JEFFREY L. METZNER, M.D., P.C.
3300 EAST FIRST AVENUE
SUITE 590
DENVER, COLORADO 80206

TELEPHONE (303) 355-6842
FACSIMILE (303) 322-2155

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Donna Brorby, Esq.
660 Market Street, Suite 300
San Francisco, CA 94104

RE: Texas Department of Criminal Justice

Dear Ms. Brorby:

I have completed my initial assessment regarding issues related to the mental health care services provided to inmates at the Texas Department of Criminal Justice (TDCJ). I site visited the Estelle Unit in Huntsville, Texas during December 18-20, 1998. During December 18, 1998 I met with the following staff:

1. Tim Simmons (Assistant Warden),
2. Kent Dickerson (Manager of Health Services),
3. Dean Buzbee, M.S. (Responsible Psychologist),
4. Bobby Vincent, M.D. (Facility Medical Director),
5. Bryan Buck (Captain),
6. Mary Adams, RN (Facility DON),
7. Lisa Lopez, RRA (Registered Records Administrator),
8. Marciano Limsiaco, M.D.,
9. Robert Komer, D.O.,and
10. Ray Neuse, M.Ed.

Warden F.E. Figueroa was unavailable for the opening meeting due to another commitment.

Sources of information utilized in this assessment included review of the following documents:

1. Texas Department of Criminal Justice Mental Health Services Policy Manual,
2. a document entitled "University of Texas Medical Branch Managed Healthcare Psychiatric Inpatient Program" (Jester IV Unit),
3. audits by various psychiatrists (Drs. Wang, Jurczak, Conklin, Stellman, and Elliott) concerning mental health services offered at the following TDCJ institutions:
    a) Clements,
    b) Diagnostic (Byrd),
    c) Estelle,
    d) Gatesville,
    e) Goree,
    f) Huntsville,
    g) Jester IV,
    h) Montford,
    i) Neal,
    j) Ramsey I,
    k) Skyview,
    l) Stiles, and
    m) Woodman,
4. a January 1998 audit report entitled "Managed Health Care at the Texas Department of Criminal Justice" authored by the Office of the State Auditor,
5. the Texas Department of Criminal Justice Formulary (5th Edition, 1998-1999),
6. Manual of Policies and Procedures for Health Services (TDCJ Institutional Division),
7. documents relevant to heat-related illnesses,
8. critical drug list for the Estelle Unit (December 18, 1998), and
9. 30 healthcare charts of inmates at the Estelle Unit.

Overview – Estelle Unit Complex

The Estelle Unit complex generally has an inmate count of about 2800 inmates. The various facilities within the Estelle Unit usually have the following counts:

1. Main building: 2268 (which includes a 66-bed segregation unit)
2. High Security: 640
3. Geriatrics Center: 60
4. Substance Abuse Felon Punishment Facility: 188
5. East Regional Medical Facility: 120

The High Security Unit, which is a segregation unit, has inmates with Level I, Level II, and Level III privileges. Level I inmates have seven hours of recreational time per week, Level II inmates have four hours per week, and Level III inmates have three hours per week. The security classification levels for inmates in the main building range from minimum to close security. This facility consists predominantly of celled housing except for dormitory living in the geriatrics center. All the cells are double-bunked except for the High Security Unit and the segregation unit within the main building, which are single-celled.

Information regarding the mental health services at the Estelle Unit was obtained from Mr. Buzbee. The mental health services have been provided as part of the University of Texas Medical Branch system for about 1½-2 years. A psychiatrist is the Director of Mental Health systemwide and has two assistant directors (a nurse for the southern region, and a masters level LPC for the northern region). The responsible psychologist at each facility reports to one of the assistant directors.

The funded mental health staff positions were as follows:

- 2.0 FTE Social Workers,
- 1.0 FTE Psychiatric Nurse,
- 3.0 FTE Psychologists (Masters level), and
- 2 Contract Psychiatrists (providing psychiatric coverage three days per week for a total of 35 hours per week).

There were currently no vacancies within the mental health staff. Mr. Buzbee reported that staff vacancies are generally filled within about one month.

There were 222 inmates on the active mental health caseload with housing locations as follows:

1. High Security Unit (46)
2. SAFPF (55)
3. Main Building (103)
4. RMF (14)
5. Geriatrics (4)

The mental health caseload represented about eight percent of the inmate population at the Estelle Unit. In addition, there generally are about 150-200 inmates who are on the inactive mental health caseload, which means that they have had a history of mental health treatment within the Texas Department of Criminal Justice but are no longer receiving mental health treatment. The mental health roster in the main building has been

as high as 200 in the past. Several months ago the caseload in the main building significantly decreased related to a transfer of many close inmates to another facility in exchange for inmates with a minimum security classification due to the need for more workers at the Estelle Unit.

Twenty-two inmates were receiving individual therapy, fifteen inmates were receiving group therapy, and the rest of the caseload inmates were receiving case management services. The three group therapies include one rational behavior therapy group and two HIV therapy groups. There was not a significant waiting period for group therapies. Inmates receiving case management services were reported by Mr. Buzbee to generally be seen on a monthly basis. Very few of the active caseload inmates were not receiving psychotropic medications.

Co-payments are not charged to inmates receiving mental health services although the department is able to make such charges related to relevant legislation.

All inmates newly admitted to the Estelle Unit receive a "chain triage" which involves review of their healthcare records by either the nurse, psychologist, or social worker. These chart reviews are assigned according to housing units. Mr. Buzbee reported that interviews triggered by the chain triage are generally performed within 24 hours except during weekends.

Main Building

I briefly walked through three of the tiers in the A Unit (segregation unit) within the main building. I talked to three inmates in punitive segregation status and four other inmates on segregation status. One of these inmates was a caseload inmate and had just recently been admitted to a pre-hearing detention cell. Several of these inmates were doing disciplinary time following an infraction related to masturbation. . In general, treatment is not readily available for inmates with sexual disorders until they are within one or two years of completing their sentence.

Caseload inmates are seen by a mental health clinician on a weekly basis during the rounds process. A "boilerplate" progress note is written to document such rounds. These inmates confirmed that daily rounds were being made by the nursing staff.

I toured several housing units in the main building. Each wing contained three tiers of 21 cells that were all double-celled. The housing units were very clean. The showers were dark and did not appear to be very clean.

Close security inmates receive two hours per day of recreation time in a group yard.

During December 20, 1998 I met with two groups of inmates who were receiving mental health services in the main building at the Estelle Unit (see Appendix I). These inmates reported that it generally took an hour to go through pill call line in order to get their medications. They indicated that correctional officers frequently harassed them during the pill call line. Medications were intermittently not timely renewed which resulted in lapses of medications for up to a week at a time.

The inmates reported that they do meet with their counselor on a monthly basis but they do not receive counseling. These meeting were described as being very brief and characterized by answering the following question: "On a scale of 1 to 5, how do you rate yourself?"

Most of these inmates reported that their meetings with the psychiatrist was every three months. They stated that they did not receive education regarding either their medications or diagnosis.

Information was obtained regarding their experiences at Jester IV and the Skyview Unit. They reported that several doctors, especially Dr. Tchokoev, treated them disrespectfully. They frequently were perceived as not telling the truth by him.

It was reported by these inmates that indoor temperatures during the summer get very hot. However, they indicated that there were not specific provisions made for cooling for inmates on psychotropic medications except for exempting them from outdoor work. Two of the inmates reported that they had heat related problems during this past summer. The charts of these inmates were reviewed (see Appendix II).

A second group of four inmates, who reportedly were receiving mental health services (see Appendix I), were interviewed. Two of these inmates were now apparently on the inactive caseload. The inmates indicated that they periodically had problems obtaining the medications due to pill call line issues. They reported that they had very brief monthly contacts with their case managers. One of the inmates described his case manager as speaking to him in a negativistic fashion. Both of the caseload inmates reported monthly meetings with the psychiatrist. One inmate also reported heat related problems during the summer months which consisted of feeling dizzy and weak. However, this inmate did not obtain specific treatment for these symptoms. The charts of these inmates were briefly reviewed which was generally consistent with information obtained from them.

Five inmates (see Appendix I), who were all receiving mental health treatment and were in the SAFP, were interviewed in a group setting. These inmates all reported satisfaction with the substance abuse program which was a therapeutic community model. They saw their psychiatrist on a monthly basis and generally had monthly case management

meetings which were of brief duration. They did not have difficulties obtaining the medications through the pill call line.

The medical charts of these inmates were reviewed which were consistent with the information provided by these inmates. These inmates reported that water is available as needed during particularly hot days. They indicated that they had not experienced heat related problems.

I met with Marciano Limsiaco, M.D. Dr. Limsiaco had been providing psychiatric services to the Estelle Unit since 1989. Dr. Komer, who has been working at the Estelle Unit since 1994, is responsible for the psychiatric coverage for the High Security Unit. Dr. Limsiaco indicated that Zoloft is the only SSRI on the formulary and that Zyprexa, Risperdal, and Clozaril are all non-formulary medications. However, he stated that it was not a difficult procedure to prescribe non-formulary medications and that he was prescribing such medications to patients.

Dr. Limsiaco generally sees caseload inmates every two to three months once they are stable. Inmates needing to be seen on a more frequent basis are generally scheduled every one to two weeks.

It was anticipated by Dr. Limsiaco that inmates would complain about long pill call lines although they did not have problems obtaining their medications. Most of Dr. Limsiaco's caseload were being prescribed medications for treatment of either depression or anxiety. He estimated that about 20-25 percent of the caseload have a chronic schizophrenic illness. Inmates in need of a more intense level of mental health care are transferred to the intermediate care units at Skyview or Jester IV. Dr. Limsiaco reported that it was not difficult to transfer inmates to these units when clinically appropriate.

I reviewed the December 18, 1998 critical drug list which listed every medication being prescribed to inmates in this prison complex. I was unable to identify any inmates who had been prescribed either an atypical antipsychotic medication or a SSRI other than Zoloft.

<u>High Security Unit</u>

I interviewed Ray Neuse, M.Ed., who has been working in the prison system for the past fifteen years and at the Estelle Unit for six months. His primary responsibility is to monitor inmates on psychotropic medications and to perform mental health assessments. There are two clinicians assigned to the High Security Unit plus a psychiatrist. The

psychiatrist had been providing two days of eight hours per day psychiatric coverage but beginning the week of December 18, 1998 was providing one ten-hour day of psychiatric coverage per week.

The psychiatrist had been seeing inmates in the triage office on the wing but for the past 2½ months has been seeing inmates in an office setting off of the wings.

Mr. Neuse stated that there were not difficulties transferring inmates to an intermediate care unit. However, inmates with self-mutilation problems generally were returned to the High Security Unit within three days following transfer.

Mental health caseload inmates were seen by the mental health clinician on a weekly basis at the cell front. The rounds process is documented by a typed "form" progress note, which is used unless the inmate has specific complaints. They are not seen in an office setting by the psychologist or social worker unless they submit a specific request for such a meeting. In other words, there were no routine office visits with the clinicians except by request from the inmate.

During the past week, chain triages were administered to fifteen newly admitted inmates to the High Security Unit. Mr. Neuse reported that there were about ten to twenty sick call request forms for mental health that needed to be triaged per week.

During December 18, 1998, I interviewed Robert Komer, M.D. Dr. Komer is now providing one day per week of 10 hours of coverage to the High Security Unit. He reported that he generally has 25-35 minutes allotted for a new patient evaluation and generally 15-20 minutes for follow-up assessments. He usually has follow-up appointments with his caseload inmates every 14-30 days. He estimated about one-third of the caseload were receiving antidepressant medications, one-third antipsychotic medications, and one-third mood-stabilizing medications. Dr. Komer expressed some hesitancy in prescribing atypical antipsychotic medications due to their newness. He has not had difficulties obtaining laboratory results.

Dr. Komer reported that there were not significant obstacles in transferring inmates to an immediate care unit when clinically indicated.

I observed Marianne Anderson, R.N. perform segregation rounds in K unit. This was a Level I housing unit for gang members. Ms. Anderson was very comfortable with the rounds process. She reported that the mental health staff are very responsive to referrals by the medical department. Ms. Anderson indicated it was uncommon to find psychotic inmates in the High Security Unit. She reviewed with me a nursing protocol that is used when mental health coverage is provided by the psychiatrist on-call. This protocol involved obtaining a basic database prior to calling the psychiatrist.

I walked cell to cell in C Section where I briefly talked with most of the inmates on this unit and reviewed fourteen of their medical charts (see Appendix III). I also walked on the D-wing range and attempted to interview six inmates (see Appendix III).

C-wing and D-wing each had two tiers with seventeen cells on either side (total 64 cells). The noise level on both of these wings was high throughout the site visit which was described by correctional officers as being a very common. A number of problem inmates in C section were described as self-mutilators who were not on the mental health caseload. It is likely that many of these inmates (see Appendix III) had personality disorders associated with borderline and/or antisocial features which made them very difficult to treat.

I briefly talked with Captain Franky Reescano who is the captain at the High Security Unit. He estimated that about four to five inmates per week cut themselves and about 10-15 inmates require use of chemical agents for cell extractions or other similar reasons. Most of the use of chemical agents and inmates who cut themselves were in wings C, D and H.

Captain Reescano reported that many of the inmates who cut themselves return from Skyview, apparently have their medications discontinued, and then cut on themselves several days later. He reported that mental health staff will evaluate these inmates but will not provide input or consultation regarding management other than reporting that these inmates were a security problem and not a mental health problem.

Approximately 60-70% of the second shift correctional officers and about 40% of the first shift correctional officers were new (and very young) officers. It was reported that none of these correctional officers have received specific training regarding mental health although many of the older officers did have experience working with psychiatric patients at the old Estelle Unit when it was a psychiatric facility.

Review of Other Estelle Unit Audits

The July 29, 1998 mental health audit report concerning the Estelle Correctional Facility by Dennis Jurczak, M.D. was reviewed. Dr. Jurczak reported finding "serious deficiencies in psychiatric care during this audit… [he] was also struck by the number of inmates who apparently had Axis I diagnoses in the past but who were now on the inactive list with no present Axis I diagnosis… ." Dr. Jurczak concluded that "the High Security Unity is not an appropriate setting for the housing and/or care of mentally ill prisoners… the number of mentally ill inmates on the High Security Unit are not now being afforded adequate psychiatric treatment… several obviously psychotic and

extremely disruptive inmates are receiving no psychiatric care… ." Dr. Jurczak expressed significant concerns regarding the lack of usage of newer antipsychotic medications within the Estelle Correctional Facility.

Thomas Conklin, M.D. also evaluated aspects of the mental health care within the Estelle Unit during July 1998. His August 1998 report focused on review of suicide attempts and gestures among inmates in the Estelle Unit. He concluded that "review of the thirteen charts of suicide attempts and 'self-mutilation' inmates previously mentioned revealed some disturbing practices. These are as follows:

1. All suicide gestures by inmates are seen as manipulating the correctional system with the conscious intent of secondary gain. In not one case was the inmate's behavior seen as reflecting mental pathology that could be treated.
2. Diagnoses in these cases were always one of the following:
   'no Axis I diagnosis'
   'no diagnosis'
   'ASPD' (antisocial personality disorder)
   'ASPD' with borderline features' "

Dr. Conklin reported that "the mental health staff is of the opinion that all of these conditions are untreatable and so no treatment is given… ."

Dr. Conklin concluded that "the staff is too meager and too ill-trained for the job they have to do. There is no program available for seriously or chronically psychologically impaired individuals. Either a hospital system or at the minimum group and supportive therapy should be available. None of them are seen as requiring mental health services and that simply is not so… ."

ASSESSMENT: Significant problems were found in the mental health care delivery system at the Estelle Unit complex. In general, the mental health treatment available to inmates in this complex consisted of the use of psychotropic medications and case management. Case management in this context is best described as periodic monitoring in contrast to actual treatment. However, even this monitoring has significant flaws which included brief meetings with inmates and cell front assessments in the segregation units. Psychopharmacological treatment was problematic due to a formulary which did not include atypical antipsychotic medications and only one SSRI medication. There were also significant problems pertinent to the diagnostic assessment process.

Many inmates with significant behavioral problems and functional impairments, who have been diagnosed in the past as having a serious mental illness associated with psychotic features, are frequently diagnosed as either malingering or having no Axis I diagnosis. Consequently, they were not receiving mental health follow-up and/or psychotropic medications. Axis II diagnoses were either not mentioned or, when diagnosed, did not have

a treatment plan formulated relevant to the particular Axis II diagnosis despite significant associated functional impairments.

Ironically, many inmates who are diagnosed with serious mental illnesses associated with psychotic features receive little more treatment than those diagnosed without a disorder except for the use of psychotropic medications. However, these inmates were often uninformed regarding the use of their particular medications and/or have not received therapeutic trials of newer medications available such as Risperdal or Olanzapine.

The lack of a specific treatment program for inmates with serious mental illnesses is particularly problematic at the Estelle Unit complex. There was a significant number of inmates with serious mental illnesses who were housed within the High Security Unit. Such inmates were generally housed in wings C, D, and H. It was in this unit that case management services were particularly ineffective related largely to the cell front interview process in contrast to meeting with a clinician in a reasonably private office setting. Unfortunately, inmates with serious mental illnesses often did not even receive cell front monitoring due to past assessments that they did not have an Axis I disorder and/or were malingering. These diagnoses were often formulated at the Skyview Crisis Management Unit (see Appendix IV). Reference should be made to Dr. Stellman's report (see "Review of Other Mental Health Audit Reports" section) which summarizes the deficiencies in the assessment process at the Skyview Crisis Management Unit.

There clearly have been problems concerning a "heat plan" relevant to inmates being prescribed psychotropic medications. Reference should be made to Appendix II which provides an example of the potential dangers associated with lack of an adequate plan. Review of pertinent discovery documents indicated that remedial measures have been instituted relevant to this issue although I was unable to find a comprehensive policy and procedure concerning this issue relative to inmates receiving psychotropic medications.

The placement of inmates with serious mental illnesses in the High Security Unit, without adequate mental health resources being available to such inmates, has resulted in many of these inmates having their psychiatric symptoms intensified which has contributed to a harmful environment within several of the High Security Unit wings.

Review of Death Records

The medical charts of eight inmates who died during the past two years within the TDCJ were reviewed (see Appendix V). This review revealed significant system problems related to poor documentation, diagnostic assessments, and frequent determinations that an inmate did not require treatment due to "no diagnosis on Axis I." These records also revealed some of the significant obstacles faced by many inmates who were attempting to obtain mental health treatment.

Review of Other Mental Health Audit Reports

Jester IV Unit

The December 6, 1998 report by Roberta Stellman, M.D. was reviewed. Dr. Stellman described a staffing shortage that included both psychiatrists (one physician per 50 acute care patients) and other professional staff. The consequences of these staffing shortages included inadequate psychiatric assessments on the crisis management unit and noncompliance with the ten hours per week treatment recommendations by TDCJ and UTMB.

The complete lack of privacy for the inmates housed within the Jester IV unit was striking. Dr. Stellman indicated that there was "no attempt at establishing a private, confidential, and therapeutic atmosphere most conducive to self-disclosure."

The lack of adequate assessments within the crisis management pod resulted in a high rate of inmates receiving no Axis I diagnosis. "In this system, the primary treatment in this entry pod is isolation, superficial evaluation, and discharge back to the same environment that precipitated the admission in the first place. Almost all contacts with the patients are made cell side, with an interviewer standing in the corridor, outside the cell… ."

The over-reliance on imprecise diagnostic categories of not otherwise specified (NOS) and the absence of a diagnosis in those individuals admitted to crisis management was of significant concern. "Even patients who formerly were hospitalized and diagnosed with schizophrenia are treated in this facility under a non-specific category of "psychosis NOS. The documentation does not contain the physician's rationale for change in diagnosis or deletion of a former illness. There is an underutilization of Axis I diagnoses in those people admitted to the crisis management pod… The unavailability of crisis intervention therapy is evident in this facility as it elsewhere in this system. The most likely explanation is that treatment on crisis management can not be accomplished with as great a number of patients compared to so few staff… there is simply too little time to gather significant past personal and family history to accurately develop a good differential diagnosis… ."

Gatesville Unit

Dr. Stellman's December 10, 1998 report indicated that the "overall care at Gatesville is quite poor… psychological and psychiatric notes do not provide adequate present, past, and family history. Documentation of risk factors for dangerousness is obviously lacking… the gatekeepers of psychiatric care do not have the training and competencies

necessary to carry out this role with the absolute authority they are given. Inmates have no recourse or access to medical care if the gatekeeper denies it… the complete lack of privacy during psychological encounters in the high stress segregation units is unjustified… treatable conditions are not diagnosed and treatment, therefore, is not initiated… surprisingly, many inmates are not given an Axis I diagnosis. Yet the more difficult diagnosis of a personality disorder is readily made, usually antisocial personality disorder without [adequate] documentation… self-injury is too often labeled 'attention-seeking' and again the dynamics of the behavior are disregarded… being assigned or scheduled for 'counseling' may only mean one visit by the psychologist… women returning from Mountainview, Jester IV, or Skyview may not be seen routinely upon their return for an assessment of their adjustment… even when an inmate repeatedly requests a doctor's visit, staff not necessarily trained to recognize, diagnose, and treat severe psychopathology block these requests… even women on the caseload may not be seen in a timely fashion when medications are changed, their assignment is altered, or if they return from a psychiatric unit… ."

Skyview Unit

The December 13, 1998 report by Dr. Stellman summarized significant problems in the mental health care provided to inmates at this unit. Inmates on the crisis management unit received little therapeutic contact except for brief encounters and no crisis intervention treatment other than environmental isolation. "All too often previous diagnoses are removed." Dr. Stellman noted "an absence of Axis I diagnosis particularly in crisis patients… even when an individual has a major Axis I diagnosis, the label malingering is added inappropriately. Attempts by inmates to manipulate intolerable situations by self-injury and transfer are treated with a rapid return to the UOA [with] no development of treatment plan to develop better coping skills." Insufficient staffing to meet UTMB program requirements was present.

A November 2, 1998 report by Richard Elliott, M.D., Ph.D. was reviewed. Dr. Elliott indicated that approximately one-third of inmates referred to Skyview are retained for more intensive treatment and two-thirds are returned to the referring units. "Inmates are returned after an evaluation period of approximately three days which they usually do not receive medication or further treatment services." A preliminary study of clinical recidivism was done during August 1998. "Of 47 discharges during that month, 14 returned in the next one to two months. This leads to an estimate of a clinical recidivism rate of approximately thirty percent in two months."

Dr. Elliott concluded that "based on the information available at this time, I believe there are several significant deficiencies in the care of inmates on the acute unit at Skyview. First, there is a lack of physician input into assessments and medication management… ."

Dr. Elliott concluded that there was an inadequate psychiatrist to patient ratio at Skyview which, when the vacant psychiatric position was filled, would result in five psychiatrists for over 400 inmates. This was described as being "an unacceptable ratio given the high number of admissions to Skyview."

Stiles Unit

Dr. Stellman indicated in her December 1, 1998 report that "observed practices and frequency of visits, monitoring of drug levels and assessment of mentally ill inmates off the caseload is at variance with reported practices by the staff."

The diagnostic categories of not otherwise specified was reported to be used too frequently and there was an absence of the development of a differential diagnosis. "Diagnoses made at an early date are not picked up and carried through… when a diagnosis is dropped, the record does not reflect the rationale for deleting this from consideration. There is an absence of the assignment of an Axis II diagnosis… the individual treatment plan is frequently absent, when it is filled out, major problems are omitted, goals are too global, and there is no update [in the] chart if the goals are met or modified… ."

Management and assessment of inmates in isolation units were not adequate. "Several inmates were obviously psychotic or seriously impaired but were not under any professional scrutiny." Lack of timely follow-up of inmates transferred back to the Stiles Unit from an acute unit was reported.

Problems were also present concerning the use of seclusion. "Those most distressed individuals are allowed to be housed for up to three days without being seen by a trained mental health professional. There is little documented evidence of adequate crisis intervention treatment and an over reliance on isolation and transfer to a crisis management unit." There was also not enough clinical staff to provide adequate treatment to the inmates on the mental health caseload.

Woodman Unit

Dr. Stellman's December 5, 1998 report described inadequate numbers of clinical staff available (2.0 FTE Master level psychologists) to provide mental health services to this 900-bed women's unit. "Formulary and non-formulary medications are discontinued frequently upon entry into Woodman. All non-formulary medications are stopped by non-psychiatric staff without substitution or regard for consequences of the discontinuation, including withdrawal seizures and at least one case of transfer to Mountainview. Patients are not consulted about the discontinuation nor are they given information regarding possible risks concerning this practice. The medical staff do not

automatically refer any patient entering on psychotropics to the psychiatrist. Even when psychotropics are continued, there most often is a three-day delay in initiating medication."

Dr. Stellman assessed the "psychiatric practice at this facility [to be] abysmal. Patients are routinely not seen by psychiatry and there is poor responsiveness to requests for consultation by psychology or medical." Lack of timely assessments by the psychiatrists was described by Dr. Stellman.

Ramsey I Unit

Dr. Jurczak indicated in his December 11, 1998 report that "the ambulatory psychiatric care provided at Ramsey I is adequate."

James Byrd Unit

Dr. Jurczak's October 19, 1998 report indicated that "the medical and psychiatric screening, intake evaluation, care and treatment provided at the James Byrd Unit is timely and medically appropriate, the facilities are adequate for the provision of care and the staff appear professional in attitude and appearance… ."

Thomas Goree Unit

Dr. Jurczak concluded in his October 19, 1998 report that "the medical and psychiatric care provided inmates at the Thomas Goree Unit is timely and medically appropriate. The facilities are adequate and the staff appeared professional in appearance and attitude… ."

Huntsville Unit

Dr. Jurczak's October 19, 1998 report indicated that "the ambulatory psychiatric clinic facilities at the Huntsville Unit are adequate, the staff are professional in demeanor and appearance, and that a good working arrangement exists between the medical and psychiatric staffs… ." Problems in the psychiatric care described by Dr. Jurczak included documentation of baseline laboratory studies and minimizing patients' signs and symptoms which have led to "the placing of patients on the inactive list resulting in the discontinuance of treatment and monitoring."

John P. Montford Psychiatric/Medical Facility

The December 14, 1998 report by Richard Elliott, M.D., Ph.D. was reviewed. It was Dr. Elliott's opinion that "overall, psychiatric care at the Montford Unit is consistent with

community psychiatric inpatient care. The primary area of concern would be the lack of physical assessment prior to initiating treatment with psychotropic medication. A secondary area of concern is a shortage of psychiatrists… ."

Neal Unit and Clements Unit

The November 24, 1998 mental health audit report by Stanley Wang, M.D. was reviewed. Dr. Wang described significant shortages of mental health clinical staff at the Neal Unit (essentially one FTE ACP II for 350 caseload inmates). In addition, there was a full-time nurse practitioner and a part-time psychiatrist who provide medication management services to inmates at the Neal Unit. Dr. Wang concluded that "the psychiatric staffing is woefully inadequate… ."

Problems related to the pill call line and tracking medication non-compliance were summarized by Dr. Wang. These problems included long lines, arbitrary decisions by either the CMA or other pharmacy personnel "to simply cut the line off and shut the pharmacy pill dispensing," and intimidation by gang members.

Managed Healthcare at the Texas Department of Criminal Justice

A January 1998 audit report entitled "Managed Health Care at the Texas Department of Criminal Justice," which was authored by the Office of the State Auditor, was reviewed.

Significant problems in the monitoring of the TDCJ managed healthcare system were described. This report concluded that "although a number of processes exist to evaluate and/or monitor aspects of performance, these processes do not interface or link with each other to provide a comprehensive monitoring and evaluation system. Because the basis of several of the monitoring processes is self-monitoring, review of operations by another party becomes even more necessary."

Specific problems were found with the TDCJ's operational review process. These problems included:

a) No criteria of performance standards exist to determine, quantitatively, when a unit is assessed to be in compliance with the Ruiz final settlement and the department policies and procedures.
b) Compiling the results of individual unit Operational Reviews audits does not provide a systemwide identification and assessment of trends or specific and recurring areas of non-compliance.
c) Although the department's Health Services Division administers the Operation Review process and must approve the unit's corrective action plans, it lacks the authority to enforce the corrective action plans.

d) One-fourth of the units audited during 1996 did not have at least an 80 percent compliance rate.

The audit report also described significant gaps in the current QI/QM system that is maintained by each prison. For example, "some units continue to report each year on indicators that have been at 100 percent compli[ance], instead of focusing on other problem areas that could benefit from scrutiny." The department's health services division does not verify that corrective actions take place in response to various units' QI/QM findings. Medically related information and feedback received from the grievance and liaison correspondence processes were noted to not be effectively managed, communicated, or evaluated.

Other findings included the lack of a standardized system to ensure that monitoring is performed consistently across all units and the need for improvements to be made concerning the credentialing processes for practitioners.

Appendix V of this report, entitled "An Evaluation of Managed Healthcare in the Texas Prison System," which was written by Jacqueline Moore and Associates (Consultants to the Correctional Managed Healthcare Advisory Committee) was reviewed. This report specifically did not review mental health services "because they were recently transferred to the managed care system and sufficient data was not available to evaluate the effect of managed care." The current medication administration process was difficult to audit related to missed medications or not-given medications due to the nature of the pharmacy tracking system. It was also noted that the current operational review process for TDCJ did not audit the pharmacy system

Manual of Policies and Procedures for Health Services for the TDCJ Institutional Division

The TDCJ Manual of Policies and Procedures for Health Services was reviewed. This section will highlight selected policies and procedures pertinent to the mental health care delivery system. They included the following:

TDCJ Policy number A-09.1 (Privacy of Care) indicates that "clinical encounters will be performed in private (i.e., only authorized health services staff will be present), with a security chaperone present when the offender proposes a probable risk of safety to himself, the healthcare provider or others."

TDCJ Policy number C-20.1 (Training for Correctional Officers) does include a requirement for training to include the area of recognizing signs and symptoms of mental illness and suicide prevention. However, this training is for an unspecified amount of time, which is to occur at least every two years for all correctional officers who work with offenders.

TDCJ Policy number C-24.1 (Staffing Levels) indicates that "a written staffing plan shall be established by each facility to assure that a sufficient number of qualified health care personnel of varying types are available to provide adequate evaluation and treatment consistent with contemporary standards of care."

TDCJ Policy number G-51.1 (Special Needs Offenders) defines offenders with special mental health needs to include, but not be limited to, "self-mutilators, sex offenders, the aggressively mentally ill, suicidal offenders, and substance abusers." This policy indicates that TDCJ will provide services for offenders who require close medical supervision and/or multidisciplinary care. Offenders with special mental health needs are included in this group of offenders. This policy also requires the development of a written individual treatment plan for offenders receiving such treatment.

Heat Related Illnesses

I reviewed reports relevant to inmates experiencing heat-related illnesses. There were at least sixteen inmates who experienced significant symptoms related to hyperthermia from June 10 - July 30, 1998. Three of these inmates died as a result of hyperthermia. At least four of these inmates were known to be either receiving psychotropic medications or having a history of mental illness. However, in general, these reports did not make reference to the presence or absence of psychotropic medication use. There was documentation that at least one inmate who died due to hyperthermia had initially became symptomatic during a bus trip. Inmates on the same bus reported that the correctional officers were non-responsive to their complaints of elevated temperature within the bus.

Mr. Archie White died at the age of 48 years during June 30, 1998 due to exogenous hyperthermia. This inmate apparently had been prescribed tricyclic antidepressant medications based on the toxicology report. It is interesting that the autopsy report did not make a connection between the use of antidepressant medications and exogenous hyperthermia.

Mr. Anselmo Lopez was a 41 year old man who died during July 14, 1998 due to probable hyperthermia. A review of the autopsy report did not reference whether antipsychotic medications had been prescribed to this man. However, review of other documents did indicate that this inmate had been prescribed psychotropic medications.

Mr. James Moore was a 47 year old man with a history of paranoid schizophrenia who died during July 30, 1998 due to hyperthermia. Mr. Moore was receiving Haldol and Cogentin which are medications that put him at higher risk of developing hyperthermia during times of elevated environmental temperatures. The autopsy report did not make reference to the probable relationship between elevated temperatures, use of psychotropic medications, and hyperthermia.

A July 28, 1998 memorandum from Gary Johnson (Director, Institutional Division) to Wayne Scott (Executive Director) regarding heat was reviewed. This memorandum provided a synopsis of actions taken by TDCJ during the past several months "in preparation for and response to the Texas summer heat."

Summary and Opinion

Unfortunately, the significant problems found in the mental health care delivery system at the Estelle Unit appear to reflect systemwide deficiencies based on my review of healthcare records and other mental health audit reports. These significant problems included not recognizing or minimizing symptoms indicative of major mental illnesses by either over-diagnosing malingering or "no Axis I diagnosis." There appeared to be a variety of reasons for these problems which included staffing shortages, inadequate assessment procedures (e.g., cell side assessments), staff education issues, and probable clinical biases. It was striking that these problems were commonly described in the various audit reports summarized in this report.

There appeared to be a clear perception, based on review of healthcare records, by the mental health clinicians that mental health treatment was not be offered to inmates whose dysfunctional behaviors were assessed to be due to Axis II problems. Such a practice did not appear to be consistent with TDCJ Policy number G-51.1 (Special Needs Offenders). Many inmates with serious mental illnesses are not receiving adequate treatment as a result of this practice. This was particularly true for inmates who have been labeled as being "self-mutilators, manipulators, or having no Axis I diagnosis." The consequences for such inmates have included increased suffering and death (see Appendix IV – Review of Death Records).

Inmates with serious mental illnesses often have their symptoms intensified due to not only receiving inadequate treatment but by being placed in an environment that makes their mental illnesses worse, such as the High Security Unit. The housing of inmates with serious mental illnesses who continue to be symptomatic with non-mentally ill inmates creates an environment that is detrimental to both staff and inmates.

The death review process was problematic related to documentation concerning identified problems and proposed corrective actions. The review of death records (see Appendix IV) almost uniformly revealed systemwide problems related to documentation, diagnostic assessments, and inadequate treatment services. Problems related to accessing mental health treatment were clearly experienced by Inmate 805040 who encountered

major obstacles by various clinicians relative to obtaining treatment. The death of Inmate 692804 appears to have been related to a grossly negligent diagnostic process.

The number of inmates experiencing hyperthermia during the past year was very alarming. Review of discovery materials contain documentation of similar problems occurring during 1997. It is encouraging that remedial actions were developed during July 1998 although it is unclear why it took so long for such a plan to be developed. It is also unclear from review of the discovery materials the specific nature of a "heat plan" for inmates receiving psychotropic medication. It was alarming that the various autopsy reports and incident reports relevant to inmates experiencing hyperthermia did not often reference or assess the relationship between the hyperthermia and use of psychotropic medications.

Systemwide problems related to the use of psychotropic medications are present based on review of the various mental health audit reports. These problems included many inmates not having reasonable access to the use of atypical antipsychotic medications and SSRI medications (other than Zoloft), medication distribution problems, abrupt discontinuation of psychotropic medications without adequate or timely psychiatric assessments, and an unclear system relevant to monitoring patient compliance with psychotropic medications.

Significant staffing shortages are present in various units as summarized in the mental health audit reports. Credentialing of mental health staff also appears to be problematic based on the audit report by the Office of the State Auditor. It would be useful to obtain further discovery relevant to corrective action taken by TDCJ pertinent to the Office of the State Auditor's report concerning monitoring the healthcare system and the QI/QM process.

Please do not hesitate to contact me if I can answer any further questions.

Sincerely,

Jeffrey L. Metzner, M.D.
Diplomate, American Board of Psychiatry and Neurology