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

Carty v DeJongh
Civil No. 94-78

FIRST REPORT OF KATHRYN A. BURNS, MD, MPH
ON COMPLIANCE WITH MENTAL HEALTH PROVISIONS OF THE SETTLEMENT AGREEMENT
October 2014

I have completed my baseline assessment of the mental health services offered to inmates at the Criminal Justice Complex (CJC) and the CJC Annex, St. Thomas, United States Virgin Islands. Although the Settlement Agreement (Agreement) was filed in May 2013, significant long-standing deficiencies with respect to the delivery of adequate mental health care persist: There are no medical or mental health care policies or procedures; inmates requiring care are not timely identified or treated; insufficient staffing levels of both treatment and custody staff continue endangering the lives and safety of inmates and staff; inmates do not have access to higher levels of mental health care; no treatment interventions other than psychotropic medication are provided and even that is unreliable given the idiosyncratic screening mechanism in place. There is no appropriate safe housing for mentally ill inmates or those requiring placement on suicide precautions. Actual therapeutic treatment space for individual and group interventions is lacking. Detention staff are untrained in how to work with persons with mental illnesses. They use physical force, steel restraints and lock down as substitutes for treatment. Additionally, at the time of my site visit, two inmates who had been found not guilty by reason of insanity, hospitalized and discharged, had been returned to the jail from the hospital and continued to be imprisoned there for more than a year with no current or pending charges – or any apparent discharge or release plan!

Additional detail relative to the conditions of the CJC and CJC Annex is found in the remainder of this baseline report. Findings are correlated with specific items in the Agreement. I found no areas of

EXHIBIT A

compliance or even partial compliance with any of the provisions of the Agreement relative to the provision of mental health care to inmates. This report closes with recommendations for addressing the identified deficiencies in a staged response designed to assist the defendants in prioritizing the tremendous amount of work that must be done to bring the jail into substantial compliance with the terms of the Agreement by addressing and correcting the most serious/life threatening deficiencies first and then turning attention to deficiencies requiring more planning and some physical plant modification to create safe housing and appropriate treatment space.

Sources of Information:

I visited the CJC and CJC Annex May 22-23, 2014. Prior to the visit, I reviewed the Settlement Agreement and a report prepared by Dr. Jeffrey Metzner dated March 20, 2009 containing his assessment of mental health services that existed at the time. I also requested the following documents from defendants in order to prepare for the visit with updated information:

1. All medical and mental health policies and procedures including:
    a. Receiving Screening/Intake
    b. Mental Health Screening and Assessment
    c. Medication administration, including daily administration times
    d. Health care requests/referrals including any logs tracking this information
    e. Mental health classification
    f. Suicide Prevention including any risk assessment instruments, observation forms and logs tracking the number and duration of watches
    g. Disciplinary policy
    h. Mental health treatment planning
    i. Psychotropic medication
    j. Therapeutic seclusion and restraint policy and procedures including any observation logs, assessment instruments and logs tracking the number of episodes requiring seclusion or restraint and the duration of the episode(s)

k. Discharge/Release policy and procedure
l. Any policy that describes the provision of mental health care to inmates in segregation
m. Quality Improvement
n. Management information system
o. Specialized mental health housing unit

2. Staff training materials related to intake screening, suicide prevention, signs and symptoms of mental illness and responding to medical and mental health crises
3. Psychotropic medication formulary
4. Staffing plan and current table of organization including whether positions are filled or vacant; CVs of all mental health staff including verification of current licensure.
5. Program descriptions for mental health care provided, psychiatric services and any specialized mental health housing.
6. Basic population information about the facility (average number of inmates at the facility and length of stay; number of intakes and releases per month for last 12 months)
7. Number of inmates on mental health caseload, number of inmates prescribed psychotropic medication
8. Mental health crisis care information: suicide or crisis watch logs for past year including transfers to inpatient psychiatric care
9. Inmate deaths for the past 2 years including date of death, cause and manner of death (suicide, homicide, accident or natural)
10. Any contracts of memoranda of understanding regarding the transfer and provision of mental health care to prisoners in outside treatment facilities such as inpatient hospitalization
11. Any and all mental health care staff meeting minutes that address mental health care operations and coordination of care; and any written communication to the Director or Associate Director regarding mental health care as a result of these meetings.

No policies of procedures on any subject were provided. No training materials were received. Responses to most of the other types of information requested were incomplete, non-responsive to the request or not provided. Therefore, I tried to gather the necessary information while on site. During the visit, I toured the facilities to view the housing areas, programming and recreational space. I was not permitted to tour the segregation housing unit at CJC due to an apparent correctional officer staffing shortage; an appropriate correctional escort could not be provided on either day.

I reviewed mental health and medical records, medication administration records and some housing unit log books. I also interviewed the mental health director, Ms. Warren; both psychiatrists; and inmates receiving mental health services at the jail. I subsequently reviewed some incident reports and investigations as well.

Report Format:

This report is focused primarily on mental health requirements articulated in the Settlement Agreement, Section V. Medical and Mental Health Care and particularly Section V.2.x. Mental Health Care and Treatment. Although the agreement articulates detailed requirements in many areas, because it was my first visit and no written policies or procedures were provided, I have essentially grouped the mental health care requirements into the following larger categories for purposes of this first report.

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

In addition to the terms of the Settlement Agreement specific to mental health, there are number of over-arching provisions more broadly related to the provision of care such as inmate safety and supervision (Agreement Section IV) and the provision of timely medical and mental health care consistent with community standards (Section V.1 and V.2.e.) Findings related many of the specific requirement areas are also relevant to these larger concepts/requirements. For example, an adequate suicide prevention program requires a relevant policy, procedure; mental health staffing to assess risk and provide treatment; enough correctional staff to identify inmates at risk of suicide, closely monitor

inmates placed on suicide watch and provide emergency intervention in the event of a suicide attempt; safe housing and appropriate property management; proper prescription and administration of medications; access to psychiatric inpatient care if suicide risk is not abated by treatment measures employed at the jail; training for correctional staff on signs of suicide, mental illness, emergency intervention and practice drills. In the specific sections that follow, I will attempt also to indicate when there are broader implications for the larger, over-arching provisions as well.

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

Mental Health components of Settlement Agreement

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

There is no policy for intake screening. The Settlement Agreement requires that screening be conducted by qualified medical and mental health professionals and that all inmates with a positive screen receive timely and appropriate care, including transfer to a hospital when indicated. If nursing staff is not available for the intake screening, a specially trained corrections officer shall administer an initial needs survey.

The practice in effect at the jail was described as follows: Officers screen inmates at the time of booking. No description or curriculum covering any specialized training officers receive to qualify them to perform screenings was provided. Medical nurses see the newly arrived inmate the same day or the following day depending on the time of arrival. (Nurses are at the facility 8 AM - 6 PM daily.) The document used by the nurses for screening does not contain sufficient mental health information to adequately screen for mental health needs or suicide risk. Referrals are generated to the mental health

social worker, Ms. Warren. Referrals are primarily inmates who have previously been at the facility with known mental health needs and/or inmates arriving with prescription psychotropic medications.

The current practice is not compliant with the Agreement and is not set forth in policy. Correctional officers, with no specialized training, are doing all of the initial screening, even when nurses are on duty. Furthermore, the current instrument is too narrow and misses cases of inmates with serious mental health needs at the front door. For example, inmate #1 was arrested and booked into the jail on 4/2/13. He has a history of schizophrenia and has been psychiatrically hospitalized multiple times and yet, he wasn't referred to mental health for nearly two weeks. No order for continued antipsychotic medication was written until July – three and a half months after his arrival at the jail. The inmate remained highly symptomatic and quite ill a year later. Patients with schizophrenia and other psychiatric illnesses are at elevated risk of suicide and may present an increased risk of harm to others as well when they are psychotic. Rapid identification is vitally important so that treatment may begin or continue as soon as possible. Clinical studies have also demonstrated that the longer that treatment is delayed (such as in this case), the longer it takes for it to work and degree of improvement eventually achieved is less than it would have been had treatment been timely. The intake screening instrument must be revised to reflect important areas of mental health inquiry so that serious mental health needs are not missed and treatment delayed. Screening instruments are intended to cast a broad net to "catch" both known (obvious) cases as well as persons displaying more subtle signs of difficulties. Thereafter, a mental health professional can further assess and refer the inmate to the appropriate level of mental health care, including psychiatric hospitalization when necessary.

There are multiple deficiencies that must be addressed to come into compliance with the Agreement: policy and procedure, revised instrument; nursing to conduct screening during regular hours, special training for officers to do the initial screening when nurses are not present; mechanism to ensure immediate continuation of prescription medications, and timely referral to and assessment by a

psychiatrist. Policy, procedure and actual practice are also required demonstrating that acutely ill and unstable inmates are transferred emergently for hospitalization when necessary. No such policy or procedure was provided nor was there any evidence that acutely ill inmates have access to emergency care and psychiatric hospitalization.

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

There is no policy for mental health follow-up assessments. Assessments are not completed by a qualified mental health professional as defined in the Agreement. Ms. Warren, a social worker, does a psychosocial and initial assessment using forms that she created. The forms are fairly well done and contain the types of information and level of detail required. However, the Agreement requires that the mental health assessment be conducted by a "qualified mental health professional" which is defined as a psychiatrist or psychiatric nurse practitioner. Ms. Warren is neither. There is sufficient psychiatric coverage at the facility such that one of the psychiatrists could complete the assessments within three days of admission, but they do not. Additionally, as previously noted, the intake screening process must also be remedied in order to ensure that inmates requiring additional assessment are identified timely and referred.

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

There is *no* medication or psychotropic medication policy. A policy is required by the Agreement to address continuity, administration and management of medications.

The psychotropic medication formulary was requested. The response was incomplete. A document dated 03/01/13 labeled as consisting of 39 pages was produced as a pdf file. However, only the odd numbered pages were provided. The even-numbered pages were not included in the file and presumably contain the majority of psychotropic medications since only a few medications were listed on the pages that were provided: Amantadine (Symmetrel); Benzodiazepines (Clonazepam & Lorazepam); Diphenhydramine (Benadryl); Gabapentin (Neurontin); Stimulants for treatment of narcolepsy and Donepezil (Aricept). It is not clear that the formulary produced is actually in use at the facility. In fact, psychiatrist Dr. Lu was not aware that there was an actual formulary and said that virtually any psychotropic medication could be prescribed. However, if there is indeed an "open" formulary, then neither psychiatrist appears to be taking advantage of the availability of newer, and sometimes more efficacious medications.

At the time of the site visit, only seventeen (17) inmates were prescribed psychotropic medication at CJC which represented approximately 24% of the jail population. If psychotropic medication is used as a proxy for calculating the prevalence of mental illness, then, the number of inmates with mental illness in CJC is low when compared with other US jails. Only one of the five women was prescribed psychotropic medication (20%). The prevalence rate of mental illness among women in correctional facilities is generally closer to 45-50%. This is another indication that the intake screening process is under-identifying mentally ill inmates. Additionally, medical and mental health record reviews identified breaks in medication continuity when inmates entered the jail. In other words, although inmates entered on medications, they were not re-ordered timely and missed medications for days or weeks. This is highly problematic and dangerous. The medications are designed to eliminate or control symptoms of mental illness. If the medications are withheld or there are breaks in continuity, symptoms return. Such symptoms may include suicidal thoughts and behaviors, impulsive and aggressive behaviors in response to psychosis and other symptoms that create not only a management

problem for the correctional staff but a very real risk of harm to self and others, including peers and staff, at the jail. This is in addition to the psychological suffering and torment of the inmate patients themselves. Further, as noted, there is clinical evidence that when treatment is withheld, it takes longer for the medication to be effective when it is finally given and the patient's response is less robust than it would have been if treatment were provided sooner or without interruption.

The types of medications prescribed were primarily antipsychotic medications (first generation), some mood stabilizers (usually Depakote but also some lithium); and surprisingly, only 3 inmates were prescribed antidepressant medications. In other correctional settings, antidepressant medications are the most frequently prescribed medication. Although the "older" antipsychotic medications were prescribed far more often than newer medications, there was no documentation that inmates were being regularly monitored or examined for the development of movement disorders, which are common side effects of the older antipsychotic medications and part of the standard of care when they are used.

There were instances in which injectable medication orders, including orders for long-acting injectable medications, were written to be given if the inmate refused oral medications. There was no documentation of any sort that legal or clinically appropriate administrative authorization for this practice was secured. *It needs to stop immediately*. Inmates have a right to refuse treatment. An appropriate policy and procedure to override medication refusal consistent with federal and territorial law must be developed before medication can be forced on inmates. There were also incident reports in which correctional staff documented physically restraining and forcing inmates to take oral medications, essentially by shoving them into the inmate's mouth. (Incident reports 3/6/13) It is not known how many times correctional officers have engaged in this practice but it must cease IMMEDIATELY – it is creating a serious risk of death by asphyxiation. There is no medical, legal or other authority to permit or condone this practice. Note also that there was no documented investigation of this incident, which is not only inappropriate, but also appalling.

When psychotropic medication orders are written, the response in terms of getting the medication and administering it seemed timely although I did not systematically study the time intervals in every case. There continue to be problems with psychiatrist medication orders being written without a stop date. In general, medication orders are written to last 30 – 90 days in correctional facilities. At CJC, neither psychiatrist identifies how long the order is in effect. This is a deviation from the standard of care and creates unnecessary confusion for nurses charged with interpreting the orders. (This finding has been identified on prior occasions and easily remedied so it is not clear why it persists.)

A review of the medication administration records (MARs) indicated a number of idiosyncratic and improper practices. Multiple medications were written onto the same row of the MAR making it unclear which medication(s) may have been given and which may not have been given or refused. The MARs also did not contain start or stop dates. Multiple months were recorded on a single MAR page. (The standard practice is that a single page covers a single month of medication administration.) Decanoate medications appeared to be recorded on a monthly calendar rather than being on an inmate-specific MAR. March 2014 was the last month in the MAR binder so it is not clear if or whether April and May injections were noted/given. Although MAR problems are nursing practice issues, improper and ambiguous documentation negatively impacts prescriber interpretation of medication compliance rates and response to treatment.

A comprehensive medication policy and procedure can address multiple areas of existing deficiencies in practice. Nursing protocols and training around the administration and documentation of the process must also be developed and implemented.

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

No policy or training curriculum for staff in recognizing and responding to emergencies were provided. No protocol for periodic assessment of the facility's compliance with policies and procedures regarding the identification, handling and care of detainees and prisoners with serious medical and mental health conditions was provided. These items are required by the Agreement.

No contracts or memoranda of understanding regarding the transfer and provision of mental health care to prisoners in outside treatment facilities such as inpatient hospitalization were provided. No system to classify, track or monitor inmates' mental health needs was in effect. One document labeled "Bureau of Corrections Suicidal Attempts" was produced in response to the information request prior to the site visit. There were 13 "attempts" by four inmates. The attempts were dated from December 2010 through December 2013 but contained no information from calendar years 2012 or 2014.

Documentation of response to mental health crises was inconsistent; sometimes progress notes were present in the mental health file indicating that treatment staff were notified of a crisis and responded while in other situations, there was a notation in the housing unit log that an inmate was placed on lock-down for self-injurious or other crisis behavior but no corresponding referral to mental health or treatment intervention. Inmates experiencing mental health crises are not receiving treatment to address or eliminate the crises. This creates and increased risk of harm, including self-injury, inmate on inmate or staff injury and staff on inmate injury when untrained correctional officers using physical force to place inmates in lockdown status or steel restraints. (Lockdown status is locking an inmate into his cell for unspecified and unregulated periods of time and sometimes also includes steel restraints as well.) Detention staff fail to monitor inmates in lockdown status and they do not notify mental health staff of these placements. Involvement of mental health staff and correctional

officers with training in crisis de-escalation techniques reduces the likelihood that any use of force would be required. In any event, a referral to mental health is required to ensure appropriate access to care as required in the Agreement.

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

No suicide prevention policy or procedure was produced. Ms. Warren produced some documents (undated) entitled "Special Observation Monitoring Sheet" and "Mental Health Suicide or Monitoring Discontinued Form" but there was no evidence that these forms are actually in use at the facility. (Neither form was found in any of the charts reviewed when inmates were placed onto watch status by mental health or correctional staff.) Review of actual practice revealed numerous inconsistencies. There was no evidence that all potentially suicidal inmates are referred to mental health. There were instances in which placement of an inmate on a watch was referenced in the mental health file but without corresponding correctional officer observations on a monitoring sheet or the officer housing log. There were other instances in which the housing log indicated an inmate being on watch status though there was no corresponding documentation in the mental health file or any evidence that a referral to mental health had been generated. There was no indication that watches vary in intensity (close watch with officer observations and documentation at staggered intervals not to exceed 10 minutes versus constant watch with continuous observation) or that constant watches actually occurred in cases of high-risk inmates. In fact, Ms. Warren reported that officer staffing shortages frequently prevent the facility's ability to provide the one to one observation necessary for constant observation. Additionally, correctional officers are pulled from one cluster to another to assist with various tasks such as meal distribution which pulls them away from maintaining inmate observation. Documentation is inconsistent but does not support that there are two levels of watch.

(Note that there was inconsistency even in the naming of the watch levels. The observation forms created by Ms. Warren, though never officially adopted, describe "mental health watch" and "intense watch" as the levels.)

There was no evidence that a standard suicide risk assessment is conducted when an inmate is placed on watch status. There was no evidence in the mental health file that treatment intensity was increased in response to mental health crisis or placement on suicide watch. The Agreement requires that a psychiatric provider direct the care of potentially suicidal inmates. There was no evidence that the psychiatrists were involved at all; suicide precaution orders are not issued by a psychiatrist, nor is the psychiatrist called upon to conduct a face-to-face assessment. If suicide precautions are instituted at all, as opposed to simply locking inmates in their cells with no treatment, there is no evidence that the precautions are reduced or removed by a psychiatrist. Further, I did not see a single cell in either CJC or the Annex that would be appropriately called a "safe cell." All had problems with location (distance from correctional officers), limited visibility, mental health staff access for confidential treatment and unsafe environmental factors providing places to "tie off" an object that could be used in a hanging attempt.

Staff training materials related to intake screening, suicide prevention, signs and symptoms of mental illness and responding to medical and mental health crises were requested but nothing was produced in response. The officer accompanying us on the tour could not locate a cut-down tool, nor did she know where it was ordinarily located. (This is a recipe for tragedy.) Clearly, if there is training for correctional staff, it was ineffective and must be remedied.

Suicide prevention at CJC is deficient in every respect and noncompliant with all components articulated in the Agreement. (V.2.l. sections i through xii) However, Ms. Warren reported there have been no suicides in the last two years. She estimated that suicide watches occur at a frequency of one every 8-15 months although there is no actual data collection on this and as noted previously, and

watches do not result in a referral to mental health staff, immediately or otherwise. Ms. Warren also indicated that if an inmate is injured as a result of a suicide attempt, he or she is taken out for treatment at the local hospital but generally returned when medically treated and physically stable. This may happen once or twice annually. No inmates were hospitalized at the local hospital at the time of the site visit. Given that suicides occur in correctional facilities at a higher rate than in the community, it is imperative that CJC develop and maintain an adequate suicide prevention program. That no completed suicides have occurred at the facility in the past two years is fortunate, but years of clinical research and practice dictate that correctional facilities have a comprehensive suicide prevention program in place to minimize the risk of completed suicide. No such program is in place at CJC.

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

The staffing plan and current table of organization including whether positions were filled or vacant and the CVs of all mental health staff including verification of current licensure were requested prior to the site visit. The response was incomplete.

A document was produced identifying Ms. Ruth Warren as the Mental Health Coordinator and Dr. Lu as the facility psychiatrist. No credentials, license verification or work hours were included in the document provided. Information gathered on site indicates Ms. Warren is a social worker by education, training and experience and she works full time weekdays. Dr. Lu is contracted to work 2 hours each weekday for a total of 10 hours per week. There is no verification of this. Further, when on site, it was clear that that Dr. Lu is actually conducting forensic evaluations for the court rather than providing treatment to inmates for a significant portion of his hours. Further, he was not at the facility for 2 hours on each of the days that I was at CJC. Ms. Warren indicated that another psychiatrist, Dr. Napier, had started in early 2014 and is contracted to provide 20 hours of psychiatric treatment per week, 4 hours

daily in the afternoons. As with Dr. Lu, the contract is not monitored nor hours worked verified in any manner. Dr. Napier was at CJC for an hour or two on the first day of the visit, saw no inmates and was called back to the hospital to address an emergency. He did not return. He hadn't arrived at CJC by 1:00 PM on the second day of the site visit. There was no indication in the mental health files that having additional psychiatric time at the facility has increased the numbers of patients seen or improved the frequency with which patients are seen by psychiatry. Ms. Warren said that it was helpful to have two psychiatrists in terms of being able to switch some inmates who didn't like or disagreed with Dr. Lu's care to Dr. Napier, but there was no formal assignment of patients to either of the psychiatrists. In addition to Ms. Warren and the psychiatrists, there is a contract with an outside vendor for a psychologist (Thompson) and a psychology intern (Ms. Livingston) to provide 2 hours of group treatment to inmates at the jail weekly.

Dr. Lu said that he had been providing services at the jail since approximately 2000. He acknowledged doing forensic reports/competency assessments in addition to direct clinical care. He didn't view this as any sort of ethical problem or conflict or see it as taking time away from being able to provide an adequate number of clinical hours. (His progress notes in the mental health records contain elements of both clinical observations and forensic conclusions. This is improper and has been identified in the past.) Dr. Lu said generally sees inmates monthly but sometimes every 2-3 months, and that he re-writes medication orders monthly. There is no documentation to support this practice. Progress notes are quite infrequent and medication orders do not contain start, stop or duration dates.

Dr. Napier said that his contract with the jail started in late January or early February. He is contracted to work four hours per weekday. He expressed some concerns about the lack of physical space at the facility and the lack of natural light for inmates and staff. He participates in a meeting with medical staff, Ms. Warren and the contract psychologists every other Wednesday. He also thinks that correctional staffing levels are a concern; sometimes when he is seeing patients, there are no security

staff in the area and he has not been given a spider alarm. Dr. Napier mentioned considering telepsych as a way to continue to provide care at the jail whenever he was not on the island and at home in Canada. Several weeks after the visit, he telephoned me to ask my opinion about starting telepsych with the jail. In this conversation, in addition to using it for continuity purposes when he was off island, he thought it would be useful even when he was on the island and at the hospital as a way of getting his contract time in at the jail. I told him that the lack of any operational mental health policies and procedures, the paper records system, the lack of space, appropriate equipment, technological support and the lack of clerical support are factors that must be addressed before any consideration can be given to beginning telepsychiatry practice. It is not a viable option at this time.

Staffing levels of correctional officers are inadequate: suicide watches cannot be conducted appropriately; patients cannot be transported over to CJC from the Annex to participate in group treatment consistently; staff cannot conduct rounds in segregation due to correctional officer shortages; sometimes, posts are completely unmanned and other times, officers are called off their posts to assist other officers in routine tasks such as meal distribution (leaving posts completely unmanned) to name just a few examples that highlight the inadequate correctional officer staffing levels.

In summary, CJC is not compliant with the staffing terms articulated in the Agreement. Professional staffing is not clinically adequate to provide mental health treatment programs, nor is there sufficient correctional staff to support that mission. No staffing analysis was provided. No budget specific to mental health was provided. There was no evidence of 24-hour psychiatric coverage. There was no system of accountability for the contracted hours of psychiatric time on site during the day, evidence that contracted psychiatric hours are not actually provided as well as serious concerns about clinical productivity and practice (e.g., failure to conduct timely assessments, failure to manage medications appropriately, no involvement in suicide prevention and crisis care, etc.)

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

No policies or procedures regarding segregation were provided. There was no evidence that actual practice prohibits housing inmates with serious mental illness (SMI) in isolation or any evidence of review to minimize time in segregation or provide adequate out-of-cell time as required by the Agreement. There was no documentation in the mental health files that any sort of mental health review or consultation is provided at any time in the disciplinary process as required in the Agreement. This provision is important because inmate behaviors may be a manifestation of psychiatric illness; it can be identified and treated rapidly if inmates receiving disciplinary reports are referred to mental health staff. If not referred, and given a lockdown sanction, access to care is impeded, mental conditions worsen and treatment is delayed.

Additionally, some inmates are locked down on regular housing units, including the mental health treatment housing unit, cluster 1. Although not technically "segregation", the conditions experienced by the locked down inmates are similar to those of segregation in terms of out-of-cell time, access to care, property restriction, etc., and should be considered when the policy and procedures are developed for this area of the Agreement.

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

Program descriptions for mental health care provided, psychiatric services and any specialized mental health housing were requested in advance of the site visit. The information provided indicated that the services provided include individual assessments, psychosocial assessments, individual and

group therapy, referral and education services; discharge planning and linkage to community services. These are almost all done exclusively by Ms. Warren as her time permits. Mental health staffing is insufficient to actually do a course of individual therapy for a specific problem or issue. Ms. Warren can and does provide supportive counseling sessions primarily on an as-needed or requested basis rather than an actual course of treatment.

The contract psychologist and intern do one group session weekly for 5-7 inmates. Ms. Warren's office doubles as the group room. (It is very small and barely accommodates her desk and two additional chairs.) The group curriculum is 8 weeks long but the last 4 weekly sessions were cancelled for various reasons. (In one instance, there were no correctional staff to transport inmates from Annex in order to participate. On another week, corrections "forgot" to get people from Annex and one time, there were no chairs for the inmates to sit on so the group could not be conducted. Ms. Warren subsequently got additional chairs.) In any event, this very limited group treatment resource is not targeted to inmates with serious mental illnesses – they receive no group treatment or other therapeutic activity.

There is no policy addressing levels of mental health care or written protocols to describe the frequency or types of contacts to be provided for chronic or acute conditions. Staffing levels do not permit appropriate levels of mental health care. Treatment is more than psychotropic medication administration.

There are no single cells designated for special management inmates in either the main facility or annex. An adequate number of single cells designated for inmates with special health and mental health care needs is required by the Agreement. Defendants are not compliant with this provision. In CJC main, housing area "Cluster 1" was identified as the mental health treatment unit for male inmates. It consists of 11 cells; 10 have open steel barred doors and one has a solid steel door containing only a small viewing window at head level. (This solid door cell is used to house inmates on suicide precautions

though it is located farthest from the officers' station, offers poor visibility into the cell and continuous observation could not be maintained in this cell.) Each of the cells may house two inmates, none are designated as single cells. Cells contain a bunk, shelf unit, desk with bench and stainless steel commode/sink unit. There are no windows to the outside and no natural light. (Small windows to the outdoors that were originally present have been covered over/blocked permanently in response to communication and conveyance of contraband through the windows with persons outside the jail.) Cells are located around the periphery of the housing area. The central "day room" area of the unit contains 5 tables with bench stools permanently affixed to the floor, 2 telephones and 2 televisions for the inmates. No mental health programs are offered on the housing unit. Ms. Warren sometimes visits the unit to chat briefly with the inmates and/or check on their condition. Dr. Napier has accompanied her on occasion.

Ms. Warren reported that the decision to admit or discharge from the MH housing unit is not clinical. It appears to be driven by limited bed space. There is no treatment/programming space on or near Cluster 1.

For a variety of reasons, Cluster 1 is not a safe or therapeutic housing area. Clinical staff do not control admissions and discharges. The population is mixed in terms of vulnerable inmates with serious mental illnesses and predatory inmates with a history of violence. Incident reports and the log book are filled with reports of inmate-on-inmate physical fights, assaults and attacks requiring emergency transport to the outside hospital for physical care. Some of these incidents involve the use of shanks and other weapons. This happens often when it is clear that no officer was on post at the time of the incident. The officer post is unmanned for hours at a time due to staffing shortages or officers being pulled off post to assist in another area of the jail. Other times, the officers have been mandated to work double shifts. They have been provided no specific training or instruction as to how to deal with or manage inmates with serious mental illness. Such training would assist officers in better communicating

with special needs inmates, help de-escalate crises to reduce the need for using force, lockdown and physical restraint. There are incident reports in which officers use excessive physical force on inmates and use steel restraints (handcuffs and leg irons) improperly and without authorization, policy, involvement of or notice to mental health staff. Inmates have been shackled to desks or restrained in other ways that increases their vulnerability to assaults in that they cannot defend themselves or get out of harm's way. The Agreement requires implementation of special policies on the use of seclusion and restraint consistent with professional guidelines that include face-to-face assessments by a psychiatrist and monitoring by nursing and limited duration. None of these guidelines are met with the unilateral decision of corrections to place inmates in lockdown or restraint. Cluster 1 is a violent and dangerous housing area. There is no evidence of coordinated management between corrections and mental health staff. There is no evidence of any sort of structured therapeutic activity on the housing unit. Housing inmates with serious mental illness in Cluster 1 is harmful – physically as evidenced by incident reports of inmate-on-inmate assault and excessive use of force by correctional staff, as well as psychologically.

Mental health care at CJC is deficient in virtually every aspect: inadequate treatment space; inappropriate housing including deficient "safety cells" for suicidal inmates or those experiencing crises; insufficient mental health staffing levels; minimal treatment other than psychotropic medication; inadequate security staffing; no capacity to increase or respond to need for higher level of care; and no policies or procedures including those for high risk occurrences (suicide watch, restraint, therapeutic seclusion). Ms. Warren is a hard working, organized and dedicated mental health professional but one person simply cannot do everything. Additional treatment providers are necessary and the psychiatrists must be held accountable for their time and productivity in terms of patient care. Inmates with serious mental illnesses are not seen timely by psychiatry nor are they seen at regular intervals. Additionally, some interactions are not conducted in private or confidential settings. For example, Dr. Lu's patient interactions are sometimes conducted while the inmate is at the window of the medication room

receiving his medication dose. This is clearly not private and woefully inadequate in terms of the duration and comprehensiveness of the contact. There are virtually no treatment interventions for inmates with serious mental illness other than psychotropic medication. The Agreement requires adequate mental health programs for all inmates with serious mental illness and includes psychosocial rehabilitation services. These types interventions serve as an adjunct to treatment with medication, help inmates manage their illnesses/deal with symptoms, increase pro-social skills, prepare for release and ultimately, reduce criminal recidivism. Additionally, engaging inmates in structured activities is also extremely helpful in terms of jail population management – inmates have less idle, unproductive time and fewer incidents result. Also, as stated a number of times, correctional officers must be present in sufficient numbers and receive appropriate training to manage inmates with serious mental illness.

There are no contracts or memoranda of understanding regarding the transfer and provision of mental health care to prisoners in outside treatment facilities such as inpatient hospitalization or intermediate care. The Agreement requires timely transfer to a higher level of care when clinically necessary. I identified at least two inmates (patient 1 and 9) that needed a higher level of care. As stated elsewhere in this report, clinical studies demonstrate that timely access to care is vital to ensure a positive outcome/treatment response. If care is delayed, the response to treatment is less complete/robust and takes longer to achieve than when care is provided timely – and people continue to suffer.

The Agreement's requirement for transfer to outside treatment facilities when necessary is also highly relevant inasmuch as there are two patients with serious mental illness being held in the jail who have been found ***not guilty*** by reason of insanity (NGRI) and have no other pending charges. I interviewed one of them (patient #9) who clearly needs a higher level of care and should be transferred out immediately. I did not interview the other patient but understand that he was found NGRI in 1998. He was held in Corrections and Department of Health facilities until 2009 when he was transferred to

Sylmar Health and Behavioral Center in California. This patient was discharged from Sylmar and returned to CJC in January 2013. He has remained in custody since that time. Several inquiries have been made on behalf of both of these acquittees to determine why they remain in jail. I also raised the question with Mr. Robertson and Ms. Carol Thomas-Jacobs when I was on site. They said they would look into it but I have heard nothing back from them. I know of no other correctional system or facility that continues to imprison NGRI acquittees or other people who have been found not guilty when there are no pending charges. Both of these inmates must be released from jail. Given the duration of their confinement (and patient #9 mental condition), transfer to inpatient care followed by placement into intermediate care and gradual transition into the community is clinically indicated and necessary.

Mental health care is not compliant with the specific terms of the Agreement or the over-arching requirement for "timely medical and mental health care consistent with community standards and constitutional requirements including screening, assessment, treatment and monitoring of prisoners' medical and mental health needs." (Section V.1.)

RECOMMENDATIONS

This was my first site visit and is being used to establish a baseline from which a plan to move forward in addressing the requirements of the Settlement Agreement can be developed. I found no areas of compliance or partial compliance with any of the mental health terms of the Agreement. I recommend defendants consider developing a plan that calls for addressing items in stages or phases. For example, in the short term (6 months), the items of highest risk should be addressed. Other components of care can be addressed in the intermediate term (6-12 months) and finally, a third group of items or goals can be addressed in the longer term (12-24 months). This would help organize the task into manageable and achievable steps in order to reach compliance with the Agreement. The following paragraphs are intended to illustrate this recommended methodology using some of the

Settlement Agreement terms by way of example. They are not offered as comprehensive coverage nor intended to imply that doing only these items is sufficient to bring mental health care into full compliance with the terms specified in the Agreement.

In the short term (first 6 months), the areas of the Agreement that address high-risk practices or situations should be addressed. This includes revision and updating the Intake Screening process to ensure that emergency needs and continuity of care are identified in addition to other mental health needs so that a referral to mental health may be made timely. The current practice under-identifies people and does not triage or sort patients into those with chronic vs. acute care needs. Suicide prevention is another high-risk area that should be addressed in the short term. "Safety cells" must be identified and made "safe" with improved visibility. Monitoring, documentation and communication between treatment and custody staff must be addressed in policy and practice. Adoption of a standardized risk assessment instrument would be helpful in assessing and managing risk. The policy must also address increasing treatment intensity during periods of increased suicide risk and specify follow-up after a watch is discontinued. Policies and procedures for the use of seclusion and restraint must also be addressed during this period as they represent high-risk practices. Inmates in the MH cluster are placed on locked down status, which is actually a form of seclusion. This practice must be addressed by policy and include authorization by psychiatry, monitoring by corrections and involvement of mental health staff. Finally staff (mental health, medical and custody) training on the new procedures and expectations could also occur in the short term.

In the intermediate term (months 7-12), the remaining mental health policies and procedures required by the Agreement should be developed and implemented. These include setting the practice parameters for acute and chronic mental health care (e.g., frequency of contact, documentation requirements, treatment planning, individual and group counseling, medication management, etc.) A mechanism to reliably and consistently monitor the psychiatrists' contracts should be put into place to

ensure that the facility is actually receiving the 30 hours weekly specified in the contract. This virtual tripling of psychiatric time should permit the psychiatrists to do more frequent medication monitoring in addition to medication education and some supportive counseling. Dr. Lu should not be doing forensic evaluations on patients with whom he has a treatment relationship nor should his forensic conclusions be documented in the clinical record. Productivity expectations (number of patients seen per week) should be set and performance monitored. An MOU and/or contract to ensure access to inpatient care must be addressed in this intermediate term. A psychotropic medication policy that reflects contemporary practice standards must be adopted. It must address informed consent, monitoring for side effects, laboratory testing and response to treatment.

The longer term (months 13-24) should be used to address those items in the Agreement that will require additional study and likely some physical plant modification. This includes the identification and/or creation of appropriate treatment space for both individual and group interventions. Treatment space must be easily accessible to both patients and staff, permit confidentiality while also ensuring safety and security. Any housing unit used for mental health housing at CJC or the Annex will require significant physical plant modification. Another long term item is staffing, which includes a mental health staffing plan based on the needs identified by implementing acute and chronic care clinics, mental health involvement in crisis intervention/suicide prevention and timely and comprehensive release/discharge planning. Any staffing plan must also include an analysis of correctional officer staffing levels to permit adequate levels of offender supervision, escort, transportation, monitoring, documentation, staff safety and the myriad of other tasks and functions that are required of officers.

As noted, the foregoing represents one type of plan intended to systematically address the terms specified in the Settlement Agreement. It is offered by way of example and does not include each and every item of the Agreement. If defendants adopt the methodology, all of the Agreement items should be incorporated into the short, intermediate and long-term plan construct. I remain available for

continued consultation during this process or any other selected by defendants. I will plan on returning for a second site visit to assess progress at the beginning of calendar year 2015.

Respectfully submitted,

/s/
Kathryn A. Burns, MD, MPH
17 October 2014

	Record review	Interview	Comment
#1	Arrested 4/2/13; referred to MH 4/15/13 (2 weeks); initial assessment 4/15. Treatment plans 12/15/13, 4/22/14, 7/23/14. Tx Plan diagnoses are Schizophrenia, chronic; cannabis dependence, ASPD, Sickle Cell. Has had 8 psychiatric hospitalizations 1983-1997. Note by SW that Dr. Lu started medication 4/22 but there is no apparent order for medication until 7/24/13. Psychiatry visits Lu 7/12/13, 9/6/13, 9/23/13 at med room, 12/4/13 "poor understanding of legal system marginally competent"; 1/23/14, 2/4/14 - unable to assist his defense rationally; 2/10, 2/25, 2/28 met in med room; visits with Napier 3/10 and 4/9; Lu 5/20/14. Meds are Cogentin 0.5 BID, Trifluoperazine 2 BID, Lorezapam 1 QD.	Reports he is going to court 6/28 and anticipates he will be released then. Complains of leg and shoulder hurting - he has sickle cell trait. He hasn't been seen by psychiatrist "for a while", no group treatment. Has right upper extremity resting tremor. MSE-appearance hygiene fair but has body odor, lower teeth missing, thin; difficult to re-direct from pain and wanting medication for pain; garbled, mumbling speech; denied any MH problems.	Chart notes of psychiatrist contain a mixture of forensic content and clinical content but no increase in contact or changes to treatment plan when clearly highly symptomatic and ill.
#2	Arrested 11/13/13, referred to MH 11/15 and seen for initial assessment 11/15. No treatment plan until 4/23/14 - Bipolar Affective Disorder, Alcohol and cannabis abuse, cocaine dependence, Dependent PD. Dr. Lu PN 11/18/13 indicates bipolar and substance abuse but does not indicate meds. 3/21 Depakote level ordered and it is very low; blood level reordered 4/30 but no result. On 5/15, Depakote dose increased to 500 BID liquid. 5/19 Napier sees and reports calm, pleasant and normal mood. 5/20 note by Ms. Warren that Lu stopped oral medication and increased IM but there is NO note from Lu as to why and Napier's note looks like no med changes were warranted. MAR indicated Depakote 500 BID, Cogentin 0.5 BID; Haldol D 50 Q 4 wks but also same page 100 Q 4 weeks - no start or stop dates so not clear what he is supposed to get. No informed consent.	Says he stopped taking the Depakote because the pills were choking him. Sometimes sees Dr. Lu by the nurse (when going to get meds.) Booking officer did ask questions whey he arrived and he saw the nurse and got meds right away. Attends a counseling group on Wednesdays but some days they couldn't make it there. MSE- pleasant, cooperative, denies auditory hallucinations now but says he had them when younger; cheerful; concrete but answers questions appropriately; edentulous with bad breath.	Treating psychiatrist unclear; appear to be working at cross purposes or at least not on same page regarding medication management.
#3	Arrested 10/31/10; referred to MH 11/19/10 and seen same day for assessment 11/19/10. There is a treatment plan but goals and objectives are not measurable, nor do PN ever reflect back to plan. Has been in some groups. Most recent notes: 1/23/14 Lu notes that he still denies charges. 2/20/14 Lu note that there are no active symptoms, understands charge but denies it. 3/14/14 Napier notes chronic schizophrenia, odd delusions and on-going symptoms "will likely have low grade symptoms." No medication changes made or suggested. Medication orders are written at intervals of 1 to 4 months though none of the orders have end dates. Per MAR meds are Fluphenazine 2.5 BID and Cogentin 0.5 BID.	Not interviewed.	Mixed forensic and treatment roles. Low dose traditional antipsychotic - no rationale provided as to why in the face of on-going symptoms dose is not increased or other agent tried.
#4	Arrested 3/8/14; refer to MH 3/8 & initial assessment 3/8; treatment plan 3/13 indicates Panic disorder and alcohol dependence. 3/10 - seen by Napier who plans to monitor for risk suicide but no meds. 3/19 - started Remeron to decrease anxiety, improve sleep and appetite. "If not helpful, will use Celexa and Ativan." 4/9- Anxiety better but poor sleep. Increase Remeron to 30. 5/15 - Napier note "will discuss his case with his lawyer tomorrow (he consents)."	This is first jail stay, he is an illegal from Dominican Republic. Reports there is nothing wrong with his brain but he takes some medicine for anxiety and problems sleeping. He is facing very serious charges of having killed a child when he was drunk. Couple of times Dr. Napier asked him about suicide and he does sometimes have fleeting thoughts about it or thinking that he'd be better off dead. Has no plan for suicide. Has some family support (sister and aunt in NY came to visit and sister coming back in July) and a girlfriend in the community is supportive. MSE - appears depressed, speech is spontaneous, thinking organized and logical, no psychotic symptoms.	No actual suicide risk assessment. Mixing of treatment vs. forensic functions - should not be doing both. No adjustment to medication regimen in spite of noting patient is loose, irrational and delusional.
#5	Release 12/18/13 but back in less than a month. No discharge note from MH but there is some kind of form from medical in the file. Returned 1/7/14. Seen by Dr. Lu 1/13/14 - chronic schizophrenia. Med orders written 1/16/14 for Haldol D 50 Q 4 weeks, Fluphenazine 5 QD, Cogentin 0.5 QD. There have been no renewals or re-write. 5/20/14 - Seen by Dr. Lu - calm cooperative, taking meds and understands nature of charges.	Not interviewed.	Delay in receiving medication orders. Mixed role treatment v forensic…Not clear which capacity Dr. Lu is serving or when. Should not be doing both.

#6	4/12/13 - Depakote discontinued. 4/15/13 - order that all meds be discontinued (Haldol, Cogentin and Ziprasidone). 4/29 note from Dr. Lu that emotionally unstable and condition worsened. Warren note 4/29 that he was placed on suicide watch and protocol. No observation sheets in chart. 5/2 - Warren note that he still appears mad at Dr. Lu, no mention of watch status. 5/6 -Warren note that she will have patient see Dr. Lu regarding watch. 5/8/14 - See by Lu and watch discontinued. Next note 5/20 from Warren. Apparently released from jail sometime but back 12/13/13.	Not interviewed. (Not in jail at time of site visit. File reviewed because patient reported as having been on watch status.)	Watches are poorly documented in the MH file; PN do not contain time, no documentation of assessment of risk, no observation logs, no clarity regarding placement, continuation, discontinuation of watch status or follow-up.
#7	Was on suicide watch 2/1/13-2/3/13 though there is no note to document discontinuation of watch. 2/1/13 - placed on suicide watch by RN Freeman; 2/1/13 - note by Lu that says he interviewed the patient 1/31 (but no note for that date). 2/2/13 note from Lu that inmate scratched wrist with a piece of Formica and he was placed on watch. 2/4/13 note from Lu that "patient assured that he is not suicidal - does not know charges." Note doesn't say anything about watch status. The medical file could not be located to find out whether or not there were orders to begin or discontinue watch. No observation logs were in the chart nor a copy of the memo regarding watch.	Not interviewed. (Not in jail at time of site visit. File reviewed because patient reported as having been on watch status.)	Watches are poorly documented in the MH file; PN do not contain time, no documentation of assessment of risk, no observation logs, no clarity regarding placement, continuation, discontinuation of watch status or follow-up.
#8	MH file was not reviewed. MAR Depakote 250 BID, Olanzapine 10 HS. "Give Haldol IM and Ativan IM if pt refuses Olanzapine. If pt refuses Olanzapine for 3 days consecutive, give Haldol D 100 mg IM." There is another notation that Olanzapine is 20 HS.	He was in jail last year and released in December, came back in April and not sure how long he'll be in jail this time. He takes meds but doesn't know what they are called. His evening med was doubled but it is not having an effect and he is up all night. He did see Ms. Warren and a "white guy" (Napier?) since he's been back. When he was booked, the CO didn't ask him any questions about his MH or medical history. It took about two weeks to see a nurse and then he saw Dr. Lu; after that, he started to get his meds. He has never had any blood drawn to check his blood levels. He got an injection because he refused pills. He reports his diagnoses is PTSD which he developed as a result of combat in the Iraq war. He has nightmares and flashbacks.	Valproic acid level likely subtherapeutic given the small dose prescribed. If diagnosis is PTSD, haloperidol and olanzapine are not appropriate medication choices.
#9	MH file was not reviewed. MAR indicates medications are Haldol 5 BID, Trifluoperazine 5 BID and Cogentin 1 BID.	Says he came back from CA "a long time ago." Speech is hard to understand, responses to questions are disjointed and illogical. Repeats every question posed to him (to give him time to think of response?) but then he does answer. He's poorly organized and poorly oriented through he knows month and year and that he's at "St Thomas Detention Center."	Remains symptomatic with thought disorganization but no medication has been adjusted nor has a different or newer antipsychotic been tried. (He is likely a candidate for clozapine.)
#10	MH file was not reviewed. MAR indicates meds are LiCO3 450 BID, Depakote 500 QD, Haldol 10 IM prn agitation, Ativan 2 mg IM prn agitation - no start, stop or frequency	This is his 14th jail stay; has been here about 2 weeks. Has many recommendations: Dr. Lu has 4 jobs so he is not around much; Dr. Napier isn't going to work out because he doesn't know the local culture; they need more psychiatrist, psychologist and nursing to monitor constantly and prevent suicide; records should be digitalized/computerized; more activities on unit; allow inmates to create a broadcasting program inside the jail; there should be zero tolerance for fighting, etc., etc., etc. Has never had his blood drawn to check serum levels. MSE - pressured speech, difficult to control or re-direct; circumstantial and repetitive.	Improper and frankly dangerous PRN orders. Continues manic; quite likely due to subtherapeutic doses and serum levels of mood stabilizing medications.
#11	There is a court order stating he is to be released forthwith on 5/9/14. There is a family court order for psychiatric hospitalization and treatment but Dr. Lu says he doesn't need hospitalization. He is wanting to go to The Village on St Croix for 3 months. Seen by Dr. Napier 3/20 and 3/26. He ordered blood levels 3/20 of Depakote and Lithium - both low but no action taken. (Prior lab July 2013 - also low.) Seen by Dr. Lu 5/9 and 5/20. MAR indicates meds are Depakote 500 BID, Lithium 300 BID and Fluphenazine 25 mg/ml q 4 weeks (does not indicate that this is decanoate nor that this is the actual dose to be administered as opposed to the concentration of the medication.)	Not interviewed.	Not clear which doctor is treating [redacted]. Both have seen him but neither have addressed his subtherapeutic dosing of Depakote and Lithium.

#12	MH file was not reviewed. MAR indicates Haldol 5 HS and Benadryl 25 HS.	Never took meds before coming to jail; no history of psychiatric hospitalization. Has been in jail about a year. Works as laundry worker 4 days per week (M, T, Th, F). Saw Dr. Lu on Wednesday but it had been a "long time" since last seen. Hasn't met Dr. Napier. Sees Ms. Warren about every other week. Medications help her sleep. She gets Benadryl and Haldol. MSE - neatly dressed and groomed, little spontaneity but answers questions appropriately, organized and logical. No complaints about medications or side effects.	Medications are order for HS administration but there is no HS pill call.
#13	MH file was not reviewed. MAR book does not indicate that patient is prescribed any medication.	Reports history of forced MH care for calling herself Jesus/an angel. Says she has telepathic powers and a third eye. Charges were "supposed" to be dismissed. She has no current job assignment; she escaped (ran away) when she had a laundry job. She hasn't see Dr. Lu for months, met Dr. Napier once and has seen Ms. Warren a couple of times. Wanted medical marijuana and Dr. Lu told her than Prozac was the same time but then ordered Zoloft for her without explaining risks or side effects. She took it for a week but then stopped. Has no plan for her future when released: "God has the plan. Man shouldn't make them." MSE - Some inappropriate giggling, religious delusions, grandiose. Denies MI now or ever though she understands that others think she is "crazy."	Clearly SMI but functional - at least in the jail; on outside, continues to get into trouble. It would be difficult to argue for forced meds in jail setting and it's also not clear whether her delusions would respond or at least reduce the likelihood that she would act on them.