INVESTIGATION OF THE CUMBERLAND COUNTY JAIL (BRIDGETON, NEW JERSEY)

United States Department of Justice
Civil Rights Division

United States Attorney's Office
District of New Jersey

January 14, 2021

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I. SUMMARY

The Department of Justice's Civil Rights Division and the U.S. Attorney's Office for the District of New Jersey (collectively, "the Department") provide notice to Cumberland County, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §§ 1997 *et seq.* (CRIPA), that there is reasonable cause to believe, based on the totality of the conditions, practices, and incidents discovered at the Cumberland County Jail (CCJ) that: (1) conditions at the CCJ violate the Eighth and Fourteenth Amendments of the United States Constitution, and (2) these violations occur pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Constitution. The Department does not serve as a tribunal authorized to make factual findings and legal conclusions binding on, or admissible in, any court, and nothing in this Notice should be construed as such.

Specifically, the Department provides notice that Cumberland County fails to take adequate measures to protect inmates from harm, including:

- failing to adequately address the heightened risk of self-harm and suicide for inmates experiencing unmedicated opiate withdrawal;
- failing to provide sufficient screening to identify inmates at risk of self-harm or in need of mental health care for a serious mental health condition; and
- failing to provide sufficient mental health care to inmates with a clear need for care.

Consistent with the statutory requirements of CRIPA, we write to notify Cumberland County of the Department's conclusions with respect to these violations, the facts supporting those conclusions, and the minimum remedial measures necessary to address the identified deficiencies.

II. INVESTIGATION

On June 15, 2018, the Department of Justice notified Cumberland County of our intent to investigate the Cumberland County Jail pursuant to CRIPA. Our investigation focused on whether the CCJ complies with its obligations under the Constitution by taking adequate measures to provide mental health care and to prevent inmate suicides, and it covers the period from 2014 to December 2020.

The investigation was conducted jointly by the Special Litigation Section of the Department of Justice's Civil Rights Division and the U.S. Attorney's Office for the District of New Jersey. Three expert consultants in correctional operations and mental health care assisted with our investigation. Two of our experts are former high-ranking corrections officials who have served in leadership roles at correctional facilities and provided expert opinions on correctional issues to other agencies. Our other expert is a board-certified psychiatrist with significant experience in correctional settings who has also served as an expert on numerous correctional matters.

In October 2018, representatives from the Department and two of its expert consultants conducted a four-day site visit to the CCJ.[1] Over the course of our visit, we interviewed administrative staff, security staff, medical and mental health staff, and prisoners. We also reviewed an extensive number of documents, including the CCJ's and its medical providers' policies and procedures, medical and mental health records, cell assignment histories, incident reports, investigative reports, disciplinary reports, administrative audit reports, prisoner grievances, unit logs, orientation materials, and training materials. We observed prisoners in various settings throughout the facility, including in general population and restrictive housing units. We conducted exit conferences with CCJ officials in which our expert consultants shared preliminary concerns and recommendations in order to provide technical assistance during the course of the investigation.

Following our on-site review, we requested and CCJ officials produced additional documentation relevant to our investigation, including requests as recently as the fall of 2020. CCJ officials have fully cooperated with our investigation and have produced about 3,000 documents.

III. BACKGROUND

Located in Bridgeton, New Jersey, the Cumberland County Jail was originally built in the 1940s, and has undergone several expansions. The CCJ, which typically had a population of about 300 to 350 prisoners during our investigation, is run by the Cumberland County Department of Corrections. Richard T. Smith is warden of the CCJ, and is the primary administrator of the CCJ. CFG Health Systems ("CFG"), a private medical care provider, has provided medical and mental health services at the CCJ since 2013. On June 27, 2017, the Cumberland County Board of Freeholders approved a resolution allowing the county's Improvement Authority to build a new jail that would replace the CCJ. That 100,000-square-foot jail was scheduled to be completed in 2020, but completion was delayed until 2022 due to last-minute design changes. In September 2020, the county announced plans to abandon the new jail altogether. Citing declining inmate population and cost savings, the county has solicited and accepted proposals from several neighboring New Jersey counties to transfer and indefinitely house CCJ inmates at other jails. According to the proposal, the county would transfer inmates currently at the CCJ to one or more nearby jails, and incoming inmates would come to the existing CCJ for booking, intake screening, and limited detention pending transfer. These plans have not been finalized, and may face additional delay due to litigation from parties opposed to the closure plan. Thus, the county continues to house inmates at the existing CCJ facility that was the subject of our investigation, under conditions that we have reasonable cause to believe do not meet constitutional standards, as described in this Notice.

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[1] The Department's third consultant, a corrections expert with experience in overseeing the design and construction of correctional facilities, was retained for the limited purpose of providing technical assistance concerning the new facility Cumberland County planned to build to replace its existing jail. This expert reviewed the proposed plans and other pertinent documents and provided feedback on those plans.

The CCJ experienced a string of six inmate suicides between July 2014 and May 2017 that prompted our investigation. All six deaths involved inmates who used opioids prior to their admission to the jail, and all six inmates were denied medication-assisted treatment (MAT) by the jail prior to their suicides.

MAT is treatment that uses Food and Drug Administration (FDA)-approved medications in combination with behavioral therapies, such as group and individual talk therapy, to treat opioid and other substance use disorders.[2] As discussed below, MAT is the standard of care to safely and effectively treat these disorders by reducing patients' opioid use, decreasing opioid-related overdose deaths, and improving treatment retention.[3] According to the American Society of Addiction Medicine, medication treatment for opiate withdrawal should include either an opiate agonist such as buprenorphine or methadone or an antagonist such as naltrexone.[4] These medications work by interacting with the opioid receptors on the surface of brain cells.[5]

We have reasonable cause to conclude that the CCJ failed to protect inmates from harm by not providing MAT to individuals at significant risk of harm from opioid withdrawal. The CCJ routinely employed a withdrawal protocol that departed from the accepted standard of care, one designed for alcohol—not opiate—withdrawal, placing individuals using opiates at the time of their booking into the CCJ at heightened risk for severe symptoms of withdrawal, including increased anxiety and depression that was a contributing factor in each of the six suicides from 2014 through 2017.

A seventh suicide occurred during our investigation in November 2018, one month after our facility inspection of the CCJ. Although we had advised the CCJ at the conclusion of our

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[2] Substance Abuse & Mental Health Servs. Admin. (SAMSHA), *Medication-Assisted Treatment (MAT)* (Sept. 9, 2019), https://www.samhsa.gov/medication-assisted-treatment; Office of the Press Secretary, The White House, *Memorandum for the Heads of Executive Departments and Agencies: Addressing Prescription Drug Abuse and Heroin Use* (Oct. 21, 2015) at Appendix III, https://www.justice.gov/file/822231/download; National Sheriff's Association, *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* 5 (Oct. 2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

[3] Nat'l Inst. on Drug Abuse, *Effective Treatments for Opioid Addiction* (Nov. 2016), *available at* https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction. MAT is far superior to other options to treating Opioid Use Disorder, such as an opioid taper, and provides far more favorable results. *See* U.S. Dep't of Health and Human Servs., Office of the Surgeon Gen., *Facing Addition in America: The Surgeon General's Spotlight on Opioids* 23 (Sept. 2018), https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf ("[T]he research clearly demonstrates that opioid agonist therapy leads to better treatment outcomes compared to behavioral treatments alone.").

[4] Am. Soc'y Addiction Med., *ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* 6–9, https://www.samhsa.gov/sites/default/files/sites/default/files/opioid-addiction-asam-use-of-medications-in-treatment.pdf. *See also* Substance Abuse and Mental Health Servs. Admin., *Naltrexone*, https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone.

[5] Substance Abuse and Mental Health Servs. Admin., *Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence* 3, https://store.samhsa.gov/system/files/sma14-4852.pdf.

October 2018 site visit of our concerns about inadequate supervision of the holding cells where inmates undergoing withdrawal are housed, our review of this subsequent suicide raised serious concerns that the officer assigned to the withdrawal unit had not provided adequate supervision.

Since the November 2018 suicide, the CCJ has taken some steps to prevent similar deaths. The CCJ amended its initial booking screening form to include questions about thoughts of self-harm, and it has taken some steps to provide oversight of its medical contractor, as recommended by our consultants at the conclusion of our site visit.[6] In September 2019, the CCJ informed us that it had received one year's budgeted funding to begin providing MAT to inmates undergoing withdrawal from opiates, and it began providing MAT at the end of February 2020. CCJ then received a grant that funds its program to provide MAT until the end of 2020. CCJ officials acknowledge that they should continue providing medical and mental health services to inmates so long as the CCJ remains in operation. Yet, because they have been pursing plans to transfer inmates to neighboring counties, CCJ officials did not seek additional funding to provide MAT beyond the December 31, 2020 funding expiration until after a court order staying inmate transfers until at least February 2021. On January 1, 2021, the MAT program began operating under short-term funding that will sustain it through June 30, 2021. While the CCJ's nascent MAT program generally represents a positive step, these measures do not remedy all of the violations described in this Notice, and they do not provide assurance of a sustained remedy.

IV. CONDITIONS IDENTIFIED

The Department's investigation has uncovered facts that provide reasonable cause to conclude that conditions at the Cumberland County Jail violate the Constitution. In particular, the Department has reasonable cause to believe that the CCJ fails to take constitutionally adequate measures to prevent inmate suicides and provide adequate mental health care. The Department also has reasonable cause to conclude that these violations occur pursuant to a pattern or practice of resistance to the full enjoyment of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

The majority of inmates housed at the CCJ are pre-trial detainees, but the jail also holds convicted defendants sentenced to short terms of imprisonment. "A person lawfully committed to pretrial detention has not been adjudged guilty of any crime." *Bell v. Wolfish*, 441 U.S. 520, 536 (1979). Although "the Government concededly may detain him to ensure his presence at trial," that person may not be subjected to "restrictions and conditions . . . [that] amount to punishment, or otherwise violate the Constitution." *Id.* at 536–37. Among the constitutional protections afforded pretrial detainees is the right to receive adequate medical care under the Due Process Clause of the Fourteenth Amendment. *Natale v. Camden Cnty. Corr. Facility*, 318 F.3d 575, 581 (3d Cir. 2003). In the Third Circuit, courts "evaluate the . . . Fourteenth Amendment claim for inadequate medical care under the standard used to evaluate similar claims brought under the Eighth Amendment." *Id.* at 581–82. Whether analyzed under the Eighth Amendment or the Fourteenth Amendment, the standard remains the same: prison officials violate an inmate's right to medical care by showing deliberate indifference to a serious medical need. *See id.* at 582.

[6] CCJ officials also invited the Department's feedback on its design plans for the proposed new jail that it has now decided not to build.

Of specific relevance here, the Eighth and Fourteenth Amendments prohibit prison officials from demonstrating reckless or deliberate indifference to inmates with a "particular vulnerability to suicide." *Woloszyn v. Cty. of Lawrence*, 396 F.3d 314, 320 (3d Cir. 2005). *See also Palakovic v. Wetzel*, 854 F.3d 209, 222 (3d Cir. 2017) (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)) ("[T]he vulnerability to suicide framework is simply a more specific application of the general rule set forth in *Estelle* . . . , which requires that prison officials not be deliberately indifferent to the serious medical needs of prisoners."); *Colburn v. Upper Darby Twp. (Colburn II)*, 946 F.2d 1017, 1023 (3d Cir. 1991) (explaining that "a 'particular vulnerability to suicide' represents a 'serious medical need'"). Thus, we examine whether officials are deliberately indifferent to detainees' risk of suicide "under the Due Process Clause of the Fourteenth Amendment that is essentially equivalent to the claim that a prisoner may bring under the Eighth Amendment." *Palakovic*, 854 F.3d at 223.

The Third Circuit has established a three-part test to determine officials' deliberate indifference to the risk of prisoner suicides:

> (1) that the individual had a particular vulnerability to suicide, meaning that there was a "strong likelihood, rather than a mere possibility," that a suicide would be attempted; (2) that the prison official knew or should have known of the individual's particular vulnerability; and (3) that the official acted with reckless or deliberate indifference, meaning something beyond mere negligence, to the individual's particular vulnerability.

Id. at 223–24. Pursuant to this test, the facts uncovered during our investigation give us reasonable cause to believe that the CCJ was and is deliberately indifferent to the risk of prisoner suicides, as evidenced by its failure to ensure MAT—the accepted standard of care—is provided to inmates with serious medical needs as clinically indicated, and by its failure to provide detainees constitutionally adequate mental health care.

As detailed below, the combination of numerous, specific and repeated violations of the Eighth and Fourteenth Amendments at the CCJ, taken together with multiple deficient policies and processes that caused or contributed to those violations, establish a pattern or practice of constitutional violations under CRIPA. To demonstrate a pattern or practice of violations, the Department must "prove more than the mere occurrence of isolated or 'accidental' or sporadic discriminatory acts." *Int'l Bhd. of Teamsters v. United States*, 431 U.S. 324, 336 (1977). Rather, it must "establish by a preponderance of the evidence that [violating federal law] was . . . the regular rather than the unusual practice." *Id.*, 431 U.S. at 336. *See also Hohider v. United Parcel Service, Inc.*, 574 F.3d 169, 178 (3d Cir. 2009) (reviewing the *Teamsters* standard that a pattern or practice focuses on "evidence that [the alleged] discrimination was the standard operating procedure" and "proof of the expected result of a regularly followed discriminatory policy") (alteration in original); *Equal Emp't Opportunity Comm'n v. Am. Nat'l Bank*, 652 F.2d 1176, 1187–88 (4th Cir. 1981) (citing *Teamsters* when explaining that a "cumulation of evidence, including statistics, patterns, practices, general policies, or specific instances of discrimination" can be used prove a pattern or practice).

A. CCJ Staff Acted with Deliberate Indifference to Inmates Experiencing Opiate Withdrawal and Particularly Vulnerable to Suicide By Failing to Provide Medication-Assisted Treatment.

For years, the CCJ acted with deliberate indifference to inmates' serious medical needs by categorically denying MAT to inmates with Opioid Use Disorder. Indeed, the CCJ failed to provide MAT until 2020—nearly two years after our investigation began. By failing to provide adequate medical care necessary to treat inmates' Opioid Use Disorder, the CCJ exhibited deliberate indifference to inmates's serious medical and mental health needs. *See Woloszyn*, 396 F.3d at 320; *Palakovic*, 854 F.3d at 222 (citing *Estelle*, 429 U.S. at 104); *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47–48 (D. Mass. 2018). Individuals with Opioid Use Disorder often experience debilitating symptoms when undergoing opioid withdrawal—including uncontrolled pain and psychological distress—that may trigger suicidal ideation, especially during the first week of incarceration, if not properly treated.[7] At the CCJ, inadequate treatment of opiate withdrawal contributed to several inmates' suicides. With respect to the seven suicides at the CCJ since 2014, at least six of those inmates were opiate users, and the evidence uncovered in our investigation suggests that those six inmates were experiencing opiate withdrawal at the time of their suicides.

1. *Opioid Use Disorder Is Prevalent Among Those Incarcerated.*

Opioids are a class of drugs that includes illicit substances, such as heroin,[8] and prescription medications,[9] such as hydrocodone, oxycodone, morphine, codeine, and fentanyl. While many opioid medications are prescribed to relieve pain, opioids also produce euphoria, which can trigger regular use that may lead to addiction, overdose, and death.

The misuse of opioids, including prescription drugs and heroin, is a public health crisis and national health emergency.[10] The death rate from prescription opioid misuse and heroin use

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[7] U.S. Food & Drug Admin., *FDA Identifies Harm Reported From Sudden Discontinuation of Opioid Pain Medicines and Requires Label Changes to Guide Prescribers on Gradual, Individualized Tapering*, https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes; Sarah Larney et al., *Opioid Substitution Therapy as a Strategy to Reduce Deaths in Prison: Retrospective Cohort Study* 7 (2014), https://bmjopen.bmj.com/content/bmjopen/4/4/e004666.full.pdf.

[8] Under the Controlled Substances Act of 1970, Pub. L. 91-513, heroin is classified at a Schedule I, found to have a high potential for abuse and no currently accepted medical use. *See* 21 U.S.C. § 812(b)(1); U.S. Dep't of Drug Enf't Admin., *Drug Scheduling*, https://www.dea.gov/drug-scheduling.

[9] Under the Controlled Substances Act, prescription opioids are generally classified as Schedule II drugs, as they have a high potential for abuse, potentially leading to severe psychological or physical dependence, and are currently accepted medical use in treatment in the United States. 21 U.S.C. § 812(b)(2); U.S. Dep't of Drug Enf't Admin., *Drug Scheduling*, https://www.dea.gov/drug-scheduling.

[10] Exec. Order No. 17384, 82 Fed. Reg. 16283 (March 29, 2017), https://www.gpo.gov/fdsys/pkg/FR-2017-04-03/pdf/2017-06716.pdf;.

is on the rise in all demographics across the United States. Indeed, nearly two-thirds of all overdose deaths involved the use of opioids. Cumberland County has one of the highest rates of opioid deaths in New Jersey, which has been battling a record-shattering spike in drug related deaths statewide, and the rate has continued to increase. In fact, the rate of opioid deaths in Cumberland County outstrips those at the state and national levels. In 2018, the number of people who died from opiate use in Cumberland County increased by more than 40 percent compared to 2017, and the rate of death was nearly as high in 2019.

Approximately 80 percent of jail and prison inmates have a history of substance abuse, and over two-thirds of jail detainees have a substance abuse disorder. Opioid Use Disorder, in particular, is prevalent in criminal justice populations. Strikingly, across the nation, 16.6 percent of state prisoners and 18.9 percent of sentenced jailed inmates self-report that they regularly used opioids before incarceration. In New Jersey, at least 25 percent of the incarcerated population is addicted to opioids. In contrast, under 9 percent of the general public has a substance abuse disorder.

2. ***Opioid Withdrawal, Left Untreated, Has Serious Medical Consequences for Inmates Including Increased Risk of Suicide.***

Individuals entering jails with substance abuse disorders face an increased risk of suicide during their incarceration. According to a review by the American Psychiatric Association, "[h]alf of all individuals who complete suicide in lockups and detention facilities have a history of substance abuse." Am. Psychiatric Assoc., *Psychiatric Services in Correctional Facilities* 38 (3d ed. 2016). "This number is likely an underestimate because of the limitations of screening procedures." *Id.* For many of these suicides, the causes "are related to complications of intoxication or withdrawal." *Id. See also* Nat'l Comm'n on Corr. Health Care, *Standards for Health Services in Jails* 104 (2008) (explaining that "withdrawal from opiates and depressant drugs (e.g., benzodiazepines) may be, on occasion, life threatening"). The correctional health community has observed that the suicide risks associated with substance abuse in a jail setting stem from poor management and treatment of withdrawal symptoms.

If not provided appropriate treatment, newly incarcerated inmates with substance abuse disorder can experience an extraordinarily painful and dangerous withdrawal. In the short term, while experiencing withdrawal symptoms, inmates face many negative health effects, which may include uncontrolled pain, psychological distress, suicidal ideation, and suicide attempts. The risk of death or other harm associated with withdrawal is particularly acute within the first days of incarceration. In the long term, if inmates do not receive adequate treatment for withdrawal during incarceration, they face an increased risk of relapse, overdose, and death upon release to the community. *See Smith v. Aroostook Cnty.*, 376 F.Supp.3d 146, 161 (D. Me. 2019) (citing, while finding irreparable harm to pretrial inmate on preliminary injunction motion, "[s]tudies in the United States and abroad [that] have observed that access to MAT during incarceration is associated with a decreased risk of post-release overdose death"). Moreover, failing to provide individuals with Opioid Use Disorder a long-lasting or injectable dose of medication, where

clinically indicated, places those inmates at increased risk of harm upon discharge. *See Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999) (holding that upon discharge, a "state must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient . . . during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply").

3. *Medication-Assisted Treatment Is the Standard of Care for Treating Opiate Withdrawal.*

CCJ knew or should have known that MAT is the standard of care for treating Opioid Use Disorder and for preventing serious harm from unmedicated withdrawals. The President's Commission on Combatting Drug Addiction and the Opioid Crisis recommends that prison and jail officials offer MAT to inmates,[11]as does the National Commission on Correctional Health Care.[12] The Bureau of Prisons Clinical Practice Guidelines for Detoxification of Chemically Dependent Inmates similarly recognizes medical detoxification, which may include methadone or buprenorphine, as the standard of care for opioid-dependent prisoners.[13] The National Sheriff's Association also recognizes using MAT as the standard of care to treat Opioid Use Disorder and has urged jail administrators to use MAT.[14] The World Health Organization and the American Psychiatric Association explicitly recommend MAT during incarceration.

The consensus among the medical community is clear: MAT is the standard of care for treating Opioid Use Disorder as it is far superior and more efficacious than other possible treatments.[15] The National Institute on Drug Abuse, the Substance Abuse and Mental Health Service Administration, the Centers for Disease Control and Prevention, the American Medical

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11 President's Commission on Combating Drug Addiction and the Opioid Crisis, Final Report, Nov. 1, 2017, at 32, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Meeting%20Draft%20of%20Final%20Report%20-%20November%201%2C%202017.pdf.

12 Nat'l Comm'n on Corr. Health Care, *Substance Use Disorder Treatment for Adults and Adolescents*, http://www.ncchc.org/substance-use-disorder-treatment-for-adults-and-adolescents.

13 Fed. Bureau of Prisons, Clinical Guidance: Detoxification of Chemically Dependent Inmates 15–16, https://www.bop.gov/resources/pdfs/detoxification.pdf.

14 Nat'l Sheriffs' Ass'n & Nat'l Comm'n on Corr. Health Care, *Jail-Based Medication Assisted Treatment, Promising Practices, Guidelines, and Resources for the Field* (Oct. 2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf

15 Am. Soc'y of Addiction Medicine, *ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* 6–9, https://www.samhsa.gov/sites/default/files/sites/default/files/opioid-addiction-asam-use-of-medications-in-treatment.pdf.; Michael Linden, Sam Marullo, et al., *Prisoners as Patients: The Opioid Epidemic, Medication-Assisted Treatment, and the Eighth Amendment*, 46 J.L. Med & Ethics 252, 260 (2018).

Association, and the American Academy of Pediatrics all recommend that medical providers use MAT to treat individuals undergoing opiate withdrawal.[16]

4. *The CCJ's Inadequate Treatment of Opioid Withdrawal Increases the Risk of Harm and Likely Contributed to Suicides at the CCJ.*

Despite the overwhelming consensus recognizing the importance of providing MAT to inmates, from at least 2014 through 2020, the CCJ had prohibited its medical staff from providing MAT. Medical staff at the CCJ confirmed that, even though "it was a good idea" to provide MAT to treat inmates' opioid withdrawal, CCJ's policies and practices prevented them from doing so—even where the inmate had been prescribed MAT by his or her physician before entering the jail. This general ban on providing MAT extended to the administration of long-lasting injectable medication for inmates with Opioid Use Disorders being discharged from the jail. Although the CCJ apparently appreciated and understood the efficacy of MAT because it provided MAT to opioid-addicted pregnant women entering the jail, it declined to provide MAT to any other inmates.

Until February of 2020, the CCJ placed inmates identified with Opioid Use Disorder on a withdrawal protocol when they entered the jail, but the treatment—which did not include MAT—did not effectively treat opiate withdrawal. The CCJ treated *opiate* withdrawal with a protocol designed to address *alcohol* withdrawal. Specifically, the CCJ administered Librium—a medication to treat alcohol withdrawal—regardless of the drug an inmate was using.

By failing to treat opiate withdrawal, the CCJ ignored the serious medical needs of inmates experiencing opiate withdrawal. In fact, this practice likely contributed to the death of several inmates who committed suicide. *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47–48 (D. Mass. 2018) (granting preliminary injunction and finding plaintiff likely to prove an Eighth Amendment violation where jail officials denied plaintiff's request for MAT). CCJ staff and inmates acknowledged to us that the withdrawal protocols in use at the time of our visit contributed to suicides or thoughts of suicide.

The following six inmates had used opiates at the time they entered the jail, but were all denied MAT. Because MAT is the standard of care, categorically denying MAT to inmates with Opioid Use Disorder is a failure to provide adequate medical care for this serious medical condition. Each of these inmates committed suicide shortly after arriving at the jail:

- <u>The Death of A.A.</u> A.A., a 31-year-old male opiate user died by suicide on July 30, 2014, eight days after arriving at the CCJ. During his medical intake screening, he stated that he was an opiate user. His family also confirmed that he had a long history of "narcotics addiction." He also had numerous previous incarcerations at CCJ for possession of heroin. Despite this, the CCJ did not

[16] *Id.*

provide him with MAT. Instead, staff members placed him on the alcohol withdrawal protocol. A.A. likely experienced symptoms of opiate withdrawal that contributed to his anxiety, poor decision-making, and ultimately his death.

- The Death of B.B.: B.B., a 25-year-old female heroin addict, committed suicide on March 22, 2015, two days after arriving at the CCJ. Although B.B. reported during her medical screening that she consumed 20 to 30 bags of heroin each day and that she was taking MAT prior to her arrival, the CCJ did not continue her MAT. The failure to continue MAT may have contributed to her suicide.

- The Death of C.C.: C.C., a 35-year-old heroin user, hanged himself on October 29, 2015, two days after arriving at the jail. While he did not disclose his use of opioids at intake, his mother called the jail during a previous incarceration one month earlier to report that he used heroin and was at risk for withdrawal. The CCJ's failure to prescribe MAT may have contributed to his death.

- The Death of D.D.: D.D., a 43-year-old inmate who reported opiate use upon admission to the jail, committed suicide on June 3, 2016, roughly two weeks after entering the jail. Specifically, D.D. reported taking Suboxone—an approved treatment for opiate withdrawal—to treat his previous use of Percocet. CCJ staff placed him on suicide watch, but they did not continue his use of Suboxone or provide any other MAT to treat his opiate use. CCJ staff observed symptoms typical of opiate withdrawal, including depression, anxiety, distress, lightheadedness, seizures, and suicidal ideation. Yet, not only did they fail to prescribe MAT, they barely provided any mental health treatment. His vital signs were not checked, though even CCJ's inadequate protocol requires this daily, and he received no mental health treatment other than antipsychotic medication while in a suicide watch cell for three days. Nothing about his treatment was modified even after he exhibited signs of withdrawal.

- The Death of E.E.: E.E., a 21-year-old female inmate, committed suicide on February 20, 2017, two days after admission to the jail. During the medical screening, E.E. reported daily use of heroin and Suboxone. A half-hour later, she reported severe psychological distress, anxiety, feelings of hopelessness, paranoia, and a previous suicide attempt. She also reported her substance abuse as she experienced symptoms of opiate withdrawal. Staff noted that C.C. had bruises and needle marks on her body. The CCJ did not provide her with MAT despite obvious symptoms of opiate withdrawal, and she was found dead with an orange jumpsuit tied around her neck the next day.

- The Death of F.F.: Four days after his admission to the CCJ, on May 23, 2017, F.F., a daily intravenous heroin user, hanged himself in his cell. He also exhibited symptoms associated with opiate withdrawal, including feelings of

hopelessness and anxiousness. Records show that the CCJ failed to continue F.F.'s psychiatric medications even after they were verified, and that they were later changed with no clear explanation. This, combined with the CCJ's failure to appropriately treat F.F. for his opiate withdrawal, likely exacerbated his symptoms of depression and anxiety and contributed to his death.

"Where prison authorities deny reasonable requests for medical treatment, . . . and such denial exposes the inmate 'to undue suffering or threat of tangible residual injury,' deliberate indifference is manifest." *Monmouth Cnty. Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 346 (3d Cir. 1987) (quoting *Westlake v. Lucas*, 537 F.2d 857, 860 (6th Cir. 1976)). "[P]rison officials may not, with deliberate indifference to the serious medical needs of the inmate, opt for 'an easier and less efficacious treatment' of the inmate's condition." *Palakovic*, 854 F.3d at 228 (quoting *West v. Keve*, 571 F.2d 158, 162 (3d Cir. 1978)).

By denying MAT to inmates entering the jail, the CCJ acted with deliberate indifference to the serious medical needs of many inmates experiencing opiate withdrawal. *Pesce*, 355 F. Supp. 3d at 47–48 (granting preliminary injunction and finding plaintiff likely to prove an Eighth Amendment violation where jail officials denied plaintiff's request for MAT).

Following the Department's October 2018 site visit, the CCJ applied for grants to fund a program to provide MAT to all inmates who were experiencing or risked experiencing withdrawal symptoms. After receiving grant funding, it began providing MAT on February 24, 2020. The County's grant for the MAT program continues to be time-limited, and now continues through June 30, 2021. While the CCJ informed us that they are applying for a grant to fund the program beyond June 30, 2021, the funding to continue providing MAT to inmates remains uncertain.

B. Poor Screening, Classification, and Suicide Prevention Protocols Demonstrate the CCJ's Deliberate Indifference to Inmates at Heightened Risk of Self-Harm.

1. *The CCJ's Screening Process is Ineffective in Identifying Inmates with Mental Illness and at Risk of Suicide.*

The CCJ employs a bifurcated inmate screening procedure that does not adequately screen prisoners for suicide risk and serious mental illness. Upon booking at the jail, arrestees first undergo an intake screen conducted by a correctional officer assigned to the booking area ("booking officer"). During an observed intake, we saw the booking officer standing about 12 feet away from the detainee and, with rapid-fire questioning, running down the list of questions on the officer's intake screening form. None of the 15 questions on the booking officer's form included any inquiry of the detainee's current thoughts of suicide or self-harm, past suicidal ideation, or suicide attempts. Consequently, booking officers did not capture critical information about an incoming detainee's risk of suicide or self-harm. Even after revision, the booking officer's form still fails to include any inquiry of the detainee's substance use disorder or any recent drug or alcohol use that might indicate risk of harm from withdrawal.

After booking, arrestees undergo a second screen conducted by one of the nurses, usually within 8 hours of the booking officer's screen. Unlike the booking officer's screen, the nurses' screen contains clinically appropriate and relevant questions about prior psychiatric hospitalizations, recent substance use, psychotropic medications, and suicidal thoughts. Nurses do not, however, have access to a detainee's previous CCJ health record when performing intake screenings even though many detainees have had prior admissions to CCJ. As a result, every time a person is booked, a nurse performs a new screen with no access to information from that detainee's previous incarcerations to verify the detainee's responses to questions about prior substance use, withdrawal history, mental health history, or suicidal risk factors. For example, one of the detainees who committed suicide at the CCJ had a documented history of opiate use and a prior suicide attempt in his medical chart from an earlier detention, but during the nursing intake screen for his last detention, the detainee reported no medical problems, substance use, or mental health problems. There is no indication that the nurse conducting the most recent screen knew of the detainee's prior history of opiate use and suicidality in the medical chart, which contradicted his denials. Upon completion of this screen, CCJ staff cleared the detainee for placement in general population that same day and he was found hanging from a bed sheet less than 48 hours later.

2. *CCJ Staff Fail to Properly Classify and House Inmates with Mental Illness and at Risk of Suicide.*

Even in instances when the CCJ has received information indicating suicide risk factors, CCJ's classification process does not account for an inmate's mental health status and need for treatment when it makes housing decisions. As evidenced by the string of suicides at the CCJ from 2014 through our investigation, these failures continue to place inmates at risk of harm.

According to CCJ policy, "[i]nmates known to have mental health issues . . . will be housed according to health standards" and "[m]edical/mental health personnel shall be a primary part of this decision making process." In practice, however, classification at the CCJ relies heavily on an inmate's current charges, with no consideration of whether that inmate receives mental health care or poses a suicide risk. The CCJ also appears to lack a formal process for placing and reviewing inmates in protective custody. Indeed, it became clear during our site visit that security staff often did not know which inmates received mental health treatment and which inmates had attempted suicide in the past. Moreover, the classification process takes several days to complete; until then, the CCJ houses inmates of all classifications in the holding cell. This goes against accepted correctional practice to separate inmates of different classifications.

The inadequacies in the CCJ's classification process have a particularly negative impact on the housing of inmates with mental illness or at risk of suicide. The CCJ lacks special housing for inmates with heightened mental health needs. Perhaps most concerning, the institution makes no provision for female detainees with mental health issues other than assigning them to cells located inside a caged area within the female unit.

3. *The CCJ's Suicide Watch Policies and Practices Expose Prisoners to Harm.*

The CCJ also exposes prisoners to serious harm by implementing its suicide watch policies in a manner that deters inmates from reporting suicidal thoughts. CCJ staff also fail to provide adequate supervision of inmates on suicide watch, a factor in at least two of the suicides at the CCJ.

a. *Unnecessarily Harsh Conditions on Suicide Watch*

Suicidal inmates are essentially stripped naked and kept in an empty cell, without any meaningful access to treatment other than a brief assessment by a mental health professional that does not even occur daily. CCJ policies state that inmates found at risk of suicide can be placed on one of three levels of suicide watch by medical, mental health, or custody staff. Generally, when an inmate is placed on Level 1 Watch (1-on-1 constant observation) and Level 2 Watch (enhanced observation with monitoring on irregular 15-minute intervals, with the option for constant observation), CCJ staff remove the inmate's standard-issue clothing and bedding and replace them with a one-piece green velcroed jumpsuit (colloquially referred to by staff and inmates as a "turtle suit") and a rubber sleeping mat. Suicide cells are approximately five by nine feet in dimension, with a narrow "window" in the solid steel cell door, and a camera for observation. Unlike inmates in protective custody, who may come out for an hour per day to shower, inmates on suicide watch are prohibited from showering. One correctional officer advised that inmates on suicide watch face severe restrictions on items that they may have in the cell. In addition to clothing, toiletry items are prohibited, and even toilet paper is disallowed. Inmates on suicide watch have to request toilet paper from the correctional officer, who tears the paper off the roll and hands it to the inmate. One staff member admitted witnessing incidents where a nurse or correctional officer placed inmates on suicide watch with malice and for non-mental health reasons. Even if the CCJ intends for these measures to reduce suicide risk, in practice, these harsh conditions undermine this goal by deterring inmates from reporting suicidal thoughts.

During our site visit, a number of inmates reported that they would rather keep suicidal thoughts to themselves than endure the stark conditions of the jail's suicide watch status. These inmates related that they generally avoided seeking mental health help because they "did not want to be in a turtle suit." In the words of one inmate, "[t]he image of people in turtle suits is the reason people don't want to talk" to mental health staff. Indeed, several inmates told us that they actually declined to share information about their mental health history or suicidal thoughts because they feared that staff would put them on suicide watch. As one inmate put it, "If you want to commit suicide, you're not going to tell anyone about it. They'll torture you. It's a punishment-it's not helpful. They treat you like an animal. It's not help. It's torture." Rather than help treat mental health concerns or prevent suicide, CCJ's management of suicidal prisoners may actually be counter-productive, deterring inmates from seeking mental health care when necessary.

b. *Inadequate Mental Health Treatment on Suicide Watch*

Inmates placed on suicide watch do not receive meaningful access to mental health treatment. Although CCJ's policies require a mental health provider to assess each inmate on suicide watch on a daily basis, in practice these assessments do not occur every day, and inmates

at the CCJ often go several days without seeing a mental health provider when they are on suicide watch. Medical records for two inmates who committed suicide at the CCJ show that these inmates did not receive daily evaluations from a mental health provider while on suicide watch. CCJ staff make no attempt to provide any therapy, counseling, or other psychosocial interventions for those identified as suicidal, other than distribution of previously-prescribed medicine. Prisoners on suicide watch usually get nothing more than a brief, cell-front assessment of their current suicidality by a mental health professional that does not always occur on a daily basis. As a result, suicidal prisoners—who do not receive any psychosocial treatment—languish in their bare cells until they simply stop saying that they are suicidal.

In one notable example, inmate H.H. had two incarcerations at the CCJ in 2018 during which he repeatedly engaged in acts of self-harm that included biting off part of his arm and chewing the inside of his lip. After a month-long admission to a psychiatric hospital, where he was diagnosed with a serious mental illness, H.H. was re-admitted to the jail and placed on suicide watch. Within a week and while on suicide watch, H.H. once again bit the inside of his mouth until he had caused a significant enough laceration to warrant a crisis referral to the emergency department. In the emergency department, H.H. stole a bottle of isopropyl alcohol from a cart and ingested the contents, causing respiratory failure and altered mental status until he returned to the CCJ six days later. At that point, CCJ staff again placed H.H. on suicide watch, where he continued to engage in self-injury until the medical chart notes end a week later. Throughout this entire time, there is no evidence in the medical charts indicating that H.H. received counseling, therapy, or other psychosocial intervention that would, for example, help him understand his self-injurious behavior or give him coping strategies to tolerate distress without engaging in self-harm.

c. *Inadequate Supervision of Inmates on Suicide Watch*

In a number of instances, CCJ staff have failed to adequately monitor inmates placed on suicide watch. Indeed, two in the string of suicides at the CCJ occurred while those inmates were on suicide watch. The details concerning these deaths are set out below.

- Inmate C.C. was on suicide watch in A-pod at the time of her suicide. The correctional officer coming onto the unit at shift change did not find the officer from the previous shift at the unit's post. The officer to be relieved came out from another inmate's cell, gave the oncoming officer a brief report with no mention of C.C.'s condition, and left the unit. C.C. was found hanging in her cell minutes later, while the second officer was starting unit rounds.

- Inmate D.D. was on Level-2 suicide watch at the time of his suicide. Although the correctional officer's log reported 15-minute checks, including up to 10 minutes before D.D.'s death, evidence indicates that correctional officers falsified these records. After these officers were charged with tampering and third-degree endangering another person, they resigned from their positions and agreed to forfeit any future public employment in New Jersey as a condition of entering a pre-trial intervention program.

That inmates were able to commit suicide while on suicide watch indicates deficiencies in the supervision of inmates on suicide watch. First, there are several important discrepancies in supervision requirements between CCJ's mental health and custodial policies. The CCJ's mental

health policy provides that Level 1 watch requires 1-on-1 constant observation by a custody staff, but CCJ's policy states that Level 1 watch only requires 15-minute checks. Similarly, with respect to Level 2 watch, the CCJ's mental health policy requires irregularly-timed checks within every 15-minute interval, but the custody policy provides that Level 2 watch requires checks in 30-min intervals that are not irregularly timed. These inconsistencies between the two suicide watch policies in the type, duration, and frequency of correctional officers' observation of inmates create confusion and exploitable gaps in the supervision of inmates. They also undermine the CCJ's ability to hold correctional officers accountable for failing to properly supervise inmates on suicide watch.

These inmate suicides also indicate that suicide watch cells at the CCJ were not suicide resistant, but had exposed anchor points from which inmates in distress were able to hang themselves. *See* Lindsay M. Hayes, *Checklist for the "Suicide-Resistant" Design of Correctional Facilities*, National Center on Institutions and Alternatives (2011), http://www.ncianet.org/wp-content/uploads/2015/05/Checklist-for-the-%E2%80%9CSuicide-Resistant%E2%80%9D-Design-of-Correctional-Facilities.pdf (explaining that "all cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts").

C. Systemic Deficiencies in CCJ's Mental Health Services Continue to Place Prisoners at Risk of Harm.

In addition to the CCJ's systemic problems with screening, classification, implementation of suicide watch, and treatment of drug and alcohol withdrawal noted above, the CCJ's mental health system has broader weaknesses. Even when staff identify prisoners with serious conditions, CCJ's mental health system does not provide adequate treatment because of inadequate staffing, inadequate staff coordination, and inadequate programs that place prisoners at risk of serious harm—including deteriorating mental health and, at worst, suicide. Our investigation found that the only mental health services provided at the CCJ are suicide risk assessment, basic diagnostic assessment, and medication prescriptions.

Although "[d]eference is given to prison medical authorities in the diagnosis and treatment of patients, ... there are circumstances in which some care is provided yet it is insufficient to satisfy constitutional requirements." *Palakovic*, 854 F.3d at 228. Prison officials act with deliberate indifference when they "opt for an easier and less efficacious treatment of the inmate's condition." *Id.* (internal quotation marks omitted). Indeed, "the quality of psychiatric care one receives can be so substantial a deviation from accepted standards as to evidence deliberate indifference to those serious psychiatric needs." *Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996). Furthermore, "systemic deficiencies" in a facility's mental health system may demonstrate deliberate indifference to serious mental health needs. *See Palakovic*, 854 F.3d at 228–29 (finding alleged deficiencies such as "a fragmented mental healthcare program with insufficient staffing and poor diagnostic procedures," sufficient to state a claim of deliberate indifference). The information uncovered during our investigation gives us reasonable cause to believe that the inadequacies in the CCJ's mental health system evidence officials' deliberate indifference to prisoners' serious mental health needs and the risk of prisoner suicides.

1. ***Inadequate Mental Health Staffing***

Inadequate mental health staffing is a central issue affecting all other deficiencies in the CCJ's mental health system. Cumberland County has contracted with CFG Health Systems, LLC ("CFG") to provide medical and mental health services at the CCJ. CFG's staffing matrix outlines a staffing plan for mental health services that on its face fails to meet its contract requirements. In its contract, CFG agreed to provide a psychiatrist 8 hours per week; a psychologist 16 hours per week; a psychiatric advanced practice nurse (APN) for 24 hours per week; and an on-call psychiatrist 24 hours, 7 days per week. Notwithstanding this, CFG's staffing matrix only provides for 4 total psychiatry hours per week, 12 total psychology hours per week, and 16 total psychiatric APN hours per week.

Our investigation revealed that not only does CFG fail to meet the contracted staffing hours, it also does not satisfy the reduced hours identified in its own staffing matrix, resulting in a level of staffing inadequate to meet the needs of the jail. The psychiatric nurse practitioner receives a list 15-20 patients per day, plus another 4-8 patients on suicide watch, for a total of 19-28 patients, to evaluate and assess during her 6-8 hour shift. This task would prove difficult even for the most efficient clinician, and it was not being completed at the CCJ. As a result, inmates on the list who the nurse practitioner could not see were carried over to the next day's list in the hope they would see the provider scheduled the next day. Consequently, inmates referred for evaluation may often wait several days to see a mental health provider, placing them at risk of harm from untreated mental illness or medication problems in the interim.

Although CFG's proposal for services states that a psychiatrist is on-call 24/7, and that practitioners available by telepsychiatry will fill staffing gaps and perform crisis assessments, we found no evidence that the CCJ had actually implemented this plan. To the contrary, our investigation revealed that the telepsychiatrist worked only for four hours on Thursday mornings, and after hours he only responded to telephone calls for medication orders.

2. ***Haphazard and Deficient Treatment of Prisoners with Mental Illness***

Mental health care at the CCJ is haphazard, incomplete, and woefully deficient. Staffing deficiencies at the CCJ factor into a failure to see inmates at clinically appropriate intervals, failure to provide any individualized treatment plans for prisoners with serious mental disorders, and lack of meaningful therapeutic interventions.

Because the mental health staff at the CCJ is so sparse, it is not uncommon for inmates with serious mental health needs to wait months for the next scheduled follow-up visit and to see a different mental health professional at each visit, leading to poor continuity of care. Systemic deficiencies or non-medical reasons that result in delay of necessary care constitutes deliberate indifference. *See Monmouth Cnty. Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987) (explaining that deliberate indifference may be found where procedures "result in interminable delays and outright denials of medical care").

In one example of delay and poor continuity of care, I.I., an inmate who was booked into the CCJ directly from a psychiatric hospital, was not scheduled for a psychiatrist appointment for

over a month after his booking. At the time of that appointment, I.I. refused. He did not see the psychiatrist until almost two months after his admission to the jail. Although the medications prescribed at the psychiatric hospital were continued during this time, when I.I. finally met with the psychiatrist, he reported ongoing psychotic and mood symptoms. His chart then reveals sporadic notes, by different clinicians and usually containing a different diagnosis, over the next several months. Ultimately, I.I. refused all medications and had become so psychotic by the time of our onsite visit that he was referred back to the psychiatric hospital for treatment.

Treatment plans are an important part of providing care to inmates, particularly those with special health needs. *See Braggs v. Dunn*, 257 F.Supp.3d 1171, 1206 (M.D. Ala. 2017) ("Treatment planning is the foundation of all forms of health care . . . . [and] is particularly important in the prison context, where prisoners have almost no ability to ensure the consistency of their own treatment[.]"). The failure to provide treatment plans is one component of a constitutionally deficient system of mental health care. *Id.* at 1267 (concluding that one "contributing factor[] to the inadequacies found in [Alabama Department of Correction's] mental-health care system" was "[f]ailing to provide individualized treatment plans to prisoners with serious mental-health needs"). At minimum, mental health treatment plans "should include the frequency of follow-up for medical evaluation; adjustment of treatment modality as clinically indicated; the type and frequency of diagnostic testing and therapeutic regimens; instructions for diet, exercise, adaptation to the correctional environment and medication; and clinical justifications for any deviation from the protocol."[17] Even though CFG's written policy for services at the CCJ requires medical staff to create individualized treatment plans for inmates with mental health needs that must be documented in the medical record, in practice, mental health treatment plans are non-existent at the CCJ. None of the medical records we reviewed contained a note that, even generously interpreted, could qualify as a treatment plan. Instead, charts routinely showed diagnostic or medication changes from one visit to another and from one provider to the next without explanation for the changes and no coherent plan of treatment that can be discerned.

Even more important, there is no meaningful therapy or psychoeducation at the CCJ. CFG providers order therapeutic interventions, such as Cognitive Behavioral Therapy or sex offender counseling, that the jail simply does not provide. This runs counter to standards that "define[] mental health services as the use of a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological and social, to alleviate symptoms, attain appropriate functioning and prevent relapse," and which dictate that "[m]ental health treatment is more than prescribing medication."[18]

3. *Inappropriate Restraint of Prisoners in Behavioral Health Emergencies*

We uncovered numerous cases in which CCJ officers handled mental health emergencies by improperly resorting to the use of restraints, particularly by restraining inmates for too long

[17] Nat'l Comm'n on Corr. Health Care (NCCHC), *Standard G-04 Basic Mental Health Services (essential)*, https://www.ncchc.org/spotlight-on-the-standards-24-3 (internal citation omitted).

[18] *Id.*

without proper assessments, and failing to refer inmates to medical and mental health professionals at the jail, who could provide appropriate treatment or transfer the inmates to a hospital for further psychiatric care. In one case, R.R. informed officers that he was having suicidal thoughts. A few minutes after R.R. was placed on suicide watch, he lashed out against an officer, punching him several times. In response, staff extracted R.R. from his cell and placed him into the restraint chair for the next eight hours. R.R.'s records contain no indication that he ever received an evaluation from by a mental health professional, even though the incident occurred while he was on suicide watch. The only time any medical personnel saw R.R. occurred when he underwent an initial check of circulation after placement in restraints, but there was no further medical involvement during the entire eight-hour restraint. Although the records lack any information as to when and how the restraint ended, R.R. was apparently transferred to a community crisis center for care. Upon his return to the jail two days later, R.R. was again placed in the restraint chair for "attempting to harm himself," with no documentation of specifics in the accompanying incident report.

In another case, S.S., an inmate with a history of suicidal ideation who had been placed in the restraint chair for self-harm just a few weeks before, was again placed in a restraint chair for over 10 hours. The suicide watch form states that S.S. was being placed in the restraint chair due to "inmate hearing voices to hurt himself." Despite the length of time S.S. spent in restraints, key documentation is missing; there are no forms indicating whether staff performed medical checks or any other reviews on S.S. during the entire 10 hours he was in restraints.

These examples illustrate the problem at the CCJ with improperly using restraints to manage behavioral health emergencies. "[C]ourts have found that continued restraint . . . , without legitimate purpose, can state a constitutional violation. *Walker v. Owens*, No. 7:13cv00425, 2015 WL 1417070, at *4 (W.D. Va. 2015) (citing cases). After guards place a prisoner in restraints and "the immediacy of the disturbance [i]s at an end," continued use of restraints "throughout a prolonged time period clearly supports an inference that the guards were acting to punish, rather than to quell the disturbance." *Williams v. Benjamin*, 77 F.3d 756, 765 (4th Cir. 1996). *Cf. Turner v. Frey*, 166 F.3d 1215, 1998 WL 787080, at *3 (6th Cir. 1998) (per curiam) (finding no deliberate indifference where prisoner was placed in restraints "at the direction of the on-site medical officer," was "monitored throughout the night," and after a break, guards reapplied restraints "under the supervision of [the] [n]urse . . . follow[ing] the directions of the medical staff at all times").

4. *Minimal Access to Higher Levels of Mental Health Care*

The CCJ fails to provide access to higher levels of mental health care for those inmates who need it. Although the CCJ's healthcare provider has committed to working with community providers to provide urgent and emergent treatment, as well as in-patient psychiatric hospitalization in acute psychiatric cases, in practice it simply does not occur. Both the warden and psychiatric APN note that crisis services are slow to respond when called, and the crisis services personnel often do not leave notes in the chart or otherwise communicate with the jail healthcare staff about the plan for a patient. As a result, many inmates in need of a higher level of psychiatric care remain stuck at the jail, where they receive minimal, if any, treatment other than medication and languish in a suicide watch cell.

5. *CCJ Policy Denies Mental Health Professionals Clinical Autonomy*

The CCJ subjects prisoners to serious harm by preventing mental health professionals from exercising their discretion in making appropriate clinical decisions regarding prisoners on suicide watch. Mental health staff at the CCJ reported that they are given no discretion in how long an inmate remains on suicide watch and are compelled to keep an individual on watch for at least 48 hours at each suicide watch level before moving them to a less restrictive "stepdown watch," regardless of the clinician's recommendations. This results in inmates remaining on a more restrictive level even if the clinician believes the inmate no longer needs to remain on that level, which indicates that the restraint is no longer for medical necessity, but rather are punitive. If the jail employed sufficient mental health staff to assess suicidal inmates and follow up with them frequently after they were removed from suicide watch, such rigid policies would not be necessary.

In addition, we found cases where custody staff explicitly overrode the recommendation of mental health professionals regarding removal of an inmate from suicide watch. In one example, a psychiatric nurse practitioner evaluated a male inmate and "cleared" him from suicide watch based on that evaluation. Still, the warden overrode this decision and kept the inmate on suicide watch because he felt there was still a risk of suicide.

6. *Poor Coordination between Mental Health and Custody Staff*

Mental health and custody staff poorly coordinate with respect to inmates requiring mental health care. In particular, the CCJ lacks systems to ensure that custody staff consider mental health status when making inmate classification decisions and reviewing disciplinary infractions. In fact, CCJ's classification system has no place to include an indication that an inmate is on the mental health roster. Additionally, a CCJ officer who regularly reviews and investigates disciplinary infractions reported that he typically does not know whether the inmate receives mental health care, and custody staff do not routinely check with medical personnel before the adjudicating committee decides the inmate's guilt or sentence. This is consistent with inmates' reports that no disciplinary officer had ever inquired about mental health factors when deciding their punishment. As a result of this failure, inmates with mental illness are at risk of being punished for behavior that is a manifestation of their mental illness.

7. *Deficient Quality Assurance and Contract Oversight*

Although CFG policy outlines a robust system of continuous quality improvement (CQI) that includes quarterly meetings of the health services administrator, director of nursing, mental health director, and jail leadership, we were provided with no documentation—despite numerous document requests—that would confirm the occurrence of these activities at the CCJ (*e.g.*, minutes of the meetings, as per CFG policy). CFG policy further dictates that minutes from the CQI meetings will be reviewed in medical/mental health staff meetings. Yet, because CCJ's mental health providers are never on site at the same time, it is highly unlikely that any meaningful staff meetings or quality assurance meetings/initiatives are actually being undertaken. Finally, even though CFG policy provides that mortality reviews will identify

specific timelines and individuals responsible for corrective action plans, we found no such information in any of the mortality reviews we received.[19]

CCJ's quality assurance program contains another major overarching blind spot: compliance oversight of its health services contractor, CFG. During our investigation, we uncovered many circumstances where CFG's program on paper (via contracts, statements of work, policies and procedures) differed greatly from its actual practices. Where, as here, ultimate responsibility for ensuring constitutionally adequate health care for inmates falls on the correctional facility, that facility must provide meaningful oversight of its health services provider to ensure that these services are being provided. Although the CCJ retained an outside medical doctor to perform quarterly reviews of CFG's performance, the two quarterly reports received demonstrate only cursory reviews that simply reiterate statements made by CFG regarding its own performance with minimal outside verification.

V. MINIMAL REMEDIAL MEASURES

To remedy the constitutional violations identified above, Cumberland County should promptly implement the following minimum remedial measures:

1. Ensure that all initial screenings are performed by staff who are trained to identify medical and mental health needs and that appropriate care is taken to accurately record a prisoner's current medications, any history of treatment or hospitalization, and any previous or current substance use.

2. Ensure that comprehensive health assessments of all prisoners are conducted within 14 days of their arrival, with a psychiatrist conducting the mental health screening or overseeing registered psychiatric nurses who conduct the screening.

3. Ensure that treatment is immediately provided to prisoners who are suicidal or psychotic, as soon as those conditions are known.

4. Ensure timely access to mental health professionals when the prisoner is presenting symptoms requiring mental health care.

5. Ensure that medication assisted treatment is immediately provided to prisoners who have been identified as having or potentially having Opiate Use Disorder at time of admission. Ensure timely access to medical and mental health professionals when the prisoner exhibits symptoms of withdrawal.

6. Ensure that all reasonable efforts are made to obtain a prisoner's prior mental health records from prior jail admissions and from community services boards or other community providers. Ensure that this information is incorporated into prisoners' medical charts.

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[19] The CCJ was unable to provide CFG's mortality reviews for all inmate deaths by suicide.

7. Ensure that appropriate, detailed treatment plans are developed for prisoners with serious mental health needs, and implement procedures whereby treatment plans are regularly reviewed to ensure they are being followed.

8. Ensure that all prisoners with serious mental health needs receive clinically appropriate therapy and counseling.

9. Ensure a mental health inpatient level of care is available to all prisoners who need it, including regular, consistent therapy and counseling, as clinically appropriate.

10. Ensure that discussions about treatment between mental health professionals and prisoners can be conducted in a confidential, clinically appropriate setting to allow for effective information sharing and treatment.

11. Ensure that adequate psychiatry coverage and psychiatry support staff is provided in order to timely address prisoners' serious mental health needs.

12. Ensure clinically appropriate medication administration practices, including psychiatric follow-up assessments with prisoners on any new psychotropic medications or dosage changes; timely and correct administration of medications, including to prisoners on lockdown status; and regular auditing of medication administration records for completeness and accuracy.

13. Ensure that suicidal prisoners receive the level of care and housing classification appropriate to their acuity, as determined by a mental health professional.

14. Ensure that suicidal prisoners receive adequate mental health treatment and follow-up care, including out-of-cell counseling as determined by a mental health professional.

15. Ensure that an order of "constant watch" observation results in staff having an unobstructed view of the prisoner at all times. Also, ensure that any staff member conducting "constant watch" observation has no other duties to complete during the time they are conducting the watch.

16. Ensure that suicidal prisoners are provided quality, private suicide risk assessments on a daily basis.

17. Ensure that the Jail's quality assurance program includes complete morbidity/mortality reviews of all inmate deaths, attempted suicides, or other sentinel events, and is adequately maintained, and identify and correct deficiencies with the mental health care system.

18. Ensure that prisoners with serious mental illness, including Opioid Use Disorder, are provided discharge or transfer planning services, especially services for prisoners in need

of further MAT at the time of transfer to another institution or discharge to the community. These services should include the following:

a. Arranging an appointment with community providers for all prisoners with serious mental illness, including Opioid Use Disorder, and ensuring, to the extent possible, that prisoners meet with that community provider prior to or at the time of discharge to facilitate a warm hand off;

b. Providing referrals for prisoners with Opioid Use Disorder who require ongoing MAT post-release;

c. Notifying reception centers at state prisons when prisoners with Opioid Use Disorder are going to arrive;

d. Arranging with local pharmacies to have prescriptions for prisoners with Opioid Use Disorder renewed to ensure that they have an adequate supply of any prescriptions that form part of their MAT to last through their next scheduled appointment.

e. Providing, as clinically indicated, a long-lasting or injectable dose of medication [e.g., Vivitrol] for individuals with Opioid Use Disorder.

VI. CONCLUSION

The Department has reasonable cause to believe that the CCJ has engaged in a pattern or practice of violating rights protected by the Eighth and Fourteenth Amendments because it fails to provide prisoners with constitutionally adequate medical and mental health care or to take reasonable measures to prevent inmate suicides. We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if State officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this letter. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this letter is a public document. It will be posted on the Civil Rights Division's website.