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U.S. Department of Justice
Civil Rights Division
Special Litigation Section
Attn: Christopher Cheng, Esq.
P. O. Box 66400
Room 1716, Main DOJ
Washington, D.C. 20035

Re: Julia Tutwiler Prison for Women

Dear Mr. Cheng:

I have completed my assessment concerning the mental health services offered at the Julia Tutwiler Prison for Women. As you are aware, I made a site visit to this prison from June 1-3, 1994. During the assessment process I had the opportunity to meet with the following staff:

1. Ms. Shirlie Lobmiller (Warden);
2. Mr. Tom Allen (Associate Commissioner for the Department of Corrections);
3. Merle Friesen, Ph.D. (Director of Treatment);
4. H. E. Logue, M.D. (Medical Director, Medical Business Management);
5. George Lyrene, M.D. (Medical Director, QuestCare);
6. Helen Thompson, Ph.D. (Staff Psychologist);
7. Jerrold Gilbert, Ph.D. (Contracting Psychologist);
8. Nancy Woodfin, R.N. (Director of Nursing);
9. Deborah Wright (QuestCare Regional Administrator);
10. Jane Guest, R.N. (Quality Assurance Coordinator); and
11. Evelyn Barbee, R.N. (Medical Business Management).

We were accompanied by attorneys representing QuestCare and the Department of Corrections throughout the three day site visit.

During the three day site visit, I reviewed the following documents:

1. policies and procedures manual (revised 1993) for QuestCare Inc.;

2. minutes of the Medical Advisory Committee (May 26, July 29, September 30, December 2, 1993);
3. an April 7, 1994 evaluation report concerning the mental health services at the Julia Tutwiler Prison for Women by Alan E. Shealy, Ph.D.;
4. various inmate grievances filed during the past year;
5. treatment division manual for the Department of Corrections;
6. institutional incident reports (May 1993 - April 1994);
7. a December 1993 mental health summary report for services offered at the Tutwiler Prison;
8. the health care unit logs for the month of April 1994;
9. the inmate handbook;
10. health care formulary; and
11. contracts between the Alabama Department of Corrections and QuestCare.

I talked to the five inmates housed in the mental health unit within the infirmary and reviewed all their charts. I briefly talked to thirteen inmates in the administrative segregation unit and reviewed charts of two inmates within that unit. I talked briefly to the four inmates who were housed in death row. I also interviewed twelve inmates who were receiving mental health services and reviewed their medical charts.

OVERVIEW

The Julia Tutwiler Prison for Women was constructed during the late 1930s and initially opened during 1942. This prison, which includes all security levels, is the only prison for female inmates within the state of Alabama. The rated capacity was 754 inmates and the count during June 1, 1994 was 727 inmates (which included fourteen inmates in the segregation unit, four death row inmates, and thirteen inmates in the medical isolation unit). Approximately 40% of the inmate population was attending trade school. The bed capacity in the dormitories ranged from 35 beds to 125 beds. Most of the dormitories were 60 bed units.

Since 1979, the Department of Corrections has contracted with various private vendors who provide all medical care (which includes psychiatric care) for inmates throughout the Department of Corrections. QuestCare, which has subcontracted the mental health services to Medical Business Management, has been the current contractor for about 2 1/2 years. A new three year contract for medical services will be awarded in the very near future.

Current mental health staffing includes the following positions:

1 contract psychiatrist (8 hours per week - recently vacant);
1 full-time Ph.D. psychologist (DOC employee);
1 contract Ph.D. psychologist (16 hours per week - two 8 hour days);
1 masters level full-time mental health clinician (DOC employee); and
2 FTE addiction specialists (one with a master's degree and one person working

towards her college degree).

All female inmates initially are admitted to the 65 bed dormitory intake unit (Dormitory 7). Psychological testing is administered in group sessions which includes a Beta Revised for IQ testing, the reading portion of WRAT and a MMPI-2. An AMMONS is administered if the Revised Beta score is less than 70. A WAIS-R is administered to inmates receiving an AMMONS score of less than 70.

A psychiatric consultation is provided to inmates who have been receiving psychotropic medications immediately prior to their admission to the prison. The mental health clinician eventually interviews each inmate for about one hour which becomes documented through a handwritten report which becomes part of the institutional file and medical record.

Helen Thompson, Ph.D., who has been working at the prison for about six years, was interviewed. She estimated that there were currently about fourteen inmates with diagnoses of either bipolar or schizophrenic disorders. Approximately 125 inmates were receiving some form of psychotropic medication. Individual and group therapies are available to the inmates. A variety of workshops are also available to inmates which have included issues related to parenting skills, stress management, depression, and reality therapy. Dr. Thompson did not think that there was currently a need for an intermediate care unit (a special housing unit with enhanced staffing and programs for inmates with serious mental illnesses who do not require psychiatric hospitalization but are unable to function adequately within the general population housing units) although she stated that inmates with severe mental illness receive enhanced treatment which appeared to be supportive in nature on an individual basis. It appeared that the time required before an inmate received a consultation by a psychiatrist ranged from one to four weeks depending on the nature of the problem.

Dr. Thompson makes rounds in the segregation unit twice per week and in death row as needed. In addition to the services offered to inmates by the two full-time DOC mental health clinicians, a contract psychologist, Jerrold Gilbert, Ph.D., was providing individual treatments to about 40-50 inmates. There was also a substance abuse program which consisted of an eight week treatment program for about twenty inmates per group. Approximately two to three parole board evaluations are performed per month by the mental health staff. Secretarial assistance is provided through the warden's office and classification services.

Inpatient psychiatric treatment is available through Bryce State Hospital although access to this hospital has been problematic due to a bed shortage. There was a five cell mental health unit (referred to as the "Green room") within the health care unit. There were five inmates in the mental health unit during the site visit. One inmate had been waiting about three months for a bed to be available at Bryce State Hospital. Another inmate was waiting for an involuntary medication hearing. Chronically mentally ill inmates are frequently housed in Dormitory 8 which was adjacent to the medical infirmary. Fourteen HIV positive

inmates were housed in the medical isolation unit.

The staff reported that restraints are rarely used within the mental health unit. Restraints are periodically used within the administrative segregation unit. It was my understanding that a specific restraint log book did not exist.

Nancy Woodfin, R.N., Director of Nursing, was interviewed. She reported that triage screening for sick call was done on a daily basis by L.P.N.s beginning at 11 PM. Ms. Woodfin was very vague in providing information regarding sick call but eventually estimated that approximately 50-60 inmates signed up for sick call each day. She was unable to estimate the number of inmates who refused to attend this triage screening except for saying that the number was low. Ms. Woodfin did not know whether any of her nursing staff had mental health experience.

There did not appear to be any timely formal mechanisms to notify the psychiatrist when an inmate refused to take prescribed psychotropic medications. However, an informal notification process was vaguely described by Ms. Woodfin. Ms. Woodfin was not aware that many lithium level results were not found in the various medical charts and/or orders for lithium blood levels were not being followed.

It was reported by Ms. Woodfin that a staffing is held every two weeks to discuss issues relevant to patients in the mental health unit.

X-rays are provided through Kilby Correctional Facility which was about 20 miles from the prison. Emergency services are available through the Central Alabama Regional Hospital which is a 40 bed institution. There were also contracts to provide medical services with two Humana Hospitals in Montgomery, Alabama.

Pharmaceuticals are obtained through a central supply in Birmingham which makes deliveries on a daily basis. A pharmacist was not on site at Tutwiler Prison. The Director of Nurses was responsible for medication administration.

Review of the QuestCare Inc. policies and procedures manual (revised 1993) and the DOC treatment division manual revealed many pertinent policies and procedures to either be absent or vague. For example, I did not find policies or procedures pertinent to medication protocols, treatment plans, quality assurance, and many other areas as outlined by various national organizations such as the National Commission on Correctional Health Care.

MENTAL HEALTH UNIT (MHU)

I interviewed all five inmates who were housed in the "Green room" within the mental health unit. This unit was essentially an observation unit within the health care unit that did not have a treatment program appropriate for inmates with serious mental illnesses.

All five of the inmates interviewed were suffering from serious mental illnesses which have been associated with psychotic symptoms. One of these inmates (CW) had been waiting transfer to Bryce State Hospital for several months. Review of the charts of these inmates revealed inadequate documentation (e.g., lack of and/or vaguely written initial evaluations, treatment plans, and progress notes), and very questionable practices regarding the use of psychotropic medications. For example, multiple medications (i.e., polypharmacy) were frequently prescribed without adequate documentation concerning the rationale for such treatment. Lithium was prescribed frequently without appropriate laboratory studies being ordered (i.e., pre-lithium work-up and/or periodic lithium blood levels). It did not appear that past medical records were reviewed as part of the psychiatric evaluation and/or treatment planning process. For example, inmate SW was prescribed lithium despite a past history which was documented in her old medical chart of a serious adverse reaction (decreased white blood count) related to lithium use. Various orders regarding lithium and Dilantin levels were reviewed which were not accompanied by laboratory results in the chart.

The MHU had significant physical plant limitations which contributed to an inadequate treatment facility for inmates with serious mental illnesses. Other factors contributing to inadequate treatment for inmates housed within this unit included lack of treatment plans, inadequate documentation concerning initial evaluation and progress notes, and very concerning and questionable medication prescribing practices.

CLINICAL INTERVIEWS

I interviewed twelve general population inmates who were receiving some form of mental health treatment. At least five (PB, ME, TD, CS, KF) of these inmates were appropriate for an intermediate care unit environment due to the presence of serious mental illnesses. In general, documentation in the medical records for all these inmates was poor for reasons related to lack of adequate initial evaluations, progress notes, and/or treatment plans. Polypharmacy was often part of the treatment (without adequate documentation concerning the rationale for such use of medications). I did not find evidence that adequate patient education was part of the treatment plan or that efforts were regularly undertaken to detect and/or treat tardive dyskinesia (i.e., use of Abnormal Involuntary Movement Scale).

The use of lithium for various inmates (TD, CS, FC, TI, AG, TF) was problematic due to lack of documentation concerning indications, inadequate evaluations (i.e., pre-lithium laboratory testing), and/or a follow-up (not obtaining lithium levels at appropriate intervals).

At least three inmates (FC, TW, and AG) described a history of current or recent significant medical problems which did not receive appropriate management. These histories appeared to be confirmed from review of their medical charts.

One inmate (TI) reported significant sedation for reasons that were unclear to her. She stated that she would get a disciplinary report if she lies down during the day due to security

regulations. Review of her medical records confirmed her history of sedation. Her medications, Mellaril 175 mg po qd, lithium 900 mg po qd, and imipramine 300 mg po qd was the most likely cause of her sedation. Review of the inmate handbook appeared to confirm the information obtained from TI concerning such disciplinary reports.

ASSESSMENT

There are serious problems concerning the mental health services offered to inmates at the Tutwiler Prison for Women. Review of medical records revealed lack of treatment plans, inadequate progress notes, and dangerous practices concerning the use of psychotropic medications. Specifically, lithium was often prescribed without adequate laboratory testing and/or monitoring of lithium levels. Polypharmacy, which generally is indicative of poor clinical practice, was not uncommon and was prescribed without adequate documentation concerning the reasons for such practice.

I was able to rather easily identify ten inmates with serious mental illnesses (i.e., mental disorders associated with psychotic symptoms and/or significant functional impairments) who were receiving treatment which represented an inadequate level of care. Specifically, these inmates required either psychiatric hospitalization or treatment in an intermediate care unit due to the chronicity and severity of their symptoms. It is very likely that lack of such treatment has or will result in many of these inmates' conditions either significantly deteriorating or not improving. The mental health unit's physical plant also causes a deterioration in the mental condition of many inmates housed within the MHU. Such a deterioration is made worse by the lack of an adequate treatment program within the MHU.

It is my opinion that the mental health services offered at the Tutwiler Prison for Women are inadequate for reasons which have already been summarized. I have provided a summary concerning my examinations of these inmates in the appendices.

Please do not hesitate to contact me if I can answer any further questions.

Sincerely,

Jeffrey L. Metzner, M.D.
Diplomate, American Board of Psychiatry and Neurology

JLM/stat

APPENDIX A

ASSESSMENTS REGARDING INMATES IN THE MENTAL HEALTH UNIT

1. SB, who is 49 years old, reported that she had been in prison since July 1992 and has been admitted to the mental health unit at least five times. She stated that she was hospitalized in the past at Searcy Hospital. She reported that her diagnosis was schizophrenia. Medications included Mellaril 100 mg po qd and Artane. SB was transferred from Dormitory 8 to administrative segregation prior to her transfer to the MHU two nights earlier. SB continues to experience auditory hallucinations. She was unclear regarding the reason for her current transfer.

   I reviewed both volumes of her chart. The admission notes were inadequate and did not contain a chief complaint or history of present problems. Admission orders to the Green room frequently stated as follows: "Admit to Green room. Dr. Thompson may release when appropriate." I did find old records from Bayside Orthopedic Center but I did not find many past psychiatric records. There was a handwritten letter from SB to the Family Care Health Center which requested such records. This letter indicated that she had not been receiving medication for over nine months in prison.

   An August 3, 1992 note indicated that "it seems wise to get records from Searcy and other hospitals... ." A September 13, 1992 note indicated a diagnosis of chronic schizophrenia. Auditory hallucinations have been present for twenty years. SB has been on a number of different medications. There were orders from January 5, 1993 to get old medical records.

   During February 23, 1994 she was started on lithium 300 mg po BID. I do not find any evidence of a pre-lithium work-up. A December 30, 1993 note indicated a creatinine of 1.3 and a BUN of 9. A November 9, 1993 showed a CBC which was within normal limits. No thyroid studies were done.

   There was a discharge order from the infirmary which was dated January 4, 1994. A March 9, 1994 note appeared to be an admission order to the Green room for one week. There was not an accompanying admission note. The lithium was stopped during February 16, 1994 and her Mellaril was eventually increased. There was a note from March 14, 1994 which raised the issue of lithium toxicity. During March 16, 1994 SB was considered for transfer to Bryce State Hospital due to her fixed delusional beliefs involving snakes in her mattress. Lithium levels apparently were not ordered until apparently March 19, 1994 which showed essentially a zero level.

   Deficiencies in this record included an inadequate psychiatric history and no documentation concerning information obtained from prior records and/or providers.

It was unclear whether psychiatric hospitalization would be helpful to this patient who described a history of chronic unremitting psychiatric symptoms. There were frequent admissions to the infirmary but lack of adequate documentation concerning such admissions. The major clinical question was whether this person should be in a hospital setting or in an intermediate care unit.

2. CB, who was 34 years old, had been in the mental health unit for many months following a transfer from Dormitory 1. She was vague regarding the reasons for the transfer but appeared to indicate it had to do with lesbian overtures. She reported that she was receiving Haldol and had been diagnosed as having a multiple personality disorder (MPD) based on trial testimony.

Review of her chart revealed the presence of a nursing plan. The patient apparently has been experiencing auditory and visual hallucinations which have directed her to injure herself and/or others. The nursing plan was not dated and appeared somewhat boiler plate in format. The plan did not comment on the patient's progress concerning achieving her goals.

A May 6, 1993 note by William Grant, M.D. indicated that he knew the patient and had testified at her trial. Dr. Grant had reviewed her mental health records prior to the trial. There was a history of numerous psychiatric hospitalizations and violent episodes. Her diagnosis has consistently been schizophrenia. Dr. Grant raised the issue of MPD. The computerized MMPI interpretation was not very helpful.

CB apparently was admitted to the prison during May 1993. She was placed in the Green room for reasons that are not documented. During July 22, 1993 she was prescribed Tofranil 150 mg hs for three months prn, Haldol 30 mg po hs for three months, and Mellaril 100 mg for three months. Benadryl was discontinued. The rationale for this medication regimen was not present in the chart. It appeared that she was seen by the psychiatrist on a monthly basis according to the physician orders.

A September 15, 1993 note indicated that a mental health evaluation was requested by a correctional officer because she was foaming at the mouth and apparently demonstrating other strange behaviors. A history of chronic hallucinations was elicited. She was again seen during September 20 and September 27, 1993 and during the latter visit her medications were then written for 12 weeks. An October 16, 1993 note indicated that she was having psychotic symptoms. A November 29,1993 note stated that CB had requested transfer to Searcy State Hospital. A psychiatric consultation was then requested. A December 31, 1993 note indicated that her psychosis was in remission. In December her Mellaril was increased from 100 to 300 mg. It was noted that she should be seen in follow-up in six weeks. Tofranil was increased from 150 to 200 mg with a similar follow-up period. Her Haldol appeared to have been changed from 30 mg to 20 mg.

An April 11, 1994 note indicated poor patient compliance with treatment. There were monthly notes by the psychiatrist which contained little information. A June 1, 1994 note by Dr. Logue indicated that she remained psychotic with the diagnosis of paranoid schizophrenia. However, he reported that she "is manageable."

There was a QA audit report dated April 18, 1994 which essentially indicated that there was no problem with her medical records. This form contained the following questions:

(1) Are the inmate's complaints well-defined and understandable?
(2) Is there a treatment plan in place for each problem documented?
(3) Is there sound objective data to support the assessment documented on medical records?
(4) Do the subjective comments reflect the objective data and assessment?

I did not agree with the assessments from this QA audit which indicated there were no problems with documentation. The QA audit was essentially a self-assessment process because the psychiatrist audited his own work. This patient was an appropriate candidate for an ICU environment.

3. SW stated that she had been in the mental health unit for about two days following a transfer from Dormitory 3. She reported her current medications were lithium and Elavil. There was not a note in the chart indicating admission to the unit. An April 11, 1994 note indicated that she was quite manic when in the Green room. There was a discharge order from the MHU dated May 2, 1994.

A May 1, 1994 EKG report indicated sinus bradycardia with no acute changes. A May 2, 1994 progress note indicated that she was started on lithium. A lithium level was ordered which appeared to require lithium levels twice per week. There were notes that lithium levels were drawn during April 29 and May 12, 1994. However, I did not find either laboratory results or documentation concerning such results.

A note by Dr. Logue (June 1, 1994) indicated that she can now control her voices but still concerned with the "dog world." Diagnosis was listed as bipolar disorder.

The first volume of her chart did have some past records although I was unable to find any that provided diagnostic and/or treatment recommendations. There were copies of records release forms sent in the past.

Review of a August 27, 1992 note indicated that lithium had been discontinued due to a WBC count of 3.3. Valproic acid was started after her WBC returned to normal. Her WBC count prior to beginning lithium was noted to have been low. Specifically, her WBC count on July 28, 1992 was 4.6 which went down to 3.3 on August 14, 1992 and returned to 7.3 on August 31, 1992. Lithium was ordered on

August 6, 1992 and discontinued on August 27, 1992. A WBC count of 5.5 was noted during February 19, 1993. Lithium was restarted on May 2, 1994. A subsequent CBC has not been ordered. (I discussed this information with Dr. Logue)

The progress notes in volume II of her medical records were much better than the progress notes during the past year.

SW was an appropriate candidate for an ICU. There were significant clinical problems concerning the use of lithium which appeared to not have been recognized by her treating psychiatrist.

4. CW reported being in the mental health unit since March 16, 1994 after having been in the administrative segregation unit since November 27, 1993. She was a 33 year old woman who was awaiting transfer to Bryce State Hospital. She reported that she was receiving 700 mg po qd of Thorazine, 100 mg po Dilantin, and 30 mg of phenobarbital. She had a history of sexual abuse and a head injury secondary to a gunshot wound. CW reported a history of auditory hallucinations. A July 15, 1993 note indicated that she had schizophrenia which was in remission.

Dr. Muhammed's notes were difficult to read. A November 29, 1993 note indicated that she attempted to hang herself. This note indicated that she was more of a management problem as opposed to being mentally ill. Dr. Muhammed agreed with the plan to transfer her to administrative segregation.

During January 11, 1994 CW was assaultive and hit a correctional officer on the right breast. The Sanity Commission made its recommendation for transfer to Bryce State Hospital during January 12, 1994. A March 17, 1994 transfer to the state hospital was ordered via an executive order. This transfer has obviously not yet occurred.

CW was placed in administrative segregation until March 14, 1994 despite the Sanity Commission's finding. The medical log for segregated inmates in disciplinary segregated status indicated a code 1 which meant "no psychological or medical complaint voiced and no evidence of physical trauma." She was in disciplinary segregation until at least February 1, 1994.

A Dilantin level was drawn during April 3, 1994 but I was unable to find any documentation of the results. There was a Dilantin level from March 9, 1994 which was within the therapeutic range. There was an April 18, 1994 quality assurance audit which indicated no problem with the medical records.

CW has been diagnosed as suffering from probable schizophrenia by Dr. Logue as per his June 1, 1994 note.

Due to time limitations, I only briefly reviewed her other two volumes of medical

records.

CW was in need of inpatient psychiatric treatment and had been waiting for transfer to the state hospital for almost three months. The medical log notations concerning her status while in disciplinary segregation were concerning due to the inference that she was not experiencing psychiatric problems despite the clear presence of a serious mental disorder.

5. GR was a 34 year old woman who stated that she had been in the mental health unit for two weeks after being transferred from Dormitory 8 due to suicidal ideation. GR had been in prison since 1984.

There were five volumes of GR's medical chart. The most recent volume was reviewed. An August 30, 1993 note indicated that bipolar illness with acute psychosis was diagnosed. Blood work had been drawn on November 1, 1993 related to orders from October 18, 1993 which included thyroid function studies, BUN and creatinine. Serum lithium level was ordered q three months. Thyroid function studies had been ordered September 13, 1993 as was lithium. Tegretol was ordered during October 18, 1993 which was apparently discontinued at the same time the lithium was stopped without an accompanying progress note. There was inadequate documentation concerning medication orders pertinent to lithium and Tegretol. Lithium was renewed during November 8, 1993. The lithium appeared to have been discontinued shortly thereafter. During November 15, 1993 lithium 900 mg was started. There was not a note concerning the reason for using this medication. A December 13, 1993 note indicated that thyroid function studies were within normal limits and that a lithium level had been obtained. Creatinine was pending. BUN within normal limits.

During March 28, 1994 her Mellaril and Elavil were discontinued. These medications were again started on April 11, 1994. An April 4, 1994 note indicated that she had a relapse of a schizophrenic disorder. An April 21, 1994 order included a CBC, SMA-12, urinalysis and thyroid function studies. These tests were ordered April 18, 1994 apparently in relationship to hematuria and nausea. Dr. Lyrene had ordered them. A May 9, 1994 order included Elavil 200 mg po hs and Mellaril 225 mg. The Mellaril was decreased to 100 mg on May 16, 1994 and her Elavil to 200 mg. Her Elavil was increased to 250 mg during May 23, 1994 and the Mellaril was changed to 50 mg po bid. A June 1, 1994 note indicated a diagnosis of bipolar affective disorder with current medications being Mellaril and Elavil.

This chart contained poor documentation. GR appeared to be an appropriate candidate for an ICU.

APPENDIX B

INTERVIEW WITH INMATES

1. PB has been in Dormitory 8 for about 2 1/2 months. She has been on Haldol 2.5 to 5 mg po qd for nine days for what appeared to be episodic psychotic episodes. She has been evaluated at Bryce State Hospital in the past. PB stated that she was in the medical dorm due to a heart condition, back problems, and her age of 53 years. She works two hours per day as a housekeeper.

   Review of her chart revealed that she had been at EMC for several years but stated that she got into a fight for the first time during December 1993.

   During February 11, 1994 she was discharged from the mental health unit. PB was moved to Dormitory 8 in March at her request due to difficulty adjusting in the dormitory.

   PB reported that her PPD was never read. A February 20, 1994 indicated that her PPD was administered. I did not find any documentation in the chart that her PPD was ever read. She denied a history of auditory or visual hallucinations. She also sees Dr. Gilbert on a monthly basis.

   A May 4, 1994 note from Dr. Gilbert indicated that it was difficult to separate facts from delusions. During June 1, 1994 she was rejected for parole for the eleventh time. She was in the Green room during March 1994 due to problems with other inmates in the south hall. It appears that she has had paranoid thinking in the past.

   She would be an appropriate candidate for an ICU environment. There is ample documentation in the chart concerning the presence of a chronic mental illness but poor documentation regarding her diagnosis. However, it should be noted that I reviewed just volume VI of her six volumes of charts.

2. BC is apparently on Prolixin decanoate. She was reluctant to talk but stated that she had no complaints and was satisfied with her treatment. Her medical chart was reviewed. She is on Prolixin decanoate, Thorazine and Cogentin.

   I am unable to comment whether she is appropriate for an ICU environment based on lack of adequate documentation in the chart.

3. TD has been on lithium for five years for treatment of an apparent bipolar disorder. She has been at EMC for the past couple of months and will be completing trade school in auto mechanics next month.

The second volume of her two volume chart was reviewed. Her serum lithium level during October 4, 1993 was 0.52. Thyroid function tests were done during October 6 and December 7, 1993. A lithium level was ordered during December 7, 1993. The lithium level was 0.22. A handwritten note by Dr. Muhammed indicated that the plan was to encourage compliance. Her lithium level during December 29, 1992 was 0.2. Patient education regarding the use of lithium appeared to be lacking. A February 23, 1993 lithium level was 0.7 and a lithium level during December 29, 1992 was 0.2.

Problems regarding management of her lithium were noted based on review of this chart.

4. ME is 28 year old woman who is from Dormitory 4. Medications included Stelazine and Benadryl. She sees Dr. Gilbert two times per week. She has been in prison for about four months.

Review of her chart indicated a diagnosis of a schizoaffective disorder with a past history of psychiatric hospitalizations. A very incomplete evaluation summary was present.

Dr. Muhammed's first progress note was dated May 16, 1994. An initial evaluation by Dr. Gilbert was performed during May 25, 1994. She was initially admitted to the Green room related to being placed on a new medication (Elavil).

Elavil was eventually discontinued. It was unclear why she was initially placed on Elavil by Dr. Muhammed. It does not appear that past records had been requested although Dr. Muhammed has a note regarding a Dr. Babcock at CMHC.

She was an appropriate candidate for an ICU environment.

5. TD is a 23 year old woman who was living in Dormitory 9 and has been in prison since 1991. She reported being on multiple medications which included Thorazine 150 mg po qd. She attends trade school and is currently working towards her GED. She was in the Green room about one year ago for about one week. She stated that other inmates accused her of being a snitch. She has a past psychiatric hospitalization history. She continues to experience auditory and visual hallucinations, paranoid thinking, thought withdrawal, insertion and broadcasting.

Her medical chart, which contained inadequate documentation, was reviewed. An April 11, 1994 note indicated complaints of auditory hallucinations with a command quality. Prolixin was prescribed.

TD complained of sedation from the use of Thorazine in the past. She reported that she would get into trouble with the correctional officers for lying down in the

dormitory related to her sedation.

TD was an appropriate candidate for an ICU.

6. CS is a 36 year old woman who is currently in Dormitory 9. She has been in prison for two years. She receives lithium for bipolar disorder which was first diagnosed during 1988. She stated that her bipolar disorder was well controlled until she came to prison. She continues to experience manic symptoms including irritability, grandiose thinking, laughing which is bothersome to other inmates, decreased need for sleep, spending sprees, and exercising poor judgment. She reported that she also has been diagnosed as having multiple personality disorder.

   Her medical chart was reviewed. An October 31, 1993 carbamazepine level was 6.3. A February 3, 1994 lithium level was 1.28. Carbamazepine level was 4.1. The lithium level was 0.4 during May 24, 1993. There have not been adjustments in her lithium prescription based on the lithium level results. A lithium level of 0.67 was obtained during April 27, 1994 as were thyroid function tests.

   Her bipolar disorder remained very symptomatic.

   She was a candidate for an ICU environment.

7. SC was a 43 year old woman who has been in prison since November 1993 and was scheduled for release in ten days. She was living in Dormitory 9. SC was receiving lithium 1500 mg po qd but reported that she became toxic during January 1994. A lithium level had been drawn which showed a lithium level of 1.0. She became toxic after this level had been obtained and stated that another level was not drawn. She reported that she came to sick call on two occasions but was unable to get an appointment with the doctor until her regularly scheduled four week appointment. She stopped her lithium due to symptoms of toxicity which included diarrhea and nausea. She was quite knowledgeable regarding bipolar disorder and the use of lithium. SC eventually had another lithium level drawn about six weeks ago but the results still have not yet been obtained.

   SC reported that she was prescribed Prozac and/or Zoloft prior to prison but has been unable to obtain this medication at the prison due to the expense. She has been treated with Vistaril and Mellaril but stated that she remains depressed. SC reported that her diagnosis includes borderline personality disorder and dissociative episodes.

   Her mental health chart was reviewed. Dr. Muhammed during January 26, 1994 ordered her serum lithium level to be repeated. The same date lithium was discontinued pending lab results. A January 28, 1994 note indicated that bloods were drawn for BUN and creatinine but apparently not for lithium. The lithium was again

restarted at 1500 mg po qd during February 2, 1994. During the same period of time orders for valproic acid, Vistaril and Prozac were written but then crossed out. SC stated that these orders were discontinued due to the expense of the medications.

Notes during February 7, 11, 1994 indicated that SC wanted to see Dr. Mendez and was having GI symptoms. The plan was to have the M.D. review notes. A February 11, 1994 indicated that medications were ordered by Dr. Mendez but she reported she was not seen by Dr. Mendez. A February 17, 1994 note confirmed her subjective complaint of vomiting and request to see Dr. Muhammed. The nurse's notes stated that the M.D. was to review the notes. A February 18, 1994 referral was made to Dr. Muhammed on the next visit. Although there were medication orders written February 23, 1994, SC reported that she was not seen because she was in court in Mobile, Alabama. It was at that time that the 1500 mg po qd was continued and lithium level was not ordered. A February 23, 1994 note indicated that she was on lithium 1500 po qd, Mellaril 100 mg po qd, and Benadryl 50 mg qd.

SC was seen by Dr. Muhammed May 22, 1994 and was given a three month order for lithium 900 mg, Vistaril 25 mg. Her Mellaril was discontinued May 2, 1994 which was 100 mg po qd. She stopped the Mellaril because it made her sick. A serum lithium level was ordered May 2, 1994 and the blood was drawn the next day. The lithium level results were not recorded in the chart. The last recorded lithium level was 0.97 (January 4, 1994).

The history provided by SC appeared to be confirmed by the documentation in the chart. This case again demonstrated significant problems with the clinical practices at the prison involving the use of lithium.

8. KG reported receiving Mellaril 300 mg and possibly Thorazine 200 po qd. These medications have been prescribed for about 6 months due to a sleep disturbance and anxiety. KG has been in prison for about ten months. She was living in Dormitory 3. KG was not experiencing auditory or visual hallucinations. She was attending trade school eight hours per day.

KG's chart was reviewed. Current medications included Mellaril 250 mg po qd and Imipramine 300 mg po qd. A May 3, 1994 note indicated that a CT scan or MRI of her head was recommended in order to rule out a pituitary lesion. I did not see any further information regarding implementation of this recommendation. She had Prolactin drawn during April 5, 1994.

Medications during April 11, 1994 included Haldol and Cogentin. I did not find a note documenting the reasons for the change in her medications.

An August 3, 1993 note by Dr. Mohammed indicated the diagnosis of a schizoaffective disorder. I was unable to read the rest of his progress note. There

were frequent notes during December and January 1994 which indicated that she wanted to see Dr. Mohammed. These requests were apparently related to her feeling very sedated. Other complaints included feelings of nausea and vomiting which were treated symptomatically with Maalox. A January 12, 1994 note at 2:00 AM indicated that she was removed from the sick call screening list due to an improperly signed complaint.

This chart contained inadequate documentation. It was also concerning that the May 3, 1994 recommendation concerning further neurological evaluation had apparently not been followed.

9. TI was a 36 year old woman who had been incarcerated for about one year. She was living in Dormitory 3. TI was receiving lithium 900 mg and Mellaril 75 mg. She has a past history of psychiatric hospitalization. TI reported having been in the Green room on two occasions. Her last admission was several days ago related to the noise in Dormitory 3. She described intermittent auditory hallucinations and paranoid thinking.

TI's medical chart was reviewed. Current medications included Mellaril 175 mg po qd and lithium 900 mg po qd. A lithium level was ordered by Dr. Logue during June 1, 1994. She was complaining of chronic sedation. A May 16, 1994 note indicated that she was also prescribed Imipramine 300 mg po qd.

A September 8, 1993 lithium blood level was 1.41. During March 16, 1994 blood was drawn for a lithium level. The lithium level during March 21, 1994 was reported to be 0.6. A lithium level during March 22, 1994 was 0.72. Thyroid function tests were done during February 1994. Another lithium level during March 22, 1994 was reported to be 0.51.

TI described experiencing significant problems regarding her sedation because she will get a disciplinary report if she lies down during the day. A May 30, 1994 note confirmed her report that she was complaining of sedation and GI symptoms. A May 21, 1994 indicated that she was complaining of nausea and vomiting. Antivert was prescribed for these symptoms. She did not remember if she were seen by a doctor. TI also complained of intermittent tremors in her hands.

A June 6, 1994 note by Dr. Logue indicated the diagnosis of either schizoaffective disorder or bipolar disorder. She continued to see Dr. Gilbert on a monthly basis.

She is a candidate for an ICU environment and certainly needs her medications readjusted.

10. AG was a 45 year old woman who had been incarcerated since January 1994 and will be released July 1994. AG is attending trade school. Medications include Elavil and

lithium although she was unclear the reasons for lithium being prescribed to her. She described experiencing upper extremity tremors in the morning.

An April 18, 1994 lithium level was ordered which was drawn during May 3, 1994. However, the chart contained no lithium level result. A pre-lithium work-up appeared to have been performed during March 1, 1994. A March 18, 1994 lithium level was ordered but the chart contained no documentation regarding the reason for the use of lithium.

AG's chart was reviewed. Medication orders during May 23, 1994 included lithium 900 mg, Elavil 175 mg, and Phenergan 25 mg po bid. AG recently received a medical work-up in Montgomery, Alabama to rule out diverticulitis. A barium enema was ordered but apparently has not been scheduled. This consultation was performed during May 31, 1994 and included several recommendations for medications (Anaprox and Dicloxacillin). AG reported that she had not yet received these medications which was confirmed by review of the nursing medication notes.

Poor documentation and lack of adequate medical follow-up were revealed based on examination of the chart of AG.

11. TW was a 27 year old woman who had been incarcerated for two months. She was receiving drug rehabilitation treatment in Dormitory 5. TW reported receiving Lithium for eighteen months related to mood swings. She was also prescribed Phenergan. Her left arm was paralyzed due to a car accident at the age of four. There was a history of two prior psychiatric hospitalizations.

Review of her medical record indicated she was receiving Phenergan 75 mg po qd and lithium 900 mg PO qd. This order stated that she was about three months pregnant upon admission. She was still put on the top bunk. A pregnancy test was not done until following a miscarriage during April 10, 1994.

She was admitted to this prison April 5, 1994. There is a physical examination form filled out dated April 20, 1994. This form made no mention of the apparent April 10, 1994 miscarriage.

An April 28, 1994 psychological interview form was filled out. An April 10, 1994 medical department form was present. She reported a negative pregnancy test following the miscarriage. I could find no documentation regarding such testing. The previously described medical form refers to a negative ICON test.

Review of TW's chart indicated significant concerns regarding medical issues.

12. TF was living in the medical isolation unit due to her HIV illness. A February 12, 1994 serum lithium level was 0.64. There was a pre-lithium work-up completed.

During February 23, 1994 she was placed in the mental health unit after she was observed hitting a wall. I cannot find documentation for the reason that she was placed on Lithium. A March 21, 1994 note indicated that she was receiving Tofranil 150 mg. This medication was discontinued during May 16, 1994 and the Elavil was started. A May 16, 1994 note indicated that she was receiving Elavil 200 mg and lithium 900 mg.

TF reported that she had been in prison for eight months. She has been on lithium for over five years related to mood swings. There was a history of four prior psychiatric hospitalizations.

Documentation problems were apparent based on my review of TF's chart.

APPENDIX A

KEY

1.	SB	Shirley Brown (168369)
2.	CB	Christolyn Brown (172096)
3.	SW	Sonya Whitlow (136698)
4.	CW	Charlene Wade (154702)
5.	GR	Gloria Richardson (129059)

APPENDIX B

KEY

1.	PB	Patricia Bullard (128094)
2.	BC	Brenda Chambers (166623)
3.	TD	Toni Deuel (150408)
4.	ME	Monica Ann Elmore (176569)
5.	TD	Terri Danner (171227)
6.	CS	Charlene Shehee (168119)
7.	SC	Sharon Cooper (168786)
8.	KG	Kathy Gafford (166686)
9.	TI	Tina Inman (172324)
10.	AG	Anne Grimes (175573)
11.	TW	Teresa Woodard (176522)
12.	TF	Tina Frost (174392)