



CORRECTIONAL MEDICAL AUTHORITY

FOCUSED REVIEW OF MENTAL HEALTH CARE

at

LOWELL CORRECTIONAL INSTITUTION

in

Lowell, Florida

on

March 4-5, 2004

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Introduction

In January 2004, the Correctional Medical Authority (CMA) received a complaint from a family member regarding psychiatric care being rendered at Lowell Correctional Institution (LOWCI). As a result, the CMA began to monitor the psychiatric services.

In the course of this monitoring, it was discovered that a new psychiatrist transferred to LOWCI around October 2003. One year prior, the CMA had received inmate complaints from Lake Correctional Institution about the care this physician had provided there. Allegations were made that psychotropic medications were being discontinued in large numbers without justification at Lake. At that time, the CMA expressed concern to the department about this practice, but their response indicated that sufficient justification was present in the case referred for review. The appearance of this clinician at LOWCI, in conjunction with a similar complaint, prompted the CMA to take a team of surveyors to review the care being rendered. This review was conducted in conjunction with a corrective action plan assessment for the close management population. The results of that assessment are available in a separate report.

March 4-5, 2004, records of general population and reception inmates at LOWCI were reviewed. Interviews were conducted with the Chief Health Officer, psychiatrists, psychiatric nurses, psychological specialists, and inmates. At the conclusion of this process, an exit conference was held with institutional and regional staff during which preliminary results of the review were presented.

The egregious nature of the concerns identified during the course of the review led to an emergency notification sent on March 5, 2004, to Secretary Crosby. This report describes those concerns and additional findings that, while not deemed emergent, require corrective action and impact the overall quality of care at LOWCI. Surveyor comments regarding several cases of concern identified during the survey follow the report's section describing findings.

Emergency Notification

Emergency Finding 1:

Psychotropic medications were discontinued without sufficient clinical justification.

A review of records and interview data confirmed that psychotropic medications were discontinued without proper documentation of clinical reasoning and without the input or consent of patients. Data gathered prior to the initiation of the survey revealed that one hundred fifty patients in the Annex were downgraded from S-3 to S-2 status during January 2004. However, interview data gained during the survey indicated that the scope of reductions over the course of the prior five months neared six hundred women.

Interviews indicated that officials became concerned about a problem with illicit sales of psychotropic medication. Some staff suspected inmates of lying to clinicians about symptoms to obtain a prescription for medication that could be sold to other inmates. In response to this suspicion, hundreds of inmates were denied mental health medication. In many of the cases reviewed, documentation in the medical records contained little more than an order to discontinue medication and a referral for substance abuse treatment. If there was a concern that a particular inmate was falsely reporting symptoms, there was no documentation of the evidence by which this

conclusion was drawn. Furthermore, medications were frequently discontinued without tapering, which is contrary to accepted psychiatric practice.

Emergency Finding 2:

Psychiatric follow-up was insufficient following discontinuation of medication.

Interviews indicated that an appointment was scheduled thirty days after medication was discontinued. At the appointment time, an S-grade of 2 was assigned. S2 inmates receive case management and counseling services by a psychological specialist but are no longer followed by the psychiatrist. Department policy calls for a minimum of 60 days of follow-up prior to an S-grade reduction. Thirty days of follow-up is insufficient to ensure adequate adjustment has been achieved without medication.

Emergency Finding 3:

Coordination of clinical care between psychiatric and psychological staff appears to have deteriorated significantly.

The appointment of the new lead psychiatrist at LOWCI was accompanied by the creation of "psychiatric staffings". As described in interviews, these staffings were held on Tuesdays of each week and consisted of the lead psychiatrist and the two staff psychiatrists, at times a psychiatric nurse, and the inmate. Medications were often discontinued during these staffings. Documentation of the staffing in the medical record was frequently deficient. Often the documentation consisted only of an incidental entry and did not specify that the patient was present during the encounter. Of concern was the absence of the psychological specialist and senior psychologist in an encounter that appears to have served as a clinical case staffing. On the other hand, interviews suggested psychiatric staff were frequently absent from the traditional staffings, or Individualized Service Plan reviews. This new psychiatric staffing format appears to divide the two disciplines. It is contrary to departmental policy and does not contribute to an integrated treatment approach.

This breakdown between disciplines was evident in the documentation of inmate encounters. In many of the cases reviewed, psychological specialists documented deterioration in mental status following discontinuation of medication. In contrast, the sparse documentation by psychiatry did not reflect the same complaints and provided no indication that the concerns and observations noted by the psychological specialist were reviewed and considered in the plan of care.

Corrective Action Plan

On March 8, 2004, the department submitted a corrective action plan to the CMA as required by statute. The CMA expressed concern that this document failed to address the urgency of the emergency findings identified and requested that a revised plan be submitted. Both documents are attached to this report.

The CMA also has concerns with the second CAP as the review relies heavily on local staff members to identify and revise existing problems. It is recommended that psychiatrists outside the region or the department be used to conduct the clinical review. Furthermore, interim progress reports every 14 calendar days should be submitted to the CMA to ensure adequate progress is made in correcting the deficiencies.

Additional Survey Findings

Records Reviewed:	
FINDINGS	
21	
Finding(s)	Suggested Corrective Action(s)
MH-1: Medication consent forms did not consistently specify pertinent side effects for each medication prescribed.	<p>Provide inservice training regarding the correct completion of the consent form.</p> <p>Monitor a minimum of ten records each month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
MH-2: Abnormal Involuntary Movement Scale (AIMS) testing was not conducted as required (see discussion below).	<p>Current policy requires AIMS testing to be administered every six months for patients receiving antipsychotic medications and every three months if abnormal involuntary movements are detected.</p> <p>Provide inservice training.</p> <p>Monitor a minimum of ten records each month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
MH-3: Past treatment records were not requested for patients who had received mental health treatment in the community.	<p>Develop a system whereby past treatment records are obtained during the reception and intake process.</p> <p>Monitor a minimum of ten records each month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
MH-4: In one case reviewed, an inmate who was menstruating was placed in the Isolation Management Room (IMR) without undergarments. A male correctional officer was assigned to this observation post.	<p>Provide appropriate undergarments for menstruating females who are being observed for suicidal behavior.</p> <p>Utilize only same-sex staff members to observe patients for whom full clothing has been denied.</p> <p>Monitor a minimum of ten or all records each month of inmates placed in the IMR to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>

MH-2 Discussion:

As is standard CMA practice, the surveyor completed a Missing Document Form when an AIMS was thought to be missing from the record. This form was given to the institutional staff so that any misfiled documents may be located. The staff member was then required to write a response on the form indicating if the form was indeed missing and any explanation of why the form might be missing. On one of these forms, the response from institutional staff was as follows:

“Per Dr. [X] AIMS completed for I/M on antipsychotic meds minimum 1X per yr. More frequently if sx/side effects present.”

The department standard required AIMS to be completed every six months. If abnormal involuntary movements are detected, AIMS should then be completed every three months.

Surveyor Comments

While documenting their evaluation of the care provided at LOWCI, surveyors included case comments on their review sheets. To illustrate the concerns that generated the above findings, these comments are transcribed below.

Inmate A

Despite a long history of Schizoaffective Disorder, the patient's diagnosis was changed and her medication discontinued because the patient's perception was that the medication helped her sleep. No documentation of AIMS testing was present in the record.

Inmate B

There was no documentation of discussion with the inmate of treatment alternatives to Risperdal. There was no mention of her previous relapse off medication. There was no discussion of the risk that her symptoms would return and no indication that the psychiatrist discontinuing the Risperdal was aware of her previous history. Her S-grade was dropped 14 days after discontinuation of Risperdal. The medication was discontinued despite her complaints of auditory hallucinations and her request that the medication be restarted.

Inmate C

Prozac was discontinued on 2/24/04 by Dr. [X], then a note by Dr. [Y] the following day decreased the patient immediately to an S-2 with no plans for psychiatric follow-up. A discussion of treatment alternatives, return of symptoms, and timely follow-up did not occur. This is a patient who was in the [Transitional Care Unit] TCU only 6 weeks prior, and this followed a discontinuation of Prozac due to a “pill line problem” (12/27/03).

Inmate D

There was no rationale for medication discontinuation. The patient's longitudinal symptom history was not addressed. The patient had signed a refusal for Risperdal due to documented akathisia on 11/3/03. Subsequent follow-up did not address side effects and symptoms previously documented. Hallucinations and affective instability erupted within days of discharge and medication treatment was re-started by Dr. [Z] on 11/20/03. Good treatment response

documented by Dr. [X] on 1/5/04. But then, Seroquel was discontinued without documented explanation.

Inmate E

Patient complains of “hyper” mood, and observed labile affect was not addressed therapeutically. What treatment options were discussed with patient? Why must referral be made to Dr. [X] to restart medication? (11/19/03). Why aren't treatment options being discussed with the patient? There is no documentation of this.

Inmate F

There were repeated requests to resume antidepressant medication secondary to irritability, anxiety, insomnia (many entries). The patient was required to “wait 90 D” to have medication restarted. No discussion of treatment alternatives to address patient's symptoms. Patient reduced to S2 despite continued complaint and no rationale or discussion of treatment options.

Inmate G

The psychiatrist discontinued Depakote and Thorazine due to complaints of tremor on 10/27/03. Diagnosis was changed from Bipolar Disorder to Adjustment Disorder by the psychiatrist, who saw her for the first time, and no medication was ordered despite continued mood and psychotic complaints. Psychiatric follow-up did occur, though it did not address concerns expressed by the referral source. No AIMS screening despite treatment with Thorazine.

Inmate H

Patient has been referred twice to the psychiatrist since 2/16/04 after claiming an overdose of medication. She has still not been seen. She was seen by a nurse on 2/16/04 with a contradictory, ambiguous progress note. Zoloft was discontinued 11/13/03 by Dr. [X], with no documentation that Dr. [X] had seen that patient at all. Patient has still not been seen by a psychiatrist for follow-up. Had “no show in pill line” several times. Patient was last seen by discontinuing psychiatrist September 2003 (medication discontinued 11/13/03).

Inmate I

Tegretol and Prozac were discontinued on 12/3/03 without any documentation of a visit/examination by the psychiatrist related to the discontinuation of medication.

Inmate J

The inmate came from the county jail with Paxil and Vistaril on 12/19/03. She was not seen for a psychiatric evaluation until 1/16/04 at which time the psychiatrist noted that she had no medication since 12/20/03. She was made an S2 with no psychiatric follow-up. The discontinuation order for Paxil was written by Dr. [X] on 12/29/03. He did not see the inmate; it was a chart review only.

Inmate K

Medication was discontinued with no clinical interview or rationale documented.

Inmate L

S1 grade is not appropriate for a patient just having completed Methadone treatment. There was inadequate documentation of the 1/27/04 staffing with no SOAP note. She should not have been made an S1 with an order for Vistaril and psychiatric recommendation for weekly psychology contacts.

Inmate M

The patient arrived from the county jail on Klonopin 1 mg q.i.d. This was discontinued with no clinical rationale and no tapering.

Inmate N

On 2/16/04, the psychological specialist indicated the need for an immediate psychiatric evaluation. It was not done until 2/25/04. The resulting recommendation was for "Therapy for Substance Abuse with psychologist", and Axis I was "1) deferred; 2) cocaine abuse". She was made an S2.

Interview Data

In addition to concerns noted in the medical records, interviews with staff and inmates surfaced concerns regarding the tone of interactions between psychiatric staff and their patients and coworkers. Listed below are excerpts from these interviews.

"I have yet to see a true suicide case here."

"There was a big drug ring going on here."

"95% of them are lying."

"You can tell who's selling because they get very angry."

"Inmates were requesting all their own meds. Refusals and game playing have gone down."

Referrals to psychiatry are "useless". Inmates are "ripped off medications, not even tapering down."

"[Medication] decisions are made over there. I'm not a part of that process."

"He yelled at me."

"I have mood swings, anxiety, and need medication." "Dr. [X] said no."

"He is almighty and all knowing."

"You have to use tactics [when talking with the psychiatrist]." "He'll sabotage."

"I was traumatized."

[He said], "I'm talking loud so you will remember."

"I became passive. He needs to be in charge."

[He said], "You're pretty and smart. I would understand otherwise."

"My mother was told [medication discontinuation] was because of budget cuts."

"[He] screamed [that] he could determine anything he wanted because he was a doctor."

[He said], "What part of English don't you understand?"

"State don't want to pay for all these meds."

"One girl said [to psychiatrist] she was court ordered, but I am, too. I wrote to my judge to try and get the papers. I told Dr. [X] and he said he didn't care."

[He said], "You don't tell me what you need. Get out of my office." "I don't care about your feelings."

"People are scared to go see him."

"He'll look at you and say, "Get out of my office. Hurry before I write you a DR."

[He was] "talking nasty to me, looked at me and said, "I'm taking you off."

CONCLUSION

During the two days allotted for the focused review at LOWCI, findings were uncovered with dangerous implications for the health of the inmates in need of mental health treatment and for the department in terms of defense against claims of medical negligence. If the staff's allegations that many inmates were lying to obtain medication for illegal purposes were true, then the documentation of that situation was absent from the medical records, leaving the impression that inadequate care was provided. If staff claims are not true, the situation represents a punitive mindset in the clinicians toward the patients they are charged to treat. The findings uncovered in this review represent a compromise to the quality of healthcare for these incarcerated mentally ill.

Expedient action by the department should be taken to ensure that no mentally ill inmate is left untreated. Furthermore, an in-depth review should be conducted to determine the presence of any systemic encouragement by administrative personnel to reduce the number of patients receiving psychotropic medications.

The CMA will monitor the concerns identified in this report with timely reviews at LOWCI to ensure that corrective action is taken and is successful in resolving the dangerous situation that has developed.