

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 #3

**Final - July 5, 2015**

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## 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 have now conducted three on-site evaluations of the jail: from February 4 to 6, 2014; September 15 to 17, 2014; and March 30 to April 1, 2015. In *Monitor's Report #2*, dated December 7, 2014, I concluded that the jail was in substantial compliance with over 90% of the agreement provisions and had made significant improvements in its ability to provide mental health care. This report, *Monitor's Report #3*, now adds information about the jail's functioning during the approximately six-month period between September 2014 and March 2015. During all stages of my involvement in this case, I have been given full access to all information requested. The parties 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
  - Three inmates chosen because they had recently been treated for mental illness, placed in isolation, or undergone routine mental health screening upon admission to the facility
  - Nursing, social work, medical, psychiatry, and security staff members
  - Facility leadership, including the Warden and Medical Director
  - Disciplinary hearing officer and inmate counsel
- 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
  - Disciplinary hearings and informal resolution of infractions
  - Group psychotherapy in the CRASH program
  - Facility tour, including the holding area, medical unit, intake medical screening area, and suicide-resistant cells
- Document review
  - Revised jail policies and procedures related to mental health care
  - Jail forms related to medical and mental health care
  - Approximately 30 medical charts of inmates housed in isolation units, receiving mental health treatment, placed on suicide watch, or placed in restraints

- Outlines and slides from medical and security staff training re: depression, suicide prevention, use of restraint chairs, and identification of mental illness
- Educational materials for jail medical staff re: mental health (parts I and II), Hepatitis C, Tuberculosis (parts I and II), opiates
- Orientation training log for new nursing personnel
- Medical staff training logs documenting participation in continuing education sessions
- Pharmacy reports from February 2015
- Suicide watch database from 2014-2015
- Restraint database from 2013-2015
- Mortality database from 2011-2015
- Inmate grievances related to mental health care in 2014 and 2015
- Log of informal complaints related to medical and mental health care in 2015
- Quality assurance reports from October 2014 and January 2015
- Statistics related to medical care in 2014 and 2015
- Minutes from medical staff meetings and emails from Medical Director to staff in 2015
- DOJ Site Visit outline prepared by Medical Director and distributed on March 30, 2015
- DOJ Site Visit Exit Interview document prepared by Medical Director and distributed on April 1, 2015
- Report of Intake Medical Screening and Mental Health Screening Compliance Audit, dated March 18, 2015

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.

### **Defendants’ Actions To Date**

The jail staff, led by the Warden and Medical Director, has continued its efforts to comply with the provisions of the MOA. Since the September 2014 site visit, the following additional steps to improve mental health care have been taken:

- The psychiatrist’s hours have been increased to six days per week;
- The psychiatric RN’s hours have been shifted so that a qualified mental health professional (psychiatrist or psychiatric RN) is at the jail seven days a week;

- Two additional evening nurses and two additional medical deputies have been added to the medical staff;
- Several jail policies related to mental health care were reviewed and revised;
- Intake medical screenings now include the hand-written time of completion;
- Deputies' completion of pre-intake screening is now being audited;
- An educational module about mental health was added to the sheriff's office annual in-service training in December of 2014; and
- A standardized calendar for sending out educational emails to the medical staff has been created

These recent changes are in addition to the improvements implemented before the September 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;
- Implementing the 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 evaluation form in order to reflect more detailed treatment goals and plan;
- Adding security staffing in the female holding area;

- Developing and implementing an annual mental health training module for all staff, including security officers; and
- Creating long-term plans to move and expand the medical department in order to have more space for patient care

At the time of the site visit, the Parish reported that it was in substantial compliance with all provisions of the MOA, with the exception of providing access to outside psychiatric hospitals. As noted during the last two site visits, no area psychiatric facilities will admit jail patients for treatment, and the Parish did not believe this was likely to change in the foreseeable future.

### 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 (%)
<i>Screening and Assessment</i>	12	0 (0)	1 (8)	11 (92)
<i>Treatment</i>	10	0 (0)	1 (10)	9 (90)
<i>Suicide Precautions</i>	7	0 (0)	0 (0)	7 (100)
<i>Suicide Prevention</i>	7	0 (0)	0 (0)	7 (100)
<i>Training Program</i>				
<i>Use of Restraints</i>	4	0 (0)	0 (0)	4 (100)
<i>Basic Mental Health Training</i>	1	0 (0)	0 (0)	1 (100)
<i>Mental Health Staffing</i>	2	0 (0)	0 (0)	2 (100)
<i>Security Staffing</i>	2	0 (0)	0 (0)	2 (100)
<i>Risk Management</i>	3	0 (0)	0 (0)	3 (100)
<b>TOTAL (#)</b>	<b>48</b>	<b>0</b>	<b>2</b>	<b>46</b>
<b>TOTAL (%)</b>	<b>100</b>	<b>0</b>	<b>4.2%</b>	<b>95.8%</b>

### 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 continues to use a three-part screening process to assess prisoners' mental health needs: (1) the pre-intake screening ("five questions") completed by deputies prior to accepting an individual into the facility, (2) the intake medical screening completed by LPNs during booking, and (3) the mental health assessment completed by the psychiatrist or psychiatric RN within 14 days of arrival at the jail. As noted in *Monitor's Report #2*, this policy is appropriate and within generally accepted standards of care for jail mental health practice. During this site visit, all of the charts I reviewed contained intake medical screening and mental health assessments that were completed within the time frame outlined by policy.

- 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
- Direct 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 continued to use the Psychiatric Risk Index (PRI) system during intake medical screening, which assigns a score of 1-5 to each inmate based on acuity of mental health risk. Since the last site visit, the jail Medical Director has trained all

of the medical staff both to assign a PRI score at intake and to document it in a consistent part of the medical chart. During the site visit, I observed LPNs performing intake screenings using the PRI system. As was the case during the last site visit, 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 18 medical charts revealed that the PRI score was completed appropriately and documented consistently in the chart. Furthermore, in the vast majority of cases, follow-up appointments with either the psychiatric RN or the psychiatrist were completed within the time frame indicated by the PRI score (see details in section III.A.1.h. below).

- 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: Substantial Compliance**

**Relevant Areas Reviewed:**

- Jail policy J-E-02a (Pre-Intake Screening), Reviewed 12/12/14
- Jail policy J-E-02b (Intake Medical Screening), Reviewed 1/6/15
- Direct observation of intake screening
- Inmate interviews
- 18 medical charts
- Discussion with jail and parish leadership during introductory meeting of site visit
- Report of Intake Medical Screening and Mental Health Screening Compliance Audit dated March 18, 2015

**Basis for Finding:**

*Monitor's Report #2* indicated that the jail was in partial compliance with this provision and made two recommendations that would help bring it into substantial compliance:

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

Both of these issues have now been rectified. Policy J-E-02 was revised in January of 2015 as recommended. In addition, as a result of a huge effort on the part of the Medical Director (going so far as to tie nurse compensation to the completion of this task), all nurses now manually document the time that the intake medical assessment was completed. Of the 18 charts reviewed, the time was documented in 15 charts (83.3%). The jail completed its own audit of 179 charts in March of 2015 and found that 99.4% of the charts contained proper documentation. Although the

percentage of properly documented charts in my review was lower than in the jail's study, it is still quite good. The average time between booking and completion of intake medical assessment in my review of the 15 completed charts was 4.34 hours (4 hours 20 minutes), which is almost exactly what the jail found in its internal audit (4 hours 15 minutes). In one case, screening was completed outside of the 8-hour time frame mandated by the MOA (11 hours 40 minutes after booking); I did not find any evidence that the inmate in question was harmed by this lapse.

In the previous two *Monitor's Reports*, I had questioned the jail's practice of not documenting the answers to the "five questions" asked by deputies prior to booking an inmate into the facility. After reviewing the matter, the jail elected to continue its practice, as the time and effort spent documenting this information was felt to be unnecessary. Instead, the Medical Director updated the jail's policies to clarify the pre-intake screening procedure (J-E-02a), and a supervisor now observes the deputies periodically to ensure that the policies are being followed. The jail also consulted with its legal counsel, who felt that any "protection" from liability that documenting the pre-intake screening results would offer is minimal. On the whole, I am satisfied with this effort as long as the jail continues to audit the deputies' pre-intake screening procedures as part of its Quality Assurance program.

- 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:**

- Minutes of medical staff meetings
- Documents related to Psychiatric Risk Index development, implementation, and revision
- Interviews with nursing staff
- Training records for medical staff, 2011-2015
- Emails from medical director to staff re: intake medical screening, PRI, restraints, etc.

**Basis for Finding:**

Training and education of the medical staff remains a jail strength. In the past six months, two new nurses have been hired, and records indicate that they have completed extensive orientation training about mental health and intake medical screening. During my interviews with the nursing staff, all were able to identify important risk factors for suicide, alcohol and drug withdrawal, and use of restraints. The Medical Director's report indicates that nurses completed an average of 23.17 hours of education and training in 2014, over half of which was devoted to mental health topics (12.46 hours). Training records support this assertion.



- 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.*

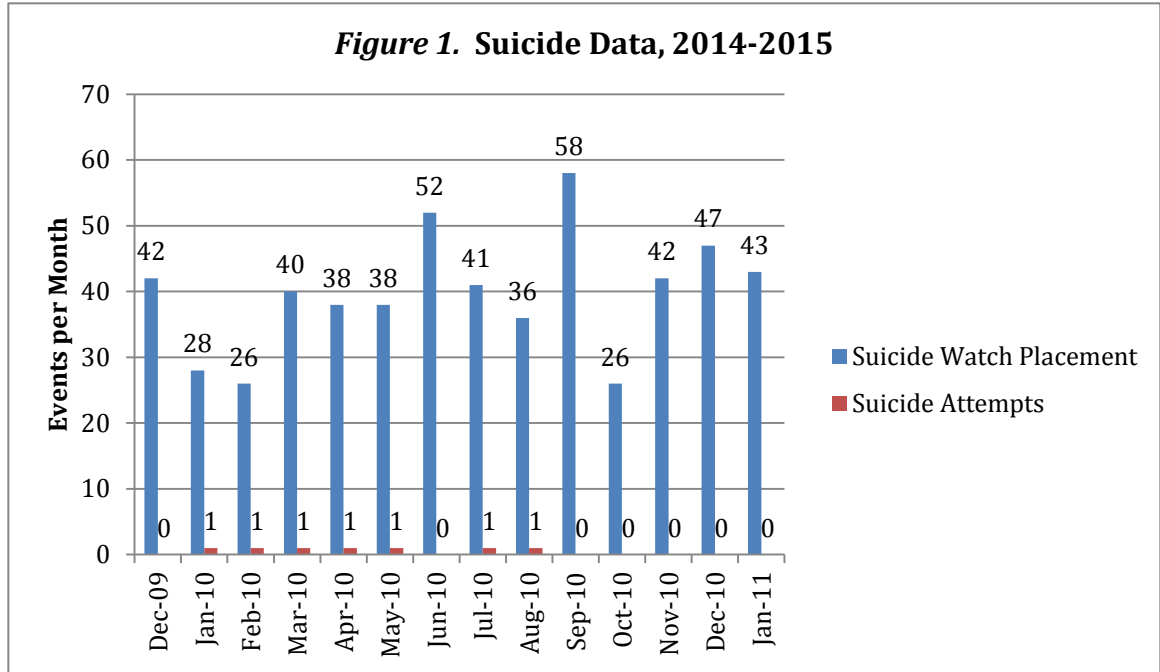
Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Direct observation of PRI assessment during intake medical screening
- Documents related to PRI development and implementation
- Interviews with nursing staff and psychiatrist
- Medical charts

Basis for Finding:

As described in previous reports, the jail has implemented a Psychiatric Risk Index (PRI) system to identify the highest-risk inmates and treat them appropriately. This system continues to work well. The number of inmates placed on suicide watch at the jail has remained fairly constant (see *Figure 1*), but there were no serious suicide attempts during the last six months, perhaps indicating that the PRI system is achieving its intended goal of identifying suicidal inmates before they act. Of course, base rates of suicide attempts are low, so this data will need to be analyzed over a longer time period before drawing any conclusions about the efficacy of the PRI system. At this time, it does appear to be accomplishing the goal of indentifying high-risk inmates and referring them to mental health treatment. The Medical Director has also indicated that he intends to refine the system over time, as it may be overly conservative, and nurses have stated that they are completing redundant assessments in some cases.



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
- Medical charts
- Jail policy J-E-09 (Segregated Inmates), created on 10/23/14

**Basis for Finding:**

The jail continues its efforts to identify suicidal inmates during the known high-risk periods: (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). The PRI system, used to identify high-risk inmates upon arrival at the jail, and its results are outlined in Provision III.A.1.f above. The psychiatric nurse continues to assess and provide counseling to any inmates who have received long sentences (>10 years) or have had a death in the family. The psychiatric nurse also monitors 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.

During this site visit, I reviewed six charts of inmates housed in isolation on March 31, 2015. Two of these inmates had no psychiatric diagnosis prior to placement in isolation, one had a diagnosis of Anxiety Disorder NOS, and three had diagnoses of serious mental illness (Bipolar Disorder, Schizophrenia, and Major Neurocognitive Disorder). In all six cases, inmates were evaluated by qualified medical and mental health professionals according to policy. However, I do remain concerned about the high percentage of inmates in isolation who have been diagnosed with a serious mental illness (50% of this sample). Although the sample size is too small to draw broad conclusions, I interpreted this finding to mean that the jail struggles to find suitable housing for inmates who are chronically mentally ill and/or at risk of victimization. The jail leadership agreed, saying that there is simply no better solution for some pre-trial and federal inmates who are unsafe to live in general population (and who cannot be transferred to a DOC facility).

- 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 in booking area and unit A-700
- Review of computerized records of monitoring
- Inmate interviews
- Jail policies related to suicide prevention

**Basis for Finding:**

Little has changed in this area since *Monitor's Report #2*. The jail continues its practice of continuously monitoring high-risk inmates in A-700 (for males) or a holding cell (for females) until evaluated by a mental health professional. Monitoring of inmates has been adequate, as there have been no recent episodes in which an inmate was found in possession of contraband (i.e., a razor or prohibited clothing items) and used it to harm him- or herself.

- 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:**

- Jail policy J-E-02 (Intake Screening) and PRI protocols
- Interviews with psychiatrist and psychiatric RN
- 18 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 (those at low risk), a mental health assessment is scheduled with the psychiatric nurse within 10 days. PRI 3 and 4 inmates (those at moderate risk) are seen by the psychiatrist at the next available appointment, usually the next business day. PRI 5 inmates are placed on suicide watch (direct continuous observation) until they can be evaluated by the psychiatrist, usually within a few hours. My review of 18 charts yielded the following results:

<b>PRI score</b>	<b>Number of charts</b>	<b>Time between intake screening and mental health assessment</b>	<b>Notes</b>
1	8	11.3 days	Data skewed by one individual who was evaluated after 30 days, all others were within 10 days
2	3	8.5 days	
3	3	4.8 days	
4	1	6.3 hours	Seen by psychiatrist the following morning
5	3	13.3 hours	All 3 inmates were placed on suicide watch at night, evaluated by psychiatrist the next morning

As I noted in *Monitor's Report #2*, the jail is technically not in compliance with the MOA on this provision, as inmates at moderate (PRI 3 and 4) and high risk (PRI 5) are typically seen by the psychiatrist the next business day and not within the stipulated time frames. However, after reviewing the medical charts, I did not find any instances where a faster evaluation by a mental health professional would have

made a significant difference in the treatment plan or outcome of the case. Furthermore, I do not see a way to provide access to mental health evaluations within the MOA-stipulated time frames unless the jail hires a psychiatric social worker 24/7. In my opinion, this step is not necessary at this time.

- 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 visits

Basis for Finding:

The jail continues to assert that no hospital in St. Tammany Parish will accept an inmate for psychiatric treatment, so there are no outside hospital facilities available. The only hope for change is that the Parish recently bought a closed state hospital in Mandeville, and it is working with Northlake Behavioral Health to provide mental health services on that site. While this is promising as a long-term solution, it is not likely to occur in the near future. In the mean time, the jail medical staff has worked to increase mental health coverage of the facility. The psychiatric RN now works on Saturdays, and the psychiatrist works on Sundays, so a qualified mental health professional is on site seven days per week. In addition, the psychiatrist has come into the jail on other days when necessary, as was the case in March of 2015, when the jail had to manage nine acutely psychotic individuals at once. Although this care does not exactly replicate the care available in an inpatient psychiatric unit, I do think that the jail staff has made significant efforts to manage crisis situations to the best of their abilities.

- 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

Basis for Finding:

All of the mental health assessments I reviewed (either through direct observation or in the medical charts) included 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:

- Quality Assurance reports from October 2014 and January 2015
- Restraint log 2014-2015
- Suicide attempt log 2014-2015
- Medical chart of one inmate who ingested an overdose of medication

Basis for Finding:

During this six-month reporting period, the jail did not complete any formal morbidity or mortality reviews related to mental health care. In one case (discussed with DOJ and the Medical Director during the site visit and reviewed in more detail in III.A.9.c below), I identified an inmate who took an overdose of medication with the intent of harming himself, though this event was not counted in the jail's statistics as a suicide attempt. The inmate did receive appropriate follow-up care after the incident, including observation on suicide watch and daily psychiatric assessments until he was stabilized. Similarly, my review of medical charts indicated that inmates on suicide watch are seen daily by both the psychiatrist (for safety assessments and medication evaluations) and the psychiatric RN (for individual counseling).

- 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, psychiatrist, and deputies in A-700 and female

- booking
- Policies related to management of suicidal inmates

Basis for Finding:

The jail's policies and practice in this area have not changed since the last site visit. All inmates are evaluated prior to placement on suicide watch by an LPN who has been trained in suicide assessment. The LPN reviews his/her findings with the on-call physician, who orders the suicide watch and makes decisions about what property the individual can have in his/her cell. 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. All of the charts I reviewed contained documentation that these policies are being followed appropriately.

### III.A.2. Treatment

- 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.*

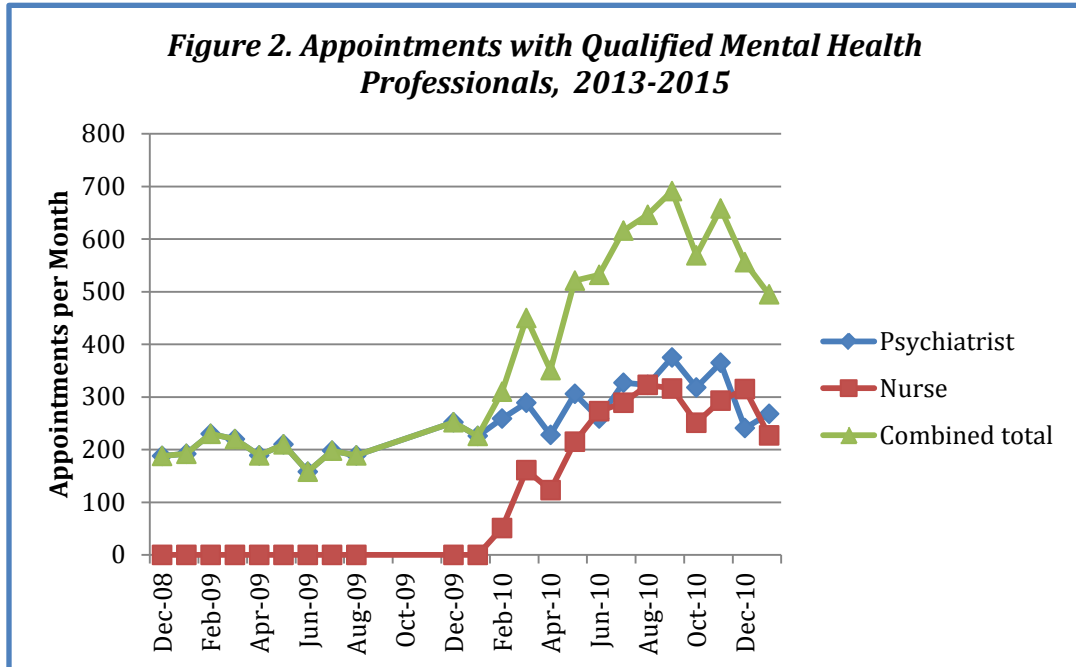
Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Jail medical statistics, 2014-2015
- Psychiatric Risk Index (PRI) protocols
- 18 medical charts
- Interviews with inmates
- Interviews with mental health and medical staff
- Direct observation of routine psychiatric appointments

Basis for Finding:

After a period of rapid expansion in early 2014, the number of mental health appointments at the jail has leveled off in the past six months. The average wait time for a sick-call appointment with a psychiatrist is still approximately one day (including weekends), which indicates that inmates have excellent access to care. The quality of care provided continues to be good, with the psychiatrist and psychiatric RN practicing in accordance with generally accepted standards.



As demonstrated in *Figure 2*, there was a slight decline in the total number of mental health appointments in January-March of 2015. This does not represent a significant change in the jail’s ability to respond to inmates concerns; it is an expected drop-off after the busy holiday period. The jail mental health staff made a concerted effort to increase services during the holidays, when suicide risk is elevated, and they are now returning to normal practice.

- 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:

- Initial Psychiatric Assessment form and follow-up progress notes
- Interviews with psychiatrist, psychiatric RN, Medical Director, and licensed drug/alcohol counselor
- Medical charts
- Direct observation of group therapy in CRASH program

Basis for Finding:

The jail continues to use the Initial Psychiatric Assessment to document both the psychiatric assessment and the treatment plan. As discussed in *Monitor’s Report #2*, this is an acceptable solution for the jail environment, where most inmates stay for a short time and do not require detailed treatment planning.



The jail has continued the same psychotherapy services that were available during the last site visit. The psychiatric RN provides individual therapy services to inmates on suicide watch, those requesting individual counseling, and those who have recently suffered a loss. DOC inmates (approximately 500 of the 1100 jail inmates) are eligible to participate in the CRASH program (a drug and alcohol psychotherapy and psycho-education group), Alcoholics Anonymous and Narcotics Anonymous groups, and pre-release counseling groups. Two additional staff members were being hired during the March site visit in order to expand the CRASH program; they had not yet started working.

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

**Finding: Partial Compliance**

Relevant Areas Reviewed:

- Jail policy BJG-III A-001 (Rules and Discipline)
- Interviews with disciplinary officer and inmate counsel
- Direct observation of disciplinary hearings
- DOJ Exit Interview document prepared by Medical Director

Basis for Finding:

For all “high court” infractions, the jail continues to refer the names of prisoners to the psychiatric RN, who then advises the disciplinary officer about any relevant mental health concerns. Since the last site visit, no inmates have “screened positive” during this process, and therefore no recommendations to the disciplinary officer have been made. In the past year (since the current procedure was put into place), only one inmate has ever been identified. This, of course, raises some concerns about whether the process is functioning effectively to identify inmates with relevant mental health considerations.

The jail still has no formal procedure for identifying mental health concerns in the “low court” disciplinary process (for pre-trial inmates and DOC inmates not subject to loss of good time credit). During the second site visit, we discussed this issue at length. The jail leadership was concerned that there was no practical way to screen 40-50 inmates per week, and the yield of useful information would be quite small. I made some suggestions in *Monitor's Report #2* about how to identify a subset of inmates for mental health consultation, but the jail chose not to revise its policies or practice in this area. While this decision is not a reason for partial compliance in and of itself, I did observe a case during this site visit where an inmate suffered from serious mental illness, but the disciplinary officer and inmate counsel were not aware. This experience, combined with the underwhelming data from the “high court” procedures outlined above, have led me to conclude that the jail's current

practices do not adequately identify inmates with mental illness or make meaningful recommendations to the disciplinary officer. The jail's response (outlined in the Medical Director's Exit Interview report) is that inmates with mental illness undergo several other screenings that would help identify them as mentally ill. This is true, but it only addresses half of the intended goal of this provision. The aim of providing information to the disciplinary officer (not just getting it from him) remains unmet.

As suggested in *Monitor's Report #2*, the jail should develop a policy for referring inmates to a qualified mental health professional that could include factors such as:

- 1) an inmate receives three 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;
- 3) the inmate counsel notices signs or symptoms of mental illness during his interactions with the inmate; and
- 4) 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 suggestions; the jail Quality Assurance staff may think of others that are better suited for St. Tammany and will accomplish the goal of identifying a sub-set of inmates for whom mental health screening is indicated.

- 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
- Medical charts
- Observation of routine psychiatric and RN appointments
- Interviews with psychiatrist and psychiatric RN

**Basis for Finding:**

The jail continues to employ five medical assistants who handle the scheduling of medical appointments. During this site visit, appointments were being scheduled according to the jail's policies and were consistent with generally accepted practice. Inmates were routinely seen for counseling, mental status checks, and safety assessments, regardless of whether they were 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
- Direct observation of psychiatric appointments
- Inmate interviews
- Interviews with nursing staff and psychiatrist

Basis for Finding:

In all of the cases I reviewed, psychotropic medications were prescribed in accordance with generally accepted practice. During interviews, inmates did sometimes complain about being prescribed different medication in the jail than they were taking at home. However, in my opinion, the psychiatrist thoroughly assessed symptoms, requested necessary records from past mental health providers and pharmacies, and explained the rationale for his treatment decisions to patients in an appropriate manner.

- 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

Basis for Finding:

There have been no significant changes in this area since the last site visit. The jail allows inmates to hold and self-administer up to four days of medication at a time, provided that there is no psychiatric or medical contraindication. The psychiatrist makes clinical determinations and orders KOP (keep on person) or DOT (direct observation therapy) medications accordingly. The jail security staff performs “shake downs” of cells looking for hoarded or misappropriated medications when the medical staff has concerns about a particular inmate. 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 (MARs)
- Interviews with inmates
- Interviews with psychiatrist, nurses, and medical administrator
- Direct observation of routine psychiatric practice

Basis for Finding:

The jail psychiatrist manages psychotropic medications and adheres to typical standards within the profession for follow-up and monitoring. In the few cases I reviewed which required routine lab tests, they were completed appropriately. In addition, AIMS exams (to monitor the side effects of antipsychotic medication) were done approximately every six months, in accordance with generally accepted psychiatric practice.

- 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 October 2014 and January 2015
- Pharmacy records from February 2015

Basis for Finding:

No significant changes have occurred in this area. Jail policy J-D-02 states that medications must be reviewed at least annually, but several other layers of medication review occur in routine practice. The psychiatrist reviews psychotropic medications at each visit. 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. During this site visit, I did not encounter any cases where medications were

renewed indefinitely (without appropriate physician oversight), nor were there any cases where a medication was prescribed without a documented medical indication.

- 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:

The jail has not changed its practices with suicidal inmates since the last site visit. Suicidal inmates still receive the following services:

- MD assessment before placement on suicide watch (unless at night, in which case and LPN performs the assessment and consults by phone with a physician);
- 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.

These evaluations are sufficient to ensure adequate treatment and follow-up of suicidal prisoners. The jail is still considering consolidating some of these individual sessions into groups (for the sake of efficiency), but it has not yet done so.

- 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: **Substantial Compliance**

Relevant Areas Reviewed:

- Medical charts
- Interview with Ms. Johansson
- Discussions with Medical Director, sheriff, and other jail leadership during site visits

Basis for Finding:

As mentioned in previous *Monitor's Reports*, access to inpatient psychiatric care remains an intractable problem in St. Tammany Parish. In response to this situation, the jail has continued its best efforts to provide adequate crisis care to inmates with acute psychiatric illness. These efforts include:

- 1) Increasing psychiatrist hours to six days per week (and more, as clinically necessary);
- 2) Borrowing intramuscular Haldol (an antipsychotic medication) from local hospitals to manage acutely psychotic individuals who require emergency medication to maintain their safety;
- 3) Working with Ms. Johansson, the liaison between the jail and the state hospital, to expedite transfer of inmates to the Jackson State Hospital forensic unit;
- 4) Transferring DOC inmates back to a DOC facility with a higher level of psychiatric care; and
- 5) Working with local courts to lower the bond or drop charges so that the inmate has access to urgent medical or psychiatric treatment.

In one instance (March 2015), the jail was tasked with treating nine acutely psychotic patients at once. Three of the patients were transferred out of the facility within 72 hours (using mechanisms 3, 4, and 5 above), and the psychiatrist and nurse both worked overtime at the jail to treat the remaining patients. While this system does not exactly replicate inpatient psychiatric practice, I do think it is adequate to meet the MOA provision of access to “crisis services” for the sickest individuals. I will continue to assess how frequently these procedures are used in the coming months.

### 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 has created uniform policies for monitoring male and female suicidal prisoners in separate locations in the jail. They considered moving females into the A-700 unit but ultimately chose not to, as it was not clear whether this could provide adequate “sight and sound separation.” Current policy indicates that suicidal females are housed in a separate cell in the female booking area. Security staffing has been increased so that an officer can be assigned to observe the female prisoner directly while she is on suicide watch, with no other competing responsibilities. A physician can order a lower level of observation and increased access to property as clinically indicated. These policies are essentially identical to the policy already in place for male prisoners in the A-700 unit. The only difference is that the female holding cell is not “suicide-proof” (e.g., it has a vent grate and telephone in the room), but the likelihood of serious self-harm is minimal if continuous monitoring is implemented per policy.

- 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 booking area (females) or the A-700 unit (males). In both locations, officers directly observe the prisoners and document their checks in computerized logs. A physician completes a form specifying the level of observation and allowable property. During the site visit, I reviewed several computerized logs and found that officers were monitoring inmates according to policy.

- 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
- Interview with psychiatrist
- Interviews with inmates

Basis for Finding:

The jail’s practices in this area have not changed. 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 the charts of suicidal inmates that I reviewed during this site visit 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
- Inmate interviews
- 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. The medical charts contained documentation that these appointments are being conducted according to policy, typically by the psychiatric RN but in some cases by the psychiatrist.

- 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
- Discussions with Medical Director and other facility leadership during initial site visit meeting

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. I still find the physicians' judgments about allowable property somewhat conservative, but the decisions are consistent with reasonable clinical practice. As I discussed with the Medical Director and facility leadership, the jail must balance the risks of being over-permissive with property (i.e., the inmate can harm himself) with the risks of being over-restrictive (i.e., the inmate feels de-humanized and acts out accordingly). The staff does appear to be trying to strike this balance.

- 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
- Interviews with inmates

Basis for Finding:

Booking cages were removed from the jail in 2012. No inmate or staff member was aware of their use for mental health treatment or any other purpose since that time.

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

Finding: **Substantial Compliance**

Relevant Areas Reviewed:

- Tour of male and female suicide watch areas
- Interviews with correctional and mental health staff
- Interviews with inmates

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

Basis for Finding:

As noted in III.A.3.a above, policies and procedures for male and female inmates on suicide watch are now reasonably equivalent. An officer monitors female suicidal prisoners in a separate cell in the holding area, and this officer has no other job duties while monitoring the prisoner. Male prisoners are monitored in A-700 (up to 5 cells monitored by one officer). I observed practices in both of these areas during the site visit, and they were in compliance with the jail's policies.

#### **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 2014-2015
- List of topics covered in pre-service and in-service training for health staff and deputies
- Slides from newly developed mental health training for sheriff's office employees
- Quality Assurance quarterly meeting reports from October 2014 and January 2015
- Tour of jail, including suicide-resistant cells
- Interviews with jail leadership and medical staff

Basis for Finding:

The jail continues to excel in the areas of training and education. Louisiana does not require LPNs to complete any continuing education in order to maintain licensure, and it only requires 5 hours per year of education for RNs. However, the jail requires 20 hours per year, and the medical staff completes an average of over 23 hours of education and training per year. In addition to this year-round training program, the Medical Director and psychiatrist have developed a new training module about mental health for use in the sheriff's office annual in-service training. This training module covers areas of mental health that are relevant to all deputies, even the "road deputies" who work outside the jail, as those officers also frequently respond to mental health concerns. It was first used in December of 2014, and the sheriff's office plans to continue it in the coming years.

- 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 2014-2015
- List of topics covered in pre-service and in-service training for health staff and deputies
- Slides and outlines from training sessions
- Orientation requirements for new nursing personnel

Basis for Finding:

Correctional officers are not routinely trained on the use of the intake medical screening instrument, as they do not administer it. They receive annual training on suicide prevention, restraints, and mental illness. In addition, correctional officers are now audited by a supervisor to ensure adequate completion of the pre-intake screening (the "five questions").

All medical staff are trained on intake screening, restraint chair use, suicide prevention, and Psychiatric Risk Index protocols on an ongoing basis. Records of the 2014-2015 training sessions indicate that all of the nurses completed the required trainings, except for two recent hires. The two newly hired individuals had completed trainings required as part of orientation to the jail and sheriff's office.

- 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 2014-2015
- Examples of post-training exams given to medical staff
- Slides and outlines from training sessions
- Interviews with medical and security staff

Basis for Finding:

There are no significant changes in this area. 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, email reminders about policy changes, 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:

- Records of medical staff education and training from 2014-2015
- Records from jail staff meetings
- Interviews with medical and correctional staff

Basis for Finding:

Correctional officers continue to receive six hours of annual in-service training, which includes CPR, suicide assessment training, and a new mental health training module. The medical staff completes at least 20 hours of training, as outlined above. Records indicate that medical staff were offered approximately 24 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 in A-700 and female booking area
- Records from correctional officer training
- Tour of A-700 unit and female booking area

Basis for Finding:

All of the correctional staff members received annual in-service training about suicide assessment, observation of prisoners on suicide watch, and recognizing signs and symptoms of mental illness. During officer interviews, all were familiar with the jail's policies and procedures about suicide watch and showed me computerized documentation of their prisoner observations. In the approximately 24 hours of computerized records reviewed (including 4 different prisoners), there was only one deviation from the policy of documenting checks every 15 minutes. In that instance, 27 minutes elapsed between the computerized reports, which the officer explained had occurred when he was involved in tending to an emergency with another inmate in the unit. No harm came to the inmate involved.

*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 beginning work at the jail and every two years thereafter. There have been no trainings scheduled since the last site visit.

*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
- Outlines from staff meetings and emails from Medical Director to staff
- Tour of medical unit

Basis for Finding:

The jail does have an emergency response bag, a restraint chair, and a cut-down tool for suicide attempts by hanging. Officers reported that they are trained in the issue of these devices, and records of staff meetings and in-service trainings support this assertion.

### 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 (Reviewed 10/22/14)
- Restraint log from 2014-2015
- Interviews with staff involved in placement and monitoring of restraints
- Quality assurance reviews from October 2014 and January 2015

Basis for Finding:

The jail's restraint policy remains the same as during the last site visit; it was updated in 2014 to shorten the maximum duration of restraint placement from 18 to 12 hours. In *Monitor's Report #2*, I expressed some concern about the significant deviation between this standard and accepted community practice of placing restraints for no more than 4 hours. Since there have been no new restraint cases to review, I have no comment on this issue other than to say that restraint placement remains an appropriately infrequent occurrence at the jail.

- 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:

- Quality assurance meeting reports from October 2014 and January 2015

Basis for Finding:

Restraints were not used at all since the last site visit. No significant policy changes have been made, and there is no new information regarding this provision to review.

- 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:

- Interviews with security officers
- Quality assurance meeting reports from October 2014 and January 2015

Basis for Finding:

There were no new restraint cases to review. During the site visit, all of the officers I interviewed were familiar with the jail's policy of monitoring inmates in restraints with direct, continuous observation and documenting the inmate's condition every 15 minutes.

- 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:

- Quality assurance meeting reports from October 2014 and January 2015
- Interviews with Medical Director, psychiatrist, and nursing staff

Basis for Finding:

Again, there were no new cases to review. The psychiatrist, Medical Director, and nurses were all aware of the jail's restraint policy and the need to document the rationale for restraint use.

### **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 2011-2015
- 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:**

As noted in previous *Monitor's Reports*, all of the medical staff receive substantial 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 24 hours of education and in-service training to the medical staff, which included at least 12 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 previous reports, I had commented that the security staff, when interviewed, could not recall receiving basic mental health training. This deficit has now been rectified, as all sheriff's office deputies received mental health training during their in-service training in December of 2014. The jail plans to continue this training on a yearly basis.

### **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 2014-2015

Basis for Finding:

Mental health staffing remains adequate to meet the requirements of the MOA. The jail medical division currently employs 19 LPNs, one RN mental health counselor, four physicians (including one full-time psychiatrist), five medical assistants, six medical deputies, and one medical administrator. Since the last site visit, two nurses left the facility for other positions, and two new nurses were recently hired. The jail was in the process of hiring two new evening shift nurses and two new medical deputies, allowing greater flexibility to distribute medications and transport inmates to and from the medical clinic. In interviews with staff, the “bottleneck” in the medical system (i.e., the ability to provide medical and mental health services with maximum efficiency) was not the staff, but rather the physical space limitations of the jail medical unit. With the addition of the full-time psychiatrist and psychiatric nurse in 2014, the jail has outgrown its space. Plans are in the works to move medical services to the space now occupied by the kitchen, though this may not occur for another 1-2 years.

- 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 Sept 2014 site visit
- Discussion of staffing plan with Medical Director

Basis for Finding:

The mental health staffing plan has not changed substantially since the detailed

review provided by the Medical Director in September 2014. As noted above, the CRASH program, (which is not under the auspices of the Medical Director but is nonetheless related to mental health care) was in the process of hiring two new counselors during this site visit, with the aim of helping expand inmates' group therapy program and reentry planning services.

- 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 *Monitor's Report #1*
- Quality Assurance meeting reports from October 2014 and January 2015

**Basis for Finding:**

Overall, security staffing remains adequate to conduct the jail's day-to-day mental health assessments and treatment. It has been improved since the last site visit with the planned addition of two new medical deputies, as the increased staffing will allow the jail to transport inmates to and from the medical unit more efficiently. In *Monitor's Report #2*, I had raised concerns about the adequacy of security searches of inmates on suicide watch and during transport to court. In early 2014, there were two instances in which inmates attempted to injure themselves using contraband materials (a razor and a plastic bag). The jail took corrective action after these two cases, and there have been no further incidents of this nature since the September 2014 site visit. During the site visit, all of the inmates on suicide watch had only

the property allowed by the physician in their cells, with no evidence of access to contraband.

- 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 jail leadership during site visit

Basis for Finding:

As noted above, two significant changes to the security staffing plan have been implemented: (1) the permanent assignment of an additional officer to the female booking area, and (2) the addition of two medical deputies. This additional staffing has allowed the jail to monitor suicidal inmates more carefully and to improve transportation from housing units to the medical area.

### **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 from October 2014 and January 2015
- Yearly medical statistics for 2014-2015

Basis for Finding:

The jail continues to employ a good system for tracking statistics, reviewing medical and mental health care during quarterly meetings, and conducting peer review of medical charts. In the past six months, two relatively small corrective actions were taken in response to identified deficits: one related to keeping track of the time of intake medical assessments, and the other concerning a policy update about pre-intake screening. In total, eight policies were reviewed or revised in 2014, reflecting the jail's commitment to quality improvement.

I will note, however, that the jail has still not implemented its plan to conduct peer review of the psychiatrist's work. The Quality Assurance reports continue to state

that the jail does not have the financial resources to conduct peer review while also paying for the Independent Monitor of the MOA. As I noted in *Monitor's Report #2*, my role at the jail is not equivalent to the peer review process. Furthermore, the cost of hiring an outside psychiatrist to conduct peer review is negligible in comparison with the other initiatives the jail and Parish have undertaken (e.g. hiring new permanent staff, making facilities improvements, purchasing the old state hospital). As in *Report #2*, I do not find this one problem to be significant enough for a finding of "partial compliance" in an otherwise excellent quality assurance system, but I renew my recommendation that peer review of the psychiatrist's work begin before the DOJ investigation is completed.

*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 from October 2014 and January 2015
- Discussion with parties during site visit on September 15, 2014
- Yearly medical statistics from 2014-2015
- Records of corrective action implementation from 2014 and 2015

**Basis for Finding:**

The jail continues to use its quarterly Quality Assurance meetings to meet the requirements of this provision. The meetings most recently occurred in October 2014 and January 2015. When appropriate, the committee has recommended

corrective action, and the jail leadership has followed through with these recommendations.

- 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 from October 2014 and January 2015
- 2014-2015 Medical Department Statistics
- One Morbidity Review from 2014 (unrelated to mental health care)
- Medical charts
- Inmate interview

**Basis for Finding:**

Overall, the jail has been conducting thorough and appropriately self-critical reviews of security and medical procedures after critical incidents. During the site visit, one case was identified in which an inmate made a suicide attempt (by his own description and using generally accepted psychiatric criteria), but this case was not counted in the jail's official statistics, nor did it undergo a formal morbidity review. Upon reviewing the case with the Medical Director, we determined that the case had been reviewed after the episode of self-injury, and an informal report was completed by the Medical Director and placed in the inmate's medical chart. The spirit of the quality assurance process was left intact, but it was unclear to me why the usual review procedures were not followed in this case. I did not find the practice of informal review to be widespread; in fact, I did not find any other cases in which such a review was conducted. However, it did raise questions about the true meaning of the jail's report that no suicide attempts had occurred at the facility in the past six months. In the future, I would strongly recommend that the jail utilize its formal process of morbidity and mortality reviews rather than creating ad-hoc procedures, as it will allow us to compare "apples to apples" when looking at trends in data about the quality of mental health care.

## **Recommendations**

Overall, the jail and Parish have clearly demonstrated their commitment to complying with the MOA, and they are to be commended for their continued hard work. At this time, I recommend that the jail:

1. Proceed with plans to hire an outside psychiatrist in the next six months to perform quarterly peer reviews of the jail psychiatrist's work;
2. Perform a review of the jail's policies and procedures related to mental health and the disciplinary process. The aim of the review is to create a system that provides meaningful information about an inmate's mental health status to the disciplinary officer and does not overburden the medical staff;
3. Utilize the jail's existing policies about morbidity and mortality reviews rather than using informal or ad-hoc procedures; and
4. Continue with plans to move the jail medical unit to a larger space, as it has outgrown its current location.

As noted in my prior reports, the lack of access to inpatient psychiatric treatment in St. Tammany Parish is a serious problem that extends well beyond the jail population. I strongly urge the Parish to explore its options with Northlake Behavioral Health (and other facilities, if there are any) to provide inpatient psychiatric care to inmates, even if only in a small number of cases. Without this action, there is no way that the jail will be in 100% compliance with the MOA in the foreseeable future.