UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Graves v. Arpaio No CV 77-0479-PHX-NVW

REPORT OF KATHRYN A. BURNS, MD, MPH ON CORRECTIONAL HEALTH SERVICES COMPLIANCE WITH SECOND AMENDED JUDGMENT FEBRUARY 2010

This is the third report being filed with the Court reporting on Correctional Health Services (CHS) compliance with the terms of the Court's Second Amended Judgment as it pertains to the delivery of mental health care to pretrial detainees confined in the Maricopa County Jails. Dr. Lambert King, medical consultant, and I conducted two site visits since the last reports to the Court. One of the visits was conducted September 14-17, 2009. The mental health review focused primarily on:

- Processes and programming in Lower Buckeye Jail (LBJ) residential Mental Health Unit (MHU)
- Mental health rounds in segregation (4th Avenue and Estrella rounds observed)
- Medication issues including medication distribution (evening medication pass in MHU observed)
- Meetings with mental health clinical and administrative leadership
- Development of mental health services monthly report for external monitoring and internal management (Appendix A)
- Inmate patient file reviews

Informal feedback and recommendations were provided to CHS and shared with plaintiffs' counsel shortly after the visit. Findings and subsequent CHS actions in addressing the recommendations made during the September visit will be covered in this report.

A third, more recent site visit was conducted January 25-28, 2010. This visit focused primarily on mental health clinical file reviews to determine whether or not recommendations and improvements were reflected in the mental health care provided and documented in the clinical record. Eighty (80) records were reviewed. The findings will be discussed in the report areas that follow and summarized in narrative format near the end of the report. The details of the reviews have also been entered into a spreadsheet and appended to this report as Appendix B: Mental Health Clinical Record Review Summary.

The body of this report is organized around the items in the Second Amended Judgment specifically related to the delivery of mental health care: intake/receiving screening, access to appropriate level of care and psychotropic medications. The item from the order is followed by a summary of the findings from both site visits. These are followed by a quantitative description of the findings of the clinical record reviews and a conclusion section that contains overall recommendations for CHS as well as proposed timeframes for next site visits, court reports and areas of focus.

Intake/Receiving Screening

"Defendants shall provide a receiving screening of each pretrial detainee, prior to placement of any pretrial detainee in the general population. The screening will be sufficient to identify and begin necessary segregation, and treatment of those with mental or physical illness and injury; to provide necessary medication without interruption; to recognize, segregate and treat those with communicable diseases; to provide medically necessary special diets; and to recognize and provide necessary services to the physically handicapped."

September 2009 Findings re: Intake/Receiving Screening:

All inmates continued to be screened for mental health needs at the time of admission to the jail. The following actions were planned:

- The Brief Jail Mental Health Screening (BJMHS) instrument was being incorporated into the existing receiving screening process. This instrument has been published in the scientific literature and tested.
- Recommendation: I advised CHS to consider a review of the current screening process in order to assess the effectiveness of the existing tool in identifying mental health needs in addition to measuring the timeliness of mental health follow-up, psychotropic medication continuity, the prevalence of persons with serious mental illness (SMI) and when it is determined. This would be a quality improvement study of the existing process and would also serve as a baseline against which to compare the effectiveness of the screening process following the incorporation of the BJMHS to determine whether or not the additional instrument contributes additional accuracy to the screening process.

January 2010 Findings:

The audit of effectiveness recommended in September had not occurred at the time of the January site visit due to staffing shortages in the CHS Quality

Improvement Team. The clinical record review revealed that the screening process appropriately identifies persons with immediate mental health needs. However, significant problems persist in ensuring timely availability of psychotropic medications. CHS has attempted to address this issue by 1) initiating a process to track the timeframes involved in the non-formulary drug request process from the time of physician order through the medical director review and approval process and 2) piloting a process at Estrella and LBJ in which psychotropic medications are kept in stock for immediate access (rather than having to order them from the out-of-state pharmacy.) The standing quarterly CHS Quality Management audits continue to quantify the amount of time it takes for medications to be administered and include, but are not specific to, psychotropic medications. It is not clear that any of these monitoring steps or the stock medication pilot are being truly analyzed for effectiveness, the identification of problems and initiation of actions to correct any deficiencies. This is in part because of the newness of the procedures but is also related to the unavailability of mental health staff to participate in quality improvement activities secondary to their direct care clinical responsibilities.

Access to Appropriate Level of Care

"All pretrial detainees confined the jails shall have ready access to care to meet their serious medical and mental heath needs. When necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided or shall otherwise be provided with appropriate alternative on-site medical services."

Two measures of access to care in addition to receiving screening were reviewed in September: rounds in segregation and self-referrals (Health Care Requests – formerly known as "tank orders.")

<u>September 2009 Findings re: Rounds in Segregation:</u>

Mental health staff are conducting weekly rounds in each long-term segregation unit. Staff report they have had a positive effect in reducing the frequency of mental health crises, self-injurious behaviors, and the need for transfers to the residential Mental Health Unit (MHU.) There is no question that this activity is positive, however, due to the high security level of these inmates and a lack of confidential treatment space in many areas of the jail, the mental health staff are not rounding per se as much as they are attempting to conduct actual clinical treatment encounters at the cell front.

Rounds are designed to be brief, cell front assessments for purposes of identifying inmates in need of further, more in-depth assessment and/or treatment which is to be provided in confidential settings. Rounds cannot substitute for actual mental health treatment.

There remains a lack of confidential treatment space in many areas of the jail but most especially in higher security level areas. Mental health staff subsequently more or less "make do" with whatever is available and compromise confidentiality by attempting to conduct treatment at the cell front and/or in other common areas

(day rooms, hallways, etc.) A recommendation was made that mental health staff conduct an assessment of confidential treatment space need (including the need for additional security escorts) at all jails but particularly in the higher security areas such as segregation.

January 2010 Findings re: Rounds in Segregation:

Rounds continue to serve as the primary clinical intervention for inmates in high security settings. This is not treatment. It is not confidential from other inmates or correctional staff.

At Estrella, a separate room has been created for private interviewing and treatment near the close custody area but it is not clear how often this room is being used by mental health staff and if there are any barriers, such as the unavailability of sufficient numbers of security staff to provide inmate escort to the area.

At 4th Avenue, a team of CHS and correctional staff are meeting to examine existing space and discuss more efficient use of office/clinic space as well as Maricopa County Sheriff's Office (MCSO) staff resources. The due date for a recommendation from the staff committee and plan for implementation, including any additional physical plant or staff resources, has not been identified.

September 2009 Findings re: Self-referrals (Health Care Requests - HCR)

There was no systematic mechanism to determine the appropriateness or timeliness of responses to inmate health care requests, with the exception of the process for dental requests. The only process in place to monitor the effectiveness and efficiency of responses to inmate medical and mental health requests occurs as an incidental finding during a more comprehensive chart review if the inmate

actually made any requests during his/her incarceration. (The dental request process has been recently revised to include a more prospective and on-going monitoring of triage and timeliness of response.) A recommendation was made to create an HCR log process to identify date of request, type of request, date of response (similar to that which has already been developed for dental requests) to determine whether or not responses are timely and/or appropriate. This will permit the development of triage response expectations (such as routine, urgent, emergency response timeframes) and a process to monitor system needs by tabulating the dispositions of the requests.

January 2010 Findings re: Self-referrals (HCRs)

There is still no system to track Health Care Requests for medical or mental health. Furthermore, clinical record reviews continue to demonstrate significant problems with timely responses to inmate HCRs as evidenced by the presence of multiple requests in which an inmate is told he/she is scheduled to be seen shortly but weeks pass and they are not seen. Quality improvement in staff written response to some requests was also a finding. (See row 31 on Appendix B: Clinical Record Review Summary.)

Access to MHU and Outpatient Care

Additional analysis in September focused on the mental health care provided in the residential mental health unit (MHU) and outpatient mental health care provided in general population housing.

September 2009 Findings and Recommendations re: MHU and Outpatient:

MHU staff started to log and follow referrals for acute psychiatric inpatient care and court ordered involuntary medication. (Court ordered treatment is equivalent to inpatient psychiatric treatment as well as authorization for on-going involuntary medication). The number of petitions has increased and the percentage of approved requests has increased as well. Additional analysis is required to determine whether the increased use of acute psychiatric inpatient care persists and whether it is of sufficient magnitude to ensure inmate access to hospitalization when clinically appropriate.

Face-to-face interview rooms were identified and remodeled on some of the housing units in which the only previous options were for cell front or day room table mental health interactions. In addition, there are plans to use the visitation videoconferencing equipment for confidential individual mental health treatment interventions. Nevertheless, it appears that the bulk of interaction continues to occur either at the cell front or in the dayroom. The default mental health stance should be for confidential treatment space/location when providing care.

At the time of the September site visit, the MHU census was substantially lower than on previous visits. Clinical and administrative staff believed this to have been a consequence of additional psychiatrist time, a more unified treatment

philosophy among the psychiatrists working in the MHU and better, more cohesive treatment provision, although there was little in the way of objective data to substantiate the opinions expressed. Fewer admissions and shorter lengths of stay are among other mechanisms that can explain the lower census. Anecdotally, the Captain reported a significant reduction in calls from other jail security staff complaining about inmates returned to them prematurely and/or denied admission for problematic behaviors.

Mental health staff were advised to clearly articulate admission and discharge criteria for each housing unit within the LBJ MHU as well as patient "flow" from higher to lower levels of care prior to transition to general outpatient population care when possible. (Some inmates are so disabled by chronic and persistent mental illness that they are likely to require placement in MHU for the duration of their jail confinement.)

Each level of care (P3/P5; P2/P1A/P1B; P4; P6) should specify:

- Admission criteria
- Anticipated average length of stay
- Discharge criteria
- Security level served
- Type of watch/restraint that can be conducted at that particular level
- Frequency of intervention/documentation by discipline: psychiatry, nursing, mental health professional (MHP), etc.
- Out-of-cell time: structured as well as recreational/free time
- Group v individual interventions

- Property restriction
- Commissary access
- Any other variable deemed relevant

Outpatient MH staff were advised to conduct a similar exercise specifying admission criteria, frequency of contact by discipline, documentation requirements, duration of treatment, etc., for outpatient SMI, MH Chronic Care Clinic (CCC) and Jail Mental Health (JMH) cases. (JMH cases are those inmates with conditions that do not require treatment with psychotropic medication but do need mental health treatment.) This recommendation was intended to facilitate the development of a basis to articulate mental health staffing needs by caseload location within the entire jail.

<u>January 2010 Findings re: MHU and Outpatient:</u>

The recommendation regarding the levels of care within the MHU has been drafted and is attached to this report as Appendix C: MHU Grid.

There is a serious problem pertaining to Close Custody inmates inability to access any level of care within the MHU other than the admission level with limited out of cell time and extremely limited therapeutic activities. Both mental health and custody staff were advised that all SMI inmates need to be able to access all levels of care consistent with their level of clinical need: they cannot be denied mental health care on the basis of their security classification.

The clinical record reviews evidenced major problems with MHU level of care in terms of the adequacy and comprehensiveness of assessment; failure to use step-down levels of care within the MHU to ensure stability prior to a return to

outpatient general population or segregation care; infrequent or no changes in treatment planning or therapeutic interventions in spite of failure to improve (and subsequent exceptional lengths of stay in restrictive, admission housing) and poor coordination with outpatient mental health providers in the other jails for MHU discharge planning and aftercare. Although the proposed levels of care within the MHU have been drafted, documentation in the clinical records does not evidence that actual practice is consistent with the step-down levels of care for all inmates. A significant number of persons discharged from the MHU back into general population housing appear to fall through the cracks in terms of mental health follow-up: a delay of weeks rather than days for follow-up by a mental health practitioner and months of delay for a face-to-face follow-up appointment with a psychiatrist. These are serious deficiencies that compromise not only continuity of care but inmate safety.

Psychotropic Medications

"Defendants shall ensure that the pretrial detainees' prescription medications are provided without interruption where medically prescribed by correctional medical staff."

September 2009 Findings & Recommendations:

The chronic care policy draft regarding treatment/management of persons with mental illnesses was reviewed and discussed. Feedback regarding revision to better organize the procedure as well as including various prescribing guidelines was provided. (The draft had no reference to informed consent, administration of the abnormal involuntary movement scale, prescriptive guidelines, etc.)

I met with psychiatric staff (including those who are now sitting on the institutional Pharmacy and Therapeutics Committee) regarding the development of institutional prescriptive guidelines for continuation of outside medications, stance on polypharmacy, prescriptions for sleep, recommended frequency of follow-up contacts, prohibition of prescription renewals without examination, documentation guidelines, etc. They were receptive to the concept of developing these guidelines through consensus with the other psychiatrists to make practice more consistent across jail sites.

The following recommendations were offered:

- Charter the psychiatrists to develop and adopt institutional prescriptive guidelines as described above.
- As guidelines are developed, reports from the pharmacy that reflect the guidelines should be requested and used to monitor/supervise practice. (For example, if institutional policy prohibits the use of low dose chlorpromazine,

the pharmacy report should target that particular medication and cases of its use peer-reviewed.)

- In the interim, develop a mechanism to monitor the turnaround time for procurement of non-formulary medication requests from the date of request through the review process and actual medication availability for administration. (Of course, the monitoring mechanism would track non-formulary medication request denials as well.)

January 2010 Findings:

As noted previously, non-formulary drug requests are being tracked (date of submission, approval, reason for denial) but this process has just begun and the results have not yet been analyzed or used to correct any problems or improve efficiencies. Delays between medications ordered and actual availability and administration persisted in a significant number of cases reviewed.

A comprehensive psychotropic medication policy has not been adopted. Subsequently, idiosyncratic prescribing practices continue to exist. Such practices include prescribing medications for their sedating side effect rather than a primary indication such as psychosis or depression; and prescribing medications with a high potential for abuse in correctional settings without documenting the clinical rational for doing so. Psychotropic medications continue to be renewed, and in some cases dosages adjusted, without a face-to-face evaluation. Although occurring less often than on prior visits, it remains a significant occurrence. The intervals between psychiatric visits are too long, particularly when medications are initiated or doses adjusted. CHS explained that the process regarding adoption of a comprehensive

psychotropic medication policy as well as prolonged intervals between psychiatrist visits and resurgence of medication renewals absent a face-to-face examination were all impacted by the unexpected resignation of one full-time psychiatrist from 4th Avenue and an extensive family medical leave by another of the full-time psychiatrists. Two new full time psychiatrists had been hired and were scheduled to start working during the week of the January site visit.

Medication administration records (MARs) are more completely filled out but some of the coding remains unclear. For example, there is a code for occasions in which a medication is not given because an inmate is not in his cell. This could be due to a court appearance, recreation, visitation, programming, a family visit, release, etc. Some of these other reasons for a missed dose also have codes. The codes are not mutually exclusive and it is therefore difficult to ascertain why a medication was not administered in some instances. In addition, I saw no instances in which a notation within the progress notes of the inmate's medical record about whether or not subsequent attempts to deliver a missed dose of medication had been made, regardless of the reason for the missed dose.

Medical staff developed a process of notifying prescribers of inmate noncompliance with medication through posting an adhesive note into the inmate's medical record detailing the medication refusal/noncompliance and the number of missed doses. It wasn't clear that the psychiatrists prescribing the medications were aware of the new process or knew where to find the information in the medical records. (Sometimes the nursing notes were posted in the mental health section of the file and other times, in the medical progress note section.)

Subsequently, there was minimal evidence that medication noncompliance was subsequently addressed by the prescriber with the inmate in spite of the new process.

Quantitative Summary of Findings from January 2010 Clinical Record Reviews

A sample of eighty (80) records, some from each of the five jails housing pretrial detainees was reviewed. Twenty records were chosen for review based upon concerns raised by plaintiffs' counsel during their own site visit and record review. The remaining sixty records were chosen randomly from lists of caseload inmates provided by CHS although I did weight the sample towards SMI inmates and SMI inmates housed in segregation at 4th Avenue. Details of the reviews may be found in Appendix B but the table below summarizes the most salient findings:

Significance of Clinical Record Review Findings	Subtotal	**Total**
Care clinically appropriate, record complete		**2**
Coordination with medical deficient		**3**
Treatment alternatives to medication not provided		**4**
Quality Improvement Necessary		**24**
Medication prescribing practices	9	
Misc. (Details in Appendix B)	15	
Major issues		**47**
Continuity of care	22	
Insufficient treatment for SMI inmates in close custody	5	
Unacceptable delays in provision of treatment	14	
Quality of care in MHU	3	
Major medication issues	3	
		80

Each clinical file reviewed was classified according to the most serious problem identified although many charts contained multiple findings. Quality improvement findings (24/80 or 30%) should be interpreted as relatively "minor" and a part of routine medical analysis in which all processes are viewed with a critical eye to facilitate continuous improvement. Unfortunately, forty-seven (47) cases contained "major" issues: 58.75% of the cases reviewed. The label of "major" was applied to instances in which inmate health and safety were assessed as being potentially at risk. Major issues included serious problems with continuity of care; unacceptable delays in the provision of treatment; insufficient treatment for close custody SMI inmates; major psychotropic medication issues; and quality of care in the MHU.

Conclusions:

Persistent problems remain with respect to CHS' ability to provide appropriate mental health care within the Maricopa County Jails. Although persistently missing procedural elements such as a comprehensive psychotropic medication policy and health care request management system are impacting care, the two largest problems that cut across all levels of care at all jails and impact the ability to move forward are insufficient numbers of mental health staff to provide adequate care and inadequate availability and/or use of confidential treatment space, particularly for inmates in higher security classifications.

Mental health service provision documentation demonstrates that there are insufficient numbers of mental health staff to manage basic day-to-day functions which include comprehensive and multi-disciplinary evaluations, routine follow-up,

regular counseling, treatment planning, care coordination between levels of care and medication management. Screening and crisis intervention services are prioritized which is appropriate but done at the expense of follow-up, routine, maintenance and any preventive care. Mental health staff compromise basic tenets of treatment including the use of confidential space to provide treatment and are overly reliant on psychotropic medication as being essentially the only form of treatment provided. There is virtually no peer review and existing staff simply cannot sacrifice time away from providing direct service to participate in any form of auditing, chart review or quality improvement activities at the present time. The CHS Quality Management efforts that do exist are heavily weighted toward medical processes and outcomes rather than mental health.

I continue to believe that the provision of mental health care to detainees sent to jail only for restoration of their competency to stand trial further compromises already strained and under-staffed mental health resources. As a result of my first report, CHS and MCSO investigated the recommendation to consolidate competency restoration inmates to one or two housing units and found it unfeasible due to varying security classifications and an inability to mix them. It has also been reported to me that courts are pleased with the timeliness and relative inexpensiveness of restoration services in a jail as compared to the same services provided in a state-operated psychiatric hospital as had been done in the past. (Personal communication from Dr. Dawn Noggle.) However, there are 60-80 detainees in the jail solely for competency restoration at any given time. This "mission" continues to drain treatment resources from other inmates. I urge CHS to

seek relief from this mission through whatever means necessary to return it to the state hospital, or to seek appropriate levels of supplemental funding for the mental health staff positions necessary to provide care for this subset of detainees.

The lack of sufficient numbers of mental health staff is compounded by CHS's inability to quantify the actual numbers of staff required to manage a caseload of this size, complexity and turnover rate. Articulating service delivery interventions and frequency by mental health discipline for each level of care was the first step in being able to develop a comprehensive mental health staffing plan. This was the reason for my assisting in the development of a monthly monitoring report (Appendix A) which could be used as a management tool to identify trends and patterns and develop staffing ratios. Four monthly reports have been produced to date and the types of data and completeness of the reports are improving with each report but data collection itself has presented a number of challenges in a system in which much of the information is collected by hand rather than automated and from a variety of sources.

I am advising CHS to prepare a strategic plan to address outstanding recommendations for policies, procedures and processes which includes time frames for implementation and the processes to be utilized to determine whether the newly developed policies and procedures are being implemented appropriately, efficiently and have the intended result. Such a plan must also include a mental health staffing analysis and plan with detailed staffing ratios by discipline (psychiatry, psychology, mental health mid-level practitioner, etc.) for each mental health level of care (residential, outpatient) and caseload designation. The staffing

plan ought also to contain timeframes required to create and fund positions (or re-classify existing positions), as well as recruitment and hiring timeframes.

Certainly some gains have been made since Dr. King and I have started to assess CHS compliance with the terms of the Court's Second Amended Judgment but major systemic issues continue to exist. We are planning additional site visits this year in May and September and will update the Court of our findings accordingly in June and October. Assuming that CHS agrees to undertake a strategic planning process, I anticipate the May site visit will focus on that plan and CHS progress in meeting its goals during the interval between site visits. As noted elsewhere in the body of this report, I will also focus on access to psychiatric hospitalization; access to care for close custody inmates and begin looking at community release planning.

Respectfully submitted,

/s/

Kathryn A. Burns, MD, MPH
February 24, 2010

Appendix A: Mental Health Monthly Monitoring/Management Report Draft
Appendix B: Mental Health Clinical Record Review Summary
Appendix C: MHU grid

APPENDIX A:
MENTAL HEALTH MONTHLY MONITORING/MANAGEMENT REPORT DRAFT

Receiving Screening/Evaluation

Total # bookings/admissions during month =
Total # receiving screenings during month =
positive screenings = (this number will include those screens that are automatically printed off & the number that are positive as a consequence of the additional questions & nurse review/over-rides)
#SMI =
MH referrals =
watches initiated in booking =
immediate transfers to LBJ =
Total # receiving MH assessment =
referred to psychiatrist =

MH Care Requests during month

		4th Ave	Durango	LBJ	Towers	Estrella
# Referrals						
Triage type*	Routine					
	Urgent					
	Emergency					
Disposition**	MH assessment					
	Psychiatrist appointment					
	Watch initiated					
	Transfer LBJ					
	No MH required					
	# pending					

* These should be reported according to whatever triage classification system you develop.
** Categories should reflect your actual, most common dispositions.

MH Caseload Information (snap shot on the 15th day of month)

	4th Ave	Durango	LBJ (excl MHU)	Towers	Estrella
# SMI					
# MH CCC					
# JMH					

LBJ MHU
Admissions P3
Referral source: Intake, other jails (list)
readmitted within 30 days of discharge

Admissions P5
    Referral source: Intake, Estrella
    # readmitted within 30 days of discharge
& types of watches & restraints (list by inmate to permit calculation of shortest, longest, average LOS)
    S1
    S2
    S3
Emergency medications
Petitions for Court Ordered Treatment (inmate, date filed, approved/denied, date transfer)
    # Denied
    # Approved
    # returned from inpatient
Petitions for guardianship
Report on programming
Discharges
    Discharge disposition (by jail, releases, transfer to inpatient psychiatric care)

RULE INFRACTIONS – Consider development of policy that calls for MH input into process for disposition of SMI inmates who receive disciplinary write-ups

SEGREGATION (snap shot of 15th each month)

Location	4th Ave	Towers	Estrella
# inmates in segregation			
# SMI			
# MH CCC			
# JMH			

PSYCHOTROPIC MEDICATIONS – Will want to work with pharmacy to develop various reports relative to prescribing practices, polypharmacy, non-formulary requests, etc.

STAFFING by Location
4th AVE

Discipline	# FTE plan	# Filled	# Vacant	# Contract	Functional vacancies
Psychiatrist					
Psychologist					
Nurse					
MHP					

Repeat above for each location

MISC.
Include a cover letter with each monthly report that indicates updates, identification of trends/patterns, new QI teams, etc.
Include copies of any new relevant CHS policies drafted &/or adopted during the month.
Send information about any major incidents (injuries requiring outside treatment & deaths) as they occur rather than waiting until the monthly report.

	A	C	D	E	F	G	H	I	J	K	L	M
1	JAIL	#	DOA	RS	MHAssess	MD	Caseload	DX	Meds	Summary	Assessment	Significance
2	4A	P5	3/11/09	pos	3/11/09; 3/13/09; 4/3/09	f/u MHU 10/30/09, 11/10/09, 1/22/10	SMI	major depressive disorder, Tourettes	wellbutrin, ativan, remeron, seroquel	was sent to MHU 8/6/09-10/27/09; psych MD f/u okay; very poor med choices without justification including 2 antidepressants	polypharmacy without justification; substances of abuse without justification	QI - meds
3	4A	P5	NR		MHU 6/21/09-7/1/09; MHP f/u 1 wk	not seen after MHU d/c for 5 wks (7-14 d recommend)		r/o psychotic disorder	9/27/09 risperdal, depakote d/c'd pt refusing them	failure to adequately address med noncompliance; inadequate MHU discharge f/u	released 10/29/09	Major - continuity of care
4	4A	P5	10/13/09	neg			RTC 12/3/09			screen only pos was tx depression in 2006, nothing else; no indication psychosis, no psychosis on health appraisal; not asking for psych during rounds; 10/29/09 HCR wants Seroquel for voices; 12/22/09 HCR wants to speak to psych MD re sxs for meds-seen 12/31/09; 12/09 wants meds from Magellan; 1/4/10 wants only afternoon meds & to stop taking them by the of the month	no indication that this man is actually mentally ill; HCRs could have been better addressed & more timely (a thorough MHA & MD assess should have been done)	QI - HCR
5	4A	P6	11/5/09	pos		11/24/09	SMI, COT	bipolar	Haldol D, depakote	meds ordered 11/13/09 w/o being seen; no f/u as of 1/25/10 when MD ordered 3 wk; VPA level 39 but dose lowered per "pt request"	med orders w/o face:face; not taking advantage of DOT order; no MD f/u	Major - continuity of care
6	4A	P5	10/17/09	neg	10/26/09 HA notes Wellbutrin/Vistaril; refused MHA 10/26/09	1/6/10; 1/12/10 PA, 1/20/10 PA			Wellbutrin ordered 1/6/10	after MHA refusal, no MHP f/u or MD scheduled visit- fell through cracks; PA starts Trazodone for sedation, not antidepressant	unacceptable delay to MD appointment & medications	Major-med issue
7	4A	P5	3/26/09		5/14/09, 6/1/09	6/18/09	CCC	depression, polysubstance abuse	Celexa, Vistaril	MHP note 5/14/09 says MD referral but PN says no referral, 6/1/09 MHP says MD scheduled	MHP documentation inconsistent regarding when psych referral was made	QI necessary
8	4A	P6	11/3/09	pos	Y	11/17/09; 12/31/09	CCC	polysubstance, depression	Paxil, Vistaril	11/17/09 PA started Paxil for anxiety & vistaril for insomina, ordered labs & f/u 3 wks; labs checked by medical 11/22/09; next psych MD 12/31 - c/o not sleeping, meds not changed; ordered f/u prn if not released 2/10	missed 3 week interval for MD follow-up but, labs were drawn & checked; pt seen at 6 wks	QI necessary
9	4A	P5	NR		MHU adm 10/27/09-11/3/09; to see MHP 3-5 days, MD 10-14; MHP 11/10/09	11/17/09		aspd, polysubstance dep r/o substance-induced mood d/o		no labs to check levels, LFTs or CBC, no doc apps after 11/10 PASII; missed MHP & MD MHU follow-up time frames	released 1/17/10	Major - continuity of care
10	4A	P6	NR						Risperdal, Depakote ordered 1/13/10	after one MH assess refusal in December, not rescheduled; slef-inflicted cuts; not seen until mid-January (arrested mid-December)	unacceptable delay to MD appointment & medications	Major - delay in treatment

	A	C	D	E	F	G	H	I	J	K	L	M
11	4A	P5	7/21/09	pos	7/22/09	scheduled for 7/23/09 but not seen 'til 9/8/09, 11/3/09, 1/8/10			Wellbutrin	reports Wellbutrin at intake but doesn't get meds until 8/8/09 (got Wellbutrin in jail x2 in past); multiple HCRs 8/1/09, 8/15/09; 8/19/09; 8/26/09; 9/9/09 (seen 9/15/09); 10/11/09; 12/11/09 asking med increase	delay in receiving meds (even though tx'd with same x2 in past at jail); multiple HCRs - untimely scheduled responses	Major-med issue
12	4A	P6	11/25/09	pos	Y		SMI	schizoaffective	COT, no meds	returned DV 8/09; abilify has been d/c'd due to patient refusal; not seen by psychiatry since back in jail (Nov); 14 prior admits; multiple MHU; currently in seg	no records DV in file, no counseling re: meds; no psych visits; no indication of what COT meds are - no way to really implement COT except in MHU; inappropriately in seg; failure to utilize COT - inmate decompensated	Major - continuity of care;high security MHU necessary
13	4A	P5	NR							did refuse Trazodone 50 hs but took relevant meds (Seroquel, Depakote,Luvox, Ativan); arrested at ASH, had been there 3 yrs; discharged to DV	released 10/28/09 to DV (Desert Vista); identified @ intake & sent to MHU P5, stayed there for duration	QI - meds
14	4A	P6	11/5/09	pos	Y		CCC		Remeron, Depakote, Vistaril	labs drawn - all WNL; not seen by psych until 12/1/09 and not since; placed in safe cell at booking and seen by MHP	insufficient psychiatric follow-up	Major - continuity of care
15	4A	P2	3/25/07	pos	3/25/07	most recent 6/16/09; 11/10/09	SMI	bipolar, polysubstance dep	Prozac, Zyprexa	went to MHU immed from booking; outpt meds ordered 1/14/10 w/o being seen 2 mos - PASII did the Nov orders so not same provider; elevated lipids, TSH, Hep C w/o clear collaboration medical	appropriate ID at booking for MHU but poor outpatient f/u (intervals for MD, cell front MHP); lack coordination medical	Major - continuity of care
16	4A	P6	11/5/09	pos			CCC	Anxiety disorder, polysub	Klonopin	said he was bipolar at admission, PA did not f/u; history of heroin, beer, oxycontin - started klonopin	questionable use of Klonopin in polysubstance abuser when SSRI also effective	QI necessary

	A	C	D	E	F	G	H	I	J	K	L	M
17	4A	P5	3/27/09	pos	Y		SMI, RTC	cps	prolixin dec initially COT; seroquel	initially, had active COT which expired in Aug - not petitioned to renew; now lapsed & he refuses dec - gets seroquel per his request; spent 5 days MHU in July, not seen by psychiatrist until Sept & Nov; initially detainee, now RTC	failure to utilize COT; inadequate psych f/u in segregation; likely poor med choice given h/o COT; inadequate MHU f/u	Major - continuity of care;high security MHU necessary
18	4A	P5	9/11/09	neg		11/3/09	CCC	major depressive disorder	D/C'd	referred to psych as function of seg rounds; initially Zoloft started & increased; changed to Wellbutrin 1/15 but D/C'd it 1/20 for "noncompliance" (palming meds)	no med counseling; no face-face assessment of condition, continued need for med, reason for palming	Major-med issue
19	4A	P6	1/24/10	pos	Y		SMI		Prolixin 5 hs, Remeron 15 hs	meds verification in chart but meds not written at time of review; MHP didn't document referral for MD in spite of inmate refusal, prior caseload & prolixin verification	failure to document disposition re: referral to psych MD (pt is in JMS as SMI & theoretically, will be picked up for MD)	QI necessary
20	4A	P6	1/8/10	pos	adm P3		SMI		Risperdal, Vistaril	sent to MHU from booking 1/9/10-1/13/10; discharged to seg -not yet seen by psych; MHP 1/15 - cell & hygiene poor, taking to self, self-report med compliance (no check with nurse or MAR)	insufficient psychiatric follow-up; clinically unstable MHU discharge; inappropriate seg	Major - continuity of care;high security MHU necessary
21	4A	P4	10/5/08	pos	MHU 10/7/09-4/30/09	seen only 1x in 5 mos outpt after lengthy MHU			meds d/c'd w/o note, discussion	inadequate outpt f/u after relatively lengthy MHU admit; meds d/c'd w/o note	inadequate MD f/u; inappropriate med management	Major - continuity of care
22	Durango	P6	1/18/10	pos	MHP note 1/18/10	none as of 1/27/10	SMI, COT		benadryl, prozac, lithium, risperdal	med orders w/o face:face; no MD assess; no MHA but there is comprehensive psychologist note 1/20/10	COT in outpatient - may not be possible to utilize appropriately; no MHA or MD appointment for SMI according to timeframes	Major - continuity of care
23	Durango	P6	1/4/10	neg			NA				false positive Magellan	QI necessary
24	Durango	P6	12/8/09	pos	12/8/09 to MHU	12/17/09, 1/14/10	SMI		Magellan cocktail; different CHS cocktail	MHU 12/8/09-12/14/09, MHP & MD f/u okay in outpatient but appears to need more frequent contact - question release from MHU. Magellan meds were Risperdal, Cogentin, luvox, Buspar, tegretol, restoril. In jail - haldol, ativan, cogentin, depakote, prozac. In community, lives in group home; brought in gun & threatened to kill self.	no rationale not to use Magellan meds; concern premature MHU release; had been on Buspar in community - why use Ativan in jail? There should be staffing to discuss meds, closer F/U or MHU program for duration of jail stay	Major - continuity of care
25	Durango	P6	12/8/09	neg							false positive Magellan	QI necessary

	A	C	D	E	F	G	H	I	J	K	L	M
26	Durango	P5	9/24/09	pos	10/7/09	10/14/09 to MHU	SMI	schizophrenia (PA student dx psych NOS)	risperdal consta	missed at intake, no MHA for 2 wks & another to see MD, needed MHU 10/14/09-11/6/09; seen MHP 11/18/09, 12/18/09; MD 11/19/09 & 12/31/09	long h/o SCUT documented; PA Student changes dx to Psychosis NOS & CHS starts to use that dx (with no documentation of s/s indicating why the change); not clear why this man wouldn't be better managed in MHU for duration jail stay	Major - continuity of care
27	Durango	P6	1/17/10	pos	MH note 1/21/10	1/23/10		alcohol abuse, r/o anxiety disorder	remeron started to anxiety & sleep	at booking, indicates abusing girlfriend's meds; not clear why MHP would refer him to doc at all as the first step	medication appears to be only treatment	Treatment alternatives to meds
28	Durango	P6	12/16/09	pos	12/16/09 to MHU		SMI	mood d/o, borderline pd per Magellan	depakote, cpz	MHU 12/18/09-1/8/10; MHP 1/13/10 & MD 1/14/10; next f/u MHP 2 wks, MD 4 5 wks	follow-up intervals appropriate; rationale for low dose cpz not specified	QI - meds
29	Durango	P6	12/1/09	pos	MHP note 12/1/09; MHA 12/7/09		NA			prior remote tx depression, no current s/s	false positive Magellan	QI necessary
30	Durango	P6	1/11/10	pos	1/11/10 to MHU					discharged MHU less than 24 hours because he retracted SI statements - now no f/u 2 weeks	dangerous MHU discharge w/o adequate f/u	Major - continuity of care
31	EST	P6	12/20/09	pos	12/21/09	12/23/09 meds ordered but not yet seen	SMI		prozac, vistaril	hasn't yet been seen by psych MD, meds verified by pharmacy; MHP seg note 1/11 says inmate recently returned, expects to be sentenced DOC, requests being put back on meds she took prior at Est, "informed inmate that this may not occur since she will be leaving in less than a mo & could not be monitored - also might not be given those meds at DOC"	inappropriate medication information provided by MHP; SMI in jail > mo & still hasn't been seen by psychMD	Major - delay in treatment
32	EST	P6	1/16/10	pos	1/17/10	orders written 1/17/10 & 1/20/10	SMI, COT	schizoaffective	seroquel, effexor; Haldol D 100 q 4 wks starting 1/25	referred to psych via classification d/t pt saying she's schizophrenic, on Li & seroquel & in MH housing prior	good pick-up by classification as well as screening process & Magellan	Appropriate
33	EST	P6	1/3/10	pos	1/3/10	1/13/10	SMI	mood d/o nos r/o BAD nos	Seroquel 250; zoloft 100	meds not ordered until 1/8/10 but verification rec'd 1/5/10	delay in medication (not clear why because Estrella has stock meds)	Major - delay in treatment
34	EST	P6	12/3/09	pos	12/3/09 sent MHU; 12/10/09	12/22 - not seen, meds ordered; 1/20/10	SMI, RTC	MHU 12/3-12/9; meth, etoh & cannabis abuse	Magellan - Ritalin, Trazodone, Xanax, Zyprexa, Prozac; MCJ - lithium, trazodone	seen timely f/u MHP but not MD; meds ordered w/o face:face	Very poor medication rx choices in community based on substance abuse history; likely no reason for this woman to be in jail for RTC - no reason to believe she is incompetent; waste of tx resources	QI - meds

	A	C	D	E	F	G	H	I	J	K	L	M
35	EST	P5	8/31/09	neg	9/28/09; 10/30/09 seen at request DO for agitation, pacing; scheduled psych 11/4/09	11/6/09 doesn't want meds; 12/14/09 seen again, starts risperdal f/u 2 wks - not yet seen	SMI, RTC completed 12/31/09 now held to maitain			9/28 MHA plan was to see again to determine whether MD referral necessary but not seen again until referral from dorm officer 10/30; scheduled MD appt 11/4 but not seen 'til 11/6 and then refused meds although said to be psychotic - not seen again until 12/14	inadequate diagnostic assessment; failure to follow psychotic pt on no meds adequately; untimely f/u med initiation to determine efficacy	Major - delay in treatment
36	EST	P6	1/21/10	NR	1/21/10; scheduled MHA Est 1/26/10					previously in MHU 8/09; note from RN McBride in booking "very dramatic theatrics at pre-booking"	inapprorpriate nursing characterization	QI necessary
37	EST	P6	11/23/09	pos	11/23/09	12/14/09; 1/11/10; 1/13/10; 1/25/10	SMI		seroquel 50; klonopin 2 bid; Celexa, Lamictal	meds renewed 1/13/10 w/o face:face; had Walgreen report meds 11/25/09 - meds not ordered until 12/14/09	delay in medications; poor med regime from TX; meds renewed w/o face:face now being seen almost too often by different MH providers (at expense of others not being seen)	Major - delay in treatment
38	EST	P6	12/19/09	pos	no MHA	seen f/u MHU 1/13/10 (within week) but no chart	SMI	bipolar, polysubstance dep	eskalith, benadryl, prozac	meds verified 12/22 but no orders written until 12/29 & by then, she needs transfer to MHU 12/29-1/6/10; MAR indicates "med not available" several days	delay in receiving meds leading to hypomanic/manic episode requiring MHU admit; no MHA on chart; MD sees after MHU but no chart available	Major - delay in treatment
39	EST	P5	7/30/09	pos	7/30/09 to MHU 'til 9/2/09; f/u 9/18/09	adequate f/u	SMI	schizoaffective/ bipolar	seroquel 50; Depakote 500 HS (VPA level 57 on 1000, no re-checked)	transferred to P5 from booking; low dose, likely subtherapeutic mood stabilizer & antipsychotic; prolixin was d/c'd due to EPS (appropriately); use of Trazodone for sedation	questionable prescribing - subtherapeutic doses for degree of illness by history	QI - meds
40	EST	P6	12/16/09	neg			SMI per Magellan			not seen at all this tour; may be false pos Magellan match		QI necessary
41	EST	P5	10/23/09					pregnant	none d/t pregnancy	reported taking "street drugs" - Seroquel from boyfriend at intake; 11 wks preg but wants Doxepin for "stress"; seen by psych - no meds ordered; reports PTSD, flashbacks and history of depression to MHP who writes a SNTP 11/17/09 which says "MHP f/u, therapy tools" for the PTSD but there have been no further appointments	inadequate diagnostic assessment; no follow-up of SNTP; over-reliance on meds as sole treatment	Treatment alternatives to meds
42	EST	P6	12/4/09	neg	12/15/09 refused	12/11/09 meds verified	SMI, COT	schizophrenia	prolixin dec, prolixin 10 bid, cogentin	Magellan x-check picked up SMI even though screen neg; supposedly to be released early Feb	inadequate frequency f/u MHP and MD for COT patient; failure to capitalize on COT	Major - delay in treatment
43	EST		6/18/09	neg		8/31/09, 10/5, 11/2, 12/14; f/u 4 wks but not seen	CCC	reports prior dx bipolar - no sxs	vistaril ordered but d/c'd 10/29 secondary to "email from admin"	not clear that this person is a psych pt, only bipolar by self report - no sxs; no interventions beyond MD visits	inadequate diagnostic assessment; failure to close case	QI necessary

	A	C	D	E	F	G	H	I	J	K	L	M
44	EST	P6	1/8/10	pos	1/10/10		SMI			refused participation MHA but MHP notes that pt is Magellan; seen on seg rounds 1/24; tx'd with antipsychotic meds on prior tour MCJ		Major - delay in treatment
45	EST	P5	10/19/09	pos	sent to MHU 10/20/09-10/26/09; MHP 10/28/09; another MHU til 10/30/09	11/10/09; 11/24/09	SMI, COT 5/19/09-5/19/10		depakote, klonopin, vistaril, prolixin dec; VPA 51 on 12/28/09	seen on seg rounds but not otherwise; chart contains Magellan information	poor f/u MHU in segregation; needs to be in MHU instead of seg for duration	Major - continuity of care;high security MHU necessary
46	EST	P6	11/23/09	pos	12/2/09		CCC	pregnant	doxepin ordered but d/c'd secondary pregnancy	pos FH suicide & 2002 attempt by cutting; seen MHA 12/2/09 per pt's request, reports dx bipolar with anxiety tx'd with Trazodone 7 yers previously; f/u 5 weeks - not done; Doxepin ordered by MD (25-50 mg) but subsequently d/c'd by on-call after learing pt pregnant (d/c'd w/o face:face)	inadequate MD and MHP f/u; meds d/c'd appropriately but no other MH interventions provided	Treatment alternatives to meds
47	EST	P6	1/14/10	pos	1/15/10 sent to MHU	not seen yet following MHU discharge	SMI, COT	h/o bipolar	Haldol D	rec'd no medication at all while in P5 (rec'd dec shot when leaving 1/19)- reason for discharge MHU not clear particularly in light of COT	failure to follow through on COT; no rationale to release to Estrella; HA not yet completed; missed MHP f/u after MHU release time frame	Major - continuity of care
48	EST	P6	1/4/10	NR	1/5/10 sent MHU		MHU 1/5-1/13/10	adjustment disorder	none	not yet seen at Estrella; MHU rec f/u by MHP in 4-5 days	appropriate MHU transfer for non-responsiveness to screening; inadequate post-discharge f/u	Major - continuity of care
49	EST	P6	12/24/09	pos	12/24/09 sent to MHU	1/18/10	SMI	bipolar	tegretol, seroquel 800, remeron	MHU admits 12/25-12/30, 12/31-1/7, 1/7-1/11; can't handle being in dorm ref to MH by custody; placed in ad seg as PC - older, frightened inmate cannot handle dorm	not clear why this imate couldn't have simply stayed in MHU rather than being held in seg	Major - continuity of care;high security MHU necessary
50	EST	P5	NR	pos		12/3/09; order to be seen 1-2 wks dated 12/22 but not seen	SMI, RTC		cpz 400 bid; Klonopin 2 bid; started Li for mood stab but c/o tremor & it was d/c'd	HCR 1/10/10 hearing voices, need to see psych; 1/6/10; 12/28 - hearing voices, wants Trazodone - response that Trazodone is not for voices, you will be seen; 12/16 need to see psych before I leave - the last psych MD visit was 12/3/09	too infrequent psych MD assessment during active medication adjustment	Major - continuity of care
51	EST	P6	1/21/10	pos	1/21/10	not seen yet	SMI			no meds ordered, no med verification but listed as Magellan SMI	likely false positive partial Magellan match	QI necessary
52	LBJ	P5	3/2/09	pos	3/2/09 to MHU thru 1/20/10					released 1/20/10	inadequate frequency psych contact during seclusion; inadeqate intervention med refusal	Major - continuity of care
53	LBJ	P5	6/7/09	pos			SMI				inadequate MH f/u infirmary pt	Coordination of care with medical

	A	C	D	E	F	G	H	I	J	K	L	M
54	LBJ	P6	1/24/10	pos	1/24/10		SMI		Magellan meds celexa & risperdal ordered 1/27/09		not scheduled for MD visit/meds order at intake	Major - delay in treatment
55	LBJ	P6	12/16/09	neg	12/29/09	1/8/10 meds ordered	SMI per Magellan			Medical notes Wellbutrin & Abilify as meds during HA 1/4/10	negative RS but SMI per Magellan - not picked up until 12/29/09 & without meds 3 wks	Major - delay in treatment
56	LBJ	P6	12/18/09							MHU 12/21-12/30/09 & returned to MHU - not clear why discharged the first time	poor continuity of care MHU, opt; failed to start Clozaril in jail, inadequate diagnostic asessment in MHU	Major - continuity of care
57	LBJ	P5	1/27/09	pos	1/27/09				haldol, cogentin, cpz 50, risperdal, cogentin	1/31/09 - medical HA indicates cerebral shunt, "delusional & disoriented vs lying/manipulating"; 2/13 - seen in f/u from intake & medical referral - refer to psychiatry; 2/19 MD - no psych meds; 5/7/09 acute decomp SCUT, admit P3; MD 8/31, 10/23,11/5; MHU 5/7-5/8/09 neither MHP or MD met f/u time frames but there's another MHU 5/7/09-7/1/09 but another 6/15/09-7/1/09	inadequate coordination between MHU & opt; inadequate MHU assessment MHP & MD; inadequate freq opt contact; documentation does not tell the story of this man's condition or treatment well	Major - continuity of care
58	LBJ	P4	9/19/08				SMI, RTC found competent		haldol, benadryl, prozac	extremes of behavior - petitioned x2 (9/30 - dismissed; 10/29 - r/o delirium which was done & neg, adm still denied)	complicated case - there is INS hold on pt so there is motivation to stay, has been found competent to stand trial; fluent in English when chooses, otherwise, they have brought in an interpreter; no modification tx plan or interventions to address actual problems (head banging, feces smearing); haven't gotten tx records from federal prison	Major - MHU
59	LBJ	P6	12/10/09	pos	12/10/09	1/14/10	SMI			MHU 12/11/09-12/18/09 after having been "cleared" for GP by MHP; MHP 1/15/10	not clear why im sent to MHU as MHP "cleared" him for GP; inadeqate MHU f/u	Major - continuity of care
60	LBJ	P6	11/17/09	NR				MD (Carr) adds Histrionic to dx			added Axis II disorder in jail but community provider has not such dx; may be attributing manic sxs to wilfull misconduct, misbehavior	QI necessary
61	LBJ	P6	11/20/09							sent to Desert Vista (DV) 11/23/09-1/20/10	managed by PA who is not independent practitioner without psychiatric oversight	Major - MHU
62	LBJ	P6	11/29/09	pos	12/3/09 refer MD	12/29/09			med verification 12/31	released 1/12/10	unacceptable delay to meds	Major - delay in treatment

	A	C	D	E	F	G	H	I	J	K	L	M
63	LBJ	P4	9/3/08					mood d/o nos, ASPD	no meds	Magellan referral declined 12/08, 7/09. reason for extended stay P5 not clear since not treated; espisodes crying without reason, up all night yelling	inadequate psychiatric f/u in extended MHU stay; inadequate tx interventions; inadequate diagnostic assessment	Major - MHU
64	LBJ	P6	11/18/09	neg			SMI				false positive Magellan	QI necessary
65	LBJ	P5	7/3/09	pos	7/4/09 to MHU		SMI		risperdal, cogentin, depakote, trazodone, remeron later added	MHU 7/4/09-8/21/09, not seen timely by MHP or MD after MHU discharge; meds renewed 1/21/10 w/o accompanying note & after having started new med in December	polypharmacy; not seen for a month after MHU d/c; use of trazodone for sedation, not antidepressant; meds renewed without face:face	Major - continuity of care
66	LBJ	P6	12/24/09	pos	1/4/10	1/5/10	SMI			no MHA or MD in 4th Ave but Y for MH is marked on booking	failure to initiate meds at intake (approx 2 wk delay); SMI not appropriately assessed by MHP at intake or referred on to MD	Major - delay in treatment
67	LBJ	P6	11/17/09	pos			SMI				inadequate MH f/u infirmary pt	Coordination of care with medical
68	LBJ	P5	5/27/09	pos	5/27/09 to MHU		SMI, COT		Magellan - Depakote, Trazodone, Prolixin, Wellbutrin, Artain; CHS d/c'd Prolixin & started Seroquel	MHU 5/27/09-7/1/09; opt doc d/c's Prolixin based solely on pt report that Seroquel works better & just after MHU stay where he cannot be monitored appropriately	failure to coordinate care with Magellan; failure to document objective rationale for changing Prolixin to Seroquel in COT pt in jail where Seroquel is highly abused	Major - continuity of care
69	Towers	P5	8/20/09	pos	9/2/09	9/29/09, 10/6/09, 11/25/09, 1/13/10	SMI closed by Magellan 4/08		depakote, remeron, vistaril	seen within 2 wks of admission	case had been closed > yr in community, two wks for MHA okay	Appropriate
70	Towers	P5	4/22/09	pos	4/23/09	5/1/09	SMI		haldol, cogentin, abilify & trazodone ordered 5; trazodone d/c'd 6 & haldol increased, remeron added, seroquel 7/7	7/7 note in chart intercepted by custody: "I am getting 300 mg Seeroquels. 1 item per 100 mg. Did you want them? Will get them in a day or two." MD response was to crush Seroquel rather than assess whether actual need. Im refused crushed, continues to manipulated for wellbutrin & seroquel (uncrushed)	2 antipsychotics with no s/s psychosis; irrational med management	QI - meds
71	Towers	P6	12/31/09	pos	12/31/09	1/5/10	SMI		zoloft, klonopin, abilify	info from Magellan delayed 1/4, med orders not written 'til 1/5, Abilify not given 'til 1/6; MHP note 1/11 indicates pt seen b/c refused meds mult times but doesn't indicate referral to MD	delay in medications; MHP disposition to refer to MD re noncompliance not apparent in note	Major - delay in treatment
72	Towers	P5	10/14/09	pos	10/14/09	10/15/2009, 12/16/09; 1/7/10	SMI	bipolar	haldol, cogentin, trazodone added & increased	MHP notes 10/28, 12/14, 1/14/10 - reports med compliant; addition of trazodone for sedation; inmate reports not sleeping - no check with collateral; dose increased without face:face	no check with collateral (DO or MAR), use of trazodone for sedation not antidepressant; meds increased w/o face:face	QI - meds

	A	C	D	E	F	G	H	I	J	K	L	M
73	Towers	P6	11/21/09	pos	11/22/09 to MHU	MHU 11/22/09-1/4/10; MD 1/14/10	SMI	bipolar	VPA therapeutic	missed MHP f/u in 3-5 days after MHU d/c; there are missed dose med stickers in MHU chart with evidence f/u by MD in MHU notes, moved through P levels, attended groups, seen outside cell on occasion	missed MHP f/u after MHU d/c but saw MD & MHU care appropriate	QI necessary
74	Towers	P5	4/22/09	pos			JMH		remeron, paxil, klonopin, tegretol	10/9/09 - took 3 pills from another inmate - he thought was seroquel but it was cpz; taken to infirmary & called ambulance 10/10/09 0520, returned 10/11/09; MHU	no history of treatment in community, h/o polysubstance abuse; inadequate diagnostic assessment - not clear that he needs any psychotropic, much less several. MH needs to address pill trading esp in light of providing him benzos to barter.	QI - meds
75	Towers	P5	9/16/09	pos	9/17/09 to MHU	11/10/09, 12/29/09	SMI			3 MHU stamps all start with 9/17/09 but discharges reflected as 9/22/09, 10/28/09, 11/6/09. MHP 11/25/09, 1/4/10, 1/12/10. MD saw with 4 days of actual discharge MHU but MHP was late.	delay in MHP f/u MHU d/c for fragile inmate (2 failed releases MHU); poor f/u in opt - PN medical 12/25 than inmate seen upon referral from DO for crying; when psych MD sees 12/29 - no mention of this event or f/u. Frequency of contact insufficient for condition - may be able to use fewer meds. (Released to DOC 1/27/10)	Major - continuity of care
76	Towers	P6	12/23/09	pos	12/23/09 to MHU	1/12/10	SMI, COT	substance-induced mood d/o	prolixin, vistaril	MHU 12/24-12/29/09 with notes indicating uncoop with assess through 12/28 but d/c'd 12/29/09; COT not indicated on chart; MHP f/u 12/31 okay & MD 1/12 okay (within 2 wks)	inadequate diagnostic assessment; premature release MHU; failure to recognize COT	Major - continuity of care
77	Towers	P5	8/3/09	pos	8/5/09	8/5/09	SMI		meds ordered 8/3; clexa added 11/5	several missed doses Abilfy - im not present, 2 days med not available; celexa ordered for c/o feeling depressed, low energy, sleeping too much - no other intervention or alternatives considered	medication appears to be only treatment	Treatment alternatives to meds
78	Towers	P5	6/2/09	pos	6/6/09, 6/8/09	6/10/09	SMI		loxitane, depakote	although med orders written 6/2/09, HCR reports no meds given as of 6/6/09	delay in being seen by MHP for MHA, delay in medication receipt	Major - delay in treatment
79	Towers	P4	9/9/08	pos			SMI		lamictal, seroquel per Magellan; Wellbutrin, ativan, cpz, lithium, remeron	per Magellan - sells his meds in the community; 2 antidepressants, Klonopin, CPZ poor choices in jail	rx rationale not documented clearly - meds are prescribed based solely on self-reported sxs with no objective measures of sx or response	QI - meds

	A	C	D	E	F	G	H	I	J	K	L	M
80	Towers	P4	12/1/08	pos	12/2/08	12/16/08, 2/25/09, 5/7/09, 5/26/09, 6/2/09, 12/21/09, 12/30/09	SMI, RTC completed 11/9/09 now held to maintain		lithium, haldol, cogentin, elavil	admitted from LBJ infirmary (lipoma excised) to MHU 5/26/09-12/15/06; MHP 12/15/08, 3/3/09, 3/31/09, 4/29/09, 1/13/10	no MHP f/u MHU admission for a month, MD within 6 days of release; coordination with medical for hypothyroid, anemia not clear (lithium may be cause - other mood stabilizers not considered); has been on iron for months with no effect anemia (but it is not serious per Dr. King)	Coordination of care with medical
81	Towers	P5	10/8/09	pos	10/8/09 to MHU		SMI, RTC, ISTU	TBI, schizoaffective	seroquel, klonopin, navane, cogentin, tegretol	meds verified 10/8 from group home; remote head injury with sz d/o, medical vulnerability; went back & forth MHU then PC for medical vulnerability	no reason not to have this inmate maintained in MHU for duration; unrestorability likely known in advance so using jail for RTC at all just wrong on many fronts & whether he'll be able to go back to his special group home not clear; chart itself poorly organized & difficult to follow; not good communication betw MHU & opt	Major - continuity of care
82												
83	Note: Blank areas do not imply that the data was not present, only that it was not recorded (unless otherwise specified) because of its irrelevance to the analysis.											

MHU Grid - GvA Recommendation

MH Unit	Unit Description	Admission Criteria	ALOS	Out of Cell Time	Seclusion Restraint Levels	Classification	Duties/Responsibilities					Therapeutic Activities	Property Guidelines	Transfer/ Discharge Criteria
							MD	PhD	RN	LPN	MHP			
P3 (male) and P5 (female)	Admission and acute mental health units. Patient poses a significant danger to self or others, or displays severe psychosocial dysfunction. Units are equipped with 24 hour monitoring, safe cell placement, and all levels of seclusion and restraints. Goal is to keep patient safe while evaluating and achieving stabilization.	A. Individual has been evaluated by licensed clinician. B. Suicide attempt. C. Current DTO/DTS threats or behavior. D. Recent history immediately prior to arrest of self mutilation, significant risk-taking, loss of impulse control. E. Recent history immediately prior to arrest of violence resulting from an Axis I or Axis II disorder. F. Command hallucinations directing harm to self or others. G. Disordered/bizarre behavior/ psychomotor agitation or retardation that interferes with the ADLs. H. Disorientation/ memory impairment due to an Axis I disorder. I. Manifests major disability in social/interpersonal functioning, leading to dangerous or life-threatening functioning. J. Severe or life-threatening side effects from psychotropic drugs.	48 hours to 72 hours. Close Custody patients are housed on P-3 or P-5B the entire time they are on MHU.	Close Custody patients, post 72 hour evaluation, come out 2 hours per day if psychiatrically stable.	Level 1 Level 2 Level 3 Welfare Check	All	Psychiatric assessment, pharmachological treatment, patient movement and guide level of treatment decisions.	Assess for level of care within MHU when provider not on duty. Provides consultation in development of tx plans and group curriculum. Carries case load and provides specialized therapy to patients needing more intense treatment. Provides psychological testing when indicated.	(1) Initial Assessment. (2) Mimumum weekly charting, more frequent as directed by provider. (3) HourlyWalks; (4) Daily Breifing. (5) CIWA On all new pts. from intake.	(1) Medication Administration .	(1) Gather collatoral information/records. (2) Consent for treatment. (3) Begin development of Tx plan. (4) Begin discharge planning. (5) Mental Health assessment. (6) Educational & supportive counseling. (7) Assesses need for, writes and testifies for Court Ordered Evaluation for Treament.	(1) Pharmacological Tx; (2) Behavior Management;. (3) Crisis intervention	No personal property in cell except for Close Custody patients which can have one book, 5 pictures, personal & legal mail, paper & crayons per Tx Plan.	**Transfer to step-down unit on MHU:** Not danger to self or others, further assessment and stabalization needed, and likely not to function safely in GP, needs detailed D/C plan. **Transfer to GP criteria:** When psychiatrically stable and MHU is no longer least restrictive environment.
P2	Patients no longer present with acute suicidal behaviors, continuing with psychiatric stabilization. Services iinclude medication management, development of SNTP, 1:1 psychotherapeutic counseling and education. Patients who, because of their level of functioning, require more structure and staff support may remain on P-2 as the least restrictive environment.	No DTO/DTS statement or behavior. No longer at highest acuity level. Continue to require high level of structure, treament, and monitoring.	48 hours to 8 weeks	One hour out in day room plus one hour outdoor rec	Welfare Check	All except Close Custody	Same as above	Same as above	(1) Continous assessment for LRE. (2) Minimum Weekly Charting, more frequent as directed by provider. (3) Daily Briefing. (4) HCR.	(1) Medication Administration; (2) Review HCR and gether information for the RN.	(1) Provides ongoing supportive counseling as outlined in the patient's SNTP. (2) Assists in connecting patient with community resources to ensure continuity of care. (3) Assesses need for, writes and testifies for Court Ordered Evaluation for Treatment.	Same as above with addition of written materials. (Therapeutic education and worksheets, books, journal, etc).	Able to have personal property, commisary	**Transfer within MHU:** Patient is psychiatrically stable. Continued assessment needed and supportive treatment in the form of more time out in the dayroom and therapuetic groups and activities. **Transfer to GP criteria:** When psychiatrically stable and MHU is no longer least restrictive environment.

P1	Patients are stable on prescribed medications, have an SNTP in place and are functioning at baseline level. This unit allows patients to participate in therapeutic groups and activities.	Psychiatrically stable and able to participate in group activities.	2 – 8 weeks, however some will remain on MHU for the duration of their incarceration as the least restrictive environment.	Three hours out in day room plus one hour outdoor rec	Welfare Check	Minimum & Medium	Same as above.	Same as above.	Same as above.	Same as above.	Same as above with addition of providing groups and therapeutic activities.	Same as above with addition of groups and therapeutic activities.	Same as above.	Same as P-2.
P5A	Population is a combination of P-2 and P-1 except are females	Psychiatrically stable and able to participate in group activities.	2 – 8 weeks, however some will remain on MHU for the duration of their incarceration as the least restrictive environment.	Six hours in day room plus one hour of outdoor rec	Welfare Check	Maximum Medium Minimum	Same as above.	Same as above.	Same as above.	(1) Medication Admistration.	Same as P-2 with addition of providing groups and therapeutic activities.	Same as P-2 with addition of groups and therapeutic activities	Same as above.	Same as P-2.
P4	Patients are stable on prescribed medications and have an SNTP in place and are functioning at their baseline level which is higher than patients housed on P-1. This unit allows patients to participate in therapeutic groups and activities as well as more time to enteract	Psychiatrically stable and able to participate in group activities.	2 – 8 weeks, however some will remain on MHU for the duration of their incarceration as the least restrictive environment.	Six hours in day room plus one hour of outdoor rec.	No Levels	Maximum Medium Minimum	Psychiatric assessment, pharmachological treatment, patient movement and guide level of treatment decisions.	Assess for level of care within MHU when provider not on duty. Provides consultation in development of tx plans and group curriculum. Carries case load and provides specialized therapy to patients needing more intense	(1) Continous assessment for LRE. (2) Minimum Weekly Charting, more frequent as directed by provider. (3) Daily Briefing. (4) HCR	(1) Medication Administration. (2) Review HCR and gether information for the RN.	Same as P-2 with addition of providing groups and therapeutic activities.	Same as P-2 with addition of groups and therapeutic activities	Able to have personal property, commisary	Same as P-2.
P6	Patients are stable on prescribed medications and have an SNTP in place and are functioning at their baseline level. This unit allows patients to participate in therapeutic groups and	Psychiatrically stable and able to participate in group activities.	2 – 8 weeks, however some will remain on MHU for the duration of their incarceration as the least restrictive environment.	One hour out in day room plus one hour outdoor rec.	No Levels	Ad Seg/NOC	Same as above.	Sames as above.	Same as above.	Same as above.	Same as above.	Same as above.	Same as above.	Same as P-2.
P1B Close Custody	When census and/or acuity indicates need for additonal Close Custody housing space, P1B will be used as a Close Custody Unit	No DTO/DTS statement or behavior. No longer at highest acuity level.	2 to 8 weeks	Same as above.	No Levels	Close Custody and Maximum	Same as above.	Same as above.	Same as above.	(1) Medication Administration	(1) Provides ongoing supportive counseling as outlined in the patient's SNTP. (2) Assists in connecting patient with community resources to ensure continuity of care. (3) Assesses need for, writes and testifies for Court Ordered Evaluation for Treatment.	(1) Pharmacological Tx. (2) Behavior Management. (3) Crisis intervention	No personal property in cell except for Close Custody patients which can have one book, 5 pictures, personal & legal mail, paper & crayons per Tx Plan.	Transfer to GP criteria: When psychiatrically stable and MHU is no longer least restrictive environment.