Puget Sound Mental Health

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General and Forensic Psychiatry

EXPERT EVALUATION:
MENTAL HEALTH STAFFING ANALYSIS FOR THEORLEANS PARISH PRISON
July 10, 2013

In the following, I offer an analysis of mental health staffing needs for the Orleans Parish Prison (OPP). The United States Department of Justice asked me to conduct this analysis. This report is the product of the undersigned.

EXPERT INFORMATION

Education, Training, and Experience

I received a Bachelor of Science in Chemistry from the Massachusetts Institute of Technology in 1979 and completed medical school at the University of Washington in 1983. I then did a one year fellowship in the Department of Physiology and Biophysics at the University of Washington (UW). I did my internship and psychiatry residency at Cambridge Hospital, Harvard Medical School, finishing in 1988. For the next two years, I was an Assistant Clinical Professor at UCLA stationed at the Sepulveda Veterans Administration Hospital. From 1990 to 2008 I held a variety of positions at the UW and the Center for Forensic Services (CFS) at Western State Hospital (WSH) in Lakewood, Washington. These included: Program Director, Center for Forensic Services (1990-2003); Director, Electrophysiology Laboratory (1992-2003); Program Director, UW/WSH Forensic Psychiatry Fellowship, UW (1998-2008); Supervising Psychiatrist, CFS (2003-2006); Forensic Psychiatrist (2006-2008). I then became the Chief of Psychiatry for the Washington State Department of Corrections, a position I hold now. In that role, I am responsible for program development and staffing models for psychiatric and mental health services. I have also maintained a private forensic psychiatry practice since 2000. My current appoint at the UW is Clinical Associate Professor. I am board certified by the American Board of Psychiatry and Neurology in General (No. 32747) and Forensic (No. 078) Psychiatry.

In my current position as Chief of Psychiatry for the Washington Department of Corrections, I am responsible for the psychiatric staffing model and co-responsible for mental health staffing in general for all 15 institutions in the prison system.

Publications and Presentations

My publications in the last ten years are:

Kruh, I.P., Whittemore, K., Arnaut, G.L.Y., Manley, J., Gage, B., Gagliardi, G. The concurrent validity of the psychopathic personality inventory and its relative association with past violence in a sample of insanity acquittees. International J Forensic Mental Hlth 4(2):135-145 (2005).

Gage, B.C. Book review: Principles and Practice of Forensic Psychiatry (2nd Ed.), Richard Rosner (ed.). Journal of Forensic Sciences 50(1):257 (2005).

Gage, B.C. The Growing Problem of Cognitive Disorders in Corrections. Iceberg 19(2) (2009). www.fasiceberg.org/newsletter.htm.

Gage, B.C.; Stern, M. Setting Up an Involuntary Antipsychotic Administration Mechanism – The Harper Solution. DVD through MHM production grant. 2010

My public and academic lectures in the last ten years are:

Civil Commitment—Presentation to the Seattle Forensic Institute, April 2003

How to Identify a Client with Mental Illness—Presentation at the Tenth Annual Washington Criminal Justice Institute, September 2003

Competency & Informed Consent; Legal Liabilities for the Professional—Presentation at Mental Health and the Law in Washington, January 2004

Primer on Conducting Involuntary Medication Hearings—Presentation at the Fall Conference of the Washington State Association of Municipal Attorneys (with Mike Finkle, J.D.), October 2004

Competency and Informed Consent: The Law and the Role of the Clinician—CME for Franciscan Health System, June 2006

Is Evil Good for Psychiatry—Grand Rounds, UW Department of Psychiatry and Behavioral Sciences, June 2006

Competency and Informed Consent: Passive Acceptors and Incompetent Refusal of Treatment—CME for Franciscan Health System, November 2007

Dim Rea: Mental Health Evaluations of Diminished Capacity and *Mens Rea*—CLE, Department of Assigned Counsel, December 2007

Diminished Capacity: Approaches to the Evaluation of *Mens Rea*—Presentation at the Symposium on Diminished Capacity Sponsored by The Washington Institute for Mental Health Research and Training, May 2008

Sentencing Policy for Mentally Ill Offenders—Panel at the National Association of Sentencing Commissions Annual Conference, August 2008

Youth in Corrections—Diverse Youth in Transition: Navigating a difficult Passage, presentation and Panel for the American Psychiatric Association's OMNA on Tour, September 2009

Correctional Psychiatry—Washington Department of Corrections Continuing Medical Education, October 2009

Leston Havens—for the Luminaries of Psychiatry lecture series sponsored by the

University of Washington Department of Psychiatry and Behavioral Sciences, December 2009

Involuntary Psychotropic Administration: The Harper Solution—American Correctional Health Services Association Professional Development Conference, March 2010

Securing the Body, Freeing the Mind: Risk Oriented Treatment of the Mentally Ill Offender—Washington Behavioral Health Care Conference, May 2010

Risk Assessment—Co-Occurring Disorders and Treatment Conference, October 2010

Depression and Chronic Pain—Washington Department of Corrections Continuing Medical Education, October 2010

Effective Use of Older Psychotropic Medications—Washington Physician's Assistants Continuing Medical Education, November 2010

Changing Personality or Changing Behavior: Treating Cluster B Personality Disorder—Washington Behavioral Healthcare Conference (with Jude Bergkamp, PsyD, MA), June 2011

Interaction of Psychotherapy and Psychopharmacology—Washington Behavioral Healthcare Conference (with Bart Abplanalp, PhD & Julie Shinn, MA), June 2011

Delirium Is a Syndrome—Washington Department of Corrections Continuing Medical Education, September 2011

Setting Up an Involuntary Antipsychotic Administration Mechanism – The Harper Solution—National Correctional Health Care Conference, October 2011

Don't Panic: Panic Disorder in Medical Settings—Washington Department of Corrections Continuing Medical Education, September 2012

Reducing Liability When Using Physical and Chemical Restraint—Webinar for OmniSure Consulting Group, LLC, December 2012

I also conduct annual didactics to UW fellows and residents including: criminal responsibility, competency, risk assessment/risk management, right to treatment/right to refuse treatment, civil commitment, ethics, treatment of the violent patient, conditional release, psychopathy, correctional psychiatry and other topics.

Over the last four years, I have been deposed twice:

2011 – Williams v. McDonnel Douglas Corp, et al. (King County Superior Court, Washington)

2010 – Kono v. Kitsap Mental Health (Kitsap County Superior Court, Washington)

My only testimony was in this case:

2013 – Lashawn Jones, et al v. Marlin Gusman, Sheriff, Orleans Parish; et al

Fees
My fees for this case are based on a day rate of $1200.

DATABASE

The following constitutes the database for this mental health staffing estimate.

- OPP medical and mental health staffing records
- OPP policies pertinent to health services
- Forms used in the conduct of clinical practice at OPP produced by OPP
- Pharmacy data from OPP
  - Formulary
  - OPP reports on psychotropic usage
- Routine and ad hoc reports generated by OPP regarding:
  - Medical and mental health services delivered
  - Suicide monitoring
  - Sentinel events
  - Sick call
  - Emergency room transports
  - Use of force
  - Special Operations Division investigations
  - Morbidity and mortality reviews
  - Death reviews conducted by OPP
  - OPP census and demographic data including reports from April 2013
- Deposition of Dr. Samuel Gore in Lashawn Jones, et al v. Marlin Gusman, Sheriff, Orleans Parish; et al
- Content and rosters of training conducted at OPP regarding medical and mental health
- Inmate grievances
- Interviews of OPP medical, mental health, custody, and administrative staff
- OPP Medical Department response to Dr. Inglese's request for budget information dated March 2013
- Report by Richard Inglese, M.D. dated 3/14/13
- Report by James Austin, Ph.D. dated June 28, 2013
- Order Approving Consent Judgment and Certifying Settlement Class in Lashawn Jones, et al v. Marlin Gusman, Sheriff, Orleans Parish; et al
  - Consent Judgment

ASSUMPTIONS

Based on review of the above materials, OPP is best characterized as a medium sized urban jail. Its demographic composition is consistent with other jails of its size. There is nothing in the database to suggest that the OPP prisoner population varies systematically or significantly from similar facilities. It is expected that 15-25% of the population will have a serious mental illness. For the purpose of this report, I will assume the lower end of this estimate, consistent with the

directive to provide minimally adequate services. About 5% of the jail population will have severe mental illness or behavioral problems including psychosis, self-injurious behavior, suicidal ideation, severe mood disorders, and other serious mental disorders; this population requires placement in a specialized or residential mental health setting.

The OPP population is assumed to be ca. 2400 with approximately 8% being female, 2% under 18, 14% under 21 and 1% over 60 (consistent with this type of jail setting). There are 80-100 intakes per day with recent figures closer to 80, which will be used as the estimate for intake-related resources. Should this number decline, these staffing projections can be modified in a linear fashion as they are based on overall population and would not be substantially impacted by the number of facilities utilized within the OPP. If the population were to drop below about 1,000 the staffing ratios would begin to increase slightly owing to loss of economy of scale. This is unlikely and it is assumed that linear corrections to these staffing predictions are reasonable. However, it is critical to note that functions such as intakes and assessments are not driven by total population but by numbers of admissions. Thus it is important to make staffing adjustments based on both overall census and admission rates.

Note that available information does not include length of stay distribution information. This is important because for those with very short lengths of stay (less than two weeks), it will generally not be necessary to provide more than the intake assessment and crisis services. In other words, assessments by mental health (whether psychologists or social workers) and psychiatric prescribers would not be necessary. In what follows, I assume that about 50% of admissions are for less than two weeks; this number may vary substantially depending on the population mix in the jail.

Psychiatric sick call is currently being conducted at a rate of about 700 per month. The sources and nature of these sick calls is not clear from the database. Because mental health services are virtually absent, these figures are of little value. With better mental health coverage, the numbers of sick calls should decrease substantially while overall visits increase substantially. Thus, calculations must be based on population data rather than existing OPP mental health utilization statistics. Service utilization will also be reduced by improvements in safety and security. As such changes are anticipated as part of the consent judgment, lower limits of service utilization will be employed in the following calculations.

The number of prisoners on Direct Observation for psychiatric reasons has been fairly stable at about 28 per day for some time. This will be used to estimate associated resource needs. While a small percentage of those will not require Direct Observation in the future owing to general improvements in jail conditions (including safety and security as well as mental health treatment), better detection of mental illness will lead to some prisoners who are currently undetected (owing to their being "quietly mentally ill" in their cells) being identified as needing such services. It is likely that Direct Observation will be needed at levels similar to the present. If there are long term reductions in Direct Observation, it will be necessary to maintain mental health staffing levels and general improvements in safety and security to continue to achieve this outcome. But it will allow a reduction in deputy time that is dedicated to Direct Observation, providing significant savings.

A relief factor of 1.25 will be used to assure consistent coverage for continuing education, vacations and sick leave. This is provided for functions that are essential on a daily basis (such as intake and nursing) and for which coverage by others is untenable.

Direct patient contact is expected to constitute 70% of clinician time for psychiatrists, psychologists, social workers, and other non-nursing staff providing therapeutic interventions.

At all times, minimal standards in terms of time of contact and frequency of contact are employed. This is consistent with the provisions of the Consent Judgment and will be specified in the calculations.

It is assumed that Templeman 5 will remain the location for the residential mental health beds, even upon opening of the new jail facility. Physical plant considerations mostly contemplate programming space, which is essentially non-existent on the Templeman 5 tiers, and direct observation capacity. It has a capacity of 316; it will be assumed that 120 (5% of 2400) have a severe mental illness, some of which are housed on the female unit. Other mentally ill can be treated in a general population (GP) setting.

Templeman 5 was also the location for housing females and some with medical needs not requiring placement in a medical setting. The female population has reportedly been moved. Depending on the location and nature of the facilities this move may create inefficiencies in the treatment of those females with severe enough mental illness to require residential level services. But for the purposes of this report, the females are subsumed in the general calculations without any adjustment even though they may be housed elsewhere.

After accounting for the 120 most serious mentally ill, there are about 2300 general population prisoners remaining. As noted in the assumptions, about 15% (345) of these will be expected to require mental health services. It is expected that a larger percentage of prisoners will be assessed for mental health services than actually need them. A minimal estimate is that 20% of the population will require some degree of assessment by mental health staff after referral from the initial screening, sick call, or referral by staff.

Not all 345 requiring mental health services will require psychotropic medications and some may also refuse. It is estimated that about 300 will be on psychotropic medications, with about 100 of those being in the residential mental health unit (there will be prisoners on no medications in that setting both due to refusal and due to having conditions for which medications are not indicated). Again, this is a lower limit estimate.

A final assumption is that about 75% of the OPP population has a problem with substance abuse or dependence.

In the following, a model employing on-call mental health coverage after hours and on weekends is assumed. OPP may choose to staff with mental health professionals after hours but this is not required as long as response times and services are sufficient to manage emergent and urgent mental health conditions. This may include the utilization of emergency room services. The costs of such services are not factored into this model primarily because it is understood that the

availability of the current emergency service availability is likely to change and that no clear alternative has been developed. This will need to be included in the cost analysis once this is clarified. For the present, a model that utilizes telephone call psychiatric services at market rate with emergency room back-up when emergent evaluation is needed is assumed.

This staffing report does not address the custody staffing, including for Direct Observation, nor medical practitioners treating the medical problems of the mentally ill. The custody staffing needs for direct observation of mentally ill for danger to self or other behavioral problems will depend to a substantial degree on the physical plant. It is reasonable for one officer to monitor up to five prisoners at a time if they can all be viewed continuously and simultaneously from a single observation point. This can be done by video camera as long as there are regular direct observations (usually every 15-30 minutes). The current physical plant arrangement does not allow for this level of observation both because of problems with sight lines from existing stations and camera placement. It is unlikely that Templeman 5 will be able to be retrofitted to allow observation of five offenders at once, especially those who are high risk and needing an individual cell. Regardless of the physical plant or video capacities, it is necessary for the officer to be dedicated to that position without other duties and able to observe at all times whether by direct physical observation or by video.

MENTAL HEALTH STAFFING ESTIMATES

A psychiatrist is currently the Director of Psychiatric Services. This function should take no more than 0.4 FTE. Functions of this position include program development, quality assurance, utilization management, participation in executive leadership, and clinical supervision.

Intake and Initial Assessment

All prisoners require initial screening for mental health conditions. This is between 80 and 100 per day. It is reasonable to expect the initial medical and mental health screening (including interview, abbreviated record review, examination, and documentation) to take about 30 minutes. Thus about 40 hours per day of direct screening time is required each day; this does not include other functions. This screening process requires two nursing staff on duty 24/7 to assure timely and adequate evaluation (as this is a post the 70% productivity factor is not included):

2 FTE/shift x 2 shift x 1.4 (weekend coverage) x 1.25 (relief factor) = 7 FTE

Initial assessment will be needed for about 20% of those from intake. Using the low end number of 80, this means there could be about 16 assessments by a mental health clinician each day. Note that this will also accommodate most urgencies as this assessment can be done on the next working day when necessary. Given that 50% will be released before assessment, this number is revised downwards to 8 per day. This initial assessment may be done by a masters level clinician or above. An hour is provided for the assessment including interview, record review, and documentation. This will require:

8 assessments/day x 7 days/week x 1 h/assessment = 56 hours/week

Assuming 70% clinical productivity and the 1.25 relief factor, this entails:

1/0.7 x 56 x 1.25 = 120 hours/week or 3.0 FTE.

Summary
Intake coverage thus requires:

7.0 FTE intake nurse (minimum specially trained LPN) – shared medical/mental health screening
3.0 masters level mental health clinicians

Residential Mental Health (Templeman 5)
The bed capacity of Templeman 5 is 316 As noted in the assumptions, there are expected to be about 120 prisoners with severe enough mental health needs to require placement on a residential mental health unit. Of these, about 28 will be on Direct Observation at any time.

Most of the remaining beds in Templeman 5 are occupied by female prisoners and some prisoners with medical needs not arising to the level of needing a specialized medical setting.

Nursing Staff
Per OPP policy, which is consistent with industry standards, those on Direct Observation (primarily for self-harm) are to be evaluated by nursing staff 8 times each day (4 times per 12 hour shift). To provide a minimal assessment and complete associated documentation requires 10 minutes on average. Thus for 28 prisoners on watch each day, this requires the following amount of nursing time each day:

8 x 10 min x 28 = 2240 minutes or 37 hours

This amounts to slightly more than 1.5 FTE of a 24/7 staff. In addition 0.5 FTE will be necessary to cover pill line, medical treatments, medical emergencies, and other nursing duties, including with the non-mentally ill in Templeman 5. Note that it is expected that virtually all those in the mental health unit are expected to be receiving medications at pill line. To cover this for 7 days per week requires 1.4 times that amount: The total nursing staff needed per shift for these daily routine functions is:

(1.5 + 0.5) x 1.4 = 2.8 FTE

Given that nursing staff work in 12 hour shifts, 5.6 FTE are required on Templeman 5. Multiplying by the relief factor of 1.25 gives:

5.6 x 1.25 = 7.0 FTE

Licensed Practical Nurses with proper mental health training are minimally adequate to serve this function. Medical Assistants may be able to perform some functions but it would be necessary to demonstrate their capability of performing a basic mental status examination, including assessment of imminent danger to self or others, in addition to medical evaluations. In general, Medical Assistants are not trained to perform such functions and will thus not be included in these calculations.

These nursing staff require a Psychiatric Nurse Supervisor who should be a Registered Nurse (RN) with psychiatric training or experience. This position need not be 24/7 but can be a day shift position. Relief would not be required for this position unless this RN is included in a pool or nurses serving other required posts. This is not the preferred approach as psychiatric nursing requires a different skill set than medical nursing. However, it will be necessary to have a nursing supervisor available to Templeman 5 during evenings and on weekends. This position need not be a psychiatric nurse and can be shared with other units. It is estimated that this

function will require no more than 0.5 FTE across all shifts. This would include one half time for all weekday night 12 hour shifts and weekend day and night shifts (note that a 2-day weekend is 40% of a FTE). Note that if the Templeman 5 Psychiatric Nurse Supervisor works 8 hour weekday shifts this will leave 4 hours each weekday "uncovered"; however, the allotted time is sufficient as this function will be shared across different settings:

(0.5 x 1.4 for nights) + (0.5 x 0.4 for weekend days) = 0.9

With relief this comes to:

0.9 x 1.25 = 1.125 FTE

This gives a total nursing complement for Templeman 5 of:

7.0 LPN
1.0 Psychiatric Nursing Supervisor
1.125 Off shift nursing supervisor (may be a shared position; this is the portion attributable to Templeman 5)

Psychiatry

One psychiatrist is sufficient to cover 120 residential patients in the presence of sufficient other mental health providers to do daily assessments of those on Direct Observation and to assist in initial assessments of new patients. No relief is provided for this position. It is expected that psychiatrists will cover for each other and receive assistance from medical providers.

Psychology, Social Work, and Other Therapeutic Staff

A 1.0 Licensed Clinical Social Worker (LCSW) is necessary to provide placement services, coordination of aftercare, benefits assistance, and some direct care to this population.

Those on Direct Observation require daily assessment by a Masters or above clinician. While it is preferable to have this occur 7 days per week, it is reasonable for nursing staff to consult with an on-call provider on weekends and only conduct an in-person evaluation in order to reduce the level of observation or if there is an urgent or emergent problem. As such, an on-call mental health clinician is sufficient to provide this coverage as long as it is possible to secure an immediate assessment by a licensed clinician and access to emergency mental health services (either through an emergency room or an on-call mental health provider with psychiatric consultation available who can be at the facility timely) is available at all times. During weekdays, it is expected that each patient on Direct Observation will require on average a 15 minute assessment (including interview and documentation). This requires:

28 patients/day x 0.25 hours/patient x 5 days/week = 35 hours/week (1 FTE)

Given that there is essentially no programming space on Templeman 5, it is assumed that the bulk of therapeutic interactions will be individual.

For treatment purposes, it is expected that a masters of above clinician will meet weekly for an average of 30 minutes with each patient. This requires:

120 patients/week x 0.5 hours/patient = 60 hours/week (1.5 FTE)

It is estimated that an additional FTE will be required for initial assessments, treatment team meetings, and other administrative functions.

Lastly, 0.5 of a chemical dependency professional is needed for Templeman 5 owing to the necessity of addressing chemical dependency in the mentally ill both owing to its contribution to poor mental health outcome and its association with risk.

The total therapeutic staff needed on Templeman 5 are:

1.0 LCSW + 2.5 Masters Clinicians + 0.5 Chemical Dependency Professional

No relief is provided for these positions.

Administrative Support

A full time clerk is necessary for Templeman 5 to do filing, transport records, scheduling, and data entry. Relief is necessary for this position.

Summary

Templeman 5 mental health staffing amounts to

9.125 FTE nursing staff
1.0 FTE psychiatrist
4.0 FTE clinical counseling staff
1.25 FTE clerk

General Population

Per the assumptions, about 345 prisoners will require mental health services. About 120 of these will be in the mental health unit, leaving about 225 in GP. It is estimated that 200 of these will be taking psychotropic medications.

Nursing

Nursing requirements for GP are limited to sick call triage, pill line, and after hours crisis response. Normally, these duties are performed by medical nurses with mental health consultative back-up during evenings and weekends. The nursing staffing detailed in Dr. Inglese's report are adequate for these purposes.

Psychiatry

Psychiatric assessment will be required for most of those seen for initial mental health assessment. Most all of the 8 mental health assessments per day noted above will be on psychotropic medications and/or have a serious mental health condition and will therefor result in a psychiatric assessment. It is estimated that there will be 6 psychiatric assessments per day of new patients. Assuming there is a reasonably thorough initial assessment by a masters or above clinician, the initial psychiatric assessment can be done in 45 minutes (including charting). This requires:

6 assessments/day x .75 h/assessment x 7 days/week = 31.5 hours per week

At 70% clinical productivity, this requires:

1/0.7 x 31.5 = 45 hours/week or about 1.0 FTE

An additional 0.5 FTE will be necessary to conduct follow-up visits for those with those remaining in OPP more than two weeks. Note that it is reasonable to have outpatient level services delivered by a mid-level prescriber certified in psychiatry.

Psychology, Social Work, and Other Therapeutic Staff

The need for social work services for the mentally ill in GP is limited. Most of these individuals are capable of re-establishing or seeking their own services in the community. 0.25 FTE of social work time is sufficient.

Most of the work in GP will be crisis response, brief supportive therapy, and initial assessment for referral to psychiatric services. Though there are no robust studies available regarding number of necessary contacts, it is estimated that about 5% (110) of GP will need contacts each week, most for single or small numbers of visits. These visits should average about 30 minutes across different service types. This includes therapy, crisis response, assessment, aftercare planning, and PREA assessments. This requires:

110 contacts/week x 0.5 h/contact = 55 hours per week

At 70% clinical productivity, this requires:

1/0.7 x 55 = 79 hours per week or 2.0 FTE

An additional 1.5 FTE chemical dependency counselor will be needed for general population. This person would do assessments, treatment, coordinate services such as AA and NA, and assist in aftercare planning. This will not allow contact with all those with chemical dependency issues but will allow contact with the most severe and who are ready to accept services.

Administrative Support

Administrative support needs for the GP clinicians is nearly as intensive as for the residential mental health unit. Thus about 0.25 FTE administrative support is needed. With relief, this comes to about 0.3 FTE

Summary

Minimally adequate outpatient level services can be delivered in GP with the following resources:

Nursing staffing per medical
1.0 FTE psychiatric prescriber
3.5 FTE clinical counseling staff
0.3 FTE administrative support

On-Call Mental Health

As noted above, the array of on-call mental health services depends on how OPP elects to achieve urgent and emergent service needs. It is reasonable not to have on site mental health professionals as long as robust mental health emergency room services can be reliably accessed and/or if on-call mental health professionals can respond to OPP at any time. For this assessment, only a psychiatrist available for telephone call with emergency room back-up is assumed.

Weekday telephone psychiatric call can be expected to cost about $500/day. Weekend call can be expected to cost $750/day. Annual costs are:

(5 x $500 + 2 x $750) x 52 = $156,000

STAFFING COSTS

The table on the following page is from OPP data supplemented as noted by Dr. Inglese. In general, the annual salaries correspond to statistics from the Bureau of Labor Statistics (BLS) for salaries in New Orleans. The RN salaries are notably low with BLS showing 68,000. The remainder are reasonable. As such, I will use OPP data except for RN salary, for which I will use the BLS data coupled with OPP benefits data for a night RN, which will be slightly low ($68,000 + $8000 + $875 + $5674 = 82,549).

Orleans Parish Sheriff's Office
Jail Medical Salary & Benefit Projection
with projected staffing to meet OJD requirements (in 2013)

Billet	Staff Member	Status	Hourly Rate	# of hours / week	Annual Salary	Overtime Rate	Overtime Hours / week	Overtime Salary	Gross Salary	Pension	Medicare	Health Ins*	Employee Total	Number of Positions	Cost
1	Medical Director	FT			$ 231,379				$ 231,379	$ 30,657.72	$ 3,355.00	$ 5,674.20	$ 271,066	1	$ 271,065.91
2	Health Services Administrator	FT			$ 80,000				$ 80,000	$ 10,600.00	$ 1,160.00	$ 5,674.20	$ 97,434	1	$ 97,434.20
3	Director of Psychiatric Services	FT			$ 195,457				$ 195,457	$ 25,895.40	$ 2,833.84	$ 5,674.20	$ 229,860	1	$ 229,860.44
4	Director of Operations	FT			$ 56,025				$ 56,025	$ 7,423.31	$ 812.36	$ 5,674.20	$ 69,935	1	$ 69,934.88
5	QI Coordinator - RN	FT	$ 25.00	40	$ 52,000	$ 37.50	0	$ -	$ 52,000	$ 6,890.00	$ 754.00	$ 5,674.20	$ 65,318	1	$ 65,318.20
6	E&T Coordinator - LPN	FT	$ 19.00	40	$ 39,520	$ 28.50	0	$ -	$ 39,520	$ 5,236.40	$ 573.04	$ 5,674.20	$ 51,004	1	$ 51,003.64
7	Infection Control Coordinator	FT	$ 16.34	40	$ 33,987	$ 24.51	0	$ -	$ 33,987	$ 4,503.30	$ 492.81	$ 5,674.20	$ 44,658	1	$ 44,657.52
8	LPN day	FT	$ 17.50	40	$ 36,400	$ 26.25	2	$ 2,730	$ 39,130	$ 5,184.72	$ 567.39	$ 5,674.20	$ 50,556	19	$ 960,569.89
9	LPN night	FT	$ 18.25	40	$ 40,040	$ 28.88	2	$ 3,003	$ 43,043	$ 5,703.20	$ 624.12	$ 5,674.20	$ 55,045	16	$ 880,712.34
10	RN day	FT	$ 26.50	40	$ 50,960	$ 38.75	2	$ 3,822	$ 54,782	$ 7,258.62	$ 794.34	$ 5,674.20	$ 68,509	6	$ 411,054.92
11	RN night	FT	$ 27.00	40	$ 56,160	$ 40.50	2	$ 4,212	$ 60,372	$ 7,999.29	$ 875.39	$ 5,674.20	$ 74,921	2	$ 149,841.77
12	Staff Physician - Medical	FT	$ 82.69	40	$ 171,995	$ 124.04	1	$ 6,455	$ 178,445	$ 23,648.97	$ 2,587.45	$ 5,674.20	$ 210,351	2	$ 420,701.28
13	Staff Physician - Psychiatrist	FT	$ 82.69	40	$ 171,995	$ 124.04	2	$ 12,900	$ 184,895	$ 24,498.57	$ 2,680.98	$ 5,674.20	$ 217,749	1	$ 217,748.58
14	Nurse Practitioner	FT	$ 44.23	40	$ 91,998	$ 66.35	1	$ 5,456	$ 97,448	$ 12,686.91	$ 1,384.06	$ 5,674.20	$ 115,153	2	$ 230,305.89
15	Psychologist/LCSW	FT	$ 25.00	40	$ 52,000	$ 37.50	0	$ -	$ 52,000	$ 6,890.00	$ 754.00	$ 5,674.20	$ 65,318	1	$ 65,318.20
16	Masters Level Social Worker	FT	$ 24.25	40	$ 51,480	$ 27.13	1	$ 1,931	$ 53,411	$ 7,076.89	$ 774.45	$ 5,674.20	$ 66,936	5	$ 334,680.22
17	Clerk	FT	$ 12.09	40	$ 24,960	$ 18.06	0	$ -	$ 24,960	$ 3,307.20	$ 361.92	$ 5,674.20	$ 34,303	12	$ 411,639.84
18	Dentist	FT	$ 70.00	40	$ 145,600	$ 105.00	0	$ -	$ 145,600	$ 19,292.00	$ 2,111.20	$ 5,674.20	$ 172,677	1	$ 172,677.40
19	Dental assistant	FT	$ 14.00	40	$ 29,120	$ 21.00	2	$ 2,184	$ 31,304	$ 4,147.78	$ 453.91	$ 5,674.20	$ 41,580	2	$ 83,159.78
					$ 1,611,957			$ 40,681	$ 1,651,738	$ 218,855.27	$ 23,950.20	$ 197,809.80	$ 2,002,353		$ 5,169,666

**No data was available from the OPSO regarding health insurance. Therefore, I used the health insurance cost from the St. Tammany Parish Sheriff's Office as a cost basis.*
Completed March 14, 2013

Psychiatric Prescribers
There are a total of 3.4 FTE psychiatric prescriber. I will assume that the Director of Mental Health will continue to be a psychiatrist at 0.4 FTE (slightly higher salary than staff psychiatrist) and the 1.0 FTE on the residential mental health unit (Templeman 5) will also be a psychiatrist. The general population may be served by psychiatric ARNPs. The cost is thus:

0.4 x $229,840 + 1.0 x $217,749 + 1.5 x $115,153 = $482,415

Mental Health Nursing
This is limited to Templeman 5 nursing staff. It includes a psychiatric nurse supervisor and off-shift nursing supervisor coverage as well as dedicated nursing staff. The cost of an LPN is calculated using the average of night and day LPN costs (i.e. $52,801) as they will be evenly split across shifts. The total cost is:

7 x $52,801 + 2.125 x $82,549 = $545,024

Social Workers, Psychologists, and Chemical Dependency Counselors
There were no cost estimates available for Masters Psychologists. In general, they are similar to those of an LCSW. OPP may elect to use all social workers so this is used as the general figure for psychologists and social workers.

Chemical Dependency Counselors have mean salaries of $37,000. Benefits are estimated to be $14,200, slightly more than for an LPN earning a salary of $36,400. This brings the total to $51,200.

Overall costs for this category are:

(3.0 + 2.0) x $65,318 + (0.5 + 1.5) x $51,200 = $428,990

Administrative Support
The total cost for a clerk is $34,303. Thus 1.55 clerks cost:

1.55 x $34,303 = $53,170

Summary of Mental Health Annual Salaries
The total annual cost of staff dedicated to mental health is:

$482,415 + $545,024 + $428,990 + $53,170 = $1,509,599

Adding the $156,000 for on call psychiatric services, the total mental health costs (excluding supplies, medications, and administrative overhead) are:

$1,509,599 + $156,000 = $1,665,599.

COMPARISON WITH OTHER REPORTS

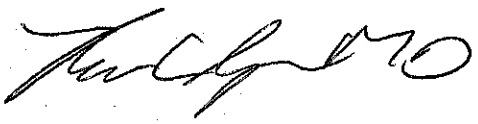
Neither Dr. Inglese nor Dr. Austin indicate how they arrived at the numbers. Dr. Inglese states that these are estimates and Dr. Austin appears to indicate that his estimates are based on work by Dr. Gore (OPP Medical Director) and his staff. The following table provides a quick summary of the number of positions recommended by each.

	Gage	Inglese	Austin
Director of Psychiatric Services	0.4	0.5	Not addressed
Psychiatric prescribers	2.0	2.0	1.5
Nursing (RN, LPN, MA)	9.125	9.0	Not directly addressed
Mental Health Clinicians (social workers or psychologists)	5.5	6.0	3.0
Chemical Dependency Professionals	2.0	Not addressed	Not addressed
Administrative Support	1.55	2.0	Not directly addressed

With regard to overall nursing staffing (including RN, LPN, and Medical Assistants), Dr. Inglese estimates needing 48; Dr. Austin estimates 42. For clerical staffing, Dr. Inglese estimates 12; Dr. Austin estimates 4.

In summary, the mental health related staffing need estimates by Dr. Inglese and I are very comparable while those of Dr. Austin are substantially lower.

Respectfully submitted,



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