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

Bureau of Justice Assistance (BJA)

Residential Substance Abuse Treatment (RSAT) Program for State Prisoners

Training and Technical Assistance Resource

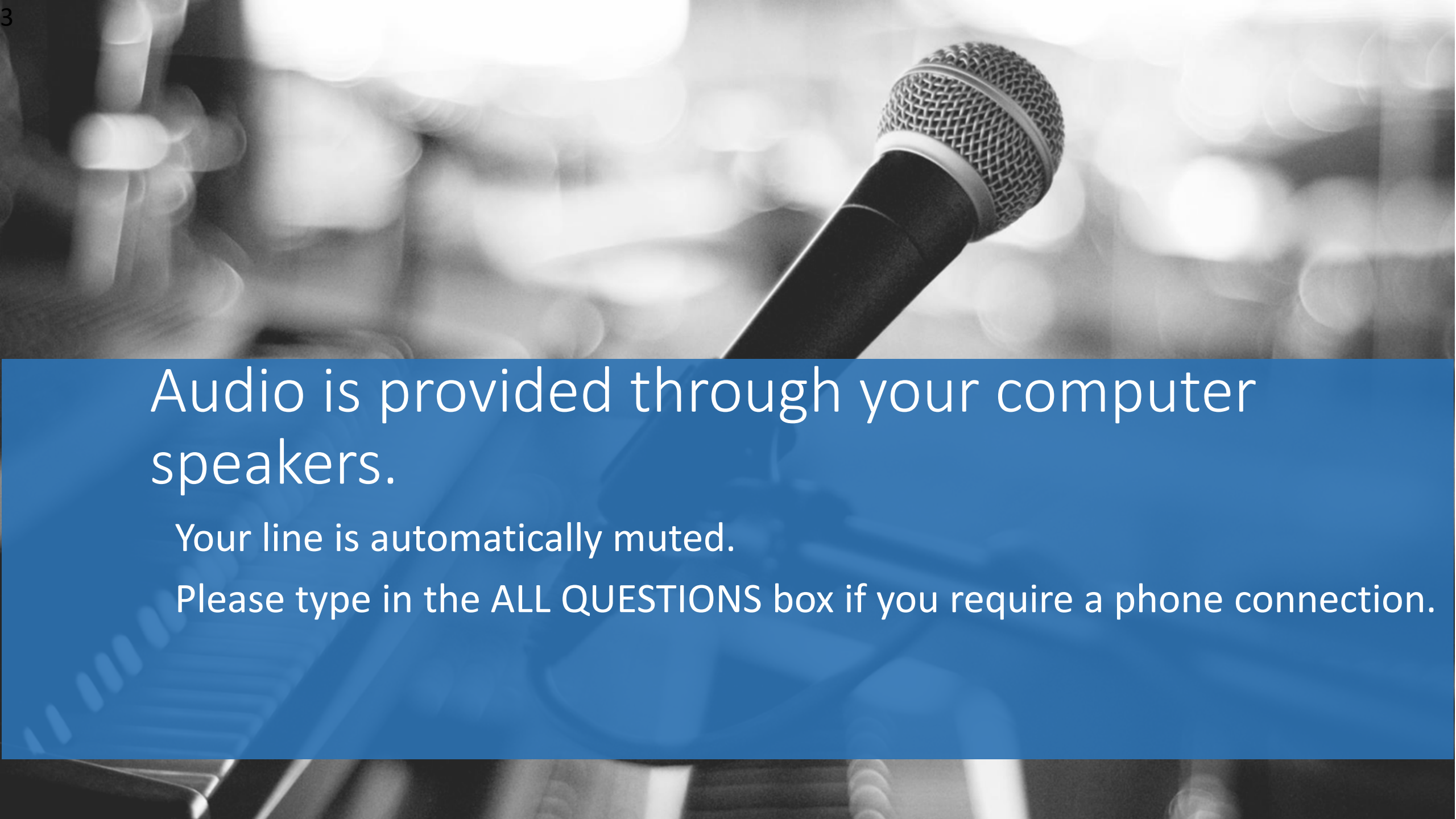
This project was supported by grant No. 2019-J2-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

BJA's RSAT PROGRAM

Advocates for Human Potential, Inc.

This event is being recorded.

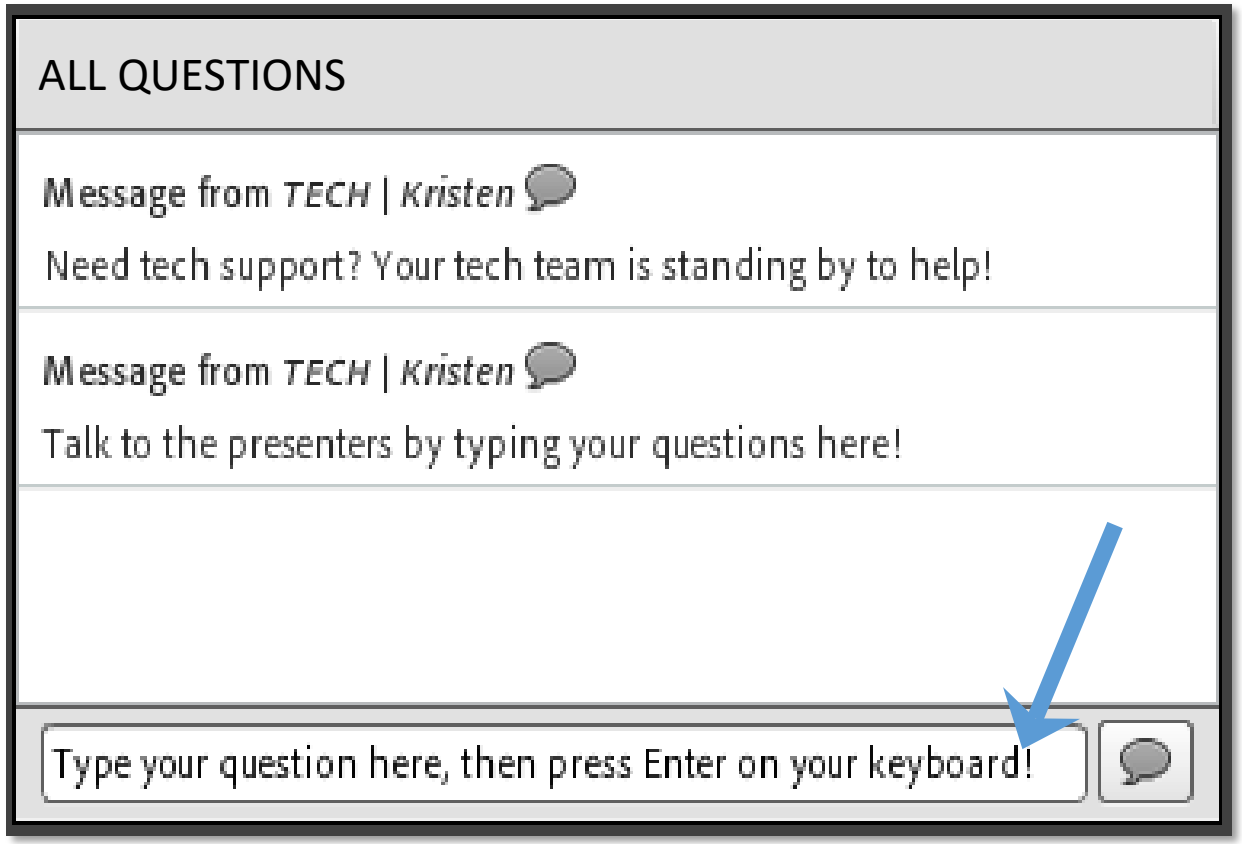
Audio is now broadcasting.

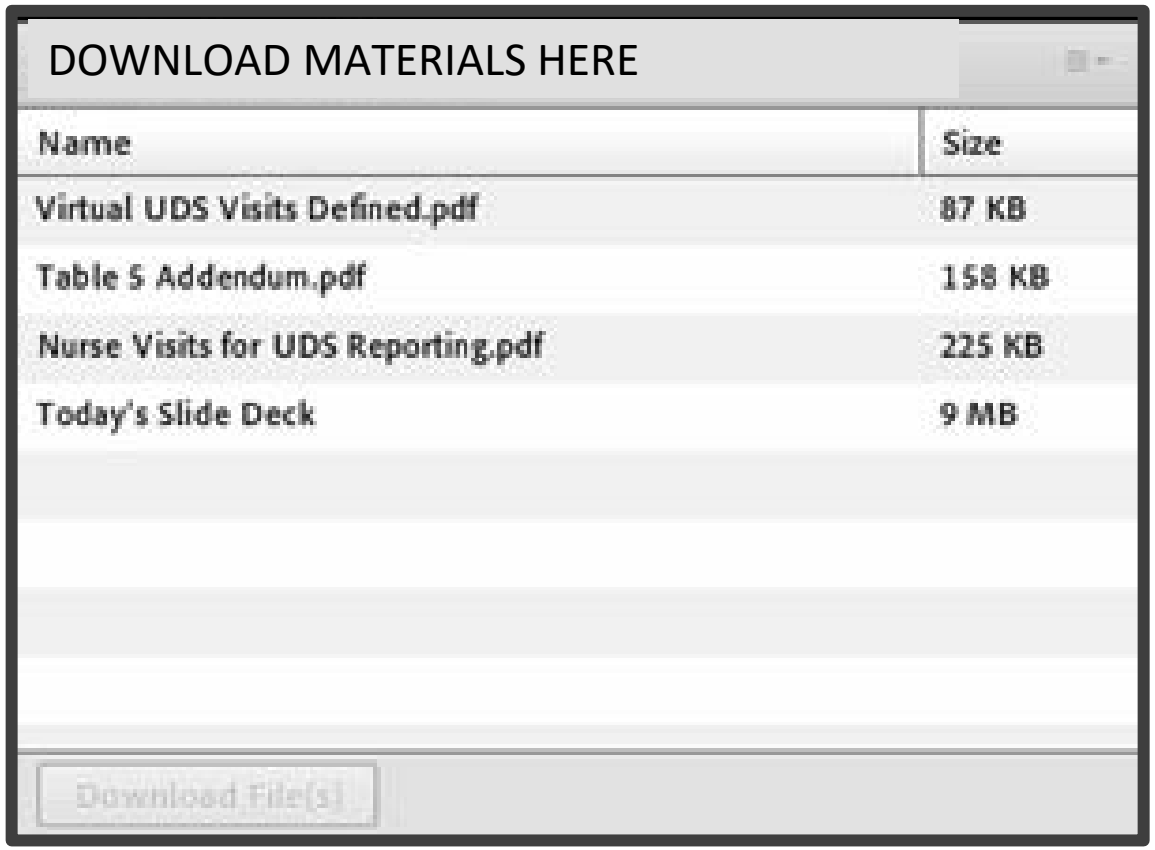


Audio is provided through your computer speakers.

- Your line is automatically muted.
- Please type in the ALL QUESTIONS box if you require a phone connection.

Questions and Answers, Download Materials

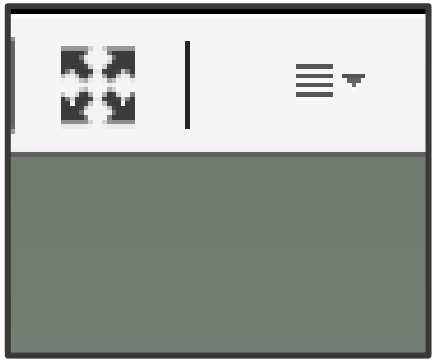




BJA's RSAT PROGRAM

Customize Your Experience

- Use the maximize arrows to enlarge the presentation screen (and the same arrows to shrink it back to size)



- Use the drop-down menu by the computer speaker icon to adjust and select your speakers

Type in the chat box and tell us where you're joining from.

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

Bureau of Justice Assistance (BJA)

Residential Substance Abuse Treatment (RSAT) Program for State Prisoners

Training and Technical Assistance Resource

This project was supported by grant No. 2019-J2-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

BJA's RSAT PROGRAM

Advocates for Human Potential, Inc.

Today’s Speakers

Andrew Klein, Ph.D
Senior Scientist for Criminal Justice
Advocates for Human Potential, Inc.

Civil Rights of Institutionalized Persons Act

42 U.S.C. §§ 1997 et seq. (CRIPA)

On June 15, 2018, the Department of Justice notified Cumberland County of its intent to investigate the Cumberland County Jail (CCJ) pursuant to CRIPA.

The Investigation

WHO:

► Special Litigation Section of the Department of Justice's Civil Rights Division

► U.S. Attorney's Office for the District of New Jersey

HOW:

► Four-day site visit,
►interview administrative, security, medical and mental health staff, and prisoners
reviewed 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;
► observed prisoners in various settings throughout the facility, including in general population and restrictive housing units;
► conducted exit conferences with CCJ officials.

Cumberland County Jail

300 to 350 prisoners

Built 1940s with several expansions since

CFG Health Systems (CFG) medical providers since 2013

Cause of Investigation

- Six inmate suicides between July 2014 and May 2017
- All six used opioids prior to admission to jail
- All six were denied medication-assisted treatment (MAT) by the jail prior to their suicides

Facts Found

"…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."

Facts Found — Addendum

- Seventh suicide occurred one month *after* Justice Department jail inspection.
- Jail failed to follow recommendations provided at the conclusion of prior inspection.
- Officer assigned to the withdrawal unit had not provided adequate supervision

Conclusion

Reasonable cause to conclude that conditions at the Cumberland County Jail violate the Constitution. In particular, CCJ fails to take constitutionally adequate measures to prevent inmate suicides and provide adequate mental health care. 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.

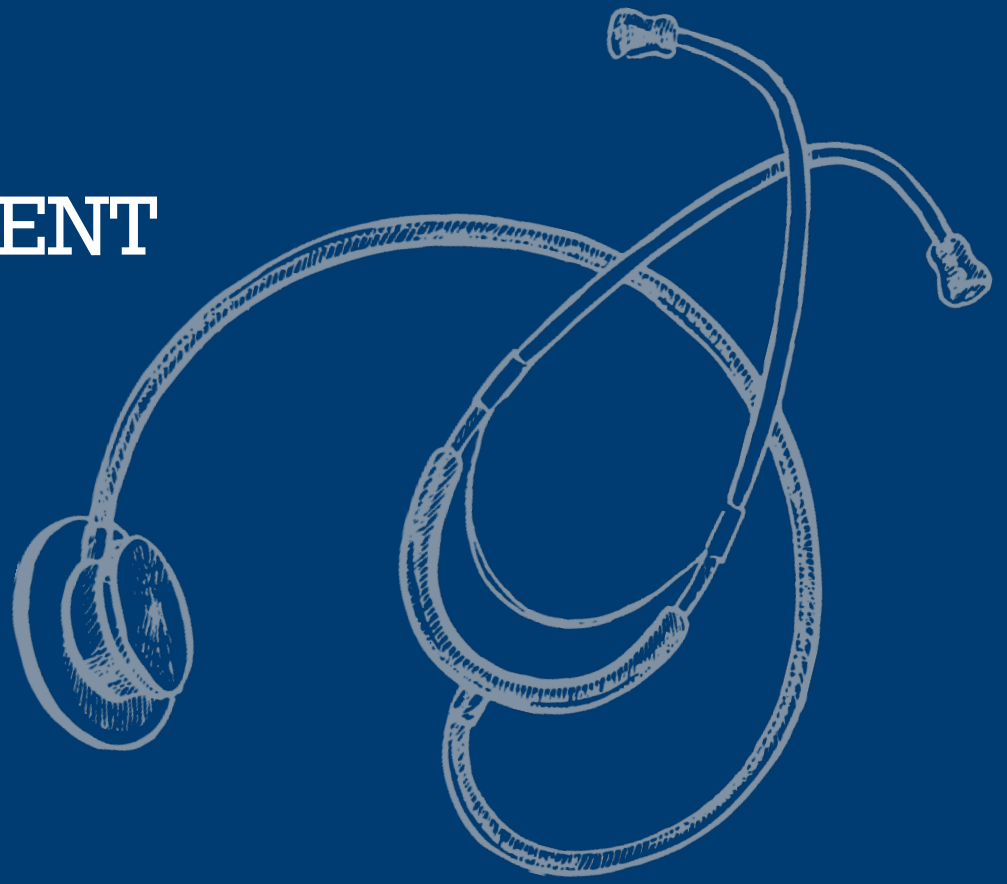
Rights of Pretrial Detainees

- Right to receive adequate medical care under the Due Process Clause of the Fourteenth Amendment.
- 8th Amendment (cruel & unusual punishment) or the 14th (due process): prison officials violate an inmate's right to medical care by showing *deliberate indifference* to a serious medical need.
- 8th and 14th Amendments prohibit prison officials from demonstrating reckless or deliberate indifference to inmates with a "particular vulnerability to suicide."

The Third Circuit: 3-part test to determine officials' *deliberate indifference* to the risk of prisoner suicides:

- 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;
- that the prison official knew or should have known of the individual's particular vulnerability;
- that the official acted with reckless or deliberate indifference, beyond mere negligence, to the individual's particular vulnerability.

MEDICATED-ASSISTED TREATMENT (MAT)



Key to Justice Dept Finding: Medicated-Assisted Treatment (MAT)

CCJ was and is *deliberately indifferent* to the risk of prisoner suicides:

- (1) failure to ensure MAT—the accepted standard of care—is provided to inmates with serious medical needs as clinically indicated
- (2) failure to provide detainees constitutionally adequate mental health care

By failing to provide adequate medical care necessary to treat inmates' Opioid Use Disorder, the CCJ exhibited *deliberate indifference* to inmates' serious medical and mental health needs.

Why MAT is so crucial?

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. The evidence uncovered in our investigation suggests that those six inmates were experiencing opiate withdrawal at the time of their suicides.

Source: 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-opioidpain-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.

DISCUSSION: BACKGROUND

1. Opioid Use Disorder Is Prevalent Among Those Incarcerated.

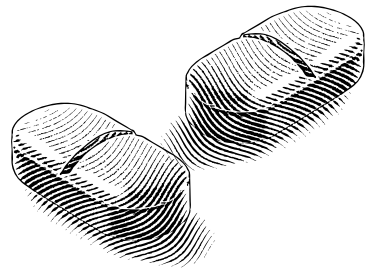
Self admitted Opioid Use

- 16.6 percent of state prisoners
- 18.9 percent of sentenced jailed inmates

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

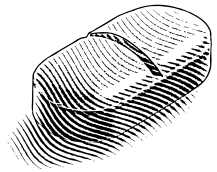
Suicide risks associated with substance abuse in a jail setting stem from poor management and treatment of withdrawal symptoms. The risk of death or other harm associated with withdrawal is particularly acute within the first days of incarceration.

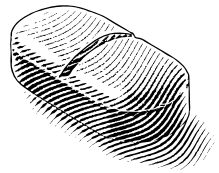
In the long term, if inmates do not receive adequate treatment for withdrawal during incarceration, they face an increased risk of relapse, overdose, and death upon release to the community.



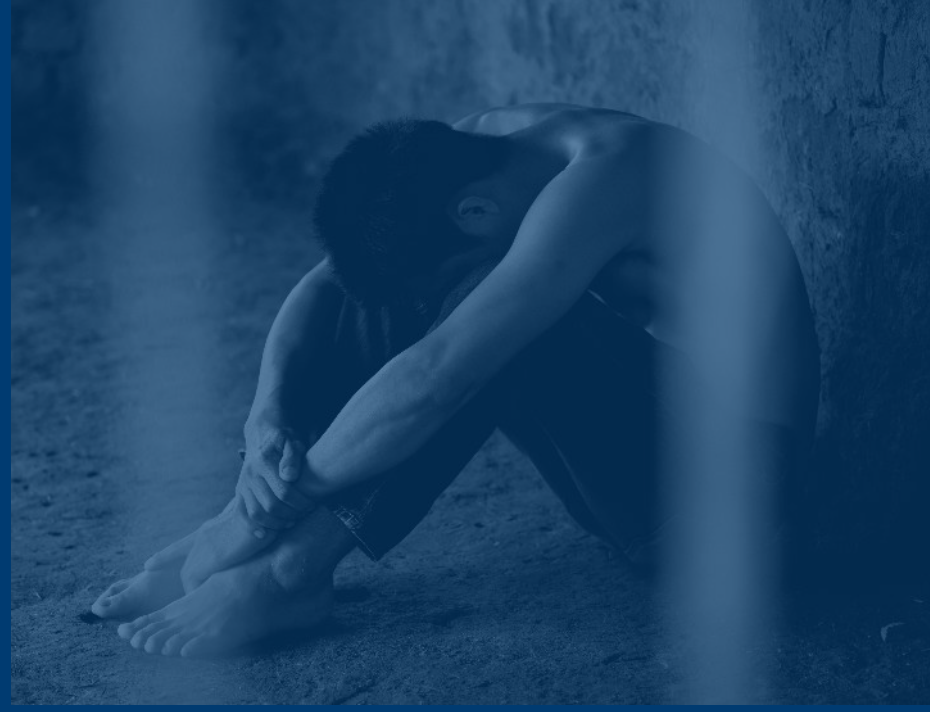
3. Medication-Assisted Treatment Is the Standard of Care for Treating Opiate Withdrawal.

MAT is the standard of care for treating Opioid Use Disorder as it is far superior and more efficacious than other possible treatments



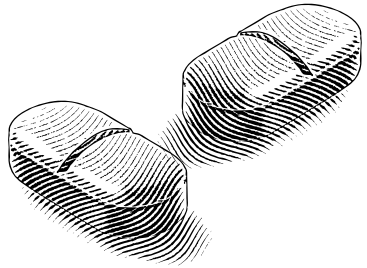


4. The CCJ's Inadequate Treatment of Opioid Withdrawal Increases the Risk of Harm and Likely Contributed to Suicides at the CCJ.



Medical staff confirmed CCJ's policies and practices prevented MAT—even where the inmate had been prescribed MAT by his or her physician before entering the jail.

Categorically denying MAT to inmates with Opioid Use Disorder is a failure to provide adequate medical care for this serious medical condition.



6 SUICIDES DESCRIBED

Case 1

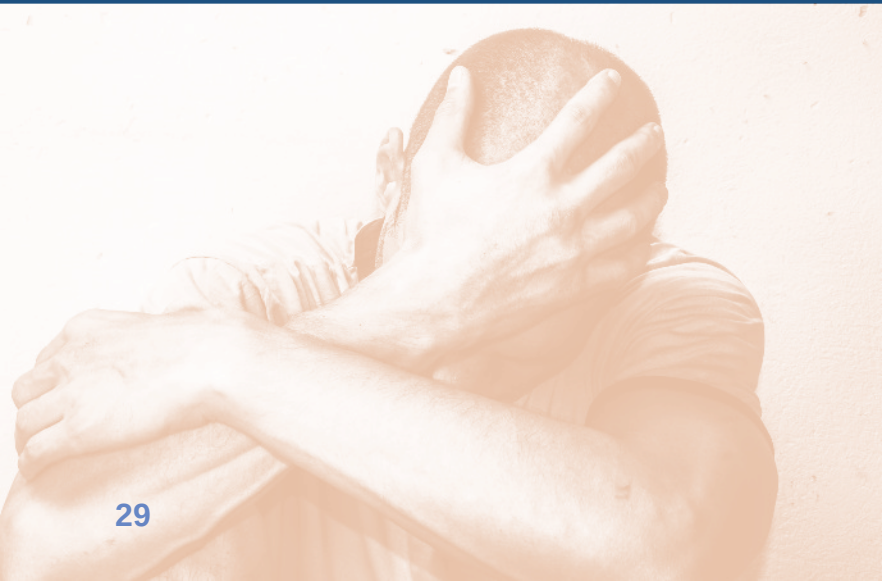
A.A., a 31-year-old male opiate user, died by suicide on July 30, 2014, eight days after arriving at the CCJ. During his medical intake screening, he stated that he was an opiate user. His family also confirmed that he had a long history of "narcotics addiction." He also had numerous previous incarcerations at CCJ for possession of heroin.

Cases 2 & 3

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.

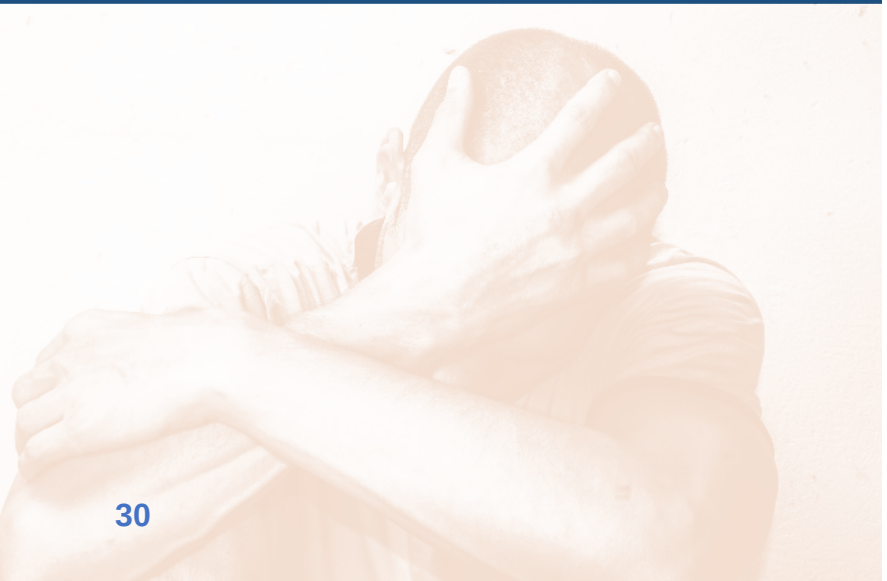
C.C., a 35-year-old heroin user, hanged himself on October 29, 2015, two days after arriving at the jail. While he did not disclose his use of opioids at intake, his mother called the jail during a previous incarceration one month earlier to report that he used heroin and was at risk for withdrawal.

Case # 4



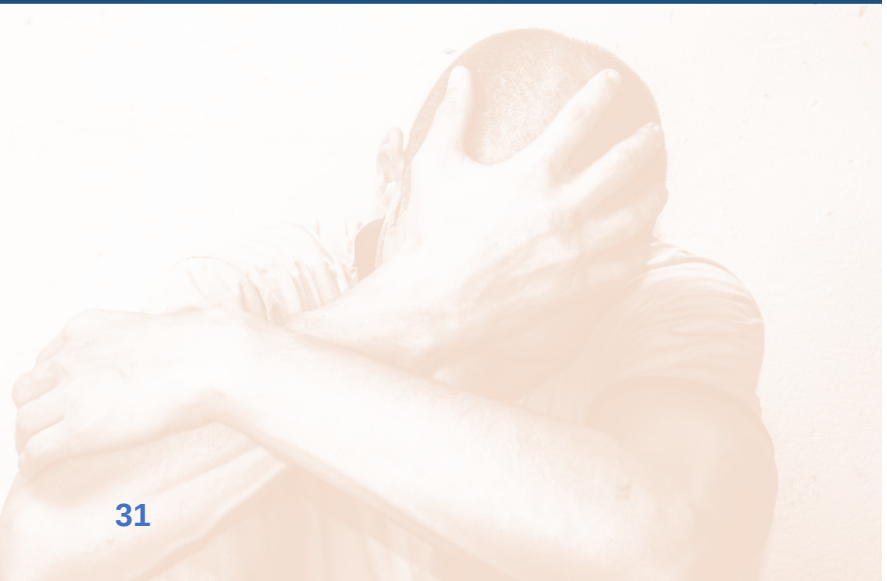
D.D., a 43-year-old inmate who reported opiate use upon admission to the jail, committed suicide on June 3, 2016, roughly two weeks after entering the jail. Specifically, D.D. reported taking Suboxone to treat his previous use of Percocet. CCJ staff placed him on suicide watch, but they did not continue 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, although 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.

Case # 5



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 told of previous suicide attempt. She was found dead with an orange jumpsuit tied around her neck the next day.

Case # 6



Four days after admission to the CCJ, on May 23, 2017, F.F., a daily intravenous heroin user, hanged himself in his cell. He had 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.

Specific Practices Cited:

Poor Screening, Classification, and Suicide Prevention Protocols Demonstrate Deliberate Indifference to Inmates at Heightened Risk

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

- Upon booking at the jail, intake screen by a correctional officer. None of the 15 questions includes any inquiry of the detainee's current thoughts of suicide or self-harm, past suicidal ideation, or suicide attempts.
- Also 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.

Intake Screening (continued)

- Second screen by nurse, usually within 8 hours of the booking officer's screen. Clinically appropriate questions about prior psychiatric hospitalizations, substance use, psychotropic medications, and suicide thoughts. But no access to a detainee's previous CCJ health record even though many detainees had prior admissions to CCJ.
- (For example, one detainee reported no medical problems, substance use, or mental health problems. Upon completion of this screen, detainee was placed in general population and was found hanging from a bed sheet less than 48 hours later. Same detainee had documented history of opiate use and a prior suicide attempt in his medical chart from an earlier CCJ detention!)

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

- CCJ's classification process does not account for an inmate's mental health status and need for treatment when it makes housing decisions.
- Classification relies heavily on an inmate's current charges, with no consideration of whether that inmate receives mental health care or poses a suicide risk.

2. (continued)

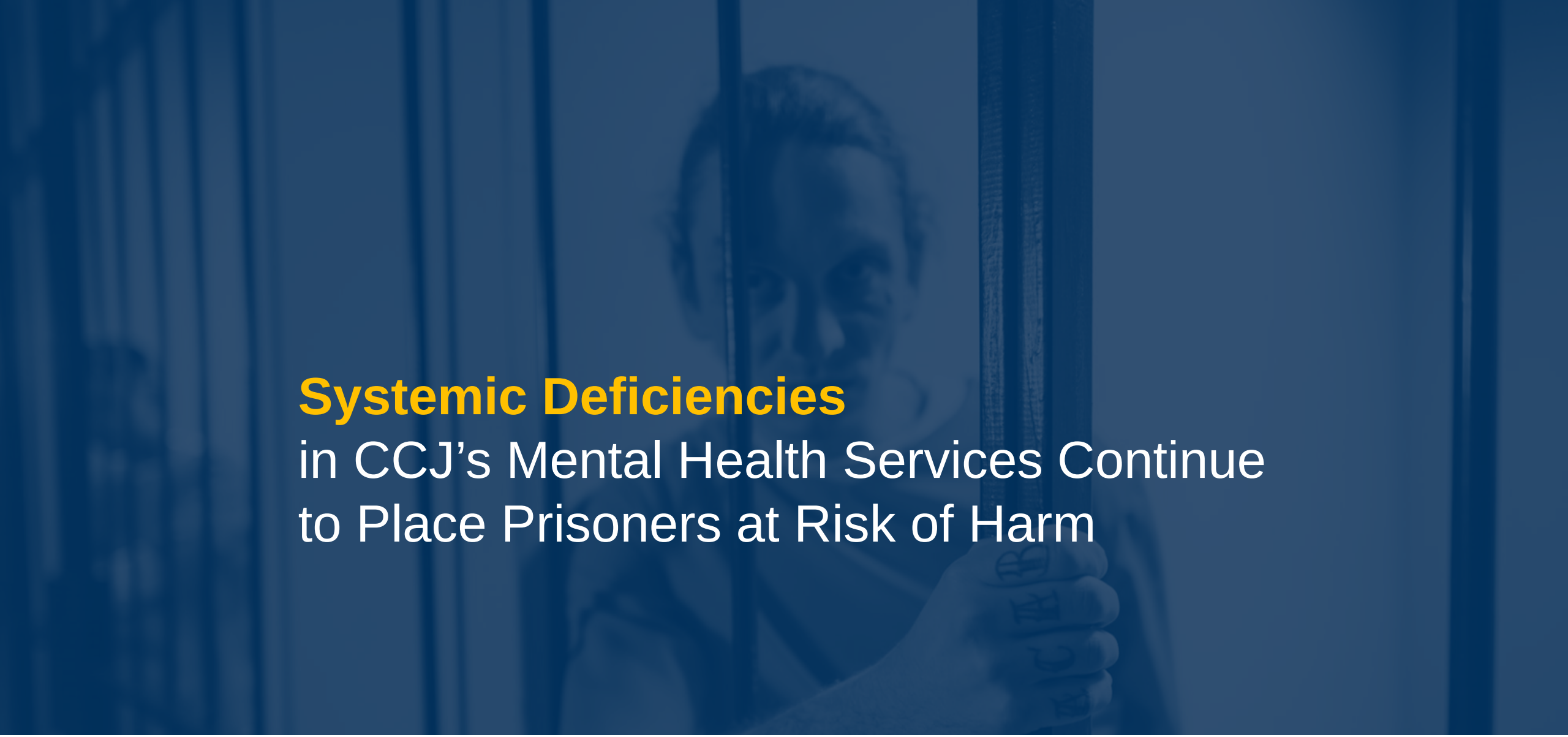
- Security staff often did not know which inmates receive mental health treatment and which inmates had attempted suicide in the past.
- Classification takes several days to complete, so inmates of all classifications placed in the holding cell, against accepted correctional practice to separate inmates of different classifications.
- The CCJ lacks special housing for inmates w/ heightened mental health needs. No provision for female detainees with mental health issues.

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

Unnecessarily Harsh Conditions on Suicide Watch

- Inadequate Mental Health Treatment on Suicide Watch
- Inadequate Supervision of Inmates on Suicide Watch

►Suicide watch policies deter inmates from reporting suicidal thoughts.



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

Systemic Deficiencies (1 & 2)

CCJ's mental health system does not provide adequate treatment — inadequate staffing, inadequate staff coordination, and inadequate programs — even with deteriorating mental health and suicidal.

Only mental health services provided are suicide risk assessment, basic diagnostic assessment, and medication prescriptions.

Systemic Deficiencies (3)

3. Inappropriate Restraint of Prisoners in Behavioral Health Emergencies

- e.g. Minutes after R.R. placed on suicide watch, he punched an officer. Staff extracted R.R. from his cell, placed him into the restraint chair for 8 hours. No indication 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 no further medical involvement during the entire 8-hour restraint. Then R.R. was apparently transferred to a community crisis center for care. Upon his return two days later, R.R. again placed in the restraint chair for "attempting to harm himself," with no documentation of specifics in the accompanying incident report.
- S.S., an inmate with a history of suicidal ideation, 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."

"[C]ourts have found that continued restraint . . . , without legitimate purpose, can constitute a constitutional violation"

Systemic Deficiencies (4, 5, & 6)

- Minimal Access to Higher Levels of Mental Health Care
- CCJ Policy Denies Mental Health Professionals Clinical Autonomy
- Poor Coordination between Mental Health and Custody Staff
- Deficient Quality Assurance and Contract Oversight

Justice Department's MINIMAL REMEDIAL MEASURES

1. Initial screenings by staff trained to identify medical and mental health needs, accurately record a prisoner's current medications, any history of treatment or hospitalization, and any previous or current substance use.
2. 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.

Remedial Measures (3, 4, & 5)

- Obtain prior mental health records from prior jail admissions and from community services boards or other community providers, incorporate into prisoners' medical charts.
- Prisoners with serious mental health needs receive clinically appropriate therapy and counseling.
- Discussions about treatment between mental health professionals and prisoners conducted in a confidential, clinically appropriate setting.

Remedial Measures (6 & 7)

- Clinically appropriate medication administration, including psychiatric follow-up assessments on any new psychotropic medications or dosage changes

- Suicidal prisoners receive the level of care and housing classification appropriate to their acuity, as determined by a mental health professional.

Remedial Measures (8 & 9)

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

- "Constant watch" observation with unobstructed view of the prisoner at all times by staff with no other duties to complete during the time they are conducting the watch.

Remedial Measures (10 & 11)

- Suicidal prisoners are provided quality, private suicide risk assessments on a daily basis.

- Jail's quality assurance program includes complete morbidity/mortality reviews of all inmate deaths, attempted suicides, or other sentinel events.

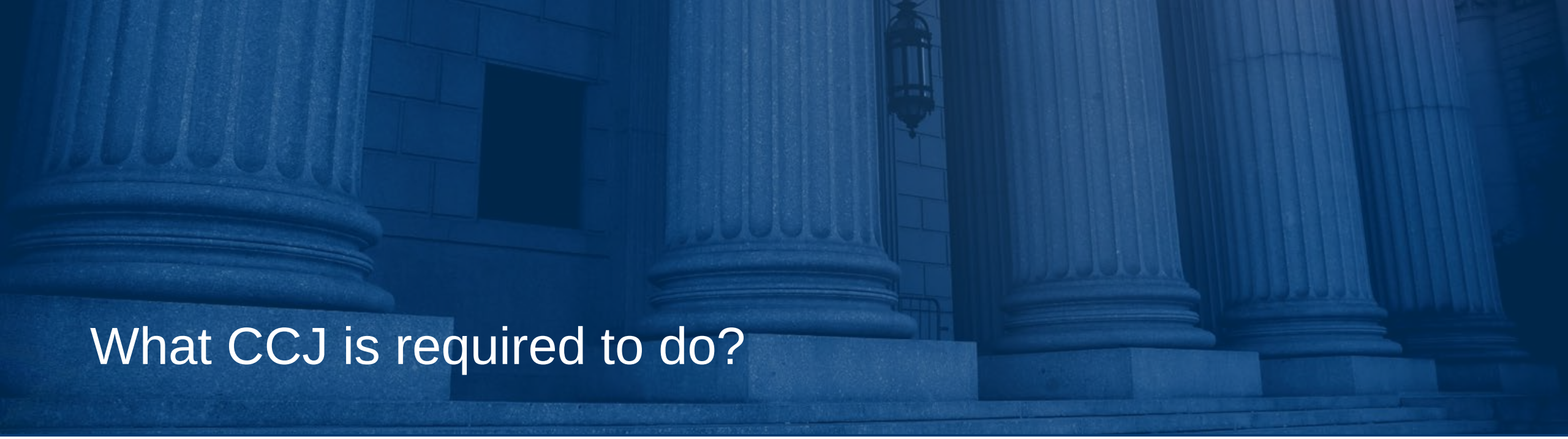
Remedial Measures (12)

►Prisoners with serious mental illness, including OUD, are provided discharge or transfer planning services, especially services for prisoners in need of further MAT

a) Arrange an appointment with community providers for those with serious mental illness, including OUD. If possible, have prisoners meet with that community provider prior to or at the time of discharge to facilitate a warm hand off

b) Arrange with local pharmacies to have prescriptions for prisoners with OUD 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;

c) Provide, as clinically indicated, a long-lasting or injectable dose of medication [e.g., Vivitrol] for individuals with OUD.



What CCJ is required to do?

CCJ was given 49 days to comply, or the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if State officials have not satisfactorily addressed Justice Dept 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, posted on the Civil Rights Division's website.

What CCJ has done?

Since the November 2018 suicide, CCJ has taken some steps to prevent similar deaths.

- amended its initial booking screening form
- taken some steps to provide oversight of its medical contractor
- 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.

York County, PA Grand Jury Report

In March 2021, the York County, PA grand jury released its 174-page report on the death of an inmate who died after being subdued in a restraint chair. According to the grand jury, Everett Palmer, Jr., a military veteran, “was tweaking on meth, meaning acting irrationally because of drug toxicity.” Finding no criminal negligence, the jury found the death preventable, and released 24 recommendations to prevent future jail deaths.

BJA's RSAT PROGRAM

Cell Extraction

- A negotiator or de-escalator should be engaged prior to a cell extraction
- Medical staff should be required to be present prior to a cell extraction
- EMS should be summoned to the prison prior to a cell extraction
- York County Prison should reconsider the use of electronic stun devices during cell extractions

Drug and Alcohol Intake

- A presumptive drug screen should be conducted on people being admitted to the prison
- Prison staff should develop and implement trainings on how to recognize developmental disabilities
- Communication between York County Prison and behavioral health systems should be improved
- The use of previously prescribed medications should be continued upon entry to the prison
- Drug screenings should be expanded to assess substance-abuse issues

BJA's RSAT PROGRAM

Drug Treatment and Support

- Crisis-intervention team training should be expanded among prison staff
- Prison inmates should be trained as certified peer counselors
- Medical-assistance benefits should be continued during pretrial detention
- Comprehensive drug and alcohol programs should be developed at York County Prison
- Improve information-sharing between agencies and health-care providers, both within York County and outside of it
- Motivational interviewing should be used by screeners by the sheriff's office

Reentry

- The critical need for housing, especially among those needing mental-health treatment, must be addressed
- Collaboration and partnerships must continue between government agencies and health-care and other service providers, including through the Criminal Justice Advisory Board, the York County Reentry Coalition, the Community Action for Recovery and Diversion program — and through the Stepping Up Initiative, which seeks to reduce the number of people with mental-health issues who are jailed
- Establish a York County wellness, diversion and reentry center, and expand local behavioral-health services

Funding

Criminal-justice initiatives and behavioral-health services must be properly funded, and a criminal-justice reinvestment strategy should be developed in York County.

BJA's RSAT PROGRAM

QUESTIONS

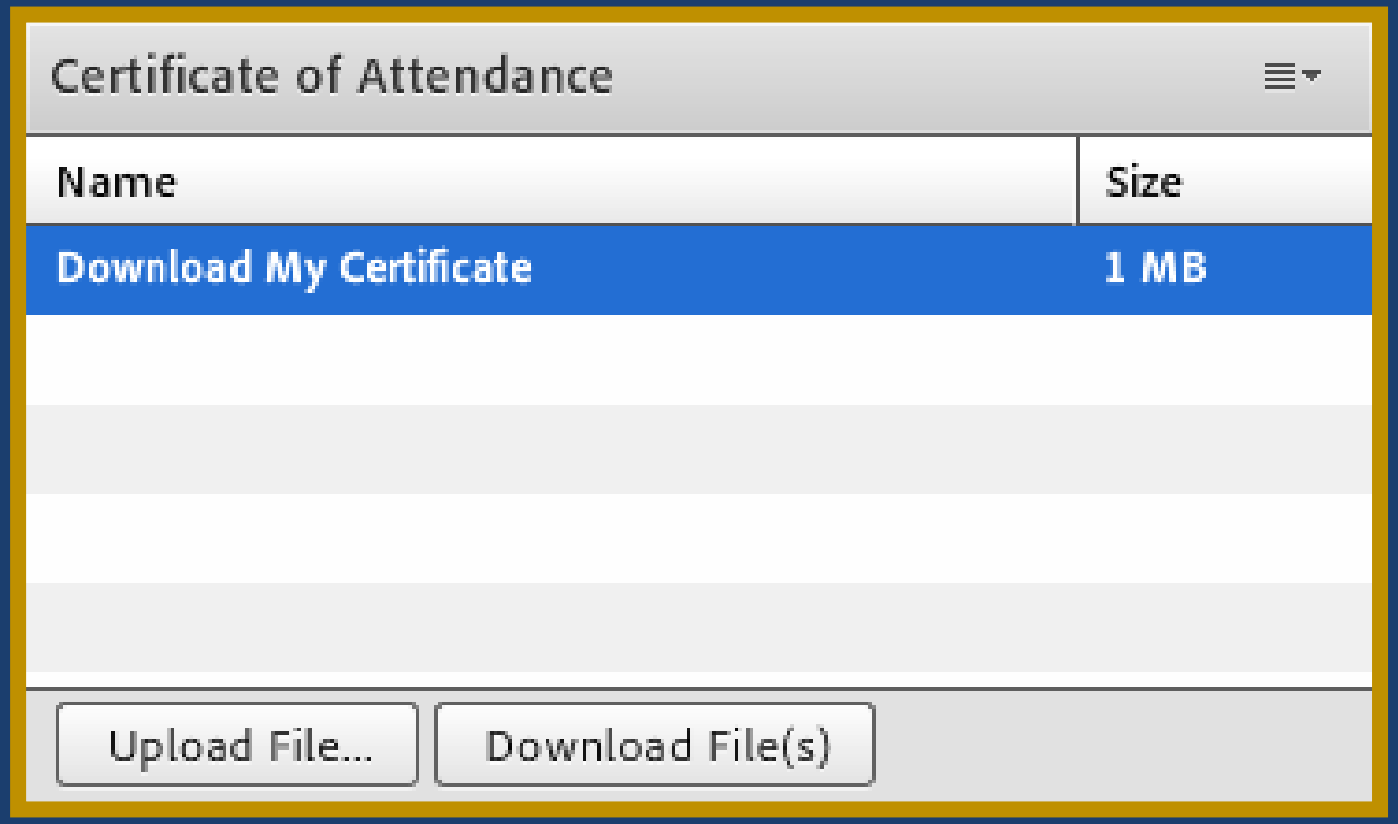
- Type your questions in the Q&A box on your screen.

Speaker Contact Info:

Andy Klein | aklein@ahpnet.com

CERTIFICATE OF ATTENDANCE

Download Now!



BJA's RSAT PROGRAM

CERTIFICATE OF CONTINUING EDUCATION

1 Continuing Education Hour (CEH) approved by NAADAC, the Association of Addiction Professionals

Pass 10-question quiz with 7 correct answers

Download certificate upon completion of the quiz

April 21, 2021 RSAT webinar CEH quiz link:

https://survey.alchemer.com/s3/6305211/April-21-2021-RSAT-Webinar-CEH

BJA's RSAT PROGRAM

CONTACT

http://www.rsat-tta.com/Home

Stephen Keller
RSAT TTA Coordinator | skeller@ahpnet.com

BJA's RSAT PROGRAM