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March 2, 2013

Southern Poverty Law Center
Attention: Katie Schwartzmann, Esq.
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4431 Canal Street
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Re: Jones v. Gusman
Civil Action No: 2:12-cv-00859

Per your request, in order to assess the current state of mental health and psychiatric treatment at the Orleans Parish Prison (OPP), an investigatory site visit was conducted at the facility December 18 and 20, 2012. In addition, requested facility records were reviewed, and interviews of both staff and current inmates were performed.

The listing of documents reviewed was voluminous and therefore impractical to include in this report. When specific medical records or facility documents were utilized in the formulation of an opinion or to illustrate an example, they will be noted in the body of this document. In addition, common medical abbreviations will be deciphered for the reader. Scientific literature utilized in the formulation of the opinions contained in this report will be cited and included in the bibliography (Attachment A).

In order to organize the information regarding the following issues and opinions in a manner most useful to the reader, where possible, the following report is organized in accordance with the Consent Judgment filed 12.11.12. It is opined that the provisions of the Consent Judgment, while limited, are necessary, and targeted toward addressing the deficiencies discussed in the ensuing report. Fulfillment of the requirements of the Consent Judgment should result in improvements in mental health and psychiatric care.

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Screening and Assessment

Per the facility policy and procedure entitled "Receiving Screening" individuals presenting to OPP are to be screened by trained health care personnel. Review of the policy did not indicate a timeframe within which these screenings were to be completed. Individuals are screened for a number of maladies, including but not limited to current and previous suicidal ideation; current and previous mental health treatment; current and previous substance use; and they are observed for signs and symptoms indicative of a mental illness. Given the data provided for review, it was not possible to determine the average amount of time that elapsed between admission and screening for a sample of individuals. Staff interviews performed during the investigatory site visit revealed that in general, these screening assessments are performed within 12 to 24 hours of admission. Timeliness of receiving screening assessments would be appropriate to include in quality assurance monitoring.

This reported time lapse between admission and receiving screening is concerning. It is well documented that the initial period of incarceration (e.g. first hours) are the highest risk period for suicidal ideation and self-injurious behavior. Hayes and Rowan (1998) found that 50% of incarcerated individuals who complete suicide do so within the first twenty-four hours of confinement, with 28.5% of those events occurring within the first three hours. In a suicide prevention policy outlined by Hayes (2011), screening for suicide risk should occur immediately upon confinement and prior to housing assignment. The ability to reduce suicide completion through screening immediately upon contact utilizing identified suicide risk factors has been shown to be highly effective in preventing suicide.

On the OPP initial screening questionnaire, incarcerated individuals are queried regarding the use of prescription or psychotropic medications. Despite positively endorsing such or providing information pertaining to specific medications taken before entering confinement, prison staff rarely continued medications unless the individual actually brought in the prescription medication. This was reported in interviews with multiple medical staff (physicians and nurses) and was corroborated by interviews of incarcerated individuals and review of medical records.

The lack of medication continuation is of particular concern given that many psychotropic medications require regular dosage maintenance in order to avoid rapid decompensation resulting from re-emergence of psychiatric symptoms; potentiation of seizure activity due to sudden discontinuation of antiepileptic medications utilized for mood stabilization; withdrawal or detoxification symptoms related to a history of treatment

with benzodiazepines; and other psychiatric complications resulting from rapid discontinuation or significant drops in therapeutic medication levels.

Other medications take a period of time for an individual to reach a target dosage. This slow upward titration of medication is performed in order to reduce the incidence of severe side effects. In the case of the medication Lamictal, if the dosage is missed for three or more days, the individual must restart the dosage titration from the beginning, a process which can take up to four weeks to reach a target dosage of 100 mg. During this period, the individual is likely to experience an exacerbation of symptoms. If the dosage titration is not done gradually, the individual is at risk for a life-threatening rash called Stephens Johnson Syndrome. With appropriate dosing, the risk of developing this condition is 0.8% whereas the risk is higher with inappropriate dosing.

In another example, individuals prescribed benzodiazepines (e.g. Klonopin) for anxiety or other indications may experience a withdrawal reaction that is very dangerous, with the possibility of blood pressure abnormalities, increased heart rate, seizure, and death. Furthermore, psychiatrists frequently utilize blood pressure medications in order to treat impulsivity, agitation, and irritability among other symptoms. Medications such as Clonidine must be tapered to discontinuation in order to avoid rebound hypertension, which is a dangerous spike in blood pressure.

Rapid discontinuation of antipsychotic medications may result in withdrawal dyskinesias, which are temporary movement disorders. Furthermore, individuals who experience an exacerbation of symptoms due to a lack of medication will require time for these symptoms to respond to pharmacotherapy. For example, risks associated with longer duration of untreated psychosis are well documented in the scientific literature. Delays in treatment of psychosis have been linked to neurodegeneration, persistence of symptoms, poorer social outcomes, increased difficulties in cognitive functions, and poorer response to future attempts at treatment with antipsychotic medications.

Individuals who experience a delay in the treatment of depression are at risk for continuation of depressive symptoms and/or exacerbation of symptomatology. The most serious risk of untreated depression is suicide. Other risks include self destructive behaviors, self injurious behaviors, disruption in social relationships, poor attention, poor concentration, poor motivation, and self medication via substance abuse. Delays in the treatment of bipolar mood disorder have been associated with more frequent and severe episodes of depression and mania, and longer episodes of depression. Youth with untreated attention deficit disorders

experience difficulty with attention and concentration resulting in difficulties in educational performance. Untreated attention deficit disorder can also cause exacerbations of challenging behaviors.

Substance Abuse and Detoxification

Substance use is a significant problem for incarcerated individuals. Mumola (1999) reported statistics regarding substance use in incarcerated individuals and found "83% reported past drug use and 57% were using drugs in the month before their offenses, compared to 79% and 50%, respectively, in 1991 (p.1)." Regarding a breakdown of substance use by type, Mumola (1999) found that "over 80% of state prisoners said they had used drugs at some point in the past…marijuana (77%)…cocaine-based drugs, including crack (49%)…hallucinogens (29%), stimulants (28%), opiates including heroin, and depressants (both 24%)…One in seven state prisoners reported using inhalants in the past (p. 3-4)."

Hiller et al. (1999) found that prison-based treatment programs were associated with decreased recidivism and increased lengths of time between arrests in incarcerated individuals who receive substance abuse treatment programs while serving time. These authors highlighted the importance of creating effective policies providing for correctional-based substance abuse treatment programs, as well as coordination and follow-through to aftercare treatment programs necessary to provide a comprehensive continuum of care.

The scientific literature provides much support regarding the importance of and effectiveness associated with later outcomes when substance abuse treatment is provided during incarceration. Pelissier et al. (2001) found completion of residential alcohol and drug programs while incarcerated was associated with decreased arrests following release from prison, as well as decreased substance use in the first six months following release. These researchers also found that cognitive-behavioral programs inclusive of relapse prevention and cognitive skills were utilized and effective in the course of treatment.

Fiscella et al. (2004) found rates of alcohol dependency among arrestees at approximately twelve percent. They also discussed the need for detoxification as "withdrawal symptoms often begin before arrestees have been formally charged with a crime (which may take up to 72 hours)…arrest in detention may result in…morbidity among alcohol…dependent individuals…" In a second publication, Fiscella et al. (2004) reviewed signs and symptoms associated with alcohol withdrawal and indicated "a number of jail deaths from inadequately treated alcohol withdrawal have been reported. Drug and alcohol dependence

are also associated with high rates of psychiatric morbidity…stress of acute withdrawal may increase suicide risk…"

Accurate, early identification of withdrawal symptoms coupled with clinically appropriate detoxification is crucial in the provision of care in incarcerated individuals given the high prevalence rates of alcohol or substance use among this population. In 2009, the Federal Bureau of Prisons published Clinical Practice Guidelines outlining guidelines for the identification, assessment, and detoxification procedures that should be followed to prevent alcohol or substance withdrawal.

With regard to identification, the Clinical Practice Guidelines distinguish between early, middle, and late symptomatology associated with each class of substances. The specific purpose of outlining these symptoms is to aid in the early identification of withdrawal symptoms in order to avoid life-threatening medical complications. Immediately upon entry into a facility, the process of monitoring for signs and symptoms associated with alcohol or substance withdrawal should begin. This process begins with a thorough clinical interview pertaining to an individual's history of alcohol or substance use prior to entry into a prison facility, which can alert medical personnel to the possibility of withdrawal even before presentation of withdrawal symptoms. Moreover, co-morbid psychiatric and/or medical conditions must also be assessed to prevent further complications. This is extremely important to ensure the health and physical safety of individuals entering the prison facility, as withdrawal symptoms can be life-threatening if undetected and unaddressed through appropriate medical intervention. The purpose of thorough assessment is preventative in nature to meet the ultimate goal of averting withdrawal.

The Clinical Practice Guidelines advise the use of standardized assessment measures or screening tools to evaluate withdrawal potential, as well as evaluate ongoing symptom presentation during the course of detoxification. Finally, the Clinical Practice Guidelines also outline specific detoxification protocols for all substances based on their classification (e.g., alcohol, benzodiazepines, opiates). The need for early identification is necessary to expedite the administration of detoxification procedures in order to preserve the health of individuals where alcohol or substance withdrawal is an issue. Effective detoxification can occur across multiple housing environments and does not necessarily require procedures to be provided in a specific setting (i.e., psychiatric unit). As such, there is no reason that detoxification cannot occur immediately upon entry into the system, if clinically indicated.

Facility policy and procedure entitled "Intoxication and Withdrawal" revealed procedures for identifying and responding to withdrawal symptoms. This policy also provided guidelines for detoxification of substances based on classification. Despite these procedures, records review demonstrated a failure by medical staff to follow the outlined policy and procedures. At times, records indicate that individuals were assessed for alcohol and substance use at the time of screening and intake. However, there is concern regarding the delay in conducting screening and intake, as discussed earlier, as some individuals will begin the withdrawal process during this gap between entry and screening or intake. Moreover, once withdrawal potential is identified through screening or intake, there was no indication in reviewed records that individuals were placed on detoxification protocols. There was also no evidence that staff focused on early, middle, or late signs of withdrawal when assessing individuals. Even though the use of standardized screening tools was identified in the policy and procedure, there was also no indication from reviewed records that staff utilized standardized screening tools.

There was no indication in reviewed records that preventative steps were taken to avoid active withdrawal through application of detoxification protocol. Individuals receive detoxification or medical attention only when they have reached the late stages of withdrawal and when the medical and physical risk approach much closer to life threatening. The dangers for individuals receiving late response to withdrawal poses a number of risks to the individual including, but not limited to, blood pressure and pulse abnormalities; seizure activity; delirium; and death. For further information via a case example, please note the discussion in the section entitled "Special Populations – Women" and the case of CF.

Additional documentation reviewed supported the opinion above that individuals were not sufficiently identified and appropriately treated for detoxification. The following examples were gleaned from a review of records regarding individuals transported to the emergency room in full substance withdrawal.

- AC – was routed to the emergency room and returned to OPP with a documented diagnosis of "narcotic withdrawal." Per the documentation, this individual was arrested on 11.17.12, routed to the emergency room due to "ingestion of pills" and upon return, "paperwork from LSU…confirmed pregnancy and methadone daily use." This individual was "routed again…pregnancy and methadone use…while waiting for this route to take place, inmate had a seizure in IPC…" Documentation from OPP revealed,

"observed with seizure activity…no seizure meds given since yesterday." This example illustrates several issues, specifically delay in treatment for seizure, resulting in seizure activity, and delay in treatment for "narcotic withdrawal" with multiple emergency room visits within a 48 hour period.

- IR – was admitted to LSU interim hospital with a diagnosis of "Alcohol Withdrawal." Per the discharge summary, "presented from Orleans Parish Prison, after being incarcerated for three days with altered mental status and confusion…likely due to alcohol withdrawal…heavy drinking history with six to 12 beers per day…" Other medical issues identified included diabetes, hepatic stenosis, acute kidney injury and right rib fracture. OPP records were not available for this individual; however, this case illustrates an individual incarcerated for three days with onset of alcohol withdrawal inclusive of a change in mental status suspicious for an absence of appropriate detoxification at OPP.

- IR2- was routed to the emergency room 3.13.12 due to "presenting with bizarre behavior does indicate history of alcohol use but has been in jail for eight days. Evaluate for delirium vs. possible detox." Additional medical records were not available for this individual; however, the advent of detoxification due to a history of alcohol use is suspicious for an absence of appropriate detoxification at OPP.

- MK – was routed to the emergency room 3.30.12 for "DT's…needs hospitalization for safe detox monitoring. Disoriented." Per ambulance service records, this individual "has been in jail for about a day." OPP records were not available for this individual; however, this case example is suspicious for lack of attention to this individual's detoxification needs with an escalating course requiring emergency treatment.

Access to Care

Interviews with multiple incarcerated individuals revealed a disjointed process with regard to access to care. Individuals reported that nursing rounds on their units did not occur on a regular basis, although interviews with nursing staff indicated a requirement for daily nursing rounds on each housing unit.

Incarcerated individuals indicated that sick call request forms could be obtained via nursing staff, "if they have one…then you fill it out and you give it to them the next time they come through." In the absence of

nursing staff, many individuals indicated obtaining sick call forms from "the deputies…they will tell you there is nothing wrong with you…or sometimes they will give you a form if they have one." Individuals did express frustration that when sick call forms are submitted, they are charged a $3.00 fee regardless of whether they are seen by a physician. They indicated that in some instances, they do not see the physician and are unaware as to why their request was not addressed. In these cases, they are reluctant to file a second request due to their fears of redundant charges for the same or similar medical complaint.

Access to health care at OPP must be improved. It is inappropriate for incarcerated individuals to request health care from security staff who may either purposefully or unintentionally impede or delay the individual's receipt of health care. It is generally accepted that incarcerated individuals must be able to access medical services independently. This would require the placement of a locked box in the dayroom area of each housing unit where incarcerated individuals could place their sick call request. This box must be checked on a daily basis by medical staff. On disciplinary units, where individuals have limited time outside of their cells, nursing staff must make daily rounds in order to assess the individual's condition (both physical and mental health) and accept sick call requests from the incarcerated individuals. A review of policy and procedure documented entitled "access to care" and "sick call" did not indicate the process by which incarcerated individuals actually request care. This must be defined in policy.

A review of a small sample of sick call forms for the months of October and November 2012 provided by the facility Medical Director revealed that of a sample of 41 sick call forms in the month of October, four were related to mental health issues. Of 68 sick call forms in the month of November, five were related to mental health issues. These documents indicated that in general, all were reviewed by nursing staff within one day of submission. The mental health sick call forms were then assigned a triage level "B" for evaluation by the psychiatrist. Data revealed that on average, these individuals were evaluated by psychiatry within 11.6 days of referral. The range was five days to 27 days, with a median of 13 days.

A review of policy and procedure entitled "Basic Mental Health Services" indicated the procedure by which an incarcerated individual would access a psychiatric evaluation; however, a description of the triage system and acceptable timelines for completion of a psychiatric evaluation were not included. It is generally accepted that an urgent referral for a psychiatric evaluation should be completed within 24 hours, and a routine referral for a psychiatric evaluation should be completed

within 14 days. These are issues that should be included in facility policy and procedure, and should also be subject to quality assurance monitoring.

In addition to the issues discussed above, there was evidence of challenges with the "sick call" system illustrated via a review of grievances. For example, a sample of grievances for the month of May 2012 was provided by OPP for review. Of a total of 15 examples, there was an average of 7.6 days until the grievance was addressed, with a range of four to 19 days. In the 16th example, it was noted that the individual filed the grievance on 5.21.12, but was discharged from the facility on 5.15.12, six days earlier.

Another example, regarding DC, indicated that this individual filed grievances in an effort to access mental health care on two occasions. The first was filed 5.15.12 and the second 5.23.12. On both occasions, this individual complained of psychotic symptoms. On 5.15.12 it was noted, "I spoke with the nurse when I first came to jail. I'm bipolar and I need my medication. I'm hearing voices and seeing things…I need my medication and treatment." The second grievance filed 5.23.12 stated, "I need to see the doctor. I'm hear [sic] voices, and I'm seeing things. I'm…bipolar and skiczarfrit [sic]…please help me!...because I feeling [sic] like demonds [sic] arounds [sic] trying to take my soul." Neither of these grievances were addressed by the time this individual was discharged from the facility. This example is concerning in the time lapse between the initial grievance, the apparent lack of attention to this individuals complaints of mental health symptoms and the potential for a delay in the treatment of psychotic symptoms. Unfortunately, this individual's OPP medical record was not available for review.

There were issues reported with regard to those individuals referred for treatment at Feliciana Forensic Facility (FFF). Specifically, in the past, OPP received information regarding each individual committed to FFF so that evaluation and treatment could begin at OPP. Per the facility medical director, this information is no longer provided to OPP, and as such, they are not aware when an individual has been committed to FFF and is awaiting placement there. Upon return to OPP from FFF, notification including evaluations and medication lists are provided to allow for continuity of care.

Psychiatric and Mental Health Treatment

Treatment

During the investigative site visit, a number of individuals were interviewed. The majority of individuals reported a history of mental health diagnoses

and treatment. In addition, the majority of individuals indicated they were either not currently receiving mental health services, or were receiving inadequate mental health services during their incarceration at OPP. Given the paucity of mental health resources available, it is opined that there is a population of unidentified and untreated individuals and an absence of other therapeutic modalities outside of psychotropic medication. This was confirmed via record review as outlined in the examples included below obtained via a visit to disciplinary segregation in the old prison building. The following individuals were selected at random for interview. Additional examples can be located in the discussions in sections headed "women" and "youthful offenders."

- RT (2330031) reported he had been housed in disciplinary segregation since 11.1.12. He stated, "I got 90 days in here…I got in two fights when I was in the tents." He reported a history of a diagnosis of bipolar mood disorder, and stated he had been treated with medications including Lithium and Risperdal via the mental health center. He indicated he was not currently treated with psychotropic medications. He reported current symptoms including poor sleep and increased energy levels. He evidenced loosening of associations, grandiosity, and pseudointellectual speech. His presentation was consistent with a possible diagnosis of bipolar mood disorder. It was considered that untreated mood symptoms may have contributed to behavioral challenges resulting in disciplinary segregation.

  This individual's facility medical record was reviewed. Documents consisted of a medical intake screening. Per this document, this individual did not report any mental health issues; however, it was apparent that his condition had deteriorated during his incarceration. This had gone unrecognized. A review of the record did not reveal daily mental status checks performed by a trained health care professional (i.e. either a trained nurse or a qualified mental health professional). Were these occurring, this individual's mental health issues would have been recognized and could have been addressed by a referral for a mental health assessment and treatment as needed.

- RL (2338937) reported a history of multiple incarcerations at OPP. He reported a history of diagnoses including "bipolar mood disorder and schizophrenia." He indicated a history of substance abuse, specifically alcohol consumption at a quantity of one pint per day, prior to his arrest. He did not recall undergoing a detoxification protocol upon entrance to the facility. He indicated that initially, he

was not treated with psychotropic medication, and was participating in a work release program. He described experiencing increasing signs and symptoms of mania, ultimately "I walked off of work release…I was manic…I needed to drink and smoke pot or something." He indicated that while in his opinion, substance abuse treatment would be beneficial for him, "they don't have that here." He indicated following the above event, he was evaluated by the psychiatrist and prescribed Zyprexa, an atypical antipsychotic medication he had been previously prescribed by his community provider. He reported ongoing symptoms consistent with a mood disorder including increased sleep and signs and symptoms of depression. He also reported a medical history significant for diagnoses of Hepatitis B and Hepatitis C.

This individual's facility medical record was reviewed. He reported a history of chronic alcohol consumption during the medical intake screening performed 9.27.12. There was no documentation of any detoxification protocol initiated. At that time, he reported a history of a diagnosis of bipolar mood disorder and schizophrenia, and treatment with specific medications, inclusive of dosages.

An initial health assessment was performed 10.2.12. At that time, a history of diagnoses including Hepatitis B and C was documented. An initial psychiatric evaluation was performed 10.22.12, approximately one month following his admission. At this time, past medical history was documented as "no previous medical problem reported." There was no documentation of a review of the initial health assessment, which included documentation of this individual's history of hepatitis. A diagnosis of "bipolar" was checked off, but the documentation did not include a listing or discussion of specific symptoms present in order for this individual to meet the diagnostic criteria required.

No laboratory examinations were requested and there was no documentation of weight or vital sign monitoring prior to the prescription of the atypical antipsychotic medication Zyprexa. In light of his diagnosis of Hepatitis B and C, alternate antipsychotic medication that avoids liver metabolism could have been considered (i.e., Invega). There was no documentation of abnormal involuntary movement monitoring, which should occur at baseline and every three months during the course of treatment. This individual was scheduled for a follow up appointment three months following the initial evaluation (1.21.13).

Given the potential for metabolic side effects with antipsychotic medication, specific screening and monitoring for side effects is generally accepted. Per consensus recommendations by the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity, baseline and annual monitoring should include at a minimum: personal/family history; body mass index; waist circumference; blood pressure; fasting blood glucose; fasting lipid profile; and white blood cell count. At four weeks and eight weeks following the start of treatment, body mass index and white blood cell count should be monitored. At 12 weeks following the start of treatment, body mass index; blood pressure; fasting blood glucose; fasting lipid profile; and white blood cell count should be monitored. Based on the results of this monitoring, additional testing or consideration of an alternate medication could be required.

This example was illustrative of numerous issues, specifically absence of monitoring for detoxification in an individual who reported chronic alcohol dependence, delay in access of mental health treatment, inadequate psychiatric evaluation, and inadequate screening and monitoring for both abnormal involuntary movements and metabolic side effects.

- AD (2303613) reported a history of psychiatric treatment prior to incarceration. He indicated he was experiencing poor sleep and increased auditory hallucinations. He reported placing a sick call request to see psychiatry, and recalled one occasion where he was housed on a unit specifically for individuals with mental health disorders, "but I didn't get any medicine…and I am not taking any now…and I haven't seen the doctor in a while." This individual appeared sad, and he reported feelings of sadness, daily crying, poor energy, poor sleep, and auditory hallucinations. On presentation, he exhibited soft, slow speech and slowing of motor movements, all of which were consistent with a mental illness.

  A review of this individual's facility record revealed that he was placed on suicide watch in October 2011 "per a court order." The "initial evaluation of suicide inmates" form was completed on 10.5.11, with an initial psychiatric evaluation dated 10.6.11. A "contract for safety" was completed on 10.6.11, where the individual wrote, "I never was suicidal." Per the psychiatric evaluation, the individual denied a history of psychiatric illness or

treatment with psychotropic medications. Per the "Psychiatric Treatment Plan Orders" dated 11.1.11, there was no Axis I diagnosis evident, and he was scheduled for follow up "prn." Per the "annual health assessment note" dated 11.26.12, "depressed for eight to nine months…diagnosis depressed…referral: psych reason depression." There was no documentation indicating this referral was completed.

The next mental health contact was documented via a "direct observation order set" dated 3.24.12 where this individual was placed on direct observation due to suicidal ideation. The only psychiatric documentation associated with this incident included a "psychiatry chronic care treatment plan" dated 3.30.12. Per this documentation, "denies any suicidal or homicidal ideations…signs contract for safety of self or others…states he never said he was suicidal, but that his 'rap' was misunderstood." The diagnosis was documented as "location seeking behavior" which is not a DSM-IV-TR diagnosis. Direct observation was discontinued at this time, and follow up was scheduled "prn."

This case illustrated the lack of follow up with regard to mental health issues even in the presence of a referral from medical staff following the annual health assessment. This individual required suicide watch via direct observation on two occasions yet was not regularly followed via psychiatry clinic.

The following are examples of interviews or observations conducted on the psychiatry tier:

- RC (2343624) was interviewed. This individual indicated he was not currently taking medication. He was noted to lie under the bottom bunk, hiding from deputies attempting to monitor his behavior. He was overtly paranoid, and noted to be responding to internal stimuli. He mumbled and exhibited loosening of associations.

  This individual's medical record was reviewed. Per the intake medical screening dated 11.23.12, there was no history of medical, psychiatric, or substance abuse concerns, with all question checkmarks negative. On 11.26.12, this individual signed a contract for safety, indicating he has no suicidal or homicidal thoughts to harm self or others, on 11.27.12, he was transferred to the psychiatry unit.

Per the initial psychiatric evaluation dated 11.27.12, "'I'm homicidal, suicidal.'…Reports previous attempt to hang self, but won't give details…outpatient treatment at Central City 'a week ago'… prior arrests without Axis I diagnosis…affect irritable…partial cooperation…no Axis diagnosis evident at this time…no psych meds necessary at this time…housing acute psychiatric units…Direct Observation…follow-up date 11/29/12."

The "Initial Evaluation of Suicidal Inmates" completed by nursing staff 11.27.12 reported, "I feel people are trying to kill me or I'll hurt somebody else…Does inmate have a plan?...Yes, cutting their throat off…Psychotropic medications – none…Alert, oriented, affect normal…thought process clear…behavior normal."

The Psychiatry Chronic Care Treatment Plan, dated 11.29.11 indicated, "…uncooperative with interview attempt. Unable to verbally redirect…not cooperative…mood not given…? S/H ideations…does not appear to respond to internal stimuli…attitude uncooperative…diagnosis rule out adjustment reaction; rule out location seeking behavior…may go to court with continued direct observation by security."

Provider Note/Order dated 12.12.12. documented "patient extremely belligerent, Bizarre, thinks that I will 'harm him'…I did not examine the patient…nurse unable to examine and obtain a BP…patient soiled in stool…history of psychiatric disorder…refuses meds…would defer to psych for further management of psychosis, before dealing with medical issues."

Psychiatry Chronic Care Treatment Plan dated 12.13.12 documented, "rule out adjustment reaction, rule out Location Seeking Behavior…No Psych meds necessary at this time…Direct Observation…12.17.12 Psychiatry Chronic Care Treatment Plan…Inmate uncooperative with interview attempt. Unable to verbally redirect. Observed on tier interacting with other inmates…thought processes organized…does not appear to respond to internal stimuli…No psych meds necessary at this time…direct observation."

This case illustrates the lack of investigation into the individual's symptoms. It was notable that the majority of the psychiatric documentation in this case was similar for each clinical encounter. There was no notation that the information from the primary care provider was noted, inclusive of the description of the individual as

"bizarre" and "soiled in stool." It should also be noted that other individual's on the unit pointed out this individual to the investigators, "you need to check on him…there is something really wrong with him." This individuals cell was malodorous with feces on the walls and windows. The totality of this information in conjunction with this individual's observed mental status and behavior during the site visit is very suspicious for a diagnosis of psychosis. This indicating the possibility of an extended duration of untreated psychosis.

- TS (2342012) was observed on the psychiatry unit on two occasions. On the first observation, he declined to speak. He was noted lying in his cell on a mattress on the floor. He evidenced a flat affect, slow movements and poor eye contact. Staff indicated that he had a history of refusing meals. On the second observation, he evidenced psychomotor retardation, in that he was noted to move in slow motion. He evidenced soft slow speech. His affect remained flat and he had little interaction with others.

  This individual's medical record was reviewed. The Medical Intake Screening on 11.3.12 indicated no history of medical, psychiatric, or substance abuse issues.

  On 11.4.12, the Initial Evaluation of Suicidal Inmates was completed by nursing staff. It was documented, "No words spoken, patient will not speak…bizarre behavior… No previous psych history per intake screening… talking to himself…bizarre behavior, running into wall, talking to himself but would not speak to staff."

  The Initial Psychiatric Evaluation was performed 11.5.12 and documented, "disorganized and disoriented, standing naked in cell. Abnormal vital signs…Prior OPSO arrests without psych meds." On 11.9.12, the Psychiatry Chronic Care Treatment Plan, indicated, "routed back to LSU Interim… extremely agitated, banging head into wall, fighting deputies…"

  11.10.12, due to documentation of "banging head on wall…fighting deputies…four deputies to restrain" this individual was prescribed Thorazine 50 mg IM.

  11.11.12 LSU Interim Hospital documented, "from OPP…bizarre behavior…third visit this week for the same…sitting in a chair in the room with repetitive movements of his hands for no particular purpose…everything short of a lumbar puncture has been

performed in the workup of this patient…he has psychiatric resources available for him provided by Orleans Parish Prison…medically cleared…he has no evidence on this visit or prior visits of delirium or medical illness…has been seen by psychiatry here as a courtesy who feels like this could certainly be a primary psychiatric issue."

11.13.12 Psychiatric Treatment Plan Orders, documented "Diagnoses: Delirium vs. Substance Induced Psychosis…No psych meds necessary at this time…Housing: Acute Psychiatric Unit…Discontinue Direct Observation."

On 11.17.12, the diagnosis was changed to "rule out psychosis, not otherwise specified; rule out delirium." This individual was not prescribed psychotropic medications. Similar documentation was noted on subsequent clinical encounters, including documentation of "uncooperative with interview…appears in no apparent distress."

This record is an example of a case where delirium or other causes of altered mental status were ruled out by an appropriate emergency room visit. Upon return to the facility, the individual has continued to engage in bizarre behavior with minimal communication suspicious for a psychotic process; however, at the time of the last progress note documented 12.6.12, no medications had been trialed.

Psychiatric Evaluation

An appropriate psychiatric evaluation facilitates the differential diagnosis of psychiatric disorders as the basis for individualized treatment. This not only allows for the identification of specific symptoms and diagnoses forming a basis for the rational use of psychotropic medications, but also assists in guiding psychotherapeutic interventions. A complete psychiatric evaluation includes but is not limited to: history of present illness, past psychiatric history, past medical history, family history, current medications and response to them, history of treatment with medication and response to them, medication allergies, social history including substance abuse, collateral information (interviews of parents, review of prior mental health records) and a mental status examination.

Examples of psychiatric evaluations reviewed in the medical records received were sparse with regard to detail. Symptoms resulting in the diagnosis were included via a list with checkboxes for the physician. The symptoms were general, and did not include information regarding duration or severity of symptoms. There was little to no individualized

information regarding the patient's specific symptom experience or their course of illness outside of the available checkboxes.

A separate document, "Psychiatric Treatment Plan Orders" was attached to the initial psychiatric evaluation. This document was also a series of checkboxes for documentation of diagnosis, medications, laboratory examinations requested, housing recommendations, level of observation required, specialty referrals, patient education requirements, mental health clinic referrals, records requests, and follow up required. The adequacy of treatment planning will be addressed in the section entitled "Treatment Plan." In addition, this form included a signature space for completion "with each new medication ordered" that indicated, "I have been informed of the proper way to take my prescribed medication as well as the potential side effects. I wish to take the above ordered medications." The issue of adequacy of informed consent will be addressed in the section entitled "Psychotropic Medication Management."

As noted above, there was not appropriate documentation of target symptoms to support the assigned diagnosis. In addition, there were options in the diagnosis section that were not based on DSM-IV-TR criteria including "drug seeking behavior" and "location seeking behavior." This was concerning, as dismissing suicidality or other mental health symptoms as "drug seeking" or "location seeking" in the absence of a comprehensive mental health or psychiatric evaluation would result in missed opportunities to address an individual's mental health concerns resulting in a lack of identification and delay of treatment. Moreover, individuals with mental illness are vulnerable in that they may be victimized by other individuals and seeking safety as a result. The conditions on the mental health tier are restrictive, and it is concerning that individuals would seek placement on a unit such as this. This calls into question the need to consider milieu issues on other units with regard to safety.

In review of the records available, documentation did not include the formulation of diagnoses and there was not adequate justification for prescribing psychotropic medications. Given these deficits in documentation coupled with the lack of documentation of diagnostic criteria, there was no support or justification for prescribing psychotropic medications. As such, in an effort to improve psychiatric evaluation standards, quality improvement via peer review would be beneficial in assisting to increase and maintain standards for evaluation and documentation.

Prescription of Psychotropic Medications

Psychotropic medications are indicated when an individual exhibits symptomatology related to a specific psychiatric diagnosis. Unfortunately, in incarcerated individuals, psychotropic medications have been used in an effort to suppress aberrant behaviors. This has resulted in over prescription, polypharmacy, and the use of medication in place of habilitation. There are specific concerns with regard to the over prescription of sedating antipsychotic medications. This was a point of concern at OPP.

The issue of mental illness among incarcerated individuals has gained substantial attention in scholarly research. Studies pertaining to the prevalence rate of psychiatric disorder or mental illness have been of specific focus. Research has consistently shown that between 10% and 15% of incarcerated individuals meet criteria for a mental illness (see Teplin 1994; Teplin et al., 1996; Peters, et al., 2008; Baillargeon, et al., 2009). Of incarcerated individuals diagnosed with mental illness, 70% of them also had co-occurring substance use disorders (Baillargeon et al., 2009).

Other studies have shown that between 6% and 20% of incarcerated individuals met criteria for a severe mental illness (i.e., schizophrenia, major affective disorders); however, when considering all mental disorders, the lifetime prevalence is much greater (Weinstein et al., 2005). Six percent of incarcerated males exhibited symptoms consistent with or had been diagnosed with a severe mental illness within two weeks of arrest (Weinstein et al., 2005). Research has consistently documented a breakdown of mental illness among incarcerated individuals across correctional settings with 1% being diagnosed with schizophrenia, 2-3% with mania, and 8-15% with major depressive disorder (Weinstein et al., 2005). More recent research per Steadman et al. (2009) indicated that rates of mental illness among incarcerated males was 14.5% and among incarcerated females was 31%. These percentages reflected the "prevalence of serious mental illness (defined as major depressive disorder; depressive disorder not otherwise specified; bipolar disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not otherwise specified." When including other diagnoses (e.g. posttraumatic stress disorder; anxiety disorders; and substance use disorders), it is opined that these prevalence rates would be higher.

When considering data regarding individuals receiving psychiatric treatment at OPP, results indicated that approximately 11.7% of incarcerated individuals were receiving treatment with some type of

psychotropic medication. It should be noted that the data provided for review and utilized in the calculations above were suspect with regard to reliability. Data were provided for a set of individuals; however, it was not possible to determine if these individuals were currently in the facility, and in some cases, it was reported that the individuals were no longer at the facility. In addition, no population sheet or daily census was provided, so it was not possible to determine the accuracy of the information.

Due to the manner in which data was presented, it was not possible to determine the percentages of males v. females prescribed psychotropic medication. Regardless, given the data, it was apparent that there were likely a number of individuals residing at the facility experiencing untreated mental illness. This was confirmed via interviews of individuals who were exhibiting signs and symptoms consistent with serious mental illness who reported they were not prescribed psychotropic medication. In many cases, this was confirmed by record review (see IH; TS; TE; RC).

An analysis of medication type was conducted utilizing the OPP patient prescription log, which included aggregate data for both incarcerated males and females. For the 377 individuals receiving at least one psychotropic mediation (e.g., antidepressant, antipsychotic, mood stabilizer), there were a total of 563 medication prescriptions prescribed to this group. Of these, 277 (i.e., 49%) of these individuals were prescribed a typical or atypical antipsychotic medication. An additional 56 prescriptions (i.e. 10%) were for side effect medications associated with antipsychotic treatment.

Data indicated that when medications were prescribed, there was an overreliance on sedating typical and atypical antipsychotic medication in lieu of other psychopharmacological interventions. Relative to the prevalence rates for diagnoses including schizophrenia, mania, or depression, all of which may have psychosis as part of their presentation, in addition to pharmacological indications for atypical antipsychotic medications in the treatment of certain mood disorders, it is clear from the data, in comparison with typical prevalence rates, that use of antipsychotic medication at OPP is significantly disproportionate to that of well-established prevalence rates for severe mental illness.

Using a total population of 3200 inmates (per interview of Samuel Gore, M.D., Gambit), the above indicated that 11.7% of the population was prescribed psychotropic medications. Per Primm et al. (2010), "estimates from interviews with jail inmates in 2002 and with state and federal prisoners in 2004 revealed that more than half of all inmates have a recent history of mental illness yet only 34% of federal prisoners, and 17% of local

jail inmates have been treated for mental illness." This data in conjunction with the interviews performed during the site visit indicated the substantial risk of individuals currently incarcerated at the facility not receiving necessary mental health services.

Per an interview in Gambit, Dr. Gore indicated that "he estimates about 45 percent of the inmates at Orleans Parish Prison (OPP), of an average daily population of 3,200, have indicated during an entrance screening that they may have some form of mental illness, albeit not medically diagnosed in many cases and not severe in most. He can't say how many acute cases he has, but says between seven and nine percent of OPP inmates have a prescription for psychotropic drugs."

In order to ensure appropriate diagnosis and pharmacological intervention, assessment (as discussed above) is absolutely critical. Appropriate assessment facilitates the differential diagnosis of psychiatric disorders as the basis for the rational use of psychotropic medication. In this way, the "scatter shotgun" approach to pharmacology is avoided. In some cases, medication may not be appropriate, as it does not treat the source of the problem (e.g., a significant trauma history). Medication can reduce the frequency of problematic behavior via sedation; however, this may suppress functional adaptive behaviors. This being said, there are situations when medication (and treatment with multiple medications or polypharmacy) is absolutely appropriate, however, the medication must be symptom specific. Unfortunately, it was difficult to ascertain if polypharmacy was problematic at OPP as the data provided for review were inadequate in order to determine the specific indications for medications prescribed to each individual.

The review of medical records performed in this case did not reveal the identification of specific target symptoms for treatment with psychotropic medications. Additionally, as individuals were not seen regularly for follow up medication management monitoring, it was not possible for the treating psychiatrist to determine the benefit of the medication with respect to specific symptomatology. While records revealed that in many cases the psychiatrist recommended that individuals prescribed psychotropic medication return to clinic in one month, data revealed this would be impossible given the current psychiatric resources. For example, for 377 individuals currently prescribed psychotropic medications to engage in monthly medication reviews, this would require a total of 94 hours per month (allowing for 15 minute medication reviews). The current psychiatric staffing allows for 160 hours per month indicating that 59% of the psychiatrist's clinical availability would be consumed by this activity.

Regardless, data presented for review indicated very few monthly clinical encounters outside of those individual's housed on the psychiatry unit.

As discussed in other areas, record review did not reveal documentation that the psychiatrist was notified when individuals experienced difficulties during their incarceration outside of suicidal ideation requiring direct observation (e.g. medication side-effects, exacerbation of behavioral challenges, isolation, etc.). Events such as these should be reported to the psychiatrist such that a determination can be made with regard to the need for an immediate clinical consultation with the individual to address emerging symptoms.

Psychotropic Medication Management

Given the possibility of negative and/or potentially dangerous side effects resulting from treatment with psychotropic medication, medication monitoring is absolutely necessary. This would include among other indices: abnormal involuntary movement monitoring for individuals prescribed antipsychotic medication; routine laboratory examinations (medication levels and ancillary laboratory examinations including electrocardiograms); vital sign monitoring, and weight monitoring.

As discussed above, records reviewed revealed that psychotropic medications were not adequately monitored via monthly medication management clinical encounters. This frequency of medication monitoring is not consistent with generally accepted practices where individuals are seen for medication management on a monthly basis in an effort to determine their response to medications or lack thereof, if side effects were experienced, to review laboratory examinations and other clinical data necessary for monitoring of specific medications.

In rare cases, laboratory results were noted in the medical records. There was no progress note or documentation regarding a review of the laboratory results with the individual, or in the cases of youth with their parent/guardian. There was no facility laboratory matrix or protocol located in the documents available for review. This would ensure that laboratory or other side effect monitoring necessary for review of a specific medication would be requested.

For example, individuals treated with second generation antipsychotic medications are at risk for the development of metabolic syndrome (e.g. weight gain, diabetes, high blood pressure, high cholesterol). Record review did not reveal consistent adherence to guidelines for monitoring of these medications.

In order to illustrate this, monitoring of second-generation antipsychotic medications will be discussed. It should be noted that other psychotropic medications have specific monitoring requirements as well; however, given the large percentage of individuals prescribed this type of medication at OPP, this class was chosen as an example. Given the potential for metabolic side effects with antipsychotic medication, specific screening and monitoring for side effects is generally accepted.

Per consensus recommendations by the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity, baseline and annual monitoring should include at a minimum: personal/family history; body mass index; waist circumference; blood pressure; fasting blood glucose; fasting lipid profile; and white blood cell count. At four weeks and eight weeks following the start of treatment, body mass index and white blood cell count should be monitored. At 12 weeks following the start of treatment, body mass index; blood pressure; fasting blood glucose; fasting lipid profile; and white blood cell count should be monitored. Based on the results of this monitoring, additional testing or consideration of an alternate medication could be required. In addition, the American Academy of Child and Adolescent Psychiatry practice parameter recommends electrocardiograms for individuals "with a family history of cardiac abnormalities or sudden death, or a personal history of syncope, palpitations, or cardiovascular abnormalities, a baseline EKG and subsequent monitoring should be carefully considered."

Record review did not reveal adherence to the recommended medication guidelines for atypical antipsychotics or other psychotropic medications. For example:

- RL (2737937) was prescribed Zyprexa 10 mg at bedtime 10.22.12. No laboratory examinations were ordered. It was noted that this individual would be scheduled for follow up on 1.21.13, approximately three months later.

- SO (2345078) was prescribed medications including Risperdal, Seroquel, Depakote, Propranolol, and Lithium. On the initial evaluation, the prescribing psychiatrist did not perform informed consent, as this box was not signed on the treatment plan. In addition, laboratory monitoring including lipids, weight, vital signs, and complete blood count were not requested. As discussed above, a lipid panel, weight monitoring and vital sign monitoring, and a complete blood count would be necessary.

- MS (2174118) was prescribed medications consisting of Benadryl, Seroquel, and Effexor. A review of this individual's medical record was conducted during the site visit. The record was sparse, and documents were not in chronological order. There was no documentation of weight monitoring, no abnormal involuntary movement monitoring and no documentation of laboratory examinations included in the paper record.

Per the interview with the facility psychiatrist, medication management is complicated by the poor medical record system, "there are issues with getting paperwork filed in the charts." He indicated that there is difficulty with receipt of laboratory results, "we don't always get them."

It was not possible to determine medication compliance as medication administration records (MAR) were reportedly retained electronically. Per policy and procedure entitled "Health Record Format and Contents;" however, "MAR's are part of the inmate's medical record." Completed MAR's were not printed and placed in the individual's record; therefore there was no objective method for the psychiatrist to determine compliance with medication. This would be an appropriate data point for pharmacy to provide to the psychiatrist via a weekly report regarding individual compliance levels for treatment with psychotropic medication.

This would be difficult to discern for those individuals who were approved for "Keep On Person" (KOP). Per the policy and procedure entitled "Medication Services", these individuals were provided a seven to fourteen day supply of medication and were then responsible for self administration. Per policy "while the KOP program encourages inmates to assume responsibility for their medical care, the medical staff is encouraged to switch to directly observed, or daily administered therapy if safety concerns are identified. Seriously ill inmates…with serious active psychiatric disease…and inmates with demonstrated medication noncompliance do not participate in self-medication programs."

Reportedly the psychiatrist approved KOP, and this was included in the "Psychiatric Treatment Plan Orders" document; however, there was cause for concern as there were instances of medication hoarding with subsequent overdoses of medications reportedly attributed to Keep on Person. The potential for victimization of individuals approved for KOP should be considered. Individuals possessing medication may be targeted, "strong armed," or experience interpersonal violence via other individuals in their effort to gain access to coveted psychotropic medications.

Burns (2011) indicated "most correctional facilities require that staff administer every does of psychotropic medication directly to the inmate for whom it is prescribed." This indicating that KOP would not be a generally accepted practice and must be reconsidered at OPP.

Treatment Planning

Per the facility policy and procedure entitled, "Continuity of Care During Incarceration", there is a requirement for treatment planning, "care for acute and chronic illnesses utilize an individualized Treatment Plan which…standardizes care…for chronic problems…clinical justification for all orders…outlines standard frequency/timing of follow-up...default follow-up is three months for stable chronic conditions…outlines treatment plan…prompts counseling and education." A review of the treatment plan generated by psychiatry following evaluation revealed this as an order sheet, and plan of treatment with psychotropic medication. There were no individualized goals or objectives included.

A review of the policy and procedure entitled, "Basic Mental Health Services" revealed that "an individualized, comprehensive treatment plan is developed by…psychiatrist…the multidisciplinary team including psychiatrists, physicians, nursing staff, social workers, substance abuse counselors, and correctional officers uses a biopsychosocial approach to alleviate symptoms, attain appropriate level of functioning, and prevent relapse." One of the duties of the psychiatrist is to "lead the multidisciplinary team." Review of records did not reveal biopsychosocial summaries, nor did not reveal documentation of multidisciplinary treatment team meetings or interventions. The treatment planning document described above, located in the medical records, was not created via an interdisciplinary method, and was not a treatment plan for overall mental health care and treatment. Given the review of multiple records, it was notable that for individuals who were not prescribed psychotropic medications, no additional mental health care was documented as provided. As discussed in the section entitled "Mental Health Counseling" there was a complete absence of mental health interventions outside of psychotropic medications.

Informed Consent

The facility policy and procedure "Informed Consent and Right to Refuse" indicated that "OPSO requires informed consent for…psychotropic medication administration…for these cases, inmates are provided appropriate medication information, including but not limited to risks and benefits prior to undergoing such treatment or procedure…" The policy also makes provisions for consent with regard to those individuals who are not competent to make informed decisions. It is opined that this would

include youth housed in the facility, as there is a population of youth charged and / or convicted as adults who are below the age of 18.

Informed consent for treatment with psychotropic medications is necessary. This process must include a discussion of the risks, benefits, side effects and alternatives to treatment with a particular medication as well as allow for any questions regarding the treatment. The informed consent process must be performed by the prescribing practitioner, and include a discussion with parent(s) or guardian(s) for youth under the age of 18 years. Although this facility houses youth charged as adults, it is my opinion that parental involvement in the informed consent process is necessary for all youth regardless of their legal charges.

Informed consent is needed prior to the prescription of psychotropic medication for any patient, but it is particularly important in child and adolescent treatment. This is due to the fact that there are a limited number of medications approved by the U.S. Food and Drug Administration (FDA) for the treatment of youth; however, medications are frequently prescribed "off label" in this population. Additionally, there are a paucity of controlled studies addressing the efficacy and safety of the use of medication in this population. For example, while it is acknowledged that the benefit of treatment with antidepressant medication is outweighed by the risk of side effects, there are specific warnings that must be conveyed to both the youth and their parent/guardian prior to instituting treatment with antidepressant medications. Youth must be aware of potential side effects such that they can both recognize them and report them.

For example, due to research indicating increased suicidal thinking and behavior among children and adolescents treated with antidepressant medications, the FDA instituted a "black box" warning regarding this potentiality. A "black box" warning is the most serious type of warning in medication labeling. The warning indicates that children and adolescents prescribed antidepressant medications must be closely monitored for any worsening in depression, emergence of suicidal thinking or behavior, or unusual changes in behavior, such as sleeplessness, agitation, or withdrawal from normal social situations. Close monitoring is especially important during the first four weeks of treatment.

Medical records reviewed revealed cursory informed consent documentation. The informed consent acknowledgement was located on the same form as the physician order for a particular medication and did not document specifics regarding side effects discussed, alternatives, or queries asked by the individual. In addition, there was no

documentation included with regard to information provided to the individual for their review following the clinical encounter. There was also no documentation regarding consultation with a parent or guardian.

A review of facility policy and procedure entitled, "Informed Consent and Right to Refuse" did not reveal procedures for use in cases of medication refusal in order to override the individual's objection via either an administrative or legal process. There were several individuals noted on the psychiatry unit who were experiencing signs and symptoms of serious mental illness. These individual's were not prescribed psychotropic medication. Per interviews with staff and medical record review, they were reportedly refusing medications. Per an interview with the facility medical director, there is currently no provision for forced medication in the facility. As such, individuals are not provided necessary medications and are allowed to decompensate in the absence of treatment.

Review of policy and procedure revealed that in policy and procedure entitled, "Emergency Psychotropic Medication" there is an administrative procedure for involuntary medications. It was unacceptable that this process had not been implemented with individuals noted on the psychiatry unit. This must be addressed via available policy and procedure, or consideration of legal proceedings in order to petition the court to allow treatment of serious mental illness. As noted several times in this report, there are documented harms associated with failure to treat including but not limited to suicidal ideation and self-injurious behavior.

Mental Health Counseling

Burns (2011) stated, "appropriate use of psychotropic medication for treating psychiatric illness is the standard of care, but is only one component of an effective treatment plan for inmates with serious mental illness. Others include group and individual therapy, psychoeducation, and therapeutic activities such as recreational therapy, activity therapy and opportunities for education and work within the correctional system."

A review of documentation did not reveal information regarding other therapeutic interventions with mentally ill inmates outside of psychotropic medication management. There was one social worker employed at the facility. He reportedly engaged in individual therapy and crisis intervention. A review of multiple records revealed documentation of these activities consisting of one encounter in one record. Given the paucity of mental health resources available at OPP, there was a significant population of unidentified and untreated individuals; an overreliance on antipsychotic medication for those individuals identified;

and an absence of other therapeutic modalities outside of psychotropic medication.

Medical and Mental Health Staffing
Currently, psychiatric and mental heath staffing at OPP is woefully inadequate. There is one psychiatrist (40 hours per week) and one social worker (40 hours per week). Given the number of individuals housed at OPP, these staff would be unable to perform even basic assessments to a level of acceptable quality. With a total facility census ranging between 2600 to 2700 individuals (Jim Austin, 2012), it is estimated that 14% of incarcerated males and 30% of incarcerated females would require assessment, evaluation, and treatment. This service requirement is increased due to the rapid turnover of individuals entering the facility.

As stated in many areas of this report, data provided for review were confusing and, in many instances, did not appear to accurately respond to the query. It is opined that as the services at OPP are disjointed, there is little organized data collection. In order to determine the utilization of psychiatric resources, a listing of all psychiatric clinical activities for the previous 90 days was requested. This listing, spanning from 9.24.12 to 12.18.12 revealed marked variability in the utilization of resources. For example, there were two clinical encounters dated 9.24.12 with the next clinical encounter documented 10.2.12, a span of seven days. Interviews with the facility psychiatrist and other staff indicated that he has not had a vacation in some time, therefore there was concern regarding the accuracy of this data.

In the month of October 2012, data indicated 22 clinical encounters, in November 2012, data indicated 54 clinical encounters, and in the first 18 days of December there were a total of 88 clinical encounters. If this data were correct, this indicates a poor use of clinical resources, and may partially explain the large number of individuals in need of treatment who have been unidentified. This is further indication of the lack of monthly medication management reviews for individuals prescribed psychotropic medications as discussed in the sections entitled "Prescription of Psychotropic Medications" and "Psychotropic Medication Management."

Suicide Prevention
Research has substantiated that the rate of suicide in correctional systems is significantly higher when compared to the community setting (Hayes, 1988; Blaauw et al., 2005; Daniel, 2006; Baillargeon et al., 2009; Hayes, 2011; Hayes, 2011). In some studies, the suicide rate in incarcerated individuals was noted to be between five to nine times higher when compared to non-incarcerated populations (see Daniel, 2006; Hayes,

2004). The Department of Justice reported that suicide completion in jail occurred at a rate of 48 individuals per 100,000 (Mumola, 2005). According to Hayes (2011), suicide is the leading cause of death in the correctional setting.

In an effort to prevent suicide and decrease the risk of suicide completion in correctional setting, a plethora of research within the scientific literature has investigated factors associated with increased risk for suicidal gestures, attempts, and completions. Risk factors for incarcerated individuals are similar to that of non-incarcerated populations; however, the scientific literature has identified unique factors related to incarceration, associated with increased risk of suicide. Factors that have been correlated with increased suicide risk include previous suicide gestures or attempts, substance abuse, presence of a psychiatric disorder(s), history of treatment with psychotropic medication, age (i.e., between 25 and 34 years), and race (i.e., Caucasian). Please see Blaauw et al., 2005; Baillargeon et al., 2009; and Hayes, 2011 for further information.

According to Mumola (2005) "nearly half of jail suicides occurred in the first week of custody (p. 8)." Hayes and Rowan (1998) found that the first three hours following confinement was the highest risk period for suicide completion. Juveniles placed in adult correctional settings also pose a significant risk as the rate of suicide among this population is eight times greater than that for juveniles housed in juvenile settings (Daniel, 2006).

The fact that suicide rates are higher in correctional setting compared to the community setting is undisputed in the scientific literature. In light of this, research has begun to focus on effective strategies and/or interventions for preventing suicide through assessment of specific associated risk factors. Hayes (2011) developed a comprehensive suicide prevention program utilizing what research has shown to be associated with suicide risk. Included in the program was staff training, intake screening immediately upon confinement, increased communication between personnel managing inmates, specific housing characteristics, level of supervision, intervention strategies and equipment, reporting of suicide, and mortality review.

A review of the OPP policy and procedure entitled "Suicide Prevention Program" revealed that the policy was lacking specific detail across most areas outlining protocol for suicide prevention and response. The policy indicated that staff is to receive suicide prevention training during orientation and biennially, which is provided through the OPSO Training

Division, medical department, and psychiatry. The orientation provided through the OPSO Training Division was not provided for review.

A review of suicide prevention training provided by Michael Higgins, M.D., was conducted. The outline of this training included only statistics related to suicide rates and characteristics associated with suicide risk. The training was generally lacking in detail required by OPP policy and those outlined by Hayes (2011) in the literature. There was no discussion of documentation, communication, assessment, recognition of suicidal inmates, supervision and handling of inmates, or interventions to be used if an individual is discovered following a suicide attempt. The information provided did not equip staff or personnel with skills or interventions that could be translated to everyday use in order to more effectively identify suicide risk, manage suicidal individuals, or respond effectively to suicidal behavior/attempts. Statements in the training minimized risk factors associated with increased suicide potential, specifically suicidal gestures, which were referred to as "a cry for help" or "manipulation."

A general concern noted throughout the OPP policy entitled "Suicide Prevention Program" was the paucity of detail or timeframes associated with certain activities in response to suicidal ideation. For instance, the policy documented that qualified health care personnel perform the initial medical screening in an effort to identify inmates with suicidal ideation requiring immediate intervention; however, the policy entitled "Receiving Screening" does not include timeframes within which this screening must be performed. As such, the screening could occur, as stated by facility staff, 12 to 24 hours following arrival, indicating that individuals would not be screened early in the high-risk period.

Per policy, medical personnel can obtain verbal orders related to the actions necessary following suicidal behavior. The policy noted that all "objects that could be used to harm themselves will be removed (e.g. shoestrings, belts, eyeglasses, etc)." There was no notation with regard to individualized suicide prevention plans for individual's requiring suicide watch. This was concerning as during the investigatory site visit, individuals currently on suicide watch were observed. These individuals were noted to have property in their cells that is prohibited per policy including shoelaces, clothing, and multiple pieces of tile flooring chips. Discussions with correctional officers on this unit indicated that they were aware of which individuals were currently on suicide watch, but were not aware of what property they were allowed to have in their cells.

The policy documented that individual's on suicide watch will be evaluated by a licensed clinician at the next daily psychiatric sick call.

Policy also required psychiatric follow-up should occur; however, there were no details regarding within what timeframe this should occur. The lack of operationally defined actions compromises the effectiveness of suicide responses and leaves open far too much subjective interpretation by individual personnel, which compromises the policy's integrity and renders its applicability ineffective.

In situations where a person was identified as having suicidal ideation or increased risk for suicidal behavior, individuals were placed on suicide precautions consisting primarily of direct observation by correctional staff at irregular fifteen-minute intervals. Interventions or precautions were not individualized, such as varying levels of monitoring (e.g., constant observation, every fifteen minute, step-down). No continuous one-to-one monitoring within arms length was available to ensure the safety of any individual on suicide precautions. There were no individualized step-down criteria for discontinuation of suicide precautions once an individual was identified. In other words, all individuals were managed in the same manner without an individualized suicide prevention plan based on a personalized risk assessment focusing on unique features potentiating suicidal risk that a person may exhibit.

During intake, screening of past suicidal ideation or attempts was conducted; however, records did not indicate that these individuals were flagged or identified outside of those individuals identified as requiring immediate suicide watch. There was no protocol outlined for mitigating risk or providing follow-up care to individuals who presented with predictors of increased suicide risk.

Medical records of individuals who were identified as having a history of suicidal ideation or requiring direct observation suicide watch were reviewed. In general, these records were difficult to read with the exception of specific check boxes. Individualized physician documentation was sparse and generally devoid of detail. There was no documentation with regard to specific risk factors or a risk assessment pertaining to self injurious behavior. There was a general treatment plan document that indicated the individual required direct observation; however, there were no individualized treatment or property recommendations outside of specific medications prescribed. Despite that fact that some individuals experienced multiple instances of placement on direct observation or suicide watch, they were not referred for counseling, and there was no documentation of counseling located in the records. In addition, multiple records revealed "contract for safety" documents, where individuals signed these documents indicating they did

not want to hurt themselves or anyone else, and if they did have these thoughts, they would notify security and/or medical staff.

The use of safety contracts is generally ineffective in reducing risk of self harming behavior. Existing research does not support the use of suicide contracts as a way of preventing suicide nor does it replace sound clinical judgment (i.e. thorough assessment of suicidal risk factors). As indicated by Garvey et al. (2009), a safety contract is often a shorthand way of documenting suicidal risk; however, over reliance on the act of contracting in the absence of a thorough assessment of suicide risk is inappropriate and does not replace formulation of an individualized treatment plan addressing suicidality.

Use of Restraints

Per documentation and interviews with facility staff, there had been no recent utilization of restraints in mental health services. It was estimated that the last use of restraints during direct observation suicide watch was in 2009. It was noted per a review of the facility policy and procedure entitled "Restraint and Seclusion" that policy still allowed for the utilization of restraint for mentally ill individuals via the use of ambulatory cuffs and five point restraints. Although restraints were not recently employed on the psychiatry unit, the use of restraints reportedly continued in the intake and booking area. The individuals restrained in this area were restrained to a "restraint chair…or if they are disruptive they can get shackled to a chair…that happens more during Mardi Gras...if they are disruptive, they usually go to psychiatry." During the site visit, staff working in intake and booking were unable to locate the restraint chair.

Per the facility policy and procedure entitled "Restraint and Seclusion" there was no provision for the utilization of a restraint chair. Per interviews, individual's placed in the restraint chair remain in the large room with other individuals. The chair is placed close to the front of the room where nursing and security are seated. Given the number of individual's possibly present in the intake and booking area at any one time, it would not be possible for staff to adequately monitor a restrained individual and ensure their safety from other non-restrained individual's. This practice is unsafe and should be discontinued.

There was cause for concern with regard to the use of chemical restraints in lieu of physician restraint. Staff interviews revealed the use of intramuscular injections of antipsychotic medications in response to behavioral challenges. These injections were ordered by either psychiatry or the primary care physicians in response to nursing reports, most

frequently in the absence of a face-to-face clinical encounter between the individual and the physician.

Special Populations

Women

Research has supported the fact that incarcerated women have psychiatric, mental health, and behavioral needs that are uniquely different from those of incarcerated men. To address these distinct needs, gender-specific programming for incarcerated women has gained attention and support for its use in the prison system (see Bloom & Covington, 1998; Blitz et al., 2005). Bloom and Covington (1998) highlighted differences between incarcerated women and their male counterparts. Specifically, the researchers found that incarcerated women were less likely to commit violent crimes and typically were involved in nonviolent property offenses, more likely to have long-standing substance abuse problems, more likely to be poor, uneducated and unskilled, have at least one child under the age of 18 years, and have been exposed to physical or sexual abuse in comparison to incarcerated males.

A Special Report presented by the U.S. Department of Justice in 1991 conducted an extensive assessment of incarcerated women wherein one in eleven incarcerated women were surveyed. Findings from the survey identified that "female inmates largely resemble male inmates in terms of race, ethnic background, and age. However, women are substantially more likely than men to be serving time for a drug offense and less likely to be sentenced for a violence crime…more than 4 in 10 reported prior physical or sexual abuse (p. 1)." Moreover, the pathways leading to incarceration also differed for incarcerated women wherein childhood victimization and subsequent alcohol or substance use increased participation in nonviolent crimes such as selling and soliciting drugs, prostitution, and robbery (U.S. Department of Justice, 1991; Wright et al., 2007; Messina et al., 2010).

With regard to psychiatric or mental health issues, Blitz et al. (2005) found that incarcerated women were more likely to experience depressive disorder whereas incarcerated men were more likely to experience psychotic disorders. Additionally, in incarcerated women identified as having special psychiatric or mental health needs, seventy-five percent of this population had been diagnosed with an Axis I disorder, a personality disorder, or an addictive disorder. In this study, gender-specific treatment was generally absent or under utilized when assessing the treatment approaches for incarcerated women.

A specific concern for incarcerated women centers on parenting, as incarcerated women are often the primary caregiver of children under the age of eighteen relative to their male counterparts (Wright, Salisbury, & Van Voorhis, 2007). The separation from their children coupled with the anxiety and worry regarding their children's welfare poses a unique challenge for incarcerated women. Research has found that these concerns are often ignored in the context of services, which the gender-responsive treatment highlights as an important factor inclusive in appropriate treatment.

A significant body of research has emerged demonstrating the effectiveness of psychiatric, mental health, and behavior outcomes among incarcerated women receiving gender-specific treatment. In a study evaluating the effectiveness of gender-specific substance abuse treatment, Messina et al. (2010) found that this treatment modality lead to a far greater reduction in substance use, longer stays in aftercare programs, and decreased recidivism compared to women who had not received such treatment.

In light of gender differences in the incarcerated population, the need for gender-specific programming has been substantiated in order to develop sound theoretical treatment approaches targeting the unique needs of incarcerated women (Bloom & Covington, 2005). Bloom and Covington (2005) outlined the essential principles and criteria for providing gender-specific services and treatment. These included the notion that "equality does not mean sameness" or the fact that treatment approaches used with incarcerated men does not provide similar treatment opportunities or outcomes for incarcerated women.

During the investigative site visit at OPP, it was evident that there was no utilization of gender-specific psychiatric or mental health treatment for incarcerated women. In interviews with six randomly selected incarcerated women at OPP residing on a unit designated for women with mental health issues, there was limited evidence that these women were receiving any form of organized psychiatric or mental health treatment. Although they had reportedly participated in psychiatric evaluations, only one reported receiving psychotropic medications, despite all of the women interviewed exhibiting overt signs and symptoms consistent with severe mental illness. Additionally, there was no evidence that these incarcerated women had access to appropriate alcohol and substance abuse treatment outside of basic detoxification as part of psychiatric and mental health programming.

The following examples were gleaned via the interviews discussed above:

- JB (2343195) reported a history of a diagnosis of a mood disorder. She also reported a history of treatment with psychotropic medication. She indicated having difficulty sleeping, reported an increased rate of thought, described symptoms of anxiety, reported mood lability, and evidenced an increased rate of speech. Over the course of the interview, she evidenced mood instability, she was initially smiling, than began crying stating, "I need help." Per her report, she was not prescribed psychotropic medication at the time of this interview.

  This individual's medical record was reviewed. There was no psychiatric evaluation or treatment documented. At the time of intake to the facility, this individual was noted to be cursing, screaming, and threatening to nursing staff. She refused to sign her intake screening documents. Her history of diabetes was noted, and there was notation of medication refusals for blood sugar monitoring and insulin. This case illustrates an individual with increasing signs and symptoms consistent with a mood disorder who was not recognized by the facility and in need of mental health treatment. It should be considered that her refusal to comply with treatment for diabetes could be directly related to her significant mental health symptoms.

- IM (2341079) reported a history of treatment with psychotropic medications. She indicated that during her initial screening she did not disclose her history of mental health treatment because "no one asked me." She indicated that due to a lack of treatment with medication, she "came in and I got in a fight…then I had to go on lockdown…now I am in here…and I still need my medication."

  This individual's medical record was reviewed. Per the medical intake screening performed 10.23.12, a history of a diagnosis of seizure disorder and "bipolar" was documented including treatment at "metropolitan." There was also documentation of a previous suicide attempt in 2010. There was notation that this individual was "hitting her head on the police car door" and that she was referred "for psychiatrist review…eval for meds." An initial psychiatric evaluation was performed 10.24.12, "reports not knowing why sent to psych. No paper work sent…for transferring…diagnoses: marijuana abuse…no psych meds necessary at this time…general population…obtain psychiatric records from LSU interim…follow up 11.12.12…re-eval diagnosis, review records." Although these records were requested late in the

month of December, documentation of other mental health clinical contact were not included. As noted below, this individual has serious mental health needs that were not addressed, potentially contributing to an altercation and placement on lockdown.

Records from Interim LSU Public Hospital were reviewed, per these records; this individual had a history of "bipolar disorder, unspecified; suicidal ideation; sedative, hypnotic or anxiolytic abuse, unspecified; and cannabis abuse, unspecified." Records dated 9.23.12 indicated that this individual was "found down…after ingesting ETOH, and various…pills…admits to using various narcotics…says she is bipolar…" Initially on presentation, "patient requesting to go home and saying she wants everyone to let her die…told that she was unable to leave secondary to PEC…she began to get very irate…" A psychiatry consult was performed 9.24.12, during which a history of bipolar mood disorder was noted, as well as a history of suicidal ideations, auditory hallucinations, and inpatient psychiatric hospitalizations. Per this consultation, she was diagnosed with "mood disorder, not otherwise specified; rule out substance induced mood disorder v. major depressive disorder v. bipolar disorder; polysubstance dependence; rule out borderline personality disorder…medication recommendations Abilify 5 mg in the morning." It was documented that the patient was ultimately discharged from the hospital 9.25.12 with plans for outpatient mental health treatment.

- TP (2345963) reported she was admitted to OPP in the previous 48 hours. She indicated she was seen by psychiatry "at 5:15 this morning…I didn't get to talk to him too much…he started me on some medicine…I don't know what it is…he didn't tell me what the side effects are…I have diabetes…my doctor prescribes me Klonopin…I have taken it since 1994…I know if I don't take it I could have a seizure." It was not clear if this individual was being monitored for a potential detoxification reaction related to benzodiazepines. It was notable that this individual displayed irritability and mood instability.

  This individual's medical record was reviewed. Her intake screening was performed 12.17.12 where she reported a history of psychiatric treatment with medications including Prozac and Wellbutrin. She also reported a history of alcohol dependence and a history of 15 episodes of substance abuse treatment with the most recent occurring in 2012. Following the screening, verbal orders were obtained from the facility medical director to begin detox protocol.

She was evaluated by psychiatry 12.19.12 and diagnosed with polysubstance dependence. At that time, the detoxification protocol was discontinued. The evaluation did not note the history of previous substance abuse treatment noted in the screening. This case history indicated cause for concern as the patient reported daily use of benzodiazepines; however, the detoxification monitoring was discontinued following the psychiatric evaluation.

- GM (2335258) reported a history of a diagnosis of depression. She recalled treatment with antidepressant medication, but indicated she had not taken this medication in several years. She reported current signs and symptoms consistent with a mood disorder including social withdrawal, crying, feeling sad, poor energy and a lack of motivation. She was unable to recall undergoing a psychiatric evaluation, but indicated plans to complete a sick call request. It was notable that this individual evidenced a sad affect.

  This individual's medical record was reviewed and revealed no notations of psychiatric assessment or other mental health involvement. This individual was housed on the same unit with other female mental health patients, and given her presenting symptoms, it was concerning that she had not been referred for a mental health evaluation and treatment.

- LB (2345834) reported she had been at OPP for a total of five days. Initially, Ms. Boggs reported a history of treatment with benzodiazepines, "they did a detox…but I didn't get any medicine to do it." She also reported a history of treatment with psychotropic medication due to a history of a diagnosis of Bipolar Mood Disorder, "I took Depakote…the last time I took it was the day before I came in here." She reported symptoms including irritability and poor sleep. She stated, "I can feel my mood starting to spike." It was notable that this individual exhibited irritability and grandiosity.

  This individual's medical record was reviewed. At her intake screening on 12.16.12 she reported a history of a diagnosis of anxiety and bipolar mood disorder. She also reported a history of four suicide attempts in August 2012, placing her at high risk for suicide. She was referred for a psychiatric evaluation due to a history of daily use of benzodiazepines (Ativan and Xanax). The psychiatric evaluation was performed 12.18.12. At that time, there was notation by the psychiatrist of the previous diagnoses, and a notation regarding the history of suicide attempts. At that time, the psychiatrist ordered detoxification protocols, which began 12.18.12

at 0650 hours. There was documentation of vital sign monitoring from 12.18.12 to 12.20.12. This individual's history of treatment with the mood stabilizer Depakote was not noted in the record. It was concerning that this individual's history of a mood disorder and suicide attempts were not consistently addressed, given that at the time of the investigative site visit, she was exhibiting increasing signs and symptoms consistent with a mood disorder.

- CF (2345424) reported she had been in the facility for nine days. She was labile, irritable, paranoid, screaming at her peers. She verbalized delusional ideations stating she was "going to a wedding…and I have a pregnancy in my tubes…they need to get it out." She was reportedly prescribed no psychotropic medications. Her pulse was measured at 100 beats per minute (this is elevated) and her skin was clammy. Given the apparent emergent nature of her condition, it was reported to OPP nursing staff who assessed her and planned to route her to the emergency room to determine the presence or absence of a delirium. It was concerning that her condition had deteriorated to this level without acknowledgement by OPP medical or mental health staff. Both peers and security staff indicated that she had been in a similar state for several days prior to the interview.

  This individual's medical record was reviewed. She was admitted to OPP 12.11.12. At that time, she reported a history of daily use of Xanax 2 mg four times daily. She indicated her last dosage of Xanax on 12.10.12. She was evaluated by psychiatry on 12.13.12 at 0537 am. Following this evaluation, detoxification protocols were ordered. Per the alcohol and benzodiazepine withdrawal flow sheet, vital sign monitoring began12.13.12 at 0900 hours. At this time, she had been in the facility approximately 36 hours. The flow sheet indicated that on 12.13.12 at 2100 hours she experienced elevated blood pressure requiring a dosage of Valium 10 mg per protocol. Subsequent vital sign monitoring on 12.14.12 at 0300 indicated elevated parameters (blood pressure 157/105 and pulse 72). Medications were not provided as a result of this measurement, as the protocol indicates that diastolic blood pressure must measure greater than 105. Vital sign monitoring ended 12.15.12 at 0300, by the time she was interviewed for the investigative site visit, she had apparently begun to experience either detoxification delirium or acute psychosis, which was per this record, not noted by medical or psychiatric staff.

- IH (2341431) declined to exit her cell in order to be interviewed. Per her peers and security staff, this individual routinely remained in her bed and declined to interact with others. Her room was dirty and malodorous, with approximately ten plates of molded rotten food lying on the unoccupied upper bunk. Both peers and staff reported her apparently paranoid behavior. She was reportedly not prescribed any psychotropic medications, however, appeared to be suffering from psychotic symptomatology.

  This individual's medical record was reviewed. There was no documentation indicating psychiatric evaluation or assessment. There was an intake screening document dated 10.27.12, which indicated that she refused to answer the majority of queries, and did not sign the document. There were nurses notes regarding segregated inmate dated 10.29.12, 11.5.12, 11.12.12, 11.23.12, and 12.3.12. In each instance it was noted that this individual's mental status was "appropriate." There was no additional information included in the records. Given the psychiatric symptoms noted during the investigative monitoring visit, it was considered that this individual either presented to the facility with psychotic symptoms (e.g. paranoia) or experienced an exacerbation of symptoms in segregation. Regardless, it was concerning that this individual had not been evaluated by psychiatry, and that her mental status reviews while in segregation were occurring at a frequency of seven to ten days. Mental status checks for individuals in segregation should occur on a daily basis in order to observe for deterioration in mental status and to ensure the absence of suicidal ideation.

The facility has a policy and procedure outlining an administrative process for forced medication treatment; however, document review and interview indicated this process had not been utilized for IH or any other individual housed at the facility. For further information regarding this issue see the discussion under "Informed Consent." Risks associated with longer duration of untreated psychosis are well documented in the scientific literature. Delays in treatment of psychosis have been linked to neurodegeneration, persistence of symptoms, poorer social outcomes, increased difficulties in cognitive functions, and poorer response to future attempts at treatment with antipsychotic medications.

Given the above, it was apparent that assessment and treatment programs specifically geared toward incarcerated females were necessary. In addition, many issues noted in the interviews outlined above were similar to those noted in interviews with incarcerated males,

specifically lack of treatment with psychotropic medication, lack of identification of psychiatric symptoms, delays in recognition of delirium, unacceptable duration of untreated psychosis, and lack of utilization of administrative forced medication procedures.

Youthful Offenders

Between 1990 and 2004, research documented a 208% increase in the number of youthful offenders (age 18 or younger) residing in adult correctional settings with youthful offenders accounting for 1.4% of the population state jails (National Council on Crime and Delinquency, 2006). Youthful offenders in adult correctional settings were often placed in this setting due to the severity and nature of the adjudicated crime (Wollard, et al. (2005). Not surprisingly, research has reliably documented differing psychiatric and mental health needs of this population from that of incarcerated adults.

With regard to psychiatric and mental heath functioning, Teplin et al., 2002 found that between two-thirds of males and three-quarters of females met criteria for one or more psychiatric disorders with 15% to 20% of those meeting criteria for a serious mental illness (in Woolard et al., 2005). Mental health issues are predominately attention deficit hyperactivity disorder; conduct disorder; oppositional defiant disorder; and depression. Recent research demonstrated an increase in posttraumatic stress disorder in incarcerated youth (American Academy of Pediatrics, 2001).

The prevalence of suicide was also higher for youthful offenders when compared to non-incarcerated youth (Metzer, 2002). Risk factors associated with increased rates of suicide in youthful offenders included age (i.e., below age 21 years), presence of a psychiatric disorder, pre-existing history of emotional, physical, and/or sexual abuse, prior verbal reports of suicidal thoughts, suicide attempts, or suicidal gestures, institutional stressors (e.g., unit placement, work assignment, disciplinary confinement, interpersonal conflicts, legal processes, and parole setbacks), and psychosocial stressors (e.g., loss of a love one, mental conditions) (see Hayes, 2004; Wasserman, Ko, & McReynolds, 2004; Daniel, 2006; Abram et al., 2008). Of deaths involving youthful offenders, 67% of the deaths during incarceration were attributed to suicide (American Academy of Pediatrics, 2001).

When considering the specific needs associated with incarceration or detention coupled with differing developmental profiles for adolescents, simply adjusting adult correctional programs and practices inadequately accounts for the needs of adolescents. In other words, a "one size fits all"

program based on adult populations is inadequate in addressing the specific programmatic and developmental needs of adolescents. The approach fails to account for unique aspects of adolescent development and requires a more qualitative approach toward program development for adolescents.

Woolard et al. (2005) specifically stated, "the inaccuracy of adult classification tools has been cited as a contributing factor to the high rates of victimization and self harm…the inability of adult classification instruments to correctly…account for the victimization and self harm potential of juveniles, has been cited as contributing to increased security risks (Reddington and Anderson, 1996)." There are tools designed for use with adolescents, and "are more likely…to include age appropriate items and definitions…such as previous level of psychological and physical maturity, and family, school and peer difficulties…also more likely to include 'dynamic' risk factors." As youth grow and mature, their ratings on these risk items may change. These differences highlight the need for assessment and classification tools geared toward the adolescent population.

Research has supported that the "one size fits all" approach has not historically been successful in managing violent behavior outbursts, behavior problems, or staff injuries in the context of incarceration. Rather, Liberman (2011) reviewed behavior interventions that have been shown to be more effective in reducing and controlling behavioral difficulties exhibited by adolescents. Specifically, the author identified positive programming and activity scheduling, which involves scheduling activities that allow social interaction; satisfaction of completing constructive pursuits; and opportunities for positive staff interactions as successful means of reducing challenging behavior and increasing adaptive behaviors. Additionally, social learning therapy involving token economy systems, incentive programs, and contingency management plans has also been beneficial in managing behavior problems in adolescents.

Inherent in the aforementioned behavior interventions is the use of both preventative strategies and de-escalation responses in the face of aggressive or problematic behavior. De-escalation interventions have been long supported as appropriate for use in conjunction with behavior modification and are recommended for use before administration of punitive measures occurs. De-escalation is often very effective in managing behavior and, if applied in concert with an appropriate behavioral management program, significantly reduces the need for reliance on punitive interventions.

Punitive interventions rarely lead to any real measurable changes in behavior. Punitive interventions do not teach skills or allow for issues to be addressed, they simply result in immediate cessation of the problem behavior. Additionally, the potential for abuse with punitive interventions is concerning. Studies involving the attitudes of correctional officers toward adolescents indicate that adolescents are often perceived as more volatile and difficult to manage than adult inmates (Austin, Johnson, and Gregoriou; 2000). Such attitudes, coupled with the availability of punitive interventions lead to the possibility for inappropriate use or, in some cases, abuse of the intervention.

Youth are frequently subject to "Disciplinary Segregation," also referred to as "solitary confinement." Many youth placed in segregation commit no offense, but are subjected to isolation as a means of protection from adult inmates within adult correctional facilities that house youth offenders, or due to the inability of the facility to address behavioral challenges. Youth may experience 22 to 24 hours of isolation each day resulting in experiences of disorientation, chronic sadness, hopelessness, and depression secondary to prolonged isolation. Youth with pre-existing or untreated mental health disorders will often experience a worsening of psychiatric symptoms. Research has validated that youthful offenders with mental health disorders are subject to a high rate of suicide and suicidal attempts during incarceration.

Research has consistently documented that the psychiatric and mental health needs of youthful offenders in adult correctional settings are often neglected due to a lack of appropriate screening for mental illness, a lack of developmental and age appropriate psychiatric or mental health treatment, and a lack of individualized programming. Redding (2003) stated, "many adult correctional systems are ill equipped to handle juveniles…do not provide special staff training on handling juvenile offenders or provide special programming for juveniles (p. 140)." He also reported, "To meet the needs and ensure the safety of the growing number of juveniles incarcerated in adult prisons, these facilities must take a number of steps, including development of classification systems, special housing units, and programming tailored to the needs of juveniles (especially services in the areas of general and special education, mental health, and substance abuse)…important for prisons to address the developmental, emotional, and mental health needs of juveniles and implement effective behavioral management techniques for handling disruptive youth…(p. 140)."

Youthful offenders at OPP are housed on a general population tier in the old prison facility. Youth who are unable, for a variety of reasons (e.g. fear

of assault, history of experiencing sexual assault), to tolerate this environment are housed in protective custody in the Conchetta facility. Interestingly, at the time of the investigatory site visit, there were more youthful offenders housed in protective custody (n=15) than there were housed on the general population tier (n=9). In both areas, there was no evidence of structured programming or therapeutic interventions targeting the needs of these youthful offenders. In addition, document review did not reveal specific training for security staff with regard to youthful offenders.

Youthful offenders housed in protective custody were subjected to cell confinement 23 hours per day. They reportedly attended school one afternoon per week for approximately three hours. They were provided outdoor recreation one time per week for approximately two hours. They were reportedly allowed out of their cell for one hour per day in order to shower. This unit milieu was not consistent with protective custody, but rather disciplinary or segregation. As such, these youth were punished for requesting protection from others or from events occurring in general population.

During the investigative site visit, the following youth housed in protective custody were interviewed:

- KL (2331325) was a fifteen-year-old male. He reported he had been housed in protective custody for approximately three months. He reported a history of a diagnosis of attention deficit disorder and previous treatment with stimulant medications. He indicated he had placed a sick call request approximately three weeks prior to this interview, but had yet to be evaluated by psychiatry. This youth's medical record was not provided for review.

- JC (2343540) was a sixteen-year-old male. He reported that he had been housed in protective custody for approximately two weeks. He indicated that he had placed a sick call request to see the psychiatrist and was evaluated, "he had me sign some papers…I don't know what they were…I used to take medicine…it was to help me focus…when I took it I made good grades…without the medicine I can't focus at all." This youth reported signs and symptoms consistent with depression including feeling sad and increased sleeping. He also indicated that during his stay on protective custody he "started talking to myself…I don't know why." He reported little contact with security staff, "but the nurse comes around some nights and I talk to them a little." This youth's medical record was not provided for review.

- WA (2343543) was a fifteen-year-old male who has been in protective custody for six weeks. He reported experience a mandibular fracture while in general population resulting in his placement in protective custody. He reported a history of treatment with medication for attention, concentration, and impulsivity. He stated, "I think I saw the doctor…he didn't ask me about medicine though…I filed a grievance, but nothing happened…I didn't put in another sick call because that doesn't work either." This youth reported having increased energy, "but there is nothing I can do with it…I am so bored all the time."

  This youth's medical record was provided for review. There was no psychiatric or mental health documentation included in the record.

- SN (2329515) was a seventeen-year-old male who had been housed on protective custody for approximately five months. He reported prior placement on the juvenile tier, but "I had to move from there…I got threatened…I have enemies there." He reported a history of psychiatric treatment in the past due to symptoms of depression. He reported signs and symptoms consistent with a mood disorder, he reported feeling sad, anxious, and stressed, "no one talks to me…the nurse is supposed to come see me…she doesn't come…the deputies stay in the booth all the time and they don't talk to us either." This youth's medical record was not provided for review.

- AJ (2306833) was a seventeen-year-old male who reported he had been housed on protective custody for approximately seven months. He reported a history of treatment with stimulant medications in the past. He stated, "I have been on lock down so long, that we get angry…and then we have thoughts of hurting each other…I am so angry all the time…we get angry and then we take it out on each other…I think we should have a group or something, we could talk about it…we could all watch the basketball game together…I think I need counseling."

  This youth's medical record was reviewed. There was information regarding a request for services submitted by the youth. Per documentation dated 11.30.12, "patient requested, history of attention deficit hyperactivity disorder and wants Adderall." This youth was seen by a social worker 11.30.12 "acknowledged increased stress…discussed stress management and relaxation techniques…stated he was diagnosed with ADHD and was taking

Adderall prior to incarceration…spoke of poor decision making due to his environment and lack of positive male role models…acknowledged difficulty trusting others which often prevents him from allowing others to help him." There was no documentation that this youth was referred to psychiatry for an evaluation to determine the need for medication. Other than grievances filed by the youth, there was no other health care information included.

- AS (2300100) this individual was reticent to speak. Other youth and staff indicated that he does not speak often, "he stays in bed mostly." This youth spoke briefly, and although he denied signs or symptoms of depression, he appeared sad, and his affect and behavior were suspicious for a diagnosis of mental illness.

  This youth's medical record was reviewed. Per the medical intake screening dated 8.16.11, this youth denied any history of mental health treatment or symptoms of a mental health disorder. On 8.22.11, this youth was brought to medical for "bizarre behavior." He was seen by nursing, and was not referred for a psychiatric evaluation; however, per documentation the nurse provided him with a "contract for safety…which was read by inmate…contract…was signed."

  On 1.19.12, this youth was placed on direct observation due to complaints of suicidal ideation. A psychiatric evaluation was performed 1.20.12 with a diagnosis of "mood disorder, not otherwise specified…suicidal, but won't give a reason why." No medications were ordered, and the youth was maintained on direct observation. The youth was next seen by psychiatry 1.22.12, "no longer suicidal…did a lot of thinking." The "Psychiatric Treatment Plan Orders" documented 1.22.12 indicated that the youth could return to general population with a diagnosis of "Adjustment Reaction." A subsequent psychiatric follow up was performed 2.8.12, "no suicidal ideation…feels much better..." Following this encounter, it was noted that there was "no Axis I diagnosis evident at this time" and that the youth should follow up "prn."

  This case illustrates failure to routinely follow up with a youth with a history of suicidal ideation and ongoing signs and symptoms indicative of a mood disorder.

Youth interviewed collectively reported a lack of structured activity, little interaction with adults, hours of boredom, and feelings of anger and

sadness. Noted on the unit was one television that was blaring loudly yet difficult to understand, with an extension cord running across the room and up to the television as a power supply.

A number of the youth interviewed described histories suspicious for diagnoses of attention deficit disorder. In absence of medication, these youth would have difficulty with concentration, focus, and increased activity levels, which would make their ability to tolerate placement in this type of unit difficult.

As noted in the literature review above, youthful offenders require additional age/developmentally appropriate services inclusive of a structured behavioral management system, where there are expected predictable rewards for identified target behaviors and expected predetermined consequences for behavioral challenges. In addition, treatment or rehabilitative efforts are required. Treatment efforts may be tailored to the population via an overarching treatment milieu (e.g. use of Aggression Replacement Therapy). In addition, youth interviewed described and exhibited a myriad of mental health symptoms that would need to be addressed via individualized treatment such as psychopharmacological intervention and individualized therapies in response to treatment goals determined by a treatment team inclusive of the youthful offender.

As noted above, youth housed on the PC unit reported experiencing cell confinement 23 hours per day. While they were able to communicate with each other through the cell doors, they were experiencing difficulties associated with prolonged isolation. Grassian (2006) described "severe psychiatric harm" resulting from solitary confinement wherein individuals experienced either reoccurrence of preexisting mental illness or acute mental health symptoms. He noted that individuals exposed to isolation experienced consistent symptoms including: hyperresponsivity to external stimuli; panic attacks; difficulty with thinking, concentration, and memory; intrusive obsessional thoughts; overt paranoia; problems with impulse control; and delirium.

Metzner, et al (2007) reviewed the need for the establishment of treatment plans and programming to reduce reliance upon seclusion and restraint for adults. They also discussed utilization of assessment and prevention/management strategies for behavioral challenges. When any type of seclusion is absolutely necessary, they recommended the development of specific guidelines for limited use. For example, they indicated that the location of the seclusion should occur in the infirmary where 24 hour nursing is available for assessment of the individual;

individuals should have access to specific items (mattress, blanket, and clothing that are suicide safe); the event must be time limited inclusive of a face to face assessment by a qualified mental health clinician within four hours; face to face assessments by a qualified mental health professional every 12 hours following the initial assessment; and face to face consultation with a physician within 24 hours. For individuals requiring seclusion for periods longer than 24 hours, consultation by a second psychiatrist should be obtained. They also indicated "very brief periods of release do not reset the 'clock' for assessments."

Scientific literature pertaining to the effects of seclusion with children and adolescents is sparse; however, in the context of incarceration it is a rarity. One article authored by Simkins, Beyer and Geis (2012) was located. They indicated that "it is undisputed that the psychological effects of isolation are detrimental to both the mind and the spirit…based on what is known about adolescent development an d teen brain studies, isolation is likely to be more damaging to a juvenile than to an adult…the use of such measures should be limited to those rare occasions when a young person poses an imminent threat to others safety." Simkins et al. (2012) elaborated on the harmful effects of isolation on juveniles. Specifically, while in isolation, youth cannot participate in programming inclusive of education, and isolation exposes youth to increased risk of suicide, re-traumatization, depression and agitation.

The American Academy of Child and Adolescent Psychiatry issued a policy statement regarding Solitary Confinement of Juvenile Offenders in April 2012. They reiterated the negative effects of solitary confinement outlined by Grassian (2006) and Simkins et al. (2012). They further delineated the difference between solitary confinement and "brief intervention such as 'time out' which may be used as a component of a behavioral treatment program…or seclusion, a short term emergency procedure…should only be used for the least amount of time possible for the immediate physical protection of an individual where less restrictive interventions have proven ineffective."

With regard to seclusion, suicide completions and engagement in self-injurious behaviors have resulted in the absence of adequate supervision and monitoring (Brown et al., 2000). Use of restraint and seclusion in psychiatric populations has been associated with reintroduction of traumatic experiences exacerbating posttraumatic stress symptomatology or mental health conditions (in Frueh et al., 2005). Frueh et al. (2005) found that individuals subjected to restraint and/or seclusion reported it as harmful and traumatic, consistent with the diagnostic criteria for posttraumatic stress disorder, as well as frightening. They also

experienced concern for their physical safety and feelings of helplessness. These experiences were "both traumatic and harmful…associated with psychological distress. (p. 1130)." Pre-existing conditions were worsened by exposure to restraint and seclusion, which further highlights the needs to assess the unique history of each individual prior to administration of restraint or seclusion.

In the context of Supermax adult correctional settings, the deleterious effects of confinement and seclusion have been well documented (Haney, 2003). Specific effects include psychological consequences associated with lack of social contact, sleep disturbances, anxiety, panic, rage, loss of control, paranoia, hallucinations, and self-mutilation. Metzner and Dvoskin (2006) also documented psychological harm associated with seclusion in Supermax correctional settings. Seclusion has been associated with exacerbation of pre-existing conditions, as well as psychoses, depression, and anxiety in individuals with a history of mental health problems. Individuals without a pre-existing history of mental health problems experienced a greater amount of irritability, anxiety, and dysphoric symptoms.

Structured Behavioral Management System

Youth interviewed reported a lack of structured activity, little interaction with adults or each other, hours of boredom, and feelings of anger and sadness. Youth housed in general population indicated some times where they were able to gather in the day room and engage in concocting a treat made out of honey buns and candy that all shared. Three youth interviewed on general population all expressed concern with regard to the presence of mold on the unit, "you get sick here because of the mold." Two youth noted feeling unsafe, "you have to fight to protect yourself." Another youth stated, "it is not safe in here…you can get messed over, beat up, jacked up."

Youth housed on protective custody, as noted above, were confined to their cells for 23 hours per day. A number of the youth interviewed described histories suspicious for diagnoses of attention deficit disorder. In absence of medication, these youth would have difficulty with concentration, focus, and increased activity levels, which would make their ability to tolerate placement in this type of unit difficult.

Behavioral management programs can be an effective tool to encourage youth to maintain positive behavior, assuming that a youth understands the parameters of the expected behavior, is given rewards appropriate to age and believed by the youth to be sufficiently beneficial to stimulate their desire to participate in the program. In addition, the

rewards must be consistently provided, and frequent in order to maintain the interest of the youth (i.e. small daily rewards that cumulate in a larger weekly reward). It is recognized that a behavioral management program that is inconsistently implemented is worse than no behavioral management program at all.

To enable a behavior management program to be a positive, successful, program that encourages good behavior, the facility staff must ensure that the youth have a daily schedule that keeps them active and engaged in order to alleviate boredom and down time which increase behavioral challenges, to clearly define the expectations of the program and to encourage the youth with age appropriate rewards within a regular time frame that motivate youth to participate. It should be noted that over time, specific rewards become "stale" and youth are not motivated to work in order to earn them. As such, the reward menu should be regularly reviewed. In addition, if youth earn a specific reward, it must be provided, or youth will not respect the program and as a result, increased behavioral challenges may occur.

As described by Nelson et al. (2005) behavioral management programs can effectively "reduce the number of behavior incidents across a majority of youth…reducing occurrences of …minor behavior problems that occupy a great deal of staff time and distracts them from addressing…the needs of youth who have more serious behavioral and emotional issues…[need to] establish a climate in which expectations are clear, routines well structured and appropriate behavior receives staff recognition and reinforcement." Nelson et al. further stated, "strategies based on punishment are ineffective…especially with youth who display significant mental health conditions and educational disabilities…" In a facility where behavioral challenges are often met with punitive consequences, such as lockdown or isolation, promoting positive behavior is critical.

Medical Records

The medical record serves as a means of communication between health care providers allowing for continuity of health care. Medical records received for review were disjointed and did not follow a chronological sequence, some documents were not dated, and in some cases, there was little continuity of information between providers (e.g. different birthdates). It was noted that in many records specific information was not included, and therefore, presumed not to exist. Records that were received revealed sparse documentation. Per an interview with the facility medical director "we know that treatment notes should be in the chart…but we are having a difficult time with that." It was reported that

there was an electronic record where some information was included; however, electronic information was not regularly reconciled with the paper record. The facility must formulate an organized medical record and ensure appropriate documentation.

Discharge and Transition Services

Per Mellow and Greifinger (2007), "discharge planning is increasingly prioritized by correctional systems throughout the nation to prepare prisoners for their reintegration into their home communities… it is in the public interest to pave the road enabling access to medication and health care services because these services prevent the expensive relapse of communicable disease, chronic disease and mental illness."

Per the code of ethics adopted in 1990 and promulgated by the American Medical Association (1992), "The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care." Taken together, both the code of ethics and public interest indicate the necessity of discharge and transition planning for individuals upon their release from a correctional environment.

Per OPP Policy entitled "Discharge Planning," incarcerated individuals with serious mental illness are to receive discharge planning when release is imminent. According to the policy, incarcerated individuals are to receive a supply of medication upon discharge to prevent gaps in medical treatment before he/she is able to make contact with a community provider. The amount of medication supplied at the time of discharge varies from between one to two weeks supply depending on the incarcerated individual's "Keep On Person" (KOP) status. The incarcerated individual is to be supplied with a list of community resources at the time of discharge. Moreover, the policy indicates that in "identified complex cases," a clinical social worker provides case management, in conjunction with discharge planning, for individuals identified as having "severe mental illness; complicated medical patients; homelessness; and developmental delay."

Review of records received in this case did not reveal documentation of any discharge or transition planning. In fact, in no records were discharge prescriptions located, indicating that upon discharge, individuals were not provided medications for continuity of care outside of those medications

in their possession via the Keep On Person status. There was also no evidence in the records that a clinical social worker provided individualized case management to incarcerated individuals who were identified as having complex issues.

Per an interview with the facility psychiatrist, "we don't get notice of transfer…the majority of people follow up at Metro (indicating Metropolitan Human Services Authority)…in the past, they could walk in the next day…but after Katrina, now you have to make an appointment, and you can wait two or three months."

Per the policy, an incarcerated individual is supplied with one to two weeks of medication; however, there is no possibility that an individual can be released from incarceration and obtain a psychiatric or medical appointment within seven to fourteen days. The process of obtaining an appointment and liaison with a community provider would have to occur well in advance of the actual discharge to ensure transition of psychiatric and medical care once the individual returns to his/her community. A complicating factor also involved in discharge planning centers on the fact that government insurance (i.e., Medicaid or Medicare) is suspended during to incarceration, which would require "re-linking" the incarcerated individual to these resources prior to or shortly after discharge. This process would require adequate planning in advance to ensure that the individual was able to financially access psychiatric and medical care/medications. Although it is acknowledged that OPP staff is not always aware of an individual's discharge date, in cases where a discharge date is set, appropriate discharge and transition services must be provided.

As outlined in Mellow and Greifinger (2006), a facility should establish formal linkage systems with commonly accessed providers in the community, such as community mental health centers, public health departments, low-income clinics, and/or previous physicians or psychiatrists. The process of linkage to community providers is an active one involving communication and collaboration between the prison facility and community providers. Supplying an individual with a list of community resources at the time of discharge is woefully inadequate and does not substitute for adequate discharge planning.

Additionally, the aforementioned authors also recommend supplying an individual with "a concise and accurate summary of pertinent information (p. 93)" at the time of discharge, which would include "a problem list, medications, results of laboratory and diagnostic tests, scheduled tests or visits, third-party coverage for medication care and any other information

that would be important for the subsequent practitioners to know (p. 93)." Given that there is no evidence in records that this is provided, it is recommended that this be incorporated into discharge planning.

Discharge planning should include liaison between the prison facility and community providers. This would ensure that incarcerated individuals would have adequate medication coverage without a break in access, as well as a continuity of care. Collaboration between community mental health centers or human service authorities in an individual's returning parish would be a necessary component to ensure continuity of care. In an effort to reduce recidivism, providing individuals with access to Assertive Community Treatment Programs or Forensic Assertive Community Treatment Programs should be considered. Moreover, incarcerated individuals should be provided a list of pertinent information to take from the facility to community provider. To ensure these elements are included in discharge planning, it is advised that OPP establish a comprehensive system for discharge planning, as well as adequate staff and resources to allow for adequate discharge planning.

Compliance and Quality Improvement

Information regarding data collection and quality improvement efforts undertaken by the medical and mental health staff at OPP were requested. These documents were reviewed and indicated a sporadic quality improvement process, with meetings occurring 4.21.12, 10.18.11, 9.8.11, and 12.16.10. Unfortunately, the majority of information included in these documents was illegible, as it had been blacked out prior to submission. Given the documents reviewed, it appeared that quality improvement reviews were performed following sentinel events as these meetings occurred sporadically, and the legible information included revealed information regarding either or both suicide attempts and completed suicides. In these cases, it was documented that staff either planned to review policy and procedure, provide specific training, or perform a psychological autopsy regarding specific individuals. Documentation of these specific corrective action measures was not included in the documents available for review.

As noted above, the review of available documentation regarding quality assurance revealed a disjointed process that did not lend itself to a cogent review of the system or services provided. Review of the deposition of the facility medical director, Samuel Gore, M.D. revealed that there is no formal process for the review of provided medical or psychiatric care. In addition, he reported that there is no formal peer review process for psychiatry. Reviews that are performed are done in response to complaints or grievances.

Information regarding these reviews was not included in the documents received. An appropriate facility wide quality improvement program would include a review of the facility policy/procedure and systems issues that could negatively impact an individual's access to or receipt of psychiatric and mental health treatment. It would also include a review of the care provided for appropriateness and adequacy.

It is pertinent to note that in general, the documents received for review were disorganized and did not always include necessary information. This was concerning and was opined to be a reflection of the disjointed services provided at the facility. Given the deficits in data reporting, availability, and delivery, it would be impossible for facility medical and psychiatric staff to determine resource needs or to perform systematic quality assurance monitoring.

Initially, it will be necessary for OPP to begin to categorize and update data. For example, a listing of all individuals receiving psychiatric and mental health services, pharmacy data regarding medication prescription, review of medication compliance data, etc. Once they have basic data available, they can then begin to analyze said data for trends.

It will be necessary that OPP quality assurance monitoring review four general areas, include a review/analysis of the resulting data, and corrective action as needed. Additionally, a predetermined percentage of all available records should be reviewed (e.g. 10%).

1. Process measures- this type of quality assurance would determine if behavioral health services are provided in keeping with implemented policy and procedure (e.g. were evaluations performed within a specific timeline; were laboratory examinations required via laboratory parameters ordered, reviewed and addressed; did individuals receive the mental health services as directed by their treatment plan; were requests for mental health services performed in a timely manner; were psychiatric evaluations performed in a timely manner, etc.). For process measures regarding psychiatric evaluation and treatment, monitoring should be done via a medical model in concert with quality assurance monitoring performed for medical services.

2. Outcome measures- this type of quality assurance would determine if behavioral health services provided were of benefit to the individuals. Specifically, did they result in a reduction of the individual's symptoms and improvement in their functioning? This could be determined via review of statistics regarding acts of violence and the use of segregation. Additionally, pre and post testing measures could be utilized (e.g. reduction in the scores on depression scales). It is recognized that improvements in the indices discussed above would be multifactorial and not solely the result of behavioral health services. Other outcome measures could include satisfaction surveys with individual's receiving psychiatric and mental health services.

3. Peer review/Treatment integrity- this type of quality assurance would include a critical review of behavioral health services provided via a peer-review process (e.g. psychiatrists would periodically review each other's work and provide feedback). Additionally, group therapeutic process could be observed with feedback provided to the clinician facilitating the group in order to ensure adherence to a specified modality of treatment and provide opportunities for coaching and improvement of the provided services.

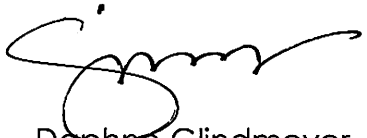
4. Selected studies – If a specific issue is suspected, or specific difficulties are observed with one particular service area, specific quality assurance studies could be performed with a critical analysis of the data in order to determine the need to adjust processes or treatments in order to improve efficacy.

Any comprehensive quality assurance process must include both the synthesis and review of collected data on a regular basis. Data must be collected on a continuous basis and reviewed so that issues can be addressed in a timely manner. These issues may include challenges with the practice and documentation attributed to a specific staff member or they may identify systems issues. Issues that are identified must be addressed via a documented corrective action plan (e.g. staff training, staff supervision, policy/procedure review) (Ruiz, 2010).

The above opinions are offered to a reasonable degree of medical certainty. Should additional information become available which alters the opinions or recommendations offered in this report, an addendum will

be authored. Should you have any questions, or require any further information regarding this report, please contact me at 504.392.8348.

Submitted by,



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