U.S. Department of Justice

Civil Rights Division

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

May 1, 2006

The Honorable Jim Doyle
Governor
State of Wisconsin
Office of the Governor
115 East State Capitol
Madison, WI 53702

Re: Investigation of the Taycheedah Correctional Institution

Dear Governor Doyle:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Taycheedah Correctional Institution ("Taycheedah"), in Fond du Lac, Wisconsin. On March 25, 2005, we notified you of our intent to investigate conditions at Taycheedah 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 of conduct that violates the constitutional or federal statutory rights of persons who are served in public institutions such as Taycheedah.

On May 16-18, July 18-21, and October 6-7, 2005, we conducted on-site inspections of Taycheedah with consultants in the fields of sexual misconduct prevention and correctional mental health care. While on-site, we interviewed administrative and correctional staff, mental health care providers, and inmates. Before, during, and after our on-site inspections we received and reviewed a large number of documents, including policies and procedures, clinical records, and other materials provided to us by Taycheedah staff. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we provided an extensive debriefing at the conclusion of each of our inspections, in which our consultants expressed their initial impressions and concerns. We appreciate the full cooperation we received from State and

Taycheedah officials throughout our investigation. We also wish to extend our appreciation to the administrators and staff at Taycheedah for their professional conduct and timely response to our requests.

Having completed our investigation of Taycheedah, we conclude that sexual misconduct prevention practices meet or exceed constitutional requirements. We commend Taycheedah for implementing policies and procedures aimed at preventing, minimizing, and detecting sexual misconduct, particularly the facility's development and dissemination of brochures for staff and inmates regarding sexual misconduct.

Based on our investigation, however, and as described more fully below, we conclude that certain conditions at Taycheedah violate inmates' constitutional rights by failing to provide for inmates' serious mental health needs. We detail our findings below.

I. BACKGROUND

Taycheedah is a state-operated, post-conviction facility that currently houses approximately 600 maximum and medium security female inmates. In 2002, Taycheedah expanded its physical plant to include a 64-bed mental health unit, a 64-bed segregation unit, and a 240-bed minimum security unit. In December 2004, the State of Wisconsin ("State") relocated the female inmates' Assessment and Evaluation Unit to Taycheedah. This 75-bed unit provides intake screening for all women entering the Wisconsin Department of Corrections.

II. FINDINGS

Prison officials have an affirmative duty under the Eighth Amendment to ensure that inmates receive adequate food, clothing, shelter, and medical care. Farmer v. Brennan, 511 U.S. 825, 832 (1994). Inmates' Eighth Amendment rights are violated when prison officials exhibit deliberate indifference to their serious mental health needs. See Estelle v. Gamble, 429 U.S. 97, 100-105 (1976); Maggert v. Hanks, 131 F.3d 670, 671 (7th Cir. 1997). Deliberate indifference may be inferred when the quality of care provided to inmates is "such a substantial departure from accepted professional judgement, practice, or standards as to demonstrate that the person responsible did not base the decision on such judgment." Estate of Cole by Pardue v. Fromm, 94 F.3d 254, 261-62 (7th Cir. 1996).

Taycheedah fails to provide inmates with mental health care that complies with these constitutional standards. We found that Taycheedah: 1) fails to timely and appropriately provide psychiatric treatment, including monitoring of psychotropic medications and performing laboratory tests; 2) fails to provide an adequate array of mental health services to treat its inmates' serious mental health needs; 3) fails to ensure that administrative segregation and observation status is used appropriately; 4) fails to ensure that mental health records are accessible, complete, and accurate; 5) fails to respond to medical and laboratory orders in a timely manner; and 6) fails to ensure that an adequate quality assurance system is in place.

A. Psychiatric Treatment

Taycheedah fails to provide sufficient mental health care staff to meet the inmates' serious mental health needs. See Wellman v. Faulkner, 715 F.2d 269, 274 (7th Cir. 1983) (understaffing of prison medical personnel and delays in treatment led to constitutionally inadequate care). Access to a psychiatrist is a basic constitutional requirement for correctional mental health care because a psychiatrist is necessary to address psychiatric emergencies and to provide ongoing evaluation for and ongoing monitoring of administration of psychotropic medications. Id.

Psychiatrist staffing at Taycheedah is grossly inadequate. Taycheedah employs only two part-time psychiatrists who carry a caseload of more than 400 patients at a time, which is well above the maximum recommended caseload, according to generally accepted standards. The care that Taycheedah's two psychiatrists are able to provide is further limited by the lack of adequate support staff, causing them to spend an inordinate amount of time searching for charts, looking for medication records, and handling other administrative functions.

As a result, inmates suffer from lack of treatment and are continually placed at risk of becoming a danger to themselves and others. For example, there are unacceptably long delays between the time inmates' mental health needs are identified and their initial visit with a psychiatrist. Further, when the psychiatrist is not at work, there is no one to fulfill her responsibilities. As a result, inmates with serious mental health needs are left untreated, sometimes for as long as several months, which causes them to suffer and puts them at risk of harm to themselves and others.

1. Failure to Appropriately Evaluate and Monitor Psychotropic Medications

Taycheedah fails to timely and appropriately evaluate inmates for the administration of psychotropic medications and monitor their continued administration. Many Taycheedah inmates require psychotropic medications to avoid the unnecessary suffering of acute episodes of mental illness. A physician, preferably a psychiatrist, is needed to evaluate whether psychotropic medications should be initiated and to evaluate the continued administration for proper dosage and effectiveness. See Wellman, 715 F.2d at 272-73. Generally accepted correctional mental health care standards require that a physician see a patient usually before, but clearly shortly after, a prescription for psychotropic medication is written. Patients who remain untreated, or who are treated without being seen by a physician, may suffer from a worsening of their symptoms, including suicidal and homicidal thoughts, or from the potentially lethal side effects of medication. Taycheedah consistently fails to follow this practice. Instead, inmates on psychotropic medications formerly prescribed by another facility continue to receive the medications without active monitoring by a physician of the consequences, effectiveness, or potential side effects.

For example, Inmate #13[1] was identified upon initial screening as having bipolar disorder, a mood disorder characterized by serious mood swings, impulsive behavior, suicidality and potential psychosis. On December 20, 2004, she was started on Lithium Carbonate, a mood stabilizer prescribed for bipolar disorder, by a nurse's order stating "per County Jail." The order was co-signed by a physician, but there was no indication that the physician ever saw the inmate. On February 23, 2005, the order for Lithium was renewed for three months. This order specifically stated "not seen," and was accompanied by a request for a "new psychiatry appointment," reflecting that the inmate had still not been seen by a psychiatrist. Based upon the date of the first psychiatry report, April 16, 2005, Inmate #13 was prescribed psychotropic medications but did not see a psychiatrist at Taycheedah until almost four months after she was admitted.

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[1] For the purposes of this letter, we identify all Taycheedah inmates by the number assigned to the inmates by the United States' mental health experts in their report. A key with the inmate names will follow under separate cover.

In another case, the intake screen for Inmate #19, dated February 16, 2005, indicated that she had a history of depression and anxiety attacks, and had been on numerous psychotropic medications in the past. Medication orders for Lexapro (an antidepressant) and Amitryptyline (also an antidepressant) were written by a nurse, "per health transfer summary," and co-signed by someone who might have been a physician. However, there was no indication that she had been seen by the physician. On February 22, 2005, the Lexapro was discontinued and Celexa (another antidepressant) was started. Again, there was no indication that a physician saw her, nor was there any notation reflecting why her medication was changed. On April 28, 2005, both the Amitryptyline and Celexa were renewed, with a note that clearly stated that she had not yet been seen by a physician. Based upon the date of the first psychiatry report, June 6, 2005, Inmate #19 was prescribed psychotropic medications but did not see a psychiatrist at Taycheedah until almost four months after she was admitted.

Inmate #15's intake screen, dated March 3, 2005, noted that she was previously diagnosed with bipolar disorder and had attempted to commit suicide numerous times. A medication order for Depakote (a mood stabilizer used for bipolar disorder) was written by a nurse, "per Racine County Jail." Again, while the order was co-signed by a physician, there was no indication that the physician actually saw the inmate. A doctor's order, dated June 6, 2005, stated, "please schedule new psychiatric evaluation, any psychiatrist," clearly indicating the physician's concern that the patient had not yet been evaluated by a psychiatrist. The first psychiatric note was dated June 10, 2005, more than two months after Inmate #15's admission to Taycheedah. While that note stated that she was to be seen for follow up in two weeks, as of July 2005, there were no further psychiatric notes in her chart. This indicates that Inmate #15 had been prescribed psychotropic medications but had not seen a psychiatrist for at least four months after her admission to Taycheedah.

Patients on psychotropic medications must be seen regularly by a physician, preferably a psychiatrist. As noted by our mental health consultants, generally accepted correctional mental health care practices require that a psychiatrist actively monitor the consequences, effectiveness, and potential side effects of psychotropic medications. Our mental health consultants further noted that gross delays between administering a psychotropic medication to an inmate and having the inmate see

a psychiatrist, such as the multiple four-month delays at Taycheedah, represent a significant departure from generally accepted correctional mental health care standards.

2. Failure to Appropriately Administer Psychotropic Medications

Taycheedah lacks sufficient nursing staff to meet inmates' serious mental health needs for long-term maintenance on psychotropic medications. Wellman, 715 F.2d at 272 (recognizing treatment of mental disorders, such as with psychotropic medications, as a serious medical need). Because there are too few nurses, many nursing functions, such as medication monitoring and documentation, are relegated to the correctional staff. The correctional staff is not trained to perform these functions, placing inmates' safety in jeopardy from dangerous errors and omissions.

One of the nursing functions that is being performed by the correctional staff is the distribution of medication and monitoring of potential adverse reactions or side effects. Taycheedah correctional officers informed us that they do not receive training on the potential adverse reactions or precautions that should be taken when distributing psychotropic medications. As a result, they would not be able to ensure that medication is taken properly or to identify the signs of potentially dangerous adverse reactions. For example, initial doses of antipsychotic medications can result in what is referred to as an oculogyric crisis, in which the patient's eyes roll back in her head and are stuck there. If the patient does not receive immediate treatment, the paralysis can progress down the airway and possibly lead to death from suffocation.

The nursing staff has also relegated the responsibility for completion of Medication Administration Records (MARs) to correctional officers. Nurses receive extensive and specific training on MARs. Relegating the responsibility for MARs to correctional officers who do not receive such training falls well below correctional mental health care standards. This issue is further explained below in subsection D.

B. Mental Health Services

Taycheedah fails to provide adequate mental health services to meet the serious mental health needs of its inmates. See Wellman, 715 F.2d at 272 (recognizing treatment of mental disorders of mentally disturbed inmates as a "serious medical need"); Balla v. Idaho State Board of Corrections, 595 F. Supp.

1558, 1577 (D. Idaho 1984) (mental health treatment must involve psychiatric and psychological counseling as well as psychotropic drugs). Taycheedah falls well below these standards through its failure to provide a minimal array of mental health programming, crisis services, and specialized treatment for inmates with acute mental illness.

1. Screening and Evaluation for Mental Illness

Staffing for psychologists at Taycheedah is insufficient to provide timely and systematic screening and evaluation for mental illness among inmates. Generally accepted correctional mental health care standards dictate that inmates be seen by a psychologist within 24 hours if they are acutely mentally ill, or within a week of admission, at the latest. Insufficient staffing in Taycheedah's Assessment and Evaluation Unit impedes the facility from having an adequate systematic intake assessment and triage process. The psychologist supporting intake assessments at Taycheedah is unable to see referred inmates for two to four weeks. Inadequate systemization of the intake and assessment process and delays in referrals put inmates who are in need of immediate attention at severe risk of harm to themselves and others.

2. Crisis Services

Taycheedah fails to provide adequate crisis services to adequately manage the psychiatric emergencies that occur among its inmates. We observed that a large number of Taycheedah's inmates are severely psychotic, imminently suicidal, or physically aggressive, due to decompensation of their conditions. Their decompensation is no doubt due, in part, to the lack of programming and use of segregation to control behaviors associated with their illnesses. We noted a large void in crisis services available to inmates, resulting in actual harm and significant risk of harm. As is typically the case where no other alternative exists, Taycheedah staff resort to the use of segregation and observation status to control inmates' dangerous behavior, which not only fails to solve the problem, but often exacerbates it.

Staff informed us that there are many instances when inmates require inpatient psychiatric care but do not receive it. Staff also stated that some inmates are housed in administrative segregation solely because their psychiatric symptoms are so severe that there is simply no other place to put them. Part of the problem is likely because there is only one psychiatric inpatient facility in the area where inmates are sometimes sent.

Staff acknowledge that this facility, known as the Winnebago Mental Health Institution ("Winnebago"), is often full to capacity and ill-equipped to handle the behavioral issues that arise when housing inmates. As a result, inmates in need of critical care remain at Taycheedah, where they do not get the care they need, and end up being placed in administrative segregation or observation status. This often leads to decompensation and further dangerous behavior. For example:

- On June 19, 2005, Inmate #58 fatally asphyxiated herself while in administrative segregation. This inmate was severely mentally ill, exhibiting almost daily incidents of aggression and self-injurious behavior, using virtually any property she could access to harm herself. She swallowed pen inserts and other solid objects, resulting in numerous trips to the emergency room. She went on periodic hunger strikes, during which she would refuse to ingest food and liquids for days at a time. This inmate had only recently returned to Taycheedah at the time of her death, after a long stay at Winnebago. She was discharged from that facility when it was determined that she could no longer benefit from the services and her behavior was too difficult to manage in the less secure environment.

Inmate #58 clearly needed an intensity of mental health services that the State was unable to provide given the current options for incarceration of seriously mentally ill female inmates.

- Inmate #51 has a very severe degree of mental illness and exhibits serious suicidal ideation. She has been back and forth between Winnebago and Taycheedah for over a year. Her behavior is difficult to manage in both facilities because of her serious attempts at self mutilation. She expressed her ability to manipulate both institutions when she stated, "I know what to do to get back to Winnebago." However, Winnebago staff members state that after significant attempts, they have no further treatment options that will improve her condition; thus, they send her back to Taycheedah. At the time of our second visit to Taycheedah, this inmate was under one-on-one supervision, while in observation status, to prevent her from hurting or killing herself. None of the staff members we spoke with regarding this inmate believe that she is receiving appropriate treatment, yet noted that they had no better alternative.

This inmate is also in need of therapeutic treatment, such as individual and group counseling, that Taycheedah does not presently offer.

Taycheedah's failure to provide alternatives to manage psychiatric emergencies is unacceptable. Not only does it jeopardize the safety of the inmates, but it creates a strain on existing resources due to the reoccurrence of dangerous behavior.

3. Acute Mental Illness

Taycheedah fails to provide adequate treatment to inmates with acute mental illness. Taycheedah operates its Monarch Special Management Unit ("Monarch") to provide specialized treatment to those inmates at Taycheedah with the most acute mental illnesses. We found, however, that this unit provides almost no programming and, as a result, the vast majority of inmates are unoccupied for most of the day. This lack of active treatment creates a high risk of exacerbating psychiatric symptoms and dangerous behavior, especially in inmates who are already in need of critical care.

Further, inmates in the segregation unit of Monarch receive no treatment except for medication. The Seventh Circuit has recognized that there is extensive medical and psychological literature establishing the harmful effects of isolation and segregation on mentally ill inmates. Scarver v. Litscher, 434 F.3d 972, 975 (7th Cir. 2006); Davenport v. DeRobertis, 844 F.2d 1310, 1316 (7th Cir. 1988). Despite the increased need for treatment of mentally ill inmates in segregation, those inmates do not even receive consistent psychotropic medication management, a most basic correctional mental health deficiency. See, e.g., Wellman v. Faulkner, 715 F.2d 269, 272 (7th Cir. 1983) (defendants' recognition that the most obvious serious deficiency of their medical system was the lack of access to psychiatric care). For example, Inmate #43 told us that when an inmate with mental illness is sent to segregation, "they are bumped down the waiting list" to see the psychiatrist. One of the psychiatrists informed us that visits to segregation are difficult in an already overwhelming day, as they must work around security restrictions and rules.

Moreover, correctional officers working in the Monarch Unit receive little or no specialized training, which falls below generally accepted correctional practices for such units. It is critical that correctional officers, especially those working in

specialized units, be able to recognize the signs of mental illness since they are generally the first to respond to behaviors and need to decide whether the behavior warrants disciplinary measures. In short, inmates at Taycheedah who are in the greatest need of care are the least likely to receive it.

4. Mental Health Programming to Address Serious Mental Illness

Taycheedah fails to provide adequate mental health programming to treat the serious mental health illnesses of its inmates. As a result of the limited number of psychologists, psychologists are limited to performing initial diagnostic assessments and managing crises. The significant attention that these duties require prohibits psychologists from performing active treatment, such as programming and counseling, which has been shown to decrease patients' serious mental health symptoms and help prevent mental health crises. See Wellman, 715 F.2d at 272 (treatment of mental disorders is a serious medical need). Counseling for seriously mentally ill inmates is necessary to prevent serious psychiatric crises, dangerousness to self and others, decompensation of mental health, and the need to place inmates in segregation and observation status. Indeed, in the absence of therapeutic measures, staff resort to managing serious behaviors with disciplinary, rather than therapeutic, responses. To address such potential harm, the Seventh Circuit has upheld court-ordered correctional mental health care staffing that mandate psychiatric social workers, clinical psychologists, and behavioral clinicians. French v. Owens, 777 F.2d 1250, 1255 (7th Cir. 1985). In addition, generally accepted correctional mental health practice is to provide non-medication therapy for inmates to address self-injurious behavior.

Although Taycheedah's Annual Report for Fiscal Year 2005 describes an elaborate array of programming, we found that very little actually exists. In fact, most of the inmates we interviewed stated that they receive no programming or they wait as long as three years to receive it. This lack of sufficient programming falls well below generally accepted correctional mental health care standards and results in an increase in psychiatric emergencies.

C. Inappropriate Use of Segregation and Observation Status

Taycheedah's use of administrative segregation and observation status for inmates with severe mental illness violates their constitutional rights because Taycheedah imposes

a significant penalty on inmates whose behaviors are symptomatic of their mental illness. See Hallett v. Morgan, 296 F.3d 732, 746-47 (9th Cir. 2002) (distinguishing between sanctions that are minor and intended to deter behavior versus sanctions that punish inmates for symptoms of their mental illness and upholding the former); Coleman v. Wilson, 912 F. Supp. 1282, 1320 (E.D. Cal. 1995) (constitutional violation when prison staff punished mentally ill inmates without regard to what caused inmates' behaviors or without considering effect of punitive measures on inmates' mental illnesses); Arnold v. Lewis, 803 F. Supp. 246, 249-51 (D. Ariz. 1992) (finding that defendants improperly punished inmates for symptoms of mental illness by placing them in lockdown). This practice is ineffectual, falls below correctional mental health care standards, and can be extremely detrimental for persons with mental illness because it can severely worsen their symptoms, especially self-destructive behavior. See Scarver, 434 F.3d at 975 (noting it was "a fair inference" that conditions including isolation aggravated the symptoms of inmate's mental illness); Davenport, 844 F.2d at 1316 (Seventh Circuit's recognition of ill psychological effect of solitary confinement or segregation). We found that 44 out of 59 individuals in segregation during our tour in July 2005 had serious mental illnesses and were observed to be in significant distress.

We found that many inmates at Taycheedah with mental illness are placed in administrative segregation due to threats or attempts to kill themselves. During our review of inmate disciplinary charges which resulted in segregation, we found that, as a result of attempting to harm themselves with writing instruments or parts of mattresses, certain inmates had been charged with "misuse of state property" (i.e., facility writing instruments and mattresses). Executive staff corroborated this finding by informing us that inmates are sometimes charged with self-abuse as a disciplinary infraction.

Punishing inmates for behaviors that they lack control over is ineffectual and destructive, but appears to be a practice that Taycheedah consistently resorts to because of the lack of appropriate alternatives. For example, we interviewed Inmate #2, who was housed in segregation, during our visit. She was deemed to be a danger to herself, having been observed punching herself in the eye, a clear symptom of psychosis. Her charts revealed that she has a long history of serious mental illness, exhibiting symptoms such as eating her feces and drinking her urine. During our interview of this inmate, she made such comments to us as:

"I eat rotworms," "I see more Gods when I take Haldol," I blackened my eye with my fist," and "I get upset over the melody that plays in my head." According to notes, she was in segregation due to "inappropriate behavior." However, correctional staff informed us that she was in segregation because she received "lots of tickets" for soliciting sex from numerous male and female staff members, which the officers described to us as "crazy." During our interview, Inmate #2 told us that she had been housed in segregation four or five times since 2002 for "disrespect."

Moreover, Taycheedah does not have a "step down" process in place to allow inmates to earn their way out of segregation by exhibiting positive behavior. See Hallett, 296 F.3d at 746-47 (noting that acceptable sanctioning system imposed only minor sanctions on potentially mentally ill inmates who engaged in self-harm). A system such as this is a necessary component according to generally accepted correctional mental health care standards. Without a "step down" process, inmates have no motivation to change their behavior. Long periods of segregation, often with no end in sight, are particularly damaging for persons with mental illness because the lack of stimulation, active treatment, and social interaction exacerbates their symptoms. Indeed, several inmates expressed to us that they had so much additional time added to their segregation status due to bad behavior that they had no motivation to change. Our consultants supported this conclusion, based upon review of the segregation status report prepared by the facility on July 20, 2005. This report indicated that most inmates were sent to segregation for six months to a year, and in some cases, 18 months or more. Absent a "step-down" process to potentially reduce such long segregation periods, inmates have little incentive to improve their behavior while in segregation.

We observed one particular example in which Taycheedah placed a 15-year-old girl in long-term segregation. This inmate, Inmate #3, was reportedly placed in administrative segregation on November 21, 2004. She was adjusted back to segregation on July 14, 2005 and her current release date is June 26, 2006. We interviewed the inmate through her spit mask since spitting was reportedly a problematic behavior of hers. She was quite cooperative and pleasant, but admitted that she felt that she will "never" get out of administrative segregation because staff members "just keep adding time." As of July 2005, she was not receiving any education services, as she allegedly "refuses" from the door of her cell. The inmate was diagnosed as suffering from

attention deficit disorder and intermittent explosive disorder; however, she was not receiving any medication as of our July 2005 visit, reportedly because her mother would not consent. Placing an un-medicated, mentally-ill teenager in segregation, with little or no stimulation, and no education services causes psychological damage that may be irreversible. The waiting time for her release from segregation would feel like a lifetime to a girl of this age. Punishing inmates for mental health symptoms that are beyond their control is unacceptable and ineffectual at modifying the behavior.

D. Mental Health and Medication Records

Taycheedah fails to keep centralized, complete and accurate records to adequately provide mental health care to its inmates. There is no central record-keeping system and the records themselves contain errors and omissions that jeopardize inmates' mental health treatment and can have dangerous consequences. Accessible and up-to-date records are essential for treating professionals to provide adequate care.

The absence of a centralized record-keeping system inhibits treating professionals from accessing the necessary information to provide treatment. For example, psychological notes are kept by the Psychology Department, and psychiatric notes are kept by the Health Services Unit. We noted that while the psychiatric notes are included in the Psychological Services charts, psychological notes, which contain important information about the inmate's history, symptoms, and behavior, were only sometimes found in the Health Services notes. In fact, one psychiatrist informed us that important information gathered by psychology staff was consistently unavailable. Lack of necessary information can lead to significant mistakes in diagnosis and treatment.

Moreover, we found that the charts themselves were inadequately maintained. Oftentimes there were unacceptable delays, as much as several months, in getting notes into charts, and some notes were missing altogether. For example, we noted many errors and omissions during our review of Medication Administration Records ("MARs"). MARs are critical to patient care because they contain information on when medications were ordered, when the orders were filled, whether the patient actually received the medication, and, if not, the reason the patient did not receive it. Physicians rely on the accuracy of this information to make informed decisions regarding patients' medication regimens.

The deficiencies we found in these documents were further supported by our observations of several correctional officers as they distributed medication to inmates. Even though staff were aware that we were monitoring them, we noted several errors in the recording of information, including the failure to note that inmates received a dose and the failure to record an inmate's refusal to take a dose. The correctional staff involved expressed great discomfort with performing this daily duty because they felt inadequately prepared. Several staff members indicated to us that it is frequently unclear whether an inmate actually received the medication that was ordered. Indeed, the psychiatrist relayed to us that she has been quite upset over the MARS because she is unable to determine whether a dosage change is appropriate due the lack of recorded information. These omissions in documentation can lead to serious consequences, as the following examples illustrate.

- A medication order for an inmate was placed in her chart on August 25, 2005. On September 1, 2005, a nurse removed the order from the chart for filling by the pharmacy. The medication arrived on September 13, 2005; however, no notation was made in the MAR that it had been received or whether it had been administered to the inmate. The physician, who was unaware that the inmate was not receiving the medication for this long period of time, saw that the inmate's symptoms were worsening, and changed the inmate's dosage.

This situation put the inmate at serious risk of harm, as this change in dosage may have been unnecessary or even contraindicated, and could have resulted in serious side effects. In another instance:

- As discussed earlier, Inmate #58 fatally asphyxiated herself while in administrative segregation on June 19, 2005. Prior to that, she was ordered several medications to be taken orally and two others to be given intravenously, as needed. While the progress notes intermittently stated that she refused her oral medications and requested injections, the MARs were unintelligible as to what she had been given on any given day. For instance, some entries reflected "R" or had a circled "R," which could mean medication "received" or could reflect the officer's initials. The lack of a consistent system for indicating medication received made it impossible to determine

> from the records what medications the inmate was actually receiving, as well as what measures were needed to control her dangerous behavior. Staff acknowledged to us that they were aware of this problem.

Some of these documentation deficiencies would likely be addressed if Taycheedah had an adequate quality assurance system in place; however, we noted that Taycheedah does very little, if anything, by way of practices in quality assurance.

E. Medication and Laboratory Delays

Taycheedah fails to respond to medication and laboratory orders in a timely manner, preventing inmates from receiving adequate treatment. See Wellman, 715 F.2d at 274 (significant delays in providing treatment led to constitutionally inadequate care). Our investigation revealed significant delays between the time medication and laboratory tests are ordered and when the inmates actually receive the necessary medication or test. This deficiency falls well below generally accepted correctional mental health care standards and puts inmates' mental health at risk.

1. Medication Orders

Taycheedah fails to provide inmates with the medication ordered to treat their mental illnesses in a timely manner. Timely response to medication orders is necessary to provide accurate and appropriate treatment, and to prevent symptoms from worsening. We observed significant delays in providing ordered medications during our review of Taycheedah's medical records, which was reinforced during our interview of clinical staff members. The source of the delays appears to arise from a number of problems in the process of filling medication orders.

First, psychiatrists often do not write prescriptions until late in the day. This delays nurses from taking prescriptions from the charts for processing. Second, the nurses do not consistently take the prescriptions from the charts in a timely manner, and, in some instances neglect to do it at all. Next, all prescription processing is done at a centralized Wisconsin Department of Corrections pharmacy, where there are only 14 pharmacists serving the entire State correctional system. Pharmacy staff stated that the average turnaround time is 72 hours; however, Taycheedah staff members strongly objected to

that estimate and stated that it often takes much longer, sometimes even weeks, for the pharmacy to fill prescriptions. Fourth, once prescriptions are filled, they must be processed by the Health Services Unit, which creates another opportunity for delay. Finally, after processing, the medication must be documented properly in the inmate's medication chart, which is yet another opportunity for delay.

As a result of these significant delays in providing prescription medications, inmates with severe psychiatric symptoms go untreated or are under-treated for unreasonably long periods of time, causing them to suffer and putting them at risk to themselves and others.

2. Laboratory Orders

Taycheedah fails to respond to laboratory orders in a timely manner, and sometimes, not at all. Laboratory tests are often critical for physicians to make accurate diagnoses and to ensure that psychotropic medications are adequately monitored. Indeed, a number of medical illnesses have symptoms that are very similar to psychiatric illnesses and must be ruled out by laboratory tests to make an accurate diagnosis. For example, low thyroid function may mimic depression, while high thyroid function may mimic mania. Thus, a thyroid screening should be performed before an accurate diagnosis of bipolar disorder can be made. Morever, certain psychotropic medications require frequent blood analysis to monitor for side effects, some of which may be dangerous if undetected. For instance, some psychotropic medications may cause diabetes; life threatening increases in cholesterol; pancreatic, liver, or kidney damage; or immune dysfunction.

Our investigation revealed serious delays and omissions in completing laboratory orders. For example, Inmate #13 was diagnosed with bipolar disorder and prescribed Lithium Carbonate, a mood stabilizing medication. A lithium level and thyroid stimulating hormone test (necessary to monitor any potential thyroid problems caused by the lithium) were ordered on April 16, 2004. As of July 2005, no results from those tests were in the inmate's chart, and it was unclear whether the tests were actually ever done.

Taycheedah is not providing adequate mental health care because it fails to ensure that inmates are receiving prescribed medications and necessary laboratory tests. Significant delays and omissions such as those described cause inmates to suffer and their symptoms to worsen.

F. Quality Assurance

Taycheedah's quality assurance system is grossly inadequate. See Coleman, 912 F. Supp. at 1308 (requiring quality assurance program for correctional mental health system). Quality assurance programs are necessary in a correctional mental health setting to identify basic minimal individual and systemic issues that need to be addressed in the delivery of mental health services. Lack of quality assurance leads to focusing efforts and resources on problems and issues that may not be critical or compelling. A quality assurance system is especially necessary in a system struggling with insufficient resources to ensure that its limited resources are channeled in the most efficient manner possible.

We found very little, if any, practices to ensure quality assurance at Taycheedah. Further, the formal efforts that are in place are severely undercut by Taycheedah's totally inadequate data systems. For instance, when the Mental Health Director's office attempts to monitor prescribing practices, this can only be done by a hand count of the medications listed on a several hundred page printout. The absence of an adequate quality assurance system results in errors or omissions left undetected that put inmates at risk of serious harm. For example:

- The medication records for Inmate #19 reflect that her Celexa (an antidepressant medication) was discontinued; however, there was no notation in her chart as of the following week to reflect whether she had been seen by a physician or why this medication change had occurred.

The absence of any clinical documentation made it unclear whether Inmate #19 no longer had the diagnosis of depression, whether she had some untoward effects or allergy, or whether she was simply refusing to take it. In another case:

- Inmate #20 was seen by a psychiatrist on March 17, 2005, and a follow up appointment was ordered in six weeks. Four months later, there were no further psychiatrist notes in the chart, although orders for medication changes were written three months after the appointment was ordered.

Again, without any notes, it is impossible to determine the reason for the medication change. Review of these charts to ensure that they are completed properly is necessary to ensure that inmates are receiving adequate treatment and are not put at risk from medical errors.

III. RECOMMENDED REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and to protect the constitutional rights of inmates, Taycheedah should implement, at a minimum, the following measures with respect to mental health care:

A. Psychiatric Treatment

1. Provide adequate on-site psychiatry coverage for inmates' serious mental health needs. Ensure that psychiatrists see inmates in a timely manner and that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis.

2. Ensure that medications are provided to inmates in a timely manner and that they are properly monitored.

3. Provide nurse staffing adequate for inmates' serious mental health needs. Ensure that nursing functions, such as distribution of medications, are performed by nurses or other properly trained staff.

B. Mental Health Services

1. Provide adequate on-site psychology coverage to ensure that psychologists see inmates in a systematic and timely manner to evaluate inmates for their serious mental health needs. Provide adequate staffing to ensure timely and appropriate mental health screening and referrals.

2. Provide an adequate array of mental health programming, including individual and group therapy, to meet inmates' serious mental health needs and prevent decompensation and mental health crises.

3. Ensure that adequate crisis services are available to address the psychiatric emergencies of inmates.

4. Provide adequate programming in the Monarch Unit to meet inmates' critical mental health needs.

C. Segregation and Observation Status

1. Ensure that administrative segregation and observation status are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control.

D. Mental Health Records

1. Ensure that Taycheedah's mental health records are centralized, complete, and accurate.

E. Medication and Laboratory Delays

1. Ensure timely responses to orders for medication and laboratory tests and prompt documentation thereof in inmates' charts.

F. Quality Assurance

1. Ensure that Taycheedah's quality assurance system is adequate to identify and correct serious deficiencies with the mental health system.

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We hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns regarding Taycheedah's mental health care. Assuming that our cooperative relationship continues, we will be sending you under separate cover our consultants' evaluations. Although their evaluations do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

We are obligated to advise you that, in the entirely unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney 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,

Wan J. Kim
Assistant Attorney General

cc: The Honorable Peggy A. Lautenschlager
Attorney General
Wisconsin Department of Justice

Matthew J. Frank
Secretary
Wisconsin Department of Corrections

Ana Boatwright
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