide precautions and the use of restraints is also a matter of concern and likely reflect both the lack of adequate communication with the custody staff concerning issues relevant to suicide prevention and the use of restraints, as well as inadequate mental health staffing allocations at the CJC.

Ms. LaPlace has contacted Dr. Tom Tyne, a psychologist on St. Thomas, to perform a series of in-service workshops for corrections staff on mental health issues, including suicide prevention. Ms. LaPlace submitted her proposal to Attorney General Frazier, and asked for budget authority to complete a contract with him, but has not heard back from Mr. Frazier. As of August 8, 2007, no in-service classes had been offered for many years (according to information obtained from correctional officers).

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.

Assessment: The suicide prevention program at CJC is not adequate. Mental health staff is infrequently involved in the suicide precautions process (e.g., initiation, assessment, or termination of suicide precautions). The cells used for suicide watch are very problematic from a physical plant perspective. They are not retrofitted for suicide prevention purposes and significant visibility issues exist. Fifteen minute checks are very difficult to perform due to custody staffing issues.

Since it is very common for healthcare staff to not be notified about inmates being placed on suicide precautions, and given staffing allocation shortages, such inmates may not receive timely mental health interventions.

Recommendation: 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 training also needs to be provided concerning CPR.

ACUTE REFERRALS & HOSPITALIZATION

Under the Agreement, Defendants must transfer all prisoners in need of emergency mental health intervention or hospitalization to either the Roy L.

Schneider Hospital or a community mental health center (CMC). [SA ¶¶IV.V.2-3, 6.

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.

Recommendations: CJC should develop an MOU with a hospital that provides inpatient psychiatric care that describes the procedure for admitting and discharging CJC inmates that should include the criteria for admission and discharge.

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

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. [Sept. 8, 2004 Order]

During my 2006 site visit, I spoke with BOC Director Rosaldo Horsford regarding the BOC's efforts since my April 2005 tour to construct and open the forensic facility. This facility had not yet been opened. Mr. Horsford indicated that construction issues currently focus on a sewage line and the electrical system. No other construction had occurred except for the pouring of a concrete floor for a conference room. The BOC did submit a supplemental budget request for 34

correctional officers and healthcare staff positions during the fall 2005. Mr. Horsford believed that the budget request had been approved. He did not know of any recruitment efforts by the BOC to hire staff for the facility.

As of May 2006, there had apparently been some discussions with the Department of Health about contracting out the mental health services for this forensic unit, although Director Horsford described these discussions as very preliminary in nature and inconclusive. The BOC did not implement my recommendation last year that it consult with an expert experienced with architectural/treatment issues for a forensic facility. I again provided the BOC with a referral to Joel Dvoskin, Ph.D.

It appears that the BOC has made little progress in the past year to open the forensic facility, given the limited information I have received.

As of November 2006, Defendants had made no effort to complete a contract with the Department of Health to operate the forensic facility. See Appendix III, Ex. I, Defendants' Responses to Plaintiffs' First Set of Interrogatories, response to Interrogatory 18. They had not hired any personnel for the facility, had not hired a construction firm, nor contacted any consultant to assist them in constructing and opening the facility. Nor had they developed a staffing plan, construction time line, construction budget, or operational budget for the facility.

According to a newspaper report, Attorney General Frazier on June 28, 2007 told the Virgin Islands Senate Finance Committee that he had offered the job of facility director to a psychologist, and that his goal was to complete the facility by the end of the year.

During my site visit, I asked to speak with BOC staff person who could describe to me the Government's efforts over the past year to construct, staff, and open the forensic facility. No one spoke with me about the facility during my tour.

Recommendations: I reiterate my previous recommendations that the BOC 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 should be hired well in advance of the unit's opening, so that they can develop policies and procedures and hire key staff. The BOC should also develop a budget and a timeline for the construction project, and hire either a construction firm with experience building forensic facilities, or a consultant to help oversee

the project. It is my understanding that these recommendations are now court ordered. See Carty v. DeJongh, Civil No. 94-78, Order (D.V.I. Nov. 20, 2006).

QUALITY IMPROVEMENT PROGRAM

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.

MEDICATIONS

The jail still does not have a formulary. Last year, Darby, the medications vendor, was bought by Henry Schein, Inc. On October 12, 2006, Ms. LaPlace wrote to Attorney General Kerry Drue asking for authority to pursue a new medication vendor. The BOC had been experiencing difficulties with the current vendor in obtaining medications in a timely manner. Ms. LaPlace was particularly interested in soliciting a proposal from Doctor's Choice, which has local pharmacies in the territory. Ms. LaPlace has not received a response to her request. Now, Ms. LaPlace purchases from local pharmacies medications that she cannot obtain from Schein.

The CJC's medical office also does not have a working fax machine, so staff cannot fax medication orders to the vendor or to local pharmacies.

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

NGRI Inmates

As of late 2004, the BOC transferred four prisoners from the CJC to Golden Grove after they were deemed not guilty by reason of insanity (NGRI). The four prisoners are Inmates 15, 16, 17 & 18 (see Key to Appendix I). Following a July 19, 2004 hearing, the Court ordered the Government to transfer all of the NGRI patients to an appropriate forensic unit by August 19, 2004. [July 21, 2004 Order ¶ 1]. These prisoners were transferred to the forensic unit at the Juan Luis Hospital in St. Croix in 2005, and were moved back to ACF seven weeks later. On March 22, 2006, the Court entered the following order:

> Defendants shall move the four prisoners adjudged not guilty by reason of insanity, who have been previously identified in this case, to the psychiatric unit at the Juan Luis Hospital or the Roy L. Schneider Hospital or to both hospitals, as the case might be, until such time as the Defendants complete retrofitting and staffing an appropriate forensic unit at the Golden Grove Correctional Facility.

[Mar. 22, 2006 Order ¶10].

As summarized in my May 2006 report, the four NGRI patients were receiving grossly inadequate mental health treatment at that time. They received psychotropic medications that were last ordered during April 2005 without any further monitoring of these medications by a physician.

I had noted that each patient had been hospitalized at the Juan Luis Hospital (JLH) for about 7 weeks until their discharge in April 2005, with clinical improvements being documented. The four NGRI patients were discharged because JLH staff was concerned that the hospital's accreditation would be jeopardized if they remained housed there.

In May 2006, I also toured the "temporary" forensic unit under renovation at ACF, which was clearly not yet completed.

During my 2006 site visit I learned that no psychiatrist has been on staff at ACF since Dr. Hendricks' resignation five months earlier, and that there was no current mental health staff providing services at the prison. Ms. LaPlace did describe a staffing plan for the prison, but it was my opinion that it was unlikely to be implemented in the near future given the unwieldy and time-consuming NOPA

process, and the lack of medical leadership in the BOC. As result, the four patients would continue to languish untreated in the jail.

I had recommended that these patients be immediately assessed "by a psychiatrist relevant to their current psychotropic medications as well as ongoing monitoring." I also recommended that they be transferred to an appropriate mental health treatment setting.

During my August 7, 2007 site visit to ACF, Jennifer Charles, MSW reported that the psychiatrist position there had remained vacant until very recently when arrangements were made to have Dr. Hendricks provide limited psychiatric care to inmates at ACF, including the current five NGRI inmates. It was not clear to me the number of hours of coverage that are provided by Dr. Hendricks. Despite Dr. Hendricks' contract, as per the June 2007 medical assessment team report, the healthcare staffing situation at ACF is "at a critical level."

Unfortunately, I learned during my August 7, 2007 site visit that these four NGRI patients, along with one additional NGRI patient (Inmate 19 – see key to Appendix I), remain housed in general population units at ACF. I briefly interviewed Inmates 15, 16, & 18 in a group setting. See Appendix I. None of these inmates were able to clearly state the reason they were currently incarcerated. All of these inmates reported receiving medications. They provided inaccurate information regarding the frequency of being seen by a psychiatrist.

These inmates reported generally not being locked down in their cells. None of them were receiving any form of ongoing mental health counseling, although they had recently been informed by Ms. Charles that she would be starting some group therapies for them.

I interviewed Inmate 17 individually. He also reported receiving psychotropic medications. The information obtained from him was similar to the information obtained from the other inmates.

I reviewed the healthcare records of these inmates. Appendix I summarizes my findings.

These inmates, who all experienced significant symptoms of serious mental illness, were receiving inadequate psychiatric treatment that was also dangerous due to lack of adequate monitoring related to both their clinical conditions and prescriptions of psychotropic medications.

It was my understanding from Warden George and Defendants' Responses to Plaintiffs' First Set of Interrogatories at 9 (response to Interrogatory 20) that the Government had not contacted any psychiatric facilities about these men since March 2006, when Warden George called six "maximum security forensic hospitals" about accepting them.

I spoke briefly to Warden George about her past attempts to transfer the NGRI inmates to an appropriate forensic facility. Because there are clinical issues surrounding such potential transfers that are clearly not within Warden George's expertise, it is not surprising that these transfer attempts have been unsuccessful. It is my recommendation that the responsibility for arranging such transfers should be the responsibility of a Department of Health's mental health clinician and coordinated with the BOC.

Recommendations: These inmates need immediate assessment by a psychiatrist relevant to their current psychotropic medications as well as ongoing monitoring. They should also be transferred to an appropriate mental health treatment setting.

2007 Summary

There is very little change from my 2006 assessment. Significant problems continue to exist relevant to the CJC mental health system, although there were some positive finding present.

As during 2006, positive findings included the following:

1. Lisa LaPlace, R.N., who provides the glue for the very fragile healthcare system at CJC, has filled the position of Territorial Nursing Coordinator. However, due to staffing vacancies and allocation issues, she remains functionally as the head nurse at CJC and is unable to devote much time in the role of Territorial Nursing Coordinator.
2. Cluster 3 does appear 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.

Negative findings included the following:

1. The BOC medical director position is vacant.
2. Essentially all of the key leadership positions in the current healthcare

organizational chart are vacant.

3. There is not an established budget for the healthcare services.
4. 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. This problem is directly related to the three previously listed problems.
5. 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 relevant to mental health issues.
6. There are significant problems related to the mental health assessment process due primarily to lack of adequate numbers of mental health staff and lack of relevant policies and procedures.
7. Treatment plans were absent.
8. There are significant problems related to the provision of timely psychiatric services.
9. Needed psychosocial interventions for inmates with serious mental illnesses are rarely available at the CJC.
10. Group counseling was not available for inmates with serious mental illnesses.
11. Despite providing a better environment for inmates with serious mental illnesses, as compared to the other clusters, Cluster 3 does not provide enhanced mental health programming, or even adequate mental health programming.
12. 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.
13. Inmates in need of inpatient psychiatric hospitalization are not transferred to the Roy L. Schneider Hospital due to significant access problems.
14. There appears to have been little, if any, progress concerning construction of a forensic facility since my May 2006 site visit.
15. An ineffective discharge planning process for mentally ill inmates continues to exist at CJC.
16. The five NGRI inmates at ACF are receiving grossly inadequate mental health treatment. The lack of any psychotropic medication monitoring by a physician is a very dangerous practice.

For ease of reading, the following is a listing of the Recommendations sections of this report. These recommendations are modified versions of recommendations I

made in my May 2006 Report that have not been implemented:

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.

Recommendations: The infrastructure of the mental health system is lacking and 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 II.
3. A reasonable working relationship between custody and healthcare management staffs.
4. A hiring process 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 budget which includes mental health services.

Recommendations: 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 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.

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.

Recommendation: 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 training also needs to be provided concerning CPR.

Recommendations: CJC should develop an MOU with a hospital that provides inpatient psychiatric care that describes the procedure for admitting and discharging CJC inmates that should include the criteria for admission and discharge.

Recommendations: I reiterate my previous recommendations that the BOC 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 should be hired well in advance of the unit's opening, so that they can develop policies and procedures and hire key staff. The BOC should also develop a budget and a timeline for the construction project, and hire either a construction

firm with experience building forensic facilities, or a consultant to help oversee the project. It is my understanding of these recommendations are now court ordered (see Carty v. DeJongh), Civil No. 94-78, Order (D.V.I. Nov. 20, 2006).

Recommendations: D5 NGRI inmates at a cf. need immediate assessment by a psychiatrist relevant to the current psychotropic medications as well as ongoing monitoring. They should also be transferred to an appropriate mental health treatment setting.

Recommendations from prior reports that have not changed and are yet to be implemented:

Recommendations: 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. . . .

Recommendations: 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. I was told that there are only three psychiatrists who provide services on St. Thomas, and therefore there is a strong chance that the BOC would be unable to find a replacement should Dr. Lu decide to terminate his contract. 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.

Recommendations: As I recommended last year, 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.

Recommendations: Correctional officers should 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.

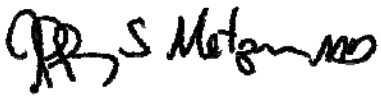
Recommendations: CJC should develop an MOU with a hospital that provides inpatient psychiatric care that describes the procedure for admitting and discharging CJC inmates that should include the criteria for admission and discharge.

Recommendations: The BOC has made little progress in the past year to open the forensic facility. I reiterate my April 2005 recommendation that the Bureau 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 should 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 also develop a budget and a timeline for the construction project, and hire either a construction firm with experience building forensic facilities, or a consultant to help oversee the project.

Recommendations: The NGRI inmates need immediate assessment by a psychiatrist relevant to their current psychotropic medications as well as ongoing monitoring. They should also be transferred to an appropriate mental health treatment setting.

Please contact me if I can answer any further questions.

Sincerely,



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