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 #2

Final – December 7, 2014

Reena Kapoor, MD, *Independent Monitor*
Law & Psychiatry Division, Yale School of Medicine
34 Park Street
New Haven, CT 06519
Phone: (203) 974-7420, Fax: (203) 974-7178, Email: reena.kapoor@yale.edu

Introduction

Since January of 2014, I have served as the Independent Monitor of the Memorandum of Agreement between the Department of Justice (DOJ), the Parish of St. Tammany, and the St. Tammany Sheriff regarding the provision of mental health care at the St. Tammany Parish Jail. I conducted a preliminary evaluation of the jail from February 4 to 6, 2014, where I found that many of the concerns that were outlined in DOJ's original findings letter (July 2012) had already been resolved. I issued a final report on May 11, 2014. This report concluded that the jail was in substantial compliance with over 60% of the agreement provisions and had made significant improvements in its ability to provide mental health care.

I conducted a second site visit of the jail from September 15-17, 2014, and found that the jail has continued its efforts to improve mental health care. Many of the recommendations we discussed during the February 2014 exit interview were implemented immediately. Where there were disagreements or areas that the jail felt it could not comply with recommendations, the staff has attempted to implement work-around strategies. During all stages of my involvement in this case, I have been given full access to all information requested. Both the jail and the sheriff's office have been cooperative, transparent, and committed to resolving this matter as quickly as possible.

Methodology and Definitions

The conclusions in this report are based upon:

- Interviews
  - Four inmates were 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 and Medical Director

- Direct observations
  - Intake medical screening
  - Routine psychiatric evaluations
  - Mental health assessments and psychotherapy sessions conducted by RN
  - Psychiatric evaluations of inmates placed on suicide watch
  - Facility tour, including the holding area, medical unit, intake medical screening area, 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 explaining the jail's medical staffing plan and chain of command
- St. Tammany's initial compliance report (February 26, 2014), including security staffing plan
- Outlines and slides from medical staff training re: suicide prevention, restraint chairs, and identifying mental illness
- Correctional officer annual in-service logs
- Medical staff training logs documenting participation in continuing education sessions
- Pharmacy reports from August 2014
- Three morbidity reviews and three morbidity reports from 2014
- Two restraint reviews from 2014
- Suicide watch database from 2014
- Restraint database from 2013-2014
- Inmate grievances related to mental health care in 2014
- Quality assurance reports from April and July of 2014
- Statistics related to medical care in 2014
- Minutes from medical staff meetings in 2014
- Minutes from physicians' meetings in 2014

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.

At the request of DOJ, the format of this report is slightly different from Report #1 in that it comments on every provision of the agreement, rather than focusing only on areas of noncompliance.

Defendants' Actions To Date

The jail staff, led by the Warden and Medical Director, has continued its impressive effort to comply with the provisions of the agreement. The St. Tammany Parish Sheriff's Department has supported these efforts, providing additional resources as necessary. St. Tammany has taken many important steps to improve mental health care at the jail in 2014, including:

- Implementing a Psychiatric Risk Index, a system of classifying and triaging inmates during intake screening based on suicide risk and need for treatment;

- Ensuring that mental health assessments are performed by the psychiatric RN or psychiatrist based on acuity and risk, rather than uniformly at the time of "roll-back" from the booking area into the jail
- Implementing a protocol for follow-up care after inmates are removed from suicide watch
- Providing individual psychotherapy with a psychiatric RN while inmates are on suicide watch
- Revising procedures for mental health care while in isolation
- Implementing policies for mental health screening before adjudication of serious disciplinary violations
- Hiring a medical administrator to assess the adequacy of issues such as nursing care, access to medication, medical clinic environment and safety, and compliance with regulations
- Revising the restraint policy
- Revising the psychiatrist's initial intake form in order to reflect more detailed treatment goals and plan
- Adding security staffing in the female holding area, which has been the site of two previous suicide attempts
- Developing and implementing an annual mental health training module for all staff, including security officers
- Creating long-term plans (in the next 2 years) to move and expand the medical department in order to have more space for patient care

These recent changes are in addition to the improvements already implemented before the February 2014 site visit:

- Removing all "booking cages" from the facility and creation of a policy prohibiting their use in the management of suicidal prisoners
- Hiring of a full-time psychiatrist
- Hiring of an RN-level psychiatric nurse
- 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

At the time of the site visit, the Parish reported that it was in substantial compliance with all of my recommendations and all provisions of the agreement, with two exceptions:

- Moving female inmates on suicide watch out of the holding area. Plans for this are in progress, pending arrival of a new group of correctional officers in October of 2014; and

- Providing access to outside psychiatric hospitals. In fact, this problem has worsened since the last site visit, as a major psychiatric treatment facility in the area closed in early 2014.

Summary of Compliance

The Memorandum of Agreement contains 48 separate provisions. The summary of compliance in each area is as follows:

Provision	Total # of Provisions	Noncompliance (%)	Partial Compliance (%)	Substantial Compliance (%)
Screening and Assessment	12	0 (0)	2 (17)	10 (83)
Treatment	10	0 (0)	1 (10)	9 (90)
Suicide Precautions	7	0 (0)	1 (14)	6 (86)
Suicide Prevention Training Program	7	0 (0)	0 (0)	7 (100)
Use of Restraints	4	0 (0)	0 (0)	4 (100)
Basic Mental Health Training	1	0 (0)	0 (0)	1 (100)
Mental Health Staffing	2	0 (0)	0 (0)	2 (100)
Security Staffing	2	0 (0)	0 (0)	2 (100)
Risk Management	3	0 (0)	0 (0)	3 (100)
TOTAL (#)	**48**	**0**	**4**	**48**
TOTAL (%)	**100**	**0**	**8.3%**	**91.7%**

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts

- Jail policy J-E-02: Receiving Screening
- Direct observation of intake medical screening
- Direct observation of psychiatric nurse's evaluations
- Policies and procedures related to the Psychiatric Risk Index
- Staff training re: Psychiatric Risk Index

Basis for Finding:

The jail's policy is to employ a three-part screening process for suicide risk and mental illness. First, inmates are asked by deputies before entering the facility (among other things) about any serious illness or injury, recent hospitalization, and thoughts of suicide or self-harm. Next, the jail completes an intake medical screening on all inmates as part of the booking process. LPNs complete these intake screenings. Finally, all inmates receive a Mental Health Assessment within 14 days, though in many cases it occurs sooner. The mental health assessments are completed either by the psychiatrist or the psychiatric RN, depending on acuity. Follow-up care after these assessments is arranged based on clinical need.

This policy is appropriate and within generally accepted standards of care for jail mental health practice. Chart review indicates that the policies are being followed as written. All of the charts reviewed contained a complete intake medical screening and Mental Health Assessment.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Computerized intake screening form
- Observation of LPNs performing intake screenings during site visit
- Policies related to Psychiatric Risk Index (PRI)
- Internal memos documenting revisions and refinements of PRI
- Medical charts

Basis for Finding:

The jail has developed a new policy related to mental health screening, which aims to identify those inmates who are at highest risk of self-harm and those with immediate treatment needs. This system is called the Psychiatric Risk Index (PRI), which assigns a score of 1-5 to each inmate. The score is based on evidence-based risk factors for suicide in jails, such as prior history of attempts, recent substance use, and current suicidal ideation.

During the site visit, I observed LPNs performing intake screenings using the PRI system. All of the essential questions about suicide risk were included in the screening assessments, and scores were assigned according to the policies developed by the Medical Director. A review of 10 medical charts revealed some discrepancy in where the PRI score was documented in the chart (in the nurses' orders or on the screening form itself), but the substantive task was performed accurately in all of the charts.

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.*

Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Jail policy J-E-02 (Receiving Screening)
- Direct observation of intake screening
- Inmate interviews
- 12 medical charts

Basis for Finding:

As noted in *Monitor's Report #1*, the jail appears to be conducting most intake screenings within a few hours of the prisoner's arrival at the facility. However, the exact time between arrival and screening could not be assessed, as the computerized intake screening forms do not record the time of completion. I understand from conversations with the Medical Director that making such a seemingly small adjustment to the computer system is actually prohibitively expensive, costing several thousand dollars. In lieu of this expense, I would recommend that:

- LPNs manually record the time after completing each screening
- The jail clarifies the appropriate time frame between admission and intake screening in Policy J-E-02 to be in compliance with the MOA

An additional issue arose in *Monitor's Report #1* regarding documenting the "five questions" that deputies ask before allowing prisoners into the booking area. During this site visit, I was told that no documentation of this screening is kept, as it would be burdensome and not clinically useful, given that the deputies and medical staff already employ a protocol for following up on positive and negative screening results. When the screening is negative, the inmate is accepted into the jail. When the screening is positive, a nurse is called to assess the prisoner immediately and determine whether he or she should be accepted by the jail. During the site visit, I observed this procedure being followed, and jail medical statistics indicate that approximately 10% of all intake screenings are conducted in this manner (as STAT

evals).

From my perspective, it is advisable to document even the negative screenings for the purpose of protecting the jail from liability, as it is certainly possible for an inmate to have an adverse outcome in the holding area before intake medical screening (e.g., suicide attempt, serious alcohol withdrawal symptoms) and later claim that he/she informed the jail beforehand of the risk. In fact, in the case of A.A., a prisoner attempted suicide in the holding area before intake medical screening. However, this is more an issue of risk management than of proper medical protocol, so I defer to the jail's legal advisors and quality assurance team about how it chooses to handle documenting the "five questions."

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Documents related to Psychiatric Risk Index development and implementation
- Interviews with nursing staff
- Training records for medical staff, 2011-2014
- Review of slides from annual training on suicide prevention and identification of mental illness

Basis for Finding:

All members of the medical staff undergo extensive training in suicide assessment, identifying mental illness, and intake screening. The training (and successful completion of post-training exam) is documented in each employee's education file. Since implementing the Psychiatric Risk Index in 2014, the medical staff has received additional training about how to categorize prisoners accurately and consistently. Numerous emails and memoranda indicate that the nursing staff has directed questions about the PRI to the Medical Director, who has responded by clarifying ambiguous areas of the protocol and revising the instrument as necessary. Interviews of the nursing staff during the site visit reflected some mild frustration about the number of revisions that the PRI has undergone since its inception, but all staff had a good understanding of the screening instrument and suicide risk assessment in general.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Documents related to Psychiatric Risk Index development and implementation
- Interviews with nursing staff and psychiatrist
- Medical charts

Basis for Finding:

As described above, the Psychiatric Risk Index system has been implemented in order to improve identifying and treating high-risk inmates. When an inmate scores 3 or higher on the PRI, the nurse is required to consult with the on-call physician about the case and determine appropriate follow-up. In most cases, this follow-up occurs at the next available psychiatric sick call appointment (with an average wait time of 1 day, per the jail's annual statistics). PRI 5 inmates are placed on constant observation (suicide watch) in A-700 until they are evaluated by the psychiatrist. Chart reviews indicated that the PRI protocols are being followed as written.

In my opinion, the PRI system improves the medical staff's ability to prioritize inmates with the highest needs, and it meets the requirements of the MOA. I would note that the PRI classifications are quite conservative, with many inmates receiving scores >3. As an initial starting point, there is nothing wrong with a conservative approach. Over time, the Medical Director and quality assurance team may wish to collect data about whether the current classifications and follow-up protocols are resulting in an efficient use of resources.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Mental Health Screening form
- Psychiatrist's initial evaluation form
- Interviews with inmates
- Interviews with nursing staff and psychiatrist
- Review of protocols related to mental health screening in isolation (segregation) units

Basis for Finding:

In the jail setting, there are several high-risk periods for inmates to engage in self-harm. While self-harm is dependent upon a number of individual factors (history of

attempts, active mental illness symptoms, etc), an elevated risk of suicide or self harm generally occurs during (1) the first 72 hours of incarceration, (2) after receiving bad news such as a long sentence or loss of a family member, or (3) during placement in isolation (segregation).

In the past year, the jail has implemented additional mental health evaluations during these high-risk periods. As described above, the PRI system has improved the medical staff's ability to identify high-risk individuals during the first few hours of incarceration. The psychiatric nurse now also routinely meets with prisoners who have received long sentences (>10 years incarceration) to assess suicide risk and offer support. Records indicate that she performed 55 such counseling sessions in 2014, in addition to seven grief counseling sessions when an inmate had a significant loss. These visits are an important part of the jail's enhanced suicide prevention program.

The jail has also utilized the psychiatric nurse in monitoring inmates placed in isolation. Inmates in isolation receive the following medical and mental health contacts:

- Before isolation placement, medical staff reviews the charts for any medical contraindications to placement in isolation;
- Inmates are evaluated cell-side by the LPN staff daily for wellness checks;
- Within 36 hours, a nurse performs an initial assessment of the inmate to assess for any acute medical or mental health problems;
- Within 7 days, inmates are evaluated by the psychiatrist and an internist; and
- Every 3-4 weeks, a mental health professional (usually the psychiatric nurse) evaluates the inmate during an out-of-cell assessment.

Records confirm that the psychiatric nurse met with inmates in isolation at least every 3-4 weeks, and in many cases much more frequently. All of these efforts represent a comprehensive effort to identify inmates with mental illness in isolation and provide them with necessary treatment in both urgent and non-urgent cases.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Correctional officer interviews
- Review of computerized records of monitoring
- Inmate interviews
- Jail policies related to suicide prevention

Basis for Finding:

Inmates with a PRI score of 5 during the initial assessment are observed in the A-700 unit until they are evaluated by a mental health professional. Inmates with a PRI score of 3-4 (those at moderate risk) are not observed continuously unless such observation is ordered by the consulting physician. Although this is not technically in compliance with the MOA, I do not think that direct observation of prisoners at moderate risk of self-harm is clinically indicated as a routine practice. No equivalent practice exists in community settings, and I do not see a reason to create a different practice in a jail setting.

For inmates whose risk of self-harm is assessed after the initial intake (e.g., during a mental health appointment or upon referral by a security officer), high-risk inmates are observed directly and housed in A-700 until evaluated by a mental health professional. Again, those at moderate risk of self-harm are typically not observed continuously, but this is not clinically indicated as a routine practice.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Intake screening policies and PRI protocols
- Interviews with psychiatrist and psychiatric RN
- Medical charts
- Direct observation of intake screening and routine mental health assessments

Basis for Finding:

Mental health assessments are scheduled according to the PRI score, as determined by the LPN staff during intake medical screening. For PRI 1 and 2 inmates, a mental health assessment is scheduled with the psychiatric nurse within 10 days. My review of charts indicated that these screenings are being completed according to this protocol. The psychiatric nurse works Monday through Friday, so sometimes the screenings are completed after 11-12 days (depending on where the weekends fall), but this delay is not clinically significant.

For PRI 3 and 4 inmates (those at moderate risk), chart review indicates that the

inmates are seen by a psychiatrist at the next available appointment, typically the next day.

PRI 5 inmates are placed on suicide watch (direct continuous observation) until they can be evaluated by the psychiatrist. Depending on the time of day, this may happen within a few minutes, or it may happen the following morning. Although this practice does not fully comply with the MOA, I do not see a way to ensure an evaluation within 2 hours during the overnight shift, unless the jail were to employ an additional mental health professional to come into the facility at night and perform these assessments. I am uncertain of the clinical utility of such a practice. High-risk inmates already have an in-person nursing assessment (by nurses who are trained in suicide assessment) at the time of being placed on suicide watch, and a physician is consulted by telephone. It is unclear what practical value an assessment by a social worker or psychiatric RN would add, as long as the inmate will see the psychiatrist the following morning.

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.*

Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Medical charts
- Direct observation of intake screening
- Discussions with Medical Director, Warden, sheriff, and sheriff's counsel during the site visit

Basis for Finding:

As in the first site visit, I did not encounter any instances where high-risk prisoners could not be assessed immediately within the jail (except, as noted above, during the nighttime hours, when they have an immediate nursing assessment and until the following morning for a mental health assessment). However, should an outside hospital be necessary, none is available. The jail continues to assert that no hospital in St. Tammany Parish will accept an inmate for psychiatric treatment, and there is no hope of changing this situation in the foreseeable future. In fact, access to outside hospitals has worsened since the first site visit, as one of the few local hospitals with a psychiatric inpatient unit recently closed.

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.*

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Direct observation of mental health assessments by psychiatrist and RN
- Review of Mental Health Assessment forms
- Medical charts
- Log of psychiatric RN appointments in 2014

Basis for Finding:

Initial mental health assessments are completed by the psychiatric RN or the psychiatrist, depending on the inmate's level of acuity. Both assessments include the factors enumerated in Appendix A (of the MOA) and are consistent with generally accepted standards for correctional mental health assessments.

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).

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Two restraint reviews from 2014
- Three morbidity reviews from 2014
- Medical charts of four inmates involved in critical incidents in 2014

Basis for Finding:

Adverse events are rare at the jail, but when they occur, inmates receive appropriate follow-up care. Review of four charts of inmates involved in adverse events in 2014 (restraints, serious suicide attempts) indicates that the mental health staff performed appropriate follow-up. In 100% of the charts reviewed, the inmates were evaluated by a physician within 24 hours. When possible, the inmates also received follow-up counseling with the psychiatric RN after the event.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts of inmates placed on suicide watch

- Interviews with nursing staff and psychiatrist
- Suicide watch policies

Basis for Finding:

All inmates are evaluated by the medical staff before placement on suicide watch. These evaluations are typically done by LPNs who have been trained in suicide assessment, and their findings are reviewed with the on-call physician. After placement on suicide watch, inmates are assessed at least every 12 hours by an LPN and once per day by a physician (usually the psychiatrist). The psychiatric RN sees each inmate on suicide watch for a counseling appointment at least once, and she can recommend additional sessions as clinically indicated. Inmates are assessed in-person by a physician before discontinuing suicide watch. After release from suicide watch, each inmate is seen by the psychiatric RN for a follow-up appointment within three days and by the psychiatrist within 7-10 days. Chart reviews indicate that these policies have been followed appropriately. All of the charts that I reviewed contained good documentation of assessments by the LPN staff and psychiatrist, and the more recent ones also contained documentation of assessments by the psychiatric RN (both during and after suicide watch).

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.

Finding: **Substantial Compliance**

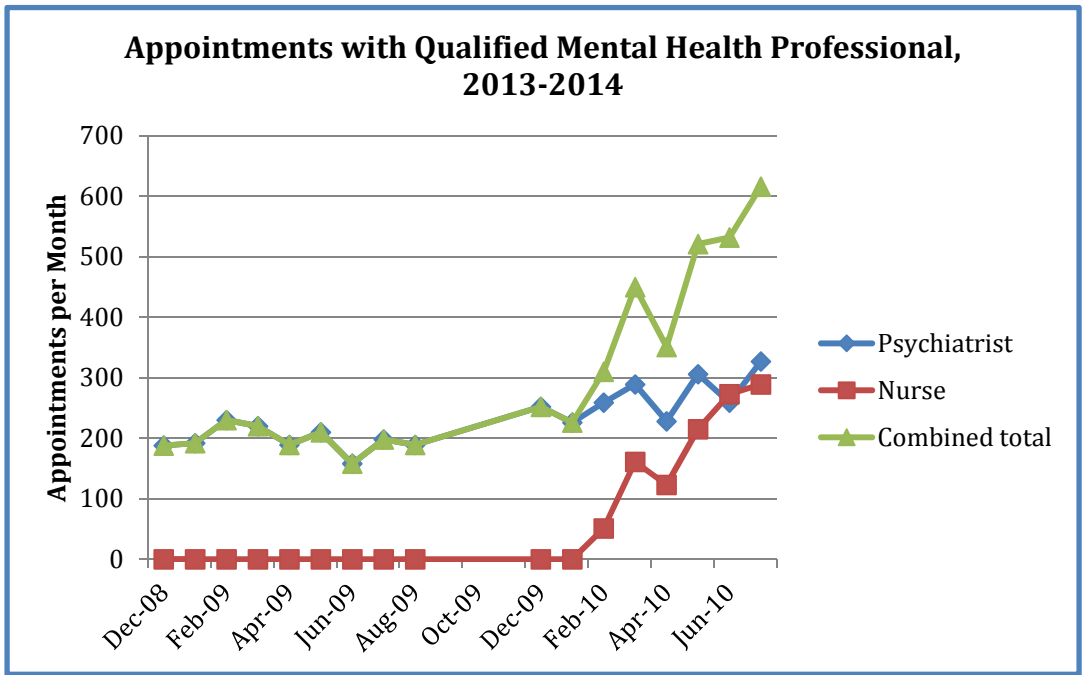
Relevant Areas Reviewed:

- Jail medical statistics, 2013-2014
- Psychiatric Risk Index (PRI) protocols
- 12 medical charts
- Interviews with inmates
- Interviews with mental health and medical staff
- Direct observation of routine psychiatric appointments

Basis for Finding:

As depicted in the chart below, the jail has tripled the number of monthly mental health appointments conducted in the past two years, with more than 600 appointments in August of 2014. The average wait time for an appointment with a psychiatrist is just over one day (including weekends), which indicates that inmates have excellent access to care. The quality of care provided also appears to be good.

My impressions of the psychiatrist and psychiatric RN (based on observation and chart review) are that they are caring, competent mental health professionals who practice in accordance with generally accepted standards.



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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Revised Initial Psychiatric Assessment form and follow-up progress notes
- Interviews with psychiatrist, psychiatric RN, Medical Director, and licensed drug/alcohol counselor
- Medical charts

Basis for Finding:

The jail has revised the Initial Psychiatric Assessment form to include items typically found in stand-alone treatment plans, such as diagnosis, goals of treatment, medications, and plan for follow-up. Given that most patients stay at the jail a very short time, creating a separate document for treatment planning would likely serve no practical purpose. The inclusion of the treatment plan in the initial psychiatric assessment accomplishes the intent of the agreement. The follow-up progress notes have also been revised so as to eliminate confusion about which

document is the "treatment plan," which is also very helpful.

Since the addition of the psychiatric RN to the medical staff, the jail has routinely been providing individual therapy services to inmates. The jail also provides a limited number of group programs to DOC inmates (those who have already been sentenced but reside at the jail because of prison overcrowding). These programs were developed and implemented by a licensed drug and alcohol counselor, and they include the CRASH program, Alcoholics Anonymous and Narcotics Anonymous groups, and pre-release counseling groups. The jail is exploring options to expand the DOC groups to include parish (unsentenced) and federal inmates, though this option is not currently available.

c. Mental health evaluations completed as part of the disciplinary process include recommendations based on the prisoner's mental health status.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Jail policy BJG-III A-001 (Rules and Discipline)
- Interview with disciplinary officer
- Email from Medical Director dated 9/26/14 explaining rationale behind current policy

Basis for Finding:

The jail has revised its disciplinary procedures to include a review of inmates' mental health status before adjudication for all "high court" infractions (the more serious type). The psychiatric RN reviews charts on a weekly basis after receiving a list of prisoners from the disciplinary officer, and she informs the disciplinary officer of any current mental health diagnosis that should be considered during the disciplinary proceedings. To date, only one such individual has been identified, and his charges were appropriately dismissed on two occasions at the recommendation of the mental health staff. Nonetheless, the new policy and its implementation are in compliance with the MOA.

During the exit interview, we discussed whether inmates involved in "low court" disciplinary proceedings should also be screened by the mental health staff. The jail has not done this already because of the high volume of inmates (approximately 40-50 per week) involved, as well as the additional screening mechanisms that already capture these inmates and provide them with mental health services. For example, and inmate with mental illness who receives a "low court" disciplinary infraction and is placed in punitive segregation will then be evaluated by the mental health staff within 36 hours as part of the isolation screening protocol. If there are concerns about his/her mental health status at that time, he/she can be removed from isolation and treated as the mental health staff recommends.

In my opinion, the current procedure of only screening high court inmates is likely sufficient, as long as the jail has some procedure for bringing worrisome inmates involved in the low court to the attention of mental health staff when indicated. For example, the jail could consider developing a policy for referring inmates to a qualified mental health professional when:

1) an inmate receives 3 or more disciplinary infractions within a short time period (e.g., one month), perhaps indicating mental instability;
2) the disciplinary officer notices signs or symptoms of mental illness during his interactions with the inmate; and
3) any staff member has reason to believe that the inmate is purposely committing disciplinary infractions in order to stay in isolation (perhaps indicating untreated paranoia).

These criteria are simply suggestions; the jail Quality Assurance staff may think of others that are better suited for St. Tammany. The basic idea is that inmates whose disciplinary problems may be a result of mental illness can be brought to the attention of mental health providers, even if such a screening is not done in every case.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Records from daily sick call schedules
- Tour of medical records room, including observation of computerized scheduling system
- Medical charts
- Record of psychiatric RN counseling appointments
- Observation of routine psychiatric appointments
- Interviews with psychiatrist and psychiatric RN

Basis for Finding:

The jail has an adequate scheduling system for appointments with the psychiatrist and psychiatric RN, which is run by the jail's five medical assistants. The appointments are scheduled either according to the jail's screening policies (e.g., mental health assessment within 14 days of arrival at the facility) or according to the clinical recommendations of the mental health staff. Chart reviews indicate that the mental health providers frequently schedule appointments for counseling, mental status checks, and safety assessments, regardless of whether the inmate is

prescribed medication.

e. Prisoners receive psychotropic medications in a timely manner and that prisoners have proper diagnoses for each psychotropic medication prescribed.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts
- Inmate interviews
- Interviews with nursing staff and psychiatrist

Basis for Finding:

All of the chart reviews indicated that psychotropic medications are prescribed in accordance with generally accepted practice. The psychiatrist is knowledgeable about the scientific literature related to psychotropic medications, and he routinely explains his rationale for prescribing a particular medication during the inmates' appointments. They are not always happy with his reasoning, particularly when they are accustomed to taking a different medication at home, but I found the psychiatrist's medical decisions to be reasonable.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts
- Interviews with physicians, Medical Director, and nursing staff
- Inmate interviews
- Discussion during exit interview of first site visit

Basis for Finding:

The jail allows inmates to hold and self-administer up to 4 days of medication at a time (meds are passed by the nurses twice weekly), provided that there is no psychiatric or medical contraindication. This process was discussed at length during the first site visit, as there had apparently been a disagreement during the initial DOJ investigation about the appropriateness of KOP (self-administered) psychotropic medication. In my opinion, KOP psychotropic medications can be acceptable, as long as a clinical determination about the inmate's ability to safely

store and administer the medications is made. During my observations of the psychiatrist's practice, he did make those clinical determinations and order KOP or DOT (direct observation therapy) medications accordingly. Furthermore, the jail security staff performs random "shake downs" of cells looking for (among other things) hoarded or misappropriated medications. When an inmate is found with the wrong medication, he or she is evaluated by a physician, and a clinical determination is made about whether to continue KOP meds, switch to DOT, or discontinue the medication altogether.

g. Psychotropic medications are reviewed by a Qualified Mental Health Professional on a regular, timely basis, and prisoners are properly monitored.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts, including Medication Administration Records (MAR)
- Interviews with inmates
- Interviews with psychiatrist
- Direct observation of psychiatric practice

Basis for Finding:

The jail psychiatrist manages psychotropic medications. Chart reviews indicate that the psychiatrist follows evidence-based prescribing practices and adheres to typical standards within the profession for follow-up and monitoring of psychotropic medications. Routine lab tests (e.g., monitoring of fasting lipids and HbA1c every 6 months for patients on atypical antipscyhotics) and AIMS exams (for patients on antipsychotics) were difficult to assess, given the short time that most patients spend at the jail. However, I did see evidence in the charts and during my observations of psychiatric appointments that these tests are being done appropriately.

h. Standards are established for the frequency of review and associated charting of psychotropic medication monitored.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Jail policy J-D-02: Medication Services
- Medical charts
- Quality Assurance quarterly meeting notes from April and July 2014
- Pharmacy records from August 2014

Basis for Finding:

The only policy related to frequency of medication review that I saw was in J-D-02, which indicates that medications must be reviewed at least annually. However, in practice, several other layers of medication review occur at the jail. The psychiatrist reviews psychotropic medications at each visit. Depending on clinical need, these reviews can occur as often as every day or as infrequently as every three months. Both of these time frames are consistent with community practices. In addition, all charts contain a Medication Administration Record that documents acceptance or refusal of every medication dose. Finally, the jail Quality Assurance team reviews aggregate data about pharmacy expenditures and medication prescriptions during its quarterly meetings.

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).

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts
- Inmate interviews
- Tour of male and female suicide watch areas
- Log of psychiatric RN appointments in 2014

Basis for Finding:

Since the last site visit, the jail has expanded the mental health services offered to suicidal inmates to include individual psychotherapy services. Records from 2014 indicate that the psychiatric RN performed dozens of counseling sessions with inmates while they were on suicide watch. In addition, the jail has expanded its routine follow-up services after suicide watch to include a counseling session with the psychiatric RN. In total, suicidal inmates receive the following services:

- MD assessment before placement on suicide watch;
- Daily MD assessments while on suicide watch, usually with the psychiatrist;
- One routine individual psychotherapy session with the psychiatric RN while on suicide watch, plus additional sessions as clinically indicated;
- MD assessment before being taken off suicide watch;
- Follow-up counseling with the psychiatric RN within three days of being taken off suicide watch; and
- Follow-up with the psychiatrist within 7-10 days of being taken off suicide watch.

In my opinion, these appointments are sufficient to ensure adequate treatment and follow-up of suicidal prisoners. The jail is exploring options to consolidate some of

these individual sessions into groups, which may be more efficient in the long-run. However, I do think that the current practices are compliant with the MOA.

j. Crisis services are available to manage psychiatric emergencies that occur among prisoners. Such services may include, but are not necessarily limited to, licensed in-patient psychiatric care, when clinically appropriate.

Finding: **Partial Compliance**

Relevant Areas Reviewed:

- Medical charts
- Discussions with Medical Director, sheriff, and other jail leadership during site visits

Basis for Finding:

As mentioned above, access to inpatient psychiatric care remains an intractable problem at the jail. My understanding of the problem is that Louisiana has very few inpatient beds to begin with, and most hospitals will not make them available to persons in the sheriff's custody. In response to this problem, the jail psychiatrist (who lives locally) sometimes sees patients on nights and weekends in crisis situations. In addition, the jail has implemented a few work-around strategies to provide necessary emergency care when they have inmates who are too ill to be treated safely at the jail:

1) Ms. Johansson, who works as a liaison between the jail and the state hospital, can sometimes expedite transfer of inmates found incompetent to stand trial and awaiting treatment for competency restoration;
2) DOC inmates, those who have already been sentenced but are housed at the jail due to prison overcrowding, can be transferred back to a DOC facility with a higher level of psychiatric care; and
3) For pre-trial inmates with small charges, the Warden or Chief of Corrections can consult with the court about lowering the bond or dropping the charges so that the inmate has access to necessary (usually urgent) medical or psychiatric treatment.

These work-around strategies do represent an important effort by the jail not to keep severely ill inmates in circumstances that will exacerbate their health conditions. However, given the limited access to psychiatric beds, they are only available in the most extreme cases, and they are rarely available immediately.

III.A.3. Suicide Precautions

a. Suicide prevention procedures include provisions for constant direct supervision of actively suicidal prisoners and close supervision of special needs prisoners with lower levels of risk (e.g., 15 minute checks).

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Tour of male and female suicide watch areas
- Inmate interviews
- Security officer interviews
- Review of computerized monitoring records

Basis for Finding:

The jail responded to my concern about monitoring of suicidal female prisoners by stationing an additional officer in the female holding area. When a female prisoner is on suicide watch, the officer's primary responsibility is to observe that inmate and document the observations every 15 minutes. The longer-term plan is to move female suicidal inmates into A-700, where the male suicidal inmates are housed. This will allow officers to create uniform protocols for observing all suicidal inmates, including the use of a lower level of observation for inmates who need extra attention (but not full suicide precautions) due to withdrawal symptoms, dementia, or psychosis. This lower level of observation is already in place for male inmates, but it can also be used for female inmates once they move into A-700.

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.*

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Computerized logs of officer observations
- Interviews with inmates, officers, and nursing staff

Basis for Finding:

Suicidal inmates are monitored by officers either in the holding area (females) or the A-700 unit (males). In both locations, officers directly observe the prisoners and document their checks in computerized logs. Officers also have a form filled out by the physician for each inmate that specifies the level of observation and allowable property (e.g., mattress, clothing). As noted above, these documents should ideally be placed in the medical chart in order to maintain a complete record of suicidal prisoners' treatment. Currently, the log of 15-minute observations is not placed in the medical record because of computer limitations

(see provision III.A.5.c below).

c. All prisoners placed on suicide precautions shall be evaluated by a qualified mental health professional before being removed from suicide watch.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Jail policies regarding suicidal inmates
- Medical charts
- Morbidity reviews from 2014

Basis for Finding:

All inmates on suicide watch are evaluated by the psychiatrist before being removed from suicide watch unless he is unavailable, in which case they are evaluated by another physician (all of whom have been trained in suicide assessment). LPNs do not make assessments to remove inmates from suicide watch. All of the charts reviewed contained documentation of a physician assessment before discontinuing suicide watch.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts
- Interview with psychiatric RN
- Log of psychiatric RN appointments in 2014
- Jail policy J-G-05a, Suicide Prevention

Basis for Finding:

The jail's policy is for inmates to have a follow-up appointment with the psychiatric RN within three days of discharge from suicide watch. Chart review and the psychiatric RN's appointment log both indicate that these appointments are being conducted according to policy.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Tour of A-700 unit
- Jail policy J-G-05a, Suicide Prevention
- Interviews with psychiatrist and officers in A-700

Basis for Finding:

Each inmate on suicide watch is assessed by a physician at the time of suicide watch placement, and a clinical determination about allowable property is made. A form is completed, which the officer keeps at his/her desk while the inmate is on suicide watch. On my tour of the A-700 unit, I observed that each inmate had property in his cell in accordance with the written plan. In general, I thought that the physicians were a bit too conservative in their judgments about allowable property, restricting basic comfort items such as a blanket, mattress, or "boat." However, reasonable clinicians can disagree about the risks and benefits of allowing certain items. I did not see any cases where an item was restricted out of malice or totally without clinical justification.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Tour of jail
- Interviews with facility leadership

Basis for Finding:

During the site visit, no booking cages were used for any part of mental health treatment, including for suicide watch. My understanding is that the cages were permanently removed from the facility in 2012.

g. Policies for the use of isolation cells (i.e., suicide-resistant cells) are developed and implemented.

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
- Computerized logs of suicide watch monitoring
- Jail policy J-G-05a, Suicide Prevention

Basis for Finding:

As noted in *Monitor's Report #1*, policies and procedures for male suicidal inmates are adequate. For suicidal females, the jail has enhanced its ability to observe them by stationing an additional officer in the female holding area, and it is in the process of moving suicidal females into the suicide-resistant cells in A-700. We discussed this plan during the site visit, and I supported it from a mental health standpoint, as I do not see a clinical reason why suicidal inmates should be separated by gender. There may be legal or security reasons not to mix male and female inmates, but I do think that moving females into suicide-resistant cells would be an improvement over the current practice of keeping them in the holding area (often times together with other inmates). When females are in individual, suicide-resistant cells, the jail staff will also be better able to implement policies regarding property restrictions, which are not really enforceable when suicidal prisoners are mixed together with "regular" prisoners.

III.A.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;
(8) mock demonstrations regarding the proper response to a suicide attempt; and
(9) the proper use of emergency equipment.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical staff education and in-service training records from 2014

- List of topics covered in pre-service and in-service training for health staff and deputies
- Slides and outlines from training sessions
- Quality Assurance quarterly meeting reports from April and July 2014
- Tour of jail, including suicide-resistant cells
- Interviews with jail leadership and medical staff

Basis for Finding:

The jail excels in the areas of training and education. All staff members receive training in mental health assessment, suicide prevention, and restraint use. The training program is multi-modal, including formal didactic presentations (both before and during jail service), case studies, emails from the Medical Director, policy reviews, discussions during staff meetings, and practical demonstrations where staff members are presented with mock scenarios. The training is different for health staff and deputies; it is tailored to their level of education and role within the jail.

As was the case in *Monitor's Report #1*, the jail medical director is the driving force behind many of the training and education efforts. However, the Medical Director and his staff have also assembled binders containing the outlines for training sessions and staff meetings, post-training exams, Powerpoint slide sets, and numerous other documents that would allow another individual to implement similar training in the Medical Director's absence.

b. All correctional, medical, and mental health staffs are trained on the suicide screening instrument and the medical intake tool.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical staff education and in-service training records from 2014
- List of topics covered in pre-service and in-service training for health staff and deputies
- Slides and outlines from training sessions

Basis for Finding:

Correctional officers are not routinely trained on the use of the intake screening instrument, as they do not administer it. They receive annual training on suicide prevention and how/when to refer prisoners to mental health staff for assessment, which is appropriate to their role in the jail. All medical staff are trained on intake screening, restraint chair use, suicide prevention, and Psychiatric Risk Index protocols. Records of the 2014 training sessions indicate that the all of the nurses completed the required trainings, except for those hired just before the September

site visit.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Records of medical and security staff training from 2014
- List of topics covered during pre-service and in-service trainings
- Examples of post-training exams given to medical staff
- Slides and outlines from training sessions
- Interviews with medical and security staff

Basis for Finding:

Before beginning their duties at the jail, all staff (security and medical) must complete suicide prevention training from the sheriff's office training division. Medical staff undergo additional training from the jail medical staff regarding depression, suicide prevention, suicide in jails, and mental health assessment. After beginning work at the jail, all staff participate in a year-round education program in addition to the sheriff's office annual in-service training. The jail's yearly training program consists of didactic lectures, case studies of attempted suicides, reviews of jail policies, and post-training examinations.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Sign-in sheets from annual correctional officer in-service training in 2014
- Records of medical staff education and training from 2014
- Records from jail staff meetings
- Interviews with medical and correctional staff

Basis for Finding:

Records indicate that correctional officers receive 6 hours of annual in-service training, which includes CPR and suicide assessment training. A mental health module was added to the required in-service training in October 2014 (its implementation will be assessed during the next site visit). Medical deputies and

medical staff complete many more hours of training on topics such as suicide prevention, identification of depression, substance intoxication and withdrawal, and infectious disease control. Records indicate that medical staff were offered approximately 16 hours of in-service education and training in 2014, and the majority had completed all of these trainings.

e. All correctional staff is trained in observing prisoners on suicide watch and step-down unit status.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Interviews with correctional officers
- Records from correctional officer training
- Tour of A-700 suicide watch unit and female holding area

Basis for Finding:

All of the correctional staff members received annual in-service training about suicide assessment and observation of prisoners on suicide watch. During officer interviews, all were familiar with the jail's policies and procedures about suicide watch and could show me computerized documentation of their prisoner observations.

f. All correctional staff is certified in cardiopulmonary resuscitation.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Records from CPR training for medical staff and correctional officers
- Interviews with medical staff and correctional officers

Basis for Finding:

Records indicate that the correctional and medical staffs are CPR certified before being assigned to work at the jail. Both also receive updated instruction every two years, most recently in June of 2013.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Interviews with medical staff
- Tour of medical unit

Basis for Finding:

The jail does have an emergency response bag, including a cut-down tool for suicide attempts by hanging. Officers reported that they are trained in its use. In addition, the jail's Medical Administrator indicated plans to assess and update the contents of the emergency response kit as necessary.

III.A.5. Use of Restraints

a. Policies for the use of restraints on prisoners with mental health needs are continued, further developed, and implemented.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Policy J-I-01: Restraint and Seclusion (Revised 6/12/14)
- 2 restraint reviews from 2014
- Medical records of 2 inmates (D.C. and T.P.) who were restrained in 2014
- Interviews with staff involved in placement and monitoring of restraints
- Quality assurance reviews from April and July 2014

Basis for Finding:

Use of restraints in the jail remains quite low, and restraints are being used appropriately as a last resort in cases where inmates are at risk of immediate bodily harm. The Restraint Reviews indicate that, in the two cases in 2014, the inmates were monitored every 15 minutes, as required by policy. In both cases, restraints were used for relatively short durations:

- Case 1: approximately 3.5 hours
- Case 2: approximately 6 hours

Since the last site visit, the jail's restraint policy has been updated to shorten the duration that an inmate can be placed in restraints without an additional physician's order. The duration is now 12 hours, as opposed to 18. As mentioned in *Monitor's Report #1*, the community standard for restraint placement is 4 hours. During the site visit, the parties and I discussed this issue at length so that I could understand the reasons why the jail thought it impractical to reorder restraints every 4 hours. In essence, the jail's argument is that, since there is no physician on site after hours, there would be no point in having a nurse call the physician every 4 hours to update

him about the inmate's condition, as no physician would ever discontinue restraints based solely on an LPN's verbal report. It seemed simpler to eliminate the additional phone calls and require restraint renewal every 12 hours, which is consistent with the NCCHC guidelines.

In reality, all of this is an academic point, as inmates are very infrequently restrained and already spend relatively short durations in restraints. After reviewing all of the available data, I can support the jail's current policy allowing for up to 12 hours of restraint use between physician orders. If the jail's data about restraint use changes substantially in the next reporting period, and inmates are restrained in larger numbers for longer times, we may revisit this issue.

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.*

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Two restraint reviews from 2014
- Charts of two inmates in restraints in 2014

Basis for Finding:

In both cases, a physician ordered the restraints. One restraint review (B.B.) identified a minor error in transcribing the physician's verbal order onto the order sheet, but this was not a substantial error, as the Restraint Use form had simultaneously been completed by the psychiatrist. In both cases, restraints were applied appropriately and for the shortest duration possible.

c. *Restrained prisoners with mental health needs are monitored at least every 15 minutes by correctional staff to assess their physical condition.*

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Chart of inmates in restraints (C.C and D.D.)
- Interviews with security officers
- Tour of holding area and A-700 suicide watch areas, including review of computerized logs
- Two restraint reviews from 2014

Basis for Finding:

During the site visit, all of the offers interviewed were familiar with the jail's protocol to monitor inmates in restraints with direct, continuous observation and document the inmate's condition every 15 minutes. As was noted in *Monitor's Report #1*, documentation of these checks is not kept in the medical charts. During the site visit, the security officers explained that there is no easy way to identify and print the logs for one inmate using the current computer software. The logs are kept as a chronological record, so documentation about an inmate in restraints is usually mixed in with others on suicide watch. While I do not think this is a problem warranting an immediate corrective action, it is something to keep in mind the next time the jail has an opportunity to update its computer software. Documentation of the inmate's checks while in restraints should ideally be kept in the medical file.

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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Two restraint reviews from 2014
- Charts of two inmates in restraints in 2014

Basis for Finding:

Both of the inmate charts contained complete documentation of the physician's order for restraint use, the physician's assessment and rationale for restraint use, and nurses' checks of inmates while in restraints.

III.A.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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Education and In-Service Training records for all medical staff in 2014
- List of Pre-Service and In-Service required training
- PowerPoint slides from mental health and suicide assessment training modules
- Minutes from jail medical staff meetings
- Interviews with medical and security staff

Basis for Finding:

Records indicate that all of the medical staff receive more than adequate training in the recognizing and treating mental illness, both from the jail medical staff and from the sheriff's office training division. In 2014, the jail offered approximately 16 hours of education and in-service training to the medical staff, which included at least 8 hours devoted to mental health topics (e.g., PRI classification, depression, suicide prevention, isolation, restraint use, and mental health screening). This is in addition to the six-hour training on suicide prevention and restraints required by the sheriff's office Training Division.

In *Monitor's Report #1*, I had commented that the security staff, in contrast to the medical staff, could not recall receiving basic mental health training. A mental health training module has now been developed, and the PowerPoint slides were provided to me for review. The training module is excellent, and it was implemented as a standard part of annual in-service training for security staff in October 2014. In addition, all officers underwent supplemental training in use of the restraint chair this summer. I reviewed documentation indicating that all officers were trained on 4/18, 5/8, 6/1, 6/3, 6/4, 6/8, and 6/18/14.

III.A.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:

a. 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;

b. 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

c. *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.*

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Mental Health Staffing Plan, provided during site visit
- Interviews with mental health and nursing staff
- Medical chart reviews
- Jail medical statistics for 2014

Basis for Finding:

Mental health staffing is adequate to meet the requirements of the MOA. The hiring of a full-time psychiatric RN has greatly increased the capacity of the staff to provide mental health assessments, and the full-time psychiatrist has also increased the number of patients he sees per month by approximately 50% in 2014. At the moment, these two practitioners are able to meet the demands for mental health care. They each see an average of 15-20 patients per day, which is a substantial volume for psychiatric providers and may put them at risk of burnout down the road. However, I did not detect this during the site visit; both individuals indicated that the workload was manageable.

Two LPN positions were unfilled at the time of the site visit. While the LPN staff does not exclusively perform psychiatric tasks, adequate staffing is essential to ensure that intake screenings and medication administration are carried out appropriately. The jail should make every effort to fill these positions.

In *Monitor's Report #1*, I had also commented on the issue of LPNs performing mental health assessments, which may be outside the their scope of practice. We discussed this issue during the site visit, and the parties were still unclear about whether regulations regarding LPN practice in Louisiana prohibit LPNs from performing mental health assessments. From my perspective, the LPNs did appear to be well trained in conducting intake medical/mental health assessments and suicide risk screenings. As was the case during the first site visit, I did not find any instances where inmates were harmed because of the care provided by the LPN staff. During my interviews with nursing staff, several indicated that they chose to work at the jail because of the increased opportunity for education and skill development around mental illness, substance abuse, and infectious diseases. While I remain uncertain about the legalities of LPNs functioning in their current capacity at the jail, I do not

think that they are providing sub-standard clinical care.

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

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Mental Health Staffing Plan and Chain of Command, provided during site visit
- Discussion of staffing plan with Medical Director

Basis for Finding:

The mental health staffing plan was provided by the Medical Director to me and the DOJ attorney on September 16, 2014. We reviewed and discussed it together at that time.

III.A.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 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.*

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Interviews with security and medical staff
- Interviews with inmates
- Staffing plan provided before issuing *Monitor's Report #1*

- Morbidity reviews from 2014
- Quality Assurance meeting

Basis for Finding:

Overall, security staffing appears to be adequate to conduct the jail's day-to-day mental health assessments and treatment. As noted above, the volume of mental health appointments has more than tripled in the past year (see graph in III.A.2.a above), and more medical deputies and/or security staff for inmate transport may be necessary in order to keep up with the mental health clinic's demands. However, I did not find any instances during this site visit where patient care was delayed because of inadequate security staffing.

I raise one other noteworthy area related to security staffing. In two of the critical incident reviews this year, E.E.. and F.F., significant security concerns were identified for corrective action. In one case, an inmate was able to carry a sharp implement from the jail into the courthouse, and in the other, an inmate attempted to self-injure in a suicide watch cell using a plastic bag that had mistakenly been left in there. It is not clear to me whether increased staffing would have prevented these incidents, so I did not rate this provision as "Partial Compliance." However, the incidents do raise concern about the vigilance of correctional officers when monitoring prisoners with mental illness. This will be an area of increased scrutiny during the next site visit.

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

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

Basis for Finding:

There is no new security staffing plan to review, as the plan is essentially unchanged since the first site visit, with the exception of an additional officer being assigned to the female holding area. When a female inmate is on suicide watch or in restraints, this officer's primary responsibility is to directly observe that inmate. During other times, the officer can assist with booking and other duties in the holding area. This additional staffing represents an important improvement, as the female holding area has been identified as a high-risk area for self-harm. My

understanding is that security staffing will improve even further after a new class of officers begins working in October, as additional officers will be permanently assigned to the male and female holding areas. I will follow up on the revised staffing plan before the next site visit.

III.A.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.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Quality Assurance Quarterly Meeting reports dated April 21 and July 17, 2014
- Yearly medical statistics for 2014

Basis for Finding:

As described below, the jail employs a good system for tracking statistics, reviewing medical and mental health care during quarterly meetings, and conducting peer review of medical charts. My one reservation has to do with peer review of the psychiatrist's work. The Quality Assurance memo dated 7/17/14 identifies me as the person responsible for peer review of the psychiatrist's work until after completion of the DOJ investigation. While I see how my oversight of mental health services at the jail does, in part, overlap with the function of psychiatric peer review, I do not view them as interchangeable. True peer review would involve clinical discussions about patient care in a much more detailed, informal, and private format than an official *Monitor's Report* allows. It would be unfair to the psychiatrist to receive critiques about patient care in a public, semi-annual report rather than the more private, collegial manner employed in reviewing the other physicians' work.

I do not believe that the lack of psychiatric peer review is itself a reason to find "partial" rather than "substantial" compliance. However, I would recommend that the jail implement its original plan to hire an outside psychiatrist to conduct peer review as soon as possible.

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;

(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;

(3) provide oversight of the implementation of mental health guidelines and support plans;

(4) review policies, training, and staffing levels;

(5) monitor implementation of recommendations and corrective actions; and

(6) refer appropriate incidents to the Morbidity/Mortality Committee for review, as necessary.

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Quality Assurance Quarterly Meeting reports dated April 21 and July 17, 2014
- Discussion with parties during site visit on September 15, 2014
- Yearly medical statistics from 2014
- Two morbidity reviews from 2014
- Two morbidity reports from 2014
- Two restraint reviews from 2014
- Records of corrective action implementation from 2014

Basis for Finding:

In *Monitor's Report #1*, I commented that the jail had not formed a Mental Health Review Committee that was distinct from the quarterly Quality Assurance meetings. During this site visit, the parties discussed the intent behind this provision of the MOA with me, and we jointly concluded that all of the required functions of the Mental Health Review Committee are satisfied by the Quality Assurance meetings. The meetings are attended by the Medical Director, Warden, chief of corrections, psychiatrist, an internist, and a security administrator. There is no formal risk manager present, but the Medical Director is able to function in this role (to advise the group re: compliance with NCCHC regulations, DOJ requirements, etc). The group meets quarterly and has, when appropriate, recommended corrective action after reviewing morbidity and restraint reports.

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.

(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:

- *(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.*
- *(ii) Ensure that the review shall include an inquiry of:*
  - *(a) circumstances surrounding the incident;*
  - *(b) facility procedures relevant to the incident;*
  - *(c) all relevant training received by involved staff;*
  - *(d) pertinent medical and mental health services/reports involving the victim;*
  - *(e) possible precipitating factors leading to the suicide; and*
  - *(f) recommendations, if any, for changes to policy, training, physical plant, medical or mental health services, and operational procedures.*
- *(iii) When appropriate, the Review team shall develop a written plan (and timetable) to address areas that require corrective action.*
- *(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.*
- *(v) Ensure a final mortality review report is completed within 30 days after the pathological examinations are complete.*

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Quality Assurance Quarterly Meeting reports dated April 21, 2014 and July 17, 2014
- 2014 Medical Department Statistics
- Two Morbidity Reviews from 2014
- Two Restraint Reviews from 2014

Basis for Finding:

There have been no deaths at the jail in 2014, so there are no mortality reports to review. The jail is conducting appropriate reviews after critical incidents such as serious suicide attempts and restraint use. The reviews are thorough and thoughtful, and they have identified areas for improvement in jail procedures. For example, in one instance, an inmate managed to lacerate his arms seriously at the courthouse, when he should not have had access to sharp implements. A security investigation was recommended during the morbidity review, and one was completed, identifying the source of the sharp object. In another case, a morbidity review revealed that an inmate had not had a Mental Health Evaluation within 14 days per protocol, and corrective action was taken. Overall, the jail has been

conducting thorough and appropriately self-critical reviews of security and medical procedures after critical incidents.

Recommendations

Thanks to the commitment and hard work of the jail staff, the majority of problems with mental health care at the jail have been resolved in a relatively short period of time. I am now in the fortunate position of making recommendations about issues that are either very minor or likely to be addressed by plans already in progress. At this time, I recommend the following:

1. Record the time of intake medical screening by hand, if it cannot be done in the computerized form.

2. Perform an analysis of whether documenting the five pre-screening questions asked by deputies at the door really is so burdensome that it justifies the potential for increased liability in the event of a prisoner lawsuit.

3. Proceed with plans to hire an outside psychiatrist to perform quarterly peer reviews of the jail psychiatrist's work prior to the next DOJ site visit.

4. Revise the policy about mental health screenings for inmates involved in "low court" disciplinary proceedings in accordance with the factors outlined above.

5. Continue with plans to revise current policies and procedures regarding female suicidal inmates to include the use of suicide-resistant cells and a designated treatment space.

6. Continue the jail's plans to expand its group psychotherapy program.

7. Fill the vacancies in the nursing staff.

All of the parties agree that the lack of access to inpatient psychiatric treatment is a serious problem; it harms patients and frustrates the medical staff. I have not made a specific recommendation about this simply because I cannot think of any strategy within the jail's control that would alleviate the problem. Improving access to inpatient psychiatric care will likely require a collaborative effort with Louisiana's Office of Behavioral Health and/or local private mental health providers, which may be beyond the scope of this MOA.