(b) (6)
DENVER, COLORADO 80206

TELEPHONE (b) (6)
FACSIMILE (303) 322-2155
TAX ID #84-0848664

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REPORT FOR THE
U.S. DEPARTMENT OF HOMELAND SECURITY
OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES

September 27, 2013

Investigation regarding Henderson Detention Center
The Complaint reviewed in this report was Complaint No. 13-08-ICE-0184

Prepared by (b) (6), M.D.

Executive Summary

This assessment regarding the mental health services at the Henderson Detention Center (HDC) was limited in scope due to the very small number (10) of ICE detainees receiving mental health services at the HDC during the September 24-25, 2013 site visit.

Positive aspects of the mental health system included the following:

1. A low rate of suicides.
2. A small number of ICE detainees with a mental illness.
3. Access to a higher level of mental healthcare when clinically indicated via transfer to an ICE facility in the San Diego, California area.

Problematic aspects of the mental health system included the following:

1. Inadequate mental health staffing allocations.
2. Lack of sound privacy in the context of clinical assessments/treatment.
3. Lack of up-to-date policies and procedures, reportedly related to the formation of Corizon.
4. Inadequate initial psychiatric evaluation forms.
5. Inadequate suicide risk assessment forms.
6. Suicide risk assessments being performed by nursing staff, who are not psychiatric nurses.
7. Camera cells used for suicide prevention purposes are not suicide resistant
8. Lack of informed consent being documented regarding the use of psychotropic medications.
9. Lack of reasonable access to Quality Improvement (QI) studies.

Summary of Recommendations (only Level 1 recommendations are summarized in this section)

Standards and Procedures *(based on ICE National Detention Standards (2000))*

A. General

1. The facility should keep statistics relevant to the percentage of newly booked detainees whose healthcare screen results in a mental health referral. (Level 1 recommendation)
2. Perform a needs assessment regarding mental health staffing allocations and make adjustments as indicated. (Level 1 recommendation)

B. Facilities

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1. The default practice of always having a correctional officer present during clinical interventions is not within the standard of care related to issues of privacy and confidentiality. This practice should be changed to only having correctional officers present when clinically indicated for safety reasons. (Level 1 recommendation)

C. Informed Consent

1. Obtain written informed consent regarding use of psychotropic medications. (Level 1 recommendation)

D. Transfer and Release of Detainees

1. Based on the record review of Detainee 1 (see Appendix I), HDC should work with ICE to develop policies and procedures relevant to discharging ICE detainees who are on a suicide watch and have not yet been evaluated by mental health clinician. (Level 1 recommendation)

Suicide Prevention

A. Training

1. Suicide prevention training should occur on an annual basis. (Level 1 recommendation)

B. Housing/Hospitalization

1. The camera cells used for suicide prevention purposes should be made suicide resistant. (Level 1 recommendation)

C. Identification and Intervention

1. Develop and implement an appropriate suicide risk assessment instrument. (Level 1 recommendation)
2. Develop training and credentialing processes for the nurses who will be conducting suicide risk assessments. This should involve supervision by the psychiatrist. (Level 1 recommendation)

Policies and Procedures

1. Up-to-date policies and procedures need to be finalized and implemented. (Level 1 recommendation)

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2. Revise the initial psychiatric examination form and the suicide risk assessment form to include relevant data sections, a narrative summary, and treatment plan. (Level 1 recommendation)

Quality Improvement (QI)

1. HDC's access to QI documents needs to be improved. (Level 1 recommendation)

Referral Issue

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation of complaints it received that included issues regarding the adequacy of the mental health services offered to ICE detainees at the Henderson Detention Center (HDC). I reviewed relevant aspects of the mental health care services at HDC to assess compliance with the ICE National Detention Standards (2000).

Sources of Information

Documents reviewed included the following:

1. IHSC Directive # 03-03 (Care of Chronic Conditions),
2. The healthcare record of the Complainant,
3. Henderson Police Department's procedures regarding the following:
    a. Medical Screening,
    b. Mental Health Services,
    c. Medical Services,
    d. Supervision of Booking Area,
    e. Restraint Chair,
    f. Uncooperative/Combative Offenders,
    g. Booking Process,
    h. Receiving Arrestees,
    i. Admission Documentation,
    j. Suicide Prevention and Intervention,
    k. Training,
    l. Use of Force,
    m. Video Recording and Photographing Inmates,
    n. Care of Chronic Conditions,
4. Offices of Detention Oversight Compliance Inspection Report (May 7-9, 2013), and
5. Healthcare records of 10 ICE detainees receiving mental health treatment during the site visit.

I visited the HDC from September 24-25, 2013. During the site visit I had the opportunity to interview (b) (6), R.N., DON, H.S.A, and (b) (6), R.N.

Introduction

The Office of Professional Responsibility (OPR), Office of Detention Oversight's (ODO) May 2013 report re: the HDC in Henderson, Nevada, included the following excerpts:

> HDC is owned by the City of Henderson and is operated by the Henderson Police Department. The 127,200 square foot facility, which opened in 1994, houses inmates from the City of Henderson, local law enforcement agencies, the United States Marshals Service, and other federal law enforcement agencies. U.S. Immigration and Customs Enforcement (ICE) began housing detainees at HDC in January 2011, under an intergovernmental service agreement with the United States Marshals Service. Male and female detainees of all security classification levels (Level 1 - lowest threat, Level II - medium threat, Level III - highest threat) are detained at the facility for periods in excess of 72 hours. HDC allocates a total of 300 beds for ICE detainees. At the time of this CI, HDC housed 239 detainees (216 male; 23 female). The average daily detainee population at HDC is 254. The average length of stay for a detainee is 24 days. Corizon, a private medical contractor, provides healthcare for ICE detainees at HDC. The City of Henderson provides food service. The facility holds no accreditations.
>
> The Superintendent is the highest ranking City of Henderson official at HDC, and is responsible for oversight of daily operations at the facility. In addition to the Superintendent, supervisory staff at HDC consists of four lieutenants and six sergeants. Non-supervisory detention staff consists of 63 corrections officers, 12 detention center technicians, eight central control room operators, two classification technicians, and five cooks.
>
> Correctional healthcare contractor Corizon provides medical services at HDC. The facility holds no accreditations; however, policies and procedures mirror the National Commission on Correctional Health Care standards for health services in detention facilities. The clinic is administered by a full-time Health Services Administrator, who is a registered nurse. The Health Services Administrator also serves as the Director of Nursing. The Medical Director is a physician and is the designated clinical medical authority. In addition to the Health Services Administrator and the Medical Director, medical staff includes seven registered nurses, four licensed practical nurses, three medical assistants, an advance practice nurse, and a psychiatrist. Staff is supplemented by two on-call registered nurses and two on-call licensed practical nurses. Dental services are provided by two on-call dentists. There were no vacancies at the time of the review. ODO confirmed staffing in the medical clinic is sufficient to meet detainee healthcare needs. Training files and credential files for all medical staff were complete, and professional licenses were primary source verified. ODO reviewed the training records of ten detention staff members and all health services personnel, and confirmed each file contained documentation of current certifications in cardio-pulmonary resuscitation, automated external defibrillators, and first aid.
>
> ODO reviewed the medical records of six detainees who were placed on suicide watch during the 12 months preceding this CI and confirmed management of suicide watches is consistent with facility policy and the NDS. All suicide watch cells are under 24-hour

audio-video surveillance. In each case reviewed by ODO, a wellness check was documented every 15 minutes. At HDC, authorization for release from suicide watch is provided by a psychiatrist. ODO confirmed training in suicide prevention and intervention covered all elements required by the NDS. Review of training records confirmed ten of ten custody staff and all healthcare personnel received initial and on-going training in suicide prevention and intervention.

On September 24, 2013, the ICE detainee count at the HDC was 198, with 10 detainees receiving mental health services. Staff reported that statistics on ICE detainees were generally not maintained separately from statistics on its total population. The HSA estimated that 21-32% of the total inmate population at HDC were on the mental health caseload. The total inmate count during September 24, 2013 was 460 with a HDC capacity of 543 inmates.

The following section summarizes my findings regarding compliance with the 2000 ICE National Detention Standards (NDS) on mental health services.

STANDARDS AND PROCEDURES

A. General

Standards: According to the NDS, every facility is obligated to provide its detainee population with initial medical screening, cost-effective primary medical care, and emergency care. The Officer in Charge (OIC) also is responsible for arranging for specialized health care, mental health care, and hospitalization within the local community.

All facilities must employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees. The OIC, with the cooperation of the Clinical Director, is responsible for negotiating and keeping current arrangements with nearby medical facilities or health care providers to provide required health care not available within the facility. These arrangements must include securing appropriate custodial officers to transport and remain with the detainee for the duration of any off-site treatment or hospital admission.

A health care specialist must determine medical treatment, except when there is disagreement on the type or extent of treatment that is medically necessary. In such cases, ICE will make the determination, in consultation with the Chief of Medical Staff and in accordance with the medical policies of the U.S. Public Health Service's Division of Immigration Health Services (IHSC).

Findings: The healthcare staff consists of the following positions:

1. a psychiatrist, who provides eight hours per week of on-site services (.2 FTE*),
2. a family physician, who provides 10 hours per week of on-site medical services,
3. a nurse practitioner, who provides 10 hours per week of on-site medical services, and 13.5 FTE RNs and 5.5 per diem nursing staff (i.e., nurses working on a temporary

contract basis), which when combined result in functionally 19 FTE nursing positions.

Nine of the 19 FTE nursing staff positions are RNs.

The nursing staff work 12 hour shifts; generally 2 to 3 nursing staff work during the evening shift and 2-5 nursing staff work during the daytime shifts (7 AM-7 PM). There is always at least one R.N. per shift.

*Full-time equivalent (FTE) is a unit that indicates the workload of an employed person in a way that makes workloads comparable across various contexts. An FTE of 1.0 means that the person is equivalent to a full-time worker (i.e., 40 hrs/ week), while an FTE of 0.5 signals that the worker is only half-time

The physicians provide continuous coverage via the telephone.

A physical examination is completed by a R.N upon admission, which is later reviewed and co-signed by the facility's part-time physician.

Any detainee in need of emergency room type services are transported to the University Medical Center (UMC) for such services. Detainees in need of inpatient psychiatric care were reported to be transferred to a facility in San Diego in consultation with ICE. UMC is also used for off-site medical appointments, which generally number 30+ visits per month. Emergency room visits are uncommon (0 to1 visit/month). Inpatient psychiatric care is even less common (1-2/year).

A 0.2 FTE psychiatrist allocation is not adequate for providing timely and appropriate mental health services for an inmate mental health caseload population that was reported to generally exceed 100 inmates. At least 1.0 FTE psychiatrist is needed for every 200 mental health caseload inmates in a jail setting (see American Psychiatric Association: Psychiatric Services in Jails and Prisons, 2nd Edition. Washington, DC: American Psychiatric Association, 2000).

Recommendations:

1. (b) (5) [redacted]
2. Perform a needs assessment re: mental health staffing allocations and make adjustments as indicated. (Level I recommendation)

B. Facilities

Standards: The NDS require that adequate space and equipment will be furnished in all facilities so that all detainees may be provided basic health examinations and treatment in private.

Further, medical records must be kept separate from detainee records and stored in a securely locked area within the medical unit.

Findings: Nursing staff and the psychiatrist reportedly provide assessment/treatment in a multipurpose room within the housing units. At least one correctional officer is always in the room during such clinical interventions due to reported safety issues.

Recommendations:

1. (b) (5) [redacted]

C. Medical Personnel

Standards: The NDS require that health care staff have a valid professional licensure and/or certification. IHSC will be consulted to determine the appropriate credential requirements for health care providers.

Findings: The psychiatrist was reported to be licensed and board certified in psychiatry.

Recommendations: None.

D. Medical Screening (New Arrivals)

Standards: The NDS require that all new arrivals receive initial medical and mental health screening immediately by a health care provider or an officer trained to perform this function. This screening shall include observation and interview items related to the detainee's potential suicide risk and possible mental disabilities, including mental illness and mental retardation. For further information concerning suicide intervention and prevention, see the "Detainee Suicide Prevention and Intervention" Standard.

In addition, the NDS require that the health care provider of a facility conduct a health appraisal and physical examination of each detainee within 14 days of arrival. If there is documented evidence of a health appraisal within the previous 90 days, the facility health care provider may determine that a new appraisal is not required.

All detainees shall be evaluated through the initial screening for their use of or dependence on mood and mind-altering substances - alcohol, opiates, hypnotics, sedatives, etc. Detainees reporting the use of such substances shall be evaluated for their degree of reliance on and potential for withdrawal. The Clinical Director (CD) or contract equivalent, shall establish guidelines for evaluation and treatment of new arrivals who require detoxification. Treatment

and supportive measures shall permit withdrawal with minimal physiological and physical discomfort.

A detainee will be hospitalized only on the order of a physician and with administrative notification. Detainees experiencing severe, life-threatening alcohol or drug withdrawal will be immediately transferred to an acute care facility.

Detoxification will be carried out only at facilities qualified to do so in accordance with local, state, and federal laws.
All non-ICE facilities shall have policies and procedures to ensure the initial health screening and assessment is documented.

Health appraisals will be performed according to NCCHC and JCAHO standards.

If language difficulties prevent the health care provider/officer from sufficiently communicating with the detainee for purposes of completing the medical screening, the officer shall obtain translation assistance. In some cases, other detainees may be used for translation assistance if they are proficient and reliable, and the detainee being medically screened consents. If needed translation assistance cannot be obtained, medical staff will be notified or the screening form will be filled out to refer the detainee to medical personnel for immediate attention.

If a detainee requires emergency medical care, the officer will immediately take steps to contact a health care provider through established procedures. Where the officer is unsure whether emergency care is required, the officer should immediately notify the on-duty supervisor. If the on-duty supervisor has any doubt whether emergency care is required, the on-duty supervisor will immediately take steps to contact a health care provider, who will make the determination whether emergency care is required.

Findings: Upon admission, generally within 20 minutes, an intake receiving screening form (see Attachment 1) is completed by nursing staff. If completed by a LPN, the form is reviewed by a RN. This form includes relevant mental health screening questions. Clinical judgment is used by the nursing staff to determine whether or not a referral to the psychiatrist is indicated. Statistics are not kept relevant to the percentage of intake receiving intake screening assessments that result in a mental health referral.

Detainees in need of detoxification are almost always handled via the medical department, although the psychiatrist occasionally writes orders relevant to detoxification.

For Spanish-speaking-only detainees, interpretation services are usually provided by bilingual correctional or healthcare staff. For other languages, interpretation services are provided via a telephone resource line.

Recommendations:

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1. See recommendations in section A.

E. Sick Call

Standards: Each facility will have a mechanism that allows detainees the opportunity to request health care services provided by a physician or other qualified medical officer in a clinical setting.

All facilities must have a procedure in place to ensure that all request slips are received by the medical facility in a timely manner. If necessary detainees will be provided with assistance in filling out the request slip, especially detainees who are illiterate or non-English speaking.

Each facility will have regularly scheduled times, known as sick call, when medical personnel will be available to see detainees who have requested medical services. Sick call will be regularly scheduled in accordance with the following minimum standards:

1. Facilities with fewer than 50 detainees - a minimum of 1 day per week;
2. Facilities with 50 to 200 detainees - a minimum of 3 days per week; and
3. Facilities with over 200 detainees - a minimum of 5 days per week.

The health care provider will review the request slips and determine when the detainee will be seen.

All detainees, including those in Special Management Units, regardless of classification, will have access to sick call. In addition to sick call, all facilities will have emergency procedures for medical treatment as provided below.

Findings: Sick call request forms are available via the nursing staff, who are reportedly within each housing unit three times per day. Mental health requests are triaged immediately after the detainee provides the RN with a sick call request. When clinically indicated, a referral to the psychiatrist is then initiated.

Information obtained from a small sample of ICE detainees was not consistent with detainees receiving timely responses to sick call requests.

Recommendations:

1. Perform a QI process relevant to timely responses to mental health sick call requests. (Level 2 recommendation)

F. 24-Hour Emergency Medical Treatment

Standards: Each facility will have a written plan for the delivery of 24-hour emergency health care when no medical personnel are on duty at the facility, or when immediate outside medical attention is required.

Findings: As previously summarized, UMC is used for off-site 24 hour emergency care and physicians and the nurse practitioner are available on a continuous basis.

Records from UMC are frequently delayed several hours to one day following these clinic visits.

Recommendations: None.

G. Delivery of Medication

Standards: Distribution of medication will be according to the specific instructions and procedures established by the health care provider. Officers will keep written records of all medication given to detainees.

Findings: All medications are administered by nursing staff. Detainees did not report any difficulties in obtaining medications that have been prescribed to them by Dr. Sussman.

Recommendations: None.

H. Special Needs

Standards: The medical care provider for each facility will notify the OIC in writing when a detainee has been diagnosed as having a medical or psychiatric condition requiring special attention (e.g. pregnancy, special diet, medical isolation, AIDS, etc.).

Findings: The HSA reported that the OIC is notified in writing when a detainee has been diagnosed as having a medical or psychiatric condition requiring special attention.

Recommendations: None.

I. Informed Consent

Standards: Medical treatment will not be administered against the detainee's will. The facility health care provider will obtain signed and dated consent forms from all detainees before any medical examination or treatment, except in emergency circumstances. If a detainee refuses treatment, the ICE will be consulted in determining whether forced treatment will be administered, unless the situation is an emergency. In emergency situations, ICE shall be notified as soon as possible.

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Findings: Informed consent forms (see Attachment 2) specific to psychotropic medications were reportedly used at HDC. However, there were no informed consent forms present in any of the 11 healthcare records reviewed.

Recommendations:

1. Obtain written informed consent regarding use of psychotropic medications. (Level 1 recommendation)

J. Confidentiality and Release of Medical Records

Standards: All medical providers shall protect the privacy of detainees' medical information to the extent possible while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well-being of detainees.

Where a detainee is covered by the Privacy Act, specific legal restrictions govern the release of medical information or records.

Copies of health records may be released by the facility health care provider directly to a detainee, or any person designated by the detainee, upon receipt by the facility health care provider of a written authorization from the detainee. (Form I-813 may be used for this purpose). In absence of the I-813, a written request may serve as authorization for the release of health information if it includes the following (and meets any other requirements of the facility health care provider):

1. Address of the facility to release the information;
2. Name of the individual or institution that is to receive the information;
3. Detainee's full name, alien number, date of birth and nationality;
4. Purpose or need for the information to be released;
5. Nature of the information to be released with inclusive dates of treatment; and
6. Detainee's signature and date.

Following the release of health information, the written authorization will be retained in the health record, and a copy placed in the detainee's A-file. IGSA facilities shall notify INS each time a detainee's medical records are released.

Detainees who indicate that they wish to obtain copies of their medical records will be provided with the appropriate form. The INS will provide the detainee with basic assistance in making the written request (if needed) and will assist in transmitting the request to the facility health care provider.

If INS receives a request for a detainee's medical records, the request should be forwarded to the facility health care provider or the requester, (if other than a detainee) should be advised to redirect their request and provided with the appropriate name and address.

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Findings: HDC has a combined medical/mental health record. Filing is done by nursing staff and was reported to be up-to-date. Records are maintained in a manner to ensure confidentiality.

Recommendation:

1. Perform an audit to ensure that elements of this provision are being met. (Level 2 recommendation)

K. Transfer and Release of Detainees

Standards: ICE shall be notified when detainees are to be transferred or released.

Medical/Psychiatric Alert. When the medical staff determines that a detainee's medical or psychiatric condition requires either clearance by the medical staff prior to release or transfer, or requires medical escort during deportation or transfer, the OIC will be so notified in writing.

Notification of Transfers, Releases, and Removals. The facility health care provider will be given advance notice prior to the release, transfer, or removal of a detainee, so that medical staff may determine and provide for any medical needs associated with the transfer or release.

Transfer of Health Records.
When a detainee is transferred to another detention facility, the detainee's medical records, or copies, will be transferred with the detainee. These records should be placed in a sealed envelope or other container labeled with the detainee's name and A-number and marked "MEDICAL CONFIDENTIAL."

Findings: The HSA reported that an effective medical/psychiatric alert system was in place. Compliance was also reported relevant to notification of transfers, release, and removals as well as transfer of records. A procedure was in place to provide detainees with copies of their medical records when requested. However, this information was not consistent with the case of Detainee 1 (see Appendix I)

Recommendations:

1. Based on the record review of Detainee 1 (see Appendix I) HDC needs to work more closely with ICE in developing policies and procedures relevant to discharging ICE detainees who are on a suicide watch and have not yet been evaluated by mental health clinician. (Level 1 recommendation)
2. Perform an audit to ensure that elements of this provision are being met. (Level 2 recommendation)

L. Medical Experimentation

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Standards: Detainees will not be used in medical, pharmaceutical or cosmetic experiments or research. This will not preclude an individual detainee from receiving a medical procedure not generally available, but determined medically necessary by the primary health care provider. In IGSA facilities, IHSC shall be notified.

Findings: Medical research is not conducted at HDC.

M. Quarterly Administrative Meetings:

Standards: Formal, documented meetings will be held at least quarterly between the OIC of each facility and the HSA of the medical facility. Other members of the facility staff and medical staff will be included as appropriate. Minutes of the meeting will be recorded and kept on file. The meeting agenda will include, but not be limited to, the following:

1. An account of the effectiveness of the facility health care program;
2. Discussions of health environment factors that may need improvement;
3. Changes effected since the previous meetings; and
4. Recommended corrective actions, as necessary.

Findings: A quarterly Medical Administration Committee (MAC) meeting occurs. HDC was unable to produce minutes of these meetings due to them being electronically stored at the central office in Tennessee.

Recommendation:

1. Easy access to such minutes should be made available to HDC staff. (Level 3 recommendation)

Suicide Prevention

N. Training

Standards: All staff will receive training, during orientation and periodically, in the following: recognizing signs of suicidal thinking, including suspect behavior; facility referral procedures; suicide prevention techniques; and responding to an in-progress suicide attempt. All training will include the identification of suicide risk factors and the psychological profile of a suicidal detainee.

Findings: Healthcare staff received several hours of annual training relevant to suicide prevention. The syllabus for this training was not available during the site visit.

Correctional officers receive suicide prevention training via a computerized course every two years.

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Recommendation:

1. (b) (5) [redacted]

O. Identification and Intervention

Standards: Suicide potential will be an element of the initial health screening of a new detainee, conducted by either the health care provider or a specially trained officer. Detainees identified, as "at risk" for suicide will be promptly referred to medical staff for evaluation.
Upon change of custody, the staff with custody will inform the staff assuming custody about indications of suicide risk.

All staff working with detainees will keep current on the proper course of intervention and referral for a detainee who shows signs of suicide risk.

Findings: If a detainee is referred due to suicide risk issues, a registered nurse does a suicide risk assessment using both a suicide prevention screening form and a mental health risk assessment tool (see Attachment 3). If determined to be a significant suicide risk, the detainee will be placed on suicide precautions. Such "405" detainees are subsequently referred to the psychiatrist. 405 detainees will be placed in a camera watch cell, observed at least every 15 minutes by custody staff, and have limited property as determined by custody staff. Property generally includes a suicide smock, blanket, mattress, and one book.

These detainees will be evaluated by the psychiatrist during his next on-site day, which is often determined by the needs of the HDC. A psychiatric evaluation form (see Attachment 4) will be completed and a progress note form (see Attachment 5) will be used for subsequent assessments.

The last suicide at HDC was reported to have occurred about five years ago.

Statistics reported by HDC indicated that from 20 to 42 detainees per month were placed on suicide watch during the past eight months. No suicide attempts have been reported during the past eight months, which raises issues regarding the definition used by HDC regarding a suicide attempt. Only one ICE detainee (Detainee 1) was reported to have attempted suicide during the past year.

Suicide risk assessments are completed by nursing staff reportedly using the mental health risk assessment tool. However, I received confusing information whether this form was being used during the past year due to the transition from PHS to Corizon. In addition, this form was flawed in a number of ways that included lack of a "history of present problems" section, lack of a narrative section for formulation and treatment plan purposes, and the overreliance on the use of checkboxes. Non-psychiatric nurses generally do not have the appropriate training to conduct suicide risk assessments.

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Recommendation:

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2.

P. Housing/Hospitalization

Standards: The OIC may allow a potentially suicidal detainee who presents no imminent danger to life or property (as determined by medical staff) to remain in the general population, but only under close observation, and only upon the written recommendation of the Clinical Director (CD). Officers shall check on the safety of such detainees at intervals ordered by the CD. Precautions must be taken with any personal possessions that could aid in a suicide attempt. If danger to life or property appears imminent, the medical staff has the authority, with written documentation, to segregate the detainee from the general population. A detainee segregated for this reason requires close supervision in a setting that minimizes opportunities for self-harm. The detainee may be placed in a special isolation room designed for evaluation and treatment. The isolation room will be free of objects or structural elements that could facilitate a suicide attempt. If necessary, the detainee may be placed in the Special Management Unit, provided space has been approved for this purpose by the medical staff.

Observation of imminently suicidal detainees by medical or detention staff shall occur no less than every 15 minutes. The CD may recommend constant direct supervision.

In CDFs or IGSA facilities, the OIC shall report to INS any detainee clinically diagnosed as suicidal or requiring special housing for suicide risk. When imminent risk of bodily injury or death is determined, medical staff will make a recommendation for hospitalization for evaluation and treatment. If the detainee refuses, it may be necessary to petition the appropriate federal court to intervene against the detainee's will for hospitalization and treatment.

A detainee formerly under a suicide watch may be returned to general population, upon written authorization from the CD.

Findings: See previous section.

The camera cells used for suicide prevention purposes are not suicide resistant.

Recommendations:

1. The camera cells used for suicide prevention purposes should be made suicide resistant. (Level 1 recommendation)

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Additional Information

Policies and Procedures

Up-to-date policies and procedures were lacking reportedly due to the transition to Corizon.

Recommendations:

1. Revise and implement mental healthcare policies and procedures, including revised forms as summarized in other sections of this report. (Level 1 recommendation)

Nonemergency Involuntary Administered Psychotropic Medications

The HSA reported that involuntary psychotropic medications are not used at HDC.

Restraints for Mental Health Purposes

Although a policy and procedure exists for the use of restraints for mental health purposes, the HSA reported that they do not use restraints for mental health purposes by practice.

Quality Improvement (QI)

QI studies were reportedly performed on a monthly basis, but reports could not be accessed during the site visit since they were stored in the corporate headquarters server. I was unable to assess the adequacy of the QI process but have significant concerns based on HDC's lack of adequate access to such reports.

Recommendations:

1. HDC should have timely access to QI reports.

Detainee Interviews

I interviewed 9 ICE detainees in two group settings (4 detainees per group) and one detainee individually during the morning of September 25, 2013. These inmates reported that their contacts with Dr. (b) (6) lacked sound privacy because at least one correctional officer would be present in the room and/or the contact occurred in the dayroom of their housing unit. They all indicated that the sessions were very short in duration (5-10 minutes). None of detainees reported knowing the name of their psychiatrist. Several inmates reported a lack of timely responses to sick call requests to see the psychiatrist.

I also reviewed the healthcare records of all these inmates, in addition to two other inmates (see Appendix I). I did not find any signed consent forms for the use of psychotropic medications in

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the healthcare records or reference to having obtained informed consent. In addition, the standard form use for the initial psychiatric assessment basically only documented information relevant to the following:

1. substance abuse history
2. past history of psychiatric treatment
3. mental status examination
4. diagnosis
5. treatment plan in the context of medications to be prescribed.

Notably absent from a documentation perspective regarding the initial evaluation included the following sections:

1. history of present problems
2. past medical history
3. family history
4. marital history
5. interpersonal relationship history
6. occupational history
7. educational history
8. legal history
9. military history

Due to the documentation deficits summarized above, I had significant difficulty assessing the adequacy of the psychiatric assessments and timeliness of scheduled follow-up appointments.

Summary

Positive aspects of the mental health system included the following:

1. A low rate of suicides.
2. A small number of ICE detainees with a mental illness.
3. Access to a higher level of mental healthcare when clinically indicated via transfer to an ICE facility in the San Diego, California area.

Problematic aspects of the mental health system included the following:

1. Inadequate mental health staffing allocations.
2. Lack of sound privacy in the context of clinical assessments/treatment.
3. Lack of up-to-date policies and procedures, reportedly related to the formation of Corizon.
4. Inadequate initial psychiatric evaluation forms.
5. Inadequate suicide risk assessment forms.
6. Suicide risk assessments being performed by nursing staff, who are not psychiatric nurses.
7. Camera cells used for suicide prevention purposes are not suicide resistant.

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8. Lack of informed consent being documented re: the use of psychotropic medications.
9. Lack of reasonable access to QI studies.

Please contact me if you have further questions.

Sincerely,

(b) (6)

(b) (6), M.D.
Clinical Professor of Psychiatry

University of Colorado School of Medicine

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REPORT FOR THE

U.S. DEPARTMENT OF HOMELAND SECURITY

OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES

Investigation regarding Etowah County Detention Center

Complaint Numbers 11-11-ICE-0291
11-12-ICE-0316
11-12-ICE-0318
11-10-ICE-0260
11-12-ICE-0325
12-01-ICE-0005
12-01-ICE-0010

Presented by (b) (6), M.D.

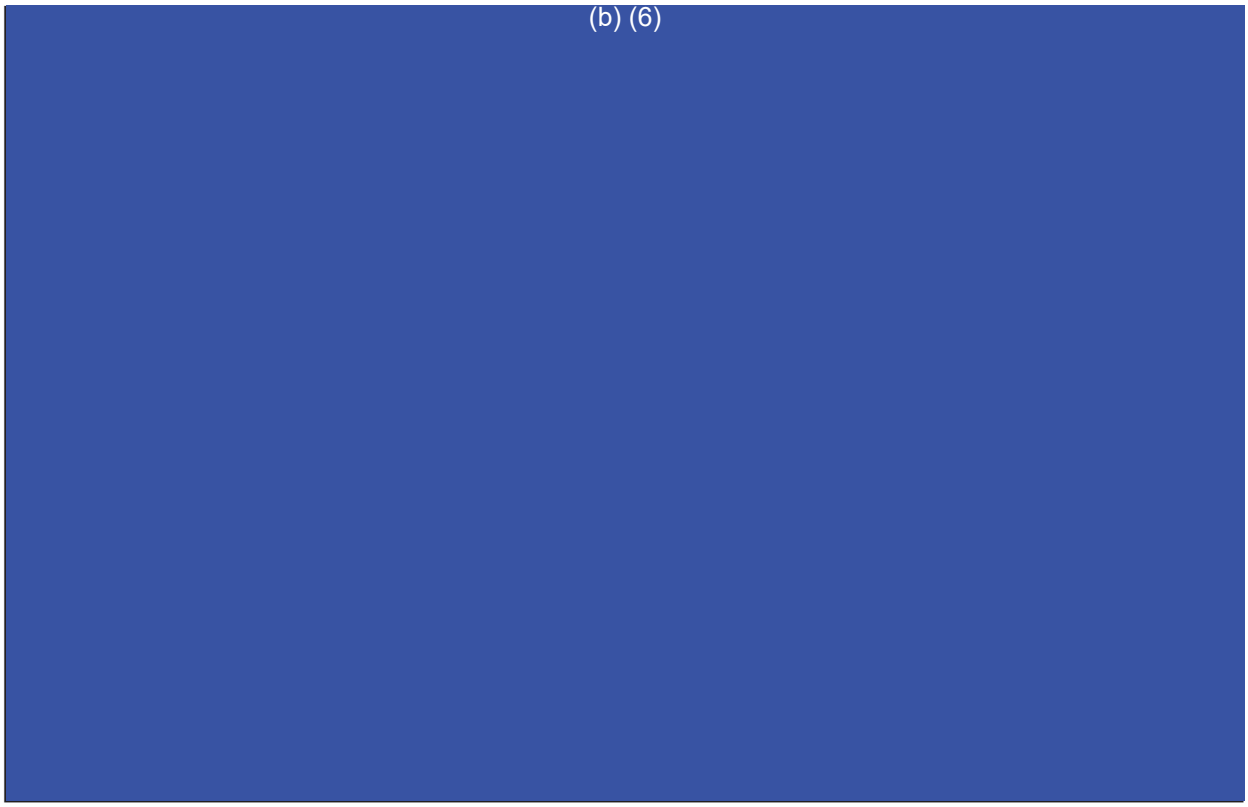
ETOWAH COUNTY DETENTION CENTER (ECDC)

Site visit May 23-25, 2012

INTRODUCTION/REFERRAL ISSUE

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation of complaints it received relating to the Etowah County Detention Center (ECDC) in Gadsden, Alabama. The complaints raised a variety of allegations regarding the conditions of detention for detainees being held by U.S. Customs and Immigration Enforcement (ICE) at ECDC, including inadequate medical and mental health care. Although the overall CRCL investigation addressed additional allegations, my review focused on the adequacy of mental health care for ICE detainees at ECDC.

PROFESSIONAL QUALIFICATIONS



METHOD OF REVIEW

1. Site visit:
   I spent full days at ECDC on May 23 and 24, 2012, and a half day on May 25, 2012. I toured many areas of the facility, including Units 3, 9, 10, which house ICE detainees, and the medical unit.

2. Interviews:
    a. I participated in group meetings with ECDC clinical and custody administrators at the start and end of the three day site visit;
    b. I met and spoke privately with detainees, both individually and in groups, on Units 9 and 10;
    c. Dr. (b) (6), the primary care physician with our survey team, and I met for over an hour with (b) (6), RN, BSN, who serves as director of the medical unit, and then with Dr. (b) (6), the family physician in charge of Doctors' Care Physicians, P.C., which provides all health care services at ECDC; and
    d. I spoke with custody and clinical staff during visits to housing units, the segregation unit, and the medical unit.

3. Document reviews: I reviewed all documents provided by CRCL and additional documents provided at ECDC, including those from the following categories:
    a. Complaints by detainees and their advocates;
    b. Patient records of complainants and others, including those described in Appendix A of this report;
    c. Policies and procedures, including the ECDC Medical Unit Policy and Procedure Manual;
    d. A list of all detainees in the following categories:
        i. currently followed for mental health problems;
        ii. currently on psychotropic medications;
        iii. on suicide watch between 1/1/12 and 5/22/12; and
        iv. referred to CED Mental Health Center, which is the county mental health service provider, between 11/1/11 and 5/21/12;
    e. ICE Detention Inspection Form Worksheets for ECDC from August, 2010 and July, 2011; and
    f. Mental Health Training materials.

EXECUTIVE SUMMARY

I received full cooperation from all staff at ECDC during this site visit. They provided me with unrestricted access to detainees, documents, medical records, and all parts of the facility. I met privately with detainees wherever and whenever I wanted.

Consultative reviews such as this always focus on things that need change. I also encountered strengths and positive findings at ECDC, some of which I describe below. The bulk of this report, however, responds to the request to address conditions and practices in need of improvement or enhancement.

Without exception, the clinical staff members that I met appeared dedicated and well-intentioned. In addition, clinical and correctional administrators generally acknowledged the need for the changes identified in this report, expressed interest in making those changes, and solicited feedback and recommendations. Many of the current shortcomings in services arise

primarily from a need for better resources, especially recruitment and use of qualified staff with adequate mental health expertise, rather than lack of effort on the part of existing clinical staff. The willingness of clinical and correctional leadership to address current deficiencies bodes well for making needed improvements to the clinical program.

Despite the generally good intentions of existing staff, ECDC has serious deficiencies in mental health services. Two of these deficiencies have particular significance. First, ECDC has been using individuals without the necessary education, credentials, and experience to evaluate and care for the mental health needs of patients to provide almost all these services. The only exception occurs under rare circumstances when patients receive assessment or therapy from professionals at the CED Mental Health Center. Second, a psychiatrist does not prescribe the psychotropic medications at ECDC, and the non-psychiatric physician, Dr. (b) (6) who prescribes these medications does not personally evaluate patients for purposes of mental health assessment and monitoring. In almost all instances, he relies on evaluations by other staff who lack qualifications to prescribe and monitor medications and, as noted above, to evaluate and care for patients with mental health problems. Many of the other important deficiencies in mental health assessments, interventions, monitoring, follow-up, and documentation identified in this report likely arise, at least in part, from the absence of qualified professionals, including a psychiatrist. These absences and associated service problems leave ECDC out of compliance with prevailing standards of care.

Broad areas for improvement identified during this survey include the following:

1. ECDC needs to provide services by one or more qualified mental health professionals.
2. The quality of mental health services, including assessments, interventions, monitoring, follow-up, and documentation, need substantial enhancements.
3. A psychiatrist, or a psychiatric nurse practitioner or physician's assistant under the supervision of a psychiatrist, must regularly see all patients on psychotropic medications. In relatively stable and uncomplicated cases, a licensed non-psychiatric physician could substitute for a psychiatrist.
4. Mental health services must take place in settings that provide sight and sound privacy.
5. All routine clinical services, including medication administration and segregation welfare checks, should occur only during normal waking hours.
6. The segregation unit requires continuous and uninterrupted monitoring by custody staff.
7. Several practices and circumstances surrounding suicide watches and risk assessments need modification.

Addressing these concerns will likely have implications for the number of staff needed, as well as for their credentials. Some detainees need services but have not been receiving them. If identified and treated, they will add to the caseload. In addition, current patients who need more frequent and substantive contact will further add to the workload if newly recruited mental health professionals provide indicated services for them. Addressing the almost unmet need for regular assessments, interventions, monitoring, and follow-up by psychiatrists will have additional staffing and resource implications.

OVERVIEW

ECDC provides services to ICE detainees under an Intergovernmental Agreement with the U.S. Marshals Service. The facility has a capacity of 879, and it has not gone over capacity in at least the last 18 years. ECDC averages 350 male ICE detainees and usually has between 300 and 375. At the start of this site visit, ECDC had 325 ICE detainees and a total census of 749. Overall, the facility averages about 12,000 receptions per year, and approximately 25% of their non-ICE detainees are pretrial. County inmates have an average length of stay of 49 days.

ECDC has three 120 bed general population units for its ICE detainees. A 12 cell segregation unit, which can have double bunking, serves both the detainee and inmate population. Disciplinary segregation can last 30 to 60 days, and administrative segregation can last longer. The segregation unit officer could not recall any ICE detainees staying more than 30 days in segregation.

Since 2005, medical, dental, and mental health services at ECDC have been provided under a contract with Doctors' Care Physicians, P.C., a private entity owned by (b) (6), M.D., a local family practitioner. Dr (b) (6) comes to the facility on an as needed basis, but he can review entries in the electronic medical record from off-site. A nurse practitioner works every Tuesday. The health services administrator, (b) (6), is an RN who takes call 24:7. Other staff include three additional full-time RNs, several LPNs, a laboratory technician, a radiology technician, and several unlicensed medical assistants. The facility has 24:7 staffing, but no RN on-site from 6 p.m. until 7 a.m.. There are no medical records or clerical staff.

MENTAL HEALTH CARE IN ETOWAH COUNTY DETENTION CENTER

All new arrivals at the facility undergo a medical and mental health reception screen in the booking area before proceeding to one of the cellblock units. An RN, LPN, or a medical assistant (e.g., an unlicensed LPN student) typically conducts the screen, which takes place in a small room without a door in the booking area. Two individuals can sit immediately adjacent to each other on one side of a counter for their screening. They have no separation or partition for sound or sight privacy.

Within 14 days of arrival, an RN conducts a more detailed medical and mental health intake screening. If a new detainee has positive mental health findings on their reception screen, they reportedly have their intake screening done almost immediately. In some medical records that I reviewed, I found instances in which the intake screening took place within 24 hours of a positive reception screen, and in all cases less than 72 hours.

Individuals with positive mental health intake screens are referred for a "mental health evaluation [full]." I also found instances in which these occurred within 24 hours of a positive intake screen or of a significant finding on the initial reception screen.

ECDC has had only one individual designated as their mental health staff person. This individual (b) (6) recently stopped working at the facility. She was an unlicensed, "community

mental health officer" with a bachelor's degree. She helped to train a radiology technician to function as her backup mental health staff person, and the radiology technician now functions as the only designated mental health staff person at the facility. One or the other of these two individuals have conducted all of the mental health assessments and interventions at the facility. The only exception has been rare instances in which detainees have been referred for evaluation or services from CED Mental Health Center, a community mental health provider that serves the counties of Cherokee, Etowah, and Dekalb. The almost exclusive indication for referral to CED has been self-injurious behavior or significant threats of self-harm. Until recently, detainees had to go to the CED community office for services. A CED therapist can now come to ECDC to see patients, but patients still must go to CED to see a psychiatrist. Among the records that I reviewed, I found only one individual who had seen a CED therapist or psychiatrist. According to ECDC statistics, between 11/1/2011 and 5/21/2012, three individuals had a total of nine appointments with staff from CED.

Dr. (b) prescribes all of the psychotropic medications used at ECDC. He reads the notes and relies on the assessments of his mental health staff, but he does not see patients himself as part of prescribing their psychotropic medications. He typically continues psychotropic medications that a detainee was taking on arrival at the facility, but he rarely starts new psychotropic medications other than SSRIs (selective serotonin reuptake inhibitors). (b) (6), and now the radiology technician, decide whether to refer a detainee to Dr (b). If they determine that a detainee has a depression due to "situational" factors, they will follow the detainee themselves rather than making a referral. In one chart that I reviewed of a patient with a serious psychotic disorder (see discussion regarding Patient (b).[1] in Appendix A), Dr. (b) started a prescription for an antipsychotic medication after the detainee had a psychiatric assessment done by Dr. (b) (6) at CED. Psychotropic medication prescriptions cover 180 days before they must be renewed. The facility uses an electronic MAR (medical administration record), and Dr. (b) receives notification of any medication refusal by the patient. With the exception of Patient (b), who received psychotropic medication under a court order, no involuntary medications have been administered at least since 2005.

The facility uses a generic "consent to receive psychiatric medications" form. This single form covers "antidepressant, antipsychotic, anxiolytic and mood stabilizing medications." As a result, some of its information is not relevant to the particular medication that the patient takes, and more detailed information relevant to that medication is lacking. The form also states "in order to make an informed decision, you must be provided with sufficient information by your doctor who is prescribing such medications." As noted, however, Dr. (b) prescribes the psychotropic medications at ECDC, but he does not meet personally with the patients.

Detainees can put written requests to see mental health in a sick-call box on each unit. These requests are gathered and reviewed by an RN six days a week, but not on Saturday. Mental health requests go to the designated mental health staff person, either (b) (6) or the radiology technician, for triage.

[1] The names and alien number for detainees are not contained in the body of this report to protect the privacy of these individuals. Their names and alien numbers are included in Appendix B so this report can be shared without the appendix containing their personally identifying information (PII).

All mental health appointments take place either in the medical unit (usually in the x-ray room, which has a large plexiglass window in the door) or in the conference room near the medical unit. Detainees are brought to the medical unit in handcuffs, but the cuffs are usually removed when clinical staff see the patient.

At the time of this visit, ECDC had 25 detainees on the active mental health caseload, all of whom were on psychotropic medication. Detainees who need psychiatric hospitalization would go to Mountain Hospital in Gadsden, but no detainee has been hospitalized at least since 2005. Ms. (b) (6) could not recall this ever happening.

ECDC has had no suicides since at least 2005 and only three detainees on suicide watch between 1/1/12 and 5/22/12. All patients are placed in a suicide safety smock for the duration of their suicide watch. Patients are either on a constant or 15 minute watch. A suicide assessment takes place every day in the medical unit, once a day for five days after the patient returns to general population, once a week for two weeks after that, and then monthly for as long as the patient remains in the facility.

Med 5, adjacent to the nurses' station, is the main cell used for suicide watch. The wall between Med 5 and the nurses' station has a large window. Med 5 and other watch cells in the medical unit, however, contain anchor points that could be used for hanging attempts. The sinks in these cells have metal towel racks and on one side they each have a metal bracket with a hole in it. They also each have a vent covered by 3/8 inch metal mesh on the walls just below the ceiling. Each of these cells has areas with limited line-of-sight observation. For example, even in Med 5, which has the greatest ease of observation compared to other watch cells, the area between the sink and the door cannot readily be seen by people sitting at the desk at the nurses' station. The metal bracket that provides an anchor point on the sink is located in this area.

Every Monday morning, the medical unit director and the designated mental health staff person meet with facility administration and representatives from the programming and substance abuse staff. Substance abuse services and treatment plans are separate from the medical and mental health services and treatment plans. A monthly meeting takes place that includes the medical unit director, Dr. (b) , and all of the registered nurses. The medical unit director and Dr (b) (6) also have a quarterly meeting with facility administration. The designated mental health staff person does not participate in the monthly or quarterly meetings.

The segregation unit does not have an officer stationed on it. Instead, an officer mans a control room that does not have visibility or continuous sound monitoring of the unit. Inmates or detainees have call buttons in their cells that turn on a light in the control room to get the attention of the officer. The officer can then activate an intercom to communicate with the person in the cell. The officer, however, conducts regular rounds on the segregation unit and on two other units, Unit 1 for mental health inmates and Unit 2 for high-security inmates. Units 1and 2 do not house detainees. At the time of this visit, the segregation unit, Unit 1, and Unit 2 had populations of 9, 20, and 17, respectively. Rounds on the segregation unit include a security check, which consists of the officer observing the inmate or detainee through the cell door. If the cell occupant is in bed or under his blanket, the officer rattles the door to make sure that the inmate moves. Officer rounds can last for 10-15 minutes and occur every half hour. During this

time, no one monitors the control room, and while the officer is on Units 1 and 2, residents of the segregation unit have no way to contact staff until the officer returns to the control room and notices the lit call button on the control panel.

A nurse, usually an LPN, administers medications on each unit twice a day, usually at 4 a.m. and 4 p.m. During the 4 a.m. rounds, the nurse asks each inmate or detainee whether they are having mental health problems or want to see someone from mental health. These welfare checks include all cell occupants. The expectation is that the nurse will wake up inmates and detainees for the welfare check regardless of whether they have a medication to receive. An officer accompanies the nurse who administers medications on the segregation unit. According to the officer, and the segregation logbook, medication administration on the segregation unit takes approximately 15 minutes.

Detainees with whom I met, spoke favorably about the nurses, especially the nurses who do the medication passes. They consistently reported, however, that they have no access to a psychiatrist. Some appeared to have significant mental health significant unaddressed mental health issues (see Appendix A).

ANALYSIS AND RECOMMENDATIONS:

Overarching Rationale: ICE's 2000 National Detention Standards (NDS) state that "[a]ll detainees shall have access to medical services that promote detainee health and general well-being." ICE's Performance-Based National Detention Standards 2011 (PBNDS 2011) require that "detainees have access to appropriate and necessary medical, dental and mental health care, including emergency services." Non-dedicated IGSA facilities also "must…meet or exceed the intent represented by" the requirement that "Medical facilities within the detention facility shall achieve and maintain current accreditation with the standards of the National Commission on Correctional Health Care (NCCHC), and shall maintain compliance with those standards."

These standards have relevance to all of the recommendations below. They provide broad, additional support to the other more focused rationales for the numbered recommendations that follow.

1. (b) (5)

Rationale: The NDS on Medical Care states "[a]ll facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees" and "[t]he health care staff will have a valid professional licensure and or certification." In addition, the standard states, "Health appraisals will be performed according to NCCHC and JCAHO standards."

PBNDS 2011 define a "Mental Health Provider" as a "Psychiatrist, clinical or counseling psychologist, physician, psychiatric nurse, clinical social worker or any other mental health professional who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients." They further state that "The facility shall have a mental health staffing component on call to respond to the needs of the detainee population 24 hours a day, seven days a week."

NCCHC standards define a "qualified mental health professional" as "a psychiatrist, psychologist, psychiatric social worker, licensed professional counselor, psychiatric nurse, or others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients." The standards also specify that "mental health staff do not perform tasks beyond those permitted by their credentials" and "*a license that restricts practice* to correctional institutions is not in compliance with this standard" (emphasis in original). The NCCHC standards require a qualified mental health professional to perform the following "essential" services:

- Full mental-health evaluations for individuals with positive mental health screens
- Mental health appointments that provide "timely assessments in a *clinical setting*" (emphasis in original) and "treatment"
- Individualized treatment planning
- Suicide risk evaluations

And the following "important" services:

- Evaluations for crisis intervention counseling and long-term follow-up of victims of sexual assault
- Psychological autopsies

The NDS, PBNDS 2011, NCCHC standards, and this recommendation all recognize the fundamental principle that only qualified individuals provide medical and mental health services. When a detainee screens positive or is otherwise referred for a mental health evaluation or intervention, the standard of care requires that a properly trained and credentialed mental health professional provides these services. The individuals designated to serve as "mental health" staff at ECDC have not had the requisite qualifications and the facility has not been in compliance with these standards of care.

Because ECDC has, in effect, been functioning without a mental health staff, I recommend recruiting one or more qualified individuals as soon as possible. Alternatively, ECDC could use qualified mental health professionals from CED to provide all of the necessary services. If only one individual will have these responsibilities, it would be prudent to retain someone who has at least a couple of years of experience working with patients who have significant psychopathology.

For at least the following reasons, ECDC may need more than one qualified mental health professional to meet the needs solely of the detainee population:

a. (b) (5)

b.

c.

d.

e.

2. (b) (5)

Rationale: NCCHC essential standard J-G-04 states, "mental health services are available for all inmates who require them." It defines mental health services as "a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functioning, and prevent relapse." It requires "treatment documentation and follow-up" of mental health services and that "[o]utpatients receiving basic mental health services are seen as clinically indicated, but not less than every 90 days." Standard J-E-05 requires that the "health record contains results of" mental

[2] (b) (6) Mental Health Problems of Prison and Jail Inmates, U.S. Department of Justice Office of Justice Programs, September 2006, NCJ 213600.
[3] Associated Press, Official says state prisons like a 'mental health center,' Athens [AL] New Courier, December 21, 2007.
[4] Mentally ill crowding jails, officials say, Tuscaloosa News, April 19, 2012.

health screenings and evaluations. PBNDS 2011 requires treatment plans that include "regular follow-up appointments based on level of acuity."

The quality of mental health services at ECDC does not meet these standards, most notably for reasons stated in Recommendation 1 above. Other findings related to quality and areas in need of improvement are described below.

The currently used mental health forms would benefit from substantial revision. For example, on the "mental health evaluation (full)" and on other mental health evaluation forms, the section on "mental status exam" has minimal, and sometimes contradictory, options for observations. Some charts have "calm" circled under the subsection on "appearance" and simultaneously have "agitated" circled in the subsection on "behavior." No explanation is provided for these apparently mutually exclusive observations. The subsection on "thought process" has only three options - "poor concentration," "accelerated speech," and "well organized" – and the form has no prompt for observations on thought content. Some significant omissions in this area include the absence of prompts regarding hallucinations (e.g., auditory, visual, or command), delusions (e.g., persecution, grandiosity, ideas of reference, thought insertion, control, or broadcasting), or depressive feelings (e.g., hopelessness, worthlessness, or guilt). Although the form has places to address history of violence and suicidality, it has no prompt regarding current thoughts, intents, or plans. Other areas of the forms have similar deficiencies.

Some significant mental health problems appear to be missed during assessment despite their severity (see, e.g., discussion of Patient (b) , Patient (b) and Patient (b) in Appendix A). In other cases, evidence of follow up on important positive findings often cannot be found (e.g., statement on admission by Patient (b) . that "other inmates are trying to kill him"; Patient (b) reporting "hallucinations"; and Patient (b) appearing "anxious" and "disheveled" and reporting a suicide attempt on admission). The threshold for referral (i.e., self-harm) to a qualified mental health professional or a psychiatrist at CED has been too high, but this should cease to be a problem if the recommended staffing changes are made.

The quality of documentation needs improvement. Many of the notes in the medical records contain sparse and inadequate information and often read almost identical from encounter to encounter and patient to patient. Significant positive findings (e.g., agitation, hallucinations) warrant further description or explanation. Encounter notes need to provide more information, along with an explicit assessment and plan. The absence of important details makes it difficult to determine if standard criteria are being used and met to make diagnoses, or to meaningfully assess changes over time and treatment response. The treatment plans also read almost identical from one patient to the next, and they typically offer no substantive treatment goals or objectives other than to "assess" risks of harm or need for medications.

If chart notes mention a need for specific follow-up, monitoring, or treatment, these things must occur and be documented (e.g., Patient (b) and Patient (b) treatment plans stating "assess risk of harm" and "assess need for psychotropics"). Follow-up cannot be "per protocol," as some treatment plans indicate, when no protocol exists.

Some patients and circumstances require more frequent contact than they currently receive. Monthly appointments for a patient such as Patient (b) are barely adequate. When such patients refuse an appointment, as Patient (b) did on 12/7/11, they require rapid follow-up and should not wait until the next monthly appointment.

(b) (5)

When staffing levels and expertise allow, (b) (5)

As a cautionary note, "moderate" symptoms or presumptive "situational" etiologies for symptoms or diagnoses (e.g., hallucinations or depression), as recorded in several of the records that I reviewed, do not lessen the need for appropriate treatment. An individual who meets diagnostic criteria for depression, regardless of its cause, requires regular follow-up and treatment. In addition, a "moderate" depression has symptoms in excess of those required to make the diagnosis and causes more than minor impairment in functioning. Some patients described as having situational causes for depression or moderate symptoms or impairments appear to receive little or no follow-up or treatment.

3. (b) (5)

Rationale: The NDS state, "[a]ll facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees" and "[t]he health care staff will have a valid professional licensure and or certification. The USPHS, Division of Immigration Health Services, will be consulted to determine the appropriate credentials requirements for health care providers."

The required "competencies" for psychiatrists in the ICE Health Services Corps (formerly the USPHS, Division of Immigration Health Services) include "Board Certified or Board eligible in Psychiatry." The "duties and responsibilities" of the psychiatrist include, among other things, the following: "Prescribes and monitors psychiatric medication treatment services including monitoring the side effects of medication and/or adverse reactions. Offers comprehensive

psycho-educational information with each medication… Assessment of Involuntary Movement Scale (AIMS) is used if identified treatment carries the risk of inducing a movement disorder."

PBNDS 2011 state that "[a]ny detainee prescribed psychiatric medications must be regularly evaluated by a duly-licensed and appropriate medical professional, at least once a month, to ensure proper treatment and dosage."

NCCHC Jail Standards require a "sufficient number of health staff of varying types provide inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care." NCCHC Standards for Mental Health Services require a "sufficient number of mental health staff of varying types (e.g., psychiatrists, psychologists, social workers, nurses) is available to provide adequate and timely evaluation, treatment, and follow-up consistent with contemporary standards of care." They go on to state that "[w]here permitted by state law, psychiatric nurse practitioners or physician assistants under the supervision of a psychiatrist can substitute for a portion of the psychiatrist's…time," and all inmates must have "timely" access to a providers clinic for "an appointment with a mental health specialist (e.g., neurologist, psychiatrist, or neuropsychologist)."

The above standards underscore the need for every correctional and detention system to have sufficient psychiatry time to provide vital services to individuals receiving psychotropic medications. Information conveyed to a psychiatrist by a non-prescribing, qualified mental health professional can supplement but not replace the need for direct contact between the prescriber and the patient. The standard of care requires direct contact with patients on ongoing psychotropic medication regimens. (b) (5)

Patients on some medications also require monitoring that currently does not take place. For example, patients on valproic acid (e.g., Patient (b) .) need baseline CBC (complete blood count) and periodic monitoring of liver function tests. Similarly, patients on antipsychotic medications (Patient (b)) need baseline and periodic monitoring for metabolic syndrome and for abnormal involuntary movements, such as tardive dyskinesia.

The generic "consent to receive psychiatric medications" form used at ECDC does not provide appropriate or sufficient information. ECDC should replace this single form with different forms that provide more relevant and detailed information specific to the class of medication that the patient takes.

The guidelines that I offer below can help determine an appropriate frequency of visits. Please note, however, that PBNDS 2011 requires at least monthly contact with a licensed and appropriate professional for detainees on psychiatric medications. Although in my opinion carefully selected, stable patients as described below could reasonably be seen less frequently than every 30 days, this would not appear to comply with the new PBNDS requirements. In addition, the language in the standards lacks full clarity regarding who can prescribe psychotropic medications. A non-psychiatric physician (i.e., one who has not completed a full four year psychiatry residency program and therefore lacks board eligibility) does not fall within

the USPHS, Division of Immigration Health Services definition of a "mental health provider" and might not have "appropriate" credentials as required under NDS or PBNDS 2011.

The following classes of patients should be seen a psychiatrist, or a psychiatric nurse practitioner or physician's assistant under the supervision of a psychiatrist if permitted by state law, at least every thirty (30) days (more frequently if clinically indicated):

a. (b) (5)

b.

c.

d.

e.

(b) (5)

Follow-up intervals between sixty (60) and ninety (90) days should generally be limited to patients who meet all of the following criteria (if necessary, a licensed non-psychiatric physician could substitute for a psychiatrist, or a psychiatric nurse practitioner or physician's assistant under the supervision of a psychiatrist, for these patients – although this too might not meet standards as described above):

a. (b) (5)

b.

c.

d.

e.

f.

g.

4. (b) (5) [redacted]

Rationale: The NDS specify that "[a]dequate space and equipment will be furnished in all facilities so that all detainees may be provided basic health examinations and treatment in private." For newly arrived detainees, the PBNDS 2011 state, "Initial screenings shall be conducted in settings that respect detainees' privacy."

NCCHC designates privacy of care as an "important" standard, J-A-09. They state, "Discussions of patient information and clinical encounters are conducted in private" and "without being observed or overheard." Security personnel cannot be present unless "the patient poses a probable risk to the safety of the healthcare professional or others." The ECDC Medical Unit Policy and Procedure Manual contains almost identical language to the NCCHC Standards.

Health and mental health screening in the booking area currently take place in a room with no door. The set-up also allows screening of two detainees, or inmates, simultaneously and side by side. This arrangement enables staff or other detainees or inmates to observe and overhear the encounter. In addition to being out-of-compliance with standards, the current practice at ECDC can inhibit new detainees from sharing sensitive but important personal information with the screener.

5. (b) (5) [redacted]

Rationale: NCCHC designates access to care as an essential standard, J-A-01. In their Standards for Mental Health Services, they state that access to care "is the foundation on which National Commission on Correctional Health Care standards are based." An example of an "unreasonable barrier" to mental health services provided by the NCCHC is "deterring inmates from seeking care for their serious mental health needs such as holding sick call at 2 a.m. or delaying sick call appointments when these practices are not reasonably related to the needs of the institution." The ECDC Medical Unit Policy and Procedure Manual has almost identical language.

Scheduling medication administration at or around 4 a.m. constitutes an unreasonable barrier to services. This practice discourages detainees from taking medications, as noted in the group complaint letter from detainees on Unit 9, which states "a lot of detainees skip their meds because they don't want to get up that early."

(b) (5) [redacted]

(b) (5)

6. (b) (5)

Rationale: The NDS standards for both the disciplinary and administrative Special Management Units state, "In addition to the direct supervision afforded by the unit officer, the shift supervisor shall see each segregated detainee daily, including weekends and holidays."

The PBNDS 2011 state, "SMU cells must also be conducive to maintaining a safe and secure environment for all detainees, with particular emphasis on allowing for full visibility and appropriate observation by staff and wherever possible on eliminating potential safety hazards such as sharp edges and anchoring devices."

(b) (5)

7. (b) (5)

Rationale: The 2000 NDS state, "Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainees will receive preventive supervision

and treatment." They go on to state "The detainees may be placed in a special isolation room designed for evaluation and treatment. The isolation room will be free of objects or structural elements that could facilitate a suicide attempt."

A suicide prevention program that "identifies suicidal inmates and intervenes appropriately" constitutes an essential NCCHC standard, J-G-05.

(a) [redacted]

(b) [redacted]

(c) [redacted]

(d) (b) (5) [redacted]

[redacted]

SUMMARY OF RECOMMENDATIONS:

1. (b) (5) [redacted]

2.

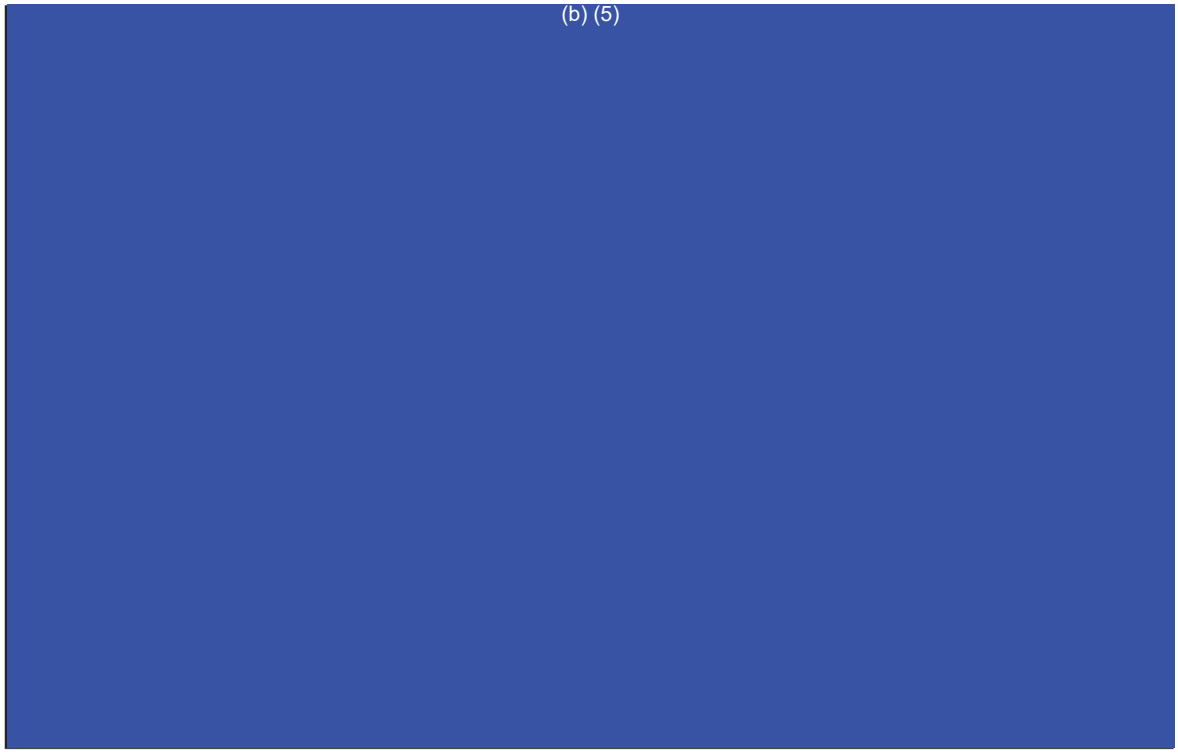
3.

4.

5.

6.

7.



Appendix A
Summaries of Selected Case Reviews

Several general observations apply across all medical records that I reviewed.

Notes in the medical records generally contain sparse and inadequate information and often read almost identical from encounter to encounter and patient to patient. None of the records contain documentation of signs and symptoms of mental illness sufficient to support the diagnoses made. For example, the records of the patients below who have diagnoses of depression typically do not comment on important diagnostic features of depression such as affect, behavior, interest or pleasure in activities, weight loss or gain, appetite, sleep patterns, fatigue or loss of energy, self-deprecatory feelings, impaired concentration, or thoughts of death or suicide. Many notes attribute a patient's depression or increased depression as "due to being locked up more," or similar statements.

The treatment plans also read almost identical from one patient to the next, and they typically offer no substantive treatment goals or objectives other than to "assess" risks of harm or need for medications. The treatment plans often specify follow-up and monitoring "per protocol," but ECDC mental health services do not have written protocols for these tasks. The treatment plan also calls for a description of the "frequency of monitoring by a psychiatrist," but none of the ones that I examined specify a frequency. They typically say no more than "review of meds and mental health evaluation by a physician."

Although Dr. (b) (6) prescribes all of the psychotropic medications, none of the records that I reviewed have mental health notes written by him or other indications of the patient being seen by him for assessment or monitoring of those medications. The only chart that I found with a psychiatry note concerns Patient (b)., who had three assessments with a community psychiatrist in July and August 2011.

1. Patient (b).:

The intake admission screen on 11/29/11 indicated that Patient (b). had "depression." The 14 day history and physical was completed on 11/30/11 and the "mental health evaluation (full)" was completed on 12/14/11. Neither document provides details regarding the patient's signs, symptoms, and history of depression. The latter document provides a diagnosis of "major depression moderate." Subsequent mental health encounter notes do not provide information about Patient (b) s depression.

Dr. (b) prescribed fluoxetine 20 mg every day for 180 days on 11/29/11, but there is no documentation that Patient (b) was seen by Dr. (b) At the time of my chart review on 5/24/11, Patient (still had not seen a physician, but his fluoxetine was scheduled for renewal on 5/28/12.

I spoke with this patient on his unit, and he reported that he has not seen a psychiatrist since he arrived at ECDC eight months ago.

2. Patient (b) .:

Patient (b) arrived at the facility on 6/23/11, and due to a positive intake screen, he had his "full" mental evaluation done the following day on 6/24/11. He received a diagnosis of bipolar disorder with moderate depression, and his global assessment of functioning (GAF) scale was rated at 60, which indicates moderate symptoms and moderate difficulty functioning. He was continued on his psychotropic medications: fluoxetine 20 mg/day and valproic acid 1,000 mg/day.

Since his arrival, his liver function tests have been checked only once on 12/16/11 and he has not had a CBC or valproate levels checked.

The medical record documents mental health contacts with the patient in 2011 on 7/29, 8/29, 9/26, 9/28, 10/5, 11/5, 12/5, and 12/26. The contacts in September and October occurred while the patient was in segregation and the contacts on 12/5 and 12/26 occurred subsequent to written requests on 12/3 and 12/25 by the patient to be seen. He reportedly went four days without medication when admitted to the segregation unit because his medications had been KOP. As of the time of this review, the patient had been seen in 2012 on 2/22, 2/28, and 5/2.

3. Patient (b)

The "full" mental health evaluation dated 8/16/11 states, "unable to sleep starting to have hallucinations due to being locked in cell all the time - states depression getting worse day-by-day." The note contains no elaboration on these reported symptoms, but concludes with a diagnosis of depressive disorder NOS (not otherwise specified) with moderately impaired functioning. The goals and objectives on the treatment plan were "assess risk of harm to self and others…assess need for psychotropic medication…follow-up to assess efficacy of meds, if prescribed, and to assess mental health stability." I could find no indication that these assessments occurred.

Patient (b) next saw someone from mental health on 9/10/11 after he said "I want to speak to counselor and meds I haven't received either." The note contains no other written findings other than a statement that "feelings change every day. Denies any SI." In the section on the encounter form that prompts for "actions that have changed or can change feelings or thoughts," the RN has written "read Bible and pray a lot." The note contains no impressions, assessment, or follow-up plan. There are no other mental health notes.

4. Patient (b):

This patient has been at ECDC since at least 2007. An admission form dated 3/12/07 states "feels like other inmates are trying to kill him." He apparently did not have mental health treatment until July 2011. He had appointments with Dr. (b) (6) a psychiatrist at Mountain View, on 7/28, 8/18, and 8/31/11. He received a diagnosis of schizoaffective disorder, chronic state at that time. On 10/30/11, he started on (b) (6), a long-acting intramuscular antipsychotic medication. He has continued to receive this medication every two weeks with the exception of a gap from 12/6 until 2/16/12, which may have been due to lapse of a court-order approving treatment. Other than a weight taken on 2/16, he has had no other weights, lipid profiles, fasting blood sugars, or recorded monitoring for metabolic syndrome. He has not had an AIMS exam (abnormal involuntary movement scale).

Patient (b) had mental health appointments on 11/7 and 12/7 in 2011, but he was not evaluated on 12/7 because he "refused to come and talk." As of the time of this review, he had mental health encounters in 2012 on 1/9, 2/15, 3/12, 4/13, and 5/15.

I interviewed Patient (b) on his unit, and he has obvious signs of his mental disorder and a likely medication-induced, Parkinsonian-type tremor.

5. Patient (b)

The medical record for this detaince indicates that he reported "no mental health" issues or history of treatment. The record has a determination of no current mental health issues. The detainee, however, has a letter dated January 24, 2012, from a community therapist who reports treating him since June 2010 for "severe PTSD" arising from war-related, childhood traumas and "torture" in Sierra Leone. The letter states that the detainee "continues to need long-term therapy if he is going to ever be able to live a productive life."

6. Patient (b):

Patient (b)'s intake evaluation on 1/23/12 noted that he appeared "anxious" and "disheveled" and reported a suicide attempt that occurred in November 2011. He received an "urgent mental health referral," and had his intake evaluation by a registered nurse on the following day, 1/24/12. Other than his history of a suicide attempt in November, this evaluation found that he had no mental health history, had a normal mental status examination, and concluded that the detainee had no current mental health issues. Neither evaluation provided details regarding the reported suicide attempt. An LPN conducted the "full" mental evaluation on 2/4/12 and concluded that Patient (b). had a "mild depression." The treatment plan stated "assess risk of harm" and "assess need for psychotropics," but I could find no documentation that these assessments occurred.

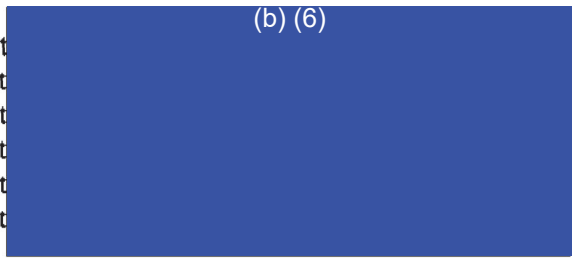
Patient (b) had follow-up mental health encounters on 3/12 and 3/28 in 2012, and daily "suicide evaluations" on 5/20 – 5/24 2012 because of a "self-harm statement." The evaluation

on 5/21 described the patient as "not cooperative…argumentative…[and] rolling his eyes." He also accused the nursing staff of trying to poison him the previous day. The assessment note from the following day, 5/22/12, states "Denies S/I" and in the section for "changes in feelings and thoughts" during the past 24 hours, the note reports "NONE." The note concludes "(b) (6) spoke with this detainee also and we are in agreement it is okay for him to RTU [return to unit]. Spoke with (b) (6). and he agreed." None of these notes provide information about the "self-harm statement," assessment of depressive symptoms, assessment of the patient's accusation that nurses were trying to poison him, detailed mental status evaluation, or the rationale for concluding that the patient could return to his unit. An RN "14 day history and physical" evaluation on 5/23, however, concluded that the patient's current mental health issues included "anxiety, depression, and paranoid schizophrenia" and that he needed a referral for evaluation by a "qualified mental health professional."

This patient gave a typed and hand-written statement to one of the other team members on this visit, which was passed along to me. This statement rambles in an almost unintelligible fashion. It refers to bringing "mozzarella sticks" in his socks aboard an airplane, apparently to test TSA security procedures and the possibility of a terrorist having "Bypass surgery, resection and installation [of explosives] inside in a abdominal container what will be filled up by liquid ingredient" (sic). At one point he asks to "talk FACE to FACE with DHS special agents why [sic] familiar with 'Smart Technology." Much of the remainder of the writing on a full typewritten page and a full hand-written page is too disorganized to decipher.

Appendix B

Names and Alien Numbers for Detainee Patients



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University of Massachusetts
UMASS Medical School

Commonwealth Medicine
University of Massachusetts Medical School
Center for Health Policy and Research
333 South Street, 13E779
Shrewsbury, MA 01545-2732
(b) (6)
508-856-4850 (fax)
(b) (6) (e-mail)

(b) (6), M.D.
Professor of Clinical Psychiatry

~~CONFIDENTIAL~~

REPORT FOR THE

U.S. DEPARTMENT OF HOMELAND SECURITY

OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES

August 25, 2012

Investigation regarding Clinton County Correctional Facility

Complaints reviewed in this report include:

- 11-05-ICE-0326 regarding detainee (b) (6)
- Grievances filed by detainee (b) (6)

CLINTON COUNTY CORRECTIONAL FACILITY (CCCF)
Site visit August 20-22, 2012

INTRODUCTION/REFERRAL ISSUE

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation of complaints it received alleging civil right and civil liberties abuses of individuals in U.S. Immigration and Customs Enforcement (ICE) custody at the Clinton County Detention Center (CCCF) in McElhatten, Pennsylvania. The complaints raised allegations regarding the conditions of detention for detainees being held by ICE at CCCF, including inadequate medical and mental health care. After a preliminary document review of the suicide of a detainee ((b) (6)) at the facility, CRCL determined that a site visit would be necessary to conduct a system-wide review of the facility's mental health, and suicide prevention programs. Grievances regarding mental health care filed by detainee A (b) (6) were also among the complaints leading to this investigation. Although the overall CRCL investigation addressed additional allegations, my review focused on the adequacy of mental health care for ICE detainees at CCCF.

PROFESSIONAL QUALIFICATIONS

(b) (6)

METHOD OF REVIEW

1. Site visit:
   I spent full days at CCCF on August 20 and 21, 2012, and a participated in exit interviews during the morning of August 22, 2012.

2. Interviews:
   a. I participated in group and individual meetings with CCCF clinical and custody administrators;
   b. I met and spoke privately with male and female ICE detainees, both individually and in groups;
   c. Dr. (b) (6) the primary care physician with our survey team, and I met several times with (b) (6), RN, who oversees medical services, and once with Dr. (b) (6), the family physician who has the contract for medical and dental services at CCCF;
   d. I had discussions with Warden (b) (6), (b) (7) and Deputy Warden (b) (6), (b) (7)(C) and;
   e. I spoke with custody and clinical staff during visits to housing units, the segregation unit, and medical areas.

3. Document reviews: I reviewed documents provided by CRCL and additional documents provided at CCCF, including those from the following categories:
   a. Mental health complaints by detainees;
   b. Records of over thirty patients, including the complainants, all patients currently or recently taking psychotropic medications, the patient who recently committed suicide, and twenty ICE detainees recently discharged from CCCF;
      i. A list of all detainees currently on psychotropic medications (CCCF otherwise has no detainees who receive ongoing mental health services);
   c. Mental Health Training materials, including videotaped training session.

EXECUTIVE SUMMARY

I received full cooperation from all staff at CCCF during this site visit. They provided me with unrestricted access to detainees, documents, medical records, and all parts of the facility. I met privately with detainees wherever and whenever I wanted.

The clinical and custody staff members at CCCF that I met appeared dedicated and well-intentioned. These good intentions, however, cannot substitute for lack of services. Clinical and correctional administrators at CCCF generally acknowledged the service deficiencies and need for changes identified in this report. Most of the deficiencies in mental health assessments, interventions, monitoring, follow-up, and documentation identified in this report arise, in large part at least, from the absence of qualified professionals, including adequate coverage by a psychiatrist. These absences and associated service problems leave CCCF out of compliance with prevailing standards of care.

For all practical purposes, CCCF has no mental health program or staff. Two to three hours a month of psychiatry coverage and the absence of other qualified mental health professionals is grossly inadequate. Other than this minimal amount of psychiatry time and the possibility of hospitalization, detainees have no meaningful access to mental health care.

Mental health assessments at intake to CCCF and during incarceration consist of little more than inquiries about current suicidal thinking and mostly by staff who lack adequate mental health training or qualifications. Compounding this failure to adequately assess detainees at the facility, I found instances in which critical information was not conveyed by other ICE contract detention centers when they transferred detainees to CCCF. As a result of these assessment and communication failures, serious needs of detainees go unidentified and unmet.

In instances where needs of detainees are identified, CCCF lacks the resources to competently address them. In at least one case, a detainee who had a recent serious suicide attempt and had been taking a medication for the underlying severe mental illness had an assessment by only an LPN and did not have that medication prescribed on admission to the facility. A decision regarding continuation of a medication, or a substitution of an alternative medication, should be made only by a licensed prescriber, and in a case of this seriousness, by a psychiatrist.

Therapeutic services such as counseling are not provided at CCCF. Mental health care at CCCF consists solely of provision of psychotropic medications to some but not all detainees who need them. Monitoring and scheduled follow-up of those detainees who receive medications is almost nonexistent and fails to meet minimum standards of care.

Compounding the absence of basic assessment and treatment services, some practices at CCCF actively discourage detainees from seeking help. If a detainee acknowledges feeling depressed and having thoughts of self-harm, the standard response at CCCF involves placing the detainee naked in a cell in the segregation unit with only a safety smock for coverage. The detainee receives no counseling or therapy and remains in segregation without clothes until current suicidal thoughts are denied. Detainees understandably view this response as humiliating, even punitive, and as a result, they do not seek help when needed. A suicide watch should have a significant therapeutic component that includes opportunities for at least daily counseling in a private setting to address and hasten resolution of the crisis. Removal of all clothing and use of a safety smock should occur only for compelling clinical reasons that include active efforts to cause self-injury.

In sum, my findings substantiate the allegations of inadequate mental health services that led to this investigation. At CCCF mental health assessment involves little more than inquiries about suicidal thinking, detainees who acknowledge such thoughts typically receive non-therapeutic and contraindicated responses that discourage requests for help, and treatment needs are either unidentified, unmet, or occasionally met with mostly negligent medication management. These circumstances compromise safety and create avoidable risks of serious harm to detainees.

Broad areas for improvement at CCCF identified during this survey include the following:

1. CCCF needs to provide services by qualified mental health professional[s].

2. Mental health services, including assessments, interventions, monitoring, follow-up, and documentation, need to be implemented where absent and substantially enhanced in quality where already provided.
3. A psychiatrist, or a psychiatric nurse practitioner or physician's assistant under the supervision of a psychiatrist, must regularly see all patients on psychotropic medications. In relatively stable and uncomplicated cases, a licensed non-psychiatric physician could substitute for a psychiatrist.
4. Several practices and circumstances regarding monitoring of inmates in segregation, conditions of suicide watches, and conducting suicide risk assessments need modification.

For its part, ICE needs to establish, promulgate, monitor, and enforce basic standards of mental health care for detainees in contract facilities. The absence of, or serious deficiencies in, essential services found during my review do not require a mental health expert to identify them. They should be readily apparent even on cursory review, as well as during the initial contracting process with prospective facilities. For example, examining a staffing matrix from a contract facility should reveal a complete absence of coverage by qualified, licensed mental health professionals and major inadequacies in psychiatry coverage. In addition, almost all of the findings and recommendations in this report involve easily identifiable problems in well-established and basic standards of care. To address the root cause of this situation, such basic standards need to be incorporated into contract requirements and monitoring procedures, and reflected in negotiated per diem rates. This is not a matter of providing optional or ideal services. Instead, it is a matter of avoiding deliberate indifference that falls below constitutional muster by failing to provide any services at all for most detainees that need them and grossly inadequate, negligent services for a few others. Stated most simply, ICE contracts must ensure that contract facilities retain at least a bare minimum of qualified mental health professionals to provide essential and critical services. Anything short of this will render the recommendations in this report unachievable, fail to meet standards of acceptable care, neglect the needs of detainees with serious mental illnesses, and risk serious but avoidable adverse events.

OVERVIEW

CCCF usually has approximately 300 inmates, about 25 of whom are female. At the time of this survey, they had 44 male and six female ICE detainees. The ICE detainees arrive under final order for deportation and the usual length of stay is 2 to 3 weeks, but some remain at the facility for many months. (b) (7)(E)

(b) (7)(E)

for segregation inmates, and mental health watches take place in cells one and two. Meals are served on the housing units. The facility also houses about 90 County inmates, 109 DOC boarder inmates and seven US marshal detainees. CCCF receives approximately 2000 new receptions per year.

(b) (6), RN, overseas medical and mental health services at CCCF. She works from 4:30 PM to 7:30 PM Monday through Friday, but she is on call 24 hours a day, seven days a week throughout the year. Four LPNs cover the 7 AM to 3 PM and 3 PM to 11 PM shifts seven

days a week, providing 1.5 FTE coverage during each of those shifts. The facility has no medical staffing from 11 PM to 7 AM.

Ms. (b) (6) and the LPNs work for Dr. (b) (6), who has the contract to provide medical services at the facility. Dr. (b) (6) comes to the facility on Thursdays for about two to two and a half hours. He also takes call 24 hours a day, seven days a week. They have one physician's assistant who works 2 to 3 hours a day on Mondays and Fridays and a second physician's assistant who works 2 to 3 hours a day on Wednesdays. The physician's assistants also work for Dr. (b) (6) and one of them also takes call for the facility. Another physician is available for coverage when Dr. (b) (6) is on vacation.

Dr. (b) (6) contract does not include mental health services. (b) (6), an employee of the county Department of Mental Health and Intellectual Disabilities, spends a couple of hours one day a week at the facility. Ms. (b) (6) has a Bachelor of Science degree in Administration of Criminal Justice and she is a Pennsylvania "302 delegate," which allows her to authorize involuntary transport to a psychiatric facility for individuals who may need hospitalization under state commitment statutes. She conducts crisis evaluations, and she screens detainees before they are referred to the psychiatrist. She cannot provide counseling or other therapeutic services, she is not allowed to write notes in the medical or mental health records, and she cannot view a detainee's records without written permission from the detainee. Dr. (b) (6), a psychiatrist, spends a couple of hours one day a month at the facility. Dr. (b) (6) s responsibilities, however, do not include coverage for the state prison inmates, who make up about one third of the population at the facility. CCCF must submit a Treatment Authorization Request (TAR) to ICE before they can schedule a detainee to see Dr. (b) (6), even for a follow-up appointment (e.g., chart of detainee (b) (6)). Dr. (b) (6) or the physician's assistants are available to see detainees when Dr. (b) (6) is not available.

The facility has no regularly scheduled meetings at which medical or mental health staff participate. According to Ms. (b) (6), Dr. (b) (6) meets with the Warden "every couple of months as needed," and Ms. (b) (6) meets with the LPNs on an as needed basis to review new medications or policies as they come out. The Warden can also call a "team leader meeting" that includes the nursing staff and custody administration when problems arise, such as issues involving specific inmates. Ms. (b) (6) sometimes attend those meetings if they involve mental health matters.

The facility does not have American Correctional Association or National Commission on Correctional Health Care (NCCHC) accreditation, and they do not conduct quality improvement activities.

MENTAL HEALTH CARE IN CLINTON COUNTY CORRECTIONAL FACILITY

New intakes remain in a booking/holding area until completion of processing and an evaluation by medical staff. The area has two observation cells that face an officer's desk-station, and three additional cells in a small wing off of the main booking area. These additional cells have many anchor points from which an inmate could tie-off a ligature. For example, they have bunk beds

with metal ladders and vertical supports for the upper bunk, holes in the metal bed frame, hooks that do not appear to easily break away, and large bore mesh in vents below the ceiling. An officer is supposed to monitor this area at least every 30 minutes.

An LPN sees all new intakes before they leave the booking area and go to their cellblock for housing. If an inmate arrives after 11 PM, they remain in the booking area until a nurse can see them the next morning. A language line is now available for non-English speaking inmates.

The LPNs who conduct intakes do not use a standardized form, but they do write a short progress note in the medical record. In approximately 30 charts that I reviewed, these intake notes had no mental health-related information other than the following identical statement, "Suicidal. Denies." The charts also contain a "Physical Examination" form signed by a physician's assistant, usually within a few days of reception. Other than a check box for indicating whether "Mental Status" is "normal" or "abnormal," the only mental health-related information on almost all of these forms consisted of the words "suicidal" and "attempts" followed by circles with "/" marks through them (i.e., ø: the symbol for the term "without"). No further mental-health screening routinely occurs as part of or after the intake process.

Psychiatric medications are usually prescribed by one of the two physician's assistants, and sometimes by Dr. (b) (6) or by Dr. (b) (6), the psychiatrist. In at least one chart that I reviewed, a physician's assistant gave a telephone order to start a detainee ((b) (6)) on the antidepressant medications paroxetene and trazodone based on information conveyed by one of the LPNs. Each medication was ordered for a duration of three months without a scheduled follow-up appointment with the physician's assistant. Scheduled patient follow-up with a prescriber after starting a medication is at the discretion of the prescriber. In almost all charts with psychotropic medication orders that I reviewed no target symptoms are noted and the plan for follow-up was either "PRN" or medications were ordered for three to six months without scheduled follow-up (e.g., (b) (6)). These patients would typically not be seen unless they put in a sick call request asking to see the prescriber. Along with the absence of scheduled follow-up, essential monitoring does not occur. For example, one detainee ((b) (6)) on an antipsychotic medication had no baseline or scheduled monitoring for tardive dyskinesia (Abnormal Involuntary Movement Scale – AIMS exam) or metabolic syndrome. This detainee was also not being followed by a psychiatrist.

Several detainees reported that they have not received responses to any written sick-call requests that they have placed in the collection box on their unit despite the passage of weeks or months. When they inquire about the lack of response, they report being told that the medical department never received their requests. I could not find the written requests detainees claimed to have submitted filed in the medical records that I checked ((b) (6)). Ms. (b) (6) reports that some resolved written requests are destroyed rather than filed in the charts.

CCCF does not provide mental health services other than medications. They have no regular caseload for mental health care and no capacity to provide counseling or other professional therapeutic care.

LPNs dispense medication four times a day on the housing units. If a patient refuses medication for three consecutive days, the LPN puts the patient on the schedule of the physician assistant to be seen. The only "keep-on-person" medications are acetaminophen, ibuprofen, and creams.

Detainees housed in the L-block segregation unit are seen by LPNs during medication administration rounds, but the nurse does not ask mental health-related questions. No mental health screening occurs prior to placing a detainee in segregation, and no periodic mental status examinations are done while detainees remain in segregation.

If a detainee tells a Correctional Officer or other staff person that they do not feel safe or are having suicidal thoughts, they are held and monitored in one of the two booking cells that face the officer's desk until they can be seen by an LPN or physician's assistant. The usual disposition involves a suicide watch conducted in either cell one or cell two of cellblock L, the segregation unit. Detainees on suicide watch always have their clothing taken away, and they receive a suicide smock. This is a custody decision that does not involve medical or mental health. While on suicide watch, the detainee will be seen by the LPN who conducts the medication rounds on the first and second shifts. They do not have contact with mental health professionals, and they do not receive mental health counseling or intervention as part of the suicide watch. When a detainee on suicide watch says that he or she no longer feels suicidal, the psychiatrist or a physician assistant will be contacted to discontinue the order for the mental health watch.

Several problems exist regarding the adequacy of the medical and mental health records, including the following:

- Mental health and medical information are kept in separate charts, and staff providing mental health services are not allowed access to a patient's medical chart without written permission from the patient;
- The charts have no problem list;
- Critical information contained in charts from prior admissions may not get documented in the chart for the new admission (e.g., detainee (b) (6) had been admitted on October 29, 2010 after a suicide attempt at another county facility, and she had been on suicide precautions during her stay at CCCF. She left CCCF on February 11, 2011, but was readmitted on January 13, 2012. The admission note for the 2012 admission states, "denies suicidal ideation and attempts," and provides no other mental health-related information.)

Illustrative Case Example: The case of (b) (6) illustrates many of the problems described in this report. I interviewed this detainee for about forty-five minutes on August 21, 2012 and she provided the following information:

> Over at least the past six months, while still in the community, the detainee had been increasingly depressed in response to loss of her job, financial difficulties, loss of her car, and threatened eviction. Five months ago, she made a suicide attempt by drinking a "cleaning product," but a friend stopped her after "a couple of mouthfuls." Three months ago she called a crisis center, and they dispatched the police to pick her up under 302 commitment provisions because of suicidal statements. She was evaluated at a hospital and at the Germantown crisis center, but they sent her home when she promised to follow

up with outpatient treatment. She began weekly appointments with a therapist, and she started seeing a psychiatrist who started her on Abilify (aripiprazole), an antipsychotic medication with antidepressant properties. Prior to starting the medication she had been extremely depressed, agitated (pacing all day and night), continuously tearful, without energy or appetite, considering suicide by jumping off a bridge, hearing voices, and may have been experiencing delusions of thought withdrawal. She had a good response to the medication and no side effects.

Prior to transfer to CCCF on August 10, 2012, the detainee had been at Montgomery County detention center. She told staff there that she felt depressed, and in response they removed all of her clothes, gave her a safety smock, and put her on a suicide watch. She said, "They never see you so what's the use of putting you on a suicide watch." Upon transfer to CCCF, she states that she told staff that she wanted to continue on Abilify, but they told her that she could not receive that medication at this facility. She did not want to take an alternative medication. She now reports sleeping only three or four hours a night and having worsening depression and crying spells. She was tearful throughout the interview with me but otherwise appropriate, without psychotic symptoms, and not actively suicidal.

In contrast to the information obtained during my interview with her, the CCCF medical record for detainee (b) (6) consists of solely the following information related to mental health:

- The "USM Federal Prisoner/Alien in Transit" form dated August 9, 2012 lists "Suicidal (Full)" in the field for "Current Medical Problems."
- A computerized "Medical Observation Report" dated August 10, 2012 has "Y Depression" (i.e., "Yes Depression") checked next to the fields for "Medications" and "Medication for Present Problem." An "N" for "no" appears in the field for "Risk of suicide."
- The LPN admission note dated August 10, 2012, states the following: "PMH – Depression. Rt. Meds Ø…attempted suicide May 2012 by drinking cleaning solvent. Denies suicidal ideation at this time…F/U for PE & PRN"
- The Physical Exam form completed by a physician's assistant and dated August 17, 2012 has "normal" checked in the box for "mental status." The written portion of the note has the following information: "PMH-depression – ø suicide/homicide ideations – states that she does not want meds…Suicidal – denies @ this time…Attempts - + May 2012 – Drank cleaning solvent."
- An LPN note from August 20, 2012 indicates a pulse of 133 and states, "Detainee tearful states has been incarcerated for 11 days but feels like it has been 11 months…Denies suicidal ideation… Advised detainee to contact medical immediately if depression ↑ or has feelings of hopelessness. Will continue to monitor. F/U PRN"

The above case of detainee (b) (6) *illustrates several serious deficiencies in communication, assessment, monitoring, and treatment, including the following*:

1. Failure to convey adequate transfer information;
2. Incorrectly stating "no" for suicide risk on the Medical Observation Report;
3. On the LPN admission note of August 10, 2012:
    a. Incorrectly noting that the patient had not been taking medications;
    b. Failure to immediately refer the detainee for a medication evaluation;

c. Failure to conduct an adequate suicide risk assessment;
d. Failure to conduct any mental status examination or to immediately refer the detainee for a comprehensive mental health intake evaluation, and;
e. Failure to schedule follow-up other than "PRN."

4. On the Physical Exam form completed by a physician's assistant on August 17, 2012:
   a. Failure to adequately document a mental status examination;
   b. Incorrectly indicating that the detainee did not want medication instead of noting that she wanted to continue on the aripiprazole rather than an alternative;
   c. Failure to conduct an adequate suicide risk assessment;
   d. Failure to refer the detainee for a complete psychiatric assessment despite the serious history and significant issues involving an antipsychotic and mood stabilizing medication, and;
   e. Failure to schedule follow-up despite the detainees serious history
5. On the LPN note from August 20, 2012:
   a. Failure to adequately document a mental status examination;
   b. Failure to conduct an adequate suicide risk assessment;
   c. Failure to refer the detainee for a complete psychiatric assessment despite the worsening symptoms of depression, and;
   d. Failure to schedule follow-up.

REVIEW OF SPECIFIC COMPLAINTS LEADING TO THIS INVESTIGATION:

1. CRCL Case 11-05-ICE-0326 regarding suicide of detainee (b) (6)
   The ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO) conducted a Detainee Death Review subsequent to the suicide by hanging of detainee (b) (6) on February 23, 2011. He had been admitted to CCCF February 14, 2012 after being taken into custody in the community. On February 16, 2011, an LPN read the detainees PPD as positive. As a result, the detainee was moved to the male segregation unit, L-block, pending a chest x-ray. At the time of his death, the detainee had been in ICE custody for nine days at the CCCF. The following are among the findings from the OPR review:
   a) No mental health screening is performed by LPN nursing staff during medical screening;
   b) The LPN used another detainee to translate during the medical screening of detainee (b) (6);
   c) No mental health questions are asked during the physical exam screenings by Physician Assistants;
   d) Correctional officers who have no specialized training conduct the medical and mental health screening for new detainees;
   e) The Booking Report completed by the intake officer did not include answers to the inquiries regarding "thought about/attempted suicide," "Serious mental or medical problems," or "previous mental/emotional problems?" questions regarding alcohol or use of "street drugs" also were unanswered;
   f) The detainee refused breakfast and lunch on the day of the suicide; and
   g) The CO assigned to L Block failed to monitor the detainee at least every thirty minutes as required by facility policy for a couple of hours prior to the suicide.

My review substantiates these findings. The Physical Examination form completed on 2/22/11 by Gene T Schrack, PA-C, has a mark in the "normal" column next to "Mental Status." The form contains no other information related to this detainee's mental status. The Progress Notes prior to the detainee's suicide do not include any comments or information related to mental health history or mental status.

In addition to lack of adequate mental health screening as part of the intake process, adequate mental health screening and monitoring did not occur as part of the detainee's placement in the segregation unit. There is also no indication of clinical inquiry during nursing rounds into the detainee's refusal of meals on the day of the suicide.

Recommendations numbers 1, 2, and 7 below have direct relevance to this case. The management of this detainee at CCCF fell below the standards described in those recommendations.

In sum, the detainee did not appear to have a meaningful or adequate mental health assessment at any point during the nine day incarceration, which included seven days in segregation. Although these findings do not meet prevailing standards of care and create a risk of adverse outcomes, I cannot determine whether appropriate assessment and monitoring would have prevented the suicide.

2. Detainee (b) (6) filed one of the complaints and grievances leading to this investigation. Review of his records supports his complaint about inadequate psychiatric follow-up. Despite being started on several new psychotropic medications and undergoing dosage adjustments, his scheduled follow-up with a psychiatrist was either "PRN" or in three months. Written responses to his grievances included the following, "We do not have a psychiatrist available on a daily basis - there are other inmates who need to be seen - not just you - you were seen on more than one occasion" (7/23/12), and "we do not provide MH maintenance counseling here - we deal with crisis situations" (2/13/12). Thus, his appropriate requests for essential services were denied due to their lack of availability at CCCF.

RECOMMENDATIONS AND RATIONALES:

Overarching Rationale: ICE's 2000 National Detention Standards (NDS) state that "[a]ll detainees shall have access to medical services that promote detainee health and general well-being." ICE's Performance-Based National Detention Standards 2011 (PBNDS 2011) require that "detainees have access to appropriate and necessary medical, dental and mental health care, including emergency services." Non-dedicated IGSA facilities also "must…meet or exceed the intent represented by" the requirement that "Medical facilities within the detention facility shall achieve and maintain current accreditation with the standards of the National Commission on Correctional Health Care (NCCHC), and shall maintain compliance with those standards."

These standards have relevance to all of the recommendations below. They provide broad, additional support to the other more focused rationales for the numbered recommendations that follow.

1. **With the possible exception of reception and intake screening, a "qualified mental health professional" must conduct all mental health encounters. (e.g., comprehensive mental health assessments, follow-up evaluations, therapeutic services, mental health treatment plans, segregation initial assessments and evaluations, and suicide evaluations). CCCF needs to recruit at least one, if not more, qualified mental health professionals.**

Rationale: The NDS on Medical Care states "[a]ll facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees" and "[t]he health care staff will have a valid professional licensure and or certification." In addition, the standard states, "Health appraisals will be performed according to NCCHC and JCAHO standards."

PBNDS 2011 define a "Mental Health Provider" as a "Psychiatrist, clinical or counseling psychologist, physician, psychiatric nurse, clinical social worker or any other mental health professional who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients." They further state that "The facility shall have a mental health staffing component on call to respond to the needs of the detainee population 24 hours a day, seven days a week."

NCCHC standards define a "qualified mental health professional" as "a psychiatrist, psychologist, psychiatric social worker, licensed professional counselor, psychiatric nurse, or others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients." The standards also specify that "mental health staff do not perform tasks beyond those permitted by their credentials" and "*a license that restricts practice* to correctional institutions is not in compliance with this standard" (emphasis in original). The NCCHC standards require a qualified mental health professional to perform the following "essential" services:

- Full mental-health evaluations for individuals with positive mental health screens
- Mental health appointments that provide "timely assessments in a *clinical setting*" (emphasis in original) and "treatment"
- Individualized treatment planning
- Suicide risk evaluations

And the following "important" services:

- Evaluations for crisis intervention counseling and long-term follow-up of victims of sexual assault
- Psychological autopsies

The NDS, PBNDS 2011, NCCHC standards, and this recommendation all recognize the fundamental principle that only qualified individuals provide medical and mental health services. When a detainee screens positive or is otherwise referred for a mental health evaluation or intervention, the standard of care requires that a properly trained and credentialed mental health professional provides these services. CCCF does not have individuals with the requisite qualifications and the facility has not been in compliance with these standards of care.

CCCF needs to begin providing therapeutic services by qualified professionals to detainees, along with basic assessments.

Because CCCF has been functioning without a mental health staff, I recommend recruiting or contracting for one or more qualified individuals as soon as possible. If only one individual will have these responsibilities, it would be prudent to retain someone who has at least a few years of experience working with patients who have significant psychopathology.

For at least the following reasons, CCCF would benefit from more than one qualified mental health professional to meet the needs solely of the detainee population:

a. The facility will need someone with appropriate credentials to serve as back-up for times when the primary coverage person is unavailable.
b. More than one individual will likely be needed to provide on call coverage 24 hours a day, seven days a week.
c. A mental health caseload will need to be established after recruitment of a qualified professional. Most studies, supported by actual experience, have found that between 15 and 20% of jail and prison inmates have a serious mental illness (a 2006 Bureau of Justice Statistics report put the number much higher, estimating that 64% of jail inmates have a mental health problem).[1] I am unaware of studies that have reliably estimated the prevalence of mental health problems among the ICE detainee population, but it is unlikely that this prevalence would differ significantly from that found across other inmate populations. General prevalence findings, along with my discussions with detainees and observations made during the site visit, indicate that CCCF does not provide mental health services to many detainees who need them.
d. Services are best delivered by multidisciplinary mental health teams that include at least a psychiatric social worker, psychologist, and psychiatrist, as each discipline adds its own valuable expertise.

2. CCCF needs to implement adequate mental health services, including assessments, interventions, monitoring, follow-up, use of problem lists, and documentation. CCCF had made translation services available prior to this site visit, and they should maintain this capacity going forward.

Rationale: NCCHC essential standard J-G-04 states, "mental health services are available for all inmates who require them." It defines mental health services as "a variety of psychosocial

[1] James DJ, Glaze LE: Mental Health Problems of Prison and Jail Inmates, U.S. Department of Justice Office of Justice Programs, September 2006, NCJ 213600.

and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functioning, and prevent relapse." It requires "treatment documentation and follow-up" of mental health services and that "[o]utpatients receiving basic mental health services are seen as clinically indicated, but not less than every 90 days." Standard J-E-05 requires that the "health record contains results of" mental health screenings and evaluations. PBNDS 2011 requires treatment plans that include "regular follow-up appointments based on level of acuity."

The almost complete absence of mental health services at CCCF does not meet these standards. Additional findings related to quality and areas in need of improvement are described below.

CCCF should implement the use of standardized mental health forms that include at least a reception screen, an intake mental health screen, a comprehensive mental health evaluation, and a suicide risk assessment instrument. Intake and comprehensive evaluation forms, for example, should include prompts that cover details within all major areas of a mental status examination including appearance, orientation, mood, affect, psychomotor behavior, speech, cognitive capacities, thought processes, and thought content, as well as suicidal thoughts, intent, and plan. CCCF need not create these tools from scratch. Many good examples of these forms and assessment instruments can be found, including at almost any correctional system or facility that has accreditation from the NCCHC.

CCCF currently fails to identify, or follow-up on, significant mental health problems, but the presence of qualified staff conducting adequate screening and evaluation can address this problem. The presence of active suicidality should not be a required threshold for receiving appropriate mental health care and treatment.

The quality of documentation also needs significant improvement. Most of the notes in the medical records contain grossly inadequate information and read almost identical from encounter to encounter and patient to patient. Encounter notes need to provide necessary information, along with an explicit assessment and plan. The absence of important details makes it difficult to determine if standard criteria are being used and met to make diagnoses, or to meaningfully assess changes over time and treatment response. Problem lists and basic treatment plans need formulation. As soon as possible, CCCF should have these services provided at a minimally adequate frequency by qualified mental health professionals. Prior to the end of this site visit, Ms. (b) (6) began the process of drafting a problem list format for inclusion in CCCF medical records.

Part of the provision of, and access to, adequate mental health services includes the availability of translation services for detainees who need them. The 2000 NDS specify that "[a]dequate space and equipment will be furnished in all facilities so that all detainees may be provided basic health examinations and treatment in private." For newly arrived detainees PBNDS 2011 state, "Initial screenings shall be conducted in settings that respect detainees' privacy." NCCHC designates privacy of care as an "important" standard (J-A-09). They state, "Discussions of patient information and clinical encounters are conducted in private" and "without being observed or overheard." Lack of translation services and use of other detainees, or non-medical/mental health staff, as translators without availability of translation services and consent

of the detainee is out-of-compliance with standards. This practice can inhibit new detainees from sharing sensitive but important personal information with the screener. I note, however, that CCCF had instituted use of a language line for detainees who need it prior to this site-visit investigation.

I also recommend integration of substance abuse services with mental health services. Serial or parallel treatment of co-occurring substance abuse and psychiatric disorders lacks the efficacy of integrated treatment of both disorders at the same time and by the same treatment team.

If staffing levels and expertise allow, I recommend consideration of group therapies such as medication education and management, stress reduction, and coping skills.

I also recommend including a mental health representative in medical staff and facility leadership meetings.

3. **A psychiatrist, or a psychiatric nurse practitioner, or physician's assistant under the supervision of a psychiatrist if permitted by state law, must regularly see all patients on psychotropic medications. In stable and uncomplicated cases, a licensed non-psychiatric physician could substitute for a psychiatrist. The frequency of follow-up visits with the prescriber should be based upon clinical need, with a maximum follow-up interval that does not exceed ninety (90) days for highly stable patients, or thirty (30) days for higher acuity individuals. In addition to diagnostic assessment, the psychiatrist's contacts with patients must include medication education, monitoring for side effects, and appropriate laboratory and other testing.**

Rationale: The NDS state, "[a]ll facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees" and "[t]he health care staff will have a valid professional licensure and or certification. The USPHS, Division of Immigration Health Services, will be consulted to determine the appropriate credentials requirements for health care providers."

The required "competencies" for psychiatrists in the ICE Health Services Corps (formerly the USPHS, Division of Immigration Health Services) include "Board Certified or Board eligible in Psychiatry." The "duties and responsibilities" of the psychiatrist include, among other things, the following: "Prescribes and monitors psychiatric medication treatment services including monitoring the side effects of medication and/or adverse reactions. Offers comprehensive psycho-educational information with each medication… Assessment of Involuntary Movement Scale (AIMS) is used if identified treatment carries the risk of inducing a movement disorder."

PBNDS 2011 state that "[a]ny detainee prescribed psychiatric medications must be regularly evaluated by a duly-licensed and appropriate medical professional, at least once a month, to ensure proper treatment and dosage."

NCCHC Jail Standards require a "sufficient number of health staff of varying types provide inmates with adequate and timely evaluation and treatment consistent with contemporary

standards of care." NCCHC Standards for Mental Health Services require a "sufficient number of mental health staff of varying types (e.g., psychiatrists, psychologists, social workers, nurses) is available to provide adequate and timely evaluation, treatment, and follow-up consistent with contemporary standards of care." They go on to state that "[w]here permitted by state law, psychiatric nurse practitioners or physician assistants under the supervision of a psychiatrist can substitute for a portion of the psychiatrist's...time," and all inmates must have "timely" access to a providers clinic for "an appointment with a mental health specialist (e.g., neurologist, psychiatrist, or neuropsychologist)."

The above standards underscore the need for every correctional and detention system to have sufficient psychiatry time to provide vital services to individuals receiving psychotropic medications. Information conveyed to a psychiatrist by a non-prescribing, qualified mental health professional can supplement but not replace direct contact between the prescribing psychiatrist and the patient. The standard of care requires direct contact with patients on ongoing psychotropic medication regimens. These contacts must include, at a minimum, personal evaluation and diagnostic assessment, patient education, and monitoring for treatment efficacy and side effects. Current practice at CCCF does not meet this standard of care.

Patients on some medications also require monitoring that currently does not take place. For example, patients on antipsychotic medications need baseline and periodic monitoring for metabolic syndrome and for abnormal involuntary movements, such as tardive dyskinesia. Prescribers also need to provide basic information, such as common side effects, to patients about the medications that they take. The records at CCCF show no indication that this has been occurring.

The guidelines that I offer below can help determine an appropriate frequency of visits. Please note, however, that PBNDS 2011 requires at least monthly contact with a licensed and appropriate professional for detainees on psychiatric medications. Although in my opinion carefully selected, stable patients as described below could reasonably be seen less frequently than every 30 days, this would not appear to comply with the new PBNDS requirements. In addition, the language in the standards lacks full clarity regarding who can prescribe psychotropic medications. A non-psychiatric physician (i.e., one who has not completed a full four year psychiatry residency program and therefore lacks board eligibility) does not fall within the USPHS, Division of Immigration Health Services definition of a "mental health provider" and might not have "appropriate" credentials as required under NDS or PBNDS 2011.

In my opinion, the following classes of patients should be seen a psychiatrist, or a psychiatric nurse practitioner or physician's assistant under the supervision of a psychiatrist if permitted by state law, at least every thirty (30) days (more frequently if clinically indicated):

a. Patients with psychotic disorders, particularly those who have a history of decompensation despite medication compliance;
b. Patients with potentially severe mood disorders, particularly those with a history of suicidality and/or mania;
c. Patients undergoing trials of medication or dose adjustments;

d. Patients with serious, persistent mental illness with a pattern of poor medication adherence and/or poor treatment alliance; or
e. Patients on psychotropic medications who do not meet any of the criteria above but have been in the facility for less than three (3) months. Such patients should generally be seen at intervals of thirty (30) days or less for at least the first three months of their incarceration, or longer depending upon their adjustment.

In my opinion, follow-up intervals greater than thirty (30) days should generally be limited to patients who do not meet the above criteria and are deemed by their treating psychiatrist as clinically stable for a lower frequency of follow-up. Please note, however, that follow-up less frequent than every 30 days might not meet standards as described above.

In my opinion, follow-up intervals between sixty (60) and ninety (90) days should generally be limited to patients who meet all of the following criteria (if necessary, a licensed non-psychiatric physician could substitute for a psychiatrist, or a psychiatric nurse practitioner or physician's assistant under the supervision of a psychiatrist, for these patients – although this too might not meet standards as described above):

a. Does not meet the above criteria for follow-up at least every thirty (30) days;
b. Does not present a risk of harm to self or others;
c. Does not have severe behavioral dyscontrol;
d. Does not have a risk for psychosis;
e. Does not have a serious medical condition that might interact with the patient's psychiatric condition;
f. Is on a well-established and stable medication regimen that has minimal risk of serious side-effects; and
g. The patient is comfortable with the proposed frequency of follow-up.

4. **Detainees who have been taking psychotropic medication prior to admission to CCCF must be seen by a psychiatrist (or another licensed prescriber within the parameters noted above) to determine whether to continue the medication or make a medication change. LPNs cannot make these determinations.**

Rationale: See above.

5. **CCCF should examine its handling of detainee sick slips and other requests for services to ensure that these requests are received, responded to, and retained in the medical record.**

Rationale: Sick-call requests are a fundamental component of access to care required by existing standards.

6. **The medical and mental health charts should be combined into a single record.**

Rationale: Separate charts create potentially dangerous breakdowns in communication and result in uncoordinated, substandard care. Ms. (b) (6) instituted this recommended change prior to the end of our site visit.

7. **CCCF should ensure that detainees in segregation receive regular mental health monitoring on rounds and through periodic mental status updates.**

Rationale: The 2000 NDS state, "Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals" and "A medical professional shall visit every detainee in administrative segregation at least three times a week." NCCHC Jail Standards (J-E-09) and Standards for Mental Health Services (MH-E-07, an "essential" standard) address the need for screening and regular monitoring of inmates in segregation. For example, as a compliance indicator, the mental health standards state, "On notification that an inmate is placed in segregation, mental health staff reviews the inmate's mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation. Such review is documented in the clinical record." The standards also require monitoring of segregated inmates with frequencies based on the degree of isolation. Individuals "under *extreme isolation* with little or no contact with other individuals are monitored daily by medical staff and at least once a week by qualified mental health professionals [emphasis in original]," and "inmates who are segregated and have limited contact with staff or other inmates are monitored 3 days a week by medical or qualified mental health professionals." The Jail Standards specify that the medical staff must be a "qualified healthcare professional," defined as someone "who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for patients." Pennsylvania Code Section 21.148 addresses standards of nursing conduct and states, " (a) A licensed practical nurse shall: (1) Undertake a specific practice only if the licensed practical nurse has the necessary knowledge, preparation, experience and competency to properly execute the practice."

CCCF fails to comply with standards for screening detainees when first placed in segregation or monitoring detainees while they remain in segregation. Mental health screening does not occur at the time of placement, and meaningful monitoring does not take place for detainees in segregation. The LPNs who do medication rounds in the L-Block segregation unit ask no mental health-related questions and do not assess the mental health of detainees in the unit. They do not meet the "requirements for qualified mental health professionals," and do not appear to have the the "necessary knowledge, preparation, experience and competency to properly execute the practice" of a "qualified healthcare professional" as defined by NCCHC for purposes of monitoring inmates in segregation.

The absence of adequate mental health screening and monitoring of detainees in segregation, can result in failure to detect mental illness or the development of anxiety, depression, and other mental health consequences of segregation.

The report by (b) (6), M.D., the medical consultant on this investigation of CCCF, will address issues regarding screening for TB and response to positive PPDs. I note, however, that placement in segregation due to a positive PPD is probably both unnecessary and ineffective for reasons that Dr. (b) (6) will address. In addition, isolation can precipitate or exacerbate symptoms

of psychological distress. This can pose particular danger early in incarceration (when PPD testing occurs) - a period of heightened suicide risk.

8. **CCCF should modify the following practices and circumstances surrounding suicide watches and risk assessments:** (b) (5) **(b) CCCF should restrict use of safety smocks only to situations that warrant their use as determined and documented by a qualified mental health professional; (c) CCCF should conduct adequate suicide risk assessments that consist of more than just a patient's denial of suicidal ideation.**

Rationale: The 2000 NDS state, "Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainees will receive preventive supervision and treatment." They go on to state "The detainees may be placed in a special isolation room designed for evaluation and treatment. The isolation room will be free of objects or structural elements that could facilitate a suicide attempt."

A suicide prevention program that "identifies suicidal inmates and intervenes appropriately" constitutes an essential NCCHC standard, J-G-05.

(b) (5)

(b) Routine use of safety smocks discourages individuals from voluntarily seeking help for suicidal thoughts and feelings. Most individuals experience removal of their clothing and placement in a smock as embarrassing and humiliating. The NCCHC Suicide Prevention Protocols state "removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g. restraint chairs or boards, leather straps, handcuffs, or straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior." I recommend that the detainee's medical record contain required documentation by a qualified mental health professional of the reason for removal of clothing and placement in a smock to help ensure that this is done only in appropriate instances.

(c) Suicide risk evaluations at CCCF consist of little more than a statement that the individual "denies" active suicidal intent. An individual's self-report of the presence or absence of suicidal

thoughts or intent does not constitute an adequate risk assessment. Studies have found that a majority of patients who commit suicide deny suicidal ideation immediately before they do so. Several reasons can account for this. They may have acted impulsively, or they may have deliberately misled their clinician. Even when a patient is honest, a denial of suicidal ideation does not necessarily mean an absence of suicide risk.

A meaningful suicide risk assessment should identify suicide risk factors, including acute risk factors, unique to the individual; identify protective factors; and evaluate the therapeutic alliance that the patient has with treating clinicians. Other clinical and custody staff can also provide useful information and observations. Appropriate assessments include a review of current symptoms such as depression, anxiety, insomnia, change in appetite, diminished concentration, loss of interest, and feelings of hopelessness. In addition to subjectively reported symptoms, observed objective signs include behavior (e.g., agitation or withdrawal) and affect. A diagnostic assessment also provides useful data as some diagnostic groups such as major affective disorders, schizophrenia, and borderline personality disorder have an increased risk for suicide. Depression complicated by anxiety or panic attacks can significantly increase potential lethality. The clinician can attempt to identify interpersonal, environmental, and situational risk factors. Remediable risk factors, including treatable disorders, warrant special attention and intervention. The assessment also includes a detailed exploration of suicidal thinking, intent, and plan. When a recently suicidal individual no longer reports suicidal thoughts, the clinician should explore and attempt to understand the reason for the change. So-called "no-harm contracts" never substitute for an adequate risk assessment.

9. CCCF should implement quality improvement (QI) activities.

Rationale: QI provides an important mechanism for improving services and preventing avoidable adverse events.

10. ICE should review and address its practices and make the following changes:

- **Require that essential clinical information accompany detainees when transferring from one facility to another;**
- **Eliminate the need for TARs when providing the essential services that standards require as noted in this report, including eliminating the need for TARs prior to follow-up services by a psychiatrist;**
- **Establish minimum standards for staffing, access to services, and quality of services as described above;**
- **Ensure that facilities can meet minimum standards prior to contracting;**
- **Regularly monitor facilities in a way that ensures that minimal standards are met.**

Rationale: Some practice deficiencies, such as lack of transfer of important information between facilities, require a systemic response that only ICE can provide, and some current ICE requirements, such as TARs for essential services, may be inadvertently obstructing access to necessary care.

ICE also needs to play a more active role in ensuring that contract facilities provide minimally adequate services. Most of the serious deficiencies noted in this report can and should be

detected as part of contract negotiations with and monitoring of detention facilities. Services that fall so far below all prevailing standards of care expose ICE detainees to avoidable risks of serious harm. Such conditions need not await a suicide, complaints, or other adverse events that result in an expert investigation before being detected and addressed.

(b) (6)

University of Massachusetts
UMASS Medical School

Commonwealth Medicine
University of Massachusetts Medical School
Center for Health Policy and Research
333 South Street, 13E483
Shrewsbury, MA 01545-2732
(b) (6)
508-856-4850 (fax)
(b) (6) (e-mail)

(b) (6), M.D.
Professor of Clinical Psychiatry

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REPORT FOR THE

U.S. DEPARTMENT OF HOMELAND SECURITY

OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES

October 28, 2014

Investigation regarding Houston Contract Detention Facility

CRCL Complaint numbers 13-12-ICE-0291, 14-03-ICE-0061, 12-08-ICE-0233

HOUSTON CONTRACT DETENTION FACILITY (HCDF)

Site visit August 18-20, 2014

INTRODUCTION/REFERRAL ISSUE

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation regarding complaints it received alleging civil rights and civil liberties abuses of individuals in U.S. Immigration and Customs Enforcement (ICE) custody at the Houston Contract Detention Facility (HCDF).

PROFESSIONAL QUALIFICATIONS

(b) (6)

METHOD OF REVIEW:

1. Site visit:
    a. August 18, 2014: 9 hours
    b. August 19, 2014: 10 hours
    c. August 20, 2014: 4.5 hours
2. Interviews:
    a. I met and spoke privately with male and female ICE detainees;
    b. Often accompanied by (b) (5), M.D., the primary care physician with our survey team, I met with members of the medical department, including the following individuals:
        i. LCDR (b) (6), Health Services Administrator
        ii. CDR (b) (6), Assistant Health Services Administrator
    c. I spoke with custody and clinical staff, including administrators, during tours, visits to housing units and medical areas, and as part of meetings between the survey team and facility personnel.
3. Document reviews: I reviewed documents provided by CRCL and additional documents provided at HCDF, including policies and procedures, suicide prevention training materials, a list of detainees currently on psychotropic medications or currently on the mental health caseload, and a mental health staffing matrix, including licensure status and hours. I reviewed several electronic medical records before and during the site visit. I also reviewed the ICE Uniform Corrective Action Plan, Office of Detention Oversight (ODO) Detainee Death Review for Detainee 1 and the January 16, 2014 Annual Detention Inspection of the Houston Processing Center from Glynn Maddox, Lead Compliance Inspector, The Nakamoto Group, Inc.
4. I reviewed the use of force video from September 7, 2012 for Detainee 1.

EXECUTIVE SUMMARY

I received documents and written information that I requested prior to and during the site visit. While onsite, I had unrestricted access to detainees, available documents, medical records, and all parts of the facility. I met privately with detainees whenever I wanted.

Patient medical records that I reviewed contained documentation in most instances of an appropriate frequency of contacts with mental health providers. Some unstable patients, for example, had several contacts a week with one or more of the mental health providers. These records, however, almost all covered times when the facility had two full time social workers and two contract psychiatrists. Both of the psychiatrists and one of the social workers no longer work at the facility. This raises concerns about the capacity of the mental health service to continue to see patients at the frequency that they need.

~~*Protected by the Deliberative Process Privilege*~~

Although for the most part mental health encounters occurred at intervals consistent with the patients' acuity and needs, the medical record notes often did not contain documentation of an appropriate level of services. For example, patients on psychotropic medications did not have basic monitoring for serious side effects, suicide risk assessments often lacked critical information and assessment details, segregation clearances and monitoring notes were *pro forma* and generally without meaningful assessments, mental health notes contained no assessments specific for gender dysphoria for two detainees who had this condition documented in the medical portions of their records, and in one case that ended in the untimely demise of a detainee the mental health and medical notes did not show coordination of care for the detainee's complex mental health and medical presentation that likely contributed directly to her death.

Problems with communication and coordination of care included an absence of medical and mental health intake information from referring facilities for most detainees and breakdowns in sharing of important information among medical, mental health, and custody staff. I also found no indication of mental health-related quality improvement activities at HCDF.

Suicide watch procedures are uniformly non-therapeutic, punitive in nature, and counterproductive by actively discouraging detainees from seeking help with dysphoric feelings. In some instances, detainees received disciplinary sanctions for behaviors most likely due to serious mental illness or remained in segregation for several months or longer despite having psychotic or mood disorders.

Management of detainees with gender dysphoria at best lacks clear guidance for custody and clinical staff and at worst causes humiliation and psychological harm. Despite policy requirements, appropriate medical and mental health evaluations and treatment do not take place. In two recent cases, HCDF has housed male to female transgendered detainees in its male segregation unit while subjecting them to security restrictions used for detainees placed in segregation because of aggressive behaviors (e.g., lock-down in their cells; use of cuffs for movement within the facility; inability to attend groups available to general population inmates; and until a few days prior to this site visit, inability to use the general population recreation area). These housing and excessive custody management procedures for transgendered detainees cause mental trauma and distress that results in avoidable suffering, depression, and suicidality.

I repeatedly heard detainee complaints that some custody and clinical staff interact with them in a disrespectful or abusive way. For example, detainees alleged having their legitimate health-related concerns treated dismissively by staff and experiencing reprisals by custody or medical staff if they complain. The prevalence of such allegations markedly exceeded what detainees have told me in other facilities that I have visited.

As an especially disturbing finding, I received contradictory and misleading information about the management of detainees housed in the segregation unit as overflow from the medical services unit or for protective custody related to their transgender conditions. Policies require that these

detainees receive management and access to programming and activities comparable to that received by general population detainees. Despite assurances from HCDF staff that this routinely occurred for all such detainees in administrative segregation, including explicit statements that a transgendered woman in the male segregation unit had been consistently afforded full access to programming and the general population recreation area, none of this turned out to be true. Rather than managing these detainees in a similar fashion as general population detainees, as required by policy and as portrayed to me, these detainees have instead been managed in the same fashion as those who are in the segregation unit because of dangerous behaviors. As already noted, they remain locked in their cells for approximately 22 hours per day, are cuffed when they go off the unit (e.g., for medical appointments or attorney meetings), and have no access to programming. They receive this treatment, which is disparate from treatment given to general population detainees, based solely on the location in which the facility has elected to house them for their medical and mental health conditions. This in effect, if not intent, punishes them merely for having a diagnosed condition, without their having engaged in disruptive or assaultive behaviors that would otherwise result in placement in segregation. The misinformation given to me impeded the determination of the reality of these circumstances and compromised the integrity of this facility review.

FACILITY OVERVIEW

HCDF, which opened in April 1984, is owned and operated by Corrections Corporation of America (CCA). The facility houses only ICE detainees. ICE Health Service Corps (IHSC) provides medical care at HCDF. HCDF has a daily census of approximately 900 inmates. The female population has been increasing in the past year, and recently runs about 400. The facility has about 4,000 admissions and discharges per year. They have three classification levels - high, medium, and low - with average lengths of stay of about 122 days, 75 days, and 55 days respectively.

HCDF has separate male and female dormitory housing, a 32 bed single-cell male segregation units, a four bed single-cell female segregation unit, and a 16 bed medical housing unit (MHU), with four negative pressure rooms and a four-bed mental health dorm.

MENTAL HEALTH CARE AT HCDF

Staffing

Until a few months ago, the facility had two full-time social workers and two contract psychiatrists. One of the social workers and both of the psychiatrists have left their employment at HCDF. A full-time psychiatrist position has been vacant for at least the past couple of years. Several potential candidates during that time failed their background checks for employment.

Access to Care

The medical records that I reviewed generally documented an appropriate frequency of contact with mental health staff, including psychiatrists. Some unstable patients were seen weekly or even daily by one or more of the mental health professionals. These records, however, pre-dated the recent loss of staff, and the facility will have difficulty maintaining adequate assessment and follow-up until replacement staff have been recruited.

HCDF uses its administrative segregation beds for overflow from the MHU, protective custody for detainees with gender dysphoria, and suicide watches. Available program activities in the facility include groups for meditation, anger management, and crafts. During a facility tour, a unit case manager who runs these groups told me that detainees in administrative segregation can attend these groups. The Assistant Warden, however, interjected to correct the case manager, telling him that he does not bring detainees to his groups but instead brings programming directly to them on the segregation unit if they want it. This would consist of rolling a television to the front of detainees' cells in the segregation unit and allowing them to watch a programming tape (e.g., a tape recorded meditation session that the detainee can watch through the window in the cell door). The case manager could not recall the last time an administrative segregation detainee attended a group or requested to watch a programming tape at the cell front.

Quality of Care

Some essential monitoring of inmates on medication has not occurred. For example, patients on antipsychotic medications have not been receiving Abnormal Involuntary Movement Scale (AIMS) examinations to monitor for medication-induced movement disorders such as tardive dyskinesia. The facility has no protocol for doing AIMS examinations or for other necessary monitoring, such ongoing assessments for development of metabolic syndrome by patients on antipsychotic medications.

A review of performance improvement projects back to October 2013 found none that focused on mental health issues.

Coordination of Care and Communication:

HCDF receives most of its admissions from the Texas Department of Criminal Justice, the Federal Bureau of Prisons, or local jails, but they rarely receive medical or mental health transfer information from the sending facilities. Medical and mental health staff participate in brief daily rounds that mostly involve communication of shift change information. They do not have regular or ad hoc case conferences on detainees with complex or challenging issues. Liaison and important communications between clinical and custody staff do not regularly occur. For example, in the case of Detainee 1 (described below), there is no indication that custody staff informed clinical staff that on more than one occasion they observed the detainee attempting to sequester or hoard medications. This detainee later died from a toxic medication overdose.

Climate issues:

In private meetings that I had with detainees, both individually and in groups, a few themes repeatedly emerged. These included complaints that they are not treated respectfully by many custody and medical staff and their perceptions that clinical staff are often dismissive of detainee concerns about their medical conditions and care. For example, a couple of detainees reported telling nurses that they were given the wrong medications at pill line, but the nurses allegedly ignored them. Many detainees said that they were fearful of subtle reprisals from custody staff who observed them speaking with me or other members of the CRCL survey team. These reprisals, for example, might include having their needs or requests deliberately ignored or experiencing targeted delays in receiving services.

The percentage of detainees who elected to speak with me about their concerns was markedly below the percentages in other facilities that I have surveyed. Among three 40-bed housing units that I visited, three detainees on one chose to speak with me, five detainees on another unit, and none of the detainees on the third unit. Most of those who did speak with me believed that their peers feared reprisals if facility staff observed them meeting privately with me or other survey team members. In my experience, it is more common to have fifty percent or more of the detainees on a unit attending these discussions with few, if any, expressing fear of reprisals.

Suicide Prevention

The suicide risk assessments that I reviewed contained little to no actual assessment information after reported incidents. Most documentation only indicated that the detainee denied intending to cause harm and was not currently feeling suicidal.

Copies of suicide prevention training materials for medical and mental health staff contained little information about high risk times, places, and situations in correctional settings and little guidance about how to conduct and document a comprehensive risk evaluation or appropriate intervention. The training materials used for the CCA officers generally had more useful information about corrections-specific risk factors. Neither of these curriculums included examples from the facility's own experience with suicides and suicide attempts. Medical administrators that I spoke with were not aware that the recent death of Detainee 1 was due to amitriptyline toxicity after medication hoarding.

HCDF uses its male and female segregation units for suicide watches. Detainees on suicide watch always have their clothing removed and receive safety smocks. This occurs regardless of the precipitants for the watch and even in the absence of active attempts at self-harm. Policy requires daily contact with mental health professionals while on suicide watch, but this does not always occur based on records that I reviewed. When it does occur, these visits take place at the cell front instead of in private settings.

CASE REVIEWS