Redacted Version: Inmates Names Replaced With Pseudonyms

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

C.F., D.M., L.K., A.O. and J.W., individually, and on behalf of all others similarly situated PLAINTIFFS, v. JACK TERHUNE, MARY ELLEN BOLTON, HOWARD L. BEYER, EUGENE F. O'NEILL, JOHN FORKER, DR. THOMAS FARRELL, and DR. RICHARD CEVASCO, CORRECTIONAL MEDICAL SERVICES, INC. AND CORRECTIONAL BEHAVIORAL SOLUTIONS OF NEW JERSEY, INC. DEFENDANTS.	:	Civil Action No. 96-1840 (AET) Honorable Anne E. Thompson

NEW JERSEY PRISON SYSTEM REPORT
OF DR. DENNIS F. KOSON

Prepared at the request of Plaintiffs C.F. et al.

TABLE OF CONTENTS

This report has been prepared on behalf of Plaintiffs' counsel who requested that I assess the adequacy of mental health services in the New Jersey Department of Corrections ("NJDOC") with emphasis on those institutions and housing units where the mentally ill were congregated.[1] Counsel also asked me to study the way in which seriously mentally ill inmates in the NJDOC are disciplined and sanctioned.[2]

I conducted inspections of prisons in 1996 and 1997 with Dr. Jeffrey Metzner, the NJDOC's expert,[3] and Dr. Richard Cevasco, the NJDOC's in-house psychology consultant, including Northern State Prison ("NSP"), New Jersey State Prison

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1. In April 1996, Correctional Medical Services, Inc. ("CMS"), a managed health care vendor, commenced delivery of health care services (except mental health) to the NJDOC. The mental health services portion of the contract is set forth in Appendix A and includes the NJDOC's Request for Proposals and CMS's Response. CMS subcontracted mental health services to Correctional Behavioral Solutions of New Jersey, Inc. ("CBS"), another managed health care vendor, which commenced operations on August 9, 1996. Those services, which were specified in the contract, formed the basis for the design of psychiatric and psychological services at the NJDOC. Many health services necessary for the provision of mental health services are provided by CMS, including medical evaluations, laboratory studies and medication administration.

The NJDOC through its chief psychologist, Dr. Richard Cevasco, is responsible for monitoring compliance with the provisions of the contract with CMS and also with provisions of the contract between CMS and CBS.

2. For purposes of this report, I have employed the class definition of mental illness which includes: "All persons who suffer DSM IV, Axis I and/or Axis II disorders such that they are unable to meet the functional requirements of prison life without mental health treatment, who now or in the future will be confined within the facilities of the New Jersey Department of Corrections."

3. Dr. Metzner accompanied me on both rounds of inspections. However, I have been informed by Plaintiffs' counsel that the NJDOC is reconsidering its selection of experts in this matter.

("NJSP"), Edna Mahan Correctional Facility for Women ("EMCFW"), Albert Wagner Youth Correctional Facility ("AWYCF"), and East Jersey State Prison ("EJSP").[4] Dr. Cassandra Newkirk, a psychiatrist employed by CBS, accompanied the 1997 tour of NSP. In addition, in 1996, I visited the Forensic Psychiatric Hospital ("Forensic Hospital"), where state inmates suffering mental health crises are committed. Generally, during my inspections, I toured various areas that housed the mentally ill, including administrative segregation and detention areas, congregate care units,[5] infirmaries with mental health beds, and mental health observation areas. I interviewed inmates in each housing area and reviewed medical charts with my assistant, Caren Gurwitz, a registered nurse. In addition, during the 1996 inspections, I interviewed various administrators employed by the NJDOC, CMS and CBS, various on-site mental health staff, nursing staff, and correctional officers assigned to specific housing units. At that time, only two psychiatrists were available to be interviewed. During the 1997 inspections, however, prohibitions on interviews with any correctional, medical or mental health staff as well as the imposition

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4. I did not inspect EMCFW in 1997.

5. The NJDOC lacks intermediate care facilities, sometimes referred to as special needs units. Such units require a comprehensive program of mental health services and supervision by mental health professionals and specially trained custodial staff designed for mentally ill inmates who are unable to function safely or effectively in the general population but who do not require hospitalization or crisis care.

The DOC has congregated many of the more severely mentally ill inmates, who have not received administrative segregation time, in specific general population housing units, referred to in this report as "congregate care" units, without providing any specialized therapeutic programs that are common features of intermediate care. My findings from site inspections revealed that mentally ill inmates in administrative segregation generally do not have access to congregate care housing, with the exception of inmates approved for involuntary medication.

of more restrictive time limits hampered the scope of my review.

The inability of Defendants to produce documents that had been requested in advance of the inspections also presented significant impediments to my customary evaluative protocol. Specifically, I had requested lists of mentally ill inmates, along with their diagnosis, their medications (types, dosages, frequency), and their location. The housing rosters and medication lists produced in response were flawed and outdated. I also expended a great deal of the time available to me on-site during the 1996 inspections simply trying to find patients. Often, correctional staff moved and congregated mentally ill patients to various housing settings without the knowledge of mental health staff.

The following table summarizes the number of interviews conducted in 1996 and 1997:

NJDOC Facility	**1996**	**1997**
NJSP	55	50
AWYCF	45	57
EJSP	43	48
EMCFW	8	--
NSP	58	46
TOTAL	209	201

Finally, I have been informed by Plaintiffs' counsel that a number of documents they had requested which I had hoped to review prior to completing this report have yet to be produced by Defendants. The missing records include, but are not limited to, updates of many of the inmate records, records relating to recent suicides, and post-

involuntary medication records of the involuntarily medicated inmates. My review of documents is, therefore, incomplete in numerous areas.

A brief description of the facilities at the time of the inspections is attached as Appendix B. In addition to the site inspections, I reviewed inmates files, affidavits of inmates, deposition testimony and discovery materials produced to Plaintiffs in formulating my findings and opinions.

I. CONCLUSIONS AND OPINIONS

The treatment of mentally ill inmates in the NJDOC is among the worst I have seen in my 15 years of inspecting correctional systems nationwide. The extensive shortcomings identified in mental health treatment services, the lack of any special facilities for mentally ill inmates, and the harsh disciplinary practices have the net effect of causing significant injury to seriously mentally ill inmates. Almost every medical record that I have reviewed offers evidence of the misery of mentally ill inmates.

Mentally Ill Inmates and The Disciplinary Process

When inmates are seriously mentally ill and not adequately treated, they become increasingly incapable of conforming to institutional rules of conduct and, as a result, often are charged with disciplinary infractions. The NJDOC's disciplinary process inappropriately punishes mentally ill inmates for behavior that is symptomatic of their mental illnesses and often beyond their control. Many disciplinary infractions charged against mentally ill inmates simply reflect their mental illness, such as when an inmate is

charged with attempting suicide, self-mutilating behavior, being unclean, or refusing medication. More serious conduct can also be the product of mental illness.[6] Nevertheless, NJDOC policy requires that these inmates be found guilty, thereby creating essentially a strict liability system.

Although NJDOC policy permits hearing officers to seek the input of mental health professionals and to decline to impose punitive sanctions based on mental illness, the system is largely a discretionary one that does not succeed in preventing the imposition of harsh punitive sanctions on mentally ill inmates for conduct that is symptomatic of their mental illness. Hearing officers lack both information concerning the mental health background of the inmate as well as training on identifying mental ill inmates. As a result, they often allow hearings to proceed without the inmate being sufficiently intact to contribute to the hearing or even sufficiently competent to decline to attend. For the same reasons, they often fail to seek mental health input, even when it would be relevant. Many of the mental health evaluations they do receive merely summarize the inmate's mental status and provide little information that is helpful in determining a sanction. Finally, despite their discretionary authority to do otherwise, hearing officers often impose punitive sanctions even when the record is clear that the inmate was suffering from a mental illness at the time of the infraction.

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6. Adequate mental health treatment services would minimize the disruptive and violent behavior of many mentally ill inmates. For this reason, it has been my experience that when intermediate care facilities with extensive treatment programs for the chronically mentally ill are brought on line, disciplinary infractions by this segment of the population decrease.

As a result of this disciplinary process that all but criminalizes the most common symptoms of mental illness as well as the lack of alternative housing facilities, mentally ill inmates are almost three times more likely to be found in administrative segregation than they are in general population. Yet, administrative segregation is essentially solitary confinement and functions as a prison within prison. Its primary features are isolation from other inmates, minimal sensory stimulation, and deprivation of almost all contact with other human beings. Over time incarceration in administrative segregation aggravates mental illness and can cause the onset of mental illness in inmates without a pre-existing condition. The physical conditions in disciplinary detention are worse than those in administrative segregation, and inmates have even fewer rights, but confinement is limited to 30 days.

Despite the detrimental impact of administrative segregation and disciplinary detention on mentally ill inmates, there are few mechanisms in place to rescue an inmate who is psychologically deteriorating in these facilities. Indeed, a number of inmates begin a cycle where their mental deterioration leads to new disciplinary infractions that, in turn, result in additional administrative segregation time. A significant subset of these inmates become permanently trapped in administrative segregation.

One bright spot is an emerging practice among a few administrators of removing deteriorating inmates from administrative segregation and dismissing their remaining administrative sentence. However, until this practice is codified in a written policy, numerous inmates will continue to suffer needlessly in administrative segregation. The failure to put into place uniform procedures that allow for the removal of inmates

from administrative segregation at the point of decompensation essentially imposes a sanction that threatens the mental stability of otherwise mentally healthy inmates and aggravates the condition of many mentally ill inmates. Neither case management contacts by CBS nor treatment at the point of discharge from the correctional system can remedy the injuries caused by the punishment imposed by the NJDOC.

Organization of Mental Health Services

The organization of mental health services at the NJDOC is fundamentally flawed in several ways. Each of these flaws systematically undermines both the quality and quantity of mental health services provided to mentally ill inmates at the NJDOC. These flaws include:

- Staffing: The NJDOC's mental health department has been grossly understaffed, both prior to and following the privatization of mental health care. In particular, the number of psychiatrists is woefully inadequate for the number of seriously mentally ill inmates. Moreover, the NJDOC imposes a heavy burden on remaining clinicians, especially psychologists, to perform custodial evaluations at the expense of treatment services. There are no mental health nurses, although their expertise is crucial to management of acutely mentally ill inmates and their medication compliance in a system that offers medication as the prime treatment modality. These deficiencies, in turn, affect every aspect of the treatment services discussed below and precludes any hope of adequate mental health treatment services on a system wide basis.

- Mental Health Policies and Procedures: Mental health policies and procedures that incorporate professional standards of practice and provide instruction on treatment services are an essential part of any system of mental health care. Without adequate policies and procedures, treatment services lack uniformity and quality of care suffers. The 15 mental health policies and procedures approved by CBS after more than one year of operation are so brief that they fail to provide necessary guidance to mental health and other staff. In addition, policies and procedures are lacking for

essential areas of mental health service such as psychiatric medication management, comprehensive diagnostic assessments and emergency psychiatric care. As a result, the mental health treatment services provided to mentally ill inmates at the NJDOC is in many instances substandard.

- Medical Records: Accurate, complete and up-to-date mental health charts are essential to the provision of mental health treatment services because they contain much of the information upon which treatment decisions depend. Yet, the mental health records produced to date are both poorly organized and incomplete. Critical categories of documents, including but not limited to doctor's orders, medication records, mental health progress notes, laboratory reports and Forensic Hospital discharge summaries are missing from many charts. Other documents usually kept in a mental health chart are segregated in separate "shadow files". The disorganization and incompleteness of these charts as well as the existence of multiple files for the same individual undermines every area of treatment services and prevents meaningful quality assurance.

- Quality Assurance: Quality assurance policies and procedures permit an institution to determine the quality of care provided to mentally ill inmates through the systematic study of high risk and regular areas of service provision. CBS, the primary mental health care provider, has at best a rudimentary quality assurance program. It focuses only on four areas of care and, with respect to those areas, emphasizes documentation of services rather than quality of care.

- Lack of Facilities For Confidential Evaluations and Treatment: Providing a space where patients may privately communicate sensitive mental health information to their clinician is often critical to the success of treatment. Yet, mentally ill inmates in restricted housing are rarely afforded the opportunity to communicate privately with the mental health staff treating them. Mental health contacts either take place cell-side where mental health clinicians are reduced to yelling through a crack in the door or they take place in a private room where correctional officers and a nurse may also be present. A number of inmates consequently communicate little or no pertinent information in these circumstances which, in turn, substantially undermines their mental health care.

- Lack of Spanish-speaking Clinicians: A number of the inmates interviewed during the 1996 and 1997 inspections spoke only Spanish. Although they indicated they had access to Spanish-speaking mental health clinicians for routine contacts, many complained that such clinicians were unavailable during times of crisis or when these inmates were in restricted housing.

> Such inability of mental health staff to communicate with Spanish-speaking inmates in their native language obviously frustrates, if not prevents, their treatment.

Access to Mental Health Treatment

The first step in providing access to mental health treatment is to identify that segment of the inmate population that is mentally ill and needs mental health services. During the 1996 and 1997 inspections, I discovered a significant number of unidentified seriously mentally ill inmates. The discovery of two such groups of inmates approximately twelve months apart leads me to conclude that the NJDOC has failed to identify a sizable segment of its mentally ill inmate population.

The causes of the NJDOC's underidentification of its mentally ill inmate population are threefold: First, although the inmate reception screening procedures appear on their face to be sufficient, neither the NJDOC nor its private contractors track whether the inmates identified at reception as mentally ill actually receive the mental health services they require. As a result, no one can determine whether the reception process is successful in identifying and referring mentally ill inmates for treatment services. Second, the mental health referral process, through which inmates can self-refer and staff can refer inmates for mental health treatment, is primarily an oral one. Accordingly, these referrals also cannot be easily tracked to ensure that the inmates at issue actually receive the services for which they are referred. Third, although CBS is obligated under its contract to screen and contact all administrative segregation inmates on a regular basis, these rounds were often cursory and undocumented. Until very recently, inmates who had been

prescribed psychotropic medications but refused them were dropped from the mental health system. The result is that seriously mentally ill inmates remain unidentified and untreated.

Therefore, until there is an adequate process in place to track those inmates identified as mentally ill at any point during their incarceration and determine whether they receive actually receive mental health treatment, access to mental health treatment at the NJDOC is compromised.

Diagnosis and Treatment Planning

Diagnosis and treatment planning are the foundation upon which the success of a mentally ill inmate's treatment depends. Neither a mentally ill inmate whose treatment is based on a misdiagnosis nor one whose treatment lacks an individualized treatment plan is likely to be stabilized. Despite the importance of these steps, both diagnosis and treatment planning are grossly insufficient at the NJDOC.

There is no policy and procedure guiding mental health clinicians in standards and practices necessary for adequate diagnosis. No comprehensive diagnostic assessments by mental health clinicians were ever found in any of the charts reviewed, other than brief initial psychiatric interviews. There were widespread failures to utilize outside records, even the comprehensive Forensic Hospital discharge summaries. Finally, diagnoses were commonly changed for unclear reasons, and diagnostic conflicts between mental health clinicians over time went unresolved.

Likewise, the implementation of treatment planning in late 1997 has had little effect on the treatment of seriously mentally ill inmates. Treatment plans consist almost entirely of the stereotypic copy and are virtually identical except for diagnoses and medications which were often incorrect. They were not the product of any adequate diagnostic or multidisciplinary team effort, nor were patients participants in the process. Given these inadequacies, these treatment plans were not much better than no treatment plan at all.

Treatment Services (Medications)

Psychotropic medications are the primary, and often only, treatment modality for seriously mentally ill inmates at the NJDOC. For many inmates, however, psychotropic medication alone is simply insufficient to address their mental health needs. They require some form of individual or group therapy to be stabilized. Such heavy reliance on psychotropic medication therefore is a significant limitation of treatment services at the NJDOC.

Moreover, the overreliance on psychotropic medications requires that the administration and management of this treatment modality function at least adequately. Yet, my review of the prescribing practices, involuntary (nonemergent) medication practices, and medication administration at the NJDOC uncovered a number of serious deficiencies. These deficiencies not only render the delivery of this treatment modality grossly inadequate but subject numerous mentally ill inmates to potentially life-threatening risks.

1. Prescribing Practices

The prescribing practices reviewed included choosing dosages as well as monitoring inmates for effectiveness and side effects. In addition, I reviewed the formulary policy and procedures. Among the serious flaws I found are:

- Many medications were underprescribed or prescribed in less than therapeutic doses, leaving many mentally ill inmates still entangled in the symptoms of their illness. The ramifications of this practice are very serious. Inmates whose mental illnesses remain out of control for a substantial period of time become increasingly refractory to treatment and less amenable to even appropriate treatment.

- Monitoring for physical side effects is rarely performed. For instance, muscular disorders are a common side effect of many psychotropic

medications. As a result, all standards of psychiatric practice require routine reviews of all patients on psychotropic medications to check for muscular side effects. In chart reviews, little documentation of such reviews were found, perhaps because clinicians found it difficult to clearly observe inmates in restricted housing cells as required for such reviews. During the inspections, however, I saw several inmates who were clearly suffering from such disorders.

- Monitoring for therapeutic effectiveness and safety are performed very infrequently. Certain psychotropic medications need to reach a "therapeutic window" in an inmate's blood to be safe and effective. Indeed, if these medications exceed maximum levels, inmates can experience life-threatening side effects. Standards of psychiatric practice require medical pre-screening and regular monitoring of blood levels for patients on those medications. Yet, such prescreening and monitoring of blood levels is simply not done on any systematic or regular basis for those inmates whose treatment and lives depend on it.

- The formulary of approved medications that a CBS psychiatrist may prescribe for mentally ill inmates excludes many safer and more effective new antipsychotic and antidepressant medication. As a result, inmates who are taking nonformulary medications upon admission to the prison or upon return from the Forensic Hospital are switched to other, often less effective, medications, a practice which clearly jeopardizes these inmates' continuity of care.

- Formulary procedures require that mentally ill inmates who appear to be "treatment resistant" to a particular medication nevertheless undergo therapeutic trials of all formulary medications within that class or family before a prescription for a nonformulary medication will be approved. This practice effectively denies those inmates what psychiatric "common sense" would determine to be appropriate medications for long periods of time.

2. Involuntary (nonemergent) medications

The Involuntary (Nonemergent) Medication policy as well as its companion Use of Force Involving the Involuntary Administration of Psychotropic Medication policy promulgated by the NJDOC in late 1997, together, represent an important step toward the provision of better treatment services to seriously mentally ill inmates. However, these policies contain several significant gaps. For instance, neither policy requires that mental health staff even be notified of, much less participate in, the involuntary administration process. There is also no requirement that anyone offer medication to the noncompliant inmate as a last opportunity to take his medications voluntarily, a step that could eliminate the need for any use of force. Likewise, neither policy sets forth the medical protocol that should be followed following the involuntary administration of injectable medications. Nor does either policy require quality assurance or on-going monitoring for safety and efficacy. These gaps hinder the effectiveness and safety of the involuntary (nonemergent) administration of medication program.

Furthermore, my review of a random sample of involuntary medication charts as well as other charts and videotapes indicates that mental health and correctional staff sometimes do not comply with specific protections that are part of the policies. For instance, some candidates for involuntary medication are approved, despite their current compliance with their medication regime. In addition, a few inmates at institutions not participating in the involuntary medication program nevertheless have been involuntarily medicated without a hearing at all. Some psychiatrists also have employed questionable prescription practices, such as requesting that the medications be given in a range of doses

over a range of times. Such noncompliance with the terms of the policy as well as other questionable practices further diminishes the effectiveness and safety of the program.

Finally, it is unclear from some of the charts reviewed whether the mentally ill inmates ordered to be involuntarily medicated actually received their medications. For instance, several inmates were transferred at approximately the same time they were approved for involuntary medication. Their charts, which like many of the mental health charts reviewed were disorganized and missing critical documents, did not reflect that any involuntary medications were ever given.

3. Medication Administration

An adequate medication administration process should ensure that mentally ill inmates receive their prescribed medications, are encouraged to take them, and actually do ingest them. At the NJDOC, none of these goals are consistently met. During the 1996 and 1997 inspections, a number of inmates complained that they missed dosages of their medication when the pharmacy's supply had been depleted. These intermittent interruptions of medication can significantly affect the stability of a mentally ill inmate. Indeed, one inmate committed suicide after his anxiety medication was interrupted for two weeks due to its unavailability in the pharmacy.

Even when the medications are in stock, the nurses distributing them rarely encourage inmates to take them. Although this failure may be caused in part by a lack of time due to inadequate nursing staff, it also results from a lack of experience and training. Unlike mental health nurses who have specific expertise in the area of psychotropic medication compliance, regular nurses generally have none.

If an inmate becomes noncompliant for even a short period of time, their psychiatrist will commonly cancel their medications. In a system that relies so heavily on psychotropic medication as its primary treatment modality, this practice constitutes a virtual abandonment of the inmate and should be strongly discouraged.

In addition, nurses often do not carefully watch the inmates ingest their medications. As a result, a number of inmates showed me stashes of medications that they had accumulated. Others indicated that they had thrown out their medications after the nurses had left. Such lax practices not only undermine these inmates' treatment, but substantially increase the risk of inmate suicides.

Finally, in several housing areas including those that congregate mentally ill inmates, the inmates are required to leave their cells and go to a pill line or to the infirmary to receive their medications. This practice, however, discourages medication compliance by seriously mentally ill inmates who have the greatest need for the medication but cannot tolerate a significant change in their environment.

Treatment Services (Verbal)

The availability of verbal therapy, either individually or in groups, is grossly insufficient for the number of mentally ill inmates at the NJDOC. Almost no individual therapy is available for seriously mentally ill inmates. Although select inmates in the general population can receive periodic individual therapy, most acutely mentally ill inmates receive only crisis assessment contacts, which are brief, often undocumented and do not constitute therapy. Likewise, the vast majority of mentally ill inmates in restrictive

housing receive little beyond the brief case management contacts by mental health clinicians on rounds. Group therapy is more widely available than individual therapy, but again is primarily limited to mentally ill inmates in the general population.

Yet, the effectiveness of medication therapy for many mentally ill inmates is limited. Due to any number of factors, some mentally ill inmates continue to be symptomatic while on high dosages of psychotropic medications. Others require increasingly higher dosages of medication over time to remain stable. For both groups, verbal therapy in conjunction with their medication may be more effective than medication alone. Some problems, like symptoms stemming from a history of sexual abuse, are best treated with a combination of medications and individual or group therapy. Likewise, chronically mentally ill inmates, particularly those who have functional deficiencies, including daily living, occupational and interpersonal difficulties, need more than medication. They require extensive programs that directly address their deficiencies such as individual and group therapy, recreational and activity therapy, vocational and scholastic training, and even basic instruction in hygiene and activities of daily living. For all of these inmates, the unavailability of verbal therapy significantly impedes their treatment.

Crisis Intervention

During the 1996 and 1997 inspections, I examined the most grossly psychotic inmates I have ever seen in all my years as a psychiatrist. Most but not all of these inmates were found on mental health observation in the administrative segregation

areas. One inmate had not even been identified by the mental health staff as needing observation, much less emergency crisis care. The purpose of crisis intervention is to stabilize acutely mentally ill inmates in a safe and controlled environment. The mere existence of these human beings in such states of extreme crisis demonstrates the gross inadequacy of crisis intervention at the NJDOC.

The primary causes of these glaring deficiencies in crisis intervention are threefold:

- Inadequate staffing levels leaves mental health clinicians, particularly psychiatrists, with little time to provide more than cursory crisis intervention assessments and follow-up contacts. More importantly, these clinicians also have little time to discover and monitor mentally ill inmates on the verge of a crisis and to provide the treatment necessary to prevent the crisis.

- There is a lack of appropriate facilities in which to treat mentally ill inmates in crisis. Acutely ill inmates should be treated in infirmary settings that have dedicated mental health staff as well as 24-hour nursing coverage. Several of the correctional facilities at the NJDOC have infirmary beds dedicated to acutely mentally ill inmates, many of which are not well utilized. For instance, every one of the psychotic inmates discussed above was in a facility that had dedicated mental health beds in its infirmary. Yet, not one of those inmates was housed there. None of the infirmaries that include mental health beds have mental health staff dedicated solely to the care of the inmates in them.

- There is no policy and procedure for the involuntary administration of psychotropic medication on an emergency basis. Nor does there appear to be a consistent practice of administering emergency medications, perhaps due to the inadequate number of psychiatrists. As a result, acutely ill inmates who could be quickly stabilized through an emergency injection of psychotropic medication often languish for significant periods of time.

Until staffing is increased, crisis care becomes infirmary based, and emergency medication procedures are implemented, there is little hope that the extreme examples of human

suffering I witnessed during the inspections will be the last ones to occur at the NJDOC.

Restraint Care

Therapeutic restraints are a necessary but risky tool for managing acutely mentally ill inmates who are potentially dangerous to themselves or others. The NJDOC employs them too rarely. Chart reviews revealed several instances where acutely ill inmates engaged in acts of self-mutilation, such as head-banging and skin-cutting. Although mental health staff suggested and sometimes even ordered that restraints be employed, they were not. The failure to use restraints in these instances greatly increased the risk that these inmates would succeed in inflicting serious, if not fatal, injuries to themselves.

The NJDOC also does not have the procedural safeguards in place to minimize the risks associated with the use of restraints. For instance, the administration of restraints usually is carried out in a custodial rather than medical setting. Nursing involvement appeared minimal. Although orders for restraints "as needed" are not uncommon, no person is responsible for determining whether such an order should be employed. Additionally, there is no review mechanism in place to evaluate the safety of restraint, nor even any log book to track instances of their use. These deficiencies in policy and procedure render an appropriate decision to use restraints unnecessarily risky.

Hospital Care

Particularly because crisis care at the NJDOC has been grossly inadequate,

there is an increased need for adequate hospital care to treat acutely mentally ill inmates. My review of medical records as well as the 1996 inspection of the Forensic Hospital indicate that the quality of care provided by mental health staff at that facility is more than adequate. However, there are insufficient beds available at the Forensic Hospital to meet the needs of the most seriously mentally ill inmates in the NJDOC. Inmates already determined to require hospital care and who meet the stringent criteria for involuntary commitment commonly languish for periods ranging from a few days to approximately two weeks.

Furthermore, in prioritizing inmates for hospitalization, there was undue predilection for hospitalizing inmates who were perceived as dangerous to themselves, to the detriment of other equally or more acutely mentally ill inmates in need of hospital care who were not so perceived. Interviews and chart reviews reveal that inmates who are severely mentally ill, completely disorganized, gravely disabled, and unable to care for themselves but not dangerous to themselves were sometimes not even placed on the waiting list for a hospital bed. Similarly, inmates who were extremely psychotic and violent tended not to be a priority, because so many of them were locked down. These non-dangerous but acutely mentally ill inmates languished in a state of crisis and without adequate crisis care, often for weeks before their illness either subsided as a result of medications or deteriorated to the point where they became a danger to themselves.

Suicide Prevention

My conclusion and opinions regarding suicide prevention are necessarily

incomplete given that Defendants have produced, and I thus have been able to review, the complete records of only two out of the seventeen inmates who committed suicide. Nevertheless, a review of even the limited number of charts and records produced reveals that:

- A number of clinical and procedural deficiencies and omissions, together, set the stage for the two completed suicides I reviewed.
- The administration of the NJDOC's observation policies and procedures is alarmingly lax. A number of inmates who had been placed on observation because of the risk of harm to themselves or others nonetheless were allowed access to various dangerous instrumentalities. Some then used those instrumentalities to harm themselves.
- Forensic reviews or psychological autopsies, which are universally performed following completed suicides in correctional setting, are not being conducted at the NJDOC.
- Correctional and nursing staff are not appropriately trained and utilized in identifying and referring suicidal inmates.

Unless these shortcoming can be fixed, the risk of suicide will remain unnecessarily high at the NJDOC.

Discharge Planning

Discharge planning for mentally ill inmates being released to the community is grossly inadequate. Inmates are provided with few arrangements or plans for follow-up mental health services and receive only a two-week supply of their psychotropic medications. Such minimal planning for seriously mentally ill inmates at this critical point in their treatment jeopardizes any hope for continuity of care upon their release.

Discharge planning for involuntary civil commitment to the Forensic

Hospital is necessarily more thorough. It is disturbing, however, that inmates who did not meet the criteria for commitment while incarcerated at the NJDOC would meet that same criteria upon their discharge. Either they should have been committed earlier during their incarceration or they should not be committed upon their discharge.

II. FINDINGS REGARDING THE MENTALLY ILL AND THE DISCIPLINARY PROCESS

A review of the special needs roster dated August 10, 1998 reveals a total of approximately 1,900 inmates on the special needs roster with 295 special needs inmates in administrative segregation. Assuming that the administrative segregation capacity remains at 1,114 beds, this indicates that over 25% of the administrative segregation population is on the special needs roster, a figure much greater than the incidence of mental illness in the prison population generally.[7] The sanctioning of conduct that is symptomatic of mental illness, the environmental hazards present in administrative segregation and detention, and the lack of alternative housing facilities for the mentally ill all contribute to the disproportionate representation of the mentally ill in administrative segregation.

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7. I am unable to do more than roughly estimate the percentage of the prison population in need of mental health services because Plaintiffs do not have information on mentally ill inmates at ADTC and because there may be unidentified mentally ill inmates in the system. Based on the available data and my own experience with other correctional systems, I would estimate that approximately 10% of the NJDOC population requires treatment.

A. Structure of the Disciplinary Process

1. Overview

Chapter 4 of the New Jersey Administrative Code 10A, entitled "Inmate Discipline," outlines the disciplinary rules, the sanctions, and the process for adjudicating disciplinary hearings.[8] When an inmate commits a prohibited act, the staff member who witnessed the act writes a disciplinary report about the incident, and the matter is investigated. A hearing before a disciplinary hearing officer is then scheduled, usually within seven days but within three days in the event the inmate has been placed in prehearing detention. While the inmate has a right to be present, the rules allow for *in absentia* hearings for reasons of security or inmate refusal to attend. When an inmate is charged with a serious offense, he or she may be represented by another inmate acting as counsel substitute. Written decisions by the hearing officer may be appealed to the prison administrator who has the authority to rescind the decision, order a new hearing, modify the sanctions, or uphold the hearing officer's decision. Chapter 4 contains no special considerations or dispensation for inmates who may be suffering from serious mental illness on either the hearing or appellate levels.

2. Prohibited Acts and Schedule of Sanctions

Many offenses and prohibited acts set forth in the Administrative Code are commonly committed by mentally ill inmates, and often are symptomatic of their mental

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8. For minor offenses, the Administrative Code permits a summary disposition called "on-the-spot" correction. This report does not evaluate the policies and procedures for on-the-spot discipline.

illness. Serious offenses can result in sanctions of 15 days disciplinary detention, loss of privileges, administrative segregation time for a period not to exceed one year,[9] loss of commutation time for up to one year, loss of privileges, extra duty or confinement to the inmate's housing area. Some serious offenses, such as setting a fire or misuse of authorized medications, are commonly committed by severely mentally ill inmates.[10] Indeed, an offense like misuse of authorized medication -- which may involve hoarding medication or refusing to take it -- may be closely related to the behavior of seriously mentally ill inmates.[11]

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9. An inmate might receive the maximum penalty for assault, regardless of whether the underlying conduct was spitting (John Doe # 92; John Doe # 30) or caused bodily injury.

10. A number of mentally ill inmates with a history of setting fires are sanctioned again and again when they nonetheless successfully light additional fires. John Doe #117, for instance, set a fire on March 4, 1994 because he "had no cigarettes." On May 5, 1995, the psychiatrist stated that John Doe #117 should not be permitted matches. The advice was obviously ignored. Between May 5, 1995 and December 15, 1995 John Doe #117 set three fires, resulting each time in additional administrative segregation. Likewise, John Doe #118, set six fires between April 3, 1996 and January 2, 1997, each time receiving at least 90 days of administrative segregation time. Finally, John Doe #119, received 300 days of administrative segregation and lost commutation time for setting a fire in which he suffered second and third degree burns.

11. One of the symptoms of some mental illnesses is self-injurious behavior. Though sanctions for offenses accompanying this type of behavior generally include referrals to psychology, hearing officers may also impose punishment for this conduct which often represents a plea for help. John Doe # 2, for instance, has received seventeen charges for self-mutilation for conduct including setting herself on fire, overdosing on medications, cutting herself, hanging herself and ingesting foreign objects such as a belt buckle and the lenses of her glasses. She received administrative segregation time and other sanctions for some of these incidents. When she managed to start a fire while allegedly secured in a restraining chair, she was charged restitution of $400 for the damage to the chair.

Less serious offenses may be sanctioned by up to 15 days disciplinary detention, loss of privileges for up to 30 days, up to 60 days loss of commutation time, administrative segregation time not to exceed 90 days, extra duty or two weeks confinement to room.[12] Many of these less serious offenses are closely related, if not unique, to the behavior of inmates who are seriously mentally ill. For example, the mutilating or altering of clothing or government property (to hang oneself), failure to follow safety or sanitation regulations and "being unsanitary or untidy" are almost universally unique to the mentally ill. Using abusive or obscene language to a staff member is an offense. There are certain medical conditions (*e.g.*, Tourrette's Syndrome) whose primary manifestation is the uttering of obscene language. Malingering or feigning an illness is an offense which may be greatly complicated by misdiagnosis. Other less serious offenses, such as failure to perform work or to refuse a program or housing unit assignment, conduct which disrupts, and disobeying a direct order, also are often incurred by the mentally ill.

Loss of commutation time, one of the sanctions for disciplinary infractions, generally extends the inmate's maximum release date and also extends the inmate's parole eligibility date. Thus, inmates who lose commutation time usually serve more time in prison than a similarly situated inmate, *i.e.*, one with the same conviction and the same sentence, who did not incur disciplinary charges. A process exists for recovering lost commutation time and for early release from administrative segregation (through the

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12. These time limits are for a single disciplinary offense. Inmates may accumulate greater sanctions by incurring multiple charges on the same day or over time.

Special Administrative Segregation Review Committee), but in order to qualify, inmates must demonstrate substantial improvement in their conduct, and mental illness is not generally considered as a mitigating factor. There is also an unwritten practice by which prison administrators may remove an inmate from administrative segregation based on the potential for deterioration of the inmate's mental state. At NJSP, inmates who have been approved for involuntary medication have been removed from administrative segregation pursuant to this practice.

In addition to extending the date on which an inmate becomes parole eligible, a finding of guilt adversely affects the likelihood that the Parole Board will grant an inmate parole even when other sanctions are not imposed for the conduct.

3. NJDOC Disciplinary Policies Regarding Mentally Ill Inmates

The NJDOC purports to have several disciplinary policies and practices which affect mentally ill inmates as follows:

First, hearing officers are required to seek psychological evaluations if, at the time of the convening of the disciplinary hearing, an inmate is on observation status or has been committed to the Forensic Hospital. Although no written policies require that hearing officers address the issue of competence to proceed, they must adjourn the hearing until the inmate is no longer on observation or has returned from the hospital as a limited safeguard against adjudicating the offense at a time that the inmate cannot meaningfully participate. Hearing officers also have the discretion to seek psychological evaluations if they conclude that one is needed.

Second, hearing officers are required to find an inmate who has engaged in

proscribed conduct guilty, regardless of the inmate's mental state at the time of the conduct. Put differently, an inmate's mental incompetence at the time of the infraction is irrelevant to the determination of guilt.

Third, if the hearing officer determines that the inmate cannot be held responsible for his actions due to mental illness, the hearing officer should not impose punitive sanctions, but instead should refer the inmate to the mental health staff for treatment.

Fourth, although apparently not a formal policy, hearing officers have the discretion to mitigate the sanction in cases where an inmate may be deemed responsible for his actions but nonetheless suffers from a mental illness.

4. Hearing Officers

A disciplinary hearing officer is a NJDOC staff member designated to adjudicate inmate violations of prohibited acts. The NJDOC does not provide any training to either hearing officers or administrators deciding appeals on the identification of mentally ill inmates or the connection between mental illness and behavior.

At the time of a hearing, the hearing officer generally has access to the original disciplinary report by the charging staff member, a summary of the inmate's past disciplinary record, any special reports, the inmate's statement or that of his counsel substitute, the investigator's report, and any witness statements. While a hearing officer also will be informed if an inmate is on observation for mental health reasons or has been committed to the Forensic Hospital, he is not ordinarily told whether the inmate has been diagnosed with a severe mental illness, is receiving mental health services, is taking

psychotropic medications, has refused psychotropic medications, or has been adjudicated in need of involuntary medication. Based upon the circumstances of the offense or the conduct of the inmate at the hearing, the hearing officer must determine whether or not to request a psychological evaluation.

5. Psychological Evaluations

The information contained in the psychological evaluations completed in conjunction with the disciplinary process vary widely from institution to institution, as do the number of evaluations requested. Although practices may vary among clinicians, Dr. Martha Boston (then Executive Director to CBS) testified that the purpose of the evaluation was to give the hearing officer information on whether the inmate has a mental illness and the inmate's current mental status (as opposed to his condition at the time of the offense).

Clinicians use a variety of forms for recording their psychological evaluations for courtline hearings, including a standard form generally used for confidential psychological evaluations. A form developed for use in conducting such evaluations contains a section for psychologists to transcribe a narrative of their clinical findings. These narratives usually use terms of art not designed for consumption by an untrained hearing officer. At the bottom of the form, guidelines specifically prohibit psychologists from offering opinions as to the inmate's responsibility for the "conduct" or on the inmate's "mental competence" or "accountability." Generally, the psychologists do not provide opinions as to the likely effect of an administrative sanction on an inmate's mental health.

B. Actual Disciplinary Practices

1. Competency to Proceed

While inmates have a right but not a duty to be physically present at their disciplinary hearing, there is apparently no corresponding right to be mentally present as well.

The record of John Doe #120, for instance, was reviewed with respect to his mental state at the time of certain disciplinary charges. John Doe #120 was a paranoid schizophrenic, who on October 21, 1996, grabbed a correctional officer's jacket and was charged with "disrupting" the yard. In the course of the disruption, John Doe #120 sustained a broken nose. In hearings on October 23 and October 25, the hearing officer commented that John Doe #120 was "bizarre and uncooperative" and would not sign his papers. Between the two hearings, John Doe #120 was referred to mental health staff and he was found to be extremely delusional. His delusional system was well-crystallized and circumscribed, and revolved around "correctional officers raping his wife and baby." His medications had been discontinued at NSP. The hearing officer essentially confirmed the psychologist's findings when he stated during the second hearing that "the inmate says the CO raped his wife and baby and that the inmate wished to file charges against the CO." Nevertheless, he found John Doe #120 guilty and sanctioned him to 30 days loss of recreation privileges and 15 days detention with a referral to mental health staff for a follow-up.

Moreover, some hearings are held *in absentia* because the inmate is deemed so impaired that his presence at the hearing is considered a security risk. (See

John Doe # 121 John Doe # 1, and John Doe #116). Inmates may refuse to attend their hearing, but there is no procedure to determine whether an inmate is competent to decide not to attend.

2. Mental Illness and Punitive Sanctions

Review of medical charts, disciplinary reports, and numerous interviews with inmates in administrative segregation revealed no instances where an inmate who was severely mentally ill at the time of the disciplinary infraction was found not guilty because of mental incompetence. That same review revealed few instances where punitive sanctions were not imposed. While hearing officers have absolute discretion to seek a psychological evaluation to assist in adjudicating charges against the seriously mentally ill, they rarely request them. Even when they do obtain an evaluation, they may nevertheless decide not to give it weight, as the examples below illustrate.

a. John Doe #121

During a month beginning on February 26, 1995, John Doe #121, received ten disciplinary charges, resulting in the imposition of approximately a year in administrative segregation and, ultimately, the revocation of his parole date. These infractions were directly related to the NJDOC's failure to treat John Doe #121's mental illness. Yet, no psychological evaluation was sought nor was there any mitigation of punishment.

In early 1995, John Doe #121 was incarcerated at Garden State Reception Facility ("GSRF") as a parole violator. His mental health screening exam revealed a

lengthy history of mental illness.[13] Significantly, he reported to his examiners at GSRF that he had been taking Mellaril and Benadryl to control his mental illness. As John Doe #121 was aware, these medications prevented him from being afraid and believing that people intended to hurt him.

On February 23, 1995, he was sent to Riverfront State Prison ("RFSP") without any medical records and, as a result, was no longer given his medications. His condition quickly deteriorated.[14] As he became agitated and sleepless, he tried to get his medications (resulting in one infraction arising from his unauthorized presence in the hospital area on March 11, seeking his medication), called the ombudsman, banged on his cell door (ultimately resulting in his being placed in restraints on March 12, 1995, by order of correctional, rather than medical, staff), hallucinated, and obsessed on his delusional beliefs that people were out to get him. John Doe #121 was told that he would have to wait to see a psychiatrist who only came once a month. However, after he threatened the superintendent, a regular physician finally reordered his medications. Following a hearing of these infractions during which the hearing officer never requested a psychological

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13. He had previously been incarcerated for 19 months at RFSP and adjusted well there, taking Mellaril and Benadryl at night. Following that incarceration while on parole, John Doe #121 reported that he was very stable on the same medication, working full-time for New Jersey Bell and receiving mental health treatment services and Alcoholics Anonymous counseling three times per week.

14. In a Parole Board decision recommending the denial of parole, the hearing officer acknowledged that John Doe #121 "made a sincere effort to secure the necessary medication but was unsuccessful through no fault of his own." He found that "the contrast in personality in subject when he is administered medication, vis-a-vis when medication is not available, is dramatic."

evaluation of John Doe #121, the hearing officer imposed a series of substantial sanctions and referred John Doe #121 for mental health treatment. There were no further infractions once he became stabilized on his medications several weeks later.[15]

b. John Doe #118

John Doe #118, was charged with setting a fire on December 19, 1996 after which he was placed on consent observation. Progress notes reveal he had stopped taking his medications and was grossly delusional at the time. His hearing was postponed while he remained on mental health observation, where he set another fire. Eighteen days after the initial fire, the NJDOC transferred John Doe #118 to the Forensic Hospital. A psychological evaluation was requested, and, upon his return from the Forensic Hospital, he was interviewed. Dated February 26, 1997, the evaluation stated that John Doe #118 exhibited psychotic behavior, such as wiping his face with ashes, smearing feces around his cell and refusing to shower. The hearing officer still imposed sanctions of 180 days of administrative segregation for the two fires.

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15. A year later while in administrative segregation at EJSP, John Doe #121 received administrative segregation time for another series of charges. In prehearing detention, John Doe #121 became angry that his breakfast was cold and pushed his tray of pancakes through the food port, spilling his breakfast of syrup and milk on the correctional officer's clothing. He was charged with assault with a weapon and was sanctioned to 15 days detention, 300 days administrative segregation and 300 days lost commutation time for this charge in combination with charges for causing a disruption by flooding his cell and for making threats. He was released from prison directly from administrative segregation in 1997.

c. John Doe #117

On March 31, 1995, John Doe #117, was charged with "being untidy" because he smeared feces on his cell door. In the absence of a psychological evaluation, he received a sanction of 60 days loss of commutation time, 90 days administrative segregation, and 15 days detention as well as referral to mental health staff for treatment. Three months later, John Doe #117 was charged with flooding his cell. On June 9, 1995, a psychological report found that John Doe #117 was "mentally limited and often psychotic, . . . not able to control his behavior and . . . not in good touch with reality." John Doe #117's sanction for this second offense was limited to a psychological referral.

Subsequent disciplinary officers, however, declined even to seek an evaluation or ignored its findings when requested. On July 1, 1995, John Doe #117 was again charged with flooding his cell. A psychological evaluation determined that John Doe #117 was "cognitively limited," "schizophrenic," and "not completely in control of his behavior." Nonetheless, he received detention and administrative segregation time. Subsequent charges followed for setting fires (on July 18, November 25 and December 8, 1995) and smearing feces (September 15, 1995). Some of the disciplinary reports regarding these incidents noted John Doe #117's psychiatric history. In addition, two hearings in December had to be delayed because he had been placed in observation. In none of these instances, however, was a psychological evaluation sought. In each case, John Doe #117 received additional time in disciplinary detention and administrative segregation, and often loss of commutation time as well.

3. <u>Inability of the Mentally Ill to Leave Administrative</u>

Segregation

Once placed in administrative segregation, a portion of the seriously mentally ill are unable to leave. Despite the limitations on their daily movements, some inmates continue to collect a large number of disciplinary offenses so that they accrue administrative segregation time that far exceeds their maximum sentence, and many remain in administrative segregation for years at a time. The named Plaintiffs, for instance, have spent prolonged periods of confinement in administrative segregation: John Doe # 2, spent five of six years in prison confined in administrative segregation; John Doe # 122 spent six of seven years confined in administrative segregation; John Doe # 44 , spent two of her three years confined in administrative segregation; and John Doe # 1, spent three of four years confined in administrative segregation. Other inmates have served over eight years in administrative segregation.[16]

C. Conditions of Administrative Segregation and Disciplinary Detention

1. Rules Governing Administrative Segregation and Disciplinary Detention

The rules governing administrative segregation and disciplinary detention are set forth in the New Jersey Administrative Code. Disciplinary detention is used for inmates charged with more serious infractions prior to their hearing and also serves as a sanction almost always imposed for disciplinary offenses. Inmates housed in administrative segregation and disciplinary detention units are confined to their cells for

16. *E.g.*, John Doe #117, John Doe #20, John Doe #123 and John Doe #43

over 23 hours per day.

In administrative segregation, an inmate can have one noncontact visit per week and only one collect call per week (excluding legal calls). Five hours per week recreation and exercise outside the cell is allowed, when possible,[17] as well as daily showers. Natural lighting is limited to a small window in most cells. Artificial lighting is available but is controlled from outside the cell and may be on all night.[18] Inmates have no opportunity to associate except for recreation, which is ordinarily done in a small group. Meals, bodily functions, hygiene, and sleeping are all done in the cell.

In detention, inmates are allowed only pastoral visits, but not regular visits or phone calls (excluding legal calls). Inmates in detention may not maintain any personal property. They do not receive recreation and may shower twice a week.

According to the New Jersey Administrative Code, both types of units also must have adequate ventilation, temperature and light (for visual observation). Inmates cannot be placed in unclean cells or those that have malfunctioning sanitary fixtures or lights. Bedding and mattresses, personal hygiene supplies, cleaning supplies and writing materials must be provided. Regular institutional food is provided.

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17. At EJSP, inmates reported that they received recreation only twice per week for two hours in 1996, and in 1997, once a week. At AWYCF, inmates in 1997 reported that they only received three hours of yard recreation twice per week.

18. Conversely, inmates may be left without sufficient light if the bulbs in their cells blow out and are not replaced, as in the case of John Doe # 123.

2. Administrative Segregation environment and structure of cells.

a. Administrative segregation units

At NSP, EJSP, and AWYCF, the cell structure was essentially the same, with cells arranged either in a square pod or in a row with multiple tiers. These areas are often very noisy, with doors clanging and staff and inmates communicating by yelling. The cells generally are made of gray cement, with an unmoveable sink, commode, bed slab, and a shelf. Inmates complained of mice and roach infestation at some facilities and, at AWYCF, inmates complained of lack of heat. Some cells were filthy, had peeling paint or leaks. Others needed repairs.

Conditions in 7-Wing, the administrative segregation unit at NJSP, were particularly oppressive during the 1996 inspections. The cells were small, poorly lit, crudely built, with metal walls and a metal hole for a commode which was part of a metal alcove in the back wall. Each cell contained several small shelves, a cement bed, a single naked light bulb and a switch. The door had vertical and horizontal bars. Renovations were underway, and some inmates had been temporarily transferred to C-Wing, a new, modern maximum-security pod with a spacious interior. When the renovations were completed however, the inmates were all moved back to 7-Wing.

On return to 7-Wing in 1997, renovations had been finished and some air-conditioning and ventilation problems remedied. The hole-commode in the wall could now be flushed by the inmate. There were new air-conditioning and ventilation ducts. Some inmates also had TV and personal property. Yet, several (nonrecessed) naked light bulbs had been broken for as long as a month. The plumbing was not working in one cell.

The naked light bulbs and electrical fixtures were new.

b. Disciplinary detention

Conditions in disciplinary detention facilities at the male facilities ranged from the deplorable to frankly inhumane:

- The disciplinary detention area at NJSP (also used for mental health observation) had some of the worst conditions I have ever encountered. The inmates reported little out-of-cell time, consisting of a shower every three or four days for 15 minutes and no recreation. Each of the cells visited during the 1997 inspections had the nonflushing toilets that were filled to overflowing with feces, paper and cloth. Inmates workers wearing masks were employed to drain these holes with a roto-rooter and then fill them with bleach. The result was a nauseating stench that only added to the general odor of feces throughout the area. Inmates were not given toilet paper and reported gnats or other small insects everywhere, including in their food. There was poor or no lighting in these cold cells. There was no fresh bedding, and inmates generally wore the same clothing for lengthy periods of time.

- As will be discussed more fully below under Crisis Intervention, the mentally ill in crisis are deliberately placed in these settings, to facilitate their observation. Often, as their mental condition deteriorates, the condition of their cells can become indescribably foul. For instance, many inmates who were in detention on the bottom floor of administrative segregation and were extremely psychotic, dysfunctional and deteriorating. Their cells became completely filthy, the stench of garbage and feces overpoweringly malodorous. Many were not mentally intact enough to be bothered by any of this.

- Disciplinary detention facilities at other institutions, while not as inhumane and unlivable, were very stressful because they tended to be dark and dirty. At AWYCF in particular, the detention cells were generally dirty with peeling walls and ceiling, although the toilets and sinks worked. The farthest cells on the wings had a lexan on plastic front, and a number of cells toward the end were covered with a mesh grill work.

3. Milieu

Many inmates spontaneously complained about the treatment of the mentally ill in administrative segregation and detention areas. They were upset about the conditions in which the mentally ill lived, provocation, teasing and neglect by correctional officers, lack of recreation time, clothing or any property for the mentally ill on observation status, and occasional withholding of food. During one tour, a male inmate was strip searched in front of female officers.

At EJSP in 1997, a number of inmates were psychologically traumatized and angered by the apparent medical death of John Doe # 75, who had been receiving mental health treatment services. Inmates who had lived near John Doe # 75 complained that officers and nurses were neglectful and abusive with respect to his medical complaints.

At EJSP in 1996, John Doe #124, as well as other inmates complained about the neglect of John Doe # 81, who banged on the door constantly before finally committing suicide the previous year. John Doe #124 reported that John Doe # 81 had been placed on mental health observation on constant watch for two days, where he was left naked, extremely cold, with no property and no mattress. John Doe #124, at that time, was housed in cell A, while John Doe # 81 was in cell B. Both John Doe # 124 and John Doe # 81 were later moved to C Building with John Doe # 81 in cell A or B on the flats, where John Doe #124 could see him from cell C. John Doe #124 saw correctional officers taunt John Doe # 81 by breaking his cigarettes after promising him a light. This made John Doe # 81 angry. Several hours later, John Doe # 81 hung himself.

Nurses, who were checking him every two to three hours, discovered his body. John Doe #124 also said correction officers might skip mentally ill inmates' meals out of spite. He made similar observations regarding another inmate on mental health observation in the C unit flats.

III. FINDINGS REGARDING MENTAL HEALTH TREATMENT SERVICES

My findings relating to treatment services, unless otherwise specifically noted, have applicability to the entire system of mental health care for the NJDOC inmates.

A. Organization of Mental Health Services

1. Staffing and caseloads

My review of mental health staffing patterns for NJDOC indicates that for an extended period of time—well beyond the last four years—there has been a gross deficiency in the number of trained mental health staff at all levels (psychiatrists, psychologists, and social workers). The majority of existing mental health resources has been devoted to performing evaluations for a variety of custody purposes, rather than focusing on treatment services for the severely mentally ill. Lack of sufficient staffing has adversely affected every aspect of treatment services for mentally ill inmates.

CBS's most recent mental health staffing pattern (see Appendix C, Plaintiffs' Deposition Exhibit ("PX") 240), devotes the equivalent of 78.03 full-time

clinicians and administrators to mental health services.[19] This number includes, however, those personnel not involved in providing services directly to inmates in NJDOC facilities: staff for the two juvenile facilities, now operated by the Juvenile Justice Commission, as well as central office staff, including the Executive Director. Excluding those positions, the actual figures for mental health staffing for the twelve NJDOC facilities,[20] measured in terms of full-time equivalent ("FTE") positions, and excluding administrative assistants are as follows:

Psychiatrists:	4.855
Psychologists:	25.84
Social Workers:	21
Total:[21]	51.695

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19. This number includes the addition of one full-time social worker which Dr. Boston testified had been added to the staffing pattern set forth in PX 240.

20. ADTC houses only those inmates convicted of certain sexual offenses, a number of whom are also mentally ill. I have been unable to fully assess staffing at ADTC or to determine the number of dual diagnosed inmates at ADTC who fall within the class definition. No list of patients for that facility has been provided to Plaintiffs, and, consequently, the discussion below concerning the total number of patients in NJDOC facilities excludes the number of special needs inmates at ADTC.

Dr. Cevasco estimated that, in 1997, there were two hundred special needs inmates at ADTC who required mental health treatment for co-occurring disorders. At that time, psychiatric coverage for the facility was thirty hours a week, or 0.75 FTE, but no other staff time was available for treating the dual diagnosed population. Public Safety Concepts ("PSC"), a sub-contractor for CMS, provided treatment only for sexual disorders, according to testimony of Drs. Boston and Cevasco.

21. This total represents an increase over the 1996 level of mental health staffing for the eleven facilities which CBS has staffed since privatization. The number of full-time equivalents providing staffing for NJDOC prisons (and excluding juvenile facilities, central office staff, and administrative assistants) as of October 25, 1996, two months

This total, however, greatly overstates the level of treatment services because the primary responsibility of the psychologists is to conduct evaluations of various sorts for corrections purposes, leaving very little time for actual patient care.

More specifically, as of August 1998, the mental health roster of inmates identified as mentally ill and receiving treatment services included approximately 1,960 inmates. Under the NJDOC staffing pattern, the equivalent of five full-time psychiatrists must be responsible to treat approximately 400 seriously mentally ill patients each and maintain their professional standards of practice in doing so. Because Ph.D. psychologists are devoted primarily to activities other than treatment, the 21 social workers must provide most of the other treatment services. Even the social workers, however, are required to also provide group therapy to general population inmates, many of whom do not suffer from a mental illness, thereby further reducing the amount of clinical time available for the mentally ill inmates most in need of care.

CBS conducted a study in January 1998 of all activities performed by its staff.[22] Relying on December 1997 data and assuming a caseload of 1,700 mentally ill

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after the privatization of all mental health services was 41.63.

Between 1996 and the present, however, the NJDOC opened a new facility, the Southwoods State Prison ("SWSP"). Thus, to accurately compare the staffing levels at the facilities open in 1996 with staffing for those same facilities in 1998, I reduced the 1998 FTE total (51.695) by the number of clinicians providing care at SWSP (5.5 FTEs), as those staff additions were purely attributable to the opening of SWSP. This reduction resulted in total staffing for the identical eleven facilities of 46.195 FTEs. Thus, the current staffing has increased by a total of only 4.565 FTEs since 1996.

22. A redacted version of the study was produced to Plaintiffs, and counsel for CBS represented that self-critical portions of the study had been withheld pursuant to court order.

patients, a group of in-house experts and consultants assessed all job-related activities required of their clinicians, determined the amount of time necessary for each activity, and from that, calculated how many people would be needed to perform them. Central to this complex process, of course, were the estimates of how much time certain clinical activities took. For example, to handle a mental health crisis, the study determined that a psychologist and social worker would need only 30 minutes and a psychiatrist five minutes and that an initial psychiatric diagnostic evaluation averaged 20 minutes—very unrealistic and minimal time determinations for such activities. Even using these substandard criteria, however, the overall results of the study showed that CBS lacked the staff necessary to accomplish their contractual duties, much less provide adequate treatment to all mentally ill inmates within the NJDOC facilities.

Neither CMS nor CBS employ mental health nurses, who by specialized training or experience are expert in caring for the mentally ill and provide counseling for patients who are noncompliant with their medications. While some nurses no doubt have prior experience in the mental health area, there was no evidence of any policy to assign such nurses to housing units where the mentally ill are congregated.

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Prior to the beginning of privatization, the NJDOC employed various full-time and part-time psychologists and psychiatrists to provide mental health services at fourteen NJDOC institutions which then included juvenile facilities. Of the 78 budgeted Psychology positions, only 20 were Ph.D. Psychologists, some of whom were unlicensed, and the remainder were unlicensed masters-level psychologists. There were 33 vacancies

as of June 6, 1996, and 15 licensed Psychologists. At the same time, the 4.7 FTE psychiatrists were employed mostly on a part-time contract. Many of the limited resources were concentrated at ADTC.

2. Policy and procedure

Quality of care begins with the setting forth of policies and procedures in mental health service areas that incorporate and maintain professional standards of practice. Policies and procedures should not only instruct staff to render treatment, but they should also incorporate standards of clinical practice necessary to ensure quality care. The fifteen policies and procedures drafted by CBS and approved in November 1997, after a full year of operation, are so brief and so lacking in procedural detail, that they do not provide necessary guidance for clinicians.

The mental health policies and procedures closely track the contractual requirements for the provision of care and were crafted with the ultimate aim of meeting accreditation standards for policies and procedures set forth by the National Corrections Commission for Health Care ("NCCHC"). Some of the policies, such as forensic services and participation in executions, focus on topics that are irrelevant to the provision of mental health services, even though contained in the NCCHC standards. At the same time, policies and procedures are lacking for such critical areas of service provision as psychiatric medication management, comprehensive diagnostic assessments, emergency psychiatric care, and other important topics.

Prior to the creation of the CBS policies and procedures, local operating procedures unique to each institution and varying widely in appropriateness were used.

They essentially consisted of a set of procedures for operations such as mental health observation, commitments to the Forensic Hospital, and corrections procedures involving use of force and restraints.

3. Medical Records

Reviews of integrated medical and mental health records for the initial group of named Plaintiffs revealed that prior to the start-up of medical services by CMS, the NJDOC records were extremely disorganized. They mixed up dental, medical, and mental health records in a loosely chronological order. No dividers were used, and materials were bound in a single manilla folder. More significantly, psychological evaluations and interview materials containing sensitive information was found extensively in the classification files and, therefore, was available to correctional staff.

The medical records produced by CMS were generally better organized, except for the mental health section. My review in mid-1998 of ostensibly complete medical records indicate that the mental health records continue to be disorganized and that many critical documents were missing, including evaluations, doctor's orders, medication records, mental health progress notes, laboratory reports, suicide watch and other observation forms, and discharge summaries from the Forensic Hospital and other hospitals. Interviews with staff, correspondence and quality assurance surveys by CMS and the NJDOC confirmed the continuing fragmentation and disorganization of the mental health chart. Efforts to remedy these matters have failed, perhaps due to the lack of any policy or procedure by CBS which would inform mental health staff as to how to create and maintain a mental health record. The record keeping problems were compounded by

the existence of numerous files outside of the medical chart, including separate mental health files for inmates on observation and for inmates approved for involuntary medication, and separate files maintained by individual clinicians containing therapy records, copies of evaluations and other selected documents.

The significance of these multiple files and the existence of gaps in the medical record is that no one chart contains comprehensive mental health information. A clinician simply cannot pick up a single mental health record and gain a comprehensive sense of the condition and treatment of a given patient, a situation which seriously impedes adequate mental health treatment and continuity of care.

4. Quality assurance

Even after policies and procedures are established, a system cannot assess how well the staff have actually implemented the procedures or assess the quality of care they provide in the absence of provisions for utilization review, quality assurance, staff training and the like. Procedures can direct staff, for instance, as to how to handle suicide-related emergencies; but without systematic study of critical incidents, suicide attempts and completed suicides, quality cannot be improved or maintained and risks cannot be avoided.

Until September 1997, CBS did not have a consistent quality assurance program. Half of the facilities had not conducted any mental health quality assurance studies, and a majority had not held any quality assurance meetings. In September 1997, Dr. Boston implemented a uniform Continuous Quality Assurance ("CQI") program covering the following topics only: restraints, suicide watches, treatment plans, and

psychotropic medication. CBS's current efforts focus in a limited way on paperwork, not care, and fail to address such critical areas of care as monitoring of required tests and blood levels for medications, quality of diagnosis and treatment, access to care, reception screening and many other important areas.

B. Access to Mental Health Treatment

1. Reception screening

The purpose of screening at a reception center for all new inmates is to determine their medical, mental health, and dental care needs as well as identify anyone with medical, psychiatric or dental emergencies and/or anyone who suffers from any contagious disease.

All new inmates receive a brief screening interview by a licensed clinical social worker who determines whether or not the inmate has identifiable current mental health needs.[23] A psychologist must then complete a portion of the screening form based upon an extremely limited interview. This assessment includes whether the inmate needs acute care, such as seclusion and emergency treatment or hospitalization, or whether he or she may be treated in the general population of the system. This information is forwarded to the NJDOC classification authorities who determine custody status as well as to which

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23. The reception process described above went into effect in late 1997. The previous screening system resulted in the NJDOC's complaining to CBS and CMS that reception was not identifying inmates who required mental health treatment. My review of inmtate medical records revealed that several seriously mentally ill inmates had not been screened, including John Doe #125, John Doe #126, and John Doe #127.

prison to send the inmate.

Once an inmate is transferred from reception to a prison, nursing and mental health staff are required to review the incoming charts to identify special needs inmates and to provide for follow-up care. Dr. Boston stated that she was not familiar with each institution's actual practice in this area.

Audit materials suggest the reception process does not result in follow-up care for all mentally ill inmates in need of such services. A letter from Dr. Cevasco, dated April 9, 1998, summarizes his findings on the follow-up of incoming inmates with a history of mental illness. Although I have not been provided with the underlying data for the audit which would facilitate assessing the reported results, Dr. Cevasco's findings show that while 141 of the inmates reviewed had a history of taking psychotropic medications, only 80 of the inmates were on CBS's mental health roster which suggest persistent problems with access to care. The findings also indicated problems regarding access to psychiatric care. Audits of AWYCF and EMCFW also suggest that mentally ill inmates continue to experience significant delays in obtaining treatment.

A review of the screening form used prior to privatization (see Appendix D, Screening Form) indicates that very few mental health questions were asked by the medical department, other than the history of psychiatric hospitalization and current medications. This more limited process resulted in the failure to identify some mental health patients at reception.[24]

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24. For example, despite an extensive history of treatment with anti-psychotic medications in the county jail, John Doe # 44, received no psychiatric diagnosis—and

2. Mental health referrals

A referral system was designed to catch those inmates whose mental health needs were missed at reception center screening, or who developed new mental health problems. Inmates can ask for treatment and refer themselves to the mental health treatment system. In addition, correctional and medical staff can refer an inmate who seems to be having mental health problems to the mental health system, although CBS's policies and procedures do not actually require staff to do so. Few referrals are actually recorded on the designated form, and the system is primarily an oral one. Staff members call the lead psychologist to make a referral. Because of this, mental health referrals are not logged in any way to track whether the referral process actually results in mentally ill inmates receiving treatment services.

Inmate interviews throughout the facilities visited revealed widespread breakdown of the mental health referral system. Many inmates reported an average wait of weeks to even months for psychiatric or psychological attention. While many inmates had little information or orientation about how to access mental health services, those who knew tried asking officers or nurses, and sent written referrals without receiving a response. A response, even if forthcoming, was often delayed for up to many weeks. At East Jersey State Prison in 1996, where there were no mental health staff operating in the facility other than the psychiatrist seeing his own patients, opportunities for mental health referral and attention to emergencies was nonexistent creating a very dangerous situation.

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hence no treatment—upon her transfer from the county jail to state prison.

While health services and social services were reportedly triaging mental health complaints and problems, nothing could be done about the referrals in the absence of any mental health staff.[25]

3. Case management contacts

The NJDOC contract as well as policy and procedures require that every inmate newly assigned to administrative segregation or disciplinary detention areas be screened within three days and contacted every 10 days thereafter. Social workers are responsible for screening and contacting *all* inmates in administrative segregation areas, and the psychologist is responsible for contacting all mental health patients every 10 days. Interviews during the inspections in 1996 and 1997 were conducted to determine whether, and to what extent, mental health staff were conducting the contractually required screening and case management contacts. Audits and depositions relevant to case management contacts provided additional support for my findings from the site inspections. These findings are summarized as follows:

a. While there was some evidence of screening of new inmates (*e.g.*, NJSP 1996), new inmates generally were not screened by mental health clinicians. This was especially true in detention areas where admissions and turnover were frequent.

b. The 1996 inspections of NSP and EJSP revealed that mental health staff were not conducting rounds. At the time of the EJSP inspection, no mental

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25. For example, an EJSP psychologist performing "crisis intervention" with John Doe # 30, on July 3 and July 12, 1996, "strongly recommended that John Doe # 30 be seen by the psychiatrist as the delusions are particularly threatening to him." However, no psychiatrist saw John Doe # 30, who during the next three weeks, committed infractions for which he received nearly four years of administrative segregation. He was then committed to the Forensic Hospital for three months on July 26, 1996.

health staff were employed at the facility. The inspection at EMCFW revealed that rounds were being conducted in disciplinary detention. Inmates at AWYCF reported rounds in the administrative segregation units but not in the disciplinary detention area, with the exception of contacts with identified mentally ill inmates. Although the lead psychologist and a social worker at NJSP stated that administrative segregation and disciplinary detention rounds were routinely conducted, inmates uniformly stated that rounds were not being done, and medical files contained no documentation of the rounds.

During the 1997 inspections, inmates uniformly reported seeing mental health clinicians in these areas on a weekly basis, but there was a widespread belief that they were there only to see mentally ill inmates on medications.[26] Interviews with inmates in all institutions with administrative segregation and disciplinary detention facilities reveal large numbers of unidentified and very seriously mentally ill inmates who were not on the mental health roster, were not receiving appropriate mental health care and were too sick to make their needs known. The screening and social worker contacts in administrative segregation and disciplinary detention have failed to identify and refer many of these very seriously ill inmates for mental health treatment.

c. Many inmates reported (and record reviews confirm) that mental health clinicians talked to the corrections officers rather than inmates, and when the inmate was out, only looked at the cell.

d. Although policy and procedure calls for psychologists to conduct the interviews with identified mental health patients, medical records did not reflect documentation of their rounds.[27]

4. <u>The abandoned mentally ill inmates</u>

During both sets of inspections to the institutions, CBS was incapable of

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26. It is unclear whether mental health clinicians identify themselves appropriately, as many inmates could not distinguish between mental health staff and institutional social workers who have very different duties.

27. Dr. Collins, in his deposition, indicated that the clinical contacts he made with mental health inmates were brief, and while many such contacts were made, they were never documented because of lack of personnel resources to do so.

even counting its patients and establishing the size of the caseload either for the system or for individual institutions. This inability meant that mental health staff were unable to provide follow-up services to patients who needed treatment. Patients were literally "lost" and had to re-access the treatment system, usually in the form of a crisis. In the interim, they sometimes experienced very substantial delays in accessing necessary treatment and, consequently, often suffered from a deterioration in their mental health. Continuity of care was poor, especially when mentally ill inmates were transferred from institution to institution.

NJSP illustrates the problems CBS experienced in developing an accurate count of inmates in need of mental health services. An initial list, as of May 3, 1996, of inmates on psychotropic medications in administrative segregation reflected twenty-four inmates. Another list of patients, distributed at the time of the 1996 inspections, listed thirty-seven inmates in administrative segregation and another fifty inmates in general population. However, Dr. Munoz, a psychiatrist for NJSP, indicated that he had approximately 100 patients in administrative segregation alone. To further complicate matters, Dr. Collins, the chief psychologist, indicated that when inmates refused their medication, they were struck from the mental health roster (which was essentially equivalent to the deletion of inmates from the psychotropic medications list). The August 1998 special needs rosters reflect a total of 252 patients for the entire facility, almost three times the number identified in December 1996.

Site inspections, as well as a review of inmate records, indicated the existence of a systemic under-counting of patients, not just at NJSP, but at other facilities

as well. A significant group of seriously mentally ill inmates who, though previously identified as suffering from a mental illness, had refused to take prescribed psychotropic medications had been discharged from the mental health caseload and were not being followed. (See Transcript of Hearing before the Honorable John J. Hughes, October 11, 1996.) More recently, a case management contact system has been put in place to contact and monitor the condition of this group of inmates who refused medications and continue to be very seriously mentally ill. Nevertheless, identified patients continue to be lost and go without treatment in some instances.[28]

C. Diagnosis and Treatment Planning

1. Diagnoses

Record reviews in 1996 and 1997 revealed extensive problems in the area of diagnostic assessments. First, standards of practice in psychiatry and psychology require that diagnoses of a mental disorder be expressed and described along five different dimensions or "Axes."[29] Except for an occasional Forensic Hospital discharge summary, five-axis diagnoses did not appear in any of the medical records reviewed. Psychiatrists making diagnoses generally referred to the primary Axis I psychiatric disorder without

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28. *See*, *e.g.*, the records of John Doe # 94, and John Doe # 128.

29. The first axis describes the primary mental disorder or disorders; the second, any disorder of underlying personality structure or character structure; the third includes relevant physical medical disorders; the fourth describes psychological stressors which were relevant in the evolution of the primary psychiatric disorder; and the fifth describes, broadly, the level of functioning of the individual as a result of the disorders. *See* Diagnostic and Statistical Manual IV, American Psychiatric Association.

reference to the other axes. This generalized and highly inadequate system of diagnosis makes broader mental health assessment and treatment planning virtually impossible.

A second problem, related to the one described above, is the lack of comprehensive clinical assessments for diagnostic purposes outside of those contained and supported in the rarely available Forensic Hospital discharge summaries. Psychiatric interviews were brief and highly focused on the individual's current mental status. Often, the psychiatrists did not have the benefit of outside records.

Third, where inmates had extensive Forensic Hospital stays during which complete diagnostic assessments were conducted, these settled diagnoses were frequently unavailable to treating psychiatrists, as were the hospital discharge summaries. As a result, numerous changes in diagnosis occurred that were not well-founded.

Fourth, until the development of treatment plans, diagnoses could be found in the charts, but only by inspecting progress notes where a diagnosis might be mentioned by a reviewing psychiatrist. In a few charts reviewed during the 1996 inspections, no diagnosis at all could be found.[30] Diagnoses were not included in any generalized master problem list or master diagnostic list in the chart, so a clinician could not pick up a chart and quickly identify the diagnosis of the inmate.

The cumulative effect of these problems was that different doctors performed services for the same patients using different diagnoses and, therefore,

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30. Examples include John Doe #129 (EJSP), John Doe # 4 (EJSP), John Doe #130 (EJSP), John Doe #116 (EJSP), John Doe # 131 (AWYCF), and John Doe #132 (AWYCF).

different medications, without an adequate record on which to base their diagnoses. Consequently, mentally ill inmates suffered from delays in receiving appropriate treatment, during which time they continued to suffer the untrammeled effects of their poorly treated diseases.

An example of the serious ramifications of these difficulties in diagnostic assessment are illustrated in the record of John Doe # 1 A review of his record reveals a 1985 record of hospitalization clearly diagnosing him as a paranoid schizophrenic. No psychiatrist ever referred to this past history and diagnosis. Instead, on January 26, 1994, a psychiatrist determined that there was no need for medications or any follow-up. John Doe # 1 nonetheless required repeated hospitalizations at the Forensic Hospital. On June 28, 1996, he was discharged with the diagnosis of schizo-affective disorder, with a prescription for heavy doses of injectable anti-psychotic medications. Shortly after his return to the NJDOC on July 12, 1996, a psychiatrist diagnosed him as having an antisocial personality disorder, and characterized him as seeking to manipulate his way into the hospital by attacking an officer, without any indication of his awareness of John Doe # 1 recent hospitalization or diagnosis. The same psychiatrist, one week later, also prescribed doses of anti-psychotic medications usually reserved for the seriously mentally ill. Five days later, on July 24, 1996, a second psychiatrist evaluated the patient on an emergency basis and determined that he met the criteria for involuntary hospitalization, and John Doe # 1 returned to the Forensic Hospital for two months. A year later, the lead psychologist at NJSP indicated that John Doe # 1 had another short stay at the Forensic Hospital and received a "character diagnosis" (meaning an Axis II diagnosis and one that

the clinician did not believe was serious).

2. Mental health assessment and treatment planning

Chart reviews and other information indicate that treatment planning commenced in November 1997 with the implementation of a CBS policy and procedure called "Treatment Plans". Prior to November 1997, there were no treatment plans. Even after November, 1997, the "treatment plans" in use were brief, stereotypic and bore no resemblance to a true treatment plan.[31] The body of the treatment plan consisted of a set of procedures for various staff, and several blank lines at the bottom may or may not have a written notation about encouraging medication compliance. In a system where the almost exclusive treatment modality is medication, the psychiatrist should actively participate in the treatment planning process. Instead, the social worker drafts the plans without meeting with the inmate and the psychiatrist's input is limited to providing a diagnosis and a list of medications. As a result, treatment plans lacked any reference to mental health assessments, other mental health problems and needs of the inmate, as well as any other feature mental health professionals would ordinarily expect to find in a treatment plan. Changes in the patient's condition or treatment did not result in any revision to the treatment plans that I reviewed.

Finally, mental health treatment of all kinds is customarily viewed as a collaborative effort between patient and clinician. The patient is an active participant and agrees to treatments whose necessity, risks, and benefits are explained. Ordinarily, the

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31. For instance, diagnostic and treatment recommendations by the Forensic Hospital did not surface in any recognizable treatment plan for the ex-hospital patients.

patient participates in, and signs the treatment plan. No treatment plans in the reviewed records were signed by any patient, although Dr. Boston testified that she had advised her clinicians to obtain signatures, a change that was greeted with some initial complaints.

D. Treatment Services (Medications)

1. Prescribing practices

a. Dosages

Chart reviews revealed many instances where medications were underprescribed or prescribed in less than therapeutic doses for a particular inmate in light of his circumstances. For example, John Doe #133, interviewed at EJSP in 1996, saw the psychiatrist twice a month and was on Navane and Cogentin, medications appropriate for his schizophrenia. His speech was extremely inappropriate and at times he displayed an extremely manic and euphoric affect. After the interview, he shouted nonsensical things. He would not take recreation and continuously begged for cigarettes. Another EJSP inmate (John Doe #117), whom I interviewed in 1996, was receiving a form of Decanoate injection every three weeks (long-term antipsychotic medication) and Cogentin. He was on this medication and seeing a psychiatrist every two weeks when he set a fire in 2-Down. Yet, while in administrative segregation, he was agitated, showered only once a week, and had recently flooded his cell. Likewise, at AWYCF in 1997, John Doe #134, an ex-Forensic Hospital patient, complained of ongoing panic attacks, despite taking his Ativan .5 mg three times a day.

Another important reason that psychotropic medications may be inadequate

for some inmates, even when they are closely managed by a psychiatrist, is due to the stress of living in administrative segregation. The effect of the environmental conditions on mental health is demonstrated by those inmates who had at one time been stabilized on a certain dosage of medications while in a more benign setting, such as a mental hospital. When those inmates were placed into the stressful setting of administrative segregation, they decompensated on that same dosage of medication. John Doe #121, is but one example of this phenomenon. Prior to entering the system, he had been stabilized for 15 years and quite symptom free and functional on a small dose of Mellaril and Benadryl. At the time of my 1996 interview with him, he was suffering from continuing symptoms of his illness, including delusional thinking and other forms of thought disorder. He was on the same medication at the same dosage he had successfully taken before.

On the other hand, medications were only rarely prescribed at a dangerously high dosage. Those exceptions were usually occasioned by telephone orders from a psychiatrist unfamiliar with the medical records, speaking to a nurse who was equally unfamiliar with the record or did not have it available.[32]

In general, medications also were appropriate for the diagnosis. Notable exceptions, however, appear related to diagnostic conflicts and uncertainty such as where the psychiatrist treated the patient for the wrong illness and prescribed inappropriate

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32. During a period when John Doe # 121 was extremely psychotic and received a series of disciplinary charges while he was in administrative segregation, a physician gave a telephone order for what amounted to eight times his regular dose of Mellaril which resulted in symptoms of overdose and an adverse muscular reaction to his medications which also had to be treated. He was subsequently stabilized on the same mediation in much lower doses.

medications or where the psychiatrist prescribed a medication change without any clear need to do so.[33] Usually, however, if there was a clear Axis I diagnosis of a psychiatric disorder, the medications prescribed were generally appropriate for that kind of disorder.

b. Medication management

CBS's policies and procedures require follow-up medication reviews by treating psychiatrists on at least a monthly basis, and more if the patient's clinical condition requires it. Many of the inmates interviewed who were on psychotropic medications reported approximately monthly follow-up visits with their psychiatrist. However, a significant number of such inmates reported much less frequent psychiatric reviews, some ranging to every six months and more. Often these reviews of medications were not documented by psychiatrists even where changes in medications were made. This practice appeared to improve as time went on, but records from 1996 and before contain very little documentation of medication reviews.[34]

In addition to reviewing the efficacy of medications, another purpose of follow-up medication reviews is to determine the extent to which inmates may be suffering from side effects of their medications. All standards of practice require routine reviews to

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33. For example, in 1996 after a settled diagnosis had been made, a psychiatrist treated John Doe # 135, for the wrong illness with medications that were inappropriate for his condition.

34. As is discussed above at 46-47, the mental health charts are so badly organized and deficient in critical documentation that it is impossible to tell what the prescribing practices and medication review practices of psychiatrists are. My chart review findings are consistent with other information, particularly from NJDOC and CMS audits of mental health practices which found deficiencies in documentation by psychiatrists.

check for such muscular side effects, and CBS's policies and procedures, as well as the CBS contract, require that psychiatrists perform AIMS testing periodically. This test is a form containing structured observations of inmates on medications to see whether or not they are experiencing abnormal movements or other signs of muscular side effects. This form is usually used by psychiatrists or, more often, by nurses. In chart reviews, no evidence of AIMS testing was found.

Nevertheless, both my inspections and chart reviews uncovered inmates experiencing anything from mild to sometimes severe side effects of their medications that went unaddressed for significant periods of time. John Doe #136, for example, was on various psychotropic medications that resulted in dry mouth, dizziness on standing, and urinary retention. Similarly, John Doe # 1, was prescribed intramuscular Prolixin, an antipsychotic medication, and noticed tremors which were a side effect of the medication. His psychiatrist then prescribed oral Prolixin, the very drug which had caused the problems. Some side effects I noted were severe and also represented irreversible neurological syndromes. A number of inmates who had been on antipsychotic medications for a long period of time were experiencing abnormal movement disorders associated with long-term antipsychotic medication usage, including tardive dyskinesia, an irreversible form of such disorder. These patients who were examined in the general population were, however, being closely followed by their psychiatrist, and appropriate medications had been prescribed in an effort to alleviate the side effects.

Some psychotropic medications also can have an adverse impact on various organ systems of the body and, consequently, require that a certain medical evaluation

take place prior to the initiation of these medications, as well as on-going monitoring. For instance, Lithium and Valproic acid, which are mood regulators, and Tegretol and Dilantin, which are anticonvulsants, but also used for impulse control disorders, require a preliminary medical evaluation and ongoing blood testing to make sure that no serious medical problems, including death, are being caused by these medications. Chart reviews in 1996, and particularly in 1997 (See Appendix E, listing of charts reviewed for lab work), reveal that premedication work-ups for these medications were generally missing and, where they existed, indicated that they were often ordered after the medication had started. Retesting was not seen.

In addition, many of these medications must reach a certain minimum level in the blood to be effective. Yet, there is also an upper limit to their levels in the blood beyond which serious adverse medical consequences, including death, can occur. Blood levels of these medications must hit a certain "therapeutic window" and, therefore, require frequent blood tests. In chart reviews of inmates on Lithium, blood levels after beginning Lithium or changing the dosage were generally absent as were periodic Lithium levels for stabilized patients. Likewise, inmates on Tegretol and Depakene (valproic acid) also were not properly monitored. Such omissions can be an extremely dangerous practice and are ordinarily guarded against through heavy scrutiny, quality assurance and continuous monitoring.

c. Formulary

A formulary is a list of approved medications that individual practitioners within a medical organization can use to prescribe for their patients. The rationale

underlying the use of a formulary by CMS also includes several presumed benefits, including standardization of medication prescribing practices for similar diagnoses and cost containment. A review of the CMS formulary for psychotropic medications reveals that many safe and very effective later-generation antipsychotic and antidepressant drugs are not listed. Coincidentally, these newer drugs are also more expensive than the older and less safe early-generation drugs. CMS discourages off-formulary drug requests by prescribing psychiatrists, and clinicians attempting to utilize off-formulary drugs have experienced some frustration.

Another problem with the formulary is the limitation it imposes on psychiatrists seeking to effectively treat inmates who are "treatment resistant," to a particular medication such that it has become ineffective against their illness. Treatment resistance requires a change in medication to another drug in the same or different class that might prove to be effective, or use of a newer, more potent antipsychotic or antidepressant medication with fewer side effects. One reason for the lack of effectiveness of medications for certain inmates reviewed lies in the fact they may be treatment resistant to particular medications. Yet, before a request for an off-formulary drug will be approved, formulary policy requires that therapeutic trials of all formulary drugs have failed. This "failure-based" approval process as a practical matter denies many inmates access to many very potent and effective medications.

In addition, continuity of care is compromised when inmates arrive in the system on "non-CMS formulary" drugs and are taken off them. For example, after many drug trials and a very turbulent psychiatric history in administrative segregation, John Doe

#137, was hospitalized at the Forensic Hospital and finally stabilized on Olanzapine, a new and very effective antipsychotic agent that is off-formulary. He stabilized very quickly on that drug and was returned to the prison system on July 18, 1997. An on-call psychiatrist was called, and in a telephone order, discontinued the Olanzapine without examining the patient. John Doe # 137 became increasingly psychotic and resistant to medication treatment (although he was taking it) which culminated in the use of the involuntary medication process in January 1998.

2. Involuntary (nonemergent) medications

On October 29, 1997, the policy for involuntary administration of psychotropic medication in nonemergency medical situations was promulgated, along with a companion policy entitled "Use of Force Involving the Involuntary Administration of Psychotropic Medications" which began November 17, 1997. The involuntary (nonemergent) medication policy allowed for the consentless administration of medication "in the inmate's best medical interest" for those inmates who were seriously mentally ill. In this policy, serious mental illness is defined as a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of prison life, and which is manifested by substantial suffering or disability.[35] Involuntary (nonemergent) medication may occur only upon the approval of a

35. Circumstances which meet the "best interest" test include: (a) there is a substantial likelihood of an inmate's serious physical harm to self, to others or to property as a result of his mental illness (b) as a result of his mental illness, an inmate is unable to care for himself, so that his safety is endangered; and (c) the inmate is incapable of participating in any treatment plan which would offer the inmate a realistic opportunity to improve his condition.

Treatment Review Committee based on the recommendation of the inmate's treating psychiatrist, and only after reasonable efforts to convince the inmate to voluntarily accept clinically indicated medication have been exhausted. A finding by the Treatment Review Committee permitting involuntary medication (or collection of blood tests) will be in effect for 30 days. At the end of 30 days, the same procedure takes place, which may culminate in a determination by the Treatment Review Committee that the order authorizing involuntary medication administration shall be effective for an additional 180 days. The same procedure may reoccur and the order be reviewed at 180-day intervals. The full policy and procedure is set forth in Appendix F.

The use of force policy and procedure requires that the inmate is kept in an appropriate observation status, as determined by medical or psychology staff, until voluntary compliance with medications or a Treatment Review Committee hearing. Upon a determination that involuntary medication has been authorized, the custody supervisor will make the inmate accessible to medical staff using force so that the order to administer the medications can be carried out. At the completion of the administration of the medication, the inmate is returned to the crisis stabilization cell and placed on observation until released by medical or psychological authority. The entire process, including any use of force, is required to be videotaped. Advice from medical staff is required only where the application of mace is anticipated. Appropriate procedures for continued placement of an inmate in the restraint chair are included, at the discretion of correctional staff.

There appears to be no corresponding medical or mental health policy and procedure governing the participation of mental health personnel at any time during this

involuntary administration of medication, nor does the participation of mental health staff appear to be required at all under these policies. There is, for example, no requirement that mental health or nursing staff offer medication to the inmate as a last opportunity to take medications voluntarily and, thereby, obviate the need for use of force or restraints.

To determine the effectiveness of and compliance with these policies and procedures, a random sample of six of 25 involuntary medication charts, as of March 1998, were reviewed. In addition, in 1997, other chart reviews and examinations of inmates on the involuntary medication list were reviewed (one case was excluded for lack of any involuntary medication documentation). Finally, videotapes of the administration of forced medications and the deposition testimony of Dr. Martha Boston were reviewed.

These reviews indicated the following deficiencies of the involuntary (nonemergent) medication process:

a. Relevant doctors' orders, medication administration records, procedural forms, and mental health progress notes were missing in many of the records. One record had no documentation of the involuntary medication process whatsoever. Progress notes tended to end either before the administration of psychotropic medications or shortly thereafter.

b. The outcome of the process and the actual administration of the medications were often unclear. For instance, shortly after the approval of involuntary medications by the Treatment Review Committee, several inmates were transferred to other institutions without any mention of having undergone the involuntary medication process and without the receiving institution being aware of it. For example, John Doe #138, was transferred to another institution (that does not have an involuntary medications program) on the same day his involuntary medications were approved by the Treatment Review Committee. No subsequent doctor’s orders were found, and the medication administration records did not reflect that any involuntary medications were given.

c. Candidates for involuntary medication were apparently chosen simply

because of their history of noncompliance and frequent trips to the Forensic Hospital without regard to whether they were noncompliant at the time of the Treatment Review Committee meeting.

d. Inmates who had indicated to their social worker that they wished to attend the hearing were not permitted to do so.

e. Some prescribing psychiatrists who sought involuntary medications requested that oral medications, such as Lithium, be administered involuntarily. This is not only clinically inappropriate, it is impossible. Moreover, in several cases (*e.g.*, John Doe #138, and John Doe # 86), medications were requested in a range of doses to be given over a range of times. This practice is not only clinically inappropriate but possibly dangerous. As an example, a request for a Lithium 900-1,800 mg per day could result in a serious overdose and a state of toxicity in the absence of appropriate monitoring.

f. While the administration of involuntary medication occurs in an appropriate medical setting, it is unclear what happens to the patients afterwards. Review of videotape segments portraying the involuntary medication of several inmates, reveals that the nurses involvement is brief and limited to coming in, injecting the inmate in the arm and leaving. The only comment heard was "Here's a shot". All the inmates appeared calm, cooperative and silent. No nursing or mental health staff ever offered oral medication, or sought to ascertain the inmates willingness to take it. No nursing staff stayed to determine the efficacy of the medication or unwarranted adverse effects, and no blood pressure was taken afterwards.

g. Like other very high-risk procedures in medicine, such clinical procedures ordinarily require a great deal of oversight review and clinical scrutiny for safety and efficacy. There appear to be no requirements for any review, quality assurance, or monitoring by mental health. However, even if such reviews were attempted, the medical charts are so disorganized and lacking in critical documentation that such review would hardly be possible.

Finally, a review of other materials indicates that inmates at prisons other than those approved for involuntary medication are nonetheless being involuntarily medicated on a nonemergent basis.

3. Medication administration

There are several serious problems with the administration of medication, particularly in administrative segregation and detention areas.

Medication administration was conducted by regular medical nursing staff in restricted housing areas. Caren Gurwitz, RN, who observed medication administration in various administrative segregation and detention areas in two facilities during the 1997 inspections and at one facility during the 1996 inspection, found physical limitations on the ability of nursing to effectively monitor for cheeking. Medications were handed out in paper packages, or in plastic cups. The nurses did not bring juice or medication in concentrate with them. The medications were left in the food port by the nurse who quickly stepped back. Visibility through the cell window was limited, though nurses in 1997 did check to see if the inmate swallowed the medication. In 1996, however, Ms. Gurwitz observed the nurse leave an envelope containing medication on the food port without watching to see if the inmate swallowed the medication. Collateral information from knowledgeable staff also indicates that when inmates take their medications from the food port and have to take it with water, they have to turn around to the sink to get their water, making confirmation that the inmate has taken the medication difficult.

During the 1996 and 1997 inspections of various administrative segregation and detention areas, numerous inmates indicated that they had missed doses of medication because the pharmacy's supply had been depleted. These missed doses ranged from periodic incidents to periods of one week or more. Some of these missed doses were verified by on-site chart reviews. Other complaints were quite specific and credible. Even

intermittent discontinuations of medication can adversely impact an inmate's continuity of care.

Many inmates during the 1996 and 1997 inspections also showed me stashes of medications in various amounts that they had palmed, instead of taken.[36] A 1996 review of inmates' medical records also revealed many examples of hoarding and subsequent overdoses. For example, in October 1994, John Doe # 2, was admitted to St. Francis Medical Center because she had overdosed on Elavil pills. Recommendations by St. Francis to give all medications to her in the form of a concentrate or suspension (liquids) have never been followed. John Doe #122, another named plaintiff, had a number of overdoses for such things as Navane concentrate (a liquid form of antipsychotic medication), an aspirin overdose, and a Percogesic overdose. Indeed, John Doe #122's overdose on Navane was caused when he somehow managed to grab the bottle of Navane from the nurse's medication cart.

In several of the housing units where the seriously mentally ill on psychotropic medications are congregated, inmates are required to leave the unit and go to a pill line or infirmary, especially for injectable medications. As a result, a significant number of such inmates refuse to go for the medications. Exceptions exist, such as at NJSP, where medications are delivered in the congregate care housing units.

Finally, psychiatrists cancel medications for inmates who persistently refuse

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36. *See also* the record of John Doe # 17, who accumulated and ingested an overdose of Ativan, as well as the memoranda of Dr. Don Collins, dated April 9, 1997 and February 25, 1997.

their medications but do not meet the criteria for involuntary medication. After the order is discontinued, case management contacts by social workers provide some monitoring for this group of competent refusers, but such contacts are no substitute for therapy or even a strategy to re-engage the patient in treatment or manage noncompliance with medication.

4. Impediments to treatment

Lack of space for private evaluative and treatment sessions with mental health staff are a significant impediment to mental health services for mentally ill inmates. Inmates, as well as psychiatrists, complained during the inspections that visits at inmate cells in administrative segregation or detention areas are necessarily not private. Staff need to literally yell through the bars or a crack in the door of the cell to be heard by the inmate. Likewise, even when taken from administrative segregation or detention areas to a private office for treatment, many inmates indicated that it was not uncommon for a nurse and several correctional officers to sit with the doctor. Not surprisingly, several inmates stated that they would not discuss or reveal sensitive mental health information under those circumstances. For instance, on November 27, 1996, John Doe # 140, told his psychiatrist that he refused to talk in front of correctional officers and a nurse. As a result, he was returned to his cell. He subsequently told his psychologist that, although he needs human contact, he simply would not disclose private information in front of other people besides his doctor. He was offered a cell-side visit by a psychiatrist, but refused that too.

An inability to provide treatment, particularly crisis intervention, to inmates in their native language also constitutes a serious impediment to mental health services. A

number of inmates in several institutions were interviewed (in Spanish) and spoke only Spanish. Although most had access to psychiatrists and other mental health staff who were Spanish-speaking for routine contacts, they were often deprived of counseling or treatment by Spanish-speaking clinicians during times of crisis or when they were living in restricted housing areas. The inability to communicate with mental health staff during these periods not only effectively denies these inmates access to any verbal treatment, but also greatly compromises the ability of clinicians to monitor or assess their mental status.

Finally, in 1996, inmates were required to make a contribution toward the cost of their psychotropic medications. This contributed to noncompliance with medication. The policy was subsequently revised to provide such medications without charge.

E. Treatment Services (Verbal)

The mental health care program, as formulated and implemented by CBS, is a "medications only" approach to the treatment of mentally ill inmates in the NJDOC. The vast majority of seriously mentally ill inmates in the general population receives few forms of treatment services other than medications. Even inmates in mental health crises throughout the system do not receive verbal counseling, therapy, or other forms of personal management. Policies and practices only require brief assessments of the inmate's condition and the degree of risk posed during the crisis, but very little time is allocated for this activity, and it is not therapy. Mentally ill inmates in administrative segregation and detention areas, and to some extent, congregate housing, may receive case management contacts designed to insure continuity of care and evaluate their mental

condition. But apart from these brief, and often undocumented, contacts, few individual forms of verbal therapies are offered in this system and very little by way of group therapy.

Mentally ill inmates in general population have access to a larger selection of group therapies. Such groups deal with short-term didactic subjects that are often of mental health benefit. However, mentally ill inmates have to sign themselves up for such groups. The waiting lists are very long, and other inmates such as those near parole, are given a higher priority.[37] At Mountain View Youth Correctional Facility, a monthly quality assurance report in April 1998, indicated that the psychology department was replacing its groups with home study psychoeducational "groups."

Despite the limited availability of verbal therapy, many inmates throughout the system have disorders that are best treated by a combination of medications and some form of verbal therapy or even verbal therapy alone. John Doe #141, who was housed in the administrative segregation unit of EJSP, is a good example. When he was interviewed during the 1996 inspections,[38] he indicated that he had been sexually assaulted seven weeks prior to the interview. As he was already suffering from a serious mental illness,

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37. There are several bright spots in this otherwise dismal picture. During the 1997 inspections, this examiner witnessed a group therapy session for seriously mentally ill inmates at NJSP. In addition, at the time of the 1996 inspection of EMCFW, more than half of identified mental health patients received some form of group therapy driven by their individual mental health needs. Several of the 17 therapy groups are even designed for inmates with serious diagnoses, such as schizophrenia.

38. John Doe #141 was interviewed in a private interview room at EJSP. Following the interview, he was escorted by two correctional officers back to his administrative segregation unit. When I visited the unit shortly thereafter, I observed that John Doe #141's face was red and puffy, as if he had been assaulted upon his return. A request to reinterview John Doe #141 or take pictures of his injury was refused.

the assault created what I would call a post-traumatic stress disorder. Following the assault, inmate John Doe #141 indicated he had been prescribed 200 mg. of Thorazine. In addition, he reported he also was taking Depakoate, Zoloft, and Atarax. At the time of the interview, he stressed that the medication which had helped directly following the assault was now too much. He had tried unsuccessfully to sign up for sick call. In the five months he had been at EJSP he had seen his psychiatrist twice. Given these circumstances, inmate John Doe #141 would have greatly benefitted from individual or group psychotherapy directed specifically to his post-traumatic problems.

John Doe #142, who was also housed in administrative segregation at EJSP, is another example of someone who would benefit from verbal therapy. During an interview at the 1996 inspections, John Doe #142 explained that he had been in an accident prior to his incarceration which caused medical and emotional problems. In addition, he had a history of substance abuse. A psychiatrist treated him for his emotional problems with psychotherapy and Buspar, a medication that can be used over a long period of time to treat anxiety. Upon his incarceration, he was discontinued from Buspar, presumably because it was not on the formulary. His request for counseling or psychotherapy also was denied. He had been repeatedly offered medications like Sinequan, an antidepressant, for his problems, but has refused them. Due to his history of substance abuse, he is reluctant to use medications alone to solve his problems.

A significant number of inmates with more serious disorders and consequent functional deficiencies require much more varied and intensive forms of therapeutic programming to address deficiencies in such areas as vocational/occupational

functioning, gross deficiencies in basic hygiene, and activities of daily living. Such inmates, typical of those living in congregate care units, require much more extensive individual and group treatment services than is currently offered. No housing unit operated by the NJDOC provides this type of programming which is necessary to enable the more severely mentally ill inmates to successfully adjust to their incarceration and to maintain their mental health.

John Doe #143, an inmate in a general population unit at NSP, is one such example. During the 1996 inspections, he was visibly hallucinating and his thinking was obviously grossly impaired. He also had severe memory problems in addition to his hallucinations. He reported taking medications since 1989, but nevertheless claimed to experience anxiety on a regular basis. Lacking any social work assistance, he intended to write the Parole Board to see when he would be released. He had no idea of the duration of his sentence.

F. Crisis Intervention

1. Overview

Inmates who experience a mental health crisis are often referred to mental health staff for urgent intervention. While the inadequacy of medical records did not allow for an extensive retrospective review of such interventions, other collateral materials indicate that such interventions for inmates in restricted housing areas are usually conducted cell-side, despite the problems of privacy discussed above at 71-72, while interventions for inmates in the general population are conducted in a private examination

area or the infirmary. Such interventions are usually limited to an assessment to determine the nature of the problem and the degree of risk posed.

The medical records available for review do suggest that inmates in crisis generally receive more frequent mental health contacts. As the mental health crisis escalates, referrals for psychiatric review may be made. Inmates in mental health crisis in administrative segregation settings are often transferred to the first or base floor of the administrative segregation wing and placed on mental health observation. Inmates in the general population may be placed on some form of observation in their own cells, but far more commonly are moved to mental health observation areas in detention facilities. Inmates in mental health observation who become dangerous to themselves or to others as a result of their acute mental illness may be moved to infirmary settings in the few institutions that operate mental health beds in the infirmary. Other institutions render all crisis care to inmates on mental health observation in restricted housing areas due to the danger to themselves or others.

2. Infirmary care

Of the five institutions inspected, only two (NJSP and NSP) have mental health beds either in the infirmary or, in the case of NJSP, near it that are dedicated for use by acutely mentally ill inmates. Yet, neither NSP nor NJSP had mental health staff dedicated to the mental health section of the infirmary. Acutely mentally ill inmates housed there are instead treated by visiting staff. EJSP had three mental health cells in the infirmary which appeared to be structurally safe and appropriate for the provision of intensive care to acutely mentally ill inmates. However, these cells apparently are never

used for that purpose. Similarly, at AWYCF, one bed in the 10-bed medical infirmary can be utilized for mental health, although it is out of the sight of the nursing office and has barred windows with cross bars which renders it unsafe for the provision of acute mental health care. EMCFW did not have infirmary-based mental health beds at the time of the 1996 inspection, but a new infirmary was being constructed and contained several mental health cells which were inspected and appeared to be appropriate for their intended use, provided that they could be sufficiently staffed so as to be able to operate them as crisis care beds.

During the 1996 inspection of the infirmary at NJSP, the six-bed mental health unit was physically separate from the infirmary and required visits by medical and mental health staff, although a correctional officer was permanently posted there. There were no mentally ill inmates in this unit during the inspection, despite staff assertions that the unit was generally always filled. Two of the beds, in fact, were unavailable for mental health use because they were occupied by security boarders.

In a 1997 revisit of this unit, six beds were filled and overflow was sent to 1-Left detention for mental health observation. Five of the six inmates were grossly psychotic, some to the point of being mute or incoherent. For instance, John Doe #144, ranted continuously and claimed to hear voices. He was naked, sitting on a short cement slab, eating from a food tray in which his penis was dangling. There was litter, feces, and food all over his cell. A subsequent review of his medical records revealed that he had stopped his medications approximately a month earlier and deteriorated to this point. There were no mental health progress notes, doctor's orders, mental health observation

forms, or any other indications in the medical record that he was being examined or treated in his current state. The one inmate who was not grossly psychotic, John Doe #145, spoke only Spanish. During an interview conducted in Spanish, he indicated that he had been housed in the mental health observation cell for thirteen days, but was not taking any psychotropic medication. He adamantly denied being or ever having been suicidal or mentally ill, claiming instead that he had simply gotten into a fight. It is unclear how the correctional or mental health staff accomplished their monitoring functions in light of the language barrier.

All of the mental health cells in the NSP infirmary inspected in 1996 were devoid of anything but toilets, with the exception of one room that had no commode or running water and was entirely empty. There were only three inmates in this unit at that time, all of whom were naked and claimed to be freezing. The one inmate in the completely bare cell used a cup for urine. There did not appear to be much staff contact with these inmates, as correctional officers sat nearby watching the rooms through a TV camera monitor which has blind spots. The inmates reported infrequent mental health contact. When revisited in 1997, only one mentally ill inmate, John Doe # 46, was housed in the unit. The 1996 practice of stripping inmates in observation cells has been modified and inmate John Doe # 46 was dressed in a paper gown. John Doe # 46 reported that when he refused medications, he received intramuscular injections, although this was prior to the start-up of the involuntary medication procedure. He had received mental health visits only twice in the past week. His chart had not been reviewed. Finally, one of the empty mental health observation cells was inspected. It had open grillwork making it

unsafe for housing dangerously mentally ill patients.

Review of videotapes portraying the use of restraints for inmates in mental health crisis reveals that they were used after self-injury occurred and that the inmates received no intervention from mental health staff. In the case of John Doe # 2, there were examples of self-injury occurring on tape, while she was on constant watch. During the portions of the tapes in which medical staff were present, neither they nor security staff actually spoke to the inmate very much and not for the purpose of dealing with the mental health crisis. No emergency psychotropic medication was employed for the women who were in obvious distress.

3. Mental health observation – administrative segregation

The inmates interviewed in mental health observation cells in the administrative segregation units during the 1996 and 1997 inspections were the most grossly and utterly psychotic mentally ill people I have ever seen. Acutely mentally ill inmates in mental health observation who may or may not be dangerous to themselves or others are kept for substantial periods of time, sometimes more than a month, with little mental health intervention, no emergency psychiatric medications, without being able to leave the cell for any reason and without personal possessions, clothing, any materials, or sometimes even running water. Such profound examples of mental illness as the ones discussed below are ordinarily found only in historical accounts of 19th and early 20th century mental institutions prior to the development of psychotropic medications.

Of the four inmates in mental health observation cells at EJSP during the 1996 inspection, the most clearly and grossly mentally ill, John Doe #72, was reduced to a

state of near unresponsive catatonia. Correctional officers indicated that he took meals, never spoke and never showered. He did not watch TV or read anything; he just sat in the dark and stared at nothing. Another inmate, John Doe #146, was on close observation. Although extremely delusional, he was sufficiently intact to indicate that his Prolixin was not helping him. He had a history of three Forensic Hospital hospitalizations and multiple suicide attempts, the most recent of which he was discharged from one month prior. He did not know who his doctor was and was extremely upset about being in mental health observation. The inmate next door to him, John Doe # 4, had been on mental health observation for more than a month. He was still angry about what he called the "torture" of having no clothes, mattress, any item of property, and never getting out for any purpose. Yet, John Doe # 4, even as sick as he was, felt sorry for John Doe #146.

Notwithstanding the level of psychiatric illness found in inmates on mental health observation, the most acutely ill inmate in EJSP's administrative segregation unit was not on observation. Throughout his interview, John Doe #116, stood at the window rocking and staring. His room was incredibly foul, reeking of feces and garbage. There was blood everywhere on the window. He had cut his hand on the edge of the window the day before and was rubbing his hand on the window again. He generally was not responsive to questions, instead just stared at his hand. When he finally responded to a question, he indicated that he had once been on Thorazine which had been stopped. I regarded John Doe #116 as an acute psychiatric emergency and referred him to the health services administrator for immediate attention.

At NSP during the 1997 inspection, another inmate was found in a mental

health observation cell in the administrative segregation unit who could be classified as an acute psychiatric emergency. John Doe # 52, spoke only Spanish and had been there for 15 days. He had mutilated himself by biting his body and was hearing voices telling him to kill himself. Nonetheless, he continued to refuse all psychotropic medications, and had received no emergency psychiatric intervention. He had been visited only twice by mental health staff.

Another example of a seriously mentally ill inmate who received inadequate mental health treatment was John Doe #147, who was interviewed in 1997 while on mental health observation in administrative segregation at EJSP. Earlier that day, a psychologist reported that John Doe #147 was delusional, suffered from auditory hallucinations and feared that he was being poisoned. A psychiatrist then ordered an emergency injection of Thorazine 50 mg as well as Ativan 1 mg orally which was administered shortly before John Doe #147 was interviewed. At the time of his interview, he was extremely sedated, lying on the floor under constant observation by correctional officers. He reported hearing voices and said "I want to die." A review of his medical chart and other collateral documents was conducted on site. They revealed that his diagnosis was schizophrenia, of the catatonic type, as of October 1997. He also had attempted suicide by hanging in October 1997. Prior to those notes, his last mental health note was dated July 1, 1997.

John Doe #147's record was reviewed subsequently, and in retrospect, two points about his care and treatment are noteworthy. First, a review of the daily suicide watch reports for December 10, 1997 reveals that at 8:00 a.m., John Doe #147 was

banging his head on the wall, injuring it and causing bleeding. A nurse was notified. Shortly thereafter, he was examined by the psychologist who concluded that he "appeared upset" and called the psychiatrist. It is unclear from the psychiatric and psychological notes whether they had examined John Doe #147's records or spoken with the correctional officers. No mental health staff suggested the use of restraints for his head banging behavior.

Second, while the psychiatric intervention was viewed as appropriate, John Doe #147 had received an extremely sedating medication (Thorazine) which also has an adverse impact on blood pressure that might have accounted for why inmate John Doe #147 was lying on the floor. Yet, no nurse took his blood pressure. EJSP staff also seemed entirely unaware that he had been discharged from the Forensic Hospital to RFSP with medications that were not continued on the previous day. When reviewed on site during the inspection John Doe #147's chart was entirely devoid of any Forensic Hospital discharge summary or even any notation that he had come back from the Forensic Hospital only the day before. This information would have materially aided his interim treatment while waiting two days for hospitalization.[39]

4. <u>Mental health observation in disciplinary detention</u>

Inmates from the general population who require mental health observation commonly are placed in disciplinary detention cells. Disciplinary detention cells around

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39. All the above examples occurred in institutions which had mental health beds in infirmaries. It is unclear why these inmates were not housed and treated in infirmary-based mental health beds.

the system generally are even less safe and more inappropriate than mental health observation settings in administrative segregation. Disciplinary detention cells had more furnishings like sinks, light bulbs which are not recessed, and bars, all of which an inmate could use to injure himself. Inmates in these settings also reported only sporadic mental health visits. Indeed, a number of inmates indicated that, after spending up to several weeks in such conditions on mental health observation, they had not been seen by mental health staff at all.

For example, during the 1997 inspection of NJSP in 1-Left prehearing detention, I interviewed John Doe #148, who showed me a number of slashes on his arms, wrists and neck and indicated he had been victimized by another inmate with a razor while in general population. He subsequently attempted to hang himself, was taken to 1-C (near the infirmary), and then was placed in prehearing detention on mental health observation as an overflow infirmary case. He has been on this status for several weeks and saw a psychiatrist for the first time only four days before our interview. He also reported that correctional officers visit him infrequently.

A subsequent review of his chart indicated that, on November 24, 1997, he was a special needs inmate on no medication, living in 1-EE, the congregate care unit. On that date, he was slashed by another inmate with a razor and placed in the infirmary for care and treatment. He was placed back in general population without benefit of any mental health intervention, and subsequently on December 1, 1997 (nine days prior to our interview), was placed back in 1-C mental health observation. He saw a psychiatrist for the first time five days later who prescribed a mild anti-anxiety drug. His admission on

December 1, 1997 and his discharge to a disciplinary detention cell on 1-Left on December 6, 1997 were accomplished by telephone orders without benefit of any examination by the psychologist. Other than a psychiatrist's order for Vistaril on December 5, 1997, there are no other mental health notes at all since March 1997. There are no observation forms or suicide monitoring forms. In short, his account of his stay in mental health observation was generally confirmed by the record review.

Another inmate, John Doe #95 , examined at EJSP in 1-Left prehearing detention during the 1996 inspection, refused to be interviewed. Instead, he huddled on a cement slab under a blanket while staring into space. Although he had been moved to his cell only a day or two prior, it was filled with feces and litter, including food. The water in his cell, however, had been turned off. He had refused an escort to be seen by the psychiatrist, although his condition had not changed in several days. Subsequent chart review of this time period reveals that John Doe # 95 had returned from his twenty-fifth Forensic Hospital admission on May 3, 1996 and was seen by a nurse and the psychiatrist. That was the last mental health note until December 1996. On October 3, 1996, he was admitted to the infirmary for psychiatric observation and follow-up by the psychiatrist. There are no psychiatric notes, and his next mental health contact was not until December 3, 1996 by the institutional psychologist.

5. <u>Restraint care</u>

Therapeutic restraints are commonly used for cases of medical emergencies involving danger to self or others. They are usually used in medical settings where they are initiated through a doctor's order and have time limits. The risks attending the use of

restraints, especially for long periods of time (greater than 12 hours) are serious and sometimes fatal. Complications of restraints include the development of concurrent and sometimes fatal medical conditions, the development of blood clots because of immobility, and dehydration. On the other hand, restraint care itself can be a necessary lifesaving measure in managing mental health emergencies that present a potential for self-injury or injury to others. Nursing staff are ordinarily very involved in checking for circulation and injuries, ensuring the availability of food, water, and bathroom privileges, and assessing the patient.

It appears that the NJDOC employs restraints very infrequently. CBS quality assurance documents, though listing restraint care as a topic for review, almost always identify the number of monthly cases as 0. I have not reviewed any video tapes involving instances of restraint care since the privatization of medical services, outside of the distinct area of involuntary medication. My findings are, therefore, limited.

Procedural safeguards on restraint practices appear lacking. Regional administrators for nursing indicated their ignorance of any policies and procedures for restraint care in 1996, and were generally unaware of any nursing involvement at all in restraints conducted by security. Very few mental health or nursing staff had ever seen a restraint case. There are no policies and procedures to guide what is understood by mental health staff personnel to be a medical procedure other than the one-page document taken from the NCCHC standards. All restraint orders must be placed by a physician, and

psychology's role is a coordinating one.[40]

Despite the risks inherent in the use of restraints, there is no review mechanism in place to evaluate the safety of the use of restraints. From my site inspections, it appears that no logs are kept of incidents of restraint. Under these circumstances and given that many of the medical records produced to date are incomplete, it is impossible to ascertain the magnitude of the potentially enormous risks posed to inmates who undergo this procedure.

This examiner's review of class members' medical records reveals several instances in which therapeutic restraints were clinically indicated, but for unknown reasons were never applied. For example, on October 23, 1997, John Doe #147's, was placed on constant suicide watch at RFSP after attempting to hang himself with a blanket, and making several subsequent threats to "try it again." In his suicide watch order, Dr. Blodgett stated that John Doe #147 "is extremely agitated and requires mechanical restraints." Despite Dr. Blodgett's order, John Doe #147 was permitted to beat his head against his cell door and floor for the entire twenty-nine hours he spent on watch. Dr. Blodgett (in addition to other clinicians) was informed of JOhn Doe #147's self-mutilation on October 24, but at that time opined that restraints only "might" be needed, since John Doe #147 had not beaten his head "for past hour." While on observation, John Doe #147 was given a plastic bag, in which he wrapped his head in an attempt at asphyxiation. The failure to restrain under these circumstances may jeopardize the safety of the inmate.

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40. Despite the policy, custody restraint is also sometimes ordered. For example, see John Doe # 1

In a strikingly similar episode at NJSP, John Doe # 19, was ordered "placed . . . in a restraining chair upon return" from Saint Francis Medical Center, where he was treated for a suicide-related laceration he had inflicted on February 23, 1998. The order by Dr. Andrews was dated February 25. This order was apparently not followed, since later on that same day, Dr. Kliminski saw John Doe # 19 brandish a sharp instrument while making renewed suicide threats. Dr. Kliminski requested that the instrument be confiscated, and "recommend[ed] restraints." However, no restraints were applied, and John Doe # 19 managed to "cut up" following this incident, resulting in "blood thrown all over cell & tier." These new self-inflicted wounds prompted another visit by Dr. Kliminski, who recommended "restraints as needed"; yet the officer observing John Doe # 19 after this second interview noted that John Doe # 19 once again has "cut up" and is "bloody." John Doe # 19 was finally placed in four-point restraints by order of Dr. Andrews on February 26, in a note which suggests that John Doe # 19 had not been restrained earlier because the "restraint chair is defective."

These incidents and others in which restraints are recommended "as needed,"[41] but not decisively applied to prevent self-inflicted injuries where clinically indicated, suggest confusion on the procedures to initiate therapeutic restraints. Apparently, physicians and psychologists may give standing orders to nursing staff to initiate restraints "as needed," but no single person appears to be responsible for ensuring that these or other orders to restrain are carried out.

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41. Another similar order was reviewed in the file of John Doe # 125, following a suicide attempt on January 16, 1997.

Prior to privatization, restraints were generally utilized by correctional staff. While nursing staff may or may not have been called to check restraints, other medical or mental health staff, particularly physicians or psychiatrists, were essentially completely uninvolved in the process.

The following two examples of restraints on named Plaintiffs amply illustrate the haphazard, unsafe, and inappropriate use of restraints on seriously mentally ill inmates undergoing an acute mental health crisis.

John Doe # 2 burned herself or set herself on fire, causing first and second degree burns to her arms while in a restraint chair in a prehearing detention cell. The video tape reflects that John Doe # 2 was in restraints from 9:50 p.m. on September 21 until 4:20 p.m. the following day, at which point she met with the prison psychologist and agreed not to harm herself. There is no prior appearance by anyone from mental health or any mental health notation in the record for this incident. Although the fire itself is not captured on tape, it appears that John Doe # 2 was able not only to free herself from restraints but also to set a fire in which she burned herself. She received medical treatments, including steroids for the swelling and burns. At no point did she receive a psychiatric examination or emergency treatment. There was no record of hospitalization or emergency treatment other than the treatments administered by the NJDOC staff.

Similarly, John Doe # 44, was seen on March 24, 1994 by a NJDOC physician, who ordered psychological and psychiatric consultation. She was committed to the Forensic Hospital on March 25, 1994, where she was diagnosed as having an adjustment disorder rather than an acute paranoid disorder, and was returned to the

institution on Buspar, an anti-anxiety medication. Upon her return to prison on April 11, 1994, a psychiatrist in a telephone order only prescribed her Vistaril and Dalmane. It is not clear why the change from Buspar was made. On that same day, the psychiatrist issued a telephone order for "humane restraints" without specifying any time limit. The next day, a similar physician's telephone order indicated "may use helmet," a reference to ongoing restraint care. There is no other documentation by nursing or mental health staff relating to this incident which led to immediate recommitment to the Forensic Hospital on April 12, 1994 on an urgent basis. Nearly a year later, following multiple self-lacerations and a trip to St. Francis Medical Center after putting her hand through a television, the on-call psychiatrist was beeped three times and could not be reached. On May 7, 1995, John Doe # 44 was placed on watch after cutting her wrist and "crying about the devil." One hour later, she set her cell on fire. Only at that point was she placed in a restraint chair. The order for restraint was given by a nurse.

Review of videotaped examples of restraint episodes reveals that restraints are initiated by security staff and are employed in what appeared to be housing units. Nursing staff are present initially to place gauze between the handcuffs employed and the skin and to check tightness. The inmate is seated in a restraint chair with hands, feet and torso restrained by cuffs and straps. No leather or other soft restraints were seen. The chair has no head rest, and if an inmate falls asleep, he or she must do so sitting.

G. Hospital Care

The Forensic Hospital is a 150-bed maximum security hospital operated by the Department of Human Services. In addition to crisis commitments from NJDOC, admissions to the Forensic Hospital include county jail detainees with serious felony charges, those found incompetent to stand trial, as well as those found not guilty by reason of insanity, those needing 30-day diagnostic competency evaluations, and civil commitments of NJDOC inmates upon the conclusion of their sentences. The census was full on the day of the 1996 site visit, and there were 39 NJDOC inmates in the hospital. The NJDOC averages between 15 and 20 Forensic Hospital admissions per month for which the average length of stay is approximately 30 days. On discharge, the inmate is returned to the NJDOC with a summary of their discharge medications as well as a discharge summary which includes a comprehensive diagnosis, a summary of their treatment at the hospital, and follow-up treatment recommendations.

A review of the Forensic Hospital's admission policy and procedure #308 reveals that the criteria for admission from NJDOC is identical with the involuntary civil commitment criteria everywhere. No other form of commitment, including voluntary commitment, is permissible. This policy and procedure, which was reviewed and reratified in June 1998, also established criteria for prioritizing admissions to Forensic Hospital when there is a waiting list. Critical need, safety and security issues, and legal considerations were among the aggravating and mitigating factors considered in the priority of admissions. Admissions could be refused for inmates unable to ambulate as well as those with serious medical conditions and communicable diseases.

Starting on January 21, 1997, a document entitled “Waiting List” was compiled by the Forensic Hospital which listed inmates' names, the date they were placed on a waiting list, and the date they arrived at the hospital. An analysis of this list and the waiting times for a bed revealed that the average waiting time for admission once an order for commitment was obtained was 4.5 days with a range of 0-15 days in 1997. This data also confirms the operation of a prioritizing process, and the fact that 25 of the 114 inmates were moved in zero or one day, suggest a “fast” or emergency track.

Chart reviews, however, demonstrated that the process of getting a commitment order can be lengthy. For example, for John Doe # 137, whose case is discussed above at 65, the process took 17 days, including six days following issuance of the order. An extreme example is presented by John Doe #149, who waited forty-eight days after his mental health clinicians determined that commitment was appropriate based upon his "exacerbated paranoid schizophrenia," because "other, sicker inmates take priority." His clinicians noted that John Doe #149 was "receiving numerous disciplinary charges" during this period. On any given day in 1997, as many as 15 inmates (from NJDOC and county jails) could be waiting for admission. Another list tracked the number of inmates from each prison waiting for a bed on any given day.

A more subtle form of prioritization than is expressed in the formal procedure becomes apparent from an analysis of Forensic Hospital discharge summaries, commitment papers, and chart reviews. The fastest track to the Forensic Hospital clearly lies with self-injury. Those who are dangerous to others as a result of their mental illness or those who are not dangerous to anyone are given a lower priority, regardless of their

mental status. An example of this prioritization was found in the congregate care unit at NSP in 1996. One inmate who I examined was clearly grossly mentally ill and had done something to injure himself. He was on the Forensic Hospital waiting list. Two doors away, an inmate even more acutely mentally ill and out of control, who was described as extremely assaultive to officers and others, was locked in his room and was not on the Forensic Hospital waiting list, nor was he being considered for such.

Following site visits in September 1966 to NSP, and EJSP, a list of names was prepared of inmates I believed needed acute care or hospitalization. These 25 inmates were the most seriously ill, psychotic inmates I had encountered during my site visits. I testified to this effect before the Court on October 11, 1996. CMS caused evaluations of this group to be conducted by physicians and psychiatrists, resulting in the commitment of several to the Forensic Hospital. The others were not hospitalized or placed in any acute care setting for treatment, although such settings were available in those prisons. Some received no recommendations, and others received recommendations of medications (which the patients had been refusing), or counseling (which was unavailable).

The differences of opinion in these cases are more than just differences in professional judgment. In the majority of cases (but not all), there was rough agreement about the severity of the illness but not about the need for acute or hospital care. The CMS evaluations appeared to focus on not only illness, but dangerousness to self or suicidal ideation and whether or not the criteria for hospitalization were met. Even so, one of the commitment criteria, danger to others as a result of illness did not appear to be a relevant issue, even for grossly ill and psychotic inmates who were too dangerous to

even be brought out and examined. This excessively high threshold needlessly denies many extremely ill patients access to acute care in a crisis-stabilization (infirmary) setting or at the Forensic Hospital.

H. Suicide Prevention

The analysis of the NJDOC's, CMS's and CBS's management of suicide risks presented here is necessarily brief and incomplete, as medical records for only two of the seventeen inmates who have committed suicide in the NJDOC facilities since 1994 were provided. Likewise, classification records for only one of these two were produced. Because suicides are relatively uncommon occurrences and therefore can only be studied forensically through the review of records, it is impossible to determine whether the applicable standard of care has been met with respect to inmate suicidality without substantially complete records. Forensic analyses of the two suicides for which records were provided (John Doe # 57, and John Doe # 58) are attached as Appendices G and H hereto. In summary, my findings are as follows:

1. Completed Suicides

John Doe # 58. At the time of his death, this inmate was being treated for anxiety disorder, and was facing imminent transfer and resentencing. John Doe # 58 did not receive the routine mental health care or screening called for in the NJDOC-CMS contract, and his written request to AWYCF personnel for mental health treatment just five days prior to his death apparently went unheeded. His medication had also been temporarily discontinued for two weeks because the pharmacy had run out. At the time

he hung himself, John Doe # 58 was essentially receiving little, if any, mental health treatment.

John Doe # 57. This inmate was screened after his return to prison following an escape from a minimum security facility. He was determined to require mental health follow up which did not occur prior to the completion of suicide by hanging, occurring approximately forty hours later. John Doe # 57 presented several risk factors signaling suicidality, including his recent escape, return and his break-up with his ex-girlfriend and evidence of chemical withdrawal from habituating drugs. Although some evidence suggests that EJSP personnel were aware of these risk factors, appropriate steps were not taken to manage the risk.

The retrospective analyses of these completed suicides undertaken by NJDOC and CBS amount to little more than finger-pointing, and do not attempt the structured forensic review which in my professional experience I have seen universally applied to suicidal episodes in correctional settings.[42] I have seen no written policy requiring or structuring the inquiry into the clinical management of suicides or of suicide attempts resulting in injury. On the other hand, progress has been made with respect to keeping appropriate paperwork on inmates placed on suicide watch.

2. Custody Training

Because mental health staff cannot observe all inmates at risk for suicide, housing unit officers who supervise inmates around the clock must be involved in suicide

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42. Although the NJDOC Internal Affairs Unit issues reports with respect to suicides, these reports do not generally address the clinical aspects of suicide management.

risk management. This is particularly true of a system such as the NJDOC's which relies upon a grossly inadequate mental health staffing pattern. I saw no evidence that the NJDOC's "front line" custody staff had received any specialized in-service training to identify and refer suicidal inmates. Medication nurses also have daily contact with inmates at risk for suicide, but I saw no evidence that these nurses were involved in identifying and referring suicidal inmates.

3. Significant Risks for Inmates on Watch

In several instances, mentally ill inmates placed on observation due to the danger they posed to themselves were nonetheless allowed to possess dangerous instrumentalities while on watch. These include Messrs.John Doe # 19 (sharp instrument), John Doe #147 (plastic bag), John Doe #150 (sharp instrument) John Doe # 125 (metal object), JOhn Doe #151 (matches) and John Doe # 2 (matches). Several of these inmates later hurt themselves using these same instrumentalities. These incidents evidence shortcomings in the NJDOC's protocol for placing inmates on close watch.

I. Discharge Planning

CBS and the DOC participate in deciding which inmates will require involuntary commitment to the Forensic Hospital at the conclusion of their sentence. Dr. Cevasco explained that mentally ill inmates may meet the criteria for commitment at discharge because of their inability to obtain care for themselves and yet not meet the criteria during the course of their incarceration.

Record reviews and interviews indicate that other mentally ill inmates are generally discharged directly from administrative segregation without any arrangements to

enable the inmate to access follow-up mental health services upon discharge. DOC social workers are supposed to assist mentally ill inmates in discharge planning. CBS's responsibility is limited to supplying a two week prescription of medications.

Respectfully Submitted,

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Dennis Koson, M.D.

Dated: September 8, 1998