

Memorandum of Agreement between the Department of Justice, the  
Parish of St. Tammany, and the St. Tammany Parish Sheriff Regarding the  
St. Tammany Parish Jail

# Monitor's Report #1

**Final - May 11, 2014**

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## **Introduction**

On December 1, 2013, the Department of Justice (DOJ) entered into an agreement with the Parish of St. Tammany and the St. Tammany Sheriff (collectively, “St. Tammany”) regarding the provision of mental health care at the St. Tammany Parish Jail. This agreement was reached after the DOJ conducted an investigation pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA) and issued a findings letter on July 12, 2012. The findings letter concluded that the mental health care being provided for inmates at the jail fell below minimal standards as required by the US Constitution. In particular, concerns were raised about the adequacy of:

- mental health screening, assessment, and treatment
- suicide prevention policies and procedures
- suicide prevention training for staff
- training for licensed practical nurses (LPNs) to conduct mental health and suicide risk assessments
- quality assurance measures

In January 2014, I agreed to serve as the Independent Monitor of the agreement between DOJ and St. Tammany. I conducted a site visit of the jail from February 4 to 6, 2014. Before and after the site visit, the parties provided documents for review. During all stages of my involvement, I was given full access to all information requested. At the conclusion of the site visit, I shared preliminary feedback with the parties.

This report is intended to serve as a baseline assessment of the jail’s compliance with the Memorandum of Agreement (MOA). Its conclusions are based on evaluating the jail’s operations through the end of the site visit, February 6, 2014. Given the short time that had passed since the MOA became effective, full compliance with its provisions was not expected.

## **Methodology and Definitions**

The conclusions in this report are based upon:

- Interviews
  - Five inmates chosen because they had recently been placed on suicide watch, treated for mental illness, or undergone routine mental health and medical screening upon admission to the facility
  - Nursing, social work, medical, psychiatry, and security staff members
  - Facility leadership, including the Warden, Medical Director, and Chief of Corrections
- Direct observations
  - Intake medical screening

- Routine psychiatric evaluations
- Psychiatric evaluation of inmates on suicide watch
- Facility tour, including the holding area, medical unit, intake medical screening area, restraint devices, and suicide-resistant cells
- Document review
  - Jail policies and procedures related to mental health care
  - Jail forms related to medical and mental health care
  - Approximately 15 medical charts of inmates receiving mental health treatment, placed on suicide watch, or placed in restraints
  - Memorandum from medical director dated January 22, 2014, explaining the jail's medical staffing and chain of command
  - St. Tammany initial compliance report (February 26, 2014), including security staffing plan
  - Outlines and slides from medical staff training re: suicide prevention and mental health care
  - Medical staff training logs documenting participation in continuing education sessions
  - Pharmacy reports from November and December 2013
  - Five morbidity reviews from 2013
  - Two mortality reviews, Two mortality reports, and one psychiatric mortality report from 2013
  - Three restraint reviews from 2013
  - Suicide watch database from 2013
  - Inmate grievances related to mental health care in 2013
  - Grievance database from 2013
  - Quality assurance report from December 2013
  - Statistics related to medical care in 2013

The following definitions are used in this report:

- “Substantial Compliance” indicates that the jail has achieved compliance with most or all components of the relevant provision of the agreement.
- “Partial Compliance” indicates that the jail has achieved compliance on some components of the relevant provision of the agreement, but significant work remains.
- “Noncompliance” indicates that the jail has not met most or all of the components of the relevant provision.

For the sake of brevity, I have made comments in this report primarily regarding areas of partial compliance or noncompliance. The lack of commentary about areas of substantial compliance should not be interpreted as ignoring them or diminishing their importance. In many cases, St. Tammany provided exemplary care to inmates with mental illness, which I acknowledge and commend.

A draft of this report was submitted to the parties on April 1, 2014. DOJ provided written comments on the draft on April 14, 2014, requesting that I expand and clarify several recommendations, provide technical assistance, and obtain a timeline from St. Tammany for implementing new policies and procedures. St. Tammany indicated in an email on April 21, 2014, that it had no written comments. However, I spoke with the medical director on April 23, and he indicated that most of the recommendations from the exit interview and draft report had been implemented since the site visit. The jail has not yet been able to resolve the problem with female inmates on suicide watch, but it plans to do so later this summer, when additional corrections officers have been trained.

### **Defendants' Actions to Date**

The jail staff, led by the warden and medical director, has clearly been working to comply with the provisions of the agreement. The St. Tammany Parish Sheriff's Department has supported these efforts. Many important steps have been taken to improve mental health care at the jail, including:

- Removing all "booking cages" from the facility and creation of a policy prohibiting their use in the management of suicidal prisoners
- Hiring a full-time psychiatrist
- Hiring a social worker and RN-level nurse
- Assigning a chief of corrections to oversee the provision of health care and programming at the jail
- Improving documentation of staff training in the areas of suicide prevention and mental health care
- Creating a "suicide watch" unit for males with five suicide-resistant cells and 24-hour security staff monitoring
- Providing regular training of mental health staff through meetings, emails, and off-site training sessions regarding suicide prevention
- Implementing quality assurance measures and quarterly reviews by the medical director
- Hiring of an outside psychiatrist to conduct peer review of the jail psychiatrist's clinical work
- Planning for a system of audits to assess the adequacy of issues such as nursing care, medical clinic environment and safety, medication administration, and compliance with OSHA regulations

At the time of the site visit and in its compliance report dated February 6, 2014, St. Tammany reported that it was in substantial compliance with all provisions of the agreement, with the possible exceptions of providing group therapy programs and access to outside psychiatric hospitals. A nurse and social worker had been very recently hired, and the group program was being developed. Access to outside psychiatric hospitals was considered impossible, as no hospitals in the area would accept St. Tammany inmates for evaluation or treatment.

## Summary of Compliance

The MOA contains 48 separate provisions. Each provision of the agreement was assessed, and a compliance determination was reached. The summary of compliance in each area is as follows:

Provision	Total # of Provisions	Noncompliance (%)	Partial Compliance (%)	Substantial Compliance (%)
<i>Screening and Assessment Treatment</i>	12	0 (0)	7 (58)	5 (42)
<i>Suicide Precautions</i>	10	1 (10)	3 (30)	6 (60)
<i>Suicide Prevention Training Program</i>	7	1 (14)	1 (14)	5 (72)
<i>Use of Restraints</i>	7		1 (14)	6 (86)
<i>Basic Mental Health Training</i>	4		2 (50)	2 (50)
<i>Mental Health Staffing</i>	1		1 (100)	
<i>Security Staffing</i>	2		1 (50)	1 (50)
<i>Risk Management</i>	2			2 (100)
<i>Risk Management</i>	3		1 (33)	2 (67)
<b>TOTAL (#)</b>	48	2	17	29
<b>TOTAL (%)</b>	100	4.2%	35.4%	60.4%

Overall, significant areas of strength are:

- Speed with which inmates are screened at intake
- Physician availability on site
- Frequency of follow-up appointments with psychiatrist
- Monitoring of medication compliance
- Monitoring of therapeutic drug levels, other necessary lab tests, and AIMS exams
- Use of detox protocols for treatment of drug and alcohol withdrawal
- Training of medical staff regarding suicide risk assessment
- Collegiality of relationships between security and medical staff
- Staff morale and dedication

Significant areas for improvement are:

- Suicide prevention in female inmates
- Treatment plans

- Provision of mental health care other than medication management
- Restraint and seclusion policy
- Screening for mental illness prior to isolation placement
- Basic mental health training for correctional officers
- Review of mental health treatment quality

## Substantive Provisions

### III.A.1. Screening and Assessment

a. Develop and implement policies and procedures for appropriate screening and assessments of prisoners with serious mental health needs.	<i>Substantial Compliance</i>
b. Develop and implement an appropriate screening instrument that identifies mental health needs and ensures timely access to a mental health professional when prisoners present symptoms requiring such care. At a minimum, the screening instrument will include the factors described in Appendix A.	<i>Substantial Compliance</i>
c. Ensure that all prisoners are screened by Qualified Medical Staff upon arrival at the Jail, but no later than eight hours, to identify the prisoner’s risk for suicide or self-injurious behavior.	<i>Partial Compliance</i>
d. Ensure that Qualified Medical Staff conducting intake screening receive adequate training on identifying and assessing suicide risk, and are assigned appropriate tasks and guidance.	<i>Substantial Compliance</i>
e. Ensure that Qualified Medical Staff, based on the screening, develop an acuity system or triage scheme to ensure that prisoners with immediate mental health needs are prioritized for services.	<i>Partial Compliance</i>
f. Develop protocols, commensurate with the level of risk of suicide or self-harm, to ensure that prisoners are protected from identified risks for suicide or self-injurious behavior. The protocols shall also require that a Qualified Mental Health Professional perform a mental health assessment, based on the prisoner’s risk.	<i>Partial Compliance</i>
g. Ensure that prisoners who are classified as moderate or high risk of suicide or self-harm are searched and monitored with constant supervision until the prisoner is transferred to a Qualified Mental Health Professional for assessment.	<i>Substantial Compliance</i>
h. Conduct appropriate mental health assessments within the following periods from the initial screen: (1) 14 days, or sooner, if medically necessary, for prisoners classified as low risk; (2) 48 hours, or sooner, if medically necessary, for prisoners classified as moderate risk; and (3) immediately, but no later than two hours, for prisoners classified as high risk.	<i>Partial Compliance</i>
i. Ensure that prisoners who have been classified as high risk based on a mental health screening, but who cannot be assessed within two hours, are transferred to an outside hospital or other appropriate mental health provider for assessment.	<i>Partial Compliance</i>

j. Ensure that mental health assessments include the assessment factors described in Appendix A. Qualified Mental Health Professionals will complete all assessments, pursuant to generally accepted correctional standards of care.	<i>Partial Compliance</i>
k. Ensure that Qualified Mental Health Professionals perform in-person mental health assessments no later than one working day following any adverse triggering event (i.e., any suicide attempt, any suicide ideation, and any aggression to self resulting in serious injury).	<i>Substantial Compliance</i>
l. Ensure that Mental Health Staff conduct in-person assessments of prisoners before placing them on suicide watch (segregation) and on regular intervals thereafter, as clinically appropriate.	<i>Partial Compliance</i>

**Overall Finding: Partial Compliance**

Relevant Areas Reviewed:

- Review of medical charts (see Appendix B for details)
- Review of jail policies J-G-05a (Suicide Prevention) and J-E-02 (Receiving Screening)
- Review of Intake Medical Screening and Mental Health/Suicide Risk Assessment forms
- Direct observation of intake medical screenings during site visit
- Interviews with mental health staff and medical deputies
- Interviews with inmates

Explanation of Partial or Noncompliance:

(c) During the site visit, it appeared that mental health screenings were being performed within a few hours of arrival at the facility and with appropriate diligence. Chart review largely supports this conclusion, though the exact time between arrival at the facility and intake medical screening could not be assessed, as the computerized screening form does not record the time of completion. In the 10 charts that I reviewed, eight contained intake medical screenings completed on the same day as arrival at the facility, and two were completed on the following day. It is likely that the intake screenings are occurring, on average, within the MOA’s prescribed timed frame of eight hours from arrival at the facility, but I could not assess this definitively.

Also, the initial screening (“five questions” asked by deputies before accepting the inmate into the holding area) was not documented in any of the 10 medical charts that I reviewed. Perhaps this information is documented elsewhere, but a copy should also be kept in the medical chart. Maintaining a centralized medical record is essential for patient care, particularly in the jail setting, where inmates may provide inconsistent information to different providers or at different times.

(e) and (h). The MOA requires that inmates be categorized into low, medium, and high-risk groups during intake medical screening so that mental health

assessments can then be completed within an appropriate time frame. During the site visit, medical staff explained to me that their working definitions and usual practice are:

- low-risk = no psychiatric history, no current symptoms → house in general population, refer to psych sick call PRN
- medium-risk = history of psychiatric treatment or suicide attempts, current psychotropic medication, or current symptoms (but not suicidal) → obtain medication orders from MD, house in gen pop, refer to psych sick call for appointment within 1-2 weeks
- high-risk = current suicidal thoughts, bizarre behavior, abnormal vital signs, or inability to cooperate with assessment → immediate consultation with MD, possible placement on suicide watch

These criteria and procedures are clinically appropriate, but they are not reflected on the Intake Medical Screening, which frames conclusions in terms of “inmate disposition” rather than risk. This can be confusing to the reader. An example from one chart:

25 . Inmate Disposition
1. May be housed in general population; followup in sick call PRN : yes
2. Contact physician for medication orders and/or disposition - NONURGENT : yes
Notes: placed on SW
3. Call the physician IMMEDIATELY, or route patient to hospital : no

Based on this screening, it appears that the inmate was classified as both low- and medium-risk, and also placed on suicide watch. Revising the language of this section of the screening form will help clarify risk stratification and necessary follow-up. My sense is that the jail is, in practice, already following appropriate screening and triage procedures, but they are not reflected in the documentation.

An additional issue regarding screening has to do with suicide assessments. Chart review indicates that the Mental Health/Suicide Assessment is always being completed at the time of “roll-back” from the holding area to the jail proper, regardless of acuity of the patient. In the charts that I reviewed, the average time from booking to completion of this assessment was approximately six days, and on many occasions the patient had already seen the psychiatrist before this assessment was completed. While completing the assessments in this time frame complies with NCCHC guidelines,<sup>1</sup> it does give the impression that the Mental Health/Suicide Assessment is being completed out of obligation and serves no real clinical purpose. Completing the mental health assessment and suicide assessment earlier would be more useful, particularly since the highest-risk time

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<sup>1</sup> National Commission on Correctional Health Care: Standards for health services in jails (2008), J-E-02 (Receiving Screening) and J-E-05 (Mental Health Screening and Evaluation).

period for suicide in jails is within the first 72 hours after booking.

- (f) and (l). Another high-risk period for suicide is during placement in isolation. The jail has implemented procedures for daily wellness checks by nursing staff, plus monthly (or more) out-of-cell appointments with the psychiatrist. However, no procedure exists to screen for active symptoms of mental illness, such as psychosis or suicidal ideation, prior to placement in isolation. Placing inmates with serious mental illness in isolation should be avoided,<sup>2</sup> and screening is an integral part of this effort.
- (i) I did not encounter any instances where high-risk prisoners could not be screened immediately within the jail. Therefore, I could not assess the availability of outside facilities for emergency psychiatric care of high-risk prisoners. However, the jail has indicated during the site visit and in its initial compliance report that such facilities are neither available nor utilized.
- (j) The intake screening tool has been recently revised to be in compliance with the MOA. During the exit interview of the site visit, we discussed that two of the specific items in Appendix A of the MOA are not currently included in the Intake Medical Screening or Suicide Risk Assessment (e.g., recent loss and family history of suicide). In addition, some risk factors specific to jail suicides that are included in the Suicide Risk Assessment<sup>3</sup> may be more useful as part of the Intake Medical Screening, as the Suicide Risk Assessments are being completed after the highest-risk time period has passed. In particular, inquiries about (1) first incarceration, (2) intoxication at time of arrest, and (3) high bond or charges related to serious violent offense would be helpful to include in the intake screening assessment.

#### Recommendations:

1. Record the time of intake medical screening.
2. Document the completion of screening completed by deputies (the “five questions”) in the medical chart.
3. Revise intake medical screening forms to reflect a clear categorization of inmates into low, medium, and high-risk groups.
4. Revise intake medical screening and suicide risk assessment to include additional risk factors identified above.
5. Consider performing Mental Health/Suicide Assessments in a manner that would

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<sup>2</sup> American Psychiatric Association: Position statement on segregation of prisoners with mental illness (2012). Available at: <http://www.psych.org/advocacy--newsroom/position-statements>.

<sup>3</sup> National Institute of Corrections: National Study of Jail Suicides (April 2010). Available at: <https://s3.amazonaws.com/static.nicic.gov/Library/024308.pdf>.

be more clinically useful. For example, after intake medical screening by the LPN, inmates with moderate risk (e.g., those on psychotropic medication or with significant suicide histories) could be referred immediately to a social worker or psychiatric nurse for completion of the Mental Health/Suicide Assessment. This could start the process of gathering data about the patient’s mental health (e.g., requesting outside records, verifying outpatient meds) earlier and help the Initial Psychiatric Evaluation be more focused and meaningful.

6. Develop and implement a policy and procedure to screen inmates for acute mental illness prior to placement in the isolation unit.

### III.A.2. Treatment

a. Policies and procedures to ensure adequate and timely treatment for prisoners are continued and further developed for prisoners, whose assessments reveal serious mental health needs and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate.	<i>Substantial Compliance</i>
b. Treatment plans adequately address prisoners’ serious mental health needs and that the plans contain interventions specifically tailored to the prisoners’ diagnoses and problems. Provide group or individual therapy services by an appropriately licensed provider where necessary for prisoners with serious mental health needs.	<i>Noncompliance</i>
c. Mental health evaluations completed as part of the disciplinary process include recommendations based on the prisoner’s mental health status.	<i>Partial Compliance</i>
d. An adequate scheduling system is implemented to ensure that mental health professional assess prisoners with mental illness as clinically appropriate, regardless of whether the prisoner is prescribed medications.	<i>Substantial Compliance</i>
e. Prisoners receive psychotropic medications in a timely manner and that prisoners have proper diagnoses for each psychotropic medication prescribed.	<i>Substantial Compliance</i>
f. The practice of allowing prisoners to self administer medications is closely monitored and used only when medically appropriate. Prisoners who a Qualified Mental Health Professional has deemed unsuitable for self administration shall not be allowed to self administer medications.	<i>Substantial Compliance</i>
g. Psychotropic medications are reviewed by a Qualified Mental Health Professional on a regular, timely basis, and prisoners are properly monitored.	<i>Substantial Compliance</i>
h. Standards are established for the frequency of review and associated charting of psychotropic medication monitored.	<i>Substantial Compliance</i>
i. The treatment of suicidal prisoners involves more than segregation and close supervision (i.e., providing psychiatric therapy, regular counseling sessions, and follow-up care).	<i>Partial Compliance</i>
j. Crisis services are available to manage psychiatric emergencies that occur among prisoners. Such services may include, but are not necessarily limited to,	<i>Partial Compliance</i>

Overall Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Medical charts (see Appendices B and C for details)
- Mental health policies and procedures
- 2013 medical statistics
- Morbidity and mortality reviews
- Mental health forms (Initial Psychiatric Evaluation, templates for care of chronic conditions)
- Direct observation of routine psychiatric appointments
- Interviews with mental health staff and corrections officers
- Interviews with inmates

Explanations of Partial or Noncompliance:

(b) The phrase “Treatment Plan” appears in the title of forms that appear to be (in substance) either psychiatric progress notes or physician order forms. This is confusing and inconsistent with common mental health practice, in which the Treatment Plan is a stand-alone document that identifies diagnoses, goals of treatment, and strategies and time frames to accomplish those goals. I understand the concerns about such documents being labor-intensive and impractical in a jail setting, but some mechanism to convey the relevant information must be developed, particularly for long-stay inmates receiving ongoing treatment.

(c) Information about an inmate’s mental health status and its relationship to disciplinary infractions is being considered by the Discipline Officer in some cases, but it is being done so informally through verbal communication between the officer and the inmate’s legal representative. No formal policy or procedure exists to convey this information. Developing such a policy is essential to ensure both the proper treatment of inmates with mental illness and the integrity of the disciplinary process. In some cases, inmates may receive disciplinary infractions for behavior that is a result of mental illness, and the jail must have a mechanism to convey relevant information about the inmate’s mental health so that the Disciplinary Officer can take this into account when determining the appropriate disposition.

(i) Although the treatment of suicidal prisoners has certainly improved substantially in the past two years, their treatment in A-700 is still largely limited to psychotropic medication and close supervision, with no meaningful therapy. At the time of the site visit, suicidal prisoners were seen once per day by an LPN and once per day by a physician. They were otherwise offered no treatment. Particularly because inmates have no access to inpatient psychiatric care (see [j] below), they must be provided with treatment other than medication within the jail. Such a practice would also be more in line with recent evidence regarding the treatment of

depression, which questions the efficacy of antidepressants in mild to moderate cases.<sup>4</sup> In such cases, or where personality or adjustment issues are prominent, a focus on psychotherapy makes more clinical sense than reliance on medication alone. In addition, providing psychotherapy to inmates may actually decrease the incidence of suicidal crises or medication over-use in the facility, as inmates will have additional skills with which to handle stressful situations.

(j) During the site visit, the medical director and sheriff both reported that there is no access to inpatient-level care for pre-trial detainees at the jail. DOC inmates can be transferred back to DOC if they require a higher level of mental health care than the jail can provide, but pre-trial detainees must remain in St. Tammany because no local hospitals will accept jail inmates for treatment. The result is that, on occasion, the jail is forced to manage extremely ill individuals for extended periods of time with inadequate resources.

#### Recommendations:

6. Develop and implement a policy that creates real treatment plans for patients receiving mental health care. One possible approach is to create a very brief form that is completed at the time of the Initial Psychiatric Evaluation, with the understanding that many inmates will leave the jail in a short time and not require further follow-up. For inmates who stay at the jail longer (for example, >45 days), a more thorough treatment plan can be implemented.

7. Develop and implement a policy and procedure to ensure that relevant information about an inmate's mental health status is considered during jail disciplinary proceedings.

8. Continue the jail's plans to create a group psychotherapy program. In the jail setting, including in the suicide watch unit, the clinical focus of such programs will likely be on coping skills to prevent self-harm and reduce impulsivity, adjustment to incarceration, substance abuse, interpersonal skills, and self-care (including sleep hygiene).

9. If no access to community resources for inpatient psychiatric care for acutely ill inmates can be gained, the jail should continue the process of adapting the jail to provide a similar level of care, including offering psychotherapy. I have included a few potentially helpful workbooks that therapists can use with inmates. See Appendix F. Many others are available and would also be clinically appropriate; these are meant only as examples of potential group programs.

### 3. Suicide Precautions

a. Suicide prevention procedures include provisions for constant direct supervision of actively suicidal prisoners and close supervision of special needs

*Noncompliance*

<sup>4</sup> Fournier JC, et al. Antidepressant drug effects and depression severity. *JAMA* 303: 47-53, 2010.

prisoners with lower levels of risk (e.g., 15 minute checks).	
b. Prisoners on suicide watch are immediately searched and monitored with constant direct supervision until a Qualified Mental Health Professional conducts a suicide risk assessment, determines the degree of risk, and specifies the appropriate degree of supervision. Correctional officers shall document their checks on forms that do not have pre-printed times.	<i>Substantial Compliance</i>
c. All prisoners placed on suicide precautions shall be evaluated by a qualified mental health professional before being removed from suicide watch.	<i>Substantial Compliance</i>
d. All prisoners discharged from suicide precautions receive a follow-up assessment within three working days, in accordance with a treatment plan developed by a Qualified Mental Health Care Professional.	<i>Substantial Compliance</i>
e. Policies and procedures for suicide precautions set forth the conditions of the suicide watch, including a policy requiring an individual clinical determination of allowable clothing, property, and utensils. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergent circumstances or when security considerations require.	<i>Substantial Compliance</i>
f. The use of “booking cages” for housing prisoners in order to prevent suicide attempts or as mental health treatment has been eliminated and that these cages have been removed from the Jail facility.	<i>Substantial Compliance</i>
g. Policies for the use of isolation cells (i.e., suicide-resistant cells) are developed and implemented.	<i>Partial Compliance</i>

**Finding: Partial Compliance**

Relevant Areas Reviewed:

- Tour of male and female suicide watch areas
- Interviews with correctional and mental health staff
- Interviews with inmates placed on suicide watch
- Review of correctional officer computerized logs of suicide watch monitoring
- Review of jail policy J-G-05a, Suicide Prevention

Explanation of Noncompliance or Partial Compliance:

(a) Although monitoring of male inmates on suicide watch is in substantial compliance with the MOA, monitoring and treatment of female suicidal inmates is inadequate. Female inmates are held in the booking area together with many other inmates and monitored by an officer who is also observing up to 140 inmates at once, with his back to the female booking cells. 2 serious suicide attempts (one completed) have occurred in the holding cells, indicating that this is a high-risk area that deserves close monitoring. In addition, line-level staff identified the female booking area as their single greatest concern about inmate safety in the facility.

(g) Suicide-resistant cells and policies about their use have been adequately

developed for males, but for females, the usual practices are unsafe and inadequate. Staff currently place suicidal females in the holding cell together with many other women as a way to “make do” in the absence of designated suicide-resistant cells. No meaningful treatment is provided to female inmates while on suicide watch. The holding cells contain a phone cord that has twice been used in attempted hangings, and the cells were not designed to be suicide-resistant. In addition, although the jail has policies and procedures regarding allowable items (i.e. clothing, utensils) for female inmates on suicide watch, it is impossible to enforce these procedures when the inmate is housed together with others who do not have such restrictions. Overall, these factors create an increased risk of harm to female inmates.

Additional Comment:

Review of the charts indicates that signed “safety contracts” are routinely obtained from patients prior to discontinuing suicide watches. Numerous studies have questioned the utility of such contracts, as they do not reliably prevent suicides.<sup>5</sup> While they may be used as an added measure, they should not serve as a substitute for a thorough suicide assessment by a qualified mental health professional. During this evaluation, I found no instances in which individuals were put at risk because such a contract was used inappropriately; I mention it only to direct the jail’s attention to the growing practice in mental health care of abandoning such “contracts for safety.”

Recommendation:

10. Revise current policies and procedures regarding female suicidal inmates to include the use of suicide-resistant cells and a designated treatment space. While this revision is being completed, at a minimum, an officer should be assigned to *directly observe* female inmates on suicide watch in the holding area (not on camera with his back to the cell).

#### 4. Suicide Prevention Training Program

- a. Within 90 days of the Effective Date, a suicide prevention training program is continued and updated as set forth herein. The suicide prevention training program shall include the following topics:
- (1) suicide prevention policies and procedures;
  - (2) analysis of facility environments and why they may contribute to suicidal behavior;
  - (3) potential predisposing factors to suicide;
  - (4) high-risk suicide periods;
  - (5) warning signs and symptoms of suicidal behavior;
  - (6) case studies of recent suicides and serious suicide attempts;
  - (7) differentiating suicidal and self-injurious behavior;

*Substantial  
Compliance*

<sup>5</sup> Garvey KA, et al: Contracting for safety with patients: Clinical practice and forensic implications. J Am Acad Psychiatry Law 37: 363-370, 2009.

(8) mock demonstrations regarding the proper response to a suicide attempt; and (9) the proper use of emergency equipment.	
b. All correctional, medical, and mental health staffs are trained on the suicide screening instrument and the medical intake tool.	<i>Substantial Compliance</i>
c. Before assuming their duties and on a regular basis thereafter, all staff who work directly with prisoners have demonstrated competence in identifying and managing suicidal prisoners.	<i>Substantial Compliance</i>
d. All correctional, medical, and mental health staff complete a minimum of four hours of in-service training annually, to include training on updated policies, procedures, and techniques.	<i>Substantial Compliance</i>
e. All correctional staff is trained in observing prisoners on suicide watch and step- down unit status.	<i>Substantial Compliance</i>
f. All correctional staff is certified in cardiopulmonary resuscitation.	<i>Partial Compliance</i>
g. An emergency response bag that includes a first aid kit and emergency rescue tool is in close proximity to all housing units. All staff coming into regular contact with prisoners shall know the location of this emergency response bag and be trained in its use.	<i>Substantial Compliance</i>

Overall Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Records of training and continuing education for medical staff since 2011
- Quality assurance review from Dec 2013
- Slides from recent in-service training regarding suicide assessment
- Examples of case studies used in in-service trainings
- Interviews with mental health and correctional staff

Explanation of Partial or Noncompliance:

(f) I was provided with documentation that confirms annual CPR training for all medical staff members. However, no documentation regarding CPR training for correctional officers was provided, though the officers reported during my interviews that they do receive this annual training.

Additional Comment:

The jail medical director, Dr. Inglese, has essentially been solely responsible for training the medical staff in suicide assessment. I reviewed slides and outlines from some of these training sessions, and staff members that I interviewed could converse fluently regarding suicide assessment. However, most of this training has not been formalized into policy, making it possible for the training to disappear if Dr. Inglese were to leave St. Tammany.

Recommendations:

11. Provide documentation confirming that correctional officers have been trained in CPR.

12. Formalize the requirements for staff training in suicide assessment and the curriculum that will be used in this training.

**5. Use of Restraints**

a. Policies for the use of restraints on prisoners with mental health needs are continued, further developed, and implemented.	<i>Partial Compliance</i>
b. Written approval is received by a Qualified Medical or Mental Health Professional before the use of restraints on prisoners with mental health needs or requiring suicide precautions, unless emergency security concerns dictate otherwise. Such restraints shall be used for only as long as it takes for alternative security measures to be employed.	<i>Substantial Compliance</i>
c. Restrained prisoners with mental health needs are monitored at least every 15 minutes by correctional staff to assess their physical condition.	<i>Partial Compliance</i>
d. Qualified Medical or Mental Health staff complete documentation on the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on such restrained prisoners.	<i>Substantial Compliance</i>

Overall Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Policy J-I-01: Restraint and Seclusion
- 3 restraint reviews from 2013
- Medical records of 3 inmates who were restrained in 2013 (see Appendix D)
- Interviews with staff involved in placement and monitoring of restraints
- Quality assurance review from Dec 2013

Explanation of Partial Compliance:

(a) Use of restraints in the jail is quite low, and review of the morbidity reports indicates that restraints were appropriately used as a last resort in cases where inmates or staff were at risk of immediate harm. The reports also indicate that the inmates were monitored every 15 minutes, as required by policy. In the three cases from 2013, restraints were used for relatively short durations:

- Case 1: 4 hrs 55 min, 22 hrs 45 min
- Case 2: 4 hrs 39 min
- Case 3: 4 hrs 49 min

However, the Restraint and Seclusion policy allows for restraints to be placed for up to 18 hours without an additional physician order, which is much longer than the community standard of four hours and recommendations for restraints in correctional settings.<sup>6</sup> In addition, it appears that inmates are frequently taken in and out of physical restraints by nursing staff for bathroom breaks and meals, then placed back into restraints until a physician can evaluate the inmate and order discontinuation of the restraints. This practice is also inconsistent with community practice, where a patient who is stable enough to use the restroom independently likely no longer needs physical restraints.

(c) Several notes in the medical chart make reference to direct, continuous observation of inmates in restraints by correctional officers, who documented the inmate's condition every 15 minutes. During the site visit, medical and correctional staff confirmed that this is their practice. However, no documentation of these checks could be found in the medical charts. They are likely kept in a computerized file, but a copy should also be placed in the medical chart to maintain a centralized record.

Recommendation:

13. Revise the Restraint and Seclusion policy to be consistent with community standards for the time frame of restraint placement and procedures to discontinue restraints.
14. Provide documentation of timely completion (every 15 minutes) of security officers' checks of inmates in restraints.

## 6. Basic Mental Health Training

a. All staff have the knowledge, skill, and ability to identify and respond to prisoners with mental health needs. The St. Tammany Parties shall maintain the annual in-service basic training program for Qualified Medical and Mental Health Staff and correctional staff that addresses mental health needs. The training program shall continue to ensure that the following occurs:

- (1) Training will be conducted by the Qualified Mental Health Professional or his or her designee.
- (2) Training will continue to include:
  - (i) identifying and evaluating prisoners with mental health needs and recognizing specific behaviors that may arise out of mental health needs;
  - (ii) mental health protocols developed pursuant to this Agreement; and
  - (iii) for Qualified Nursing Staff, screening instruments developed pursuant to this Agreement.

*Partial  
Compliance*

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<sup>6</sup> Metzner JL, et al: Resource document for the use of restraint and seclusion in correctional mental health care. J Am Acad Psychiatry Law 35: 417-425, 2007. See also, NCCHC Standards for Mental Health Services in Correctional Facilities (2008), MH-I-01: Restraint and Seclusion.

Overall Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Records of medical staff training and continuing education 2011-present
- Slides and case studies used in staff trainings
- Interviews with correctional and mental health staff

Explanation of Partial Compliance:

- (a) All of the medical staff reported adequate training in recognizing and treating mental illness, and documentation confirming this training was provided to me during the site visit. However, of the security staff that I interviewed, only the medical deputies could recall receiving mental health training. It is possible that correctional officers do receive mental health training, but no documentation was provided to demonstrate it.

Recommendation:

15. Provide documentation to demonstrate that all security staff receive training to recognize signs and symptoms of mental illness and make appropriate referrals to mental health staff for assessment. If this training is not already in place, it should be instituted as soon as possible.
16. As with suicide prevention training, formalize the requirements for mental health training and the curriculum to be used in this training.

**7. Mental Health Staffing**

a. Mental Health staffing at the Jail is sufficient to provide adequate care for prisoners' serious mental health needs, fulfill the terms of this Agreement, and allow for the adequate operation of the Jail, consistent with constitutional standards. The St. Tammany Parties shall continue to achieve adequate mental health staffing in the following manner:

- (1) Within 90 days of the Effective Date, or before the Effective Date, the St. Tammany Parties shall conduct a comprehensive staffing plan and/or analysis to determine if additional the mental health staffing is necessary to provide adequate care for prisoners' serious mental health needs;
- (2) The results of the staffing plan and/or analysis shall provide guidance as to the number of mental health staffing necessary to provide adequate care for prisoners' serious mental health needs and to carry out the requirements of this Agreement; and
- (3) If the staffing plan indicates the need for additional mental health staffing, the St. Tammany Parties shall develop and implement a plan to ensure that the Jail is sufficiently staffed in order to carry out the requirements of this Agreement.

b. The comprehensive staffing plan shall be submitted to the Independent Auditor and the Department of Justice ("DOJ") for review and comment.

*Partial  
Compliance*

*Substantial  
Compliance*

Overall Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Staffing plan (as explained verbally during site visit and in writing by medical director prior to site visit)
- Interviews with mental health and correctional staff
- Interviews with inmates

Explanation of Partial Compliance:

(a) At the time of the site visit, a social worker and psychiatric nurse had very recently been hired. These two individuals were hired with the intent of enhancing the jail’s psychotherapy and discharge planning services—areas that both the jail and I found needed improvement. These two individuals had begun their duties too recently for their efficacy to be assessed during this evaluation.

An additional staffing concern is the use of Licensed Practical Nurses (LPNs) for mental health services. At St. Tammany, LPNs routinely perform medical and mental health assessments, which appear to be outside of the usual scope of practice for LPNs. However, regulations regarding LPN scope of practice are variable from state to state,<sup>7</sup> and during the site visit, I did not find any instances in which patients were clearly harmed by the care provided by LPNs. Further clarification of this issue is necessary to determine whether Louisiana allows LPNs to perform duties such as mental health triage and assessment. In my experience, these duties are typically performed by social workers, psychologists, or RN-level nurses.

Recommendation:

17. The parties should clarify legal regulations for LPN scope of practice in Louisiana and provide the monitor with this information, which would aid in assessing the adequacy of current staffing.

**8. Security Staffing**

- a. Security staffing is sufficient to adequately supervise and monitor prisoners, fulfill the terms of this Agreement, and allow for the safe operation of the Jail, consistent with constitutional standards. The St. Tammany Parties shall achieve adequate correctional officer staffing in the following manner:
- (1) Within 90 days of the Effective Date, or before the Effective Date, the St. Tammany Parties shall conduct a comprehensive staffing plan and/or analysis to determine if additional correctional officer staffing levels are

*Substantial  
Compliance*

<sup>7</sup> National Council of State Boards of Nursing: Practical Nurse Scope of Practice White Paper (August 2005). Available at:

[https://www.ncsbn.org/Final\\_11\\_05\\_Practical\\_Nurse\\_Scope\\_Practice\\_White\\_Paper.pdf](https://www.ncsbn.org/Final_11_05_Practical_Nurse_Scope_Practice_White_Paper.pdf).

necessary to provide adequate coverage inside each housing and specialized housing unit, assist with monitoring prisoners on suicide precautions, and comply with all provisions of this Agreement;

(2) The results of the staffing plan and/or analysis shall provide guidance as to the number of correctional officers necessary to provide adequate care for prisoners' needs; and

(3) If the staffing plan indicates the need for additional correctional officer staffing, the St. Tammany Parties shall develop and implement a plan to ensure that the Jail is sufficiently staffed in order to carry out the requirements of this Agreement.

b. The security staffing plan shall be submitted to the Independent Auditor and DOJ for review and comment.

<i>Substantial Compliance</i>

**Overall Finding: Substantial Compliance**

**Relevant Areas Reviewed:**

- Interviews with medical and security staff
- Interviews with inmates
- Review of security staffing plan in St. Tammany's compliance report
- Telephone call with Warden Longino and others on 3/14/14 to clarify staffing plan

**Comments:**

During the site visit, I did not encounter any instances in which inadequate security staffing clearly caused harm to patients. However, as mentioned above, I remain concerned about the ability of a single officer to monitor female inmates on suicide watch in the holding area while also performing his other duties. In addition, as the jail enhances its group treatment program in the coming months, additional officers may be necessary to ensure that inmates can be transported to the groups.

Recommendations: None additional (see *Suicide Precautions* above re: staffing for females on suicide watch)

**9. Risk Management**

a. Develop and implement policies and procedures that create a risk management system to identify levels of risk for suicide and self-injurious behavior and require intervention at the individual and system levels to prevent or minimize harm to prisoners, as set forth by the triggers and thresholds in Appendix A.

<i>Substantial Compliance</i>
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b. Develop and implement a Mental Health Review Committee that will review individual and system data about triggers and thresholds, as set forth in Appendix A, and will continue to determine whether these data indicate trends either for individuals or for the adequacy of treatment and suicide prevention overall. The Mental Health Review Committee shall continue to:

(1) include the Medical Director, one or more members of the mental health department, related clinical disciplines, corrections, and an appointed risk manager;

<i>Partial Compliance</i>
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<p>(2) conduct analyses of the mental health screening and assessment processes and tools, review the quality of screenings and assessments and the timeliness and appropriateness of care provided, and make recommendations on changes and corrective actions;</p> <p>(3) provide oversight of the implementation of mental health guidelines and support plans;</p> <p>(4) review policies, training, and staffing levels;</p> <p>(5) monitor implementation of recommendations and corrective actions; and</p> <p>(6) refer appropriate incidents to the Morbidity/Mortality Committee for review, as necessary.</p>	
<p>c. Ensure that a Morbidity/Mortality Committee reviews suicides and serious suicide attempts at the Jail in order to improve care on a jail-wide basis.</p> <p>(1) The Morbidity and Mortality Review Committee shall continue to include one or more members of jail operations, medical department, mental health care department, related clinical disciplines, corrections, and an appointed risk manager. The Morbidity and Mortality Review Committee shall continue to do the following:</p> <p>(i) Ensure that an interdisciplinary review, consisting of members of the correctional, medical, and mental health staffs, is established to review all suicides and serious suicide attempts.</p> <p>(ii) Ensure that the review shall include an inquiry of:</p> <p>(a) circumstances surrounding the incident;</p> <p>(b) facility procedures relevant to the incident;</p> <p>€ all relevant training received by involved staff;</p> <p>(d) pertinent medical and mental health services/reports involving the victim;</p> <p>€ possible precipitating factors leading to the suicide; and</p> <p>(f) recommendations, if any, for changes to policy, training, physical plant, medical or mental health services, and operational procedures.</p> <p>(iii) When appropriate, the Review team shall develop a written plan (and timetable) to address areas that require corrective action.</p> <p>(iv) Ensure that a mortality or morbidity review is conducted within 30 days of each suicide or serious suicide attempt (e.g., those incidents requiring hospitalization for medical treatment). A preliminary report of the review must be completed within that time.</p> <p>(v) Ensure a final mortality review report is completed within 30 days after the pathological examinations are complete.</p>	<p><i>Substantial Compliance</i></p>

**Overall Finding: Partial Compliance**

**Relevant Areas Reviewed:**

- Quality Assurance Quarterly Meeting report dated December 3, 2013
- 2013 Medical Department Statistics
- Two Mortality Reviews from 2013
- Five Morbidity Reviews from 2013
- Three Restraint Reviews from 2013

**Explanation of Partial Compliance:**

- (b) The jail medical director is clearly committed to providing high-quality medical and mental health care to inmates and has taken many steps to ensure that the jail's medical services are reviewed routinely. However, no formal Mental Health Review Committee has been formed. Many of the suggested functions outlined in the MOA are carried out during the jail's quarterly Quality Assurance meetings, which are attended by the medical director, warden, chief of corrections, psychiatrist, an internist, and a security administrator. However, there is no risk manager present, and the purpose of the meeting is not primarily to review mental health care. I understand that process of clinical review is under revision, and the jail plans to implement a system of clinic audits to review (in part) the adequacy of mental health care.

Additionally, the jail currently has no mechanism to review the quality of the clinical care provided by the psychiatrist. An outside psychiatrist with experience in correctional health care has been hired for this purpose, but the process has not yet begun.

Additional Comment:

The medical director writes all of the morbidity and mortality reviews, quality assurance reports, and responses to grievances. Many of these documents are written in a style that, while thorough and completed in a timely manner, also give the impression of being overly defensive. This may simply be a matter of writing style, or it may be done out of an understandable effort to convince readers that the jail was not at fault after adverse events. The concern about blame is reasonable, but a less heavy-handed approach (e.g., less use of exclamation points, italics for emphasis, and phrases like 'certainly appropriate' and 'unbelievable access to mental health care') would be more consistent with an objective review.

Recommendations:

18. Develop and implement a Mental Health Review Committee, or at least delineate how the Quality Assurance meeting satisfies all of the requirements set forth in the MOA for the Mental Health Review Committee.
19. Continue with the planned implementation of clinic audits and peer review of the psychiatrist's clinical care.

## Appendix A. Detailed Compliance Findings

	Noncompliance	Partial Compliance	Substantial Compliance	Notes
<b>III.A.1. Screening and Classification</b>				
III.A.1.a.			¶	
III.A.1.b.			¶	
III.A.1.c.		¶		
III.A.1.d.			¶	
III.A.1.e.		¶		
III.A.1.f.		¶		
III.A.1.g.			¶	
III.A.1.h.		¶		
III.A.1.i.		¶		
III.A.1.j.		¶		
III.A.1.k.			¶	
III.A.1.l.		¶		
<b>III.A.2. Treatment</b>				
III.A.2.a.			¶	
III.A.2.b.	¶			
III.A.2.c.		¶		
III.A.2.d.			¶	
III.A.2.e.			¶	
III.A.2.f.			¶	
III.A.2.g.			¶	
III.A.2.h.			¶	
III.A.2.i.		¶		
III.A.2.j.		¶		
<b>III.A.3. Suicide Precautions</b>				
III.A.3.a.	¶			
III.A.3.b.			¶	
III.A.3.c.			¶	
III.A.3.d.			¶	
III.A.3.e.			¶	
III.A.3.f.			¶	
III.A.3.g.		¶		

<b>III.A.4. Suicide Prevention Training Program</b>				
III.A.4.a.			9	
III.A.4.b.			9	
III.A.4.c.			9	
III.A.4.d.			9	
III.A.4.e.			9	
III.A.4.f.		9		
III.A.4.g.			9	
<b>III.A.5. Use of Restraints</b>				
III.A.5.a.		9		
III.A.5.b.			9	
III.A.5.c.		9		
III.A.5.d.			9	
<b>III.A.6. Basic Mental Health Training</b>				
III.A.6.a.		9		
<b>III.A.7. Mental Health Staffing</b>				
III.A.7.a.		9		
III.A.7.b.			9	
<b>III.A.8. Security Staffing</b>				
III.A.8.a.			9	
III.A.8.b.			9	
<b>III.A.9. Risk Management</b>				
III.A.9.a.			9	
III.A.9.b.		9		
III.A.9.c.			9	

## Appendix B. Chart Reviews – Screening and Assessment

Chart (patient initials)	Admission to Facility	Screening by Deputy	Health Assessment	Intake Medical Screening by Nurse	Mental Health & Suicide Assessment	Suicide Assessment review by MD	Initial Psychiatric Assessment	“Treatment Plan”	Outside Records Received?
1 (AA)	1/19/14, 0906		1/21/14, 2206	1/19/14	1/21/14, 2206	1/22/14	2/5/14, 0821	2/5/14, 0843	2/6/14 (outpt)
2 (BB)	1/16/14, 2251		1/18/14, 2005	1/17/14	1/18/14, 2005	1/21/14	1/24/14, 0859	1/28/14, 0934, 2/5/14	1/21/14 (pharm)
3 (CC)	1/9/14, 0348		1/15/14, 2000	1/9/14	1/15/14, 2000	1/16/14	1/13/14, 1119		Requested 2/3/14, spoke w/ mom 2/2/14
4 (DD)	1/21/14, 1951		1/31/14, 2350	1/21/14	1/31/14, 2350	Not done	1/23/14, 1351	1/27/14, 1051	1/27/14
5 (EE)	8/29/13, 1458		9/2/13, 1850	8/29/13	9/2/13, 1850	9/3/13	9/13/13, 0900	1/30/14, 0830	9/18/13, also many forensic reports
6 (FF)	1/25/14, 2112		2/4/14, 0138	1/26/14	2/4/14, 0138	2/4/14	Prog note 1/28/14	1/28/14, 1011	2/6/14 (6 mo in community btwn incarcerations )
7 (GG)	12/6/13, 0541		12/15/13, 2205	12/6/13	12/15/13, 2205	Not done	12/11/13, 0833	12/11/13, 0833	12/9/13
8 (HH)	? (unclear if one long or several		12/17/12, 2225	12/12/12	None?	None?	Nothing labeled initial assess, first	1/18/12, 1645	11/11/11

	admissions since 2011)						note on 10/22/12, 0933		
9 (II)	7/30/12?		8/2/12, 0300	7/30/12	None?	None?	8/2/12, 0957	8/2/12, 0957	8/13/12
10 (JJ)	9/16/13, 0348		None?	9/16/13	None?	None?	9/16/13, 0910	9/17/13, 1150	none
<b>Averages</b>			6.5 days	<24 hrs (exact unknown b/c no time on form)	6.5 days	6 days (when done), not done in 50% of charts reviewed	Approx 6 days		Relevant outside records present in every chart reviewed

Notes:

- documentation clearly better in more recent charts – suicide and MH assessments completed, reviewed by MD
- difficult to tell which pts were assessed as low, medium, or high risk from charts, but all MS assessments done within 10 days
- good collection of collateral data from outside providers, pharmacy, forensic evals
- screenings done by deputies at the door are missing, maybe documented somewhere else?

### Appendix C. Chart Reviews – Inmates on Suicide Watch

Chart (patient initials)	Suicide Watch Initiated	Suicide watch stopped	Total Time on Suicide Watch	Nurse f/u during suicide watch	Psychiatry f/u during suicide watch	Nurse f/u after suicide watch	MD f/u after suicide watch
1 (KK)	1/24/14, 0902	1/24/14, 1359	4 hrs 57 min		1/24/14, 1316	1/25/14, 1025	1/28/14, 0934 2/5/14
2 (LL)	2/1/14, 1339	2/7/14, 1224	5 days, 22 hrs, 45 min	2/6/14, 2200, 2/6/14, 1055, 2/5/14, 2230, 2/4/14, 2015, 2/3/15, 2030	2/7/14, 1218, 2/6/14, 1024, 2/5/14, 1051, 2/4/14, 0834	2/8/14, 1105	2/10/14, 1106
3 (MM)	1/21/14, 2100	1/23/14, 1408	1 day, 17 hrs, 8 min	1/21/14, 2100	1/23/14, 1355	2/7/14, 0910, 1/24/14, 1054	1/27/14, 1021 1/31/14, 0907
4 (NN)	1/22/14, 1750	1/23/14, 1245	18 hrs, 50 min	None?	1/23/14, 1241	2/10/14, 1015 1/14/14, 0920	1/27/14, 1012 2/3/14, 0843
5 (OO)	5/31/13, 1000	6/11/13, 1313 sent to isolation until 7/1/13	12 days, 3 hrs, 13 min	6/10/13, 2005 6/9/13, 1945 6/8/13, 2045 6/7/13, 1948 6/6/13, 1918 6/5/13, 1952 6/4/13, 1715 6/3/13, 1955 6/2/13, 2010 6/1/13, 2119 5/31/13, 2014	6/11/13, 1255 6/10/13, 1255 6/7/13, 1400 6/6/13, 1112 6/5/13, 1230 6/4/13, 0830 6/3/13, 1311 6/1/13, 1603	6/12/13, 1315	6/14/13, 1300 6/21/13, 1421
6 (PP)	8/1/12, 1150	8/2/12, 0957	22 hrs, 7	8/1/12, 2105	8/1/12, 0957	None?	8/6/12, 1318

			min				8/7/12, 1518
7 (QQ)	9/16/13, 0240	9/17/13, 1159	1 day, 9 hrs, 19 min	9/16/13, 2030	9/17/13, 1146 9/16/13, 0910	None?	None?

Notes:

- Documentation generally better in more recent charts
- Nurses are checking suicide watch inmates in evenings, MD in AM
- Large variability in time spent on SW: most are short-stay (<2days), but with significant outliers (5+ days)
- F/u being done by nurse within 24 hrs, MD within 3-4 days

#### Appendix D. Chart Reviews – Inmates in Restraints

Chart (patient initials)	Restraint Initiated	Restraint stopped	Total Time in Restraints	Security checks q15 min	Nurse f/u during Restraint	Psychiatry f/u during Restraint	SW/Nurse f/u after Restraint	MD f/u after Restraint
1 (RR) <i>Episode 1</i>	7/25/13, 1045	7/26/13, 0930	22 hrs 45 min	Documented in computer?	7/26/13, 0330 7/25/13, 1970 7/25/13, 1830 7/25/13, 1440	7/26/13, 0930 7/25/13, 1440 7/25/13, 1045	8/15/13, 0905 8/11/13, 2027 7/31/13, 0925	8/5/13, 1002 7/30/13, 1043 7/29/13, 1313 7/27/13, 1313
<i>Episode 2</i>	7/24/13, 1015	7/24/13, 1510	4 hrs 55 min	Documented in computer?	7/24/13, 1020	7/24/13, 1510 7/24/13, 1410 7/24/13, 1045 7/24/13, 1020	See above	See above
<i>Episode 3</i>	7/20/13, 2200	7/22/13, 1347	40 hrs, 47 min?	<i>Not clear from med records or Restraint Review whether this was one long restraint episode or just being placed on suicide watch.</i>				
2 (SS)	9/16/13, 0500	9/16/13, 0939	4 hrs 39 min	?	9/16/13, 0445	9/16/13, 0900	9/16/13, 2030	9/17/13, 1146
3 (TT)	10/8/13, 1111	10/8/13, 1600	4 hrs 49 min	?	10/8/13, 1111 10/8/13, 1215 10/8/13, 1310 10/8/13, 1600	10/8/13, 1105	10/8/13, 2120 10/9/13, 2120 10/10/13, 2045	10/9/13, 1253 10/11/13, 0927 10/16/13, 1221 11/13/13, 1231

Notes:

- All 3 inmates appeared to be on suicide watch already when restraints were initiated and remained on suicide watch after restraints stopped
- Several nurse's notes re: bathroom breaks, showers while still in restraints

### Appendix E. Treatment of Chronic Mental Illness

Chart (patient initials)	Admission to Facility	Psychiatry Appts	RN appts for MH	SW or therapy appts	Diagnosis	Meds	“Treatment Plan” updates	Labs	AIMS
1 (UU)	8/29/13	1/30/14, 12/27/13, 10/11/13, 9/13/13	None	None	Schizophrenia	Haldol dec Depakote	9/13/13, 12/27/13, 1/30/14	2/4/14, 1/13/14, 9/24/13	1/30/14, 10/11/13
2 (VV)	10/18/12	1/28/14, 11/22/13, 4/9/13, 1/18/13, 10/25/12, 10/23/12	None	None	Schizophrenia	Haldol Cogentin (changed from Loxitane outpt)	10/23/12, 1/18/13, 4/9/13, 11/22/13	None	1/28/14, 1/18/13
3 (WW)	7/30/12?	2/5/14, 11/22/13, 8/19/13, 8/5/13, 3/22/13, 12/28/12, 10/8/12, 9/11/12, 8/13/12, 8/6/12	None	None	Depression	Prozac	2/5/14, 11/22/13, 8/19/13, 8/5/13, 3/22/13, 12/28/12, 10/8/12, 9/11/12, 8/13/12	9/4/12	N/A
4 (XX)	12/6/13 (also several previous admissions)	2/3/14, 1/27/14, 1/6/14, 12/16/13, 12/11/13	Several for medical, none for MH	None	Repeated self-injury	Seroquel	2/3/14, 1/27/14, 12/16/13	1/7/14 lipids, 12/11/13	N/A

Notes:

- Frequency of f/u seems reasonable for stable inmates
- AIMS and labs done basically on time in more recent charts
- No therapy visits at all in any charts, either with RN or social worker
- Where does SJ document her involvement? Separate chart?
- Why so many different kinds of progress notes (psychosis, bipolar d/o, etc)? Also, lots of writing in margins b/c space taken up by check boxes

## **Appendix F. Examples of Psychotherapy Programs and Patient Workbooks**

1. Dialectical Behavior Therapy
2. START NOW (adapting Dialectical Behavior Therapy to the correctional setting)
3. Anger Management