U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

March 14, 2007

The Honorable Linda Lingle
Governor of Hawaii
State Capitol
Honolulu, Hawaii 96813

Re: Oahu Community Correctional Center

Dear Governor Lingle:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices of mental health care at the Oahu Community Correctional Center ("OCCC" or "Jail") in Honolulu, Hawaii. On June 16, 2005, we notified you of our intent to investigate conditions of mental health care provided to detainees and inmates at OCCC pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern or practice conduct that violates the constitutional rights of persons with mental illness who are detained in public institutions. We focused our investigation on the nature of services to detainees[1] at OCCC with mental illness.

On October 11 - 14, 2005, we conducted an on-site inspection of OCCC with experts in the field of correctional mental health care. While on-site, we interviewed administrative and security staff, mental health care providers, and detainees. We also reviewed a large number of documents, including policies and procedures, incident reports, internal communication logs and medical records. In keeping with our pledge to share information and to provide technical assistance where appropriate regarding our investigatory findings, at the close of our tour, we met with several state and OCCC officials and discussed the preliminary findings of our tour. Among others, present at this meeting were

[1] OCCC houses mainly pre-trial detainees. However, the facility also houses post-adjudication inmates. For the purpose of this letter, both groups will be referred to as detainees. Further, all examples noted in this letter refer to detainees housed on OCCC's mental health modules.

the Attorney General, Mark Bennett; Interim Director of the Department of Public Safety, Frank Lopez; OCCC Warden Nolan Espinola; other counsel for Hawaii, and OCCC mental health staff.

We appreciate the full cooperation we received from OCCC and state officials throughout our investigation. We also wish to extend our appreciation to the staff and administrators at OCCC for their professional conduct and timely response to our document requests.

Having completed our investigation of OCCC, and consistent with our statutory obligations under CRIPA, I write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal remedial measures that are necessary to ensure that OCCC meets minimal federal constitutional standards. 42 U.S.C. § 1997b(a). Specifically, we conclude that certain conditions at the Jail violate the constitutional rights of the detainees confined there and subject those detainees to harm and risk of harm. As detailed below, we find that OCCC: (1) subjects detainees with mental illness to harmful methods of isolation, seclusion and restraint, including a procedure referred to as "therapeutic lockdown;" (2) fails to provide adequate treatment or therapy programs and services; (3) fails to monitor adequately detainees while isolated or secluded, including while on suicide watch; (4) fails to employ sufficient mental health staff and clinical structures to care adequately for detainees; (5) fails to have adequate policies, procedures, and quality assurance structures in place to direct the delivery of mental health services; and (6) fails to ensure adequate planning is done upon detainees' discharge from OCCC. These deficiencies expose detainees to the risk of serious harm and have, in some cases, resulted in actual harm to detainees.

I. BACKGROUND

A. Description of OCCC

OCCC is the largest jail in Hawaii and is operated by the Hawaii Department of Public Safety ("DPS"). OCCC has a design capacity of 628 and an operational capacity of 954. On the first day of our October tour, OCCC had a population of 1164, with just under 1000 male and just over 100 female detainees. OCCC is the reception center for Hawaii's jail and prison system. The facility is comprised of several "modules," two-tiered pods surrounding a day room. The Jail also has a 36-cell holding area that serves as OCCC's lockdown unit.

Modules 3 and 4 house male detainees with the most serious mental illness.[2] Many of the detainees are doubled-celled. At the time of our visit, there were approximately 56 and 40 detainees residing in these modules, respectively.

Female detainees with the most serious mental illness are housed in Module 8. Female detainees who exhibit suicidal or threatening behavior are transferred to the state's prison for females, the Women's Community Correctional Center ("WCCC").

B. Legal Framework

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of detainees. 42 U.S.C. § 1997a. The Fourteenth Amendment Due Process clause protects pre-trial detainees from being punished or exposed to conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. 520, 535-36, 560-61 (1979). Pre-trial detainees "retain at least those constitutional rights . . . enjoyed by convicted prisoners [under the Eighth Amendment]." Id. at 545. The Eighth Amendment's prohibition against cruel and unusual punishment also places an affirmative duty on prison officials to provide humane conditions of confinement, including access to adequate medical care. See Farmer v. Brennan, 511 U.S. 825, 832 (1994); Estelle v. Gamble, 429 U.S. 97, 102-03 (1976). The Eighth Amendment is violated when prison officials demonstrate "deliberate indifference to serious medical needs." Jackson v. McIntosh, 90 F.3d 330, 332 (9th Cir. 1996). Adequate medical care includes a duty to provide adequate mental health care. Doty v. County of Lassen, 37 F.3d 540, 546 (9th Cir. 1994) (holding that "requirements for mental health care are the same as those for physical health care needs"); Hoptowit v. Ray 682 F.2d 1237, 1253 (9th Cir. 1982)(analyzing mental health care requirements as part of analysis of general health care requirements).

Constitutional questions regarding the conditions of confinement of pre-trial detainees are properly addressed under the Due Process clause of the Fourteenth Amendment, rather than under the Eighth Amendment's protection against cruel and unusual

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[2] The male detainees with the most serious mental illness are housed in Module 4. Module 3 serves as a step-down unit for detainees with less serious mental illness or a less-acute status.

punishment, but the guarantees of the Eighth Amendment provide a minimum standard of care for determining their rights, including the rights to medical and psychiatric care. Gibson v. County of Washoe, Nevada, 290 F.3d 1175, 1187 (9th. Cir. 2002); Carnell v. Grimm, 74 F.3d 977, 979 (9th Cir. 1996); Jones v. Johnson, 781 F.2d 769, 771 (9th Cir. 1986). In addressing the constitutionally minimal standards for mental health care in a prison, the district court in Coleman v. Wilson, 912 F. Supp. 1282, 1298 n.10 (E.D. Cal. 1995), held that prisons must have:

> (1) a systematic program for screening and evaluating inmates to identify those in need of mental health care; (2) a treatment program that involves more than segregation and close supervision of mentally ill inmates; (3) employment of a sufficient number of trained mental health professionals; (4) maintenance of accurate, complete and confidential mental health treatment records; (5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (6) a basic program to identify, treat, and supervise inmates at risk for suicide.

As discussed below, the State frequently acts at odds with these legal standards.

II. FINDINGS

A. OCCC subjects detainees with mental illness to harmful methods of isolation, seclusion, and restraint.

Jail officials violate the constitutional rights of detainees when officials exhibit deliberate indifference to the serious medical needs, including mental health needs, of detainees. Doty, 37 F.3d at 546; Hoptowit, 682 F.2d at 1253. In the absence of adequate mental health treatments to control the psychosis-related behavior of detainees, OCCC improperly relies on a practice it defines as "therapeutic lockdown" ("TLD"). In essence, TLD is the unorthodox use of long-term seclusion in which a detainee is isolated in his or her cell and denied any staff interaction, including contact with mental health staff. The use of lockdown as an alternative to mental health care constitutes deliberate indifference to the serious mental health needs of detainees. See also Arnold on Behalf of H.B. v. Lewis, 803 F. Supp. 246, 255-8 (D. Ariz. 1992), *rev'd on other grounds*

Lewis v. Casey, 518 U.S. 343 (1996).

OCCC's policy calls for the use of TLD whenever a detainee becomes "consistently disruptive to their housing environment or become[s] a physical threat to others..."[3] Not only is a detainee isolated while on TLD, but a detainee on TLD is also denied potentially helpful interventions or contacts. For example, according to OCCC's policy, the detainee "will be allowed no privileges (e.g., reading materials, cigarettes or social interaction with staff or detainees) while on TLD."

Mental illness often manifests itself in disruptive behaviors and/or the inability to maintain appropriate behavior. Mental illness-induced behaviors can escalate to the point where the behaviors pose a threat to the individual and to others around the person. Because we focused our tour on the units housing individuals with mental illness, the detainees subjected to TLD noted in this letter were detainees with mental illness.[4]

Thus, detainees on TLD, in accordance with facility policy, are denied a constitutionally mandated right: access to mental health care and staff. Further, TLD is used without the proper safeguards normally associated with the use of seclusion, such as intensive monitoring of the individual while in seclusion.

There is nothing "therapeutic" about OCCC's use of "therapeutic lock-down." OCCC's use of TLD harms detainees in that it often exacerbates the effects of detainees' illnesses. Casey, 834. F. Supp. at 1548-9. In part, because of the risks associated with secluding an individual with mental illness, seclusion is not recognized as a treatment intervention.[5]

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[3] DPS Policy No. COR. 10D.27.

[4] As noted earlier, because we focused our review on detainees with mental illness, we are offer no opinion on the use of TLD as a potential disciplinary mechanism for detainees who do not have a mental illness.

[5] See e.g., October 29, 2002 Statement of the National Association of State Mental Health Program Directors ("NASMHPD"). NASMHPD is an organization made up of directors of state public mental healths systems. The Statement contains the following: "Because restraints and seclusion always carry significant risk of injury - both physical and psychological - we . . . emphasize that such interventions, on the rare occasions they are used, must be terminated as soon as possible." Further, the Statement

TLD, as used at OCCC, without privileges and social contacts for the detainees, can exacerbate a detainee's symptoms and impede a detainee's recovery from his or her mental illness. There was simply no discernable treatment provided to detainees on TLD except for psychotropic medications.

Detainees on TLD were reportedly on TLD for days to weeks at a time. We reviewed the records of numerous male and female detainees with mental illness who had been placed on TLD in the months preceding our tour. Detainees were often placed on TLD without adequate justification and often in contradiction to their clinical status. This practice is problematic because to take an individual suffering from depression and then seclude and isolate that person would almost guarantee an increase and worsening of depressive symptomatology.

The following examples illustrate how OCCC uses TLD on detainees with mental illness in harmful and potentially harmful ways.

♦ Detainee 1[6] - This 41-year-old man had a history of schizophrenia, with multiple hospitalizations and a suicide attempt. He had been on TLD for approximately 10 days at the time of our tour. He was still actively psychotic when we interviewed him. This detainee was not receiving constitutionally required treatment because, despite his obvious need for treatment, this detainee had been locked down in his cell (on TLD) for an extended period of time without any type of psychosocial rehabilitation interventions or regular assessments by mental health staff.

♦ Detainee 2 - This 45-year-old man had a history of post-traumatic stress disorder related to childhood sexual abuse. He had also been reporting auditory hallucinations and was taking anti-depressant medications. During his incarceration, he had been placed on TLD and suicide watch. During the approximately two weeks the detainee was on TLD, there was no evidence he was

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also refers to the position taken by NASMHPD in 1999 declaring that restraint and seclusion "<u>are safety interventions of last resort and are not treatment interventions</u>."

[6] Throughout this letter, when referring to a specific detainee, we use the term "Detainee" followed by a number to protect the identity of the detainees. We will provide to the State, under separate cover, a key to identify the detainees referenced in this letter.

seen by a mental health professional. It is our expert's opinion that the use of TLD on this detainee likely exacerbated the effects of his mental illness and increased his depression and aggression.

♦ Detainee 3 - This 29-year-old man had been at OCCC for approximately six months at the time of our tour. He had a history of schizophrenia and reported feeling depressed and suffering from auditory hallucinations. He had been placed on TLD several times during his incarceration. Our review of his records indicate that his only form of treatment was medication management. This detainee was in need of a more comprehensive therapeutic treatment approach than mere medication. Moreover, his placement on TLD likely contributed to the exacerbation of his psychotic symptoms.

♦ Detainee 4 - This female detainee had multiple incarcerations at OCCC with intermittent transfers to WCCC and a history of inpatient psychiatric hospitalization. She had a further history of significant psychiatric symptoms, including auditory hallucinations and delusional thinking. She had been placed in TLD while at OCCC. The use of TLD harmed this detainee by placing her in seclusion without adequate monitoring or therapeutic contact.

♦ Detainee 5 - This female detainee had multiple incarcerations at OCCC. She was diagnosed with a possible delusional disorder and a seizure disorder. She also exhibited signs of paranoia, and had a history of altercations with staff and other detainees. Additionally, she frequently would not take her medication, the possible result of her paranoia. She was subjected to TLD by OCCC. Inadequate care resulted in her increased psychosis, and OCCC’s response to this detainee’s worsening condition was to seclude her by placing her in TLD, again without adequate monitoring or therapeutic contact by staff.

♦ Detainee 6 - This female detainee had been exhibiting delusional thinking, auditory hallucinations, and hostile behavior towards staff. She had been placed on TLD for over three weeks. She was transferred to WCCC with suicidal ideation and paranoia. She was returned to OCCC only two days later and continued to exhibit disorganized behavior and hostility toward others. She was again placed in seclusion, where she became more withdrawn and noncompliant. At OCCC, she remained psychotic and her condition decompensated. According to our consultants, the effects of her mental illness were exacerbated by OCCC’s use of seclusion and TLD because she was not monitored adequately, not

provided necessary treatment, or assessed adequately for suicide risk. This is also an example of a detainee who needed a level of intensive psychiatric care not available at OCCC.

OCCC's use of TLD on detainees with mental illness amounts to punishment and is therefore unconstitutional. Bell, 441 U.S. at 535-37, 560-61. In fact, we found evidence of staff threatening detainees with the use of TLD.

For example, in an internal communication log-book maintained by OCCC staff, a notation indicates that a detainee was "warned to behave or he would be placed on TLD." At best, this indicates a fundamental failure to understand that an individual with mental illness often lacks the capacity to be able to chose to "behave." At worst, it indicates a punitive use of TLD. In another incident it was noted that a detainee "took an attitude so [we] placed him in TLD." Another detainee who was obstructing a security camera was also "warned" about being placed on TLD. Still another notation read: "[w]e have TLD and 4 point [the practice of physically restraining a person to a bed and securing them to the bed, usually at the ankles and wrists] orders on them in case they act up." (Emphasis added) OCCC is using a practice identified as "therapeutic" lockdown as punishment. Using lockdown as punishment for actions that are often the result of mental illness violates the constitutional rights of detainees. Casey, 834 F. Supp. at 1549-50; Arnold on Behalf of H.B. v. Lewis, 803 F. Supp. at 257-58.

OCCC also employs harmful and professionally unjustifiable seclusion on detainees by the manner in which the facility places and maintains detainees on "suicide watch." Suicide watch at OCCC involves placing a detainee isolated and alone in a single cell. This use of TLD violates the constitutional rights of OCCC detainees in two ways. First, all detainees placed on suicide watch are isolated without adequate supervision and monitoring. Second, for those detainees with a mental illness who are isolated in this manner, the detainee's mental health status is not timely assessed and reassessed by a mental health clinician or other provider of mental health services. This form of isolation often leads to a worsening of a detainee's mental illness. Constitutionally minimum standards require jails to have a program to "identify, treat, and supervise" detainees at risk of suicide. Coleman, 912 F. Supp. at 1298 n. 10. OCCC's use of TLD does not provide for the "treatment" or "supervision" required by the Coleman standards.

For example, we reviewed the records of a 34-year-old male detainee who was transferred to OCCC from another Hawaii correctional facility. He was placed on suicide watch after he attempted suicide by cutting his throat. He was noted to be

depressed and only partially compliant with his medications. This detainee was still on suicide watch during our expert's interview, a period of 16 days after placement. During the interview, the detainee was depressed and spent most of his time wrapped in a blanket. Isolating and secluding this depressed detainee for such a length of time, and without adequate contact from therapy staff, was detrimental to the detainee's mental health and was likely exacerbating his depression. In addition, our review of this detainee's records revealed a delay in initiating his needed medication – a further factor in his decline.

Similarly, we assessed the appropriateness of OCCC isolating another detainee – by admitting him directly to suicide watch upon arrival to the facility. This detainee had several previous admissions to OCCC, yet there was no explanation or written justification in the detainee's record as to why he was immediately isolated and why there had not yet been an evaluation of him at the time our expert interviewed him approximately 48 hours after he was placed on suicide watch.

OCCC's policy concerning detainees on suicide watch states that detainees "shall be assessed daily by a facility 'provider.'" This "provider," according to OCCC's policy, must be a psychiatrist, psychologist or medical doctor. However, our records review and interviews with detainees demonstrated that the providers were not following this policy and were not assessing and monitoring suicide watch detainees in a timely manner. While in isolation and on suicide watch, detainees do not have sufficient contact with security and mental health staff to provide constitutionally-required care.

For example, we evaluated one male detainee who had a history of schizophrenia requiring in-patient hospitalization. Upon a recent prior admission to OCCC, he was described as "completely incoherent." He was released less than two weeks later, only to be re-incarcerated shortly before our tour. He was placed on suicide watch, where he was at the time of our tour. There was no justification recorded as to why he was on suicide watch and no progress notes had been made during that time. During our tour, one of our experts interviewed this detainee. At that time, the detainee was still obviously seriously mentally ill. Secluding and isolating this detainee 23 hours a day was worsening his condition. This detainee is also another example of an individual who needed a more intensive level of psychiatric care than is available at OCCC.

Once on suicide watch, detainees are locked in their cells 23 hours out of the day until released by either a psychiatrist or psychologist. We found individuals who have languished in

this status for days without even a rudimentary reevaluation suicidal ideation or intent.

Generally accepted correctional practice requires adequate monitoring of suicidal detainees.[7] However, OCCC detainees are not monitored adequately while they are on suicide watch. We reviewed numerous instances where detainees, both on TLD and suicide watch, injured themselves due to psychosis-related behavior while isolated and secluded. For example, a detainee on suicide watch was "using his head to pound on the door w/sudden delusional excitement." Another inmate on suicide watch was using his blanket "as a cushion when he slams into the door." OCCC's response to this incident was to take the detainee's blanket away. Another detainee on TLD was described as "pounding, banging his door ... both feet appear to be very swollen."

Further, OCCC admitted that the facility does not follow its own policy regarding physician assessments that are supposed to occur when a detainee is placed into restraints. We found that physicians do not provide appropriate guidelines for releasing detainees from restraint and often wrote orders that called for restraint on an "as needed" basis, which is a substantial departure from accepted clinical practice. The monitoring of detainees while in restraint was also inadequate. For example, a female detainee who had been incarcerated multiple times at OCCC and suffered from severe psychosis, was both restrained and isolated at various times without adequate clinical monitoring (e.g., range of motion, toileting) or clinical contact, which resulted in a worsening of her psychotic symptoms. We also came across examples of inmates harming themselves while in restraint, such as a notation that a detainee was "banging [his] head violently" while in restraints.

B. OCCC fails to provide detainees with constitutionally adequate mental health treatment or therapy programs and services.

Jails such as OCCC are constitutionally required to provide mental health services to detainees. Madrid v. Gomez, et al., 889 F.Supp. 1146, 1255-6 (N.D. Cal. 1995). Timely mental health treatment is essential to minimize decompensation and to ensure that adequate services are provided. Detainees with mental

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[7] See e.g., the American Psychiatric Association standards of mental health services in jails which require adequate monitoring of suicidal detainees. American Psychiatric Association, Psychiatric Services in Jails and Prisons, 2nd Edition, Part 1, VIII at 14-15.

illness at OCCC do not receive adequate levels of mental health care. There are significant deficiencies in the mental health treatment programs and services for OCCC detainees. Detainees are not provided treatment programs or the range of treatment modalities, including psycho-social rehabilitation services, needed to address their illnesses. As a result of not providing access to needed levels of care, and as noted above, OCCC resorts to the harmful use of seclusion to address detainees' psychosis-induced behavior. OCCC also fails to provide adequate discharge services to detainees, increasing the detainee's risk of re-incarceration.

1. OCCC does not adequately assess or address detainee's mental health needs.

Along with assessing the manner in which OCCC treated its detainees with mental illness, we also examined the facility's ability to assess detainees with potential mental illnesses. Assessment is a critical component of a constitutionally-adequate mental health program. Coleman, 912 F. Supp. at 1298 n. 10. In general, we found that OCCC usually was able to identify detainees who may have mental health issues, however, we did note gaps in OCCC's ability to consistently do so. Upon entering OCCC, detainees are assessed by health care staff via video monitors. This system, however, has inherent weaknesses. We observed the assessment process at work. We also interviewed detainees who had potential mental health concerns that the OCCC video system failed to identify. For example, upon admission to OCCC, one detainee was experiencing serious hand tremors.[8] However, the staff member who assessed this detainee via the monitors was unable to see the detainee's hands and therefore missed this potentially serious issue. Further, when detainees are interviewed by staff, the physical layout of the facility does not provide auditory privacy. Thus, it is possible that detainees may not reveal critical information about their mental health history because of the lack of privacy.

Further, we found no detainee medical record with an adequate description of what and how mental health treatment services were to be provided for any OCCC detainee. In the absence of sufficient documentation, OCCC providers are left without an adequate understanding of a detainee's course of treatment or clinical response to treatment. Also, detainees are not routinely followed by the psychiatric social workers

[8] Hand tremors could be the result of a variety of serious health issues, including potential substance abuse and the possible reaction of an individual's not receiving a needed medication.

responsible for monitoring their treatment. OCCC's systemic failure to follow and monitor detainees with a mental illness is contrary to generally accepted correctional practice. As a result, we encountered detainees who were in need of treatment but who were essentially untreated.

2. OCCC does not provide detainees with an adequate scope or needed intensity of treatment therapies or services.

Constitutional deficiencies exist where pre-trial detainees are provided insufficient mental health programming. Casey, 834 F. Supp. at 1548, 1550. Treatment modalities at OCCC are very limited. There was no group therapy taking place. Individual counseling was an exception rather than a rule. Other treatment modalities were limited to little more than observation and monitoring. These non-medication treatment therapies are essential in the treatment of mental illness because medication therapy alone is professionally recognized as not being sufficient as the only treatment modality for persons with serious mental illnesses. For example, the American Psychiatric Association practice guideline for the treatment of schizophrenia recommends treatment that includes both psychotropic medication and psychosocial and rehabilitative interventions. OCCC does not provide these needed treatments to detainees with schizophrenia or other serious mental illnesses.

The Ninth Circuit has ruled that, if a facility can not meet the needs of detainees, then the facility must refer the detainee to an another source of care. Hoptowit, 682 F.2d at 1253; Casey, 834 F. Supp. at 1550. We noted that there were very few instances of OCCC transferring seriously mentally ill detainees who needed more intensive mental health services than that available at OCCC from OCCC to the state's inpatient facility, the Hawaii State Hospital ("HSH"). Given the limited health services provided at OCCC, it is essential that detainees have access to more intensive mental health services as needed. This inability to access intensive psychiatric care was particularly problematic for women detainees.

The following examples are illustrative of the detrimental effects of OCCC's lack of effective treatment and limited range of therapy services.

♦ Detainee 7 - This is a female detainee who was incarcerated most recently at OCCC one month prior to our tour. She was diagnosed with schizophrenia and obsessive compulsive disorder and had a history of inpatient hospitalizations, including a recent escape from the HSH. She was transferred to the State's women's prison, the Women's Community Correctional Center ("WCCC"), a few days later, after she verbalized suicidal

ideations and cut her arm. She was returned from WCCC the following day, still experiencing psychotic symptoms, including auditory hallucinations. Throughout her stay at OCCC, this detainee continued to exhibit active and serious psychotic symptoms. According to our expert, this detainee clearly needed more aggressive mental health therapies than she was receiving from OCCC. The lack of these services resulted in the detainee's continued suffering the effects of her mental illness. This detainee could have also benefitted from placement in an inpatient psychiatric setting. This detainee was among a number of detainees, particularly females, who appeared to need an inpatient level of care that was not being provided.

♦ Detainee 8 - This female detainee had been at OCCC for approximately one week prior to our tour. During intake, she was unable to be interviewed because she was experiencing disorganized thinking, lability (a physical or chemical breakdown), and auditory hallucinations. She was also having suicidal thoughts. During our interview with her, she was overtly psychotic and was reported by OCCC staff to have occasional suicidal ideations, pressured speech and marked lability. These symptoms suggested an inadequately treated psychosis. According to our expert, the treatment provided to this detainee was not adequate because there was inadequate assessment of her suicide risk and she was in need of more intense psychiatric care, including possible inpatient treatment, than she was receiving. These deficiencies resulted in her exacerbated psychotic symptoms and recurrent suicidal ideations.

♦ Detainee 9 - This female detainee, diagnosed with bipolar disorder, has had multiple incarcerations at OCCC, and a history of inpatient hospitalizations as well. During her earlier admissions to OCCC (two in 2005), she had been involuntarily medicated and restrained. At the time of our tour, she had been at OCCC just under a week. She was hostile, agitated, psychotic, destructive, and was transferred back and forth from WCCC for suicide watch. This detainee was not treated or monitored adequately despite her dangerous and threatening behaviors. She was placed in restraints pursuant to a physician’s order that gave discretion to security staff as to when to place the detainee in restraints. In our experts’ view this represents a substantial departure from generally accepted corrections practice and standards. Generally accepted professional standards of care require that restraints be applied only under specific circumstances of risk to self or others. There was inadequate clinical justification for the use of restraint and seclusion, and inadequate monitoring while she was in restraints. This situation also represents a case of OCCC’s not providing adequate discharge planning during her previous stays. She

needed an intensive level of post-release services that might have prevented her re-incarceration.

♦ Detainee 10 - This detainee was also admitted directly to suicide watch upon admittance to OCCC (a week prior to our tour). He'd had five prior admissions to the facility, including a one-week stay a few months earlier. There was no explanation or written justification in the detainee's record as to why he was immediately isolated and there had not yet been an evaluation of him at the time our expert interviewed him. It is a serious violation of professional standards to subject detainees to isolation without adequately recording the detainees progress or conducting at least daily evaluations.

In the absence of adequate non-medication therapies, OCCC relies on psychotropic medication as its primary treatment intervention. The Coleman standard requires psychotropic medication be used with "appropriate supervision." We uncovered numerous and repeated instances of psychotropic medications being used, not as a part of a treatment plan addressing a detainee's mental illness, but as chemical restraints to control a detainee's unruly behavior. For example, in one instance, a detainee with mental illness began "pounding on his door, [and] disturbing the whole module." The staff's response was to call the Health Care Unit and a nurse came to the module and gave the detainee "an injection." In another incident, a detainee was given Haldol (a powerful psychotropic medication). It was noted the detainee "appears agitated." Another detainee was given "a shot to calm him down." We came across other examples of detainees being medicated after they became "agitated." Such use of psychotropic medication constitutes chemical restraint, and is a violation of detainees' constitutional rights.

We also found evidence that psychotropic medications were being used as punishment. For example, we found the following notation in the staff's communication book:

> "Notified [Health Care Unit] of [detainee] and his total disregard for other inmates. Has order for a cocktail shot,[9] but nurse wants to be nice and give [detainee] some Tylenol. Anymore outbursts - he'll definitely get a shot."

[9] During our investigation of OCCC, we were told that the phrase "cocktail shot" is a local euphemism for an injection of a combination of psychotropic medications intended for use as a chemical restraint.

Using psychotropic medication as punishment is unconstitutional. Bell, 441 U.S. at 535-37, 560-61.

3. OCCC fails to employ sufficient mental health staff, provide adequate supervision for its staff and operate in accordance with current policies and procedures.

Jails such as OCCC must employ a sufficient number of trained mental health professionals to ensure the presence of an adequate mental health delivery system. Casey 834 F. Supp 1548 (citing Hoptowit, 682 F.2d at 1253); Coleman, 912 F. Supp. at 1298 n.10. A significant reason for many of the failures in OCCC's mental health service delivery system is the fact that the Jail does not employ a sufficient number of adequately qualified mental health staff to meet the needs of detainees. At the time of our tour, there were two psychiatrists serving OCCC. However, one was at the facility only half-time, the other less than that, equaling less than one full-time equivalent psychiatrist serving the Jail.

According to the APA guidelines, the recommended staffing for psychiatrists in jails that serve between 75 and 100 detainees with serious mental illness who are receiving psychotropic medication is one-full time psychiatrist or the equivalent. OCCC nursing staff reported to us that 217 detainees were receiving psychotropic medications and the OCCC units housing the detainees with the most serious mental illnesses averaged a population of over 110 during the time of our tour. Thus, OCCC employs only half of the APA-recommended number of psychiatrists to serve its detainees with mental illness.

The lack of sufficient staff appears to be one reason that detainees spend an inordinate amount of time restricted to their cells. According to OCCC's own documents, detainees often have to remain in "lockdown" because there is not sufficient mental health or correctional staff (Adult Correctional Officer - "ACO") to provide adequate supervision if the detainees were released from their cells.

For example, we found repeated references in OCCC's own documents that the mental health units often operate on a status known as "modified lockdown" due to an ACO shortages.[10] At other times a unit would simply be in "lockdown," again due to shortage

[10] DPS Policy No. 7.08.79 - "Module Lockdown" - defines "Modified Lockdown" as the lockdown of a module that affects up to half of the module population. The policy allows Modified Lockdown to be used when "sufficient staffing is not available . . ."

of correctional staff. For example, there are notations in an OCCC communication book stating that Module 4 is in "'lockdown' at this time due to short[age] of staff." Similarly, we found references to modules having to "run slow" as a result of lack of staff. State representatives told us "run slow" refers to adjusting a module away from normal practice because of the lack of adequate staffing. Thus, the modules would not be able to provide whatever otherwise limited activities that might have been available to detainees with mental illness. Therefore, in these instances, detainees are subjected to seclusion and/or denied treatment opportunities as a result of OCCC's lack of adequate mental health and correctional staff.

Another major reason for the deficiencies in mental health care at OCCC is that there are not adequate clinical leadership or organizational structures in place at OCCC. For example, at the time of our tour, there was no designated person in charge of mental health services at OCCC. All mental health staff we spoke with confirmed that the organizational structure of mental health services was confusing and inconsistent. The person who was serving as the Clinical Section Administrator did so only in an administrative capacity. On our tour, we were told that DPS had appointed an individual as Chief Psychiatrist for DPS. However, this was a recent development and it was unclear how this change would impact OCCC.

As a result of the absence of clinical leadership, a quality assurance or quality improvement program at OCCC was essentially nonexistent. Many of the issues we identified on our tour might have been addressed and remedied had OCCC had adequate clinical leadership and policies and procedures in place to identify and correct gaps in services.

Further, OCCC's policies and procedures relevant to mental health services are either outdated or are not being followed. For example, OCCC was violating its policy governing mental health services (DPS Policy No. 10D.04 - "Mental Health Services") in a number of key ways. The policy requires the development of "individual treatment programs with the goal of stabilizing and achieving an optimal level of functioning" for detainees in controlled or therapeutic housing. Our review of OCCC records revealed that OCCC was not following its policy regarding treatment plans as they are virtually nonexistent at the Jail. Additionally, OCCC policies call for collaboration between the psychiatrist and psychologist in the development of mental health treatment services. This collaboration was not being done.

C. OCCC fails to provide detainees adequate discharge services, increasing the likelihood of detainees being re-incarcerated.

As a matter of technical assistance only, we want to raise a concern regarding the manner in which some mentally ill detainees leave OCCC. With few exceptions, discharge services, (e.g., discharge medications, linkage with community mental health providers, initiating entitlements, housing, etc.), are not provided for detainees upon discharge from OCCC.

According to the American Psychiatric Association, professional standards and practice require that inmates in need of mental health care at the time of release "be made known to appropriate mental health service providers."[11] We were told that OCCC was beginning to work with the State's Adult Mental Health Division ("AMHD") to inform AMHD when detainees with mental health issues are being released from OCCC. It is hoped this coordination will assist detainees with accessing post-release services.

As noted from the detainee examples set forth above, we reviewed several detainee records of individuals with mental illness who were incarcerated following a previous discharge, and sometimes multiple discharges, from OCCC. Adequate links to post-OCCC mental health services could serve to avoid future incarcerations and provide for increased continuity of care.

We urge the State, AMHD and OCCC to consider and continue their work to coordinate efforts to assist detainees in need of mental health services to be able to access such services upon discharge from the Jail.

III. RECOMMENDED REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and protect the constitutional rights of detainees, OCCC should implement, at a minimum, the following measures:

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[11] American Psychiatric Association, Psychiatric Services in Jails and Prisons, 2nd Edition, Part 2, II.C at 38. Further, at least one federal court has noted the need for discharge services. In Foster v. Fulton County, 223 F. Supp.2d 1301, 1310 (N.D.Ga. 2002) the court wrote that "without adequate planning and medication upon their release from jail, mentally ill inmates are more likely to be rearrested and reincarcerated within a short period of time, usually on minor offenses such as criminal trespass or public intoxication."

1. Ensure that detainees are not placed in isolation or seclusion in a manner that would pose an undue risk to the detainee's health and safety. Accordingly, OCCC should:

a. cease the use of "therapeutic lockdown" as the practice was employed during the time of our October 2005, visit;

b. ensure that any "lockdown" procedures are not used as punishment for psychosis-related behavior or in lieu of treatment or therapy;

c. ensure that detainees placed on suicide watch are assessed adequately, monitored appropriately to ensure their health and safety, and released from suicide watch as their clinical condition indicates according to professional standards of care;

d. ensure that any use of seclusion or restraint is only used in accordance with generally accepted standards of professional practice and that any seclusion or restraint is adequately justified and documented; and

e. ensure detainees in seclusion or restraint are assessed and monitored adequately and that restraint and seclusion are not used as punishment or for convenience of staff or in lieu of adequate staff availability.

2. Ensure that detainees are assessed adequately for mental health needs and provided, where consistent with legitimate security concerns, an appropriate, confidential environment for assessment and counseling.

3. Develop and implement a mental health service program that includes an adequate range of services, and ensures that such services are monitored and revised as needed.

4. Ensure that detainees whose serious mental health needs require more intensive mental health treatment than available at OCCC are provided timely and appropriate access to either inpatient hospitalization, or a service providing a similar level of care.

5. Ensure that psychotropic medications are used only in accordance with accepted professional judgment and standards, and that medication is not used in lieu of lesser-intrusive

therapies, for the convenience of staff or as punishment, or as a substitute for adequate staff.

6. Ensure the presence of an adequate number of mental health professionals, including psychiatrists, psychologists, psychiatrist social workers, and counselors, to meet adequately the needs of detainees with serious mental illness, and to:

a. ensure the presence of adequate clinical leadership and supervision; and

b. develop and adopt policies and procedures and implement quality assurances measures to ensure that the delivery of mental health services comports with current standards of practice.

7. Ensure the presence of an adequate number of correctional staff so that mental health services are not negatively impacted by the lack of correctional staff to provide security and supervision of mentally ill detainees.

8. Finally, as a matter of technical assistance, we ask the State to consider, as appropriate and possible, providing detainees with discharge plans and services that link detainees to post-OCCC mental health services that could serve to avoid future incarcerations and provide for appropriate continuity of care should a detainee be re-admitted to OCCC.

During our exit conference, we were pleased that State officials recognized many of the problems discussed in this letter. In fact, on November 11, 2005, the State wrote to us and set forth measures the State intended to take to address the deficiencies at OCCC. Among other things, the State wrote it would be developing an “action plan” to address the issues we raised at the close of our tour. The letter also reported that the State would be seeking funds from the legislature to provide for additional mental health staff at OCCC. We commend the State’s commitment to begin remedial efforts at OCCC on an expedited basis.

In anticipation of continuing cooperation toward a shared goal of achieving compliance with constitutional requirements, we forwarded you our experts’ joint report on July 11, 2006. Although the report is the experts’ work and does not necessarily reflect the official conclusions of the Department of Justice, their observations, analyses, and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until 10 calendar days from the date of this letter.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that 49 days after receipt of this letter, the Attorney General may institute a lawsuit pursuant to CRIPA to correct the noted deficiencies. 42 U.S.C. § 1997b(a)(1). We have every confidence that we will be able to reach an adequate resolution to this case. The lawyers assigned to this matter will be contacting your attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Wan J. Kim
Wan J. Kim
Assistant Attorney General

cc: Honorable Mark Bennett, Esq.
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State of Hawaii

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Warden
Oahu Community Correctional Center

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