REPORT OF BART ABPLANALP, Ph.D.

Assignment

I have been retained by Plaintiffs' counsel to review charts in conjunction with Plaintiffs' psychiatric expert Dr. Terry Kupers, and offer opinions about the mental health care system at East Mississippi Correctional Facility (EMCF).

It is my understanding that the Mississippi Department of Corrections (MDOC), which has the ultimate responsibility for providing mental health care at EMCF, has contracted with a private vendor, Health Assurance LLC, to provide mental health care at EMCF. MDOC has contracted with another vendor, Management Training Corporation (MTC) to manage the overall correctional operations at the facility. For the sake of simplicity, I refer herein to the entities that are responsible for providing mental health care at the facility as "EMCF."

Qualifications

I am the Chief Psychologist for the Washington State Department of Corrections. I am responsible for oversight of mental health treatment services. I audit and assess access to care and quality of care at all of the facilities in the system.

I am also responsible for establishing clinical standards for all mental health staff, designing mental health guidelines and protocols, and developing policies, training and professional development for the Department's psychology staff. I provide clinical oversight for all licensed psychologists in the following Washington Department of Corrections facilities: Airway Heights Corrections Center (Spokane), Clallam Bay Corrections Center (Clallam Bay), Coyote Ridge Corrections Center (Connell), Washington Corrections Center (Shelton), Washington Corrections Center for Women (Gig Harbor), and Washington State Penitentiary (Walla Walla). My clinical oversight extends to the camp settings at Cedar Creek Corrections Center (Littlerock) and Mission Creek Corrections Center (Belfair) as well as Lincoln Park (Tacoma), the only work release in the state designed specifically for mentally ill inmates.

I serve as the mental health liaison for the Violence Reduction Pilot Program in Washington State and the statewide committee for Adults with Disabilities. I am the mental health lead advisor for the implementation of the federal Prison Rape Elimination Act (PREA), and I am the Department's mental health representative on the Inmate Re-entry and Community Safety/Dangerous Mentally Ill Inmate committee. In addition, I serve as a subject matter expert and mental health liaison with other state and federal agencies including the Department of Social and Health Services (DSHS), the Division of Developmental Disabilities (DDD), and the Division of Behavioral Health and Recovery (DBHR).

I am responsible for the development and implementation of certified Suicide Intervention Training for all mental health staff within the Department of Corrections (DOC). I am DOC Head of the Indeterminate Sentence Review Board Task Force, responsible for designing and

maintaining a system for conducting evaluations on ISRB inmates and providing clinical oversight for all ISRB psychological evaluations in the state.

Previously, I was Director of Operations for Mental Health at the Washington Department of Corrections' Reception and Diagnostic Center, where my duties included triaging the treatment and evaluation of patients, developing systems to promote the effective delivery of care, increasing productivity, and reducing waste of staff resources by improving communications between care providers, custody, and classification staff. I was responsible for supervision of Master's-level therapists and mental health counselors. Before that, as co-lead psychologist of the mental health unit Reception and Diagnostic Center, my duties included screening incoming inmates for mental illness, completing mental health appraisals on seriously mentally ill patients, compiling comprehensive psychological evaluations for the Indeterminate Sentence Review Board, writing Behavioral Health Discharge Summaries for inmates being released to the community, and responding to mental health crises.

I have also served as chief psychologist of the inpatient mental health unit of a Washington state prison, where I assessed inmates for level of mental illness and dangerousness, conducted individual and group therapy, completed risk assessments, and assisted in the development and implementation of a Co-Occurring Disorders Treatment Community Program; compiled comprehensive reports and presented testimony and evidence on Involuntary Medication hearings; and served as co-chair of involuntary medication hearings. I was lead psychologist for the Crisis Respite Program, which stabilized acutely mentally ill patients from the prison's general population. I managed hiring, firing, and supervision of Master's-level therapists and mental health counselors, including weekly supervisory meetings and yearly performance evaluations. I served as the liaison psychologist between the prison and the Mentally Ill Inmate - Community Transition Program (operated through Seattle Mental Health), and served as the Psychological Intelligence Officer of the Crisis Negotiation Team.

I have a Ph.D. and a Master's degree in clinical psychology from the University of Texas at Austin, and a B.A. in psychology from the University of Texas at Austin. I subsequently interned at the Medical College of Ohio and the Court Diagnostic and Treatment Center in Toledo, Ohio followed by a forensic postdoctoral fellowship at Dorothea Dix Hospital in Raleigh, North Carolina. My duties there consisted of conducting court-ordered evaluations regarding Competency To Proceed To Trial and Criminal Responsibility (i.e., insanity pleas), working as a crisis and behavioral management psychologist on the forensic units, serving on multidisciplinary treatment teams, leading the "Difficult Forensic Case Conference" seminars, and testifying as an expert witness in court.

I attach to this Report a copy of my curriculum vitae (Exhibit A), which includes a list of all publications I have authored in the past 10 years. I have not testified at trial or deposition during the past four years.

Rate of Compensation

My rate of compensation in this case is $100 an hour.

Facts and Data Considered

In forming my opinions in this Report, I rely on the information I gathered during the two days I spent at EMCF, April 23 – April 24, 2014, reviewing mental health records, and on the additional medical/mental health records I reviewed thereafter. I reviewed a number of charts suggested to me by Dr. Kupers and by Plaintiffs' counsel, based on their interviews of inmates at EMCF. I selected other charts randomly from lists of admissions to the Observation unit as well as patients currently residing in segregation and other living units.

I attach here as Exhibit B reviewed Name Key, supplying the names of the patients identified by number in my report; I reviewed the charts of patients identified in my report.

I expect to consider additional documents, data and facts as they become available to me and to modify or supplement my opinions if need be in light of any such new materials.

I note that in forming my opinions, I also took into consideration the conditions I observed on my tour of the segregation units, Unit 5 and 6(D), on the first day of my visit to EMCF, since I consider them relevant to the adequacy of the system for providing mental health care. The physical conditions were horrendous and included blackened, burned walls and cells; standing water; lack of adequate (or any) lighting; bloody bandages in both occupied and empty cells; exposed bolts extending up to an inch or more from the floor that posed a significant physical hazard (particularly in the unlit conditions of unit 5); gang graffiti covering the walls; the constant roar of inmates pounding on their cell doors and walls; and the apparently apathetic response of custody staff to blatant violations of security rules occurring in plain sight.

Summary of Opinions

My review of the records in this case has led me to the conclusion that mental health care at EMCF utterly fails to meet the serious mental health needs of the prisoners there. None of the minimally required components for a functioning mental health care system are in place at EMCF. The result is that from the time an inmate is admitted to EMCF to the time he is discharged, any inmate with serious mental health needs will be at significant risk of harm, because no system is in place that is capable of addressing such needs.

OPINIONS AND BASIS AND REASONS FOR OPINIONS

I. PRISONERS AT EMCF LACK ADEQUATE ACCESS TO TREATMENT FOR SERIOUS MENTAL HEALTH NEEDS

Access is a bedrock principle in any functioning health care system. Adequate access to care means that (1) patients receive necessary care within a clinically appropriate time frame; (2) there are no barriers to patients requesting and receiving care; and (3) appropriate care is available to meet the needs of the patient. The mental health system at EMCF fails on all three accounts, placing patients at a serious risk of harm.

Patients at EMCF request care through written requests. In my review of charts, I consistently found that patients seeking care faced unconscionably long delays. I likewise found these same delays when clinicians referred patients to other clinicians.

I.A. Mental Health Staff Deny Patients Access to Care

The fundamental job responsibility of any mental health clinician is to provide patient care. However, at EMCF, on a systemic basis, there is a culture in which clinicians *avoid* providing direct care to patients. At almost every turn, and in an almost robotic fashion, most mental health staff function as mere note-takers who may or may not record a patient's complaint but take no action to ensure that he receives necessary care.

The case of Patient 1 is representative of the lack of access to mental health care that was endemic in the charts that I reviewed:

> On October 11, 2012, Patient 1 told mental health staff that he was hearing voices. The clinician purportedly referred him to "appropriate staff." He received nothing that could be remotely characterized as mental health treatment.
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> On November 28, 2012, he asked to see the psychiatrist due to problems with his medications. Once again, his "concerns has [sic] been forwarded to the appropriate staff." But nothing happened in response.
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> On January 2, 2013, he once again reported medication-related issues. Staff noted that "this matter has been referred to the Psychiatrist," but nothing happened in response
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> On January 15, 2103, Patient 1 saw the "treatment team." However, there is no documentation that he was seen by a psychiatric provider (who is the one staff qualified to address his ongoing medication issues.) Amazingly, the treatment team stated that he had "no history is [sic] mental illness" and "no symptoms consistent with a severe mental illness[,]" but proceeded to assess him with two mental disorders.
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> On January 26, 2013, Patient 1 submitted a sick call request stating: "I done wrote 6 request forms. I'm stressed out and think everybody out to get me, always looking left and right paranoid. I need to talk to somebody." He was charged a $6.00 co-pay and was told that he would be scheduled for the "next available appointment" and that "mental health will follow up." However, this did not occur.
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> Five days later, he once again asked staff help. Instead of treating him, the clinician handed him a blank sick call request to fill out and submit.
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> On February 27, 2013, he submitted yet another sick call request, this time more urgent, stating that he need to talk to someone and that he did not know how much longer he could take things. Once again, he was referred to the see the psychiatrist and charged a $6 co-pay. He received no care.

> Over the next three months, Patient 1's requests for care become more dire. On March 7, 2013, he wrote to staff that: "I'm going threw [sic] so much feeling down daily. I'm stressed out and I truly need to talk to someone before I do something stupid. I truly need to see the psych doctor."
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> Patient 1 did not get to see a psychiatric provider until May 23, 2013. The provider assessed him as needing an antipsychotic medication. It had been more than a year since his previous visit and seven months since he first started seeking mental health care in October 2012.

Patient 1 was, for months on end, denied access to mental health care. At no time during that seven-month period did any clinician provide any treatment to address his symptoms or medication-related issues. Instead, his chart is peppered with boilerplate notes that appear remarkably similar to one another. Staff did nothing other than record his complaints and write hollow assurances that he would get to the psychiatrist at some point. In Patient 1's case, it was passivity on the part of the mental health staff that denied him access to care.

But, in addition, mental health staff employ *active* means to deny access. One of these means is the attempt to inappropriately narrow what constitutes a "mental health issue." I saw frequent examples of clinicians denying patients care because the clinicians felt that the patients' complaints fell outside the purview of mental health.

Staff frequently use the false dichotomy of "behavior vs. mental health" as a means to abdicate their professional responsibilities. The case of Patient 2 is illustrative. Patient 2 carries several serious mental health diagnoses, including psychotic disorder, and was housed in the unit intended to provide the highest level of mental health care in the state.

On January 6, 2014, a correctional officer asked a mental health counselor to speak with Patient 2, who was threatening to cut himself. Patient 2 explained that he was suffering from depression. The counselor dismissed Patient 2's symptoms and threats of self-harm, writing that *"This was strictly a behavior issue, not mental health*." (emphasis added).

A few hours later, the patient cut his chest and put a screw into his leg.

EMCF also relies on false distinction between "security issues" and "mental health issues" to justify the denial of access to care. Patient 3 carried multiple mental health diagnoses and exhibited extreme stress, depression, and self-destructive behavior during a period of extended lockdown. His psychological deterioration was well documented. On April 27, 2013, a mental health counselor saw Patient 3 after he stated that he was suicidal as a result of being on lockdown. The counselor wrote that "this is a security issue and not mental health."

I cannot fathom how any functioning mental health care system could tolerate such conduct on the part of staff. Mental health concerns do not arise in a vacuum. Personal circumstances have a significant impact on mental health, particularly in a high-stress environment such as a prison. It is completely inappropriate and reckless to dismiss a patient's symptoms and needs simply because they are related to a security-related circumstance such as a lockdown.

I also found staff using baseless accusations of malingering and manipulation to justify their avoidance of providing care. On May 14, 2013, a unit manager found a handwritten note by Patient 3, who was still suffering under lockdown. The note read, in part, as follows:

> No one will ever understand all of the pain that I feel or the things that I've gone through these last 4 months, but I really don't expect them to. I've felt more hurt than I've cared to feel, and life has finally dealt me enough. How much do people expect me to go through before I'm pushed over the edge? It matters not because no one will care or give a damn because I'm nothing more than a name and #. I've made peace with myself and before it's over I pray to make peace with my God. My mom already knows that I love her and so does the rest of my family, but love means little when it feels this way. I try to stop my tears but I'm struggling harder and harder with each word . . . I've begged and begged hoping that I could see mental health and maybe find some help for my problems but I've been chumped off so I guess that this is the right thing to do.

The unit manager believed the note to be a suicide note and referred it to a mental health counselor. In response, the counselor wrote a long note accusing her patient of being manipulative in order to get out of lockdown. She threatened, "the offender will receive a RVR [disciplinary infraction] if he continues to attempt to Manipulate a Mental Illness."

A few weeks earlier, on April 23, 2013, the same patient told a mental health counselor that he was suffering flashbacks from not getting his medications. The counselor accused the patient of lying and threatened him with an RVR. However, a review of the patient's medical record indicates that he had not received multiple doses of several medications, as he claimed.

Reckless accusations by clinical staff of malingering and manipulation, especially when used to justify the wholesale denial of meaningful mental health care, put inmates at risk of catastrophic harm. As Vitacco and Rogers (2010) warn, "correctional clinicians must be aware of misuses of malingering criteria and should be concerned that mislabeling an inmate as deceptive has potentially devastating consequences for an inmate who is denied treatment after being misclassified as malingering."

This is not to deny that patients may in fact malinger, feign, or manipulate. However, to outright dismiss complaints as being deliberately fabricated with no basis in fact risks missing real problems. In many cases, the exaggeration of symptoms does not necessarily imply outright falsification, but rather constitutes an attempt by the inmate to ensure that his concerns are heard. As was evident throughout the charts I reviewed, inmates frequently engaged in self-harm because they felt—with considerable basis in reality—that there was no other avenue to get staff to attend to their serious needs. Malingered or exaggerated symptoms are often a form of communication and a sign that underlying problems are not being detected.

I.B. The Lack of Confidentiality Creates a Dangerous Barrier to Care

Effective delivery of health care of any kind requires a safe, secure, confidential environment in which to discuss very personal information. This is particularly critical in the area of mental health, which is already burdened with unwarranted and stigmatizing misconceptions.

Compounding the problem is the fact that men are less likely to admit to or acknowledge psychological difficulties. This is especially true in a prison environment where acknowledgement of such issues is interpreted as a sign of weakness. At the bare minimum, mental health assessment, evaluation, and treatment needs to be conducted in an area that can ensure inmate privacy and that information ABSOLUTELY MUST be confidentially maintained.

The overwhelming majority of inmate/provider interactions in the charts reflected cell-front check-ins. Particularly in segregation, the ostensible purpose of these brief interactions was to assess the inmate's mental status and determine if he had any mental health concerns that needed to be addressed. Leaving aside for the moment that the lack of adequate lighting in many of the cells precludes a reasonable assessment of an inmate's physical condition, a cell-front interaction is not a confidential environment. Communication is through a narrow crack in a solid metal door and the noise level in the units is so intense (inmates yelling to each other, pounding on the doors, sound echoing throughout the pod) that an inmate trying to communicate to a health care worker or anyone else outside his cell would have to shout to be heard. Maintaining the confidentiality of information is impossible in such an environment. Even when inmates have legitimate or pressing concerns, the lack of confidentiality creates a disincentive to share that information. Making this problem worse is the periodic practice of having custody staff escort clinicians during their rounds. The presence of a third party (particularly non-mental health staff) significantly reduces trust and rapport; and when that third party is someone whose interactions with the inmate are generally authoritarian, if not punitive, the likelihood of the inmate giving voice to mental health concerns drops to near zero.

When inmates do not feel that the information they share will be kept confidential, they are likely not to disclose that information. As a result, their mental health concerns will not be addressed and their condition may well deteriorate, which significantly increases the risk of harm to themselves or others.

I.C. Necessary Care is Not Available to Meet the Needs of Patients

Adequate mental health treatment requires access to a variety of modalities of treatment. For some individuals, psychiatric medications are necessary; others require different kinds of treatment. But essentially very little treatment other than psychotropic medication is available to inmates with mental health needs at EMCF. I found little evidence that individual therapy of any value was going on with any inmates. Group therapy is rare. Though individual therapy and group therapy are listed as recommended treatment in *every single treatment plan*, it is in fact very rarely made available to anyone—and is completely unavailable to prisoners in segregation. Groups such as current events discussions, while valuable in many ways, are no substitute for meaningful group psychotherapy.

For example, dialectic behavioral therapy (DBT) is a core modality that is highly effective in treating certain mental disorders. Among other things, DBT is part of the standard of care for the treatment of borderline personality disorder, a mental illness suffered by many prisoners at EMCF. *It is a very painful disorder that often leads to self-harm and completed suicide.* In my review of charts, I could locate no examples of clinicians employing DBT for borderline

personality disorder or any other condition. This is not surprising given that effective use of DBT requires frequent one-on-one sessions, continuity of care, and qualified, well-trained clinicians—elements that are all lacking at EMCF.

Almost all non-medical interventions I reviewed consisted of brief case management or periodic multidisciplinary team meetings that used boilerplate approaches with no substantive interaction with the inmate or plan for addressing the problems. Many of the inmates reviewed could benefit from psycho-educational groups (understanding mental illness, medication management, stress and coping, anxiety, and depression) but few are offered. Although it is sometimes recommended that an inmate take part in a group (most often anger management), there was very little evidence that any such groups existed. On the two or three occasions where group activity was documented in the Electronic Medical Record (EMR), there was only one case in which a group occurred more than a single time.

In the absence of virtually any meaningful talk-therapies, there is a heavy over-reliance on psychiatric medications. Of all the cases I reviewed, over half of them involved a standing prescription for injectable antipsychotic medications. There is hardly ever a rationale provided in the records for an injectable medication as opposed to an oral medication and the injections appear to be used primarily as a chemical restraint. I could not find any evidence that patients at EMCF have given informed consent for treatment.

The records I reviewed were rife with recommendations for inmates to take part in treatment modalities that do not exist. One has only to look at the treatment plan of any inmate at EMCF chosen *at random* to find ample evidence of this practice. The recommended treatment in these plans is virtually identical for every inmate and consists of the following structure:

> **Objectives/Goals:** Symptom reduction or maintenance, Develop or improve coping skills, Increase adaptation to correctional environment, Improve social skills
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> **Interventions and Modalities:**
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> **Physician**
> Monitor frequency, medication, progress toward treatment goals
> Frequency: Every 30, 60, or 90 days
> Person Responsible: MD
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> **Nurse**
> Monitor frequency, medication, progress toward treatment goals
> Frequency: PRN for med distribution
> Person Responsible: RN/LPN
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> **Mental Health/Psychological Services**
> Crisis Intervention, Individual therapy, Group therapy
> Frequency: PRN by SCR, Weekly, Monthly
> Person Responsible: Psychological Specialist

Patient Responsibilities:
Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed

Once a treatment plan is completed and entered into the record, it is simply ignored. I found no evidence that any of the objectives, goals, or recommendations were followed up. There was no documentation of any attempt whatsoever to help inmates "develop or improve coping skills, increase adaptation to correctional environment, or improve social skills." These were meaningless platitudes that mental health staff did not implement, assist with, or track with the inmate in any way, shape or form.

Patient 4

Patient 4 is diagnosed with paranoid schizophrenia and antisocial personality disorder. On April 29, 2014, Patient 4 was severely agitated, making threats against himself and others. He is already housed in psychiatric observation. 4A mental health counselor observes him place a battery in his mouth, pretend to swallow it, and then take it out of his mouth. He is placed on suicide precautions. The following day, multiple staff document that he is threatening to swallow a battery. At some point, he must have told staff that he did, indeed, swallow batteries because a x-ray is ordered, although not on an emergency basis. Finally, on the following day, he reported constipation and that he was not feeling well. He was sent to the hospital where it was confirmed that he had ingested two batteries. This episode resulted in no modification of care and the patient remained in psychiatric observation without receiving any meaningful treatment. My review of his record revealed that, over the course of more than two years, mental health staff recycled the same boilerplate treatment plan over and over with little variation. This is not mental health care.

I.D. The Imposition of a Copayment Imposes a Dangerous Barrier to Care

An adequate mental health care system requires that inmates be able to voice their concerns, request care when they need it, and receive timely treatment from qualified professionals. At EMCF, however, inmates are charged an exorbitant fee for communicating their needs to mental health providers. I saw several kites (sick call requests) in which an inmate was charged $6.00 for simply informing the provider that their medication was causing painful side effects. This system ends up punishing people for taking active part in their care and removes the incentive to discuss problems with their providers, thereby hindering their access to care.

Although charging inmates a co-pay for mental health services is not unconstitutional per se, the practice of charging for even writing a sick call request with no action taken as a result is unnecessarily burdensome. There were numerous incidents in the records I reviewed that documented patients in distress over mental health and psychotropic medication issues but declined to write a sick call request because of the co-pay they would be charged. The practice of charging a co-pay creates a disincentive to makes one's needs known and constitutes a barrier to accessing care.

Patient 5 was charged a co-pay for what should have been routine follow-up regarding medication efficacy.

- 03/13/14 – Patient 5 went to sick call to complain about jaw clenching due to Perphenazine: "I would like to see you as soon as possible about my medication, because ever since re-starting my Perphenazine, (I was out of it for about 10 days), have found myself clenching my jaws and grinding my teeth." He was seen by Tina Naylor, who is not a nurse or provider, and was charged $6.00 for a patient-initiated co-pay.

Patient 6 complained of being charged for chronic care treatment and he was charged exorbitant co-pays for submitting legitimate kites:

- 01/03/14 – Patient 6 submitted the following kite: "The medication that I am taking will not let me sleep and some of it is making me sick." He was charged a $6.00 co-pay for this kite.
- 03/01/14 – Patient 6was charged $6.00 for a sick call co-pay because he was requesting a review of his medications. His kite read: "Could I talk to medical about my meds? The Burce Bar [sic] you're giving me is not letting me sleep. Thank you."

Patient 7 was also charged simply for informing the psychiatric provider that his medications were not working.

- 05/28/13 – **Medical Services Request Form**. Patient 7 wrote to medical to state that he "needs increase in meds. It's not working any more. Can't move sometimes even when I'm awake…" there is more written but it is illegible for a bit then continues "seems like they would kill me." He was requesting to see the psychiatrist and was charged a $6.00 co-pay.

II. THE MENTAL HEALTH CARE SYSTEM AT EMCF DOES NOT PROVIDE LEVELS OF CARE THAT MEET INMATES' MENTAL HEALTH CARE NEEDS, AND IT FAILS TO ADEQUATELY CARE FOR PATIENTS IN PSYCHIATRIC CRISIS

Based on their mental health evaluations, inmates should be placed at a location/unit that can best meet their mental health needs. The following are the basic levels of care for any mental health system:

Inpatient mental health – Inpatient or residential units are needed for those inmates whose mental health needs cannot be met in the general population setting. These units have a higher mental health-to-inmate ratio; the mental health staff must possess a Bachelor's degree or greater and they must either be independently licensed or supervised by a qualified licensed professional. Inpatient units should have a designated licensed psychologist assigned to them and should have have their own pill line as many of the inmates are not or should not be on keep-on-person (KOP) medications. Inpatient units are for the most severely mentally disordered inmates and as such these units need to have a much greater level of interaction with patients than in the general population. Group and individual treatment are critical for these inmates as is regular case management with their providers. Treatment plans need to be updated regularly to reflect progress (quarterly or more often if necessary). There need to be clear criteria for admission to these units, clear treatment goals, adequate monitoring and treatment of inmates, and discharge

criteria and plans to move them to less restrictive environments (bearing in mind that some individuals will not ever be suitable for less restrictive settings).

Intermediate level of care – There must be a level of care in between the inpatient and outpatient levels. The intermediate level (sometimes referred to as "step-down" program) is needed to help inmates transition from the more intense treatment, monitoring, and oversight of an inpatient unit to the more sparsely staffed outpatient level of care, which requires a far more independent level of functioning (minimal symptom impairment and accessing mental health care primarily on an as-needed basis). The intermediate level of care is crucial in that it allows mentally ill inmates an opportunity to be in a less restrictive (and consequently more risky) environment while still having greater oversight and monitoring than they would in a general population setting. This type of step-down allows inmates to gain more autonomy and helps to gauge their readiness to move to less restrictive environments.

Outpatient mental health – A minimally adequate mental health system provides for as-needed mental health treatment that parallels that provided in the community. It provides care for prisoners whose mental health symptoms do not significantly impair the individual's ability to function in general population (e.g., with minimal treatment, the inmate can participate in programs, hold a job, or otherwise satisfactorily meet the requirements supporting correctional interests).

My review of mental health charts led me to the conclusion that prisoners at EMCF do not have meaningful access to any of these levels of care. Inmates do not receive treatment at a level commensurate to their acuity and chronicity. The mental health staff continuously ignore, miss, or avoid addressing serious mental health concerns of inmates.

PATIENT 8

The case of Patient 8 is unfortunately a representative example of staff pervasively if not deliberately ignoring the plight of a man with significant psychological issues. Patient 8 epitomizes the failings of a system that lacks the basic infrastructure – in Patient 8's case, an inpatient level of care – and does not provide appropriate treatment to seriously mentally ill inmates.

> On April 16, 2014, the psychiatric NP hears loud animal noises, barking, and howling in the hallway. It is Patient 8, who presents manic and disorganized. Throughout the encounter he repeats over and over "been thinking I am a hog…a gorilla…a snake…" He is given an injection, medications are changed, and he is scheduled for a follow-up appointment in 3 months, or sooner if needed.
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> This incident is not unusual for Patient 8. On May 29, 2013, a counselor observed that "There are reports that the said offender has been barking like a dog. Offender admits to the behavior reported by his peers. He states that his barks like a dog because of confusion about his age. 'Lost numbers of how old I am....dog big red was killed....'" A few days later, he tells staff that he took someone else's medications. Staff advise him that this is a bad idea but fail to take him seriously.

> In June 2013, while in psychiatric observation, Patient 8 develops severe abdominal pain and vomiting. On June 17, 2013, he tells a mental health counselor that he has "severe abdomen pain when lying down." These reports continue for the next 19 days but he is completely ignored by medical staff. Mental health staff do nothing other than embed his complaint of pain in otherwise boilerplate notes. Finally, on July 6, 2013, a nurse examines him and finds a "large baseball size red area" on his abdomen. He has a fever and is sent to the hospital for a severe infection.

The failures here are staggering. First, EMCF fails to provide this patient with any meaningful care other than periodic medication adjustments. Otherwise, he receives no care. It is even more troubling that such a patient can be utterly ignored in a psychiatric observation unit for nearly three weeks while he develops a massive, painful, and obvious infection.

Patient 8 is a clear case of a chronically psychotic inmate who should be housed on a residential inpatient unit with in-house pill line to ensure medication compliance, unimpeded access to qualified psychiatric providers, involvement in habilitative or rehabilitative groups (depending on his premorbid level of functioning), and patient-specific case management at the bare minimum.

The record is devoid of a recent, adequate or even relevant mental health evaluation. His file includes no psychosocial or relevant developmental history nor review of past treatment modalities either in prison or in the community; there is no formal assessment of symptom onset, duration, or functional impact (other than what could be suspected based on the notes available in the chart); and there is no patient-specific treatment other than medications. In effect, there is nothing to indicate that Patient 8's situation and issues are being given anything more than a cursory acknowledgement and there is nothing to differentiate the treatment of Patient 8 from any of the other inmates I reviewed despite his being floridly and chronically psychotic.

III. EMCF FAILS TO RESPOND TO PSYCHIATRIC EMERGENCIES AND PROVIDE ADEQUATE CRISIS INTERVENTION

Any system of mental health care must have safe and secure single-person housing area for individuals exhibiting mental health or behavioral problems that interfere with their ability to be housed with others. These are often referred to as close observation areas. The units have permanent mental health staff assigned to them and the physical plant must be set up to allow for one-on-one observation by custody staff.

Any system must also have some means of responding to crisis situations both during normal business hours and outside of those times. This may consist of a designated mental health professional whose duty it is to respond to crisis calls or it may be a call-system in which emergencies are routed to a central person or location.

Based on my record review, patients at EMCF decompensate and experience psychiatric crises with alarming frequency. To the extent that meaningful mental health care is provided at all at EMCF, it almost literally requires a crisis to trigger that care. EMCF is a facility that breeds

crises because it lacks a system to provide adequate care, and yet it is completely incapable of responding to the crises it creates.

The failure to manage a psychiatric crisis is illustrated by the case of Patient 9.

> On December 4, 2013, he becomes disruptive and is placed on suicide precautions in the medical unit, where he declares a hunger strike. Two days later, having received no risk assessment or meaningful mental health intervention besides medication, suicide precautions are discontinued and is to be returned to his housing unit. For some reason, staff fail to return him to his housing unit and he remains in an observation cell.
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> On December 10, he tells staff that he took an overdose of psychotropic medication. Rather than treat this as a medical emergency and send him to the emergency room, staff decide to keep him in his cell. The following day, while preparing to return him to his housing unit (long-term segregation), he appears disoriented, uncoordinated, and unsteady.
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> Finally, he is sent to the hospital, where he is diagnosed with neuroleptic malignant syndrome, a life-threatening condition consistent with an overdose of psychotropic medications. During the weeks and months that follow, he informs staff of other overdoses. Staff fail to take those statements seriously.

The failures here are obvious: No risk assessment of an unstable patient declaring a hunger strike, and a failure to take seriously a suicide attempt that nearly cost him his life. Further, it is inexplicable how a patient in a psychiatric observation cell could obtain enough pills to nearly kill himself. The explanation for this latter phenomenon may be found in a nurse's note written later that month, when the patient – still in an observation cell – was able to "fish" with his show and obtain cleaning bottles, a broom, and a box of gloves. It is astounding that a patient in an observation unit could obtain implements of potential self-harm with such ease.

IV. THE MENTAL HEALTH SYSTEM AT EMCF FAILS TO PROVIDE EVEN MINIMALLY ADEQUATE QUALITY OF CARE

A minimally adequate health care system relies on quality clinical care in order to effectively treat patients. Quality clinical care consists of an adequate assessment of the patient's problems, development of inmate-specific treatment plans, and use of reasonable modalities to accomplish those ends. Mental health providers must meet the minimum qualifications for knowledge, skills, and abilities in their positions and there must be coordination between mental health providers and other staff (e.g., medical, custody) in order to effectively manage the needs of the mentally ill inmate in prison.

At EMCF, there is significant lack of anything resembling a diagnostic assessment, a lack of substantive interaction between patients and providers, an absence of coordinated treatment plans specific to the patient, and a lack of effective treatment modalities. EMCF relies almost exclusively on medication administration – individual therapy is practically non-existent and

group therapy is either not offered or is so rare as to be of no therapeutic value. Treatment providers are either not trained in mental health interventions or do not invest sufficient time and effort in delivery of services.

In my chart review, although I saw no shortage of notes documenting clinician interaction with patients, the overwhelming majority of these encounters were essentially meaningless and of virtually no diagnostic or therapeutic value whatsoever.

Thus, in reviewing a chart one could see that a patient was seen by a clinician several times in a single month, and yet there was no evidence of any true care of any kind being provided. As illustrated in multiple examples in this Report, merely laying eyes on a patient and exchanging a few words does not necessarily constitute a clinical encounter. Nor does merely cataloging a patient's complaints in a note constitute a clinical encounter, absent a meaningful clinical assessment and plan of care.

In the absence of virtually any meaningful talk-therapies, there is a heavy over-reliance on psychiatric medications. Of all the cases I reviewed, over half of them involved a standing prescription for injectable antipsychotic medications. There is hardly ever a rationale provided regarding the reason for an injectable medication as opposed to an oral medication and it appears to be used primarily as a chemical restraint.

Nearly all of the treatment plans are identical in all the patient charts I reviewed. The only elements that differentiated one inmate from another were the identifying information and (sometimes) the Problem List. Everything from the Objectives/Goals forward is virtually indistinguishable from one inmate to the next. There is rarely ever any mention of how the mental health symptoms impact functioning or how they will be addressed; there are no specific target behaviors identified; nor is there anything other than vague, global goals ("develop or improve coping skills") without any indication of how those goals will be accomplished. Every treatment plan consists of meaningless statements about monitoring the frequency, medication, and progress toward treatment goals and there is no metric of any kind against which an inmate's progress (or lack thereof) can be measured or compared. The frequency of meetings with the psychiatrist is unspecified (e.g., "30, 60, OR 90 days") with no indication of the factors that might dictate a monthly as opposed to bi-monthly or quarterly meeting. All of the treatment plans globally recommend individual and/or group therapy, but there is almost universally no indication of what any type of group or individual treatment would be utilized and even on those rare occasions when particular groups or interventions are mentioned (e.g., anger management or coping skills), the service is not available. The absence of a clear diagnostic rationale significantly increases the risk of harm to both the inmate and staff because an inmate's true illness is not being addressed.

At times, the care provided during mental health encounters or one-on-one counseling sessions borders on the absurd. For example, on March 10, 2014, a counselor comes to a housing unit to see Patient 3, who has been diagnosed with multiple mental health and medical conditions, including schizophrenia and seizure disorder. The patient has an abnormal mental status exam with irritable mood and agitated behavior. The counselor documents the encounter:

> Offender states that he is stressing out because he is fearful of having a seizure in his cell and not being noticed for some period of time. Provider encouraged Offender to focus on what is and not what "might" happen; and ensures Offender that Security will maintain vigilant checks to ensure his safety; as well as MH Staff continuously monitoring for all psychiatric needs.

It is disturbing that the counselor brushes off the patient's fears without exploring them. However, it is inexcusable, and even absurd given the events of two days before, when a nurse documented that this patient had been "found unresponsive in cell during pill call…Inmate appears postictal. Inmate has hx of seizures." Thus, two days before the counselor's dismissal of the patient's fears, those very fears had come to fruition – he had suffered a seizure in his cell and nobody discovered him until a nurse came around to distribute pills.

One troubling example is that of Patient 10, a 71-year-old patient who arrived at EMCF earlier this year. He had significant, recent depression, anxiety, and rumination, in addition to significant medical history, including chronic pain and prostate cancer. During his short incarceration, he expressed worry about dying in prison and had recurring dreams of his wife laughing while killing his three puppies. He was prescribed an antidepressant, which provided some relief. On May 12, 2014, he was in an one-on-one counseling session with a clinician of unspecified credentials, who documents the following note:

> Offender is seen by this provider in the classroom of unit 4 on 5/13/14. He is alert and cooperative during the interview. His mood is euthymic Offender has denied si/hi and a/v/t hallucinations at this time. He has denied appetite and sleep disturbances. Offender is given an extensive 1:1 counseling session to vent frustrations and to get help with issues. He has stated that the majority of his problems are related to his medical problems. Offender reported that he is in pain due to falling in his cell. He further stated that he has completed sick calls to see the medical doctor for the knots on his head and elbow. He has reported that his cellmate to whom was recently moved stole from him and sold items to other offenders. Offender was understanding and expressed how thankful he was to be able to speak about it. Offender also spoke about his children and how much he miss them. Offender is worried about being incarcerated at his age for something he stated that he did not do. Offender was happy about speaking with this provider and reiterated that his problems are mainly medical related at this time. This provider will terminate 1:1 counseling with offender due to him having no MH concerns. Offender will be referred to medical staff. Offender was advised that MH staff is available 24 hours a day and to alert security staff or via inmate request/ sick call when he has MH needs. Offender is able to weigh the risks/consequences of his thoughts, actions, and behavior.

There is no evidence of any treatment being provided here whatsoever. A 71-year-old man with a significant recent mental health history tells a counselor that he (1) suffers from medical problems; (2) is in pain; (3) was victimized by his new cellmate; (4) missed his children; and (5) was worried about being in prison at his advanced age. A competent clinician would have picked up on each of these cues, explored them, performed an appropriate clinical assessment and, if indicated, developed an individualized treatment plan. None of that occurred here. Instead, the counselor decided to "terminate 1:1 counseling with offender due to him having no

MH concerns." I should note that one-on-one counseling sessions appear only rarely in the charts that I reviewed and, in this instance, the counseling was terminated prematurely and without cause.

There appears to be an overreliance on the use of medications as a mental health intervention. This puts an undue burden on psychiatry as the sole providers of treatment; it also decreases the inmates' sense of self-efficacy because they come to see medications as the only means of addressing their distress. This maladaptive belief system is well-established already within the prisoner population and EMCF does a disservice to the inmates by not helping them develop better coping mechanisms.

There seems to be an excessive use of prn injections (Haldol Lactate) to deal with inmate distress. This is costly in terms of nursing time and resources and it fosters an atmosphere of crisis responding rather than thoughtful treatment.

The vast majority of mental health encounters for prisoners in segregation occur in brief cell-front interactions, with almost no office visits except in response to a crisis. From my personal observation of the segregation cells, it is quite simply impossible to perform a full mental status exam, let alone provide mental health care, through a one-inch-thick solid metal door, where the only way to communicate with the patient is to shout through a narrow crack between the edge of the door and the door jamb. It is impossible to see the patient's face while speaking with him, and security staff and other prisoners can hear everything that one is saying. Establishment of rapport or even a level of basic comfort or safety necessary for the development of a meaningful therapeutic relationship is an impossibility.

V. THE MENTAL HEALTH SYSTEM AT EMCF DOES NOT ADEQUATELY ASSESS RISK OF SELF-HARM OR HARM TO OTHERS AND PLACES INMATES AT GRAVE RISK.

Another area of significant and mortal risk at EMCF is in the area of suicide assessment. Though over half of the inmates whose charts I reviewed had made suicidal statements or had engaged in self-harm behavior (in one case an inmate nearly sliced off his nipple), there was no evidence that a formal assessment of risk of harm was ever undertaken. Even the most rudimentary assessment (suicidal intent, plan, means) was absent in all of the cases I reviewed. Also missing was any sign of consistent or meaningful follow-up with inmates.

Rather than manage risk of inmates who are suicidal or threatening self-harm by conducting a clinical assessment, mental health staff instead rely almost entirely on having the patient sign a boilerplate No-Harm Contract. These contracts are completely generic, they are non-binding, they do not include any plan for follow-up action, and they give a false sense of security to staff who may believe that their risk assessment is complete when they "leave the ball in the inmate's court" by having him sign a contract. Failure to adequately assess risk (particularly suicidal risk) is an indefensible practice.

Suicide assessments are non-existent; and there is a near total lack of safety planning and follow-up services. In addition, EMCF deliberately places inmates at risk for decompensation and harm to self or others through an established practice of requiring inmates to discontinue medications for a prolonged period of time before they can be considered for transfer to another facility.

In order to mitigate risk of suicide, it is imperative that mental health assess the risk for harm to self or others in a timely manner. While the forms used for such purposes vary from institution to institution, there is considerable overlap in the content and basic processes.

At an absolute minimum, individuals considered to be at risk for suicide (whether by their own statements or actions, information gleaned from outside sources, or due to staff concerns) need to be asked about specific risk factors including their proposed plan, the potential lethality of their actions, their access to means of committing suicide, and the likelihood of success as well as the identification of protective factors, development of a specific safety plan, and follow-up services.

Despite there being hundreds of incidents of suicidal or self-harm statements and actions in the cases I reviewed, not a single one of those instances included a formal (or even informal) suicide risk assessment. This glaring lack of attending to even the most basic assessment constitutes gross negligence and places the institution at extremely high risk.

Further increasing risk to patients and the institution is the false belief that a No-Harm Contract has any bearing whatsoever on an individual's likelihood of committing harm. In literally every case I reviewed involving an offender who had committed self-harm, expressed suicidal intent, or made statements leading staff to believe they posed a risk of harm to themselves or others, no assessment was done to address the underlying issues or to work through the problem with the inmate.

Moreover, relying on a No-Harm Contract exclusively to reduce risk is dangerous. Such contracts are no substitute for a formal assessment by a clinician. When patients harm themselves or others or express suicidal or homicidal ideation, there is rarely any type of meaningful interaction with them after the situation has resolved or the immediate crisis has passed. By not addressing the issues that led to the inmate's thoughts, actions, or statements in the first place, they are far more likely to arise again, placing everyone at further risk.

A policy reported by inmates and staff (and reflected in the records) that requires inmates to be off of their medications for at least 90 days before being eligible to transfer to another facility significantly increasing the risk of decompensation and harm. Predictably, many patients decompensate before they complete the 90 days off medication required by policy. This places the inmate at predictable (and preventable) risk of decompensation in mental and behavioral status, and places both the inmate and the staff (at the present and receiving institutions) at significant risk for harm. This reckless and unethical policy is utterly unconscionable and it gravely endangers patients. Conditions at EMCF are so abysmal that many patients discontinue their medications and risk decompensating simply to have a chance of being moved to another facility. Given that other institutions in the state by and large have some form of psychiatric coverage, this practice of destabilizing an inmate prior to transfer is unethical at best and likely constitutes malpractice.

The following case highlights numerous problem areas with EMCF mental health treatment including lack of follow-up care, boilerplate mental health rounds, failure to communicate critical information to staff, employing a false dichotomy of mental health versus behavioral issues without an appreciation of the overlap, and a lack of documentation justifying a use of force to name just a few. For the sake of simplicity, this particular case review will focus only on the failure to adequately assess or manage risk to self and others.

Patient 11

Patient 11 has an extensive history of self-injurious and disruptive behavior. He carries diagnoses of schizophrenia and substance dependence. His time at EMCF has been characterized by psychiatric crises, multiple uses of force, and self-mutilation. Patient 11 is impulsive and often cuts himself in order to have a need or want met (e.g., shower, property, and better food).

10/18/13 – Patient 11 was seen in medical due to a self-inflicted injury to the arm. The offender was calm and in no distress. He admitted to being homicidal and having auditory and visual hallucinations. He stated that his constitutional rights have been violated and he has been subjected to cruel and unusual punishment. He went on to complain that the walls are closing in and he is seeing and hearing things that aren't there. Staff noted that "there is a suspected malingering attempt." There was no information specifically identifying what exactly staff noted that implied malingering.

10/24/13 – **Psychiatry Note**. Evelyn Dunn did a review and cited an extensive history of severe mental illness including schizophrenia and personality disorder. There was a clear history of conduct disorder and/or oppositional defiant disorder. There also appeared to be a history of suicide (driving a car into a pole, hanging, cutting) as well as a family history of mental illness including the successful suicide of a maternal aunt at the age of 68. He reported a history of psychotic symptoms including command hallucinations that tell him to set fires. The mental status exam was completely within normal limits with nothing noted in terms of psychosis or non-situational depression. He reported to have received mental health treatment at Whitfield, Charter Hospital, Diamond Grove, and Lakeside Behavioral Health.

12/13/13 – Seen by NP Dunn because he cut on himself out of frustration for not being able to shower that day. There was no description of the seriousness of the wound. His mental status exam was within normal limits with no abnormalities noted. Patient 11 reported stiffness that had started several weeks earlier (which would have been several weeks after he was supposed to have been seen for follow-up). NP Dunn documented that "[Patient 11] is adamantly [sic] the medication is helping – reports mood/thoughts improved for the better." The only medication change was an increase in Artane to address muscle stiffness and stat Benadryl.

12/15/13 – As provider on duty, Howard Thomas, saw Patient 11 at 9:32am, ostensibly for suicidal statements. Patient 11 stated that he was only suicidal to justify his improper behavior. Other than stating that there was not distress or agitation consistent with suicidal ideations, there is no official assessment of his needs or a plan for follow-up.

12/16/13 – **MH Rounds**. Roger Davis did his rounds and noted that offender was cutting his arm. Staff informed. "IM was complaining about security hold, no MH issues." No follow-up; no after care.

12/17/13 – Security staff reported that Patient 11 had taken 40 pills including Risperdal and Depakote. He wanted to get out of the "hole" (HU6D). His MSE was within normal limits with the offender smiling the whole time. It was unknown if he had actually swallowed any pills at that time. He was subsequently seen by NP Dunn who discontinued all mental health oral medications and replaced them with Haldol Decanoate shots. Again, there is no suicide or self-harm assessment documented and no indication of whether the offender actually engaged in self-harm (by swallowing his pills).

12/27/13 – MHC Clara Thomas and Jacquelynn Lockett responded to the unit when the offender needed to take a shower but had a handful of pills. The pills were taken from him. It is not clear how had he managed to accumulate so many pills as the medications was supposedly discontinued on 12/17/13 (see previous note). It was also not clear why mental health was called to the unit instead of nursing. No risk assessment documented; no treatment recommendations identified; no follow-up was noted.

01/2/14 – **MH Rounds**. MHC Demarlo Nickson conducted rounds and noted that he had observed Patient 11 starting a fire because he had not had a shower since 12/23/13. There is no indication of whether or not that was true or whether the issue was even communicated with staff. The MHC apparently wrote an infraction (RVR) but it was not served at the time. His MH Rounds note specifically stated no psychiatric issues only behavioral.

01/02/14 – **Psychiatric Note**. There is a confusing note by NP Dunn indicating that the "Use Of Chemical Agent" was used on the offender. He had been upset because he was placed on property restrictions. He gets offered medications sometimes and just wants to talk to someone. He is accused of manipulating staff and may indeed be but this is a perfect opportunity to create a carrot for him. He says he does not want the Haldol shot. He wanted a time out in medical to be by himself but he was already in a single cell (which is not the same as being in medical, where it tends to be much quieter).

01/02/14 – **MH Note**. Patient 11 cut himself later in the evening due to "environmental stressors" but nothing appears to have been done other than to enter a cookie-cutter note about continuing to monitor the offender with no specific interventions planned and no follow-up noted.

If one stands back and looks at the overall picture of Patient 11's care, it is striking how episodic and reactive it is. It proceeds from crisis to crisis to crisis and from one use of force to the next without ever looking to underlying causes or how the cycle of crisis could be stopped. The most obvious solution would be to have a coordinated multidisciplinary team approach that would involve having custody, medical, mental health (and any other relevant staff) working together to develop a plan for how to respond to Patient 11's behavior. This would consist of a functional behavioral analysis that would identify what needs and concerns the inmate is trying to communicate, the reinforces and disincentives for problematic behaviors, and the antecedents

and consequences (essentially, what situations prompt a particular behavior and what that behavior accomplishes). By having a better understanding of what underlying psychological processes are operating and using a behavioral model to reward desired behaviors and extinguish undesirable ones – and by employing this strategy uniformly over time and across staff and shifts – the inmate is much less likely to be in constant crisis mode and has a better opportunity to discover, practice, and trust more adaptive coping skills and staff will be much less likely to feel compelled to be in a power struggle with the inmate that places everyone at risk for harm.

VI. MENTAL HEALTH RECORDS ARE ENTIRELY UNRELIABLE AND INCOMPLETE.

Successful management and treatment of mentally ill individuals require an accurate assessment of patients' mental health symptoms and the impact that their symptoms have on their functioning. Treatment is most effective when it targets the underlying causes of distress and interference in a person's life and the foundation upon which treatment is built is an understanding of why a person thinks, feels, and behaves the way he does. This is accomplished through a formal diagnostic interview that includes a psychosocial history (developmental history, family history, education and employment, substance use patterns, and criminal behavior), prior hospitalizations and treatment, previous diagnoses and responses to interventions, behavioral observations, and information from resources other than the patient. From these sources of information, a diagnostic rationale is proffered, which then informs the treatment approach (what symptoms or issues to target, how they will be addressed, expectations for patient contribution, strengths and weaknesses, measurable goals, and a timeframe in which to address those goals.

In none of the cases I reviewed did I find any formal diagnostic evaluation. Diagnoses were either assigned based on a limited number of self-reported or observed symptoms or they were carried over from previous interactions with no validation of the criteria that led to the diagnosis in the first place.

It is virtually impossible to provide meaningful mental health care without accurate, complete and reliable records. I found, almost literally without exception in each of the mental health charts I reviewed for patients with serious mental health needs at EMCF that their charts were grossly incomplete, unreliable, and in many cases with entries that were apparently fabricated.

Evidence abounds in the charts of questionable data: Mental Health Rounds, Treatment Plans, and Quarterly Treatment Team Reviews overwhelmingly contain boiler-plate, cut-and-paste entries, and identical information between patients. They are verbatim regurgitations of generic vagaries that contain no information specific to the inmate's mental health symptoms and there is a pervasive lack of any type of assessment, evaluation, or plan for care.

Furthermore, I found a pervasive pattern throughout all of the records I reviewed with different mental health providers documenting wildly inconsistent and incongruous observations of the same patient within a very brief period of time (e.g., MH staff #1 reporting that the inmate could not be interviewed because he was too disorganized, rambling and tangential followed by an

observation from MH staff #2 less than an hour later describing the inmate as quiet and compliant with no signs of distress and no complaints only to be followed later in the day by a different mental health provider observing floridly psychotic behavior).

In addition, mental health rounds were frequently conducted while the inmate was sleeping accompanied by the misleading observation in the corresponding mental status exams that "the offender did not appear in distress." Assessments such as this are misleading in the sense that they give the impression that the offender was alert and oriented and able to communicate when in fact that was not the case.

In the records I reviewed, I found an almost complete absence of mental health evaluations that identified the diagnoses and problems: This is one of the most egregious problems in the documentation because a solid history and assessment is the foundation upon which inmate treatment and care is based. I could find no documentation with anything even remotely resembling a psychological intake (psychosocial history, criminal history, substance abuse, mental health history, etc.). Even the most basic elaboration or explanation of inmate complaints is overwhelmingly absent. Most disturbing is the widespread, systematic lack of diagnostic rationale.

There are gaps in the record between quarterly reviews and treatment plans for many inmates and there are numerous examples of critical observations entered into the record long after they occurred. The lack of adequate documentation places inmates at increased risk of harm.

CONCLUSION

From my review of medical records at EMCF, I have come to the following conclusions:

The basic components of a functioning mental health system are not in place at EMCF: there is no adequate timely access to care; there is no exercise of professional judgment (except by the psychiatric nurse practitioner, who are clearly overwhelmed by having too many cases to follow); there are not enough qualified staff); there is no adequate follow-up; there is no system to ensure that ordered care is timely received; there is no meaningful crisis care; medication management is dangerously deficient; and staff, with extreme, limited exceptions, are plainly not trained, not competent, and not supervised. The mental health records I reviewed are utterly chaotic, stereotyped, fabricated, and devoid of content – except for the notes of the psychiatrist and psychiatric nurse. It is impossible to deliver adequate mental health care – or any medical care – without reliable records. These records are utterly unreliable.

There is no functioning system at EMCF to meet the serious mental health needs of inmates. EMCF warehouses seriously mentally ill inmates with no attempt to address their mental health needs through any modality other than medications, which often amounts to little more than chemical restraints. Though individual therapy and group therapy are listed as the responsibility of mental health in every single treatment plan I reviewed, I could find no evidence of any course of individual treatment with any inmate; only two inmates who had been involved in group treatment and even in those two cases the inmates had been involved in no more than three or

four sessions total. The vast majority of psychiatric care is provided by a nurse practitioner who is the mental health director of the facility. There is very little care provided by a psychiatrist.

There is nothing at EMCF that resembles an inpatient level of care. Inmates are stored in the medical unit or "at-risk" unit with no specific admission or discharge criteria, resulting in mentally ill inmates languishing in isolation, housed and ignored for weeks or months at a time, frequently resulting in decompensation in their mental status. They receive minimal care and treatment plans are non-existent. There is no system in place to transition ("step down") inmates from more restrictive environments. The lack of clear guidelines or processes in this area results in inmates languishing in restrictive, oppressive, unsanitary environments for months (if not years) longer than absolutely necessary.

The care provided by the majority of mental health clinicians is indifferent, ignores obvious risks, and places patients in grave danger. There are numerous examples of care that is counter-therapeutic and in fact, the MHCs have very little, if any, therapeutic function. There is widespread evidence of mental health staff doing little more than documenting that an offender complains of mental health symptoms; little if anything is ever done to explore or elaborate on those symptoms or complaints by the front line mental health staff. In addition, mental health care staff employ false dichotomies (e.g., mental health versus behavioral, mental health versus security) to absolve themselves of performing their duties. Prisoners at EMCF are ignored to the point that they have no choice but to harm them themselves to get attention. Staff dismiss this behavior as manipulative and malingering. However, it is the staff and conditions at EMCF that place prisoners in the situation of harming themselves to get their basic needs met. To the extent that care is provided, it is episodic and reactive. Many of the mental health crises that I observed in the charts could have been prevented.

There is a well-established maxim in corrections: "If it is not documented, it did not happen." There is good reason for this. Not only does the documentation constitute the legal record, but also it is the means through which clinicians provide treatment and communicate with each other to ensure continuity of care. Documentation at EMCF is so inadequate and boilerplate that it places patients at a serious risk of harm. Mental health rounds, treatment plans, quarterly treatment team reviews, and even individual progress notes overwhelmingly contain identical information between inmates. They are verbatim regurgitations of generic vagaries that contain no information specific to the inmate's mental health symptoms, to say nothing of the lack of any type of assessment, evaluation, or plan for care.

The overwhelming majority of notes by mental health staff reflect cell-front interactions that are conducted in such an appallingly disruptive environment and in such a superficial manner that reliable or accurate assessments are all but impossible. The cells are unsanitary and lack sufficient lighting and the windows are narrow and dirty. It is difficult to get a clear view of the inmate, so critical components of an assessment (e.g., facial expressions, non-verbal behavior) are impossible to discern. The cell doors are over an inch thick and the only way to communicate is through a narrow crack where the door meets the wall. The noise level is frequently so intense that both the inmate and the mental health counselor have to shout at each other to be heard. Not only does this practically guarantee an absolutely lack of privacy, but also it constitutes a barrier to accessing care as inmates cannot reliably convey their concerns with even a modicum of

confidentiality. This is most certainly not a mental health interview and using these interactions as a basis for determining an inmate's mental status is misleading if not outright fraudulent. The only potential purpose of such cell-front interviews would be to determine if the inmate needs to be brought to a confidential exam room, which rarely happens.

One of the most egregious problems at EMCF was the absence of any system or process for assessing and managing risk. Though numerous inmates had made suicidal statements or had engaged in self-harm behavior (in one case an inmate nearly sliced off his nipple), there was no evidence that an assessment of offender risk was ever undertaken. Even the most rudimentary assessment (suicidal intent, plan, means) was absent in all of the cases I reviewed. Also missing was any sign of consistent or meaningful follow-up with offenders. Rather than manage risk of offenders who are threatening self-harm by conducting a clinical assessment, mental health staff instead rely almost entirely on having the patient sign a No-Harm Contract. These contracts are completely generic and do not include any plan for follow-up action. Failing to adequately assess risk (particularly suicidal risk) is an indefensible position. The records are also rife with instances of offenders engaging in dangerous, disruptive, reckless, and at times threatening or self-injurious behaviors as a means to an end. These issues are almost universally dealt with on a case-by-case (and often punitive) manner with seemingly no appreciation of the need for a thoughtful, coordinated response. This virtually guarantees operating in full time crisis mode.

Nobody is doing any meaningful oversight or quality control whatsoever of the system at EMCF. It is apparent from those records that the system is in free-fall. And apparently nobody in management, in MDOC or in the management of its contractors MTC and Health Assurance LLC, has been paying attention to the mental health care crisis there: nobody, apparently, is trying to fix the broken system of mental health records, lack of diagnosis, treatment, and follow-up. I saw glaring, utterly unprofessional and dangerous treatment and failure to treat serious mental health needs in virtually every single case I reviewed. It is my opinion that, to the extent that the Mississippi Department of Corrections is engaging in any monitoring or oversight of Health Assurance, that monitoring and oversight is vastly deficient and reckless.

Patient 12 and Patient 13 are not at all unusual cases at EMCF and in fact problems in their care are representative of a system rife with dysfunction. The concerns raised with these two inmates – meaningless, uninformative notes; perfunctory rounds; generic treatment plans with no specific interventions targeted to the patient; staff ignoring, marginalizing, or failing to detect symptoms of mental illness; lack of follow-up care; absent treatment modalities; delays in accessing care; and missed medications and gaps in the MARS – were found in virtually every patient reviewed. In a staggering number of cases, the substandard care consisted of unethical institutional practices and dangerously irresponsible behavior on the part of staff including failure to assess risk of harm; warehousing mentally ill inmates in what amounts to segregation for extended periods of time with no plan for transitioning them to less restrictive environments; setting up barriers to accessing care by charging co-pays for merely informing treatment providers of medication side effects; and requiring inmates to discontinue medications for 90 days before being considered for a transfer.

This is not a case of one or two mentally ill inmates who fell through the cracks of the system. These are two rather modest examples of the systematic failings of the designated correctional

mental health facility for the State of Mississippi to even meet the minimum standards of adequate care for mentally ill inmates. There was not one patient whose records I reviewed who received any kind of meaningful treatment other than medication and the vast majority of them were simply warehoused with no real plan to address their mental health symptoms, stabilize them within the institution, and facilitate their transition to less restrictive environments (up to and including release to society). These problems affect all members of the mental health subclass and place them in harm's way.

Based on my review of documents, it is nearly impossible to believe that such systemic flaws are a new development. It is my professional opinion that MDOC has known of these deficiencies for years but has intentionally turned a blind eye. It is further my opinion that my review has touched on only the tip of the iceberg with regards to the breadth and depth of problems at EMCF and that without significant changes in the system, any and all mentally ill inmates sent to EMCF in the future will be subjected to the same dismal conditions, apathetic staff, and lack of substantive treatment as those highlighted in this review.

What follows are a few examples from the cases I reviewed: I stress that these are examples only, since every file I reviewed was so rife with unacceptable care that I cannot detail it all.

Patient 14

02/28/13 – Patient 14 cut himself on the neck because he needed bandage changed and he claimed that the nurses would not do it. They "declined" to do it according to patient. The notes reflect that Patient 14 denied thoughts of self-harm when questioned and he signed a No-Harm Contract.

03/02/13 – Patient 14 was seen by the Tina Naylor, MHC. He had been brought to medical by Officer Jackson and left in the medical holding tank without anyone knowing that he had been brought to medical in the first place. The notes indicated that when he was seen it was because he had made a superficial cut to his neck with the expressed purpose of getting off his living unit. He had asked to go to the bathroom and subsequently refused to return to his cell. Later, when he would agree to go back to his cell, he would refuse to allow medical staff to attend to his wound(s). The notes highlight that the offender was smiling as he was talking with staff (MHC Naylor) but Ms. Naylor reported that the inmate needed medication "due to agitation." He broke the glass in his holding cell and threatened to cut his neck and spit on anyone who came in after him.

04/16/13 – **MH Rounds**. MHC Roger Davis entered a note during rounds that described the offender as "awake, standing at his cell door. No s/s of psychosis, a/v/t hallucinations hi/si or any threats to harm self observed. IM is able to weigh the risks and consequences of his behaviors. No MH issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for MH concerns."

04/18/13 – Two days later, he was back to cutting his neck again over stress about an upcoming court case. He signed a No-Harm Contract and told that he would be assessed by medical during pill call. MH will continue to monitor offender for psychiatric and clinical needs.

04/21/13 – An entry in the record documented that Patient 14 was becoming agitated and was swinging a broomstick when coming out of his cell. The only intervention noted was that he was given Haldol Lactate and Benadryl. There is no indication of what made him agitated, how or why he had a broomstick, whether he was infracted, or whether there was any follow-up of any kind.

04/22/13 – **Mental Health Rounds**. MHC Naylor wrote the following enigmatic note: "Mental Health Rounds was conducted on 04-22-13. The above stated offender was not in his cell. MHC will continue to monitored offender for psychiatric and clinical symptoms."

04/29/13 – Mental health staff (Roger Davis, MHC) responded to the unit for an issue with Patient 14. He was apparently agitated, cutting on himself, and spraying the fire extinguisher. When staff arrived, Sergeant Diamond stated that the inmate "cut off his nipple and ate it." The Sergeant apologized for mental health being contacted: "we didn't need to call you he'll be covered by nursing." MHC Davis acknowledged his understanding of the Sergeant's statement and conveyed the message to another MHC that mental health did not need to respond to the inmate. Patient 14 was given a shot of Haldol and placed on suicide watch.

The Treatment Plan for this incident stated the following: "Please see note following regarding the above orders not implemented by the security staff as Captain Bryant the shift commander reports that he does not have sufficient staff to implement the orders. Captain Bryant informed that the orders remain as documented." The captain responded that they would follow the recommendations [presumably to administer a Haldol shot] once sufficient staff was on-site but for the time being they could not even strip him out of his property or assist the nurse in administrating medication.

(1) Mental health was not involved in assessing the offender for suicide risk. This was evidently done by the nurses, but there is no record of a suicide assessment or justification for conditions of confinement. [NOTE: it is perfectly reasonable under these circumstances to place someone in a more restricted observation setting, but there is no documentation of any assessment. What is to stop him from doing it again?]
(2) It is not at all clear if the nurses who are placing inmates on suicide watch are trained in suicide assessment or intervention.

Under the objectives goals, the provider (Nurse Practitioner Evelynn Dunn) properly noted that "Although thought processes organized and coherent, he presents with severe poor insight/ poor judgment/ poor impulsivity, with severe impulse control issues, which places the offender at a severe danger to himself. Therefore this is being placed on a Level 1 Suicide Watch with 1:1 observation." She continued: "although orders are for the offender to be placed on Level 1 Suicide Watch with 1:1 observation, with ongoing incidents of self-harm, Captain Bryant is refusing to carry out the orders to assist with administering as needed medications to the offender

as he is in need of as needed medications to assist with calming the offender due to exhibiting dangerous behaviors of cutting himself and destruction of property. As these events occurred tonight, severe disruptive behaviors as he has almost succeeded in the complete laceration of his left breast nipple."

He is noted to be extremely disruptive with spitting on staff. He burned the window out of his cell, set a fire (separate), and was noted to be smiling the whole time (inappropriate affect). He states that he needs help that he does not know why he does the things he does. He's stressed over his upcoming release thinks staff are hassling ("messin' with") him. Transient stress related paranoid ideation and possible dissociative symptoms. Labile affect noted in the notes smiling to crying and back and forth. He took lithium, Seroquel and Wellbutrin on the streets.

Concerns and Questions

- The notes paint a picture of an individual with mental health and behavioral issues who has a history of cutting on himself for secondary gain.
- When experiencing anxiety, agitation, depression, or any other form of distress, Patient 14 cuts himself, makes threats, or asks for help but staff responses are non-specific or unhelpful. It appears that his self-harm is being ignored or at least not actively addressed according to the documentation. An individualized behavior management plan (IBMP) would be the preferred method of intervention.
- Whenever the patient engages in self-harm behaviors, there is no assessment of his risk for further self-harm. Instead, he is treated medically and asked to sign a No-Harm Contract and there is not ever any meaningful follow-up.
- The underlying diagnosis is unclear. The records include (1) recurrent major depression, moderate; (2) bipolar disorder NOS; (3) rule-out personality disorder NOS; and (4) "psychotic disorder very likely." However, there are no symptoms listed to support any of these diagnoses other than "poor appetite."
- The treatment plans are entirely generic and do not address his specific issues in any way and Patient 14 is identified as "medication compliant."
- Given the inmate's volatile behavior, it is concerning that the inmate was able to get hold of a fire extinguisher and an object sharp enough to nearly slice off his nipple. The staff do not appear to be able to exercise any control over the offender's movements or his access to items that can cause serious harm.

Patient 15

01/05/13 –Roy Reeves (M.D.) saw the patient and indicated that he presented with blunt affect, appeared to be responding to internal stimuli, and complained of auditory hallucinations. The MSE checklist in the note mentioned auditory hallucinations but did not describe them nor did the checklist give any indication of anything other mental health issues with the inmate (including distractibility, which might be expected if the inmate was actively responding to internal stimuli).

APPENDIX OF CHART REVIEWS

Patient 15 was given a diagnosis of schizophrenia and although an order by the provider was made for Haldol injection on the previous visit, that order did not appear to be active in the computer. The 01/05/13 note documented that the provider ordered Haldol Dec to be resumed (and administered that day if possible) with the plan to have it ordered as an IM shot every four weeks. The plan also called for follow-up in 1 to 2 months or sooner if needed. The MAR indicated that Mr. Adams received his Haldol shot that day (01/05/13) with the next one ordered for four weeks later, on 02/02/13.

01/10/13 – A note by Lakeisha Prude (MHC) stated that Patient 15 was seen on HU4 requesting medications for side effects. The note did not describe the symptoms, though they were ostensibly from the Haldol shot. Patient 15 was referred for "possible medication management." An assessment of his mental status indicated that he was alert and oriented to all spheres and was notable only for reported hallucinations but nothing else. His diagnoses were listed as schizophrenia, paranoid type and cocaine and cannabis abuse.

01/18/13 – Patient 15 was seen during mental health rounds. The notes states that the patient reported no mental health concerns nor did he complain of agitation or distress. From the note it was unclear whether Patient 15 had received his requested medications for side effects.

02/06/13 – Note by Lakeisha Prude indicated that Patient 15 had been involved in the first session of a group called "Becoming A Healthier Person." He was noted to have been appropriate and cooperative.

02/22/13 – Linda Brown (MHC) conducted mental health rounds and documented that Patient 15 reported no mental health concerns, though again he was requesting medications for side effects. A review of the MARs revealed that a previous prescription for Cogentin had expired in December 2012. There was no indication in the records that the symptoms were noted or even evaluated by the psychiatrist.

02/24/13 – Mental health rounds (Linda Brown) assessed Patient 15 as having no problems or complaints.

02/25/13 – Provider ordered side effect medication (Cogentin) for the patient. Patient also requested an inhaler for asthma.

02/26/13 – Patient 15 had been referred to MHC L. Brown during mental health rounds. Following her interaction, Ms. Brown noted that Patient 15 needed his Haldol injection. A record review by this writer indicated that Mr. Adams had a valid order for Haldol Decanoate q28 days, but the medication had been discontinued from his MAR. His MARs were subsequently clarified and he was escorted to medical where he was given his Haldol injection and side effect medication (Cogentin). He was noted to have tolerated the injection well and was calm and pleasant during the procedure.

03/13/13 – 04/14/14 – Over the next year, nearly all of the mental health notes over this time period say almost exactly the same thing: "Offender was seen by [MHC provider] during mental health rounds on [DATE]. Offender is calm and alert. No agitation or distress noted. Offender

reports no MH concerns. MH staff will continue to monitor offender for all psychiatric needs." Roughly half the notes included the following: "He denied SI/HI and A/V/T hallucinations."

NOTE: The only deviations from this verbatim pattern of documentation were the following:

02/18/14 – The standard mental health round notes cited earlier were supplemented with the following: "Patient complained that he has been to several sick calls but has not been seen."

03/15/14 – Patient 15 sent a kite asking why he was receiving Prozac with Dr. Edwards name on the order.

03/18/14 – The standard mental health round notes cited directly above were supplemented with the following: "Offender reported that some of the nurses are bringing him Prozac. Medical staff will be notified." There is no documentation with medical that this was done.

03/19/14 – **Quarterly Treatment Team Review**. This review basically listed Patient 15's medications. With regards to mental health issues, it states "[Patient 15] reported taking psychotropic medication, compliant with his meds, reported no avt hallucinations, no thoughts of hi or si, no sleep or appetite disturbance or paranoia or delusional ideas." There is no mention in the review of his complaints of not having been seen in sick call despite having put in multiple requests nor is there anything about having received the incorrect medication.

03/19/14 – **Psychiatry Visit**. Patient 15 met with Evelyn Dunn. This is a confusing psychiatric note that is not at all clear about whether Patient 15 is or is not taking Prozac and whether he should or should not be. There are patient quotes in the note, but they did not clarify the issue.

03/19/14 – **Treatment Plan.** This plan contains the same problem list as all of his other treatment plans and lists his GAF as 77. The note's author states "Inmate is medication compliant, he has no auditory visual or tactile hallucinations. Inmate does not wake for breakfast. Inmate is awake all day, he is responsive." This verbatim quote is indicative of the cursory nature of documentation seen in all of the charts.

Under Objectives/Goals it listed "symptom reduction or maintenance, develop or improve coping skills, increase adaptation to correctional environment, improve social skills." It does not identify what symptoms need reduction or maintenance, what coping skills need development, nor what social skill need improvement.

The Interventions section contains nothing specific to the offender. It calls for monitoring progress toward treatment goals but does not indicate how progress would be measured. It identifies mental health staff as responsible for providing "crisis intervention, individual therapy, and group therapy" but there is nothing in the plan stating what problems are being addressed. No individual therapy goals are discussed and no groups are identified.

04/02/14 – The standard mental health round notes cited earlier were supplemented with the following: "Patient complains of pain during MH rounds. 'They know what's wrong with me but they will not give me anything for pain.'"

NOTE: Patient 15 had been referred earlier (03/31/14) for an external evaluation of abdominal pain and the finding was that he has gall stones.

04/08/14 – Note states that Patient 15 had "no mh concerns, no sxs of agitation or distress, no avt hall, no si/hi." He was evidently informed that he is supposed to receive pain medication (ostensibly for gall stones). This would seem to imply that he had not yet received pain medication, which makes it odd that there was no mention of pain in the note.

04/14/14 – Mental Health Note. This note is identical to the 04/08/14 one with the exception that Patient 15 requested information on pain medication.

Concerns and Questions

- Lack of any treatment other than medications
    - There is nothing in the treatment plans stating what problems are being addressed.
    - No individual therapy goals are discussed and no course of treatment is identified.
- Poor documentation
    - MH rounds do not contain any meaningful information and are nearly identical to one another for over a year. There appears to be no effort to gather details about critical areas of functioning. The notes from mental health rounds are lacking in any specificity that could differentiate one inmate from another.
    - Serious signs and symptoms of mental illness are either missed or ignored.
    - Patient 15 is requesting help for side effects of medication, but there is no description of the symptoms. Later notes fail to indicate whether these issues were formally addressed and in fact over a month later the inmate is still asking for help with side effects. This is a perpetual problem - notes are frequently stand-alone entries that do not take into account the overall course of symptoms or treatment, which speaks to the lack of continuity of care and ineffective (if not altogether absence of) communication/coordination with the provider leading to prolonged suffering.
    - There is no mental health assessment or evaluation in the records. Consequently there is no documentation of medical evidence of the disorder or symptom constellation being treated. A single symptom of reported auditory hallucinations in the absence of other symptoms does not qualify for a diagnosis of paranoid schizophrenia. While the argument could be made that his symptoms are well controlled with the medications, there is nothing anywhere in his record from the time of his admission to the present to support anything other than this single symptom, which brings into question the validity of the diagnosis and the likelihood of significantly overmedicating someone for a disorder he may not have.
    - Patient 15's notes reflect that he was involved in the first session of a group facilitated by a mental health counselor called "Becoming A Healthier Person," but there are no other notes about the group, so it is unclear whether he stopped coming to the group, if the group was discontinued after one session, or if the counselor simply did not document anything beyond the first group. There is no clinical summary anywhere in the records.

  - Quarterly treatment team reviews are superficial and fail to address very real and concerning issues about which the inmate has frequently voiced complaints. Treatment plans are virtually non-existent in the record and whatever plan exists is completely generic and includes no specific interventions for the offender.
- <u>Lack of follow-up care</u>
  - The patient complained of side effects but there is nothing in the notes explaining what those side effects were and the patient's repeated requests to receive treatment for those side effects were either ignored, not forwarded to the provider in a timely fashion, or not documented.
- <u>Medication issues</u>
  - Critical medications (Haldol) are allowed to expire while other medications (Prozac) are not being prescribed reliably.
- <u>Lack of diagnostic rationale</u>
  - There is no mental health assessment or evaluation in the records. Consequently there is no documentation of medical evidence of the disorder or symptom constellation being treated. A single symptom of reported auditory hallucinations in the absence of other symptoms does not qualify for a diagnosis of paranoid schizophrenia. While the argument could be made that his symptoms are well controlled with the medications, there is nothing anywhere in his record from the time of his admission to the present to support anything other than this single symptom, which brings into question the validity of the diagnosis and the likelihood of significantly overmedicating someone for a disorder he may not have.

Patient 16

<u>10/19/12</u> – Patient 16 arrived at EMCF and was screened for mental health issues with a brief mental health questionnaire completed by nursing (as opposed to mental health staff). The screening indicated that Patient 16 had recently experienced a significant loss, appeared overly anxious or afraid, showed signs of depression (no indication of what those were), and he reported previous suicide attempts (cutting wrists). He denied suicidal ideation or plans at the intake. He denied a history of psychiatric hospitalization or psychotropic medications, but stated that he had received outpatient mental health treatment on "numerous" occasions, most notably at Weems Community Mental Health Center in Forrest, Mississippi.

<u>12/31/12 – 01/02/13</u> – Patient 16 was referred to mental health due to "suicidal ideation." However, there was no mention of suicidal ideation in the chart notes. The intake screening in October 2012 cited past reported suicide attempts and ideation but he denied ideation at the time of the screening. The self-harm assessment completed by the provider was negative for nearly all risk factors except for relationship loss/relationship problems (recent loss of grandfather) and yet the identified plan in the chart was to place Patient 16 on suicide precautions under constant observation. There was no intake evaluation in the chart, no indication of the criteria for stepping him down off constant observation status, and no plan for follow-up. Upon direct inquiry, the inmate was negative for suicidal ideation or thoughts of dying or for self harm plan or intent to harm. The SOAP form embedded in the assessment was not filled out except for "S: suicidal ideation" and "P: Refer to Dr. Williams." The patient appears to have been transported to

Wilkins County Correctional Facility for the watch. It was unclear why it was not done at EMCF, though that would have been preferable for continuity of care. There was a note in the record from nurse Marquita Adams that indicated that the medications were Paxil 30mg PO QD prn and Risperdal 5mg followed by the notation "Discontinue." There is no explanation of the reason for the discontinuation and there were no corresponding psychiatrist orders providing a rationale for why the medications were stopped.

01/01/14 – 03/05/14 – **MH Rounds**. Several notes by MHC Randy Townsend documented the following confusing assessment: "This offender was seen on assigned housing unit by this provider. Offender appeared to be asleep. Offender did not appear to be in any distress. MHC will continue to monitor offender for psychiatric needs." [NOTE: The rounds are apparently being conducted while the offender is sleeping, which makes the statement about "not appearing to be in any distress" a rather useless observation for anyone other than a patient suffering from REM Sleep Behavioral Disorder, night terrors, or nightmares.]

01/02/13 – Note in the record cited the patient as stating that he was not ever suicidal, he was just trying to get to another pod. He indicated that the unit manager had advised that he would be changing pods on that day (01/02/13). He presented with "bright and calm demeanor." The Psychiatric Assessment Tool merely stated "discontinue suicide precautions." There were no objective findings, goals, or stated plans for follow-up.

Patient 16 returned to EMCF after being sent out for suicidal ideation. He was at the other facility for 2 weeks, but there is no record his treatment there or any aftercare plan. When he returned to the facility he met with Loretta Nichols MHC who noted that he had attempted suicide in the past by jumping from the tier two weeks prior (I was unable to locate a record of this in the EMR). . He denied suicidal thoughts and signed a No Harm Contract. There was no mention of it in the chart and no follow-up other than having him sign the Contract.

He was followed up by the psychiatrist two days later. At that time he complained that the medication made him feel slower even though he was feeling less depressed on it. The diagnostic impression by the psychiatrist was cognitive NOS only. Apparently the psychiatrist completed a checklist of yes or no to symptoms in the different domains and almost all came up negative other than depressed mood. He noted at the end that "he may be paranoid but refuses any antipsychotic agents." Decrease Paxil and discontinue Cogentin. There is no explanation of what he is basing his statement about the patient being paranoid on.

01/09/13 – **Quarterly Treatment Team Review** note. Patient complained of auditory and visual hallucinations and mood disturbance (patient claimed his mood was worse since the death of his grandfather), and he stated that he was "paranoid at times." There were no objective findings in the note, no validation of symptoms, and no indication that anything was addressed other than citing the patient's self-reported issues.

01/09/13 – **Mental Health Treatment Plan** note. This note is a non-specific, copy-and-paste verbatim note that neither assesses nor addresses problems with the patient. In summary, the MH treatment plan note consists of the following:

There are no specific target behaviors identified nor is there anything other than vague, global goals ("develop or improve coping skills") with no indication of how those goals will be accomplished. The fact that the patient received mechanical and masonry training is not meaningfully connected in any way to the patient's current functioning or treatment goals. The statement about monitoring frequency, medication, and progress toward treatment goals does not include a metric of any kind against which to compare or measure progress or lack thereof and the frequency of meeting with the psychiatrist is unspecified (30, 60, OR 90 days) with no indication of the factors that might dictate a monthly as opposed to bi-monthly or quarterly meeting. The mental health treatment globally calls for individual and/or group therapy but there is no indication of what any type of therapy would focus on (reality testing? coping skills? stress and anxiety? DBT?).

> The Objectives/Goals through Patient Responsibilities section of the treatment plan is identical in every patient whose records I reviewed. I found not a single exception.
> Objectives/Goals: symptom reduction or maintenance, develop or improve coping skills, increase adaptation to correctional environment, improve social skills.
> Other: Inmate received mechanical training and masonry training while in the Job corps.
> Interventions:

- Physician: Monitor frequency, medication, progress toward treatment goals.
  - Frequency: every 30, 60, or 90 days
  - Person responsible: MD
  - Frequency: prn for medication distribution
- Mental Health/Psychological services
  - Crisis intervention, individual therapy, group therapy.
  - Frequency: prn by SCR, weekly, monthly
  - Person responsible – psychological specialist
- Patient responsibilities – take medications as ordered, keep appointments as scheduled, complete sick call requests if needed

Interestingly, a note at the bottom under Psychiatric Evaluation cited the PP as: "IM is new to EMCF. He was seen by Dr. Powe on 01/03/13 for intake and Dr. Reeves on 01/05/13 for psychological evaluation at which time his psychiatric medications were adjusted. IM continues to have delusions and hallucinations. MSE was notable for restricted affect, thought process circumstantial, thought content hallucinations, delusions, repetitious thoughts." However, NONE of these mental health symptoms are addressed in the treatment plan.

01/14/13 – During mental health rounds with Tina Naylor MHC, the offender requested to see psychiatry about getting his medication discontinued so that he could get away from the facility. He stated that he had no mental health concerns, no auditory/visual/tactile hallucinations, and no suicidal/homicidal ideation. [NOTE: This note was written five days after the above treatment plan in which the psychiatrist indicated that Patient 16's Mental Status Exam was notable for "restricted affect, thought process circumstantial, thought content hallucinations, delusions, repetitious thoughts." There is nothing in the note to indicate what had occurred in less than a week to make the patient suddenly asymptomatic.]

APPENDIX OF CHART REVIEWS

01/16/13 – **MH Rounds**. During mental health rounds Patient 16 explained that he continued to have command auditory hallucinations telling him to do "evil things." The provider then indicated later in the note that Patient 16 denied auditory or visual hallucinations. The provider also documented that "cognitive deficits" were noticed, but did not provide any description.

01/18/13 – "[Patient 16] was seen by mental health because he was claiming suicidality. He reported slipping and hitting his head while trying to hang a ligature. When asked the reason or the suicidal gestures, he explained because of the death of both maternal grandparents, which he denied caused any overt grief reactions when seen by the undersigned two days ago. When asked other reasons, he stated 'I have problems with serving my time. I just need someone to watch over me.' He informed the undersigned two days ago that he also wanted to stop his medications to be transferred. He told members of the treatment team the same. Recommended placing on suicide observation and schedule an appointment with psychiatry."

The checkbox Mental Status Exam was all WNL (the patient apparently denied auditory or visual hallucinations according to checkbox). The problem list and objectives and goals were copied and pasted verbatim from the previous entry and signed by Ricardo Gillespie.

Patient 16was placed on suicide watch and the rounds were done a couple of times a day by mental health. All noted that he was having no problems. Interestingly on 01/19/13, the note by Marina Moss MHC stated that "Offender reported he needed a blanket. Offender will be given a suicide blanket if available. Mental health staff to continue to monitor offender for psychiatric illness." [NOTE: Why wasn't he given a suicide blanket in the first place? What are the conditions of confinement? What is the rationale for doing so or not doing so?]

> After a few days Patient 16stated "I'm not suicidal" and was removed from watch status. The notes a few days later captured the situation pretty well. The offender felt stressed maybe sad about the deaths of both grandparents right about the time of Christmas. He had seen the psychologist on the 16th and hadn't noted any problems but two days later he had suicidal thoughts and apparently had tried to make a noose. He fell and hit his head (no verification) and was placed on suicide watch. After a few days on watch, he wanted to come off. Apparently the provider talked to him after a day or two of his admission to the ward and he told the provider: "I told y'all I just needed a couple of days to myself." He denied complaints at that time. He stated that he had heard voices a couple of days before but not now. Certainly they don't appear to be the focus of clinical attention and may be more opportunistic. The problems he noted with sleeping were because it was cold and not because of any depressive or psychotic symptoms. Thoughts were normal and linear, calm and cooperative, no problems with attention or concentration.

At the time of this interview, he has not decided if he wants to resume meds or continue with requests for transfer to another facility. No disruptive behavior has been reported by security or mental health staff while he has been observed in the observation unit. However, this provider did have some concerns that he initially complains of being cold and later while this provider was in the observation unit to have him sign a no-harm contract, this provider noted that he had removed his suicide shroud and was exposing himself fully, almost naked.

APPENDIX OF CHART REVIEWS

01/25/13 – **MH office visit**. Mental health staff and Lieutenant Lee were onsite in HU2 to assess Patient 16. He explained that he would like to be placed on observation due to a tragedy he found out about yesterday. [NOTE: There is no indication of what this is.] He stated that he reported it to a CO staff the day before but received no response. Lieutenant Lee informed him he would refer him to the chaplain to allow him to follow up his claims through the family.

02/07/13 – Patient 16reported to staff that he had swallowed 30 pills. The nurse apparently took his vitals and said they were all within normal limits. Patient 16had been referred repeatedly to the chaplain to allow the chaplain to follow up with his claims through the family but he has yet to follow up. [NOTE: It is not clear whether follow-up with the chaplain did not occur because the chaplain was not available or because the inmate simply did not follow through]. All the MHCs have referred him on. [NOTE: Where would he have gotten 30 pills and what were they? No follow-up about pills. No suicide or self-harm assessment completed.]

02/09/13 – Mental health counselor Tangi Truelove responded to the offender on the unit who was frustrated that he could not get anyone to take him seriously about being suicidal. They explained the process of going on suicide watch and he opted to stay "on the zone" because he had friends there and would rather stay there and talk to the doctor. Staff informed him that he would be put on the list to see Dr. Gillespie. [NOTE: No assessment of impulsivity? The only options are Suicide Watch or stay in the unit waiting to see someone? What's going on with the chaplain? Why don't counselors meet with someone regarding grief issues? It appears for all intents and purposes that the job of the mental health counselor is simply to pass information along to someone else.]

02/19/13 – Patient 16was not getting along with offenders in B zone and wanted to move to A zone. He stated he would threaten suicidality if he was not moved. MH assessed him as malingering. Assessment, plan, and goals were all the same (copy and pasted with nothing specific to the inmate or situation). Signed off by Naylor.

02/19/13 – **Individual Counseling note**. Patient 16 met with MHC Tina Naylor. This was not individual counseling but rather case management. "He was told he would have to meet with the treatment team and was told if he kept faking illness, he would be written up. IM was appropriately chagrined and then denied any mental health symptoms." [NOTE: Does he have mental health symptoms or not? According to an earlier psychiatric note, he does.] Later in the evening when different staff were available, he claimed suicidality again. He was warned again about not claiming false emergencies and directed to sign a no-harm contract. [NOTE: If there was any real concern about self-harm, why was that not assessed? And if there was no real concern about self-harm, why have him sign a contract? It seems pretty clear at this point that the inmate's issues are primarily Axis II, but nothing appears to be done in terms of addressing those issues.]

03/05/14 – **MH Rounds**. The note by Loretta Williams from this date indicated that there were no problems noted, which is interesting given that Haldol 5mg PO BID was started four days later.

03/09/14 – **Psychiatric assessment Tool**. Roy Reeves noted the Chief Complaint as "IM with schizophrenia on Haldol 5mg BID seen for follow-up. He reports being very paranoid. In the past was on Risperdal and at one time was on Haldol Decanoate." The Mental Status Exam was all within normal limits with the exception of the presence of delusions (though the provider does not explain what these delusions are).

03/11/14 – **Quarterly Treatment Team Review**. Yet again, the Quarterly Treatment Team Review is either completely uninformative or contradictory. It reads exactly the same as the others with the exception that the Psychiatric Evaluation identified the Primary Problem as "IM is doing much better at this time. Personal hygiene is significantly improved." [NOTE: (a) There is no metric against which his progress is being measured – how is he doing much better? (b) This review does not take into consideration the numerous false emergencies he has been citing and the fact that nothing is being done to curb that other than threatening to infract him and/or making him sign a no-harm contract.]

April 1, 2014; April 7, 2014; April 14, 2014; and April 20, 2014 – **Mental Health Rounds**. The notes from the month of April 2014 by Tina Naylor (these four are just a subset) are almost all identical. Regardless of what is going on with the inmate, the notes read: "The above stated offender reported no mental health concerns, a/v hallucinations, nor si/hi at the present time. The offender was calm, cooperative, and did not appear to be in any distress. MHC will continue to monitored offender for psychiatric and clinical symptom." [NOTE: The misspelled "monitored" is copied and pasted as part of this rather ubiquitous note.]

Concerns and Questions

- Mental health rounds are inadequate
  - Rounds were sometimes conducted at times when Patient 16was asleep, yet the notes state that the inmate does not appear to be in any acute distress. This is meaningless at best and is certainly misleading as it indicates that the inmate's overall mental status is stable, which it may or may not be when he is awake.
  - Many of the mental health rounds are identical (including the same grammar, spelling, and/or punctuation errors) and do not specifically address the patient in any way.
  - Documentation during some of the rounds is inconsistent with observations from other sources. For instance, Patient 16was noted by Dr. Powe at a treatment team as having delusions and hallucinations with restricted affect, and repetitious and circumstantial thought process. However a mental health round note from less than a week later indicated that his mental status was completely normal. Even if this were true, the lack of any explanation of what had occurred to make the patient asymptomatic in the interim is poor patient care.
- Poor documentation
  - The patient was placed on restrictive conditions of confinement under constant observation for the ostensible purpose of suicidal ideation. However, there was no documentation of a suicide or risk assessment, no plan for managing the patient's care while on watch, no discharge summary, and no plans for follow-up. The events cited in the notes apparently occurred in late December 2012 and early January 2013 but they

were not entered into the Electronic Medical Record until February 2013. This lapse in documentation is a disruption of continuity of care and potentially places the inmate at risk for lack of adequate monitoring and follow-up.
    - There are several references to the patient being paranoid or delusional but there are almost no objective findings in the notes. Other than a single observation by one provider (01/09/13), there was no indication of any symptoms of mental illness. Conversely, when there is any mention of specific symptoms, the treatment plan does nothing to address them.

- Failure to adequately assess risk
    - There is no documentation of any suicide assessments despite the inmate having gone on watch on several occasions and even having been sent off-site to another location on suicide watch.
    - There was no follow-up with the inmate in the records after coming off suicide watch nor was there any indication of the mental status and behavioral requirements for the inmate to transition from suicide watch to a less restrictive (and consequently higher risk) environment.
    - Mental health providers relied on No-Harm Contracts as opposed to formulating an aftercare or safety plan for the inmate following a crisis situation.
    - Even if a patient's presenting issues at any particular time are due more to characterological issues than to a clinical syndrome, it is a dangerous to take an either/or approach to dealing with the issues (either they have mental illness OR it is behavioral). In fact, the two often coincide and the presence of behaviors that appear volitional does not mean that there is not real risk of harm present. This is why it is so critical to document assessments of risk – whether of harm to self or others – and to develop a plan for minimizing the impact of those issues. No follow-up is ever discussed with the patient other than to sign a meaningless, non-binding No-Harm Contract, be written up for creating false emergencies, or risking decompensation in mental status by forcing them to discontinue medication if they are to transfer to another institution.
    - It is particularly concerning that despite this inmate's frequent suicidal statements he was still potentially able to get 30 pills. One could argue that the inmate merely stated that he had ingested 30 pills, but without documentation one way or the other, it is impossible to know and the failure to assess the legitimacy of the threats or statements puts the patient at risk.
- Lack of diagnostic rationale
    - On several occasions later in the record, some mental health staff accuse Patient 16of malingering and threaten him with rule violations. There does not ever appear to be clear consensus between providers about what Patient 16'strue mental health needs are, largely because no one has ever completed a reasonable assessment of his symptoms and history.
- Medication issues
    - The inmate is of the understanding that in order to transfer to another facility, he must be off medications for 90 days. As he is not disabused of this notion, it can be taken as a fact (whether supported or outlined in policy or tacitly codified due to its repeated practice is inconsequential). Given that other institutions in the state by and large have some form of psychiatric coverage, this practice of destabilizing an inmate prior to transfer is unethical at best and malpractice at worst.

Patient 17

<u>Current medications include</u>:
Buspar 30mg PO BID
Lithium 600mg PO BID
Haldol Decanoate 100mg Q28 days
Depakote 1000mg PO BID
Hydroxyzine 100mg PO Q8hrs prn
Haldol 10mg PO Q12hrs prn agitation

Patient 17 is prescribed Buspar 30mg PO BID, Lithium 600mg PO BID, Haldol Decanoate 100mg IM Q28days, Depakote 1000mg PO BID, Hydroxyzine Pamoate 100mg PO Q8hrs prn, and Haldol 10mg PO Q12 hrs prn (agitation). His diagnoses include anxiety disorder NOS and a rule-out of bipolar disorder (most recent, severe with psychotic features).

10/04/12 – Patient 17 met with Steven Vance MHTMHC. Offender stated that when he takes one tablet of lithium he experiences poor ability to manage impulse control and when he takes two he experiences crying spells. He stated that his lithium level had not been checked in two months (since August 2012). He stated that he was stressed due to his mother's failing health and that the auditory hallucinations had resumed, though he did not say what they were.

10/10/12 – Patient 17 met with Steven Vance. Complained that he was getting increasingly agitated and that he wanted to assault the nurses because he was upset with medical staff. He complained that he had not received medications consistently (though he is also claiming earlier that he was flushing some of his medications). MHC Vance stated that he consulted with his supervisor regarding the issues and found that the inmate is scheduled to see the doctor Tuesday of the following week. The inmate refused to sign a No-Harm Contract even though he is currently on suicide watch level 2. He ended the session by excusing himself and walking out during the session. [NOTE: This EMR Electronic Medical Record entry is confusing for a number of reasons: (1) The offender was apparently seen while on Suicide Watch Level 2, so how is it possible for him to excuse himself and walk out during the session? Why were his threats not evaluated and if found credible, why was his level not further restricted? Why was no behavior alert given to the nurses or medical, whom he had identified as wanting to assault?]

10/16/12 – Patient 17 saw the psychiatrist after coming back from the hospital for having swallowed glass. The patient was identified as hostile, angry, and self-injurious. The Objectives/Goals were: "symptom reduction or maintenance, develop or improve coping skills. Anger control, increase adaptation to correctional environment." The plan was to schedule an appointment with an MHP in three days on suicide precautions. Nothing else is mentioned.

10/18/12 –Talked with Vance and said that he had swallowed glass to get back at the institution. His intention was allegedly to make them incur medical costs for not having listened to him when he stated he was having bad thoughts and wanted someone to talk to. CO Correctional Officer (CO) had called medical but no one was available or no assistances were obtained.

08/19/13 – Patient 17 met with Howard Thomas, MHC who noted that Patient 17 looked to have lost a lot of weight. Patient 17 claimed it was from change from Prolixin to Haldol; however, information from other sources indicated that his weight loss was due to giving his breakfast and lunch to another offender to whom he owed store debts. MHC Howard reported in the notes that he notified the shift commander about the situation since the medication Patient 17 was taking "ABSOLUTELY REQUIRES" him to eat. There was a mention in the note that the offender had been tempted to swallow some object while he was in the yard [NOTE: It is presumed that the rationale for this was to be sent to medical or segregation to avoid the inmate to whom he owed his debt, but it was not made clear in the note.] MHC Howard commended Patient 17 for not swallowing the object during yard.

08/27/13 – Dr. Gillespie entered a note in the record citing Patient 17 's history of swallowing metal objects and setting himself on fire. There was no mention of what prompted this note, no explanation of why he would swallow objects or set himself on fire, nor whether the issues were clinical or characterological in nature. It is unclear what the purpose of this entry was. [NOTE: Patient 17 allegedly has a history of swallowing objects, but the only one I could find in the records in the past 18 months was on 10/12/13 about deliberately swallowing a piece of metal so he could get off the unit that also housed an offender that had assaulted him.]

09/27/13 – Lakeisha Prude MHC observed that Patient 17 was off baseline and it was suspected that he had been snorting his medication, which was partially corroborated by the patient. [NOTE: This critical information does not appear in any of the other THREE encounters with the patient that same day and there was no indication that it was verbally communicated to the mental health providers, particularly the psychiatrist. This is a huge communication problem and significantly increases risk for the patient and liability for the institutions.]

During the month of September, Patient 17 was informed that his mother had died a month earlier. He had some prior information about it but once it was formally disclosed he felt he could officially move on. He was coping with it by writing a song in her memory (encouraged by Howard Thomas). This was actually a commendable intervention by a mental health counselor and is one of the only ones I came across in several thousand pages of documentation (see also 11/16/13).

09/27/13 – Patient 17 was brought up to medical due to observations that he appeared confused and had been observed wandering into other offenders' cells and lying on their bunks. When he was brought to medical, he was disorientated to person, place, and time and exhibited short-term memory problems. He dozed off periodically during the interaction, but denied having taken anyone else's medications. Reports indicated that Patient 17 had been exhibiting these problems for about the previous 24 hours, but when NP Dunn had met with him within that timeframe, she did not notice any cognitive problems. The notes included a mention of a crack pipe having been found in the unit (possibly in his cell), but Patient 17 was not infracted and neither an order for nor results from a urinalysis could be found.

10/21/13 – A treatment plan was completed that had Patient 17's GAF at 74. The problem list states: "Inmate is medication compliant, he has no auditory visual or tactile hallucinations. Inmate has not swallowed any objects in the past 180 days." This is followed by: "Inmate

complains of constipation following numerous surgical procedures for removing dislodged objects." There is no explanation of whether or not the inmate actually swallowed these objects, though other notes indicate that there is some validity to these statements. The "Treatment Plan" includes nothing to address the issue of swallowing objects or threatening to swallow objects or otherwise commit self-harm (e.g., antecedents and triggers, coping skills, scheduled appointments). Also, if the offender indeed snorted or flushed some of his medications (as indicated in the 09/27/23 and 10/10/13 notes, respectively), then he is most certainly NOT medication compliant and this issue should most definitely be included in the treatment plan if not addressed immediately as is poses a significant threat to the inmate's health and by extension the safety of staff given his threats to others when he is off baseline. Nothing in the previous six months of notes has even attempted to address this issue.

10/27/13 – Jacquelynne Lockett was asked by Nurse Polanco to speak with the Patient 17. She stated that he was requesting his PRN medications but she did not think the offender was agitated. The offender stated that he is agitated, he knows the warning signs of his self-injurious behaviors, and that he was in a "bad state of mind." Offender was observed and did not display signs of agitation or distress. Nurse Polanco did administer his medication.

11/16/13 – Offender was frustrated because he is locked up and particularly thinking about his family and his mother. MHC Howard Thomas helped him brainstorm about more positive things to redirect his focus. One such project is to write his songs.

11/19/13 – Offender was seen during rounds. The offender reported that he is being denied his as needed medication by the nurse(s). He reported that he feels staff want him to harm himself in order to get his as needed medication. The offender was advised that his concerns will be referred to the DON and HAS for further assessment. The staff then goes on to write "The offender reported no Mental Health Concerns, A/V/T Hallucinations, and SI/HI at this time. The offender showed no sxs of agitation or distress at this time. The offender will continue to be monitored for psychiatric and clinical needs. Refer to DON and HSA." [NOTE: The offender is certainly voicing complaints, agitation, and distress. The note is not an accurate reflection of the interaction, which brings into question the validity of any of the notes by this provider.]

12/04/13 – Seen by MHC Howard Thomas. He was irritable and frustrated. Mr. Thomas referred to appropriate nursing staff for "as needed" evaluation/assessment. MH staff to continue monitoring for all psychiatric needs. [NOTE: Why was no intervention noted? It appears that the sole purpose of rounds and meetings with mental health is for the inmates' concerns to be noted and passed on with no attempt to address the issues at the lowest level, thereby increasing the potential harm to the patient and possibly staff.]

02/10/14 – Notes indicate that Patient 17 received some bad news and he requested prn medications. His demeanor was noted to be normal. [NOTE: There does not appear to be any attempt to discuss the issue with the offender but rather a passing of the buck to psychiatry and pharmacological interventions. Why is mental health not talking to him about ways to deal with his symptoms that don't involve medications?]

NOTE: Patient 17 has a documented history of asking for prn medications when he observed mental status is normal with no notable distress. On the one hand, he makes the argument that he knows the signs of his own decompensation and that he is asking for the medications before his mental status deteriorates significantly. On the other hand, if mental health are not working with him on strategies other than requesting a prn to sleep through his time and negative emotions, they are doing him a disservice in terms of his long-term mental health.]

04/22/14 – Patient 17 asked the Nurse Polunka about getting his prn Haldol shot and she refused to give it to him. The nurse reported that the inmate was not agitated when he requested a shot so she did not give it to him. The inmate subsequently reported feeling frustrated, anxious, and restless.

Patient 17 claims auditory hallucinations but I did not see any evidence of it in the records. This may be because he does not experience them or it may be because the documentation is so poor that it is impossible to tell. He also claims to have bipolar disorder, and while he certainly has mood lability, it does not meet the criteria for mania or bipolar. He is severely axis II (cluster B). His agitation is due to situational issues. He is a manipulative individual who is an active player in organized quasi-criminal behaviors on the unit. When things go south, he threatens suicide or (more often) ups the ante to self-harm. It is a little concerning that when he makes suicidal remarks like "I'm going to hang myself if I go back to the unit" that they send him back to the unit. See 01/09/13: "I got mad because they left the guy on the same zone with me. Then I told them I needed to come to medical. My leg was sore and hurting from the fight. They took me to medical and they told me to fill out a sick call. Then I told them I was suicidal that I was going to hang myself. They sent me back to the unit. Mr. Davis told them to send me back to the unit. I told them I was suicidal." However, the mental health notes from that day were reviewed and stated that the offender was reportedly belligerent and agitated at the time. His self-report (in the 01/09/13 notes) were apparently contradictory to the previous mental health staff notes. There was reference to his explanation of having set fire on the pod because he was angry and trying to get attention for some issues. His attempts to get his needs met are dangerous, but also a bit unsophisticated and naïve. I have some questions about whether there may be some DD issues going on with Patient 17.

Other instances of him committing self harm are significantly characterological in nature including superficial cutting and swallowing knives (unconfirmed). When he does well, the psychiatrist tries to take him off some of the medications and he ends up committing self-harm as a sort of borderline-esque retaliation. He has signed numerous no-harm contracts but of course none of them last for long.

Concerns and Questions

- Lack of support for diagnostic rationale
    - Patient 17 is diagnosed with Bipolar Disorder, Most Recent Episode Unspecified, With Psychotic Features but the only symptoms of bipolar disorder that are noted are come from a brief diagnostic interview on 10/25/11 that cites Patient 17' self-reports of "bad mood swings, bad temper, and not getting enough sleep" and his reports of a history of

several years of mood swings characterized by euphoria and grandiose periods. There are no objective findings of symptoms of mania (pressured speech, racing thoughts, and increased goal-directed activity) nor are there any indicators of the time course of the cycle(s). This is particularly important given the tendency for bipolar disorder to be assessed when describing the mood lability component of Axis II pathology (most notably cluster B). There was no mention of any psychotic symptoms nor any functional impairment in the diagnosis.
    - He is also diagnosed with Anxiety Disorder Not Otherwise Specified – A review of the records found little support for this diagnosis other than a note by Gurdial Sandhu, M.D. on 03/30/13 that cites Patient 17' complaints of "feeling anxious and tense and wants to take meds for anxiety. He denied feeling depressed. No complaints noticed. No suicidal ideations. No a/v/h, no hypomanic or manic symptoms. Thought processes are coherent and goal-directed. He was started on Buspar for anxiety." He identified only two subjective symptoms and there was no mention of functional impairment.
- <u>Lack of documentation and follow-up</u>
    - There is a staggering lack of communication between and among mental health providers, medical, and custody with regards to the inmate's behaviors. He had allegedly snorted medication, but there is no plan written in the notes to relay that information to his psychiatric provider or unit staff. This issue needs to be documented in the chart as it is not only the legal record but also a principle form of communication between providers on different shifts and different days.
        - This is particularly important given that shortly after having allegedly snorted medications, he was taken to medical for severe disorientation and disorganization that placed him at risk for harm on the unit (e.g., wandering into other inmates' cells).
        - Additionally, Patient 17 had allegedly made threats to harm nurses but no alerts were given to the nurses and there was no change in his restriction level. According to the notes, it appeared that his level at the time might have allowed for him to carry out the threats he had voiced.
- <u>Inadequate assessment of risk</u>
    - There is no documentation of an assessment of harm to self or suicidal ideation in the records even though Patient 17 was placed on suicide watch.
    - Patient 17 had made threats to harm the nurses, but there was no indication that the threats were assessed or addressed. No alerts were made and no follow-up was conducted.
- <u>Lack of timely or meaningful interventions – individual therapy is practically non-existent</u>
    - Patient 17 had expressed his frustration to staff on numerous occasions and had voiced his desire to talk to someone; however nothing was available (on one occasion a Correctional Officer had tried to get Patient 17 in to see someone in mental health, but no one was available - so there is some evidence documented in the record that at least an attempt was made to help the inmate).
    - Because he was unable to talk to anyone, it appears that Patient 17 communicated his distress by swallowing glass, which prompted an off-site medical visit.
- <u>Lack of meaningful treatment plans</u>
    - The treatment plans for Patient 17, particularly the one from 10/21/13 is not only internally contradictory but ignores several critical factors that place the inmate and staff at risk of harm if and when he decompensates.

  - There is no mention of his misuse of medications that resulted in a significant deterioration in his mental status – the plan is simply copied and pasted from a template with nothing addressing the inmate's specific needs.
  - There is nothing in the treatment plan that addresses his self-harm, suicidal ideation, or danger to others despite clear indicators that he experiences these issues and has been known to act on them.
- Poor documentation
  - Mental health rounds are either lacking in specificity or contradictory.
    - For instance, on 11/19/13 the MHC cites Patient 17's complaints about being denied his medication by the nurse and his concern that "staff want him to harm himself in order to get his as needed medication;" however, the note immediately thereafter states that the inmate voiced no mental health concerns.
- Absent or inadequate risk assessment and management
  - Suicide assessments are non-existent
    - In order to mitigate risk of suicide, it is imperative that mental health perform suicide risk assessments. While the forms used for such purposes vary from institution to institution, there is considerable overlap in the content and basic processes.
    - At an absolute minimum, individuals considered to be at risk for suicide (whether by their own statements or actions, information gleaned from outside sources, or because of staff concerns) need to be asked about specific risk factors including their proposed plan, the potential lethality of their actions, their access to means of committing suicide, and the likelihood of success.
- Lack of any treatment other than medications
  - Patient 17 is noted to be frustrated, irritable, and in distress on a number of occasions and his response to these situations is to request prn medications. There does not appear to be any attempt to intervene with the inmate on a lower level than crisis response. At most, the records reflect that mental health counselors merely pass on the information about the inmate's concerns to someone else.
  - The instances in which Patient 17 is denied his request for prn medication and subsequently experiences an increase in agitation and/or exhibits problematic behaviors is not at all surprising and in fact is rather predictable given the practices at EMCF. The practice of relying on prn medications fosters an atmosphere of crisis responding in which patients require immediate gratification and do not develop any sense of self-efficacy or confidence in their ability to tolerate negative emotions.

Patient 11

Patient 11 has a history of self-injurious and disruptive behavior. He has diagnoses of schizophrenia and substance dependence (alcohol and cannabis). I could not discern if he has Axis II diagnoses officially assessed but his presentation has a significant component of characterological distress. The schizophrenia diagnosis was made primarily from his reports of psychotic symptoms and numerous hospitalizations in the community (records were unfortunately not in the EMR). There is some inappropriate affect (e.g., smiling when describing his self-injurious behaviors) but in none of the notes that I have seen for the past year are there any indications of a formal thought disorder (delusions of reference, tangential thought,

grandiosity, unfounded paranoia). He has been prescribed some medications but was either intermittently compliant with taking them or he hoarded the meds and later threatened to take them all at once.

What stands out about Patient 11 is that he has a habit of harming himself or threatening to harm himself (usually not very serious injuries) in order to get something he wants including getting back property, taking a shower, getting better food, etc. He also has a habit of leaving the tray slot open and refusing to close it in order to affect the same ends. There are at least a dozen of these incidents over the past year and most of the cases involve a lot of staff time including mental health counselors, custody staff, and lieutenants. They have resulted in preparing for and implementing a use of force on a couple of occasions and there is no mention anywhere of any attempt at creating a behavior management plan or treatment plan specific to the offender. He is an impulsive individual who seems at times to be aware of his impulsivity and takes medications to keep him on a more even keel. This may be done prophylactically or in response to acute agitation. There is no assessment in the notes that looks at psychiatric symptoms other than self-report so it seems the offender may be getting over-prescribed medication. If this were Washington DOC we would be presenting him to CRC to find out what symptoms of schizophrenia he actually has. He seems hugely cluster B with a lot of superficial self-harm but no real plan to deal with or mitigate this behavior.

10/06/13 – **Use of Force**. According to the notes he stated "I'm alright...I'm hearing voices and everything…I'm having flashbacks from 1964…" He was assessed as being oriented to all spheres with normal speech, thought processes, and no evidence of auditory or visual hallucinations, nor signs of depression, psychosis, or mania. There is nothing in the note indicating at all why there was a use of force or even what the use of force was. The mental health note was just a debriefing on his way to segregation to make sure he did not have any mental health issues. The same MHC was asked to evaluate the offender at the request of security. Patient 11 agreed to close tray slot and was not sprayed. He did not appear to be in any distress and will remain under observation for any psychiatric or mental health needs.

10/18/13 – Patient 11 was seen in medical due to a self-inflicted injury to the arm. The offender was calm and in no distress. He admitted to being homicidal and having auditory and visual hallucinations. He stated that his constitutional rights have been violated and he has been subjected to cruel and unusual punishment. He went on to complain that the walls are closing in and he is seeing and hearing things that aren't there. Staff noted that "there is a suspected malingering attempt." There was no information specifically identifying what exactly staff noted that implied malingering.

10/24/13 – **Psychiatry Note**. Evelyn Dunn did a review and cited an extensive history of severe mental illness including schizophrenia and personality disorder. There was a clear history of conduct disorder and/or oppositional defiant disorder. There also appeared to be a history of suicide (driving a car into a pole, hanging, cutting) as well as a family history of mental illness including the successful suicide of a maternal aunt at the age of 68. He reported a history of psychotic symptoms including command hallucinations that tell him to set fires. The mental status exam was completely within normal limits with nothing noted in terms of psychosis or

non-situational depression. He reported to have received mental health treatment at Whitfield, Charter Hospital, Diamond Grove, and Lakeside Behavioral Health.

At the time of this note, his unit (6C) had been on lockdown for three weeks and Patient 11 was having problems with the limited freedom. The offender was requesting medications to keep him calm.

ARNP Dunn started Patient 11 on Risperdal, Depakote and Artane. The orders called for a Depakote level and labs with a scheduled follow-up in “1-2 weeks/sooner as needed.” However, his next appointment was not until eight weeks later, on December 13, 2013. At that time, he reported stiffness that had started several weeks earlier (which would have been several weeks after he was supposed to have been seen for follow-up). At that time, he was seen not as a scheduled appointment but because he cut on himself out of frustration for not being able to shower that day. There was no description of the seriousness of the wound. His mental status exam was within normal limits with no abnormalities noted. ARNP Dunn documented that “(Patient 11) is adamantly [sic] the medication is helping – reports mood/thoughts improved for the better.” The only medication change was an increase in Artane to address muscle stiffness and stat Benadryl.

Extra: Patient 11 has a history of chemical dependency and he has abused marijuana laced with formaldehyde (“love boat”) and he claims to have broken into funeral homes to steal embalming fluid.

11/15/13 – Patient 11 was throwing urine out of his tray slot at officers and was threatening to do it to anyone else. The lieutenant stated he did not need to see mental health due to his behaviors. The note by MHC Naylor stated that “the offender did not appear to be in any distress.”

11/27/13 – Patient 11 was noted to be refusing to close his tray slot again. He said staff were treating him like a dog and felt they were deliberately provoking him in order to spray him with OC (“they lyin’ to me”). He stated that he would close the tray for MHC Naylor and Lieutenant Hall [this appeared to be his only way of exerting control]. Again, the MSE on-site was completely within normal limits.

12/05/13 – Once again, Patient 11 refused to close his tray slot but did eventually after talking to MH.

12/09/13 – MH Rounds. MHC Roger Davis stated no problems. MHC Davis uses the same note for virtually all of his interactions with Patient 11: “Offender is awake, standing @ his cell door. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm/self observed. IM is able to weigh the risks and consequences of his behaviors. No mental health issues. Continue current monitoring program.

12/11/13 – MHC Lockett saw Patient 11 at the request of security. He complained that he was left out in the rec yard and got argumentative when staff came back to get him. They had planned a use of force but he agreed to be cuffed up. He presented as calm and cooperative but agitated. He denied SI/HI and AVH.

APPENDIX OF CHART REVIEWS

12/13/13 – Seen by NP Dunn because he cut on himself out of frustration for not being able to shower that day. There was no description of the seriousness of the wound. His mental status exam was within normal limits with no abnormalities noted. Patient 11 reported stiffness that had started several weeks earlier (which would have been several weeks after he was supposed to have been seen for follow-up). ARNP Dunn documented that "(Patient 11) is adamantly [sic] the medication is helping – reports mood/thoughts improved for the better." The only medication change was an increase in Artane to address muscle stiffness and stat Benadryl.

12/15/13 – Howard Thomas saw Patient 11 as provider on duty at 9:32am, ostensibly for suicidal statements. Patient 11 stated that he was only suicidal to justify his improper behavior. Other than stating that there was not distress or agitation consistent with suicidal ideations, there is no official assessment of his needs or a plan for follow-up.

12/16/13 – **MH Rounds**. Roger Davis did his rounds and noted that offender was cutting his arm. Staff informed. "IM was complaining about security hold, no MH issues." No follow-up; no after care.

12/17/13 – Security staff reported that Patient 11 had taken 40 pills including Risperdal and Depakote. He wanted to get out of the "hole" (HU6D). His MSE was within normal limits with the offender smiling the whole time. It was unknown if he had actually swallowed any pills at that time. He was subsequently seen by ARNP Dunn who discontinued all mental health oral medications and replaced them with Haldol Decanoate shots. Again, there is no suicide or self-harm assessment documented and no indication of whether the offender actually engaged in self-harm (by swallowing his pills).

12/27/13 – MHC Clara Thomas and Jacquelynn Lockett responded to the unit when the offender needed to take a shower but had a handful of pills. The pills were taken from him. It is not clear how had he managed to accumulate so many pills as the medications was supposedly discontinued on 12/17/13 (see previous note). It was also not clear why mental health was called to the unit instead of nursing. No risk assessment documented; no treatment recommendations identified; no follow-up was noted.

12/28/13 – Patient 11 would not close his tray slot due to complaints of not having wound wrapped.

01/1/14 – Patient 11 again refused to close his tray slot. He complained of bad food (cold) and weight loss. No mental health issues were noted in the notes (not even agitation or distress). The note stated "The offender denies all mood, appetite, and sleep disturbances." No referral was made to medical to address weight loss issues.

01/2/14 – **MH Rounds**. MHC Demarlo Nickson conducted rounds and noted that he had observed Patient 11 starting a fire because he had not had a shower since 12/23/13. There is no indication of whether or not that was true or whether the issue was even communicated with staff. The MHC apparently wrote an infraction (RVR) but it was not served at the time. His MH Rounds note specifically stated no psychiatric issues only behavioral.

01/02/14 – **Psychiatric Note**. There is a confusing note by NP Dunn indicating that the "Use Of Chemical Agent" was used on the offender. He had been upset because he was placed on property restrictions. He gets offered medications sometimes and just wants to talk to someone. He is accused of manipulating staff and may indeed be but this is a perfect opportunity to create a carrot for him. He says he does not want the Haldol shot. He wanted a time out in medical to be by himself but he was already in a single cell (which is not the same as being in medical, where it tends to be much quieter).

01/02/14 – **MH Note**. Patient 11 cut himself later in the evening due to "environmental stressors" but nothing appears to have been done other than to enter a cookie-cutter note about continuing to monitor the offender with no specific interventions planned and no follow-up noted.

01/13/14 – Use Of Force. The note does not state the reason for a planned use of force, but includes a quote (evidently from the writer) that Patient 11 was smiling and joking and stated that "he likes to get sprayed so he can go to sleep." This seems like a highly dubious statement but even if it was made by the offender, it is indicative of a far more troubling issue than difficulty sleeping.

ISSUES

- **Poor documentation**:
  - 10/06/13 – A use of force was required but there is no information regarding the incident leading to the response other than an indication that the offender would not close his tray slot. Also, patient reports "flashbacks from 1964" but there is no elaboration about the symptoms.
  - 12/27/13 – Mental health was called to the unit when Patient 11 apparently threatened to take a handful of pills. It was not clear why mental health was called to the unit instead of nursing. No risk assessment documented; no treatment recommendations identified; no follow-up was noted.
- **Inconsistencies between staff reports and documentation:**
  - 11/15/13 – MHC Naylor's notes state that Patient 11 "did not appear to be in any distress," but the lieutenant stated that the offender did not need to see mental health because of his behaviors (throwing urine out of this tray slot at officers and threatening to throw urine at others). The concern is either that the note is misleading (MHC Naylor did not see the inmate and reported that he was fine) or confusing (how does one reconcile an offender's behavior being so out of control that mental health providers are prohibited from seeing him with the observation that he is not in any distress?).
- **Inadequate assessment of mental health symptoms**:
  - 10/18/13 – Offender had inflicted a minor injury on his arm and was claiming that the walls were closing in and he was hearing and seeing things that weren't there. He claimed to be feeling homicidal and made vague claims of cruel and unusual punishment, but he was not noted to be in any acute distress. Assessment did not elaborate on the nature of his complaints (auditory and visual hallucinations, cruel and unusual punishment.
- **Inadequate assessment of risk**:

  - 10/18/13 – Offender had claimed to be homicidal but other than the statement that "there is a suspected malingering attempt," there was nothing in the documentation to indicate any assessment of the validity of that threat or who might be a potential victim.
  - 12/16/13 – Roger Davis did his rounds and noted that offender was cutting his arm. Staff were allegedly informed but there was no assessment of his level of risk nor any follow-up or after care.
  - 12/17/13 – Security staff reported that Patient 11 had taken 40 pills including Risperdal and Depakote. He wanted to get out of the hole (HU6D). His MSE was within normal limits with the offender smiling the whole time. It was unknown if he had actually swallowed any pills at that time. He was subsequently seen by ARNP Dunn who discontinued all mental health oral medications and replaced them with Haldol Decanoate shots. Again, there is no suicide or self-harm assessment documented and no indication of whether the offender actually engaged in self-harm (by swallowing his pills).
  - 12/27/13 – Mental health was called to the unit when Patient 11 apparently threatened to take a handful of pills. It was not clear why mental health was called to the unit instead of nursing. No risk assessment documented; no treatment recommendations identified; no follow-up was noted.
- **Failure to address mental health or behavioral issues in treatment**:
  - Throughout the encounters there is not ever anything in place to address his issues other than medication and even that is only shoddily followed up.
- **Failure to follow medical orders**
  - 10/24/13 – ARNP Dunn had started Patient 11 on Risperdal, Depakote and Artane. The orders called for a Depakote level and labs with a scheduled follow-up in "1-2 weeks/sooner as needed." There are no notes indicating that he was seen again until eight weeks later, on December 18, 2013. The meeting was not for scheduled follow-up but rather an urgent appointment prompted by Patient 11 having cut himself out of frustration about not being able to shower. Although the inmate at that time felt good about the efficacy of the medications, he complained about neck stiffness that was apparently due to one or more of his medications.

Patient 18

01/01/12 – 06/30/12 – Nursing notes from January 2012 through June 2012 briefly state that the offender was noncompliant with medications (presumably Haldol).

12/09/12 – Records describe Patient 18 presenting with rambling speech with disorganized thoughts and some delusional processes. The notes state specifically "no agitation or distress noted," which begs the question of why he would be given a Haldol injection. Either the notes are in error and the offender was agitated or distressed (thereby potentially warranting a Haldol shot) or they were not in error and the offender was neither distressed nor agitated but was given a Haldol shot due to symptoms of schizophrenia.

12/11/12 – An Interdisciplinary Progress Note was entered by MHC Roger Davis that stated the following: "On 12/11/12 @ approximately 3 in the morning during mental health rounds inmate 13130 was observed in his cell. He appeared asleep with no body movement and blanket over his

body. No problems observed or reported. Will continue to monitor for mental health concerns." This is curious for two reasons: (1) It is listed as an Interdisciplinary Progress Note, yet there are no other disciplines other than mental health represented and (2) the inmate is not even conscious during the interaction so the utility of information contained therein ("no problems observed") is uninformative at best and dangerously misleading at worst.

12/11/12 – Later on the same date Patient 18 was given a stat Haldol shot, though not at his request and the records did not specify any less intrusive alternatives.

12/20/12 – Patient 18 requested a shot of Haldol as a prn.

12/30/12 – Patient 18 requested another injection of Haldol.

01/02/13 – Patient 18 received another Haldol injection. The notes indicate that it was given for increased agitation but it was not clear whether the request was initiated by the patient or the nursing staff. Later that evening, at 2240hrs, Patient 18 apparently received his "routine" Haldol injection. To the lay person, this seems like an excessive amount of Haldol to be given in a single day.

Subsequent to the 01/02/13 note there is nothing medication-related in the available records until August 2013:

08/12/13 – Notes stated that Patient 18 was "escorted from unit one A per security per nurse Hunter's request for the following: Haldol Dec 100mg I/M administered. No blood aspirated."

08/19/13: A standing Haldol Decanoate shot was ordered on this date. Nothing further regarding this medication was entered in the record.

01/01/14 – 02/28/14 – Mental health notes for these two months are virtually all identical with all of them stating that the offender is doing fine with no complaints.

03/01/14 – Patient 18 presented as floridly psychotic. He was described as disheveled, suspicious, and paranoid with loose associations and constricted affect. His speech was repeating, he was withdrawn, he reported bizarre hallucinations (seeing spaceships), he displayed delusional thought, and exhibited a pill-rolling tremor. He was prescribed medications for the residual psychotic symptoms and side effects and he was started on a Wellbutrin.

03/04/14 – Mental health reported that Patient 18 was in no distress, voiced no complaints, and showed no signs of mental health issues.

Patient 19

Current Diagnoses
Schizophrenia, Paranoid Type
Impulse Control Disorder

APPENDIX OF CHART REVIEWS

Personality Disorder Not Otherwise Specified

Current Medications
Haldol Decanoate IM Q28days
Haldol 10mg Po q12 (for agitation) with Benadryl 75mg IM prn agitation

01/06/13 – Patient 19 had a broken light fixture and was attempting to stab an officer with the broken glass. Tina Naylor was called in to talk to him but he wouldn't sign a no harm contract so she had no other options but to leave the scene and request that he be stripped out and isolated.

Over the next several months, Patient 19 repeatedly requested his IM Haldol Lactate shots even though he did not appear to be in any real distress. Another time he told the person doing rounds that he wanted to see the psychiatrist but would not fill out the request because he didn't want a co-pay. He got into trouble on his unit either for getting caught by security with a lot of gang money that had to be forfeited or because he told the gangs he would tell on them because they would not let him use their cell phone or because the gang just wanted to beat up on him because he is on injectable medications.

01/09/13 – **MH Treatment Plan**. Patient 19 was noted to be anxious, paranoid, withdrawn, and suicidal with self-injurious behaviors. He claimed to have a razor on his person and expressed his intention to cut himself later in the shift. He has a history of malingering or manipulation in order to influence housing assignment.

01/14/13 – **Nurse Note**. Patient 19 asked for his prn shot despite laughing and joking at the time. He claimed that he had swallowed a razor (the nurse had seen a small piece of metal in his hands earlier in the interaction). He refused vitals and did not appear to be in any distress. He was told he would get his prn Haldol but he got agitated. Looks like he was given it involuntarily though it is not clear from the documentation

01/26/13 – brought to medical because he said he was thinking about harming himself. He signed a no harm agreement and took his medications and returned back to his cell. There is no indication of any suicide assessment.

02/04/13 – **Nurse Note**. Complains of suicidal and homicidal thoughts. Several small lacerations on the right side of his neck and several longer lacerations on his lower right arm. He also wanted something for agitation so was given Haldol Lactate shot. MHC Moss then talked to him and sent him back to the unit. No assessment of self-harm or homicidal thoughts seems to have been undertaken.

02/14/13 – **MH Office Visit**. Patient 19 was seen in the clinic after saying that he took a bunch of sinus pills. He was laughing and joking. Appears in no distress.

02/16/13 – **MH Psychiatric Visit**. Sent to Central Mississippi Correctional Facility. Stated that he was put on suicide observation for having jumped on police (as opposed to the claiming to have taken a bunch of sinus pills). He was descried as loud, intrusive, agitated, and hyper with

paranoia and poor insight. Difficult to redirect. Now ordered Depakote. Two days later he was fine, no complaints or evidence of anything just referenced.

02/24/13 – told medication nurse that he wanted to kill himself. He had a handful of pills and threatened to take them. He eventually gave them to her and his cell was searched but nothing else was found.

02/26/13 – **Psychiatric Visit.** He had been placed on suicide observation status again (though for some reason is able to come out and see the provider unrestrained in the office). He became agitated and hit the keyboard and monitor and knocked them to the floor. Meeting terminated security called.

02/28/13 – **Psychiatric visit**. Claimed that he was not suicidal previously only said that to change zones.

03/08/13 – **Infirmary Progress Note**. Apparently he had set his cell on fire because he was angry at having gotten more time. He refused to sign a no-harm contract so he was kept in medical. This begs the question as to whether he would have been allowed to leave medical if he had signed a No-Harm Contract.

03/14/13 – requested his prn Haldol Lactate shot and tolerated it well.

03/18/13 – **MH Office Visit**. On 3/18/13, @ approximately 10:56 pm, this writer was asked to follow up with pass on IM 128270, due to him being in medical malingering, but states that he attempted suicide with a rope. MHC Anglin intervening upon this writer's arrival, with officers as well. This writer spoke with IM 128270 regarding his issue, he stated that he had problems seeing the Chaplain and had been throwing up blood today, and wanted to be housed in medical over night for some secondary gain. This writer informed IM 128270 that he would need to sign NO HARM AGREEMENT, before being sent back to HU 1. IM signed NO HARM AGREEMENT. RN Edwards was apprised of this issue, will make Capt Terhune aware of his threats to start a fire in his room upon return to the unit. Continue current monitoring for any mental health concerns.

03/23/13 – **MH Individual Counseling**. This was really a crisis call. Inmate was combative before being put in the shower. He had set his sprinkler head on fire and the cell was spraying water. He stated he was in need of his prn medication. Stated he was suicidal but was calm and cooperative and pleasant so the author noted him to be malingering.

03/29/13 – Roger Davis saw Patient 19 due to his having set fire to his cell and attempting suicide with a rope. He was not even formally assessed by mental health. They just had him sign a no harm contract again and sent him back to the unit.

04/05/13 – **Office Visit**. Reporting suicidal thoughts again. Once in the office said he just wanted his shot because he is having problems on his zone.

APPENDIX OF CHART REVIEWS

04/06/13 – **Injury**. Patient 19 cut himself with a razor blade to anterior right forearm because "it was the only way I could get to medical and get peanut butter and crackers." Claimed he had swallowed the razor blade. Vitals were taken and stable. He was put on the docket to be x-rayed.

04/24/13 – **MH Rounds**. During rounds he has his hand hanging out of the tray slot with a razor blade claiming he is going to cut himself if he is not put on suicide watch. "During MH rounds, MHC observed this offender with his arm hanging out of the tray slot with a razor blade in his hand. Offender stated to MHC that if we don't put him on suicide watch he is going to mutilate himself. MHC authorized the security staff to conduct a cell search on this individual. Before the officers arrived to conduct the search he began to cut himself. The security staff arrived and ordered the individual to cuff up so that he can be evaluated by medical personnel. The offender was compliant with his orders. He was escorted up the hall to Capt. Young's office and MHC began to question his logic behind cutting himself. Offender again stated "I want to be placed on suicide watch." MHC instructed LT. Nobles to take this offender's property until further notice. Lt. Nobles stated that he is not going to take his property if he is not placed on suicide watch. MHC contacted the Unit Psychologist and informed her of the Lt's statements and she stated that she would take care of it. This offender is only exhibiting this type of behavior to obtain his desired results from the staff. MHC will follow up with offender in 24 hours. The undersigned (Amy Hodgson) did speak with Captain Young in regards to this matter. Captain Young explained that because the inmates are popping their doors, it would NOT benefit [Patient 19] to be placed on property restriction due to the fact that other inmates would take [give?] him anything he wanted or asked for. Furthermore, [Patient 19] was being escorted to Medical so that he could be given his as needed injection. Captain Young also reported that [Patient 19] was manipulating in order to get some attention and get out from behind his cell door."

04/30/13 – **Nurse Note**. Late entry; 4/29/13. Inmate was escorted to medical department with a small rope wrapped around neck approximately 5 times. Rope very tight, face and neck swollen, eyes red and slightly budging Face and neck covered with dried blood. Rope cut from neck. Blood cleansed from face and neck. No skin breaks noted. Inmate reported that he bust his nose to get blood to cover face and neck. Haldol 10mg and Benadryl 50mg given IM in left gluteal. Tolerated will. Mental health staff aware and talked with inmate. [2, 5A and D]
NOTE: Is rather shocking that staff escorted Patient 19 to medical before even attempting to remove the ligature.

05/03/13 – **Emergency visit to clinic**. Stated he was suicidal and had a rope around his neck. Again. When he arrived, he stated that he was not actually suicidal but that he needed to be on HU3 because lockdown was getting on his nerves.

05/05/13 – **Nurse Note**. Set a fire in his cell and required a use of force. Was brought to medical covered in soot. Given Haldol 10mg and Benadryl both IM and escorted back to his cell.

Patient 19 was transferred to CMCF not long after that, perhaps because of a court order. It's not clear. But for the next three months he was generally not an issue. Until August when the on-duty MH staff received the following:

APPENDIX OF CHART REVIEWS

Phone Note Call from MDOC **Reason for Call:** Discuss Patient Complaint **Action Taken:** Phone Call Completed **Summary of Call:** Officer states he is acting up and pretending to cut himself but has what looks like fingernail scratches on his arm. He swallowed something that he "balled up" and put in his mouth. He stated that if he acted a fool then they would take him off suicide. I told the officer to just keep an eye on him so he doesn't hurt himself and explain to him that he will never come off suicide acting out like that. I also advised that he doesn't have an order for any meds to calm him down and maybe Dr. Sandhu will be here this morning or later today and he can address the issue then. **Initial call taken by:** Cynthia Allen, RN, August 11, 2013.

Later in August 2013 he is noted to be at times hyper-verbal with increased psychomotor agitation

08/19/13 – Patient 19 cut himself superficially on the right neck and forearm because they would not let him smoke. He was taken to the hospital offsite and placed on suicide precautions.

08/25/13 – **MH One-to-One**. The offender was seen per his request. The offender reported that he was "tired of being on lockdown...behind these cell doors." The offender reports he wants to go to Unit#3. The offender reported to the c/o he was having SI, but did not report to mental health until the c/o reminded him. The offender reports he is non-compliant with his medication and has a razor and medication in his hand. The offender reports he asked nicely not to be placed on medication and that's why he does not take it. The offender was informed that his HU assignment is not the responsibility of mh and he should address these concerns with the proper staff. The writer informed the c/o that the offender needed to be searched bc of the razor in his possession. The offender eventually handed the writer the razor and pills he had been hoarding. The offender signed a no-harm agreement. The offender did not report any mental health concerns and will remain under observation for any psychiatric and/or medical needs. Once again, signing a no harm contract without talking to the offender about other ways of getting his needs met.

08/29/13 – **Returned to EMCF**. NP Dunn did an intake. He was noted at that time to have rambling and loose speech but nothing else.

09/06/13 – **Inmate Injury**. He was seen in medical because he was choking due to having set a fire in his living unit again. Claims he did it because of problems with the vice lords.

09/17/13 – **Psychiatric Visit**. Inmate wants to dc all meds so that he can transfer to another facility. WGCF.

10/22/13 – Patient 19 set another fire in his cell again. He was noted to have suffered minor smoke inhalation but otherwise was not badly harmed. He took a shower to get the soot off. The reason for setting it appeared to be because he had gotten in debt to the Vicelords and wanted to be off the unit.

APPENDIX OF CHART REVIEWS

11/17/13 – **Office Visit.** Seen in his housing unit with a string tied around his neck again and was feeling suicidal because he lost his son. There was nothing in the notes to indicate whether this news was true or not. Regardless, no suicide assessment was completed.

Somewhere near the end of 2013 Patient 19 was switched back to Haldol Decanoate q28days.

11/28/13 – **Mental Health note**. Patient 19 set his cell on fire yet again and when he was put on property restrictions.

12/05/13 – **MH Office Visit**. On 12/5/13, @ approximately 9:58 pm, this writer was asked to assess IM 128270, due to him attempting suicide with a rope. IM 128270 was unresponsive when nurses provided medical attention, vital signs checked out. Capt Donald had cell searched , property restricted and IM 128270 stripped for 72 hour observation. IM remained unresponsive as he was prepped for observation. IM was able to weigh the risks and consequences of his behaviors. HU 1 is on lock down. Shift Commander and Charge RN was onsite and informed of this incident. MHC will continue to monitor offender for psychiatric needs. Continue current monitoring for any mental health concerns.

12/24/13 – **MH Rounds** were conducted by Roger Davis MHC at 5:43pm. Patient 19 was noted to be standing in his cell awake and alert with no signs or symptoms of psychosis or anything. No problems observed or reported.

12/28/13 – 5:35pm noted that he had set fire in his cell because he felt his life was in danger and that was the only way he could get any help. Speech was of normal pace, tone, and volume and he was cooperative and pleasant. Approximately ten minutes later he saw the nurse who noted that Patient 19 had started a fire in his cell and was confined in there for a prolonged time 45-60 minutes. Upon examination, he was found to be alert and oriented to all spheres. He had no shortness of breath, his lungs were clear, respiration was at 24 BPM, and O^2 was at 94%.

12/28/13 – IM was held overnight in a holding cell after having set fire to his cell. He inhaled a little smoke but had no burns and did not appear to be in any medical distress according to medical. He was monitored throughout the evening.

01/26/14 – **Nursing Note**. RN Atwood was called to House 6 with information that the inmate had “swallowed a bunch of pills” and he was lying on the floor. When she arrived he was standing at the door of cell 111 in Pod D. He said “look I am going to swallow this razor and this piece of metal.” The metal was later identified as a part of the sprinkler head in the cell. The notes are unclear but it appears that Patient 19 did indeed swallow both objects. Medical ordered an x-ray to verify. Vital signs taken by the nurse were all within normal limits. He state that he took 10 Thorazine tablets before shift change at 2300 (the time of this call was 1:15am). His objective was to get off house 6 and threatens to cut himself if he is not moved to intake or to medical. He was seen by Mr. Thomas and remains on house 6.

03/08/14 – Patient 19 was given a Haldol injection. The notes are unclear if this was scheduled or a prn administration.

04/19/14 – Received inmate from 3C ambulatory to medical with guard present. Patient awake and alert. Complains of being suicidal. Inmate has cut right forearm superficial laceration noted with small amount of bleeding noted. Inmate has razor blade in mouth. When guards attempted to take blade inmate swallowed it. Laceration cleansed with saline and antibiotic ointment applied with sterile dressing. Haldol 10mg and Benadryl 50 mg given per order of Nurse Dunn who was present to evaluate patient. Patient transferred back to 3C in stable condition. (NOTE: No suicide assessment is done. He is given Haldol and Benadryl after he swallowed a razor and then he returned to the unit.)

Patient 20

Current Diagnoses
Schizophrenia, Disorganized Type
Mild Mental Retardation
Reading Disorder

Current Medications
Fluphenazine Decanoate 25mg IM Q14D

Referral Question: Has Patient 20 been receiving injectable medications in the past several months?

03/08/14 – **Nursing Note**. Verbal order as follows given per Nurse E. Dunn Haldol 10mg IM with Benadryl 75mg IM as needed agitation x 30days. PRN administered at approximately 1625 to upper right gluteal.

Issue/Concern: Patient 20 reported that he is allergic to Haldol but is being forced to take it. He did indeed report to the NP that he "locked up like the exorcist" when taking the Haldol. He was changed to Prolixin, which apparently did work better.

04/01/14 – IM escorted to medical per security for his monthly Prolixin Decanoate injection administered by Nurse Taylor RN. There is no mention of any refusal or issues in particular. For all intents and purposes it looked like he was there voluntarily. In the weeks leading up to it the shots (it appears that he had three in 2013) there was no mental health notes about agitation or mental health problems.

Patient 21

Current Diagnoses
Schizophrenia
No diagnosis on Axis II

Referral Questions: Are there past suicidal attempts? Was there a treatment plan in place?

03/07/11 – First note in record. No mention of depression or history of suicidality.

APPENDIX OF CHART REVIEWS

05/04/11 – Psychiatric Progress Note indicates a diagnosis of schizoaffective versus bipolar disorder. Note makes mention of delusions but there is no elaboration on the symptoms.

Quarterly treatment team reviews

- 03/08/11 – **Quarterly Treatment Team Review.** Mental status exam notes that everything is within normal limits. The offender reportedly denied mood disturbances or suicidal ideation.
- 08/04/11 - **Quarterly Treatment Team Review.** Haldol Decanoate IM Q28D was ordered followed by an order to taper Depakote that had numerous exclamation points after it. It was not clear what the urgency was behind the Depakote taper. Patient 21 stated that he had not been compliant with the Haldol injections because they affected his vision. He noted that he sleeps two hours per day and had good appetite. There is nothing in the treatment review to address his concerns about the Haldol side effects, no mention of what was happening with the Depakote, no description of the symptoms for which he was being prescribed the medications, and no mention of depression or suicidality. Medication was changed TO Haldol rather than FROM it.
- 11/12/11 – **Quarterly Treatment Team Review.** The exact same medical orders were written in this note as the August note. The MAR was unreadable on the computer, making it essentially useless. Some medications were added including Cogentin, Thorazine 200mg PO, and Atenolol. Again, though, nothing to indicate what symptoms were present that would warrant Thorazine and Haldol.
- 10/08/12 – **Quarterly Treatment Team Review.** Patient 21 continues to state that he is noncompliant with the medication and that he occasionally gives it away. There is nothing in the treatment review to indicate that this issue was being addressed or that the providers were even concerned that it was happening. However, the medications listed in this treatment review no longer include psychotropics. Patient 21 is listed as only taking Atenolol and Cogentin. For all intents and purposes, it appears (at least according to this note) that his medications were discontinued because he was not compliant in taking them but there was no plan noted for follow-up.
- 12/17/12 – **Quarterly Treatment Team Review.** Two months later, Haldol 5mg PO BID was added and the notes cite the offender as stating that he is compliant with medications with no side effects. He denied all problems, his MSE was within normal limits, and he expressed no concerns.
- 04/29/13 – **Quarterly Treatment Team Review.** Same as 12/17/12 with the exception that potassium chloride was added. No problems reported by the patient.
- 09/12/13 – **Quarterly Treatment Team Review.** Same as 12/17/12. Potassium chloride was stopped and the medication orders were for Haldol 5mg PO BID only. No problems noted.

The patient has a diagnosis of schizophrenia (or possibly schizoaffective disorder or bipolar disorder) but there is no documentation about his symptoms or functional impairment. The patient complains of side effects of Haldol injections and states that he does not take the medication reliably and occasionally gives it away. The solution the provider comes up with is to discontinue the medication. This seems almost punitive. Two months after the medication is discontinued (10/08/12), a Quarterly Treatment Team Review was held and Haldol oral medications were added. After this time, the Quarterly Treatment Team Reviews have virtually

identical notes that are lacking in detail but state that the offender was medication compliant, that his MSEs were all within normal limits, and that he voiced no concerns. So either the offender responded much better to the oral Haldol than the injections (it's hard to tell because no symptoms are ever listed) or he just decided to stop complaining about his symptoms altogether.

Treatment Plans

03/07/11 – **Treatment Plan**. Patient 21 is diagnosed with paranoid schizophrenia only with a GAF of 70.

Problem list: The Problem list states "no paranoid ideations, this inmate has remarkable affect, eye contact."

Objectives/Goals: Similar to nearly all the other treatment plans in the records (regardless of the inmate), the objectives and goals section lists only the following: "Increase adaptation to correctional environment, improve social skills"

Other: The treatment plan states that Patient 21 is stable without medication with a note that "he will be monitored for any decompensation. He will be involved in group activity."

Interventions and Modalities: This section is identical to the Interventions and Modalities sections in every one of the treatment plans I have encountered. There is nothing particular to the inmate. See "Ubiquitous Treatment Plan" for a verbatim recap of this section.

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08/04/11 – **Mental Health Treatment Plan.** This is a very confusing and troubling treatment plan. There is a significant disconnect between patient and staff statements (and even staff's own statements), the symptoms are missed or deliberately ignored, and the interventions are vague and nonspecific. The following italicized section is taken verbatim from the treatment plan:

Patient is: *Reporting hallucinations/delusions.*

Other: *Inmate is medication compliant, he has no AVT hallucinations. He has religiosity, he prays for people through Jesus Christ. Inmate has a decreased need for sleep. His appetite is good.*

Other: *Inmate has been non-compliant he threw his medication under another inmates door, which was given to me. I confronted him about taking the medication, he agreed to be compliant.*

Objectives/Goals: *Symptom reduction or maintenance, Develop or improve coping skills, Increase adaptation to correctional environment, Improve social skills*

Interventions and Modalities:

Physician

Monitor frequency, medication, progress toward treatment goals
Frequency: Every 30, 60, or 90 days
Person Responsible: MD

Nurse

Monitor frequency, medication, progress toward treatment goals
Frequency: PRN for med distribution
Person Responsible: RN/LPN

Mental Health/Psychological Services
Crisis Intervention, Individual therapy, Group therapy
Frequency: PRN by SCR, Weekly, Monthly
Person Responsible: Psychological Specialist

Patient Responsibilities:
Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed

END OF TREATMENT PLAN

Almost the entire plan is directly copied and pasted from some master template – even the incorrect punctuation is the same: "***Objectives/Goals:*** *Symptom reduction or maintenance, Develop or improve coping skills, Increase adaptation to correctional environment, Improve social skills"*

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11/10/11 – **Mental Health Treatment Plan**. Diagnosis remains unchanged: schizophrenia, paranoid type. No diagnosis on Axis II. GAF = 58. Once again, the only thing differentiating this treatment plan from ANY other for Patient 21 was the Problem statement, which appears to be ignored entirely in the rest of the treatment plan. The following italicized section is taken verbatim from the treatment plan. Note the same exact language (including punctuation errors) in the Objectives section and the fact that it contains nothing specific to the inmate's concerns):

Problems:
Other: *Inmate is medication Non - compliant on oral medication. He is oriented in all spheres. He has no auditory, visual or tactile hallucinations.*
Other: *Inmmate has not complied with his oral medication since his discharge. Inmate is evasive abour his powers.*

Objectives/Goals:
Objectives/Goals: *Symptom reduction or maintenance, Develop or improve coping skills, Increase adaptation to correctional environment, Improve social skills*

Interventions and Modalities:

Physician
Monitor frequency, medication, progress toward treatment goals
Frequency: Every 30, 60, or 90 days
Person Responsible: MD

Nurse
Monitor frequency, medication, progress toward treatment goals
Frequency: PRN for med distribution

Person Responsible: RN/LPN

Mental Health/Psychological Services
Crisis Intervention, Individual therapy, Group therapy
Frequency: PRN by SCR, Weekly, Monthly
Person Responsible: Psychological Specialist

Patient Responsibilities:
Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed

END OF TREATMENT PLAN

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10/01/12 – **Mental Health Treatment Plan**. Identical to all other treatment plans for this offender with the exception of the initial statements by the offender and staff:
Problems:
Patient is: *Poor hygiene.*
Other: *refuses medication...l"I don't need it"*

Everything else about the treatment plan is identical down to the improper punctuation, spacing, and capitalization errors. I will not repeat it here to save space.

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04/29/13 – **Mental Health Treatment Plan**. Treatment plan is identical to every other plan for this offender with the exception of the problem list ("*Inmate is medication compliant, he has no auditory, visual or tactile hallucination. His affect is good, responses were appropriate.")* and the statement that Patient 21 was "going to try to enroll in ABE."

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10/04/12 – **Psychiatric Evaluation Quarterly Review**. Grady Corbin and Lakeisha Prude signed the following note that is somewhat confusing and uninformative. Again, it will be presented in its entirety in italics. Note that the patient is identified as both cooperative and uncooperative and that the recommendation is "no complaints."
Psychiatric Evaluation
Reason for Evaluation: *quarterly review*
Presenting Problem: *no complaints,*

Mental Status Exam
Patient Is: *Alert, Oriented*
Patient Is: *Cooperative, Uncooperative*
Psychomotor Activity: *WNL*
Mood: *Good*
Affect: *Full*

Recommendations: *no complaints*

Electronically Signed by Grady Corbin, M.Div., LPC on 10/04/2012 at 1:35 PM
Electronically Signed by Lakeisha Prude, MHC on 10/08/2012 at 8:49 AM

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01/17/14 – **Psychiatric Note.** Evelynn Dunn.
Chief Complaint: Referred to this provider - the offender escorted to medical after a brief physical altercation with peer on the unit. He was recently released from medical a few days ago after a brief admission to medical due to recent sxs of increased psychosis - he had been admitted to medical due to psychotic agitation.

MSE: 37y/o AAM. He is uncooperative for interview - refusing to talk to provider. Exhibiting sxs of psychosis - disturbances to mood/thoughts. Increased psychotic agitation on the unit - fighting with peer - intrusive behaviors leading to altercations on the unit - placing himself/others in danger. Insight and judgement - impaired due to disturbances to mood/thoughts.

Orders
1. Give as needed Haldol 10 mg IM and Benadryl 75 mg IM NOW (Nurse Bourrage LPN notified).
2. Allow to remain in medical for the night - to allow for observation of mood/behaviors - will reassess on tomorrow - psychotic agitation - may keep regular clothing.

Electronically Signed by Evelyn Dunn, PMHNP-BC on 01/17/2014 at 6:01 PM
Electronically Signed by Leah Polanco, LPN on 01/18/2014 at 1:25 AM

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01/23/14 – **Mental Health Rounds** by Loretta Nichols. The offender was seen by this provider in conjunction with Mrs. Naylor during MH rounds with security present. The offender was seen on hu 3/c. The offender reported no urges to harm self/other, no a/v/t hallucination during this visit. The offender was cooperative and no observable sign of agitation/distress noted during this visit. The offender will continue to be monitor for psychiatric and clinical needs. Inconsistent or contradictory progress notes

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02/03/14 – **Psychiatry Note**.
Exemplary note: “pt too disorganized to participate and has ongoing, nonstop psychotic symptoms:
Chief Complaint: Remains in medical infirmary on psychiatric observation due to ongoing disturbances to mood/thoughts - thoughts loose/disorganized and mood is elevated. Flooding medical - water on floor of cell and in hallway - he however reports "cleaning my cell..." He rambles loosely throughout the interview.

MSE: 37y/o AAM. Speech disorganized. He attempts to cooperate with interview - however he is severely disorganized - disturbances and loose thoughts making participation in interview difficult - too disorganized coherently participate in interview. No reports of thoughts to harm self/others. Exhibiting sxs of active psychosis and mood disturbances. Mood hyped/elevated. Insight/judgment - impaired.

Although exhibiting severe disturbances to mood/thoughts - he has a hx of stabilizing well on long-acting Decanoate injections - Haldol Dec. - will likely stabilize - however will require ongoing monitoring in medical until exhibits sxs of stabilization.

Orders
1. Haldol 10 mg IM with Benadryl 75 mg IM bid at 0900 and 2100 X 5 days (refusing oral medications).
2. Continue to monitor in medical infirmary on psychiatric observation (ongoing need of stabilization of mood/thoughts).

++

02/17/14 – **Psychiatric Note**.
Chief Complaint: Remains in the medical infirmary on psychiatric observation - continues with loose and disorganized thoughts with sxs of mania - standing on bed at interview - rambling and disorganized conversations. Remains pressured at interviews.

MSE: 37y/o AAM. Speech pressured and loose. Pleasant/cooperative for interview - he attempts to participate in interview - however thoughts loose and disorganized to coherently participate reliably in interview. Continues with disturbances to mood/thoughts - ongoing sxs of psychosis and mood disturbances at interview. Insight/judgement - impaired due to disturbances to mood/thoughts.

Orders
1. Continue to monitor in medical on psychiatric observation.

Electronically Signed by Evelyn Dunn, PMHNP-BC on 02/17/2014 at 6:25 PM
Electronically Signed by Bobbie Hunter RN on 02/18/2014 at 5:28 AM
Electronically Signed by Bobbie Hunter RN on 02/18/2014 at 5:29 AM
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02/17/14 – **Mental Health Rounds** by Roger Davis. On 2/17/14 @ approximately 3:15 pm during mental health rounds Inmate 66786 was observed in his cell . He is awake, standing @ his cell door.No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed.IM is able to weigh the risks and consequences of his behaviors. No mental health issues.Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns. Inconsistent or contradictory progress notes – HALF AN HOUR AFTER HE WAS NOTICED WITH SIGNFIICANT SYMPTOMS OF MANIA HE IS FINE.

APPENDIX OF CHART REVIEWS

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02/21/14 – **Mental Health Rounds** by Roger Davis. "On 2/21/14 @ approximately 4:20 pm during mental health rounds Inmate 66786 was observed in his cell. He is awake, standing @ his cell door. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed.IM is able to weigh the risks and consequences of his behaviors. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns." (NOTE: Again, it is curious to see a note by a mental health provider that is not identifying any mental health symptoms so soon after an offender was floridly psychotic and unable to be interviewed – see 02/17/14 note by NP Dunn. Compounding this curiosity is the fact that six days later, nurse Dunn notes that Patient 21 ***remains*** in the infirmary *precisely because he is so psychotic – see note below).*

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02/27/14 – **Psychiatric Note**.

Chief Complaint: Remains in medical infirmary - continues with sxs of mania and psychosis - elevated mood - disorganized thoughts. Reporting at interview "let me tell you my favorite gospel song...let me sing it to you...God Has Smile On Me...." He begins singing the song at interview.

MSE: 37y/o AAM. Speech pressured and disorganized. Pleasant/cooperative - however manic - too disorganized to participate in interview. Mood - ready to go - doing fine. Affect - elevated. He continues disorganized and a poor historian at interview in regards to answering questions to interview. Thoughts loose and disorganized. Insight/judgment - impaired due to disturbances to mood/thoughts.

Orders

1. Continue to monitor in medical on psychiatric observation.

Electronically Signed by Evelyn Dunn, PMHNP-BC on 02/27/2014 at 8:54 PM
Electronically Signed by Shannon Taylor, RN on 02/28/2014 at 5:41 AM

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03/10/14 – **Psychiatric Note**. NOTE: Nurse Dunn does a good job of documenting the ongoing psychotic problems with the patient and yet the observations of the mental health counselors is that there are no problems. This is some of the most clear-cut evidence that MHCs are NOT seeing the patient.

Chief Complaint: Remains in the medical infirmary on suicide observation - was placed on suicide observation - previously on psychiatric observation - however due to ongoing psychotic agitation - assaulted staff on yesterday - dashed the mental health counselor with some liquid substances - assaulted the Captain on the pm shift. Continues with severe mania and psychosis - increased psychotic agitation and mania. All personal property removed from his cell due to ongoing episodes of agitation - presenting as a danger to self/others due to psychotic agitation.

MSE: 37 y/o AAM. Speech disorganized and incoherent. Thoughts disorganized - rambling speech - ongoing disorganized behaviors. Exhibiting severe disturbances to mood/behaviors. Insight and judgment - impaired due to mood/thought disturbances.

Orders
1. Haldol 10 mg IM and Benadryl 100 mg IM every am X 3 days
2. Continue to monitor in medical on suicide observation (exhibiting severe disturbances to mood/thoughts).

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03/21/14 – **Psychiatric Note**.
Chief Complaint: Remains in the medical infirmary - resting quietly on bed - snoring loudly. Was severely agitated on last night with smearing feces on window of cell. Now - quiet - resting in bed. No disruptive behaviors reported to this provider today by the security staff nor by the mental health staff. Will not waken at this time - in need of rest/sleep due to recent hx of severe disturbances to mood/thoughts.

MSE: 37 y/o AAM. Remains in medical infirmary on suicide observation - recent severe decompensation to mental health - severe mood/thought disturbances. Insight/judgement - poor - due to mood/thought disturbances.

Although severe disturbances to mood/thoughts - he is likely to stabilize well - hx of relapses - however hx of stabilizing well on psychotropic medications - medications will be titrated as needed - will continue to monitor in the medical infirmary - severe psychosis with severe mood disturbances.

Orders
1. Continue to monitor in the medical infirmary on suicide observation.
Electronically Signed by Evelyn Dunn, PMHNP-BC on 03/21/2014 at 9:12 PM

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04/01/14 – **Psychiatric Note**.
Chief Complaint: Remains in the medical infirmary on suicide observation due to ongoing disturbances to mood/thoughts. He continues with disorganized thoughts - disorganized and incoherent.

MSE: 37 y/o AAM. Speech pressured. Uncooperative with interviews due to disturbances to mood/thoughts. Mood/Affect - irritable/disorganized. No reports of suicidal/homicidal thoughts - however presents as a danger to self/others due to disorganized thoughts and disturbances to mood. Insight/judgment - impaired.

Will continue to monitor on suicide observation for safety precautions due to severe disturbances to mood/thoughts.

Orders
1. Continue to monitor in medical on suicide observation (for safety precautions due to disturbances to mood/thoughts).

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04/06/14 – **Mental Health Rounds** by Roger Davis. On 4/6/14 @ approximately 3:15 pm during mental health rounds Inmate 66786 was observed in his cell . He is sleep on his mat, no body movement, or response.No s/s of A/V/T hallucinations, HI/SI or any threats to harm self observed.IM is able to weigh the risks and consequences of his behaviors. No mental health issues.Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.

NOTE: MH Rounds conducted while inmates are asleep – The fact that this note does not even mention the well-documented significant problems the offender has been experiencing lately could be considered gross negligence, deliberate indifference, or simply lazy and unprofessional.)

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04/23/14 – **Psychiatric visit**.
Chief Complaint: Remains in the medical infirmary on psychiatric observation. He now has regular clothing - had been on suicide observation for weeks due to severe decompensation with severe disturbances to mood/thoughts - flooded medical constantly. Exhibited mania and sxs of psychosis. Although he continues with loose thoughts at interviews and disorganized - overall - he is progressing toward stabilizing - in medial now for several months - since Jan. 2014 - due to severe decompensation - he is likely to continue to stabilize well - presents with hx of stabilizing well on psychotropic medications.

MSE: 37 y/o AAM. Speech now less pressured - conversations/speech now more organized and coherent - although he continues to derail at interviews - he is now able to be more easily redirected than at previous interviews - previously - he would become frustrated and state "fuck you..." Fairly pleasant/cooperative for interview. Mood - "ready to get to population..." Affect - slightly elevated. Denies suicidal/homicidal thoughts at interview. Denies hallucinations, delusions, or paranoia - however he continues with somewhat odd mannerisms - suggest probably still responding to internal stimuli. Denies disturbances to sleep/appetite. Some mania present - elevated mood - easily distracted at interview today - however overall - he is progressing toward stabilization - well known to this provider. Insight - poor due to disturbances to thoughts/mood. Judgment - fair at interview.

Will continue to monitor in medical - no reports of s/e to medications. Will not D/C at this time - risks of relapse if release at this time - in need of further monitoring - severe decompensation at this admission to medical - presents with an extensive hx of decompensations requiring admissions to the medical infirmary - however hx of stabilizing well on medications.

Plan

1. Continue to monitor in medical infirmary on psychiatric observation.

Electronically Signed by Evelyn Dunn, PMHNP-BC on 04/23/2014 at 3:23 PM
Electronically Signed by Santa Jenkins, LPN on 04/23/2014 at 4:35 PM

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NOTE: In none of the treatment plans is there anything about depression or suicidality. Last treatment plan was nearly a year ago (04/29/13).

Patient 4

Current Diagnoses
Schizophrenia
Antisocial Personality Disorder

Current Medications
Haldol Decanoate 150mg IM Q28
Haldol 100mg IM Q12hr per agitation

Referral question: Is there documentation of previous suicide attempts? What is the treatment plan?

08/25/12 – **MH SOAP Note**. The only mention in the notes that I could find of suicidal ideation was from a sick call from August 25, 2012 that was responded to with a no-harm contract only. No risk-assessment was documented and no follow-up was pursued. The note is presented in its entirety as follows:

> **Subjective**: Offender was seen by MHC in medical and reported having thoughts of S/I. Offender states that he is unable to sleep. Offender stated that has been seeing someone he murdered. He states that the individual was in his cell and started beating him up. Offender states that he is tired of doing time and wants to move closer to his family. Offender was encouraged to continue to work with MH staff and letting us know when he is agitated and need to talk with someone. Offender was referred to medical for his PRN. MHC provided offender with a 'No Harm agreement' and he acknowledged the agreement with his signature. MH staff will continue to monitor offender for all psychiatric needs.
>
> **Objective**:
> Attention: Alert
> Attitude: Appropriate
> Appearance: Clean
> Behavior: Calm
> Speech: Normal
> Mood: Normal
> Affect: Appropriate

Thought: Coherent
Hallucinations: Denied
Delusions: Denied
Ideation: Denied
Insight: Fair
Judgment: Good
Sleep: Normal
Appetite: Normal
Vital Signs

Prior Problems: ANTISOCIAL PERSONALITY DISORDER (AXIS II) (DS4-301.7) --
ANTISOCIAL PERSONALITY DISORDER (AXIS II) (DS4-301.7) --
SCHIZOPHRENIA, PARANOID TYPE (AXIS I) (DS4-295.30) --

END OF NOTE

Copy and paste treatment plans are in the record for the following dates:
05/25/11, 09/13/11, 09/21/11, 08/25/12, 10/03/12, 02/13/13, 05/01/13, and 03/03/14. Not a single one of these treatment plans adequately assessed or managed potential risk.

Treatment plan details

- 05/25/11 – **Treatment plan is generic and does not address psychotic symptoms or suicidal risk.**
- 09/13/11 – **Treatment plan is generic**. Does not address psychotic symptoms or suicidal risk.
- 09/21/11 – **Treatment plan is generic**. Does not address psychotic symptoms or suicidal risk.
- 08/25/12 – **Treatment plan is generic, nothing addressing suicidality.** The description in this treatment plan is conflicting. Under "Problems" the plan identifies the patient as "paranoid, reporting hallucinations/delusions, depressed." However the statement directly following it under the heading "Other" states that Patient 4 "is medication compliant, he has no auditory, visual or tactile hallucinations." Directly following this section is another heading labeled "Other," which states in part that Patient 4 "continues to repeat delusional activity that occurred when he was in medial." There is no further elaboration on what those delusional symptoms were. The rest of the treatment plan is generic and a verbatim copy of the "Ubiquitous Treatment Plan" (see addendum).
- 10/03/12 – **Treatment plan is generic with nothing addressing suicidality.** In the brief summary at the beginning of the plan, Patient 4 was noted to have no complaints, was not in any distress, and was stable. The treatment team staff documented Patient 4's having apologized to an officer whom he had assaulted the previous month (and her having accepted his apology). There was no mention of the what prompted the assault, whether it had anything to do with mental illness, nor whether the behavior had been addressed or was being addressed. No risk assessments were mentioned.
- 02/13/13 - **Treatment plan is generic with nothing addressing suicidality.** The summary of the inmate in the plan indicated that Patient 4 was medication compliant and reported no auditory, visual, or tactile hallucinations; however, he was noted to have "excessive eye

movements" and he "complained of mild suspiciousness towards [sic] two nurses in medical." Treatment team staff noted that Patient 4 had completed the "Diagnosis Group" and was enrolled in Adult Basic Education. The rest of the treatment plan is generic and a verbatim copy of the "Ubiquitous Treatment Plan" (see addendum). There was no mention of a plan to address the suspiciousness noted by the inmate.

- 05/01/13 – **Treatment plan is generic with nothing addressing suicidality.** There is a brief description of the inmate: "Inmate is medication compliant, he named his medication;" "[Patient 4] spoke of destroying his radio when he became enraged in his cell. He has been housed in a single cell to prevent any problems or harm to self or others;" and there is an observation of some potential EPS symptoms (e.g., toe tapping lateral knee movements, mouth movements, rapid change in visual focusing). However, the rest of the treatment plan is generic and a verbatim copy of the "Ubiquitous Treatment Plan" (see addendum). There is nothing in the treatment plan to address his potential harm to self or others (besides housing him in a single-man cell), no plans to address the potential side-effects of his medications, and no assessment of his psychotic symptoms.
- 03/03/14 – **Treatment plan is generic with nothing addressing suicidality.** The summary of the inmate in the plan indicated that Patient 4 had "read about a cousin's death and it is affecting him and he is trying to maintain but feels he needs an 'as needed' to do so. Provider to refer to Unit's Nurse for further assessment/administration of 'as needed' medication. MH Staff to continue monitoring for all psychiatric needs." The rest of the treatment plan is generic and a verbatim copy of the "Ubiquitous Treatment Plan" (see addendum). Patient 4 complained of needing his PRN medications and appears to have been referred for them, but it does not look like he received his medications. There are no MARs since September 2013 so it is impossible to determine.

Problems

- Treatment plans do nothing to address suicide risk, violence potential, or any other issues related to mental health.
- No record of medication administration (since September 2013).

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Patient 22

Current Diagnoses
Schizophrenia, Undifferentiated
Borderline Personality Disorder (with a history of self-mutilation – "massive self-injurious behavior")
Antisocial Personality Disorder
History of PTSD

Current Medications
Wellbutrin 300mg AM and 150mg PM
Tegretol 200mg am and 400mg PM
Thorazine 300mg PO TID

Benadryl 25mg BID

01/24/12 – 02/06/12 – **Hospital Note**. Patient 22 was sent out to the Anderson hospital between 01/24/12 and 02/06/12. The intake note identified a clear history of significant cutting behavior since the age of 10 and the doctor noted thousands of scars on his arms from years of cutting. Patient 22 was reportedly sent to the hospital for a chief complaint of "cellulitis" but the assessment at the hospital was self-inflicted injury with infection. There was neither a discharge summary nor any indication that any follow-up was pursued.

10/01/13 – April 2014 – Patient 22 was sent to the infirmary on a number of occasions since October 2013 but there was no documentation in the record to explain why he was sent there, why he remained there, nor what the discharge plans were. Given his history of self-mutilation, it is particularly important to know if his acts or threats of self-injurious behavior were the cause of his admission to the infirmary on any or all of those occasions.

04/07/14 – **Mental Health Treatment Plan**. Problem list is a recap of the diagnoses above. His GAF is listed as 75, though the patient is identified as hostile, angry, and depressed. The offender is noted to be medication compliant with no reports of auditory, visual, or tactile hallucinations. He has some "teary moments" when he thinks of his family.

Objectives/Goals – "Develop or improve coping skills, Increase adaptation to correctional environment, Improve social skills."

Interventions and Modalities:

Physician
Monitor frequency, medication, progress toward treatment goals
Frequency: Every 30, 60, or 90 days
Person Responsible: MD

Nurse
Monitor frequency, medication, progress toward treatment goals
Frequency: PRN for med distribution
Person Responsible: RN/LPN

Mental Health/Psychological Services
Crisis Intervention, Individual therapy, Group therapy
Frequency: PRN by SCR, Weekly, Monthly
Person Responsible: Psychological Specialist

Patient Responsibilities:
Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed

Like nearly all other treatment plans I have seen, this one has no specific goals or objectives nor does it identify any means of attaining those goals or objectives other than vague, non-specific recommendations. All of his treatment plans are generic. Some state he hears voices others state

that is malingered. No mention of self-injurious behavior in any of them and no plan to address any of them.

Patient 23

Current Diagnoses
Psychotic Disorder NOS
Malingering

Current Medications
Zoloft 50mg PO QHS
Stelazine 15mg PO QHS
Compelled Meds November 2013?

In late August 2013 Patient 23 may have been assaulted fairly seriously on his unit and on September 13, 2013 it looked like he wanted to get out of his housing unit (“zone”). He claimed being suicidal and there was some indication that he may have had tactile hallucinations (“cocaine bugs”). He remained on suicide watch for months with no apparent intervention other than medications and no plan identified. The MARs did not include the second page with the legend on it so it is impossible to tell if an inmate refused meds, did not receive them, or if a particular notation indicates a nurse’s signature. Lack of follow-up, discharge, or step-down. Remaining in more restrictive settings

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MHC Tina Naylor indicated that Patient 23 had disclosed to her that he has experienced mental illness since adolescence and treatment in a number of facilities in several different states including Texas, Missouri, and Louisiana but there was no explanation of why he was sent to them. The note simply cited clear “mental health problems.”

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09/09/13 – **SOAP Note. Psychiatric Assessment Tool**. (NOTE: Finally, a SOAP note that at least follows the appropriate format.)

S: "That medicine works good. I am ok."

O: 25 year-old male, who reports improvement in his sxs and that he is doing ok at this time. Reported compliance with medication regimen. Denied any side effects from the medicines. Denied any anxiety, depressive or psychotic sxs. Denied any SI/HI. Pleasant and cooperative during interview process.

A: Psychotic D/O NOS

P: Continue current meds. RTC in 3 months.

The note indicates that everything in Patient 23's mental status was within normal limits. Absolutely nothing was noted to be unusual.

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11/27/13 (1) – Enigmatic note about IM Injury:

Inmate Injury Reporting Form
Date of Injury: November 27, 2013
Time of Injury: 1014
Inmate account of occurrence: DID DOT SWALLOW ANY PILLS.
Witnesses: TRANSPORT OFFICER O'BANNER AND A FEMAL OFFICER THAT REFUSED TO GIVE THER NAME
Part of body affected: UNKNOWN
Treatment Rendered: OBSERVATION AS INMATE DENIED TAKING PILLS
Other: FEMALE TRASPORT OFFICER CAME TO MEDICAL AND STATED THAT THE INMATE WAS SUCIDAL AND HAD TAKEN SOME PILLS PRIOR TO HIM BEING TRANSPORTED TO THIS FACILITY. WHENN ASKED WHY THEY DID NOT REFER HIM TO A MEDICAL FACILITY SHE SAID WELL HE WAS CLEARED IN MEDICAL PRIOR TO TRANSPORT. INMATE APPEARS ALERT WITH FLLT AFFECT AND CONT TO BE SUICIDAL WILL BE REFERRED TO MENTAL HEALTH FOR EVAL.
Vital Signs
Height: 67
Pulse rate: 59
Pulse rhythm: irregular
Respirations: 20
Blood Pressure: 136 / 74 mm Hg

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11/27/13 (2) – **Nursing Note**. This note is from earlier in the day but different area on November 27, 2013 by Dunn. It is presented verbatim:

Chief Complaint: Transferred to EMCF today from SMCI as a new intake. Chart hx of Psychotic DO as well as hx of malingering. Current meds - Tegretol, Haldol, and Prozac. Reports he has been on suicide observation for 2 months. Reports and describes reasons for being on suicide observation "cutting on self....feeling bad..." He continues to report feeling suicidal. He reports "want to hang myself....just feeling bad....feeling bad due to thinking about what happened to me as a child..." He reports sexual abuse and physical abuse as a child - however reports he does not want to talk about it. Reports "don't want to live....hate my life...." Reports reasons for not having carried out his wishes of committing suicide - he reports these reasons "trying to get my soul right....get my guts up to do it...boost myself up....trying to see if I can fix it...it can't be fixed....scared of what it would be like..."

Past Psych HX: Reports an extensive hx of inpatient and outpatient mental health TX - reports started as a teenager - reports "my mom put me in the nut house..." Reports "was hearing voices....seeing stuff...using drugs..." Reports hx of mental health TX at Whitfield and at facilities in the state of LA and TX. Reports hx of suicidal attempts - overdosed on drugs and cutting on self. Reports family hx of mental health problems - his sister - describes his sister as "she is just like me..." Reports family hx of suicidal attempts as "my sister cuts on herself...."

MSE: Patient 23 is a 25y/o Caucasian Male. Disheveled - he is unshaven - full beard - reports he does not want to shave. Speech circumstantial. Mood - want to hang myself - I hate my life - don't want to live. Affect - flat/depressed/withdrawn/anxious. Reports suicidal - "want to hang self...don't want to live...trying to get my guts up to do it...." He repeats during the interview "I hate my life..." Denies homicidal thoughts. Thoughts loose and disorganized. He denies hallucinations, paranoia, or delusions. However reports and describes his thoughts as "hear my own thoughts....just just get intensified...like turning up the volume..." Although he denies hearing command hallucinations and insists on "just his own thoughts" - he appears internally preoccupied. He adamantly denies hearing voices and seeing things and insists "just my own thoughts..." Reports sleep - messed up. Denies disturbances to appetite. Reports mood disturbances - depression - reports depressed because of a whole bunch of stuff. Denies anger. He is adamantly that his thoughts of dying and not wanting to live are because of him thinking about his past life - he describes "all the stuff that has happened to me as a child..." He does report being sexual abused and physical abused as a child - however repeatedly states "don't want to talk about it..." Insight/judgement - impaired - exhibiting disturbances to thoughts/mood. Exhibiting sxs of psychosis and depression.

Discussed medications. He reports taking meds - however reported earlier - "medications can not help him.." Will give IM Haldol to target sxs and to promote stabilization. Due to reporting "wanting to die...." - will give long-acting Haldol Decanoate injections to assist with stabilization of the offender. Will utilize IM Haldol to ensure compliance as he is verbalizing "wanting to die...tired of my life....trying to boost myself up to do it...." Will utilize the psychopharmacological approach to assisting in the promotion of the offender's safety - as his judgement/insight is impaired - he is unable to weigh the risks and consequences of his actions/behaviors/thoughts at time of interview - has been on suicide observation for 2 months. NOTE: The order is being written for IM Haldol for compliance purposes but no mention of either patient consent or involuntary medication proceedings.

Orders
1. D/C by mouth Haldol.
2. D/C Tegretol.

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11/28/13 – **Interdisciplinary Progress Note**. From the infirmary comes this note that is rather telling about his opinion of Haldol Decanoate (11/28/13):

> Other: The offender was seen by this provider for Medical Mental Health Rounds. The offender was standing at his cell door. The offender questioned when will he get his medication. He was advised that it has been ordered and it may take a couple of days. He then reports, "If they give me a shot...I will hurt myself really bad...Will break me hand...Beat it against the wall...Punch the wall...Bang my head....Im not SI....Just got Security issues....The SCR is gone beat my ass bad....They gone kill me...Im ready to come off this shit...Ready to go to lockdown...I will run yall hospital bill up if yall try to sneak that shot shit in on me...." The offender is advised that his shot has been d/c and he has orders for Tegretol. The offender nods his head for understanding. The offender denied all A/V/T Hallucination and SI/HI at the present time. The offender is housed in Medical for SIB and SI thoughts as he is a new intake back into the facility. The offender did not appear to be in any distress. The offender will continue to be monitored for psychiatric and clinical needs.

NOTE: The offender is clearly voicing his opposition to taking the medication. Informed consent is not present in this case and there is no evidence of involuntary medication procedures having been followed. If he was compelled to take the medications it is a clear constitutional violation as they were not being administered on an emergent basis.

Concerns with Patient 23

- Involuntary medication violation – There is a mention of "compelled medications" in November 2013 but no documentation. Possible abuse of involuntary medication procedures. The notes clearly state the provider's intention to deliver injections due to the offender's statements about wanting to die but it is equally clear that the inmate does not want to take the shots so if they ended up being forced on him (other than 72-hour emergent medications) that is a constitutional violation.
- Negligent custody staff – On 11/27/13 Patient 23 was reported to have swallowed several pills in a suicide attempt. One of the female officers reporting the incident refused to give her name.
- Lack of informed consent – There is no documentation in the charts that Patient 23 consented to treatment

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Patient 24

Current Diagnoses
Schizophrenia
History of OCD.

Medications
Haldol Decanoate 150mg IM Q28D
Benztropine 1mg PO BID
Hydrochlorothiazide

09/27/13 – Patient 24 was seen by Nurse Practitioner Dunn. He complained that the medications were "not helping…still feel like I am missing something." Nurse Dunn noted that several months earlier he had violently assaulted two peers on two separate occasions, each of which had required hospital visits. At that time, he had not been compliant with oral medications and his level of agitation had been much higher. Since that time, he was placed on long-acting Haldol shots and was moving toward stabilization.

Nurse Dunn documented a normal mental status with the exception of restricted affect and some residual psychotic symptoms (mildly internally preoccupied and somewhat distracted). The picture that is emerging is of a psychotic patient who does not take medications reliably and has a history of decompensating in both mental status and behavioral acting out. This may have been grounds for involuntary medications and it certainly sounds like that is what happened. However, there is no documentation of an involuntary medication hearing or any sort of due process to forcibly compel medications.

Nurse Dunn wrote orders for Haldol Decanoate and Cogentin for 180 days and she requested labs for the offender including a Haldol level. Follow-up was supposed to happen in 3 months or sooner. It was unclear whether this actually happened.

10/15/13 – **Mental Health Treatment Plan**. The offender is subjectively described as tangential and verbally expansive with poor recall. The inmate stated that he had not been taking his medication but was unable to remember how many doses he had missed. Other than these statements, the treatment plan is identical to all the others with no specific plans nor recommendations made despite the presence of some thought disorder and the offender's own admission that he had not been medication compliant. At the very least, the treatment plan should take into account the presence of thought disorder and medications compliance/efficacy issues.

09/01/13 – 04/15/14 – **Mental Health Rounds**. MHC notes for MH Rounds for this seven-month period all say basically the same thing: that the offender is not having any problems and that all aspects of his mental status are within normal limits. At each of the treatment teams during this time period, there is a brief mention of some rapid or pressured speech, but there is nothing in the plan indicating that the issue is being addressed.

> Notable Behavioral Issues: According to the notes, Patient 24 seriously assaulted two other offenders in the recent past (each of them required a trip to the ER). Possibly more concerning than those assaults was an incident even more recently in which Patient 24 "picked up an officer" on the way to visitation because he "wanted something to do." It was not clear whether he received an infraction for these actions and his notes did not indicate any further attempts to determine what led up to the events or what role mental health may have played in them.

02/04/14 – **Mental Health Treatment Plan**. The plan mentions expansive rapid speech, mildly manic but everything else is copy and paste.

Problems – The "Problem" area notes that the inmate "continues to be obsessed with female staff" but there is no explanation of what this means, no mention of any type of risk assessment, nor any indication that this issue is being addressed through mental health, custody, nor any other modality. Under "New Problems" the treatment plan lists "history of obsessive-compulsive disorder" but does not elaborate on what that means, how the symptoms are manifest, or how they impact functioning. Potential danger to staff depending on the nature of the offender's "obsession with female staff."

Objective/Goals – The objectives and goals mention only "Symptom reduction or maintenance, develop or improve coping skills, anger control, increase adaptation to correctional environment, improve social skills." The treatment plan does not state in any way, shape, or form how that will be accomplished other than to establish uselessly vague guidelines for different treatment professionals:

- Physician – the treatment plan calls for the physician to "monitor frequency, medication, and progress toward treatment goals." This is to be done "every 30, 60, or 90 days. "
- Nurse – the same exact goals are listed for the nurse: "monitor frequency, medication, and progress toward treatment goals," though the frequency is different ("PRN for med distribution").
- Mental Health/Psychological Services – the role of the mental health professional is to provide "Crisis Intervention, Individual therapy, Group therapy" on either a weekly or monthly basis or as needed according to sick-call request.
- Patient – the patient's active role in treatment is simply to "take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed."

03/05/14 – Brief meeting with ARNP Dunn, who noted that Patient 24 was tolerating his Haldol and Cogentin well with no side effects. He stated that he was doing well; his thought processes were coherent and organized; and he denied psychotic symptoms (hallucinations delusions, paranoia), suicidal thoughts, or aggressive ideation. He also denied symptoms of depression or mania and his judgment and insight appeared intact. Medications were discussed and Patient 24 consented (presumably verbally) to Haldol Decanoate and Cogentin. The order for the medications was written for 180 days.

Medication chronology for the past year:

- April and May 2013
  - HCTZ 25 QD
  - Benztropine 1mg BID
  - Haldol Lactate 5mg/ML inject 10 Q6 hrs with Benadryl as needed for agitation
  - Haldol Dec 100mg IM Q28
  - Benadryl 50mg IM Q6 w/Haldol Lactate Injection
- June 2013 – could not read
- July 2013 – NO MAR
- August 2013 – could not read and blank
- September 2013 – NO MAR
- October 2013 (same as April and May 2013 but without the Haldol Lactate for agitation)
  - HCTZ 25 QD
  - Benztropine 1mg BID

  - Haldol Dec 100mg IM Q28
  - Benadryl 50mg
- November 2013 to present – No MARs

Issues with Patient 24

- Inadequate documentation – lack of full documentation for a diagnosis of schizophrenia; no documentation at all for the diagnosis of OCD.
- Inadequate assessment –
- Treatment lacking – The treatment plans for Patient 24 are almost all identical. Though some have language describing mental health symptoms (rapid speech, mildly manic), none have any target goals or interventions that are specific to the offender.
- Absence of documentation for involuntary medication procedures
- Lack of safeguards for staff and other offenders given the inmate's noted "obsession with female staff" and his history of assaulting other offenders and staff.

Patient 5

Current Diagnoses
Schizophrenia, paranoid type
History of OCD

Current Medications
Trilafon 4mg PO QHS

03/21/11 – **Mental Health Treatment Plan**. The Problem statement of this treatment plan actually lists some mental health symptoms that are supportive of the diagnosis: "Patient is reporting hallucinations/delusions….He continues to be paranoid, he feel that everyone is watching him." The narrative went on to note that the offender "was able to reality-test the vent: He no longer feels that someone is watching him through the vent." The behavioral observation of the offender noted that Patient 5 "has a continual smile on his semi -flat face. He voiced that his charge was accidental and not premeditated. Inmate has active auditory hallucinations 'whispering voice to kill people.' He has a fixed delusion of being telepathic. On yesterday he communicated with his girl friend." However, nothing in the treatment plan beyond this point identified any means of addressing these issues that were specific to the inmate.

6/13/11 - Patient is: Paranoid, reporting hallucinations/delusions.
Other: Inmate is medication compliant, he continue to have whispering sounds which occurred 2 days ago; the sound is a male sound
Other: Inmate sees people talking on the pod phone and he think they are talking about him. He has real trust issues. He does not have any fixed delusions of telepathic power. He will not convey what he believes would verify the delusion or nullify the delusion. He has weird dreams. Take medication as ordered, Keep appointments as scheduled, Complete Sick Call Requests if needed

9/26/11 - Patient is: Paranoid, withdrawn, reporting hallucinations/delusions.

Other: Inmate is medication compliant; he has some auditory voices telling him to kill people. The frequency is daily, visual or tactile hallucinations.

Other: Inmate is paranoid, thinks he is being watched. If inmates talk in the pod on the phone he think they're talking about him. He is able to talk telepathically to his girl-friend. No mention of plans or treatment modality other than to take medication as ordered, keep appointments as scheduled and complete sick call requests if needed.

3/19/12 – No problems noted in the problem area. The only thing in recommendations is for the patient to "consult with psychiatrist re: hallucinations, some paranoia during next med visit."

9/24/12 - Patient is: Anxious, reporting hallucinations/delusions, poor hygiene.
Other: mild aud. Hallucinations. There was a little bit of a plan on this one: "Contact office or medical if hallucinations or paranoia worsens/ monitor, Problems with executive functioning and evidence of delusions as indicated by difficulties with memory, concentration, problem-solving, mental flexibility and unable to verbalize complaints in reasonable manner."

1/14/13 – Patient 5 was described as medication compliant with no auditory, visual, or tactile hallucinations. He stated that his medication makes him feel better and there was no mention of the telepathy.

6/3/13 – Other: Inmate is medication compliant, he has no auditory, visual or tactile hallucinations. Inmate does not report any mood disturbances
Other: Inmate believes that he can communicate with his girl-friend through his minds thought waves.

9/30/13 - Other: Inmate is medication compliant; He continues to have intrusive voices two times a week. He noticed that the voices will return when he wasn't given medication for 4 days. He feels that everyone is watching him and talking about him. He does not wish to be placed on any medication that would interfere with his telepathy with his girlfriend who lives in California.

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Group Treatment: Patient 5 has a total of four group notes in his record, indicating either that (a) documentation of the groups is woefully inadequate or (b) groups are either rarely being offered and or are wildly inconsistent and unreliable schedule:

03/29/11 – Cognitive skills – building better relationships
10/03/12 – Self Management (this is the first group)
02/06/13 – Becoming a Healthier person (first class)
03/05/13 – Offender has completed part 1 of Becoming A Healthier Person

There is no explanation of whether the Healthier Person group was more than two groups or if the statement about Patient 5 having "completed Part 1" meant the whole group or just that one session. There were no other notes in the record.

02/17/14 – seen for MH Rounds by Tina Naylor. Everything was noted to be within normal limits. The offender reportedly voiced no complaints nor were there observed any signs or symptoms of mental illness. The note appeared to have been a copy-and-paste with nothing specifically relating to the offender.

02/17/14 – **Sick Call Request**. Reason: "I would like for you to PLEASE see if you can get my medicine PERPHENIZINE started again." Under recommendations, MHC Naylor wrote "the offender reports not receiving his medication. According to the EMR the offender's medication orders expired. The offender voiced no mental health concerns. The offender denied all A/V/T Hallucinations and SI/HI at this time. The offender is able to weigh the risk/consequences of his actions, behaviors, decisions, and thoughts at this time. The offender will continue to be monitored for psychiatric and clinical needs. Refer to Psychiatrist/NP for further assessment."

02/18/14 – Patient 5 reported the following to Nurse Dunn: "the whispers have increased - the panic attacks have returned" - reports the sxs increased a week ago - no medications in a week. Reports he likes the Trilafon better than the Clozaril - reports the Trilafon does not make him sleepy/drowsy like the Clozaril - on Clozaril for 3 years or so - was effective in decreasing his psychosis - with the Clozaril - his affect returned - full range of affect. He reports however - wants to remain on the Trilafon. The Clozaril was D/C'd due to abnormal labs increased his paranoia - he reports somebody told him that he did not have any WBC - reports "they never should have told me - especially me because I am already paranoid."

03/13/14 – Patient 5 went to sick call to complain about jaw clenching due to Perphenazine: "I would like to see you as soon as possible about my medication, because ever since re-starting my Perphenazine, (I was out of it for about 10 days), have found myself clenching my jaws and grinding my teeth." He was seen by Tina Naylor, who is not a nurse or provider, and was charged $6.00 for a patient-initiated co-pay. This should be part of normal follow up and not charged.

Patient 25

Current Diagnoses
Bipolar Disorder Not Otherwise Specified
Intermittent Explosive Disorder
History of Antisocial Personality Disorder

Medications
Risperdal 2mg PO QHS
Artane 5mg PO BID

> **NOTE**: During the time span of the review, Patient 25 was taking Risperdal BID and Depakote BID.

Referral Question: Does the inmate receive medications consistently or are there interruptions?

Patient 25 has a history of not receiving his medications reliably. It is impossible to tell from the MARS just how many he has missed because in addition to boxes not being filled in at all, the legend on the back of the MARs was not available so it is not possible to differentiate signatures from refusals. However, what is known is this:

Risperdal
April 2013 – missed at least 8 morning doses and at least 7 evening doses
May 2013 – missed at least 9 morning doses and at least 12 evening doses
June 2013 - missed 0 morning doses and at least 4 evening doses
July 2013 – missed at least 5 morning doses and at least 6 doses
August 2013 – MARS unreadable
September 2013 – missed at least 9 morning doses and at least 3 evening doses
October 2013 – missed at least 5 morning doses and at least 3 evening doses

Depakote
April 2013 – missed at least 9 morning doses and at least 6 evening doses
May 2013 – missed at least 11 morning doses and at least 11 evening doses
June 2013 – missed 0 morning doses and at least 3 evening doses
July 2013 – missed at least 8 morning doses and at least 3 evening doses
August 2013 – MARS unreadable
September 2013 – missed at least 9 morning doses and at least 3 evening doses
October 2013 – missed at least 3 morning doses and at least 2 evening doses

MARS are unavailable after October 2013 so it is impossible to tell what the administration was like. In summary, Patient 25 did not receive Risperdal about 16.4% of the time and he did not receive his Depakote 18.6% of the time (see table).

Month	Risperdal missed (%)	Depakote missed (%)
April 2013	25	25
May 2013	33.8	35.5
June 2013	6.7	5
July 2013	17.7	17.7
August 2013	Unknown	Unknown
September 2013	20	20
October 2013	12.9	8.1
Overall	16.4	18.6

Patient 6

Current Diagnosis
Bipolar Disorder
Depressive Disorder NOS
Impulse Control Disorder

APPENDIX OF CHART REVIEWS

Alcohol Dependence

Current Medications
Tegretol 400mg PO BID
Remeron 30mg PO QHD
Buspar 15mg PO BID

Referral Questions: Is he described as or being treated for suicidality? Is Patient 6 on a step-down program from 5D?

- **Suicidality**: Regarding an assessment of suicidality, there were five transfer screenings in the record, but all were negative for mental health issues or suicidality (including history of suicidality)

- **Step-Down Program plans**: None of the quarterly treatment reviews mention anything about a step-down to GP. There is mention in one of them about his IBMP having been updated, but the IBMP itself could not be located anywhere in the available records. Patient 6 had stated at one point that he wanted to move to D pod to take part in their programs but again no evidence could be found in the records about any type of follow-up from that request. There was also nothing in any of the treatment plans specifically addressing the step-down program. The only thing I could find was in a treatment plan from May 2013 that stated that Patient 6 "is reluctant to being in population, he alleges that he is asocial. He has an ongoing case and some of the guys are in this facility." There was nothing more mentioned about his transition or step-down issues. A subsequent treatment plan (08/13/13) also mentioned the tentative discharge date of 06/15/15 but there is not ever any mention anywhere about how this is going to be accomplished. There is no step-down process in place.

- **Mental Health and Medication Concerns**: Diagnoses in the treatment plan have been Impulse Control Disorder; Major Depressive Disorder Not Otherwise Specified, and Alcohol Dependence. The most recent treatment plan (March 25, 2014) added a diagnosis of bipolar disorder (he had actually come in a while ago with the diagnosis) but the plan does not identify any symptoms of the disorder. The MARS for June, July, August, and October 2013 all reflect active prescriptions for Zoloft, Tegretol, and Depakote but there is no diagnosis listed for any of them.

Other Issues

- **Excessive co-pays**: Patient 6 complained of being charged for chronic care treatment and he was charged exorbitant co-pays for submitting legitimate kites:
  - 01/03/14 – Patient 6 submitted the following kite: "The medication that I am taking will not let me sleep and some of it is making me sick." He was charged a $6.00 co-pay for this kite.
  - 03/01/14 – Patient 6 was charged $6.00 for a sick call co-pay because he was requesting a review of his medications. His kite read: "Could I talk to medical about my meds? The Burce Bar [sic] you're giving me is not letting me sleep. Thank you."

[Date Not Recorded: At one point he signed a refusal form that stated that "I have been made aware of any and all consequences to my health that may occur up to and including death as a result of this refusal."]

- **Inconsistent Documentation**: As with much of the mental health documentation, the observations of staff about an inmate's mental status vary wildly in just a short period of time, which gives the impression that staff are not seeing the inmate and are fabricating documentation.
    - 04/18/14 – NP Dunn reported that Patient 6 stated that he was very depressed because of recent deaths in the family, not eating or sleeping well, and "snapping" on people more than usual.
    - 04/18/14 – two hours later during **MH Rounds,** Roger Davis stated that the inmate had no complaints and did not display any signs or symptoms of mental illness.

Patient 26

Current Diagnoses
Rule-out psychotic disorder NOS
History of bipolar disorder
Polysubstance dependence

Current Medications
Haldol 100mg PO Q28days
Artane 2mg PO BID

Referral Question: During the last expert tours, he had told them that he hasn't had a treatment team or been seen by the psychiatrist since being transferred in November 2013. As of that visit, he was on monthly injections of Depakote and Haldol.

Actually, at the time he was on Risperdal 3mg PO prn that was prescribed beginning September 30, 2013 through April 29, 2014 but it was discontinued on November 5, 2013. He had also been prescribed Zoloft 100mg PO prn between October 14, 2013 and May 13, 2014. Discontinued on November 5, 2013. He was on Depakote but that was discontinued on April 22, 2014.

His claims of not having been seen by a psychiatrist are in error. According to the medical records he was seen by Dr. Gurdial Sandhu, MD on the following dates: 10/11/13, 10/14/13, 10/16/13, 10/18/13, and 10/26/13. He was seen by ARNP Dunn on 12/09/13, 12/13/13, 12/26/13, 12/29/13, and 12/30/13. Next time he was seen was on 04/21/14 and he had both a quarterly treatment meeting and a treatment plan on 04/22/14.

Patient 8

Current Diagnoses
Schizophrenia, Undifferentiated

Current Medications
Depakote 1000mg PO BID
Haldol Decanoate 150mg PO Q28D

Patient 8 has a clear history of manic and psychotic behaviors. He has delusions involving "pythons and a 72-year-old man living inside (him);" he claims he can hear his ancestors talking and he has been observed talking to himself. He "believes he is a 'mud cat and a combination of other things'." Throughout the records, there is an abundance of clear and convincing evidence both by self-report and objective observations that Patient 8 is actively psychotic. Unfortunately, there is equally clear and convincing evidence that mental health providers by and large do nothing more than document the manifestation of symptoms. Other than medications, no interventions or management strategies seem to be employed or attempted and follow-up was almost non-existent. What follows are highlights from 16 months of records for Patient 8:

01/29/13 – **Psychiatry Note**. Patient 8 was reportedly observed with pressured speech and loose associations and was hyperactive and manic. Medications reportedly had a positive effect on calming him down. The plan called for "frequent monitoring during rounds due to a history of relapse and mental decompensation."

01/29/13 – **MH Note** – Jacquelynne Lockett conducted rounds and noted that Patient 8 "reported no mental health concerns." She wrote that the plan was to continue to monitor Patient 8. It is important to note that there was no description of his state of mind even though less than an hour earlier he was observed by the nurse practitioner to be exhibiting "pressured speech and loose associations and was hyperactive and manic." NOTE: It appears that MHC Lockett did not actually see or interact with the offender in any way.

02/04/13 – **Mental Health Note**. Patient 8 was noted to be "calm and alert; in no distress."

02/14/13 – Less than two weeks later, Sergeant Hardy requested that Patient 8 be seen by mental health due to his exhibiting "bizarre behaviors." Patient 8 was noted to be exhibiting delusional beliefs including that both a python and a "72-year-old man" were living inside of him. He stated that "the things inside him were 'good people. They help me.'" A review of the MARs revealed that his next Haldol shot was due a week later (02/21/13), at which time he was noted to have continued to be delusional but not aggressive. He stated he did not want to remain in medical so he was returned to the unit. No follow-up was noted.

02/15/13 – **MH Rounds**. J. Lockett conducted rounds and stated that Patient 8's mental status was within normal limits. No concerns were noted and there was no indication of any psychotic or delusional processes. It seems readily apparent from this note that MHC Lockett did not see nor interact with Patient 8 at all unless his delusional and psychotic behavior resolved completely within 24 hours. Even if (or particularly because) Patient 8's mental status (according to MHC

Lockett) was completely within normal limits, it is a notable lack of continuity of care to not have mentioned the severely decompensated mental status that had been observed just the day before.

03/06/13 – Patient 8 reportedly requested an increase in medications. There was nothing in the records prior to this entry to indicate that there was any problem. Patient 8 had submitted a kite, but it was unreadable due to a computer error. MHC Linda Browne saw Patient 8 a couple of hours after the kite was submitted and he reported to her that he wanted an increase in the Celexa because he did not feel it was working. He was given a sick call form that he completed and he was told he would be scheduled to see the psychiatrist at the next available appointment.

03/09/13 – Patient 8 was seen by Clara Thomas and he requested a Haldol shot. No SI/HI. He was given the shot the next day by the nurse.

03/18/13 **Quarterly Treatment Team Review.** MHC Lakeisha Prude actually filled out some of the information here. She reported that his mental health issues were that he states that he "hears his ancestors daily and believes he is a mud cat. Can be seen talking to self."

Three minutes later there is an encounter from Marshall Powe for a MH treatment plan. Under Problems it notes: "Inmate is medication compliant, and has no auditory visual or tactile hallucinations. He reports hearing his mother's voice daily. Inmate has eccentric behavior, he describes himself as a "silver back gorilla." [NOTE: I would argue that hearing his mother's voice on a daily basis might constitute an auditory hallucination and it would be my expectation that a mental health professional would follow up more on the statement the offender makes about being a Silverback Gorilla. Also, it is concerning to me that apparently no communication was made between mental health professionals given that only shortly before this entry was made, he stated that he hears his ancestors daily and was making other bizarre statements such as believing he is a "mud cat," whatever that might be. No assessment is done regarding the nature of the symptoms or their impact on his functioning nor is there any indication of what the treatment might consist of other than medications. Patient 8 might as well have simply described his favorite color for all the therapeutic intervention his statements prompted.]

03/19/13 – **MH Rounds** by Linda Browne. No problems noted.

03/30/13 – **MH Rounds**. No problems noted.

04/01/13 – **MH Rounds** – same as above.

04/02/13 – **Nursing Note**. Patient 8 came to medical for an "as needed" injection of Haldol. NOTE: Given that the rounds for the previous several weeks noted not problems, it is again curious that he was in need of a prn injection of Haldol. No description or explanation is given.

04/09/13 – **MH Rounds**. No problems noted.

04/22/13 – **MH Rounds**. No problems noted by MHC L. Brown.

04/24/13 – **MH Rounds**. Patient 8 was seen for rounds. He was noted to be "upset and has been crying all night." He reported experiencing some auditory and visual hallucinations (auditory for at least two or three days), thinking about his past and how he had hurt his family and he was requesting to go to medical for a few days. NOTE: If these reports are true, then it is pretty obvious that L. Brown did not see or speak to Patient 8 when she did her rounds two days earlier (see MH Rounds above).

04/24/13 – **Psychiatry Note**. Patient 8 was seen by Dr. Dunn on the unit due to reports that he was given IM Haldol and Benadryl due to symptoms of psychosis, including responding to internal stimuli. His cellie had reportedly been complaining about Patient 8 being up all night. Patient 8 was reportedly stressed about being on lockdown status [statewide, not EMCF-specific] and not able to get out of his cell. He was pleasant and cooperative with the nurse and denied hallucinations or suicidal/homicidal ideation during that interview. His thought processes were noted to be organized and he stated that the medications were effective in reducing the intensity of the voices. Nurse Dunn noted that lockdown situations like the one in effect at the time at EMCF can have a particularly adverse effect on offenders like Patient 8 and she explained that she increased the Haldol Decanoate to help him stabilization during that time.

04/24/13 – **Medical Note**: Patient 8 was given another Haldol shot.

No other notes in the record for the next week.

05/03/13– **MH Rounds** with Linda Brown. No problems noted.

05/05/13 – **Medical Note**. Patient 8 was given another shot by the nurse. Later in the day, he saw Dr. Anderson and told him he was having some residual depression and agreed to an increase in the Celexa. NOTE: Again, while it's possible that Patient 8 presented with no complaints only two days before requiring/asking for this current shot, it is an unlikely scenario. The overall picture that has emerged is one of a severely mentally ill patient with only marginally controlled symptoms that are being missed by mental health providers because they are not checking on him (but subsequently creating documentation implying that they did).

05/20/13 – **MH Rounds** with Linda Brown. No problems noted.

05/29/13 – **MH Rounds**. MHC Marina Moss noted that the inmate was presenting as loud on the unit with disorganized thoughts. Other offenders were complaining that he was "barking like a dog." Patient 8 admitted to this bizarre behavior and explained that he does it because of "confusion about his age . . . Lost numbers of how old I am . . . dog big red was killed." He was referred to the MHD for further evaluation. It does not appear that he was seen on an urgent or emergent basis following this recommendation.

06/01/13 – **MH Note**. Patient 8 was seen by MHC Tina Naylor for an office visit – he had been brought up because he had taken another offender's meds to get high. He admitted having taken the medications, which may have explained his behavior three days earlier (see above). Curiously, the MSE was completely within normal limits. NOTE: Even if this is true, it is simply

negligent care not to be commenting on or taking into consideration the very bizarre behaviors the inmate was engaging in only days before.

06/06/13 – **Hospital Visit**. Patient 8 was sent to St. Dominic Hospital. There is an attachment in the EMR, but it is unreadable in the current system. Perhaps staff could retrieve the hard copy. It would be very interesting to see what the hospital discovered.

06/06/13 – **Medical Note**. Patient 8 had returned from the hospital and was seen by Nurse Dunn at the request of the Sergeant who had stated that the inmate was not eating and was selling his food trays (for medication). Nurse Dunn stated that the offender looked much thinner than he had several weeks earlier when she had last seen him. He was cagy about why he was selling food, but it appeared the reason was to get medications to get high. The MSE was notable for tangential thoughts and loose associations as well as some hypomanic symptoms and disturbed concentration. His Celexa was discontinued because it was believed to be contributing to his psychotic symptoms, though the note was unclear about whether that was because of side effects or because he was abusing the medication (e.g., crushing and snorting it). The note added that Patient 8 could be restarted on an antidepressant once he was stabilized.

06/07/13 – **MH Rounds**. MHC Kirby Pough made the following entry: "The offender did not report any mental health problems including but not limited to; SI/HI and/or A/V/T hallucinations. The offender did not appear to be in any distress at this time and will remain under observation for any psychiatric and/or medical needs." NOTE: Another example of rounds being done when the offender might well have been asleep.

06/07/13 – **MH Rounds** by Marina Moss. No problems noted.

06/08/13 – **MH Rounds** by Linda Brown. No problems noted.

06/09/13 – **MH Rounds** by Kirby Pough. No problems noted other than throwing up a little. Patient 8 saw Dr. Otis Anderson later on and still complained of stomach distress. Dr. Anderson also noted "some racing thoughts and pressured speech." NOTE: The racing thoughts and pressured speech were either a recent development (unlikely) or were missed by MHC Pough (likely given that MHC Pough probably had very little interaction with the offender during his rounds).

06/10/13 –**MH Rounds** by Marina Moss. The note stated that Patient 8 "was asleep and did not appear to be in any type of acute distress."

The notes continue with 2 to 3 observations per day with the same idiosyncratic observations with the following exceptions/additions:

06/17/13 – Offender complained of severe abdominal pains when lying down.

06/20/13 – "The offender was seen for Mental Health Rounds. The offender appeared to be asleep. The offender will continue to be monitored for psychiatric and clinical needs." This entry

was by Jacquelyn Lockett, MHC. NOTE: There are numerous examples of MH staff conducting rounds at midnight, one or two in the morning, or even three or four in the morning.

06/30/13 – Howard Thomas conducted rounds at 2:57am and noted "Provider observed offender asleep with no signs of distress. MH Staff to continue monitoring for all psychiatric needs."

NOTE: The bottom line is that there is no mental health treatment being provided other than medications and the only thing the MHCs do is look in the cell and even that simple act cannot be said to occur reliably. If the offender is actually interviewed at 2:30am, that is problematic. Is he sleeping during the day? It is difficult to imagine how that is even possible with all of the noise on the unit, though I suppose sedating medications could have that effect.

07/09/13 – **Lab Report**. Labs indicated that Valproic Acid level was at <4 ug/mL (range 50-100). There are MARs for June and August 2013 but not for July. The Depakote was being given BID reliably according to the June MARS (ending on June 30). A medical expert from Washington state looked at the EMR for the lab report and could not find any indication that they had been reviewed. The nursing note from later that evening indicated that Patient 8 had taken all of his medications except his Depakote.

07/06/13 – Carl Faulks had noted that the inmate had chronic weight loss that indicated some possible underlying problem.

07/13/13 – Patient 8 complained to Otis Anderson that he had not been taking the Depakote 500mg because of the size of the tablet. He said that his stomach issues were affecting his ability to take it. As a result, Dr. Anderson rewrote the orders for 250mg tablets (2PO BID).

08/07/13 – HT Rounds. Patient 8 was agitated and loud. He was angry at his cellie because his cellie states he is "talking all that Satan stuff" all night. Nothing more in the notes to elaborate on this.

Over the next month, there is nothing in any of the MH notes other than the standard cookie-cutter MSEs stating that Patient 8's mental status was always within normal limits.

09/12/13 –**Quarterly Treatment Team Review**. MHC Lakeisha Prude stated that the offender reports auditory hallucinations (derogatory voices that say they hate him). He was also noted to be somewhat paranoid about "being around all the killers." No mood problems noted.

> Two minutes after the note by Lakeisha Prude is entered, LCSW Marshall Powe writes the following entry under the Mental Health Treatment Plan section: "Inmate is medication compliant, he reports no auditory voices in the past 3-4 days." That verbatim statement is enigmatically followed by this: "He reports the voices be screaming in his mind."

Notes for the next three and a half months are again of the copy-and-paste-nothing-to-see-here variety.

12/29/13 – **MH Pod Visit** by Randy Townsend. "The offender did not report SI/HI or A/V/T hallucinations. The offender did not appear to be in any distress." He then goes on to state this

interesting non-sequitur: "Offender reported 'I do not want to take any more shots unless black people are around me.' MHC will continue to monitor offender for psychiatric needs." The statement seemed a little odd and I would have loved to have had some explanation about what was driving it.

01/08/14 – **MH Rounds** by MHC Naylor. States offender is requesting his monthly Haldol shot. She told the offender that his concerns would be forwarded to the Unit Nurse and Charge Nurse for further assessment. The Haldol was refilled on 01/17/13 but there is no indication that he received the shot either on the 8th or 17th. NOTE: There are no MARs in the EMR between the end of September and April 2014.

01/28/14 – **Unit Visit**. Roger Davis was asked to assess Patient 8 on the unit by Sergeant Telford. During his visit, Patient 8 had asked for both his prn Haldol and his monthly shot. MHC Davis said he would refer the issue to the Unit Nurse. NOTE: Once again, we have an inmate requesting his medications and there is no indication that he received it. There are occasional flare-ups of psychotic behaviors noted by the unit staff (who frankly do a better job of documenting MH issues than most of the mental health staff) but the MH staff see nothing.

02/04/14 – **MH Rounds** with MHC Naylor. Patient "reported that he is not gone [sic] take his shot unless this provider is present. This provider verbalized understanding." This is followed by the standard language of nothing wrong with the man. No explanation of why the offender would not take the shot without Ms. Naylor present or anything.

More normal notes with nothing going on with mental health (as recently as 04/15/13). Then the next day we get this:

04/16/14 – **F/U Psych Visit**. Nurse Dunn saw Patient 8 for a routine fu psych visit. He presents to interview with elevated mood – manic and disorganized. He is heard from the hallways with loud type animal noises – barking and howling type sounds. He reports "want my depakote…" he describes himself as "been thinking I am a hog…a gorilla…a snake…need a shot now…been acting too hyper and crazy." He further reports "I keep saying I am a hog…a gorilla…a snake…" He is energized and disorganized throughout interview.

Patient 27

Diagnosis
Paranoid Schizophrenia

Medications
- Haloperidol Decanoate 100mg/ml solution.
  - Inject 100mg IM Q28days starting on December 19, 2013.
- Haloperidol Lactate 5mg/ml solution
  - Inject 10mg IM Q12 hrs as needed for psychotic agitation.

- Diphenhydramine 50mg/ml solution
  - Inject 50mg IM Q12hrs as needed for psychotic agitation.
- Zoloft 50mg PO BID
- Wellbutrin 100mg PO BID

12/23/12 – Patient 27 wanted to be switched to oral Haldol for continued treatment and he complained that Cogentin causes blurred vision. His medications were adjusted to Haldol 5mg BID and Artane 2mg BID. He was scheduled for follow-up with the psychiatrist within 3 months and this apparently did happen. At that time, they changed the Haldol to 10mg QAM to address his tendency to miss evening pill line.

01/01/13 – **MH Rounds**. "Offender reported no mental health concerns. MH Staff will continue to monitor offender for all psychiatric needs." For nearly identical notes, see 01/18/13, 02/04/13 (electronically signed at 2:28am), 02/15/13 (two people did tandem rounds).

01/14/13 – **Quarterly Treatment Team Review**. Meds are still Haldol and Artane. No Zoloft listed in meds, but Patient 27 stated that he was compliant with taking it. Minor oversight. He reportedly denied AVH or SI and he denied mood disturbance, paranoia, or delusions. Denies special powers; good appetite and sleep. Wants to go to the prerelease program. He apparently has had times in the past where he had delusions of angels seeing through his eyes. As of this meeting, he was not reporting any of that. The Treatment Plan attached is the exact same generic treatment plan.

> **Medical Issues:** Offender states he is compliant with his medication of Haldol, Zoloft and Cogentin. He states he is experiencing no side effects to the medication.
> **Psychiatrist/Mental Health Issues:** Offender states he is experiencing no A/V hallucinations. He denies any suicidal ideations. He states he is experiencing no mood disturbances, paranoia, or delusions. He denies any special powers but says he has a good appetite and a healthy sleep pattern.
> **RVR's/Disciplinary Review:** Offender states he has no disciplinary action.
> **Education/Therapy Assignments:** Offender states he attends no educational classes.
> **Job Assignments:** Offender states he has a current job assignment of kitchen worker.
> **Family Support/Estimated Date of Release:** Offender states he has good family support.
> **Issues Raised by the Inmate:** Offender is requesting to go to the Pre-release program and an account balance.
> **Treatment Team Referrals/Plan Recommendations:** Continue to monitor for all psychiatric needs.

Compare to the quarterly treatment review from 6/3/13:

> **Medical Issues:** Offender states he is compliant with his medication of Haldol and Artane. He states he is experiencing no side effects to the medication.
> **Psychiatrist/Mental Health Issues:** Offender states he is experiencing no A/V hallucinations. He denies any suicidal ideations. He states he is experiencing no mood disturbances, paranoia or delusions. He denies any special powers but says he has a good appetite and a healthy sleep pattern.

RVR's/Disciplinary Review: Offender states he has one disciplinary action.
Education/Therapy Assignments: Offender states he attends no educational classes.
Job Assignments: Offender states he has no current job assignment.
Family Support/Estimated Date of Release: Offender states he has good family support.
Issues Raised by the Inmate: Offender expressed no concerns at this time.
Treatment Team Referrals/Plan Recommendations: Continue to monitor for all psychiatric needs.

And from 09/23/13:

Medical Issues: Offender states he is compliant with his medication of Haldol and Artane. He states he is experiencing no side effects to the medication.
Psychiatrist/Mental Health Issues: Offender states he is experiencing no A/V hallucinations. He denies any suicidal ideations. He states he is experiencing no mood disturbances, paranoia or delusions. He denies any special powers but says he has a good appetite and a healthy sleep pattern.
RVR's/Disciplinary Review: Offender states he has no disciplinary actions.
Education/Therapy Assignments: Offender states he attends no educational classes.
Job Assignments: Offender states he has no current job assignment.
Family Support/Estimated Date of Release: Offender states he has good family support.
Issues Raised by the Inmate: Offender is requesting a timesheet and an account balance.
Treatment Team Referrals/Plan Recommendations: Continue to monitor for all psychiatric needs.

And from 02/03/14:

Medical Issues: Offender states he is compliant with his medication of Artane, Wellbutrin and Haldol-Dec. He states he is experiencing no side effects to the medication.
Psychiatrist/Mental Health Issues: Offender states he experiencing no A/V hallucinations. He denies any suicidal ideations. He states he is experiencing no mood disturbances, paranoia or delusions. He denies any special powers but says he has a good appetite and a healthy sleep pattern.
RVR's/Disciplinary Review: Offender states he has no disciplinary action.
Education/Therapy Assignments: Offender states he attends no educational classes.
Job Assignments: Offender states he has no current job assignment.
Family Support/Estimated Date of Release: Offender states he has good family support.
Issues Raised by the Inmate: Offender is requesting an account balance, his classification points. **Treatment Team Referrals/Plan Recommendations:** Continue to monitor for all psychiatric needs.

01/28/13 – **Sick Call**. Supposedly a sick call request was sent. Could not find one in the records.

01/29/13 – **Psychiatric Note**. Patient 27 was seen by Nurse Dunn about chest pains and dizziness. His vitals checked out okay, but he stated that he would kill himself if he went back to the unit because he was still feeling chest discomfort.

02/05/13 – **Office Visit**. Dr. Gillespie noted that everything was normal, no complaints.

02/13/13 – **Sick Call**. Medical services request form for bowel movement problems. Charged $6.00. This was followed up in a timely fashion in a reasonable manner.

02/19/13 – Patient 27 was placed on suicide watch. No assessment completed.

02/20/13 – Patient 27 signed a No-Harm Contract.

02/20/13 – Patient 27 was escorted to medical after Lakeisha Prude stated that she had him in the office and he was complaining of voices. When he got to Nurse Dunn, he stated that he wanted to talk about something else. He wanted to be moved to another unit (he was in Unit 3 and wanted to go to Unit 2). She said he was not appropriate for Unit 2. He reported missing evening medication, which Nurse Dunn said was probably why he was getting increased paranoia. She agreed to have him in the holding tank rather than go back to unit 3. Then she had him sign a No-Harm Contract. He was denying SI/HI and nothing other than paranoia was noted for his psychotic symptoms so it is not clear why a No-Harm Contract was considered. She added a prescription for Haldol lactate injections every 6 hours as needed for agitation along with Benadryl 50mg IM Q6hrs.

02/21/13 – Patient 27 was discharged from medical back to Unit 3 even though he expressed a desire to go to PC rather than back to the unit.

02/22/13 – **MH Rounds.** L. Brown entered a generic note that did not make any mention of his desire for a move.

03/01/13 – Patient 27 was admitted to medical because he attempted to jump from the stairway and the Lieutenant caught him and prevented him. Again his reason was because he was tired of Unit 3. An officer stated that he was in debt to everyone there.

03/02/13 – **MH Rounds**. At approximately 3:48am during mental health rounds, Roger Davis observed Patient 27 in his cell asleep. No problems observed or reported. Later in the day, Patient 27 was complaining of hearing voices and he was given a Haldol Lactate and Benadryl combination shot.

[See 03/03/13, 03/05/13, 03/06/13, 03/07/13, 03/08/13, 03/16/13, 03/17/13, 03/19/13, 03/20/13, 03/21/13 as well as 05/15/13, 05/16/13, 05/18/13, 05/19/13, 05/20/13, and 05/21/13 for identical notes from mental health rounds conducted while the inmate is asleep. If the inmate is asleep every time you do rounds, perhaps it would be wise to do rounds at a different time. If the rounds are conducted when inmates are frequently asleep, perhaps you should question the utility of doing rounds at that time at all.]

03/08/13 – **Inmate Request**. Patient 27 sent an Inmate Request Form to see the doctor about his medications ("I need to see the doctor about my medication pleases [sic]".) He was told by Linda

Brown he had to submit a sick call request to see the doctor. This constitutes a barrier to accessing care.

03/16/13 – Patient 27 continues to request to be moved. There is no indication that his concerns are being addressed through mental health. Given that the treatment plans universally suggest "Improve Coping Skills" it is unsettling that a perfect opportunity to work on coping skills is being ignored.

03/17/13 – Patient 27 continues to complain of hearing voices.

03/18/13 – **MH Rounds**. Jacquelyn Lockette noted no complaints. There is no mention of Patient 27 having been complaining about them previously. Perhaps they were not present during that interaction but to not make an attempt to elicit their presence and impact gives the impression that every round or interaction with an inmate is a completely isolated incident that is unconnected in any way to interactions that occurred right before it. This seems to be the case here as a note later in the day by a different provider documents the following:

03/18/13 – **Infirmary note** – Loretta Williams said that Patient 27 continued to complain of hearing voices.

03/26/13 – Inmate was returned to tier 3D and he stated that he would jump from the top tier. He had wanted to go to 3B or 3D if returned to Unit 3.

05/15/13 – No concerns.

05/16/13 – "The Offender reported 'he still healing [sic] voices.'"

05/19/13 – **MH Rounds**. Jacquelynne Lockett did rounds at 3:30am and noted the same thing that Roger Davis did in all of his rounds; namely, no concerns, no signs or symptoms of problems.

05/21/13 – **MH Rounds**. Jacquelynne Lockett. "MH rounds were conducted on HU7 by this provider on 05/20/13. Offender was lying down. Offender had no MH concerns with all a/v hallucinations and si/hi denied. MH staff will continue to monitor for all psychiatric needs."

05/22/13 – **MH Rounds**. "Mental health rounds conducted on 05/22/1013 11p-7a shift. Offender was asleep and did not appear to be in any type of acute distress. Mental Health staff to continue to monitor offender for psychiatric needs."

05/23/13 – **MH Rounds**. Loretta Williams saw him on rounds in the morning and reported that he stated he is still hearing voices.

05/26/13 – **Psychiatric Visit** with Otis Anderson. There is no indication in here that Dr. Anderson had given any thought or consideration to any of the myriad notes and complaints from before.

05/27/13 – **MH Rounds**. Identical notes by Kirby Pough begin on this date and read like this: "The offender was seen during mental health rounds. The offender did not report any mental health concerns, including but not limited to; SI/HI and/or A/V/T hallucinations. The offender did not appear to be in any distress at this time and will remain under observation for any medical and/or psychiatric concerns." This is verbatim, including the misuse of a semicolon.

07/02/13 – Patient 27 again presents with the voices telling him to jump but no other symptoms noted. He is noted to be within normal limits with everything other than just getting himself into difficult situations and having no way of getting out of them other than possibly claiming that the voices told him to jump.

07/06/13 – **Interdisciplinary Progress Note**. As an example of the vagaries with which he describes his symptoms, an interdisciplinary progress note stated the following: "The offender reported: 'im [sic] hearing voices…I cant [sic] recognize them…I just dont [sic] know…I cant [sic] tell you what they are saying because I dont [sic] know myself…'" Staff really needs to do a better job of assessing this since the symptoms seem questionable and there are clear indicators that the inmate has extremely limited coping skills.

11/13/13 – **Sick Call Request**. Patient 27 submitted a sick call request for depression and anxiety. He wants to be moved off the unit because he is being extorted. Charged $6.00

11/05/13 – **MH Rounds** by Tina Naylor. Offender stated that he cannot sit still and feels anxious all the time. He was advised that he would be referred to the psychiatrist/psychiatric nurse provider. The note goes on to state that "The offender did not exhibit any sxs of agitation or distress at this time." This seems to be somewhat contradictory.

11/09/13 – Patient 27 actually jumped off the tier because he was frustrated at not being moved. This resulted in a trip to Rush Hospital for complaints of back pain.

12/20/13 – **MH Rounds**. Howard Thomas's note is significant for noting actual signs of mental illness. MHC Thomas noted during MH rounds that Patient 27 presented as "lethargic; suspicious, with blunted affect and rambled speech"; Unfortunately, the note goes on to state "reports no other MH issues/concerns. MH Staff to continue monitoring for all psychiatric needs." No plan was identified; no probing of the symptoms was done; and there was no indication of why the offender might be off baseline. This interaction occurred between 10:35pm and 6:50am. However, a little later in the afternoon there is nothing noted and no connection to earlier in the day – no indication that there might have been anything wrong. Also, this note about suspiciousness and rambling speech was a clear deviation from baseline of the previous weeks (assuming, of course, that those notes were accurate).

Near the end (December 2013) he is put back on 28 day Haldol Decanoate, Wellbutrin, and Artane and seems to be doing well. He was discharged with a detainer to Tennessee.

Patient 1

APPENDIX OF CHART REVIEWS

Diagnosis
Psychotic Disorder
MRSA

Medications
Risperdal 3mg PO QHS
Remeron 30mg PO QHS
Artane 2mg PO QHS

01/15/13 – **MH Treatment Plan**. The problem list states that "Inmate is non-compliant on medications, no symptoms consistent with a severe mental illness. 'I flush the medicine in the toilet.' He has sent 7 inmate requests to discontinue the medication." The rest of the Objectives, goals, interventions, and modalities are all identical to nearly every other patient I reviewed and are consequently totally useless.
01/16/13 – **Quarterly Treatment Team Review**. Again refers to him having flushed his medications and "no history is [sic] mental illness."

For the next six months, the visits and rounds all say the same thing, that he is fine with no voiced complaints. It is not until he sees Nurse Dunn that any problems of mood and psychotic symptoms are seen/reported/detected:

07/26/13 – **Psychiatric Visit**.

> **Chief Complaint:** The offender reports doing alright. Reports sleep is better. Reports recent increased auditory/visual hallucinations - reports seeing shadows - reports hears his name being called - reports last heard his name on last night. Reports stressing over mother who is ill. Denies suicidal/homicidal thoughts. Reports mood swings - more downs - reports hx of ADHD as a child - reports a family hx of mental health problems - sister has Bipolar - brother has schizophrenia - mom has schizophrenia - bipolar - Alzheimer's.

Practically every note between July 26, 2013 and October 31, 2013 are cookie cutter. Every MHC (with possibly one single exception) said he was fine with no complaints. The implication is that either Patient 1is note reporting symptoms to anyone but Nurse Dunn or that the clinicians doing rounds do not inquire (or if they do inquire, the inmate's complaints are lost to boilerplate documentation).

10/30/13 – Tegretol was discontinued due to undetectable levels during labs.

11/27/13 – **Psychiatric visit**. He was seen because his labs came back with undetectable Tegretol. The meds were discontinued as he did not appear to be in any acute distress.

12/09/13, 12/16/13, 12/23/13, and 01/09/14 were all nearly identical: "Mental Health Rounds were conducted on the pod by the mental health counselor, this offender provided no mental health concerns, no A/VT hallucinations, denied harm to self or others, mental health staff will continue to monitor him for his psychiatric needs."

APPENDIX OF CHART REVIEWS

01/15/14 – Patient 1 wrote a kite to Nurse Dunn stating: "I need my medication back truly I'm in this cell seeing shit can't sleep then I'm blanking out daily on officers and inmates ever since stopped medications I ain't been feeling right in this cell that I'm starting to see and hear voices so could I please talk to the doctor. I need my medication back before I do something crazy. I need to truly talk to doctor about medication." [Spelling and punctuation corrected by this writer.]

01/17/14 – **Psychiatric visit**. He requested to get back on his medications. He had stopped because he wanted to see what effect that would have on him. Now states he knows he needs them because without them he feels like he's going crazy, increase in paranoia, up all night, voices telling him to kill himself (though he denies SI) and visual hallucinations (seeing shadows."

> Patient 1 also has the ubiquitous treatment plan:
> **Mental Health Treatment Plan** Care Plan formulated by: Treatment Team **Date Care Plan Formulated:** 11/19/2013
> **Assessment Updated Problems:**
> PSYCHOTIC DISORDER NOS (AXIS I) (DS4-298.9) ASTHMA, ADULT W/O STATUS ASTHMATICUS (AXIS III) (ICD-493.90) MRSA (ICD-041.12)
> **Axis IV:** MDOC
> **Master Problem List and Objectives**
> **Problems: Other:** Inmate is partially medication complain he take medication, he has no auditory, visual or tactile hallucinations.
> **Objectives/Goals: Objectives/Goals:** Symptom reduction or maintenance, Develop or improve coping skills, Increase adaptation to correctional environment, Improve social skills
> **Other:** 01/07/2016 ERS date 03/11/2017 tentative discharge date. Inmate has a parole date for February
> **Physician** Monitor frequency, medication, progress toward treatment goals Frequency: Every 30, 60, or 90 days Person Responsible: MD
> **Nurse** Monitor frequency, medication, progress toward treatment goals Frequency: PRN for med distribution Person Responsible: RN/LPN
> **Mental Health/Psychological Services** Crisis Intervention, Individual therapy, Group therapy Frequency: PRN by SCR, Weekly, Monthly Person Responsible: Psychological Specialist

05/30/13 – **MH Rounds**. Kirby Pough notes "The offender was seen during mental health rounds conducted on 05/20/2013. The offender did not report any mental health concerns including but not limited to; SI/HI and/or A/V/T hallucinations. The offender requested to see the psych doctor stating that his meds make him sleepy. The offender did not appear to be in any distress at this time and will remain under observation for any psychiatric and/or medical needs.

08/22/13 – **MH Rounds**. "The offender was seen during mental health rounds conducted on 07/31/2013. The offender did not report any mental health concerns, including but not limited to; SI/HI and/or A/V/T hallucinations. Reports that he needs his meds reordered. The offender did not appear to be in any distress at this time and will remain under observation for any psychiatric and/or medical needs."

Roger Davis has the following identical MH Rounds for Patient 1. This raises the question of whether MHC Davis had ever even seen the inmate at all:

02/01/14 – **MH Rounds**. On 2/1/14 @ approximately 4:35 pm during mental health rounds Inmate L1159 was observed in his cell . He is awake, standing @ his cell door. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed.IM is able to weigh the risks and consequences of his behaviors. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.

02/06/14 – **MH Rounds**. On 2/6/14 @ approximately 3:50 pm during mental health rounds Inmate L1159 was observed in his cell. He is awake, standing @ his cell door. IM requesting to see Case Manager. Will refer thru MHC. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self-observed. IM is able to weigh the risks and consequences of his behaviors. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.

02/17/14 – **MH Rounds**. On 2/17/14 @ approximately 4:10 pm during mental health rounds Inmate L1159 was observed in his cell . He is awake, standing @ his cell door. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed.IM is able to weigh the risks and consequences of his behaviors. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.

02/28/14 – **MH Rounds**. On 2/28/14 @ approximately 3:28 pm during mental health rounds Inmate L1159 was observed in his cell . He is awake, standing @ his cell door. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed.IM is able to weigh the risks and consequences of his behaviors. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.

03/06/14 – **MH Rounds**. On 3/6/14 @ approximately 3:45 pm during mental health rounds Inmate L1159 was observed in his cell. He is awake, standing @ his cell door. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed.IM is able to weigh the risks and consequences of his behaviors. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.

Patient 7

Diagnosis
Schizophrenia, Undifferentiated
PTSD

APPENDIX OF CHART REVIEWS

Medications
Haloperidol 5mg PO QHS

01/02/13 – **MH Rounds**. No concerns no distress.

02/05/13 – **MH Treatment Plan**. Other than sleep disturbance from violence shootings and killings from being a high-ranking member of the gangster disciples, nothing was noted. No symptoms of psychosis. The treatment plan from Objectives/Goals forward is absolutely identical to every other treatment plan. They add PTSD to the problem list, but other than the sleep disturbance, there is nothing documented. MH Rounds over the next three months say virtually the same thing – no concerns or distress. This goes right up to 05/19/13. Then there's this:

> 05/28/13 – **Medical Services Request Form**. Patient 7 wrote to medical to state that he "needs increase in meds. It's not working any more. Can't move sometimes even when I'm awake…" there is more written but it is illegible for a bit then continues "seems like they would kill me." He was requesting to see the psychiatrist and was charged a $6.00 co-pay.
>
> 05/28/13 – **MH Treatment Plan**.
> **Patient is:** Paranoid.
> **Other:** Inmate is medication compliant, he has auditory intrusive voices and ruminating thoughts. visual or tactile hallucinations. Inmate
> **Other:** Inmate has a poor appetite at times and the other time the food is not pallatiblee. Inmate feel that "lock down is taking a toll on him"

It is not at all clear what that part about visual or tactile hallucinations means. It's just sloppy. [3 and 3A]. The treatment plan from Objectives/Goals forward is absolutely identical to every other treatment plan.

05/29/13 – Inmate is requesting medications be increased due to the auditory and visual hallucinations and paranoia.

06/05/13 – **MH Rounds**. We're back to generic no problems noted.

06/06/13 – **MH Rounds** – appended. The same counselor (Marina Moss) now states that the offender has been referred to the psychiatrist for evaluation. No indication of why. [3 and 3A]

06/06/13 – **Psychiatric Visit**. Patient 7 was able to get in to see a doctor relatively quickly and the chief complaints listed there are markedly different from what one would expect with "no problems noted."
Chief Complaint: PT SEEN; CARE AND RECORD REVIEWED. WANTS INCREASE IN RX. DENIES SUICIDAL, HOMICIDAL THOUGHTS. ALWAYS HEARING VOICES, THREATENING HIM, FEELS IN DANGER. THINKS HE CAN'T MOVE, SOMETHING HAS CONTROL OVER BODY. SUSPICIOUS, FEELS WATCHED, TALKED ABOUT, OTHERS AGAINST HIM. SLEEP REPORTED DECREASED. APPETITE STABLE. REPORTS SPATIAL DISORIENTATION AND DISTURBED PERCEPTION OF TIME.

He received an increase in medications and was noted to be hostile, angry, withdrawn, and paranoid with hallucinations/delusions. However, the treatment plan from Objective/Goals forward was identical.

06/21/13 – **Sick Call Follow-Up**. "IM refused to come to medical after 5 requests by the security staff. I personally waited on House 5 Medical office for 2 hours waiting on this IM." This was by Carl Faulks.

08/09/13 – 11/06/13– **MH Rounds**.

11/15/13 – for unknown reasons, Patient 7 was transferred to the South Mississippi Correctional Facility. From then until the time the records end (05/08/14) he is at SMCF and all the notes refer to him as doing well and staying medication compliant.

Patient 28

Diagnosis
Paranoid Schizophrenia
Impulse control disorder

Medications
Perphenazine 8mg PO QHS
Prozac 20mg PO QAM
Carbamazepine 200mg PO BID

01/10/13 – **MH Rounds**. Agitated and reportedly depressed, requesting a meeting with the psychiatrist. Referred to nursing for scheduling.

01/17/13 – **Quarterly Treatment Team Review**. Treatment plan was uninformative and generic, though it did refer to medical for psych evaluation due to an increase in depressive symptoms. No referral appears to have been made as he was not seen by a psychiatric provider for well over a month.

02/20/13 – **Quarterly Treatment Team Review**. Uninformative. Treatment plan was completely generic.

March, April, and May 2013 – **MH Rounds** consistently note no problems.

03/21/13 – **MH Rounds**. Patient 28 requested a meeting with the psychiatrist and stated he was told he would see the psychiatrist. No appointment with psychiatrist for well over a months afterwards [1B, 5C]

06/06/13 – **MH Treatment Plan**.

APPENDIX OF CHART REVIEWS

06/07/13 - 06/12/13 – **Infirmary Notes**. Patient 28 was admitted to the infirmary on psych obs due to increased stress and thoughts of suicide. Nurse Dunn noted that he would significantly benefit from coping skills and anger management, but of course those were either unavailable or nor followed up. [1B, 5E]

06/18/13 – **Quarterly Treatment Team Review**. Stated that he is not receiving some of his medications with a notation that this issue will be followed up on. Treatment plan starts off with some promise "Inmate states that he becomes overly concerned with the disparity with the treatment," but there is no further elaboration. It then goes on to give the rather enigmatic and strange description of Patient 28's presentation, which is presented verbatim: "Inmate has rapid speech, volatility and precludes to the victimization with racial overtures." An online thesaurus and dictionary search failed to produce results for the highlighted words.

July 2013 – no notes in chart.

August 2013 – all but one mental health rounds are generic and uninformative. Note: Kirby Pough had a round note that was identical to other inmates' up to and including the exact misuse of a semi-colon:

- 08/20/13 – MH rounds. "The offender was seen during mental health rounds conducted on 07/31/2013. The offender did not report any mental health concerns, including but not limited to; SI/HI and/or A/V/T hallucinations. The offender did not appear to be in any distress at this time and will remain under observation for any psychiatric and/or medical needs."

08/27/13 – **Psychiatric Visit**. Rectal bleeding, stress with staff. Sleep and appetite disturbance. Medications were adjusted (Remeron started). Nurse Dunn commented that Patient 28 "will benefit from improved coping skills," though there is no plan for how to achieve that. [1B, 5E]

September 2013 – all mental health rounds are generic and uninformative.

09/19/13 – **Psychiatric Visit**. Labs ordered, brief interview. Follow-up scheduled in 3 months.

October 2013 – all but one MH Rounds were identical.

10/24/13 – MH Rounds. Jacquelyn Lockett noted that Patient 28 reported that his medications were not working, he complained of a headache and was feeling depressed. No follow-up noted. [1B]

November 2013 – no rounds noted.

December 2013 – all mental health rounds are generic and uninformative.

12/09/13 – **Quarterly Treatment Team Review**. Patient 28 was noted to be hostile, angry, and anxious with poor hygiene. His leg bounced up and down throughout the treatment team review and he wanted to be transferred to another institution in order to get "real treatment." The

Objectives/Goals and Interventions and Modalities sections are indistinguishable from any other inmate's.

January 2014 – all but two mental health rounds are generic and non-specific, cookie-cutter.

- 01/02/14 – MH Rounds. Roger Davis broke tradition on this date with his documentation, but recovered quite nicely. Please note the highlighted sections:
    - On 1/2/14 @ approximately 5:01 pm during mental health rounds Inmate K2538 was observed in his cell. He is awake, standing in his cell. IM is requesting a psych referral due to having homicidal ideations, please note that the facility is on lock down. IM will be referred to Psych Dr. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.
        - It is important to note that Patient 28 was not seen by a psychiatric provider (or anyone other than MHCs on rounds) until 03/05/14 [1B]
- 01/10/14 – MH Rounds. Demarlo Nickson reported that Patient 28 had informed him that he was "on the verge of snapping" (ostensibly due to the conditions at EMCF) and wanted a transfer. MHC Nickson then stated the following: "MHC informed this offender that in order to obtain a mental health transfer he must be stable off of psychotropic medications for at least 90 days." Patient 28 reported that he did not want to be off medications because of the law suit he had filed.

February 2014 – all but one mental health rounds are generic and non-specific, cookie-cutter.

- 02/10/14 – **MH Rounds**. Demarlo Nickson noted that Patient 28 was depressed about some personal issue but did not want to discuss it. Interestingly, Mr. Nickson noted that "this offender appears to always be distressed about something." None of the other rounds ever make mention of this as his baseline and I would not ever have gleaned that if not for this note (especially given the fact that the day before, the mental health rounds by Roger Davis indicated the same as it always does: nothing).
- 02/28/14 – **Sick Call**. Patient 28 was seen at his cell front by Parrish Anderson, MHC. He complained of being stressed and fearful "since I got unto [sic] it unit manager banks anything I said can be held against me." Anderson had him sign a No Harm contract for whatever reason and charged him $6.00 for an inmate initiated non-emergency visit).

March 2014 - all mental health rounds are generic and non-specific, cookie-cutter.

- Interestingly, Patient 28 had requested to be in lockdown on 03/10/14 due to increasing paranoia about being harmed by others and he was in an altercation on 03/12/14. However, there was no indication of this in the 03/15/14 mental health round note observing that everything is fine, no problems, complaints, signs, or symptoms. That is not to say that Patient 28 was psychotic or had any other mental health symptoms that were simply not noted; rather, the rounds are not even taking into consideration a rather serious issue that occurred only three days before and MH seems to be blithely ignoring the importance (or even the utility) of checking in with the offender about this particular issue.

April 2014 – all mental health rounds are generic and non-specific, cookie-cutter.

04/22/14 – **Psychiatric Visit**. Nurse Dunn saw Patient 28 for a routine follow-up. He had recently had some increase in paranoia, depression, and suicidal thoughts. She included a brief history of his mental health and violence problems starting with childhood and explained her rationale for changes to his medications.

04/28/14 – **MH Rounds**. Mental health rounds were conducted by this provider along with MHC Lockett and CO Gully on 4-28-14. Offender denied SI/HI and no psychosis noted at the time of rounds. The offender reported no other MH concerns. MH staff will continue to monitor for psychiatric and clinical needs.

05/14/14 – **Psychiatric Visit**. Doing well. At baseline sad with mild anxiety. Nurse Dunn viewed him as sufficiently stable to promote from LOC E to LOC C.

Patient 9

Diagnosis
Intermittent explosive disorder
Bipolar disorder NOS
Antisocial personality disorder

Medications
Artane 5mg PO BID
Trifluoperazine 5mg PO QHS

03/15/13 – Medical Services Request Form. Patient 9 requested to be taken off all of his medication so that he could move to a facility closer to his family.

June 2013 – Patient 9 was reportedly going through a stressful time due to his mother being in surgery and the loss of several family members (unverified). He appeared rather needy during this time and was reporting to the psychologist (Gillespie) some rather bizarre visual hallucinations including "spiders, blood, and little green men," which is highly suspect in the absence of any other signs of psychotic illness. He would report during mental health rounds that he was depressed, was not getting his medications, and requesting prn medications. However, he was noted to be in no acute distress, the nurses stated that he had been getting his medications, and he did not have prn medication ordered. Later in the month (June 22, 2013) an MHC noted him to be hypomanic and agitated, again maintaining that he was not receiving his medications and that he needed a prn. He made some vague comments about potentially harming others ("I don't know what I might do . . . I have these crazy thoughts") and the intervention offered was a No Harm Contract, which he refused to sign. Throughout the month he continues to complain about the stress of the deaths of his loved ones and there is some evidence of manic or hypomanic agitation (loud, pressured speech; excessive psychomotor activity; rambling and incoherent thoughts that need redirection). On July 16, 2013, he got an RVR for walking up to Tina Naylor and pulling her hair, asking her why she was not going to see him. He continues to

complain about not receiving his medications through July and into August, but it is unclear from the notes whether or not this is true. By August 15, 2013, he gets in trouble for his aggressive outbursts and behavior. He is belligerent and profane as he complains about medical and security for not addressing the rash on his leg that he had reportedly been trying to have addressed for quite some time. It is not clear if this is just impatience with the healing process or because nothing was actually done. Nurse Dunn was of the opinion that his reported auditory hallucinations were suspect, though she seemed to be inclined to think that there may be an underlying mood component (bipolar) as she discontinued his Zoloft due to concerns that it may have been contributing to his anger. However, overall, she expressed the opinion that he is more antisocial. While in segregation near the end of the month he got in some tray slot battles with the staff but no use of force was needed.

09/18/13 – **Psychiatric Visit**. Patient 9 ambivalently stated that he wanted to discontinue his medications so that he could move to another facility. Nurse Dunn discontinued them at that time.

10/02/13 – **Treatment Plan**. Generic. Noted that the inmate was stable without medications.

10/08/13 – **Injury**. Patient 9 was involved in a fight with another inmate.

10/09/13 – **Psychiatric Visit**. Patient 9 reported that he needed to be back on medications, that he was easily irritable. Other than irritability, there were no symptoms noted. Meds were resumed.

10/16/13 – **Psychiatric Visit**. Patient 9 again reported that he wanted his medications discontinued because he wanted a transfer. Nurse Dunn discontinued them. There was no discussion noted about the benefits medications could have.

10/20/13 – Patient 9 reported that he swallowed a razor. He signed a No Harm contract with MHC Townsend and he was scheduled for an x-ray.

Throughout the month of November, he continues to complain about stress over his mother's health and his MHCs encourage him to talk to the chaplain (it is not clear from the notes if that ever happened), but there is not ever any attempt to address his emotional concerns. There is no processing noted and certainly no treatment. This is an example of a clinician failing to provide even the most basic therapeutic intervention.

11/24/13 – Patient 9 refused to close his tray slot and was sprayed with OC several times. The notes are not entirely clear about this but seem to indicate that he was not allowed to shower afterwards.

11/25/13 – **MH Rounds**. "Offender is seen by Provider on UNIT 5B as requested; reports no MH issues/concerns; states he has not slept all time...he was sprayed 3 times yesterday . . . and has not received medical attention. Provider to refer Offender to appropriate Medical Staff. MH Staff to continue monitoring for all psychiatric needs."

Patient 9 continues to express stress and worry, now claiming that his hair is falling out and just generally sounding histrionic, but again the notes all say "does not appear to be in any acute distress." Even when he had a rope around his neck and was demanding to be given his tray, covered his window, and refused to come to the door, the note by Tina Naylor (11/30/13) stated: "The offender did not voice any mental health concerns." Again, it just seems like MH is operating on a different plane of existence.

12/01/13 – **Use Of Force**. Patient 9 would not close his tray slot until he talked to mental health. He AGAIN claimed that he was stressing over family issues and indicated that he had not been able to talk to mental health. Tina Naylor's response was to tell him that he had been seen and she identified all of the dates he was seen in November (9 in total). NOTE: these were mental health rounds and did not constitute any substantive interaction. All they ever did was refer him to the chaplain. He responded to her statements with "Well, fuck it" (literally) and refused to remove his hand from the tray slot. He was sprayed at that point and he reportedly refused medical attention.

Overall, this inmate has some real problems with affect regulation, impulse control, appropriate boundaries, and manipulation. It is easy to see how his constant lying or massaging of the truth could be annoying, but there does not appear to be any real attempt to deal with the man other than responding to crises or ignoring him.

In December, Patient 9 was placed on suicide watch because he was on a hunger strike until he got what he wanted (e.g., a shower, off "loaf"). Later (12/10/13), he was in the infirmary because he took an overdose of pills (again, ostensibly due to the same stressors he has been under all this time). A staff member had witnessed him taking a handful of pills. Security wanted to discharge him the next day but Nurse Dunn noted that he appeared quite disoriented and disorganized, and incoherent. There was no indication that the medications were pumped out of his system. However, because of this presentation, he was sent to Rush hospital for several days. When he returned the clinical impression from Rush was probable neuroleptic malignant syndrome, history of bipolar disorder, and new onset of seizures. Over the next several days, he slowly started to get better. He was adamant that he wanted to die. The monitoring by mental health staff was poor afterwards. For instance:

12/20/13 – **Infirmary MH Rounds**. Roger Davis reported that Patient 9 was fine with no complaints. Several hours later, however, Clara Thomas (MHC) reported that Patient 9 "was agitated, raised his voice the hole [sic] time during the rounds." It may be that these two reports are accurate, but it just looks odd. It's particularly concerning that no specific notation was made by Davis about the cognition, which is an important issue to track for someone who is recovering from neuroleptic malignant syndrome.

12/21/13 – **Nursing note**. Patient 9 was noted to be "up and about in cell banging on the window trying to push window out at interval. no complaint voiced took medication well no inappropriate behavior noted at this time." The same nurse indicated that Patient 9 knocked on the infirmary window and may have taken several pills in plain sight of staff. She contacted Dr. Edwards who wanted vitals taken. Patient 9 would not cooperate with it so nurse Dale just watched him and did nothing since he did not appear to be in any respiratory or cardiac distress.

She documented several times subsequently that he appeared to be in no distress and was not suffering any ill effects of the pills he supposedly took.

However, a couple of days later on December 23, 2013 Patient 9 stated that he was going to hang himself with his sheet "then came over to the window and started greasing his head no further attempts made by Inmate." This is another example of ignoring the needs of the inmate, which places him at increased risk of harm. There is no intervention, no referral, no attempt at any type of a risk assessment. He makes direct statements the next day about wanting to kill himself:

12/24/13 – **Nurse Note**. Nurse Jonathan Barnett documented that Patient 9 stated he wanted to kill himself (electronically signed at 3:18pm). He took several pills, but it was not an overdose. There is no indication that this information was conveyed to mental health staff. A short time later, MHC Roger Davis conducted MH Rounds and noted the following:

- On 12/24/13 @ approximately 4:02 pm during mental health rounds Inmate 123074 was observed in his cell. He is awake sitting on his bed eating. No s/s of psychosis, A/V/T hallucinations, HI/SI or any threats to harm self observed. No mental health issues. Continue current monitoring program. No problems observed or reported. Will continue to monitor for mental health concerns.

12/27/13 – **Infirmary Progress Note**. Patient 9 had apparently been hoarding his medications. It is again not clear how or why this is even possible. This inmate has recently (and repeatedly) abused medications by overdosing on them with the expressed intention to die and he is still evidently able to hoard medications.

12/30/13 – Nurse Dunn finally considers long-acting Decanoate shots due to concerns about Patient 9's compliance. However, the real question is what are they treating? His presentation has a very strong characterological component. Nurse Dunn started Prolixin Dec for thoughts mood and symptoms of psychosis, but it is not clear what symptoms of psychosis she is referencing.

January 2014 – The new year starts off with more of the same borderline and impulse control problems. On one occasion, Patient 9 threatens to cut himself with broken glass and is demanding about getting his tray slot opened and getting showers, etc. He is placed on suicide watch on 01/03/14 where he remains for a couple of weeks with no active intervention, risk assessment, or safety plan. When he gets back to the unit, he ends up swallowing another handful of pills (01/23/14).

Over the next several weeks he does a little better, but still presents with problematic, impulsive, immature behavior. He asks for his shot then refuses it, he claims to have taken a lot of pills but it is not followed up on or verified, he goes on suicide watch and comes off again, and generally behaves in a reactive manner typical of someone with stunted emotional development and possible frontal lobe damage. In mid-May, Nurse Dunn discontinues the Prolixin Decanoate shot and switches him to oral Stelazine instead even though he has not been reliable with oral medications in the past and has in fact intentionally overdosed on several occasions.

Patient 9 is an example of an individual who appears to have mental illness and characterological problems with a fair likelihood of having frontal lobe or other neurological problems as well. It was rather commendable that the notes in the record for 2014 were not as boilerplate as most of the other inmates and records I reviewed. There are still the copy-and-paste sections characteristic of the stereotypical EMCF mental health rounds, but there was at least an attempt to include recent or relevant information in many of those notes.

The problem is that there was hardly ever any intervention or follow-up. It is almost as if the MHCs document that they “saw” the inmate but there is no substantive interaction even when the inmate’s behavior and mental status are clearly off baseline. On several occasions, Patient 9 expressed depression and anxiety over the failing health of family members but mental health clinicians did not respond to his concerns. Instead, they referred him to the chaplain though it is not clear that he either wanted to meet with the chaplain or that it even occurred. Patient 9 repeatedly expressed suicidal ideation and engaged in extremely risky behavior including overdosing on pills. On one occasion, his attempt was so serious that he ended up suffering from neuroleptic malignant syndrome. While it may be tempting to dismiss Patient 9’s concerns as “behavioral issues,” this is a dangerous and potentially deadly practice. Behavioral manifestations are certainly more readily observable than an individual’s emotional experience, but assuming that simply because one can “see” the behavior, that does not mean that there is not underlying emotional distress present. To adopt an either/or mentality when faced with inmates with problematic behaviors (and Patient 9 can certainly present that way) ignores the very real issues that these behaviors are typically a means of communicating.

As a general rule, offenders tend not have the best coping strategies. They often come from dysfunctional families that have not modeled positive or even adaptive behavior; a greater proportion of them than the general population have experienced problems in development (social, physical, emotional, and neurological); they tend to have significant histories of substance abuse and dependence (a contributor if not a cause of their inability to tolerate normal negative human emotions); and – particularly in the male population – they tend not to know how to communicate their needs in a meaningful, socially appropriate manner. So it should come as no surprise that when inmates have concerns and those concerns are not addressed, they respond in maladaptive ways. The prison system at EMCF itself fosters this kind of emergent responding. Patient 9 is an exemplary case of what can happen if staff do not have or take the time to get to know the inmate and become so overwhelmed by the behaviors of an individual that they reduce contact in order to minimize their own stress. It is a recipe for crisis responding and the message that has clearly gotten through to the inmates is that the only way they will be seen or even have anyone listen to their concerns is by taking extreme actions (e.g., claiming suicidality, engaging in self-harm, displaying reckless or dangerous behaviors, etc).

In Patient 9’s case, he is frequently being sprayed with OC for nuisance issues such as not closing his tray slot; he makes frequent suicidal gestures (jumping off a tier, overdosing on medications); and he makes claims of severe and often bizarre psychotic symptoms – frequently for some readily identifiable secondary gain (e.g., to leave the unit where he has become indebted to other inmates). However, underlying these behaviors there may be real psychological distress as well as opportunities for interventions that may help to curb the very behaviors that

keep him in a vicious cycle of getting frustrated, acting out, and being responded to with a use of force or OC.

Patient 9 makes repeated requests for prn medications. This is not all that uncommon given the charts I have reviewed. And his requests for those shots seem to serve three central purposes: (1) Fast-acting shots are a way of immediately dealing with his distress and allows him to avoid having to develop tolerance and coping skills that should be the bedrock of his treatment; (2) Requesting the shots necessitates action by custody staff, thereby providing Patient 9 with one of the only avenues for exerting any kind of power or control in his situation; and (3) When he is taken to medical it gets him out of the chaotic environment of his unit – even if only for a little while – and it frequently allows him to talk to one of the only providers in the prison that talks to inmates more than any other staff (Nurse Practitioner Evelynn Dunn).

The bottom line is that correctional staff are tasked with dealing with difficult inmates and it behooves an institution to work as a team in addressing both emotional and behavioral concerns of inmates. Without a meaningful assessment of an inmate's mental health history, symptoms, presentation, response to treatment, and readiness for change, staff will be in a constant state of responding to one crisis after another. As a result real, legitimate concerns will go unnoticed, undetected, ignored, marginalized, and untreated. Simply because someone exhibits problematic behavior, that does not mean that they are not experiencing psychological or emotional distress. And outright dismissing their presentation as being "due to behavioral issues" puts the inmate at grave risk – especially at an institution like EMCF, where inmates such as Patient 9 have clearly demonstrated a willingness to suffer severe physical damage (e.g., neuroleptic malignant syndrome) by their suicidal or parasuicidal behaviors.

Patient 12

05/23/11 – **MH Intake**. Patient 12 arrived at CMCF and his MSE was abnormal. He reported taking Lithium, Elavil, Neurontin, trazodone, and Wellbutrin. He reported a history of psychiatric hospitalizations, including a recent one at the VA. Patient 12 reported a history of bipolar disorder and PTSD related to military service and severe childhood trauma. He further reported a history of suicide attempts.

05/24/11 – **Psychiatric Visit**. The CMCF psychiatrist diagnosed Patient 12 with major depressive disorder and paranoid schizophrenia and started him on Celexa, Stelazine, and Cogentin.

06/17/11 – **Transferred to EMCF**.

12/19/11 – Returned to EMCF after going to another facility. Problem list includes bipolar disorder, rule-out schizoaffective disorder, schizotypal personality disorder, and symptoms of narcissistic and antisocial personality with a history of alcohol abuse and cocaine dependence. His prescriptions consist of Stelazine, Cogentin, and Remeron.

12/20/11 – The psychiatrist wrote an order but did not see the patient.

APPENDIX OF CHART REVIEWS

01/28/12 – **Psychiatrist visit**.

02/26/12 – Patient 12 participated in current events group.

03/06/12 – Clinician recommends getting him into a life skills group. PTSD added to problem list.

03/27/12 – **Individual Counseling**. Meaningless, uninformative session/note.

04/29/12 – Patient 12 saw the psychiatrist at the inmate's request.

09/18/12 – **Treatment Team**. Inmate complained of depression, nightmares, and flashbacks.

10/03/12 – **Psychiatric Visit**. Patient 12 reports receiving messages from God, talks to himself, reports having heard the devil, and exhibits paranoia. His thought processes are noted to be disturbed and his MSE is abnormal. Remeron and Stelazine stopped; Trilafon started.

10/08/12 – Patient 12 attended the "Diagnosis Group." This group also met on 10/15/12, 10/22/12, 10/29/12, and 11/05/12. This is the single greatest number of group sessions I have encountered for any of the inmates I have reviewed.

12/12/12 – **Treatment Team**. Patient 12 was referred for individual therapy by Dr. Gillespie.

01/11/13 – **Sick Call Request**. Patient 12 was requesting individual therapy. No response was received until 01/26/13. This is a delay of six weeks since the time individual therapy was recommended by Dr. Gillespie. The note on the SCR says referred to Unit MHC 01/26/13.

03/06/13 – Patient 12 meets with Huggins. The interaction is perfunctory with no meaningful treatment.

03/07/13 – **Quarterly Treatment Team**.

06/05/13 – **Quarterly Treatment Team**. Patient 12 states that he has not received his Cogentin in three months and does not take the other medications due to side effects. He presents as hostile, angry, and paranoid. He sees the psychiatrist and still talks to himself, though not as bad. He reports paranoid ideation and poor sleep. Trilafon and Cogentin ordered.

07/18/13 – Patient 12 was seen by MHC at request of security. He was found asleep outside his cell after refusing to enter cell with new inmate. He exhibits paranoia. The MHC noted that Patient 12 began to display symptoms of narcissistic and antisocial personality disorder.

08/19/13 – **Psychiatric Visit.** Patient 12 meets with Nurse Dunn who notes symptoms consistent with hypomania. She orders the medications continued.

09/11/13 – **Quarterly Treatment Team.**

11/26/13 – **MH Note** (Gillespie). MSE was within normal limits, but medical issues raised.

12/19/13 – Patient 12 is given reading materials on managing stress.

12/27/13 – **Psychiatric Visit**. Patient 12 meets with Nurse Dunn. She describes his mood as indifferent with increased anger, depression, and irritability. "Reports he wants to attend classes – however reports he had no success in being able to sign up for classes. Reports he would like to see the start of a PTSD class or group for the offenders with a history of military combat." [NOTE: Not a bad suggestion.]

01/03/14 – **Individual Counseling**. Session cancelled due to lockdown.

01/30/14 – **Sick Call Request**. Patient 12 wrote an SCR claiming that he had not received his Remeron since 01/26/14. The nurse states it is not on the MAR.

02/02/14 – One-on-one counseling terminated; says he has no MH problems.

04/13/14 – **MHC Sick Call**. Patient 12 indicated that he wanted to see Dr. Gillespie and was concerned about his medications being discontinued.

04/14/14 – **Psychiatric Visit**. Patient 12 met with Nurse Dunn. He was noted to be preoccupied with medical issues. Depression and sadness were noted (possibly some due to past trauma). He used the session to vent his frustration. Nurse Dunn ordered the Trilafon, Cogentin, and Remeron to be continued.

04/15/14 – **Office Visit**. Patient 12 met with Dr. Gillespie. He continues to request one-on-one frequent counseling to address PTSD and history of childhood trauma. He complains of periodic flashbacks and nightmares.

04/17/14 – **MH Rounds**. Patient 12 was informed that he would be pulled for individual counseling.

04/22/14 – Minimal note in EMR by Gillespie.

05/13/14 – **Individual Counseling**. Patient 12 met with an MHC for one-on-one counseling. He again vented his frustration with medical issues and stated that he wants to speak with someone about PTSD. Counseled on how to channel frustration. Given option to write letter to abuser.

Gaps on MARS:

- April 2013 – 5/30 doses Trilafon missed
- May 2013 - 4/30 doses Trilafon missed
- June 2013 – Order on MAR did not start until 06/05/13, so no meds until then. 2/24 Trilafon missed. 2/24 Cogentin missed
- July 2013 – 6/31 Cogentin missed, 1/32 Trilafon missed
- August 2013 – 0/31 Trilafon missed, 0/31 Cogentin missed

- September 2013 – need to look at multiple MARs – from Sept 1 to 12, 1 dose of Trilafon missed. From Sept 13-31, 4 doses of Trilafon missed = 5/30 missed for month
- For Sept 1 to 31, 2/31 Cogentin missed,
- October 2013 – 0/31 Cogentin missed. Appears No Trilafon given Oct 1 to 15

Concerns and Questions

There were, of course, many MH Rounds scattered throughout the record but they were of boilerplate variety and were not reproduced here. There are several troubling issues in Patient 12's case:

- The inmate has on multiple occasions asked for and would benefit from participation in group therapy. He participated in only a handful of group sessions in his three years at EMCF, and none of them appear to have any therapeutic value. The series of "Diagnosis Groups" in October 2012 appear to have been mere discussions of various psychiatric disorders and cannot be considered meaningful treatment.
- Patient 12 has also reached out on many occasions for individual counseling. These sessions have been few and far between and, with the exception of one or two (e.g., the session on May 13, 2014), seem to have consisted of nothing therapeutic. Instead, the counselor merely writes down the patient's complaints and circumstances.
- There are an unacceptable number of missed doses and interruptions in this patient's psychotropic medication.
- He experienced delays in accessing care.
- No attempt has been made to address this patient's ongoing symptomatology, especially his military-related PTSD.

Patient 13

December 2012 through March 2013 – MH Rounds consistently state the same thing: no MH concerns, no A/V hallucinations nor SI/HI at this time. Continue to monitor. The problem listed each time is recurrent moderate major depression. There is no indication of what symptoms are being seen that support this diagnosis, particularly since every MH Round states that no mental health concerns are present.

01/17/13 – **Quarterly Treatment Team**. Stated that he is doing fine on his current medications with no problems noted. Treatment plans are completely generic.

03/23/13 – **Psychiatric Visit**. Despite the past four months of MH Rounds stating that there are no problems or concerns, Patient 13 presented to Dr. Reeves on this date with complaints of "ongoing problems with depression" and some insomnia. Dr. Reeves ordered an increase in Zoloft.

Between 03/23/13 and 06/05/13 all the mental health contacts consisted of MH Rounds. In each and every one of them, the notes conveyed the exact same information – that Patient 13 was in no distress and he reported no mental health concerns.

06/05/13 – **Psychiatric Visit**. In contrast to all of the mental health rounds since his last psychiatric visit on 03/23/13, Patient 13 complained of sleep problems and increased anxiety attacks (he did not appear to be experiencing acute panic attacks so it appears to be more like increased anxiety and worry) and he was noted to have loose associations and inappropriate affect. The subsequent treatment plan is completely generic and devoid of patient-specific goals or interventions.

June 2013 – **MH Rounds**. The MH Rounds continue to consistently state that the inmate has no problems.

06/28/13 – **Quarterly Treatment Team Review**. The review notes that the inmate has had some recent anxiety attacks but nothing in the review addresses the issue. The subsequent treatment plan is entirely generic and identical to his other treatment plans with nothing specific to address any of his symptoms.

July 2013 though August 2013 – MH Rounds. Once again, the MH Rounds continue to consistently state that the inmate has no problems.

09/25/13 – **Quarterly Treatment Team Meeting**. Despite the previous three months' of copy-and-paste MH Rounds citing no problems, the Quarterly Treatment Team Review noted that Patient 13 reported mood swings and noted several life stressors including his father's house having burned down and the death of his mother in the past year. The author of the note observed that Patient 13 "appears to have a mood disturbance of anxiety and agitation." Absolutely nothing in the review addresses these issues and the corresponding treatment plan is – once again – completely copy and paste with no interventions or plans to specifically address the inmate's symptoms. The only thing that is different is that for some odd reason "Borderline Intellectual Functioning" is added to the problem list with no explanation.

There is nothing in the chart for another month.

10/27/13 – **Psychiatric Visit**. Patient 13 complained of unstable mood, anxiety, irritability, and sleep disturbance. GAF of 40, Remeron added.

November 2013 through December 2013 – MH Rounds noted no problems with the inmate.

01/13/14 – **MH Treatment Plan**. Problem list identifies issues with "ruminating thoughts of his deceased sister. He has distortions in relating his ruminations, and actually hearing voices; inmated [sic] has been diagnosed with cognitive limitations." Patient 13 requested to be involved in vocational activity to reduce his preoccupation with his rumination. However, the rest of the treatment plan from this point forward is copy and paste with no specific interventions noted. [NOTE: Even though the plan identified that Patient 13 had problems with ruminating about his deceased sister and may have been having trouble differentiating between his ruminations and

auditory hallucinations AND even though the inmate himself requested to be involved in some sort of vocational pursuits to deal with his ruminations, NOTHING WAS FOLLOWED UP WITH EITHER IN THE TREATMENT PLAN OR AFTERWARD.]

01/18/13 – **Psychiatric Visit**. Patient 13 was asking for a location change from "E" to "C" and in his meeting with NP Dunn, he denied having any mental health issues.

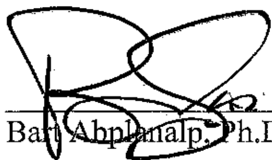
01/21/14 – **Interdisciplinary Progress Note**. By Marshall Powe. Patient 13 was seen after telling a CO that he was depressed. He was seen by M. Powe who noted that Patient 13's "tears were a mere convenience to get an audience." No intervention noted.

01/29/14 – **Psychiatric Visit**. Patient 13 saw NP Dunn and generally reported no problems other than some irritability. He requested an increase in Remeron.

Over the next three months, the pattern of interactions was nearly identical. MH Rounds consistently noted that he had no problems or complaints (with the exception of one note that indicated that he complained of not receiving his medications). His treatment plans continue to be generic and nearly identical to all the previous ones.

Other than medications, Patient 13 has received no treatment between the times reviewed (December 2012 through April 2014). His mental health rounds consistently – nearly identically – report the same thing: no problems or concerns noted or observed. His Quarterly Treatment Team Reviews occasionally mention some of the problems that he has been experiencing (that are not noted in ANY of the mental health rounds), but neither the team review nor the corresponding treatment plans even attempt to address whatever problems are noted.

Respectfully submitted on this 16th day of June, 2014 by



Bart Abplanalp, Ph.D.