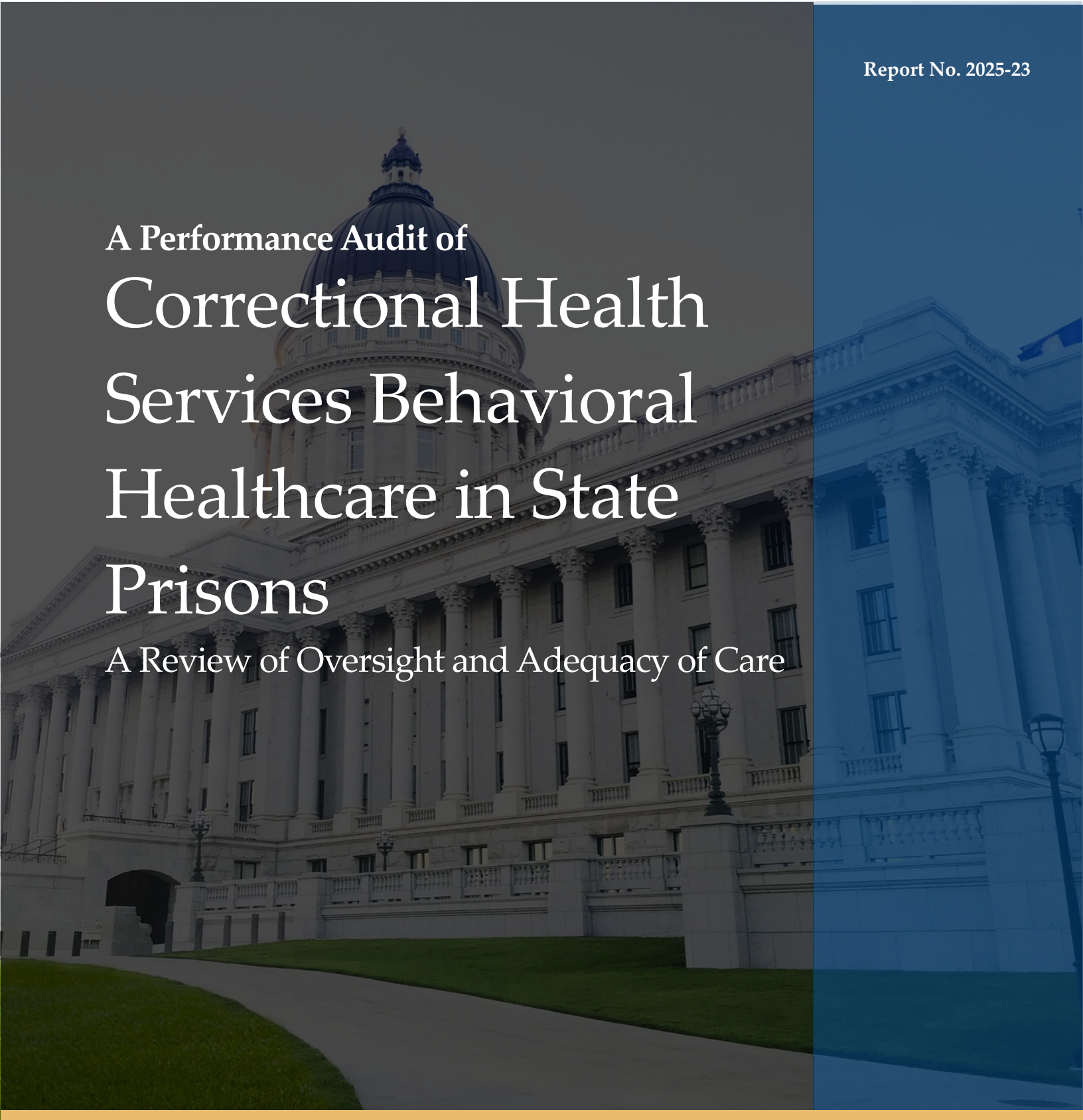
Report No. 2025-23



A Performance Audit of

Correctional Health Services Behavioral Healthcare in State Prisons

A Review of Oversight and Adequacy of Care

Office of the Legislative Auditor General

Report to the **UTAH LEGISLATURE**

LEGISLATIVE AUDITOR GENERAL 1975 - 2025


LEGISLATIVE AUDITOR GENERAL
50
1975 - 2025

Audit Subcommittee

President J. Stuart Adams, Co-Chair
President of the Senate

Senator Kirk Cullimore
Senate Majority Leader

Senator Luz Escamilla
Senate Minority Leader

Speaker Mike Schultz, Co-Chair
Speaker of the House

Representative Casey Snider
House Majority Leader

Representative Angela Romero
House Minority Leader

Audit Staff

Kade R. Minchey, Auditor General, CIA, CFE

Brian Dean, Manager, CIA, CFE

Nicole Luscher, Audit Supervisor

Brendon Ressler, Lead Auditor

Tanner Taguchi, Audit Staff

Office of the Legislative Auditor General

Kade R. Minchey, Legislative Auditor General

W315 House Building State Capitol Complex | Salt Lake City, UT 84114 | Phone: 801.538.1033

Audit Subcommittee of the Legislative Management Committee

President J. Stuart Adams, Co-Chair | Speaker Mike Schultz, Co-Chair

Senator Kirk Cullimore | Representative Casey Snider

Senator Luz Escamilla | Representative Angela Romero

November 18, 2025

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report:

"A Performance Audit of Correctional Health Services Behavioral Healthcare in State Prisons: A Review of Oversight and Adequacy of Care" [Report #2025-23].

An audit summary is found at the front of the report. The scope and objectives of the audit are included in the audit summary. In addition, each chapter has a corresponding chapter summary found at its beginning.

Utah Code* 36-12-15.3(2)** requires the Office of the Legislative Auditor General to designate an audited entity's chief officer. Therefore, the designated chief officer for the Department of Health and Human Services is Tracy Gruber. Tracy Gruber has been notified that they must comply with the audit response and reporting requirements as outlined in this section of ***Utah Code.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade Minchey

Kade R. Minchey, CIA, CFE

Auditor General

kminchey@le.utah.gov

LEGISLATIVE AUDITOR GENERAL

AUDIT SUMMARY

REPORT 2025-23 | NOVEMBER 2025

Office of the Legislative Auditor General | Kade R. Minchey, Auditor General

PERFORMANCE AUDIT

A PERFORMANCE AUDIT OF CORRECTIONAL HEALTH SERVICES BEHAVIORAL HEALTHCARE IN STATE PRISONS

AUDIT REQUEST

The Legislative Audit Subcommittee requested an audit of Utah's behavioral health system. Our office conducted an initial risk assessment and identified potential concerns in the behavioral health services offered in Utah state prisons. Based on our findings, we chose to provide two separate reports – one directed to the Division of Correctional Health Services (CHS) within the Department of Health and Human Services (DHHS) and one directed to the Utah Department of Corrections (UDC).

BACKGROUND

CHS provides mental health services for Utah state inmates incarcerated at the Utah State Correctional Facility (USCF or Salt Lake City prison site) and the Central Utah Correctional Facility (CUCF or Gunnison prison site). Although the division operates infirmaries at both locations, this review focuses on the Salt Lake City prison site as it has designated housing for acute mental health inmates.

KEY FINDINGS

- 1.1 Management Needs to Ensure Mental Health Providers Are Complying with Standards and Policy Regarding Observation and Follow-Up
- 1.2 The Division Should Implement Proactive Measures to Improve Behavioral Health Outcomes
- 2.2 Insufficient Follow-Up and Delays In Care Present Significant Concerns
- 2.3 Poor Documentation Compromises Inmate Safety
- 3.3 Mental Health Medication Management Lacks Structure and Accountability

RECOMMENDATIONS

- 1.3 The Division of Correctional Health Services should establish a systematic process for defining, identifying, tracking, and reviewing all suicide attempts to improve the quality of care and patient outcomes.
- 1.4 The Division of Correctional Health Services should design and implement a systemwide comprehensive suicide prevention program to improve the quality of care and patient outcomes.
- 2.1 The Division of Correctional Health Services should establish a structured review process to ensure that providers are prescribing medications as clinically indicated, and that medications are provided in a timely, safe, and sufficient manner.
- 3.3 The Division of Correctional Health Services should establish a system of oversight and accountability to ensure that involuntary medications are properly documented and administered.

REPORT SUMMARY

Systemic Issues Are Undermining the Effectiveness of Behavioral Health Services

Our review of CHS behavioral health services uncovered concerns with accountability, compliance, and the consistency of care. These defects undermine the effectiveness of behavioral health services. They include a lack of proper monitoring directives and inconsistent follow-up visits for suicidal inmates. Additionally, CHS standard operating procedures focus on reactive instead of proactive measures to prevent suicide.

CHS should review practice and policy for classifying and following up with suicidal inmates. CHS should also design and implement a comprehensive suicide prevention program systemwide.

Behavioral Health Services in the Utah State Correctional Facility Are Inadequate

A significant number of inmates on involuntary medication status are not consistently receiving their medications. Furthermore, inmate healthcare requests (HCRs) are not prioritized based on urgency, resulting in delays. Mental health staff are also not always offering inmates the opportunity to create critical treatment plans. These plans are essential for addressing underlying issues and outlining actions to take if suicidal thoughts recur.

CHS management should improve its oversight and accountability to ensure that all systemic deficiencies are fully addressed.

Not All Inmates Discharged from Suicide Precautions in the Psychiatric Infirmary Have Received Required Follow-Up Visits.

Division policy requires two visits to be scheduled between 24 to 72 hours after discharge and one visit to be scheduled 30 days after discharge. In our sample, we identified an inmate who waited 32 days for a first step-down visit and seven days for any type of contact from mental health staff. A second inmate waited five days without contact with mental health staff.

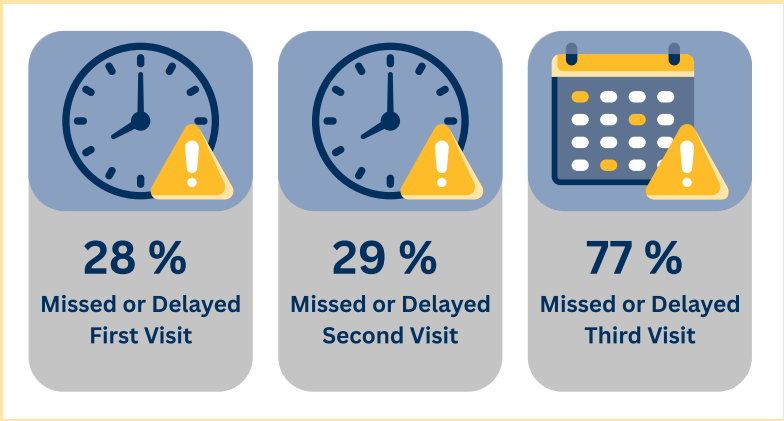


Table of Contents

Introduction

Our review of the Utah State Prison System's Division of Correctional Health Services (CHS or division) found several systemic deficiencies that negatively impacted mental health services. We are generally encouraged by the overall dedication of the division's behavioral health staff, and we have observed instances of dedication and commitment by both staff and management. However, we also identified significant deficiencies and critical issues in need of immediate action.

To assist in our review, we hired a board-certified psychiatrist with specialized expertise in correctional and forensic mental health care. Our consultant has more than 10 years of psychiatric practice, including direct clinical experience evaluating and treating incarcerated individuals. Together with our consultant, our audit team spent several months working with and observing prison behavioral health staff, interviewing inmates, analyzing data, evaluating compliance, and identifying areas of improvement. Our consultant's assessment is found in Appendix A of this report.

DHHS Has Oversight of Prison Healthcare Services

In July 2023, oversight of prison healthcare services transitioned from the Utah Department of Corrections (UDC) to the Utah Department of Health and Human Services (DHHS). In addition to this shift in responsibility, the Clinical Services Bureau (CSB) was restructured under DHHS and renamed CHS. Given the nature of our audit findings and the distinct roles now held by DHHS and UDC, we decided to release two separate audit reports, one directed to each department. This audit focuses on areas under the purview of DHHS and seeks to evaluate the adequacy, oversight, and compliance of behavioral health services in the prison system.

Operational risks identified at USCF necessitated the independent release of two full-scale audits, one directed to DHHS and the other to UDC.

At present, CHS provides medical, mental health, dental, and optometry services to inmates at the Utah State Correctional Facility (USCF or Salt Lake City prison site) and the Central Utah Correctional Facility (CUCF or Gunnison prison site). Although the division operates infirmaries at both locations, this review focuses on the Salt Lake City prison site as it has designated housing for acute mental health inmates, who require a greater level of treatment and attention.

Statute Requires Accreditation, Our Audit Process Is Separate and Functionally Unique from Accreditation

Utah Code[1] requires the division to apply for and meet all accreditation requirements set by the National Commission on Correctional Health Care (NCCHC). Although we reviewed compliance with certain NCCHC standards, we did not audit the accreditation process. Therefore, we provide no opinion on NCCHC's position. Our audit process is separate from the accreditation process and is designed to give a comprehensive and thorough review of state prison behavioral health services' operations.

CHS Should Work Toward Mental Health Accreditation

Utah Code is vague and does not mention the type of accreditation required. For context, NCCHC offers three types of accreditations for prison facilities:

Statute does not specify which of the three accreditation types apply to Utah's prison facilities. Therefore, both prison sites (Salt Lake City and Gunnison) are only accredited for health services (yellow box).

The Lack of Personnel Resources Can Be a Barrier to Accessing Care

To evaluate the impact of staffing on care delivery, we developed patient-to-staff ratios using corrections data from surrounding states (Arizona and Nevada), as well as the Utah State Hospital. Comparatively, there is a noticeable shortage in

[1] ***Utah Code*** 64-13-39

the number of prison behavioral healthcare providers in the division.[2] More information about staffing can be found in Chapter 2 of this report. Although staffing contributes to some of the issues identified throughout this report, it is the responsibility of CHS management to work with DHHS and the Legislature to ensure adequate resources. Our recommendations are directed toward improving the efficiency and effectiveness of CHS operations to ultimately help the organization improve.

[2] Providers are defined to include psychiatrists, advanced practice registered nurses (APRNs), and psychiatric nurse practitioners. However, titles and job duties may differ between organizations.

CHAPTER 1 Summary

Systemic Issues Are Undermining the Effectiveness of Behavioral Health Services

BACKGROUND

Our review of behavioral health services within correctional facilities uncovered concerns with accountability, compliance, and the consistency of care. These defects undermine the effectiveness of behavioral health services. They include a lack of proper monitoring directives and inconsistent follow-up visits for suicidal inmates. Additionally, CHS standard operating procedures focus on reactive instead of proactive measures to prevent suicide.

FINDING 1.1
Management Needs to Ensure Mental Health Providers Are Complying with Standards and Policy Regarding Observation and Follow-Up

RECOMMENDATION 1.1
Division of Correctional Health Services management should review practices and policy that are designed to adhere to best practices when classifying inmates as acutely or non-acutely suicidal. The policies when implemented should improve the care and outcomes of behavioral health services.

RECOMMENDATION 1.2
Division of Correctional Health Services management should review practices and policies that are designed to adhere to best practices when tracking step-down visits. The policies, when implemented, should improve the care and outcomes of behavioral health services and improve patient safety for inmates classified as acutely or non-acutely suicidal.

FINDING 1.2
The Division Should Implement Proactive Measures to Improve Behavioral Health Outcomes

RECOMMENDATION 1.3
The Division of Correctional Health Services should establish a systematic process for defining, identifying, tracking, and reviewing all suicide attempts to improve the quality of care and patient outcomes.

RECOMMENDATION 1.4
The Division of Correctional Health Services should review its existing prevention and intervention standard operating procedures and design and implement a systemwide comprehensive suicide prevention program to improve the quality of care and patient outcomes.

CONCLUSION

CHS should review practice and policy for classifying and following up with suicidal inmates. CHS should also design and implement a comprehensive suicide prevention program systemwide.

Chapter 1
Systemic Issues Are Undermining the Effectiveness of Behavioral Health Services

Our review of behavioral health services within Utah state correctional facilities uncovered concerns with accountability, compliance, and the consistency of care. These services play a critical role in ensuring the safety, rehabilitation, and treatment of incarcerated individuals. They are also essential for addressing mental health and substance use disorders and promoting overall institutional stability. The defects we found undermine the effectiveness of behavioral health services.

1.1 Management Needs to Ensure Mental Health Providers Are Complying with Standards and Policy Regarding Observation and Follow-Up

According to Division of Correctional Health Services (CHS or division) policy and National Commission on Correctional Healthcare (NCCHC) standards, acutely suicidal inmates must be placed in the psychiatric infirmary under constant, direct line of site observation. However, mental health providers are not adhering to CHS internal policy and are placing acutely suicidal inmates on lower-level observation orders. We identified instances of self-harm and suicide attempts occurring between checks—highlighting a critical gap in current monitoring practices.[3] Furthermore, mental health staff often miss routine follow-ups, putting vulnerable inmates at risk after they are discharged from suicide watch. Maintaining continuity of care and mental health support is important to patient outcomes.

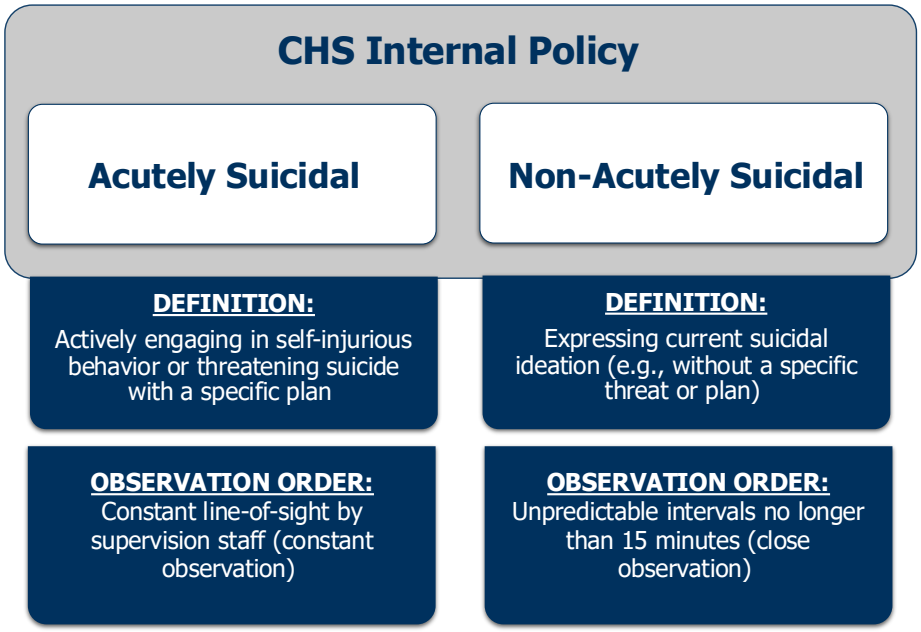
Mental health providers are not adhering to CHS internal policy, and mental health staff are placing acutely suicidal inmates on lower-level observation orders.

[3] A self-inflicted act of self-harm indicates that the person must have performed an action that caused themselves harm. Determining whether a person "intended to die as a result of the action" helps differentiate an act of self-harm from a suicide attempt. If the individual's purpose was to cause their own death, despite the severity of their actions, we classified the incident as a suicide attempt and counted it for our purposes.

Acutely Suicidal Inmates Are Admitted to the Psychiatric Infirmary Without Proper Monitoring Directives from Mental Health Providers

Incarcerated inmates are temporarily housed in the psychiatric infirmary for increased observation and care for acute psychiatric symptoms, such as severe depression, psychosis, or suicidal tendencies. The psychiatric infirmary is intended to provide a safe environment where inmates do not have access to objects that they can use to self-harm, including standard-issue clothing and bedding. The mental health provider initiates the admission process when notified that an inmate is suicidal or psychotic and not able to commit to safety. The degree of observation required for inmates depends on the acuity of their suicidal thoughts or self-harm tendencies. These should accompany the inmate when they are admitted to the psychiatric infirmary. The division's policy aligns with NCCHC standards and provides a framework for acuity levels and related observation orders, as demonstrated below:[4]

The degree of observation required for inmates depends on the acuity of their suicidal thoughts or self-harm tendencies.



Source: Auditor generated based on CHS policy and NCCHC standards.

To determine whether inmates were admitted to the psychiatric infirmary under the correct observation orders, we reviewed six months of psychiatric infirmary admissions data from October 2024 to March 2025. During our review, we found

[4] According to ***Utah Code*** 64-13-39, the division is statutorily required to be compliant with NCCHC standards.

26 instances of inmates being admitted to the psychiatric infirmary following a suicide attempt who were classified as acutely suicidal under division guidelines.[5] Despite this classification, none of these inmates were placed on constant observation as mandated by CHS policy. Furthermore, three of the 26 cases (12%) had no observation orders. As a result, all inmates were placed on the lowest level of observation for the psychiatric infirmary, which is 15-minute intervals.

Despite being classified as acutely suicidal, none of the inmates from the 26 suicide attempts we reviewed were placed on constant observation status as mandated by division policy.

These findings are particularly concerning because inmates in acute suicidal crises are at an increased risk of self-harm.[6] At least three inmates on suicide watch attempted suicide or self-harmed between their scheduled checks:

Example 1

A suicidal inmate was placed on close observation orders, contrary to CHS policy. During a routine 15-minute observation check, the officer saw the inmate lying on the ground covered in blood. The inmate had inflicted a deep arm laceration using a smuggled razor. Staff called 911, and the injury resulted in a hospital transport.

Example 2

A suicidal inmate disclosed a plan to hang themselves, qualifying them for constant observation under CHS policy. However, the inmate was admitted to the psychiatric infirmary under close observation status, involving 15-minute observation checks. When officers came across the inmate's cell, they discovered that the inmate had fashioned a homemade noose and secured it around the neck. The inmate was instructed to remove the noose but was unable to do so. Officers intervened, removed the noose, and cleared the cell without incident.

[5] Because CHS has no standardized definition of what constitutes a suicide attempt, we researched definitions used by neighboring states and adopted the following: a nonfatal, self-inflicted act of self-harm with any intent to die as a result of the behavior. Suicide attempt data and tracking are discussed in detail at a later section in this chapter.

[6] NCCHC standards specify that when an acutely suicidal inmate is housed alone in a room, continuous or direct monitoring by staff should be maintained.

Example 3

An inmate was admitted to the psychiatric infirmary after mental health staff determined that the inmate had a plan and intent to commit suicide. Despite an acutely suicidal designation, the inmate was placed on close observation orders, involving 15-minute checks instead of constant supervision. Between one of these intervals, the inmate used a smuggled razor to inflict multiple lacerations to their wrists.

The effectiveness of checks on suicidal inmates is discussed in greater detail in our report, "*A Performance Audit of Utah Department of Corrections Security Operations for Behavioral Healthcare in State Prisons: A Review of Safety and Facilitation of Care* (Report No. 2025-24)." We consulted CHS mental health providers to understand why some observation orders leading to psychiatric infirmary admissions did not align with division policy. When we asked providers about the criteria they use to determine when constant line-of-sight observation is appropriate, their responses varied. For example, one provider mentioned that the inmate needs to be actively suicidal despite close monitoring while another said they may order constant supervision if they are unable to remove the means the inmate is using in their attempt. These responses suggest an inconsistent interpretation of policy. Division management should clarify and ensure compliance with policy.

When we asked providers about the criteria they use to determine when constant line-of-sight observation is appropriate, their responses varied, suggesting an inconsistent interpretation of policy.

RECOMMENDATION 1.1

The Division of Correctional Health Services management should review practices and policies that are designed to adhere to best practices when classifying inmates as acutely or non-acutely suicidal. The policies when implemented should improve the care and outcomes of behavioral health services.

CHS Mental Health Staff Are Not Consistently Conducting Routine Follow-Up Visits for Suicidal Inmates

Because of the strong correlation between suicide and prior suicidal behavior, the division should make continuity of care for suicidal inmates a priority. However, not all inmates discharged from suicide watch have received the required follow-up assessments. This is concerning, considering that research shows that inmates

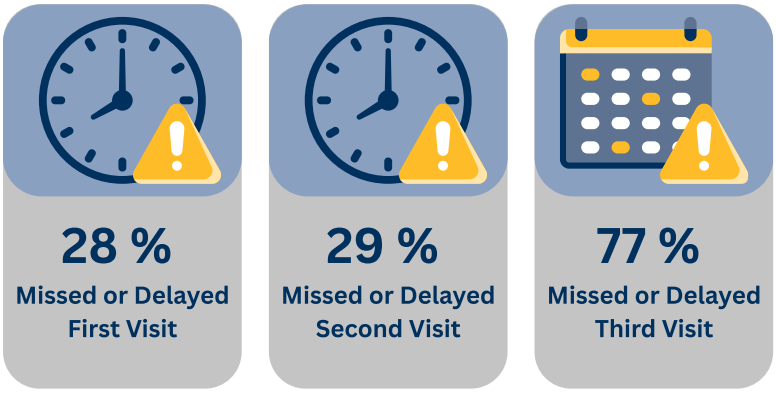
who were more recently discharged from close observation were more likely to complete suicide.[7]

The division requires mental health staff to complete step-down visits after the patient returns to their housing unit following a discharge from the psychiatric infirmary.[8] According to CHS policy,

> *Upon discharge and the patient's return to housing, the patient is scheduled for two step-down check-ins between 24 to 72 hours after discharge…. The patient will be seen for a [third] step-down visit 30 days subsequent to discharge from the psychiatric infirmary.*

We reviewed 59 cases where patients were discharged from suicide watch. Thirty-nine percent (23 of 59 instances)[9] did not receive one or more follow-up visits. Details of our observations are shown in Figure 1.1 below.

Figure 1.1 Not All Inmates Discharged from Suicide Precautions in the Psychiatric Infirmary Have Received Required Follow-Up Visits. Division policy requires two visits to be scheduled between 24 to 72 hours after discharge and one visit to be scheduled 30 days after discharge.



Source: Auditor generated using CHS data.

According to NCCHC, patients discharged from suicide precautions should be seen within 24 to 72 hours at a minimum and periodically thereafter. In our sample, we identified an inmate who waited 32 days for a first step-down visit and 7 days for any type of contact from mental health

CHS currently has no system in place to track step-down visits to improve patient safety.

[7] Boren EA, Folk JB, Loya JM, Tangney JP, Barboza SE, Wilson JS. *The Suicidal Inmate: A Comparison of Inmates Who Attempt Versus Complete Suicide* (2018).

[8] Step-down visits are designed to bridge the gap between high-intensity care (like admission to the psychiatric infirmary) and lower-intensity care (such as therapy within the housing unit).

[9] The total number of step-down visits was adjusted to account for those who were readmitted to the psychiatric infirmary.

staff. A second inmate waited five days without contact with mental health staff.

Contact with mental health staff after discharge from suicide watch is vital. Although we are not aware of any suicide attempts that have occurred because of insufficient follow-up, continuing these practices poses a significant risk. The division reports they have struggled in this area partially because of barriers such as frequent turnover and a lack of personnel resources. However, according to NCCHC, having an understaffed, underfunded, or poorly organized system that cannot provide appropriate and timely access to treatment is an insufficient reason to not provide inmates with care. To help the organization improve, CHS should develop a system to track step-down visits to ensure quality care.

RECOMMENDATION 1.2

The Division of Correctional Health Services management should review practices and policies that are designed to adhere to best practices when tracking step-down visits. The policies, when implemented, should improve the care and outcomes of behavioral health services and improve patient safety for inmates classified as acutely or non-acutely suicidal.

1.2 The Division Should Implement Proactive Measures to Improve Behavioral Health Outcomes

Current CHS suicide prevention practices are reactive, primarily triggered by crisis situations rather than aimed at early identification and prevention. Furthermore, the division does not collect or analyze data on suicide attempts, limiting its ability to evaluate risks, identify trends, or improve its approach. The goal of suicide prevention is to reduce suicide risks before they become crises and, when necessary, defuse crises before they become fatal. NCCHC requires correctional facilities to create suicide prevention programs. According to the NCCHC standard, the suicide prevention program should be carefully thought out as a system-wide suicide prevention plan that includes elements of physical safety and treatment. However, we found that CHS standard operating procedures focus on reactive instead of proactive measures to prevent suicide.

The division does not collect or analyze data on suicide attempts, limiting its ability to evaluate risks, identify trends, or improve its approach.

CHS Does Not Collect Data on Suicide Attempts

CHS has no formal mechanism for defining, tracking, or evaluating suicide attempts. Additionally, although UDC creates and tracks reports on incidents that occur within correctional facilities, this data is not shared with CHS or used to track suicide attempts.

According to NCCHC's suicide prevention in jails and prisons guide, "… any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt."[10] Because inmates with a history of suicide attempts are at significantly higher risk, the division should routinely track and analyze suicide data to better inform prevention efforts. Moreover, identifying risk patterns can uncover trends. Characteristics such as time, location, demographics, or circumstances may reveal systemic issues or uncover high-risk populations within the prison.

To illustrate the value of tracking suicide attempt data, we reviewed six months of psychiatric infirmary admissions from October 2024 to March 2025. Because CHS has no standardized definition of what constitutes a suicide attempt, we researched definitions used by neighboring states and adopted the following:

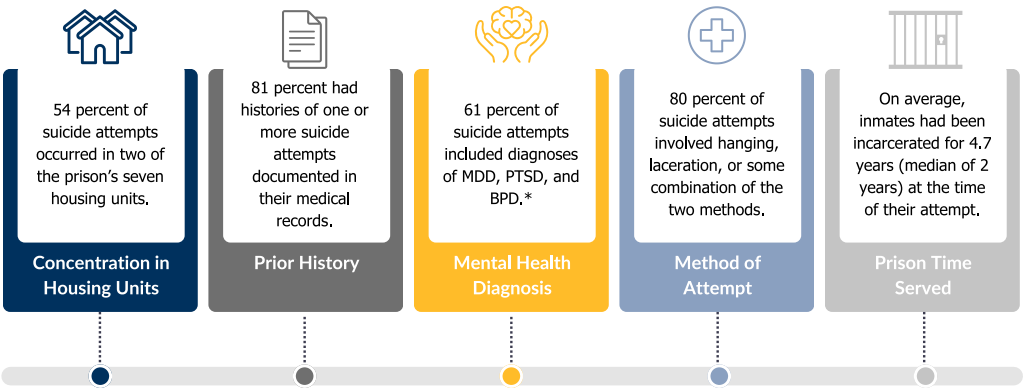
Suicide Attempt Definition Used by Other States

A suicide attempt is defined as a nonfatal, self-inflicted act of self-harm with any intent to die as a result of the behavior.

In the six-month period under review, we found that 21 unique individuals had 26 distinct suicide attempts.[11] We also observed several notable risk patterns associated with suicide attempts among inmates in our sample:

[10] NCCHC. *Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections* (2019).

[11] Four individuals had more than one suicide attempt.



** MDD, PTSD, and BPD refer to Major Depressive Disorder, Post-Traumatic Stress Disorder, and Bipolar Disorder.*
Source: Auditor generated using CHS data and inmate records.

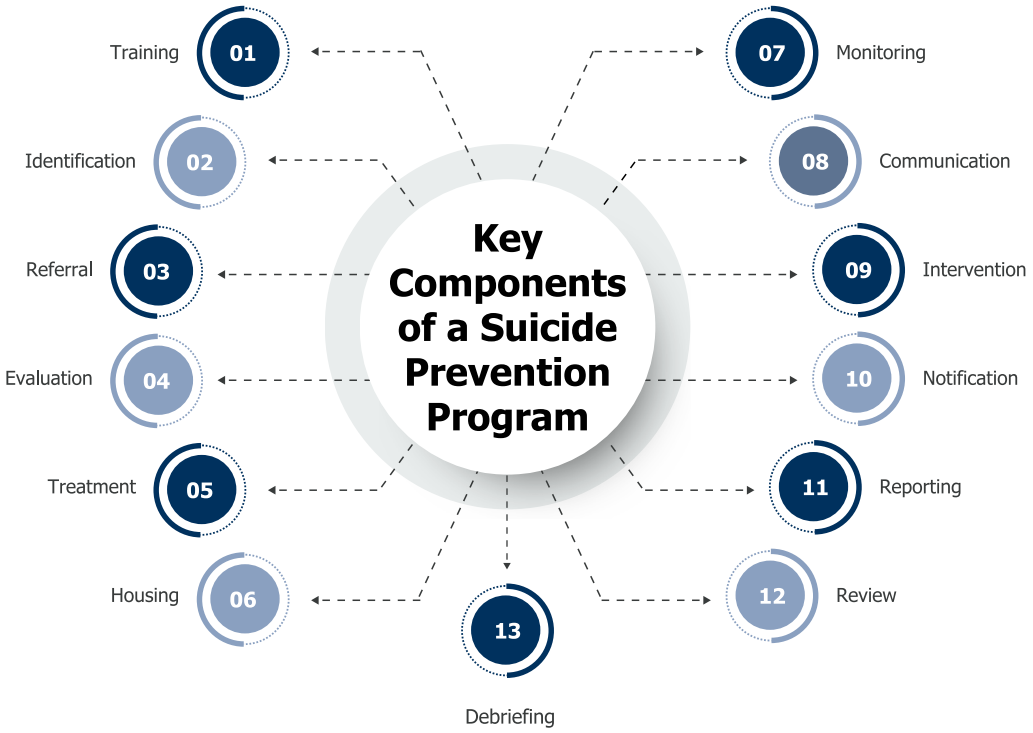
Our findings demonstrate how available data can help identify potential risk factors associated with suicidal behavior. The Utah State Hospital not only tracks attempted suicides, but executive leadership also conducts a root cause analysis. The product of this meeting is an action plan that identifies changes that can be implemented to reduce future risk. If changes are not implemented, rationale for not implementing such changes is formulated.

Similarly, the Healthcare Services Division within the Arizona Department of Corrections completes a review for attempted suicides involving a serious threat to an inmate's life. The state's psychologist determines whether an incident qualifies as a suicide attempt. Following that determination, a committee convenes monthly to review cases and make recommendations.

Collecting and analyzing such data is essential for identifying risk patterns, strengthening prevention efforts, assessing program effectiveness, and guiding resource allocation.

NCCHC standards identify 13 key components of a correctional suicide prevention program. These approaches include key proactive and reactive measures:

Both a proactive and reactive approach are necessary components of suicide prevention.



Auditor generated based on NCCHC health services standard P-B-05.

Although CHS has a standard operating procedure to respond to an active suicide attempt, additional procedures meant to address suicidal behavior prior to escalation could help CHS take a more holistic approach. To improve program outcomes, CHS should design and implement a comprehensive suicide prevention program. It should include focuses on early identification, staff training, and consistent preventive measures to help reduce the likelihood of crisis situations.

RECOMMENDATION 1.3

The Division of Correctional Health Services should establish a systematic process for defining, identifying, tracking, and reviewing all suicide attempts to improve the quality of care and patient outcomes.

RECOMMENDATION 1.4

The Division of Correctional Health Services should review its existing prevention and intervention standard operating procedures and design and implement a systemwide comprehensive suicide prevention program to improve the quality of care and patient outcomes.

BACKGROUND

The Division of Correctional Health Services (CHS or Division) offers behavioral and mental health services to those incarcerated in the state prison system. We found that these services are frequently inconsistent, noncompliant, or delayed.

FINDING 2.1
Enhanced Clinical Oversight Will Improve Medication Management

RECOMMENDATION 2.1
The Division of Correctional Health Services should establish a structured review process to ensure that providers are prescribing medications as clinically indicated and that medications are provided in a timely, safe, and sufficient manner.

FINDING 2.2
Insufficient Follow-up and Delays In Care Present Significant Concerns

RECOMMENDATION 2.2
The Division of Correctional Health Services should review standards and policies pertaining to intake and implement practices that meet these standards to ensure an appropriate level of care.

RECOMMENDATION 2.3
The Division of Correctional Health Services should ensure proper follow-up is conducted to provide inmates with behavioral health care that is adequate and appropriate.

RECOMMENDATION 2.4
The Division of Correctional Health Services should ensure that the frequency and duration of appointments is sufficient to meet the mental health needs of the population.

FINDING 2.3
Poor Documentation Compromises Inmate Safety

RECOMMENDATION 2.5
Division of Correctional Health Services management should periodically review inmate behavioral health records for adequacy, thoroughness, and completeness and document these reviews to ensure appropriate care.

CONCLUSION

Correctional Health Services (CHS) management should improve the delivery and oversight of behavioral health services to help ensure adequate and appropriate care.

Chapter 2
Oversight and Delivery of Behavioral Health Services Can Improve

Division of Correctional Health Services (CHS or division) management should improve the delivery and oversight of behavioral health services to ensure adequate and appropriate care. To assist in our review, we hired a board-certified psychiatrist with specialized expertise in correctional and forensic mental health care. Together with our consultant, our audit team spent several months working with and observing prison behavioral health staff, interviewing inmates, analyzing data, evaluating compliance, and identifying areas of improvement. As a result of our findings, CHS should take the following actions:

- Improve medication management through enhanced clinical oversight and attention to provider staffing levels.
- Address insufficient follow-ups and delays in behavioral health care.
- Improve oversight to correct poor documentation practices, which can compromise patient safety.

To understand and document these concerns, our consultant reviewed medical records for 50 randomly selected inmates with a history of mental illness. He also reviewed the records of five additional inmates who died by suicide after the prison relocated in July 2022.[12] Our consultant's assessment is found in Appendix A of this report.

[12] Sampled cases were stratified by mental health diagnosis/condition and selected at random. Mental health diagnoses and conditions were selected based on the recommendations of our psychiatric consultant. For this review, we worked with our psychiatric consultant who analyzed two samples of records for a total of 55 inmates. Both samples consisted of inmates from the Utah State Correctional Facility (USCF or Salt Lake prison site). The first sample was a focused examination of five cases involving inmate deaths by suicide. This sample consisted of all completed inmate suicides after the prison relocated to Salt Lake City in July 2022. The second sample involved a systematic review of medical records for 50 randomly selected inmates with a history of mental illness.

2.1 Enhanced Clinical Oversight Will Improve Medication Management

Of the 50 cases reviewed, our consultant identified up to 10 (20%) where CHS provided inadequate prescribed medication management.[13] Limited clinical oversight and insufficient behavioral health staffing appear to have contributed to this inappropriate care. Providers did not seem to understand the interactions of antipsychotic medications with other medications. They also prescribed medication that was inconsistent with the diagnosed mental health condition. Examples of such cases include the following:

20% of our sample group received inappropriate care because of inadequate prescribed medication management.

Medication Example 1

CHS tapered an inmate with a documented history of catatonia and schizophrenia off his medication over a two-week period. The clinical standard for this medication calls for a months-long process. The rapid taper of medication significantly increased the inmate's risk of potential life-threatening catatonic episodes.

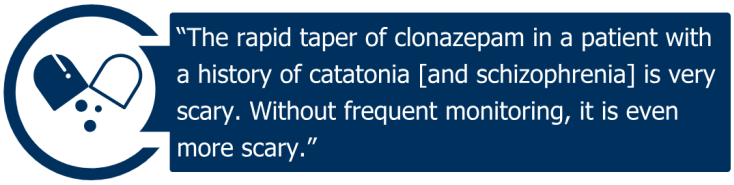
Medication Example 2

An inmate diagnosed with schizoaffective disorder and bipolar disorder was taking lithium to help manage symptoms. In this case, the inmate's lithium was stopped abruptly, which is known to contribute to worsening mental health. The inmate's psychosis was allowed to fester, and he became increasingly psychotic for months. During this time, CHS didn't bring this case to the attention of a provider.

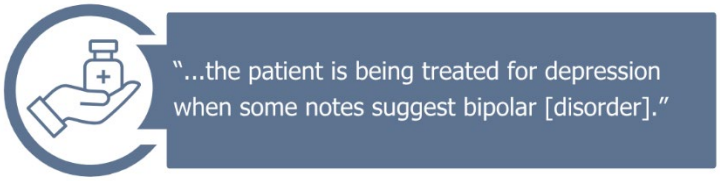
After reviewing our consultant's notes for each case categorized as "inappropriate care," three recurring themes emerged:

[13] Quality of care is achieved when medications are accurately matched to diagnoses, and providers follow appropriate treatment protocols, leading to the best possible patient outcomes and an improved quality of life.

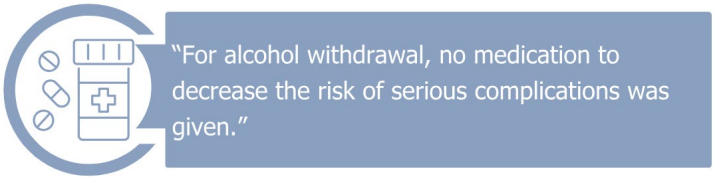
- **Premature Discontinuation of Medications**: Patients were taken off their prescription medications too quickly.



- **Incorrect Medication Management**: Patients were prescribed medications that were not appropriate for their mental health condition.



- **Omission of Necessary Treatment**: Patients did not receive medications that would normally be appropriate or necessary given the patient's condition.



Limited clinical oversight and an insufficient number of staff appear to be contributing factors in multiple cases of inappropriate care.[14]

Mental Health Services Has Limited Clinical Oversight. We are concerned that the prison's reliance on Advanced Practice Registered Nurses (APRNs) to manage complex psychiatric conditions is contributing to gaps in the quality of care. Psychiatrists are medical doctors with training in medicine who specialize in mental health. APRNs have limited training compared to psychiatrists and, as a result, may face challenges in managing high-acuity or complex cases.

The Negative Effect of Not Having a Staff Psychiatrist

Our consultant identified cases in his analysis where providers did not seem to understand the interactions of antipsychotic medications, or they prescribed the wrong medications for the diagnosed mental health condition.

[14] Providers are defined to include psychiatrists, advanced practice registered nurses (APRNs), and psychiatric nurse practitioners.

After the division's psychiatrist departed in July 2024, management had been working to hire a full-time psychiatrist but was unable to recruit one. In August 2025, management hired a part-time psychiatrist—a positive step forward in strengthening clinical leadership within the division.[15] However, prior to filling this position, the prison went one year without a psychiatrist despite management's efforts to recruit one. Division management reported that this was due to the challenges associated with offering a competitive salary.

The absence of a psychiatrist resulted in a noticeable gap in clinical leadership. Although CHS leadership worked with a psychiatrist from the Utah State Hospital to help address this gap in care, it was not sufficient:

The Negative Effect of Not Having a Staff Psychiatrist Continued

Our consultant's chart review revealed that fewer than 10% of even the most severely mentally ill inmates had ever been evaluated by a psychiatrist. Additionally, most inmates admitted to the psychiatric infirmary never see a psychiatrist.

In addition to having a part-time psychiatrist, CHS has five APRNs to prescribe medication for behavioral health. However, the division only has one APRN for every 609 inmates with moderate to severe mental health needs. Arizona reports having one APRN available for every 204 inmates.[16] Utah has a higher ratio for supporting staff positions than Arizona, suggesting that Utah's non-provider roles are more sufficiently staffed.[17] Obtaining and staffing qualified medical professionals is critical to providing quality care. Provider staffing issues are contributing factors to some of the issues identified throughout this report. CHS should determine adequate staffing needs, review internal resources and then, if

Staffing qualified medical professionals is critical to providing quality care.

[15] During the 2025 General Legislative Session, division management asked the Legislature for $23,600 ongoing and $410,200 in one-time funds for psychiatric care. This was the division's only request for behavioral health staffing since the prison relocation in July 2022.

[16] Key differences between the Utah and Arizona prison systems may not allow for a one-to-one comparison. These include the number of facilities and the number of inmates classified as having a moderate to severe mental illness.

[17] Utah support staff include certified mental health counselors, social workers, care navigators, recreational therapists, and an occupational therapist. Arizona support staff primarily include behavioral health technicians, defined as those who provide direct patient care and support, monitor and document patient behavior, participate in treatment planning meetings, implement patient interventions, and assist with daily living skills.

needed, work with the Legislature to identify opportunities to increase the number of mental health staff.

RECOMMENDATION 2.1

The Division of Correctional Health Services should establish a structured review process to ensure that providers are prescribing medications as clinically indicated and that medications are provided in a timely, safe, and sufficient manner.

2.2 Insufficient Follow-Up and Delays In Care Present Significant Concerns

CHS management needs to ensure that they provide sufficient and appropriate follow-up care. In our random sample of 50 cases that our consultant reviewed, 40% of inmates did not receive adequate follow-up care. CHS management also needs to ensure that appropriate behavioral health services are offered to inmates entering the correctional facility for the first time, and that timely services are available throughout their incarceration.

40% of our random sample did not receive adequate follow-up care.

Insufficient Follow-Up Contributes To Inappropriate Care

Our consultant determined that 20 of the 50 inmates in our sample (40%) did not receive adequate follow-up care. According to our consultant, the more gravely the patient was impaired, the less likely they were to receive sufficient follow-up care. Multiple psychotic patients with severe cognitive impairments were instructed to follow up by submitting a healthcare request. This process violates the standard issued by the National Commission on Correctional Healthcare (NCCHC) that requires flexible access to care for inmates who lack the ability to

recognize emerging health needs. Concerning examples identified by our consultant include the following:

Follow-Up Example 1

One severely ill inmate with schizophrenia, was hearing voices and having medication side effects including excessive drooling. He was instructed to submit a healthcare request if he needed future care—a process requiring cognitive abilities he clearly lacked due to his psychotic state.

Follow-Up Example 2

Another patient who was "constantly walking around naked," hearing voices, and experiencing extreme delusions was also instructed to follow up by submitting a healthcare request.

Our consultant observed multiple patients who are not receiving care in a timely or frequent manner. He noted that providers may be experiencing excessive workloads, leading to feelings of being overwhelmed or burned out. Consequently, inmates with severe mental health needs did not receive the level of attention and treatment that their condition required. The lack of consistent follow-up has led the consultant to conclude that "inmates are often abandoned," which is deeply concerning. It remains CHS management's responsibility to uphold NCCHC standards and ensure that care is both appropriate and timely.

It remains CHS management's responsibility to uphold NCCHC standards and ensure that care is both appropriate and timely.

CHS Needs to Eliminate Delays in Care to Ensure Appropriate Services Are Delivered

CHS management needs to ensure that appropriate behavioral health services are offered at intake and throughout an inmate's incarceration.[18]

Behavioral Health Services Are Not Proactively Offered to Inmates After Intake. From the beginning of January to the end of March 2025, nearly 300

[18] Prison intake is the initial admission process for newly committed offenders. It includes a documentation review, medical and mental health screenings, and formal orientation. New inmates are housed in the intake facility while their security level (classification) and program assignments are determined. This design speeds the process of getting inmates into their classification-based housing units.

inmates were housed in the intake unit for an average of 36 days without access to routine mental health services.[19] This is still the case despite CHS's standard operating procedure, which states that first-time incarceration "…is a highly sensitive period of time and may be a traumatic event in the first few weeks." Similarly, NCCHC identifies certain times and situations that are of particularly high-risk for inmates who may be suicidal. Specifically, NCCHC's suicide prevention and intervention standard identifies the days following prison intake to be a high-risk situation, highlighting an increased risk between days 2 and 14. Our consultant also identified the intake period as a very high-risk time when inmates most urgently need therapeutic support.

For the first 3 months of 2025, nearly 300 inmates were housed in the intake unit for an average of 36 days without access to routine mental health services.

Despite this awareness, CHS does not actively offer therapy or other routine behavioral health services to inmates housed in the intake unit. CHS reports that this is due to a lack of staff availability. However, restricting access to treatment during such a high-risk period of an inmate's stay could have negative repercussions. Because NCCHC standards mandate timely access to mental health care for all inmates, management is responsible for ensuring the appropriate and prompt delivery of such care.

CHS Management Needs to Ensure Timely Behavioral Health Services. Timely care is not just a problem at intake. For example, more than half of the cases (54%, or 27 of 50 cases) our consultant reviewed did not receive timely care. Some of the most concerning examples are illustrated below:

54% of our sample did not receive timely care.

Timeliness Example 1

Mental health staff did not see an inmate reporting hallucinations for over a month.

Timeliness Example 2

A mental health provider did not see an inmate with a history of severe mental illness (schizophrenia) until almost two months after his intake date.

[19] This does not include crisis intervention services or the mental health screening completed at intake.

Timeliness Example 3

On admission, medical staff did not give an inmate with a recent suicide attempt and a history of schizophrenia an antipsychotic medication for three days.

Timeliness Example 4

An inmate requested a psychiatric medication visit three separate times over three months (April to June 2025). A mental health provider had still not seen her at the time of the consultant's review (nearly three months after the first request).

Timeliness Example 5

An inmate became suicidal due to persistent psychotic hallucinations and was admitted to the psychiatric infirmary for two weeks. During this admission, providers made no diagnostic attempt nor treatment changes. Two days after discharge, the inmate was readmitted for continued suicidality. Throughout both admissions, his medications remained unchanged, mental health staff provided no therapy, and he was maintained in complete isolation—receiving no therapeutic intervention for the very symptoms driving his suicidal ideation.

Inmates housed in the psychiatric infirmary receive brief provider assessments daily, but do not have access to other behavioral health services such as psychotherapy or group therapy. Our consultant observed multiple instances where services such as therapy could have offered meaningful support. For example, many inmates in the psychiatric infirmary were suicidal due to identifiable life stressors such as divorce or bereavement—conditions that respond well to therapeutic intervention. Instead, these inmates were met with prolonged isolation.

The division previously provided therapy services in the psychiatric infirmary, but the practice was discontinued after staff reported that some inmates claimed suicidal ideation to gain access to services. Addressing delays in care is essential—not only to discourage such behavior but also to ensure timely mental health support for inmates with legitimate clinical needs.

According to our consultant, mental health provider patient encounters in the psychiatric infirmary are estimated to average approximately three minutes per visit during rounds—an insufficient timeframe for meaningful psychiatric assessments, treatment planning, or therapeutic interventions. We recommend that CHS consider offering behavioral health services to inmates housed in the psychiatric infirmary when operationally feasible and clinically appropriate. Because this involves the clinical judgment of a qualified mental health professional, we offer it as an informal recommendation for the division's consideration.

Mental health provider patient encounters in the psychiatric infirmary are estimated to average approximately three minutes per visit – an insufficient timeframe for meaningful services.

RECOMMENDATION 2.2

The Division of Correctional Health Services should review standards and policies pertaining to intake and implement practices that meet these standards to ensure an appropriate level of care.

RECOMMENDATION 2.3

The Division of Correctional Health Services should ensure proper follow-up is conducted to provide inmates with behavioral health care that is adequate and appropriate.

RECOMMENDATION 2.4

The Division of Correctional Health Services should ensure that the frequency and duration of appointments are sufficient to meet the mental health needs of the population.

2.3 Poor Documentation Compromises Inmate Safety

Documentation for inmates admitted to the psychiatric infirmary is often absent or contradictory, suggesting inadequate clinical consideration. According to our psychiatric consultant, insufficient documentation on individual patient charts made evaluating the quality of care difficult. For example, 48% of patient charts (24 of 50 cases) didn't have sufficient information. This is concerning because there are instances where it appears that the provider was unaware of the patients' prescribed medications. Furthermore, there is no evidence suggesting that diagnoses were thoughtfully discussed or considered. According to our consultant, medical providers should write medical notes, in part, to encourage them to think about the medical care they are providing.

48% of sampled patient charts lacked sufficient information.

Our consultant concluded that mental health providers do not thoughtfully assess psychiatric conditions. He noted the following examples highlighting concerns about provider documentation:

Documentation Example 1

A suicidal inmate was experiencing psychosis; however, the clinician did not indicate whether this person was having hallucinations or delusions.

Documentation Example 2

An inmate was documented as having "hallucinations;" however, in another place on the patient's chart it states, "Hallucinations: no."

Documentation Example 3

Following a completed suicide, two notes were retrospectively added to a patient chart in an attempt to document care. According to our consultant, retrospective charting after a bad medical outcome is not acceptable and is considered a breach of ethics.

CHS management needs to periodically review provider documentation to ensure adequacy and completeness. This will help ensure that inmates are receiving appropriate care.

RECOMMENDATION 2.5

Division of Correctional Health Services management should periodically review inmate behavioral health records for adequacy, thoroughness, and completeness and document these reviews to ensure appropriate care.

CHAPTER 3 Summary

Behavioral Health Services in the Salt Lake Prison Are Inadequate

BACKGROUND

A significant number of inmates on involuntary medication status are not consistently receiving their medications. Furthermore, inmate healthcare requests (HCRs) are not prioritized based on urgency, resulting in delays. Mental health staff are also not always offering inmates the opportunity to create critical treatment plans.

FINDING 3.1
Mental Health Medication Management Lacks Structure and Accountability

RECOMMENDATION 3.1
The Division of Correctional Health Services should review involuntary medication administration processes and address barriers associated with staff not administering these medications. This should ensure that staff administer involuntary medications as prescribed.

RECOMMENDATION 3.2
The Division of Correctional Health Services management should set a clear expectation that staff must administer involuntary medications. This should ensure that staff understand the importance of administering these medications and that management will hold staff accountable.

RECOMMENDATION 3.3
The Division of Correctional Health Services should establish a system of oversight and accountability to ensure that involuntary medications are properly documented and administered.

RECOMMENDATION 3.4
The Division of Correctional Health Services should review and adhere to effective involuntary medication prescription safeguards. This should ensure that inmate prescriptions are reviewed in a way that reflects qualified medical judgments.

FINDING 3.2
CHS Management Needs to Address Additional Areas of Noncompliance

RECOMMENDATION 3.5
The Division of Correctional Health Services should develop policies and procedures to standardize the process of prioritizing (triaging) inmate healthcare requests for mental health services and monitor its implementation. These should ensure that inmates are seen according to the urgency of their request.

RECOMMENDATION 3.6
Division of Correctional Health Services management should establish a system of oversight and accountability to ensure that inmate healthcare requests for mental health services are prioritized (triaged) appropriately.

RECOMMENDATION 3.7
The Division of Correctional Health Services should prioritize the creation of standard operating procedures for individualized treatment plans and monitor its implementation. This should improve behavioral health outcomes for inmates.

Chapter 3
Behavioral Health Services In the Salt Lake Prison Are Inadequate

A significant number of inmates on involuntary medication status are not consistently receiving their medications. Missing critical mental health medications compromises patient stability and increases safety and security risks. Persistent systemic and procedural deficiencies have created irregularities in involuntary medication administration. Moreover, the Division of Correctional Health Services (CHS or division) has failed to implement routine compliance reviews and verification processes. The lack of oversight and accountability is especially concerning given that individuals placed on involuntary medication status, according to internal policy, (a) are unable to provide informed consent, (b) pose an immediate danger to themselves or others, or (c) are gravely disabled.

Furthermore, inmate healthcare requests (HCRs) are not prioritized based on urgency, resulting in delayed care. Individuals experiencing suicidal or homicidal ideations are not always receiving face-to-face evaluations, and their requests are not adequately prioritized. Lastly, mental health staff are not always offering inmates the opportunity to create critical treatment plans. These plans are essential for addressing underlying issues and outlining actions to take if suicidal thoughts recur. CHS management should improve its oversight and accountability to ensure that all systemic deficiencies are fully addressed.

3.1 Mental Health Medication Management Lacks Structure and Accountability

Division management has not established accountability measures or structured processes to ensure the consistent administration of involuntary medications. Consequently, inmates placed on involuntary medication status are not consistently receiving their mental health medications. Moreover, the involuntary medications hearing committee does not reconvene for involuntary medication renewals, which is a violation of policy. Policy also requires the committee to base its decisions on sound medical judgment. To enhance clinical representation, the division should reevaluate the structure of the committee.

Involuntary Medications Are Not Always Administered According to Policy, Posing Serious Concerns

Missing critical mental health medications can affect the stability of mental health patients and introduce increased safety and security concerns.

Not all inmates are receiving their mandated medications. Involuntary medication, also known as forced medication, is the administration of psychiatric drugs without the patient's consent. The division may administer involuntary medications to patients only after a hearing committee has determined that the patient lacks the capacity to consent and poses a substantial danger to themselves or others.[20] Internal policy states:

> *The committee shall order involuntary treatment if it decides by majority vote that:*
>
> 1. *The offender suffers from a mental illness; and*
> 2. *As a result of that illness constitutes a likelihood of serious harm to self or others or is gravely disabled.*

Division management has not held staff accountable for involuntary medication administration.

After involuntary treatment is ordered, internal policies require the treating provider to "…review, monitor, and document the offender's progress." Unfortunately, division management has not held staff accountable for involuntary medication administration, nor is there a structure in place to ensure that involuntary medications are reliably administered.

We found that 77% of inmates (17 of 22)[21] had multiple missed doses of involuntary medications. Missing critical mental health medications can affect a patient's stability and introduce increased safety and security concerns. For example, one inmate missed nearly 30% of his involuntary medication doses

[20] Involuntary medications hearings for inmates are administrative proceedings, not court trials, based on the precedent set by the U.S. Supreme Court in *Washington v. Harper* (1990).

[21] To evaluate compliance with internal policy, we compared the list of offenders placed on involuntary medications with the list of admissions to the psychiatric infirmary from January to June 2025. We selected a sample of 22 inmates receiving involuntary medications who also had at least one admission to the psychiatric infirmary over the five-month review period.

over the five-month review period. During that time, the same individual was admitted to the psychiatric infirmary nine times for suicidal ideation.[22]

Systemic and procedural issues have resulted in the inconsistent administration of involuntary medications.

Persistent systemic and procedural issues have contributed to the inconsistent administration of involuntary medications. These issues include the following:

- Fusion (CHS's electronic health record system) cannot generate involuntary medication reports, limiting the division's ability to monitor compliance.[23]
- Fusion does not provide alerts for pill line staff indicating whether the prescribed medication is involuntary.[24]
- Blister packs containing involuntary medications are not clearly labeled as such, making them difficult to identify.

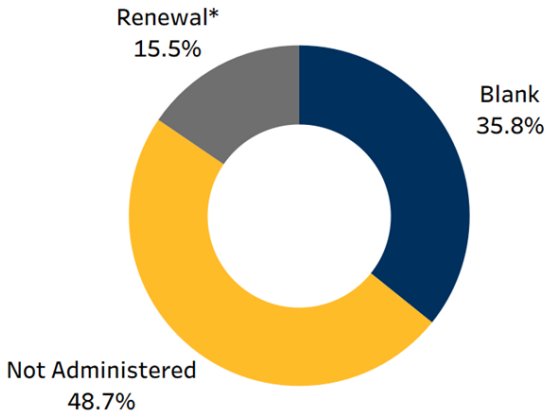
Despite these issues, the responsibility of administering involuntary medications ultimately rests on medical staff. However, management must also develop a system of oversight and establish a tone at the top to reflect the importance of administering these critical medications. According to division management, the only way to evaluate compliance with involuntary medication orders is manual reconciliation, which is not consistently occurring. Another contributing factor is insufficient documentation for missed doses. Figure 3.1 illustrates the lack of documentation associated with the administration of involuntary medications.

[22] It is important to note that without an in-depth medical review by a licensed professional, we cannot draw any conclusions between the missed medication doses and the psychiatric infirmary admissions.

[23] The identified deficiency could be resolved by collaborating with the vendor (Fusion) to implement a system enhancement; however, no work orders have been submitted to begin this process.

[24] Pill lines are designated places in the facility where inmates who require medications that must be more carefully monitored are given their daily dosages. Pill lines are held three times daily.

Figure 3.1 Pill Line Staff Are Not Documenting Missed Involuntary Medication Doses. In the sample of 433 missed medication doses for involuntary medications, 36% were left blank and 49% were marked as *not administered.*



Source: Auditor generated using data obtained from CHS's electronic medical record system.
** Refers to instances where medications were not administered due to delays in the renewal process—specifically, when prescriptions were renewed late and the medications were temporarily unavailable.*

In the sample of 433 missed medication doses for involuntary medications, pill line staff left 85% of the entries blank or marked as *not administered* with only a limited explanation such as "refused" or "no show." This is particularly concerning because the patient does not have the option to refuse treatment. Instead, the responsibility for administering the medication rests on medical staff. Documenting the reason for missed medications becomes critical to providing oversight for staff and ensuring inmates are receiving treatment. These medications are necessary for the treatment and care of those with serious mental illnesses. Therefore, the division should establish a system of oversight and accountability to ensure that involuntary medications are properly documented and administered.

85% of missed medication doses for involuntary medications were either left blank or marked as *not administered* with only a limited explanation.

Three inmates went six days without their involuntary medications before their prescriptions were eventually renewed and medications became available.

Additionally, pill line staff are not always renewing involuntary medications in a timely manner, leading to interruptions and prolonged lapses in medication administration. We reviewed the charts of 22 inmates and found that three went six days without receiving involuntary medications before their prescriptions were eventually renewed and medications became available. Extended delays could result in serious consequences, the recurrence of psychiatric conditions, and/or significant emotional instability. These delays also directly violate standards from the National Commission on Correctional Healthcare (NCCHC) requiring that "Medications are provided in a timely, safe, and

sufficient manner."[25] To avoid future lapses, management should develop a structured process to maintain continuity of care.

RECOMMENDATION 3.1

The Division of Correctional Health Services should review involuntary medication administration processes and address barriers associated with staff not administering these medications. This should ensure that staff administer involuntary medications as prescribed.

RECOMMENDATION 3.2

Division of Correctional Health Services leadership should set a clear expectation that staff must administer involuntary medications. This should ensure that staff understand the importance of administering these medications and that leadership will hold staff accountable.

RECOMMENDATION 3.3

The Division of Correctional Health Services should establish a system of oversight and accountability to ensure that involuntary medications are properly documented and administered.

Involuntary Medications Hearings Do Not Follow Policy

Decisions to continue involuntary medications are made by a psychiatrist at the state hospital following a virtual consultation with the provider.

CHS policy requires a committee hearing at least every six months to reassess whether an inmate's continued involuntary treatment remains necessary. However, these meetings have not happened for the past year. Instead, decisions to continue involuntary medications are made by a psychiatrist at the Utah State Hospital (USH) following a virtual consultation with the provider—an approach that directly violates established policy.[26] Management reports that this transition was modeled after the process used by USH. That said, policy is clear: "…a new hearing shall be held to consider the continuation of involuntary

[25] NCCHC P-D-02.

[26] Providers are defined to include psychiatrists, advanced practice registered nurses (APRNs), and psychiatric nurse practitioners.

treatment." Adhering to this policy would increase accountability and act as a safeguard in the hearing process.

The involuntary medication renewal process raises other concerns as well. For example, we identified a case in which a mental health provider renewed an involuntary medication order without obtaining prior approval. This case raises significant concerns, as the inmate continued involuntary medications for an additional six months without clear evidence or documentation supporting their necessity.

Addressing these changes may also provide the division with an opportunity to evaluate the current structure of the involuntary medications hearing committee. Internal policy requires the involuntary medications hearing committee to base its decisions on sound medical judgment; however, it only mandates the presence of a single prescribing clinician. Having only one clinician on the committee limits medical perspectives and weakens safeguards for inmates involved in the involuntary treatment process. Enhancing clinical representation could help ensure that involuntary medication decisions more fully reflect the medical judgment required by policy.

Division management should consider reviewing the current structure of the involuntary medications hearing committee.

RECOMMENDATION 3.4

The Division of Correctional Health Services should review and adhere to effective involuntary medication prescription safeguards. This should ensure that inmate prescriptions are reviewed in a way that reflects qualified medical judgments.

3.2 CHS Management Needs to Address Additional Areas of Noncompliance

Mental health staff are not consistently prioritizing (triaging) HCRs based on urgency, resulting in delays in care. Management has not provided standardized triage guidelines for mental health staff. Consequently, mental health staff incorrectly prioritized multiple requests involving suicidal or homicidal ideations. Additionally, inmates showing signs of suicidal ideation often lacked the required safety and treatment plans. Without these plans, treatment may be ineffective, potentially leading to poor health outcomes, increased costs, and compromised patient safety.

Management Needs to Improve Its Oversight to Ensure that Healthcare Requests Are Handled Appropriately and Within a Timely Manner

Management has not provided standardized triage guidelines to mental health staff, leading to inconsistent practices and delays in care. Without clear protocols, urgent cases may be overlooked. For instance, one inmate expressing homicidal ideation wasn't seen for over three weeks until auditors alerted the division to this individual. Additionally, we reviewed six months of HCR data and found that 47% (8 of 17) of HCRs expressing homicidal or suicidal ideations were triaged as "normal." The lack of guidance on triage guidelines could pose safety and security risks to all those in the prison facility.

Management failed to provide standardized triage guidelines to mental health staff, leading to inconsistent practices and delays in care.

According to NCCHC, HCRs are required to be picked up, reviewed, and triaged daily by qualified healthcare professionals. Once an HCR is collected or otherwise entered into the prison's electronic medical record, healthcare staff are required to conduct a face-to-face evaluation within 24 hours of receipt.[27] Following the face-to-face evaluation, mental health staff prioritize HCRs for mental health services based on the urgency of need. When further care is deemed necessary, response time goals range from 24 hours to 60 days, depending on the level of urgency. In 2024, the average time it took to see a therapist at the Utah State Correctional Facility was 17 days. It also took an average of 20 days to see a mental health provider. These timelines include all

[27] Privacy concerns for electronic HCRs reportedly prevent the requestor from including any additional comments outside of simply requesting a visit. Face-to-face evaluations are conducted to assess the patient's condition and determine if a referral for additional care is needed.

mental health HCRs regardless of priority. If an HCR is not prioritized correctly, an inmate with an urgent need may experience a significant delay based on staff response time goals. That said, response time goals have not been clearly communicated, creating a disconnect among staff. For example, appointment schedulers and mental health staff follow different response goal timelines, which can lead to misunderstandings and potential delays in care.

In February 2025, leadership sent an email directing mental health staff to initiate a crisis call if an HCR mentioned suicidal or homicidal ideations. However, we identified multiple requests mentioning suicidal or homicidal ideations that did not receive a face-to-face evaluation and were inappropriately prioritized. These requests warrant immediate attention and should have triggered a crisis-level response. Examples of these include the following:

Example 1

"…I get real[ly] angry because of bad thought[s] of hurting others as well as myself..."

Example 2

"…I was on suicide watch… [I'm] still hearing voices to make bad decisions…"

Example 3

"[I've] been having negative thoughts of hurting other people…"

Example 4

"…[I'm] feeling very anxious and feeling like 'cutting.'"

The HCRs in these examples were triaged as "normal," indicating that these individuals may not receive a mental health evaluation for up to 60 days or more.[28]

In previous audits of healthcare in the state prison system, we have recommended improvements for collecting and entering inmate healthcare

[28] The triage process for both paper-based and electronic-based requests largely depends on face-to-face evaluations; however, only one of the four examples received the required face-to-face evaluation.

requests.[29] These recommendations were intended to address gaps in care and strengthen the overall healthcare delivery process. CHS should similarly create specific policies and procedures for prioritizing mental health HCRs, and establish a system of oversight and accountability to ensure requests are prioritized appropriately.

RECOMMENDATION 3.5

The Division of Correctional Health Services should develop policies and procedures to standardize the process of prioritizing (triaging) inmate healthcare requests for mental health services and monitor its implementation. These should ensure that inmates are seen according to the urgency of their request.

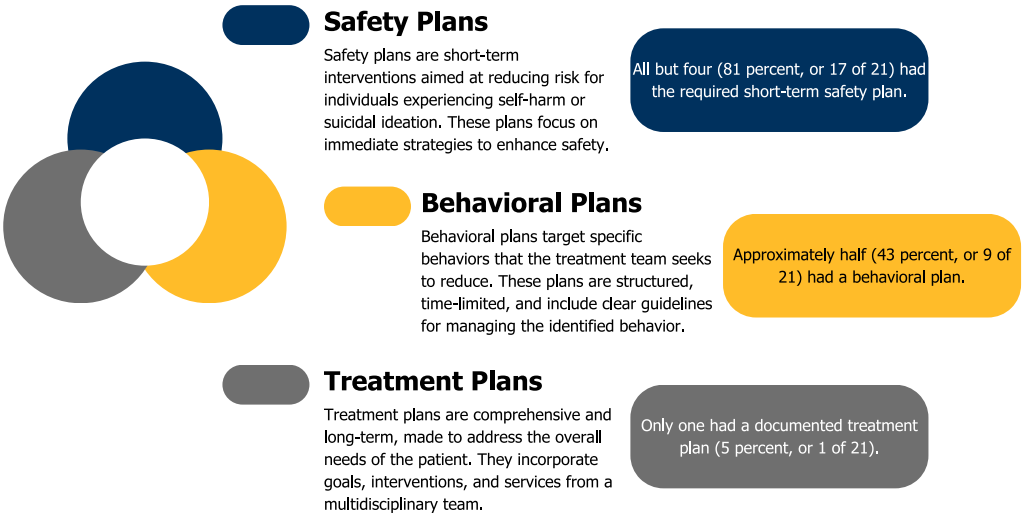
RECOMMENDATION 3.6

The Division of Correctional Health Services leadership should establish a system of oversight and accountability to ensure that inmate healthcare requests for mental health services are prioritized (triaged) appropriately.

CHS Leadership Did Not Implement Treatment Plans for Inmates Who Required Them

Mental health staff are largely not providing inmates with the opportunity to create treatment plans. Treatment plans are intended to address underlying issues and outline actions to take if suicidal thoughts recur. CHS behavioral health services offers at least three plans designed to address various levels of care. Understanding the distinction between these plans and services is crucial because different plans and services cater to different needs, ensuring that inmates receive the optimal level of care. Together, these plans form an integrated framework to provide comprehensive support, as illustrated below:

[29] *A Performance Audit of Healthcare in State Prisons* (Report No. 2021-17);
An In-Depth Follow-Up of Healthcare in State Prisons (Report No. 2023-01);
A Second In-Depth Follow-Up of Healthcare in State Prisons (Report No. 2025-12)



Of the three types of plans, safety and treatment plans are mandatory, while behavioral plans are created on an as-needed basis. In our sample of 21 inmates released from the psychiatric infirmary following a suicide attempt, we found that about half (43%, or 9 of 21) had a behavioral plan and all but four (81%, or 17 of 21) had a short-term safety plan.[30] However, of the 21 inmates we reviewed, only one had the mandatory documented treatment plan. Our psychiatric consultant's review also showed a lack of treatment plans. He found that "Meaningful treatment plans [were] absent from almost all inmates' medical records…" and that he was "…unable to locate a single treatment plan in the 55 cases he reviewed." Treatment plans are required in NCCHC standards and internal policy and are an important step in addressing the long-term needs of the patient.

Of the 21 inmates we reviewed, only one had a documented treatment plan.

The division mandates the creation of treatment plans for any inmate exhibiting signs of suicidal ideation to ensure that these individuals are identified, monitored, and treated as quickly as possible.[31] However, our review found that this process is largely not being followed. For example, one inmate attempted suicide in October 2024 and was admitted to the psychiatric infirmary twice for acute suicidal ideation and severe self-harm. Despite the seriousness of the inmate's condition, a treatment plan was never developed. In the 301 days

[30] Due to incomplete documentation, it was unclear whether the behavioral plans were connected to the suicide attempt in question. In several cases, the behavioral plans were missing key identifiers such as dates and offender numbers, making it difficult to establish a clear timeline or link them to the incident under review.

[31] Additionally, NCCHC's suicide prevention and awareness standard requires treatment plans addressing suicidal ideation (and its potential recurrence) to be developed.

following the initial suicide attempt, the inmate received only one therapy session—which was initiated at the request of custody staff.[32] Additionally, we reviewed CHS psychiatric infirmary data for calendar year 2024 and found that 41% of inmates admitted to the USCF psychiatric infirmary were admitted more than once. This suggests the need for long-term treatment. Without a clearly defined plan, treatment efforts risk becoming ineffective, potentially leading to poor health outcomes, increased costs, and compromised patient safety.

In the 301 days following a suicide attempt, an inmate received only one therapy session, which was initiated at the request of custody staff.

When asked about the lack of treatment plans, CHS management informed us that the prison's electronic medical record system could not create and store treatment plans. Upon further investigation, we found that the system had technical updates to support the creation of treatment plans in March 2024. Despite system improvements, no action was taken to implement treatment plans until June 2025 (15 months later). This delay indicates that CHS management did not prioritize the development of individualized treatment plans for inmates who required them.

Despite system improvements, no action was taken by management to implement treatment plans for 15 months.

Furthermore, CHS management reported that staffing shortages hinder their ability to initiate the necessary follow-up required to create treatment plans. However, both safety plans and behavioral plans are created more frequently. Safety plans are required in NCCHC standards and internal policy and are developed before an inmate leaves the psychiatric infirmary. In contrast, behavioral plans are not mandated and serve as short-term treatment plans to address a range of behavioral issues. Given the long-term treatment needs of some individuals admitted to the psychiatric infirmary, CHS should prioritize the creation of standard operating procedures for individualized treatment plans and monitor their implementation. This helps ensure that mental health staff are addressing the long-term needs of inmates discharged from the psychiatric infirmary.

[32] From October 2024 to July 2025, the inmate in this example received four mental health provider visits in addition to the one therapy session.

RECOMMENDATION 3.7

The Division of Correctional Health Services should prioritize the creation of standard operating procedures for individualized treatment plans and monitor its implementation. This should improve behavioral health outcomes for inmates.

Complete List of Audit Recommendations

Complete List of Audit Recommendations

This report made the following 16 recommendations. The numbering convention assigned to each recommendation consists of its chapter followed by a period and recommendation number within that chapter.

Recommendation 1.1

Division of Correctional Health Services management should review practices and policy that are designed to adhere to best practices when classifying inmates as acutely or non-acutely suicidal. The policies when implemented should improve the care and outcomes of behavioral health services.

Recommendation 1.2

Division of Correctional Health Services management should review practices and policies that are designed to adhere to best practices when tracking step-down visits. The policies, when implemented, should improve the care and outcomes of behavioral health services and improve patient safety for inmates classified as acutely or non-acutely suicidal.

Recommendation 1.3

The Division of Correctional Health Services should establish a systematic process for defining, identifying, tracking, and reviewing all suicide attempts to improve the quality of care and patient outcomes.

Recommendation 1.4

The Division of Correctional Health Services should review its existing prevention and intervention standard operating procedures and design and implement a systemwide comprehensive suicide prevention program to improve the quality of care and patient outcomes.

Recommendation 2.1

The Division of Correctional Health Services should establish a structured review process to ensure that providers are prescribing medications as clinically indicated and that medications are provided in a timely, safe, and sufficient manner.

Recommendation 2.2

The Division of Correctional Health Services should review standards and policies pertaining to intake and implement practices that meet these standards to ensure an appropriate level of care.

Recommendation 2.3

The Division of Correctional Health Services should ensure proper follow-up is conducted to provide inmates with behavioral health care that is adequate and appropriate.

Recommendation 2.4

The Division of Correctional Health Services should ensure that the frequency and duration of appointments is sufficient to meet the mental health needs of the population.

Recommendation 2.5
Division of Correctional Health Services management should periodically review inmate behavioral health records for adequacy, thoroughness, and completeness and document these reviews to ensure appropriate care.

Recommendation 3.1
The Division of Correctional Health Services should review involuntary medication administration processes and address barriers associated with staff not administering these medications. This should ensure that staff administer involuntary medications as prescribed.

Recommendation 3.2
Division of Correctional Health Services management should set a clear expectation that staff must administer involuntary medications. This should ensure that staff understand the importance of administering these medications and that management will hold staff accountable.

Recommendation 3.3
The Division of Correctional Health Services should establish a system of oversight and accountability to ensure that involuntary medications are properly documented and administered.

Recommendation 3.4
The Division of Correctional Health Services should review and adhere to effective involuntary medication prescription safeguards. This should ensure that inmate prescriptions are reviewed in a way that reflects qualified medical judgments.

Recommendation 3.5
The Division of Correctional Health Services should develop policies and procedures to standardize the process of prioritizing (triaging) inmate healthcare requests for mental health services and monitor its implementation. These should ensure that inmates are seen according to the urgency of their request.

Recommendation 3.6
Division of Correctional Health Services management should establish a system of oversight and accountability to ensure that inmate healthcare requests for mental health services are prioritized (triaged) appropriately.

Recommendation 3.7
The Division of Correctional Health Services should prioritize the creation of standard operating procedures for individualized treatment plans and monitor its implementation. This should improve behavioral health outcomes for inmates.

Appendix

A. OLAG Psychiatric Consultant Report

2025 Utah State Correctional Facility Mental Health Review

Prepared for

Office of the Legislative Auditor General

W315 State Capitol Complex

Salt Lake City, UT 84114

October 23, 2025

Prepared by

DANIEL INOUYE, MD

Diplomate, American Board of Psychiatry and Neurology

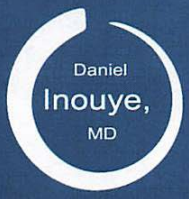


Table of Contents

Executive Summary

Critical Finding:

The Utah State Correctional Facility (USCF) fails to meet statutory and professional standards for mental health care.

Key Deficiencies:

- Zero full-time psychiatrists for 3,600 inmates (incongruent with APA staffing guidelines)
- Current non-compliance with Utah Code § 64-13-39 requiring NCCHC accreditation[1]
- Inadequate suicide prevention protocols
- Unlicensed psychiatric units operating without proper oversight

Immediate Action Required:

This audit identifies 14 critical deficiencies requiring immediate intervention. Eight recommendations are made to improve care.

[1] USCF has operated without required NCCHC accreditation for over three years. The facility lost accreditation during its July 2022 relocation and became eligible to reapply in July 2024 after completing the required 12-month documentation period under new healthcare management. An accreditation review was not scheduled until September 2025.

Introduction

Incarcerated individuals possess a right to treatment for serious medical needs, including mental illness. When governmental entities assume custody of individuals, they acquire a fundamental duty to provide life's necessities—including medical care—that the person cannot otherwise obtain. Utah Code § 64-13-39 mandates that all healthcare facilities owned or operated by the Utah Department of Corrections must apply for and meet the requirements for accreditation by the National Commission for Correctional Health Care (NCCHC). The statute requires timely pursuit of NCCHC accreditation and ongoing inspections by commission staff to ensure continued compliance. By codifying NCCHC accreditation as a legal requirement rather than a voluntary enhancement, Utah has elevated professional correctional healthcare standards to statutory mandate, creating a legal obligation for Utah correctional facilities to implement comprehensive NCCHC standards.

Review Methodology

Review Standards and Objectives:

This review evaluates USCF against nationally recognized professional standards from leading correctional healthcare organizations, including the National Commission on Correctional Health Care (NCCHC) and the American Psychiatric Association (APA).

Given the reviewer's active clinical practice and board certification in psychiatry, this evaluation prioritizes identification of practices that:

- constitute deviations from accepted medical standards,
- create risks to patient safety and welfare, or
- violate fundamental principles of psychiatric care.

Purpose and Goals:

By applying rigorous professional standards, this review aims to:

- identify vulnerabilities and compliance failures,
- improve clinical outcomes for inmates with mental health conditions, and
- ensure alignment with contemporary correctional healthcare ethics and best practices.

Reviewer Qualifications:

This review was conducted by a Harvard-trained, board-certified psychiatrist with specialized expertise in correctional and forensic mental health care.

Professional Credentials:

- **Medical Education:** Harvard Medical School, MD (2014)
- **Specialized Training:** Adult Psychiatry Residency, University of Utah and UCLA (2018)
- **Board Certification:** American Board of Psychiatry and Neurology (2018)

- **Utah Medical License:** Active since 2014

Academic Positions:

- Clinical Preceptor, Yale School of Medicine
- Adjunct Faculty, Utah Valley University Physician Assistant Program

Relevant Clinical Experience:

- 10+ years of psychiatric practice specializing in assessment, treatment, and crisis intervention
- Direct clinical experience evaluating and treating incarcerated individuals
- Court-qualified expert providing psychiatric evaluations and testimony in legal proceedings

Scope and Sample:

This review employed systematic analysis of medical records from 50 randomly selected inmates with mental health histories at USCF, plus focused examination of 5 cases involving inmate deaths by suicide. The review period spans July 2023 to July 2025.

Professional Standards Applied:

Findings were evaluated against five comprehensive sets of professional standards:

1. National Commission on Correctional Health Care. (2015). *Standards for mental health services in correctional facilities*
2. American Psychiatric Association. (2016). *Psychiatric services in correctional facilities (3rd ed.)*
3. National Commission on Correctional Health Care. (2018). *Standards for health services in prisons*
4. National Commission on Correctional Health Care. (2016). *Standards for opioid treatment programs in correctional facilities*

5. National Commission on Correctional Health Care. (2025). *Jail guidelines for the medical treatment of substance use disorders*

Quality Assurance:

Preliminary findings were discussed with USCF staff to ensure factual accuracy before finalization.

Review Limitations:

This review focuses on the most critical deficiencies identified through comprehensive chart analysis. Due to limited facility access (single 6-hour guided tour), this evaluation does not comprehensively examine:

- Administrative systems and quality improvement programs
- Staff training and credentialing processes
- Operational procedures and safety protocols
- Physical infrastructure and equipment adequacy

The findings presented represent the most urgent and well-documented deficiencies requiring attention.

Findings

Finding 1: Substandard staffing levels at the USCF are a clear and pervasive danger to inmates.

NCCHC Standards Violated: P-A-01, MH-A-01, O-A-01, P-C-07, MH-C-07, and O-C-02.

Specific Deficiencies:

- The USCF is understaffed, creating an "unreasonable barrier" to adequate health care, as defined by NCCHC standards. Adherence to APA prison care recommendations[2] would require the USCF to employ five to six full-time psychiatrists. Currently, the USCF does not employ a single full-time psychiatrist. Interviews with clinicians at the prison suggest that staffing levels are inadequate.
    - Chart review revealed that fewer than 10% of even the most severely psychiatrically ill inmates ever receive evaluation by a psychiatrist.
- Because of lack of staffing, inmates on the "psych hall," the unit used for the most gravely ill inmates (which is being used in lieu of psychiatric hospitalization), do not receive any psychotherapy. They do not participate in groups and are kept in isolation almost 24 hours a day.
    - Chart review revealed that 100% of psych hall inmates were maintained in isolation with 0% receiving psychotherapy. This is particularly concerning because many inmates were suicidal due to identifiable life stressors such as divorce or bereavement—conditions that respond well to therapeutic intervention. Instead, these inmates met prolonged isolation.
- Because of lack of staffing, practitioners on the psych hall do not perform complete histories and physical examinations.

[2] American Psychiatric Association. (2016). Psychiatric services in correctional facilities (3rd ed.). https://ebooks.appi.org/epubreader/psychiatric-services-in-correctional-facilities. Pages 9-10

- Patient encounters on the psych hall are estimated to average approximately three minutes per visit, a timeframe insufficient for meaningful psychiatric assessment, treatment planning, or therapeutic intervention. These are the facility's most severely mentally ill inmates.

- In part because of lack of staffing, practitioners are not obtaining collateral information from inmates' families, even in the cases of the most extreme psychiatric emergencies.
  - Multiple practitioners acknowledged they have never contacted inmates' families to obtain critical collateral information, even when treating patients who are nonverbal, producing incoherent speech, actively delusional, or acutely suicidal—precisely the cases where family input is most essential for safe and effective treatment.
- Because of lack of staffing, throughout the facility, inmates are often abandoned: Even cognitively impaired patients are instructed to follow up by "healthcare request," disregarding the standard requiring all outpatients to be seen at minimum every 90 days.[3]
  - For example, one severely ill inmate with schizophrenia presented with active auditory hallucinations, reporting he was hearing the FBI communicate with him, and exhibited significant medication side effects including excessive drooling. Despite his obvious psychiatric decompensation and medication toxicity, he was instructed to submit a healthcare request if he needed future care—a process requiring cognitive abilities he clearly lacked due to his psychotic state. Outside of the prison, this type of patient would be seen again within a week, if not the following day.
  - Another patient was "constantly walking around naked," masturbating in ways that bothered his peers, hearing voices, and experiencing

[3] National Commission on Correctional Health Care. (2015). Standards for mental health services in correctional facilities.
Page 103

extreme delusions. He also was also instructed to follow up per health care request. Based on my experience, outside of the prison, this type of patient would be seen within a week, if not daily.

- Because of lack of staffing, inmates are not being seen throughout the facility in a timely fashion when they request care.
    - Staff interviews revealed systematic care delays, with non-urgent mental health requests requiring three-month wait times. Practitioners described a reactive crisis management approach involving emergency "blitzes" where multiple clinicians simultaneously address backlogs in one prison unit while delays accumulate elsewhere—a chaotic system that shifts rather than solves access problems, preventing consistent mental health care delivery.
- Because of lack of staffing, inmates cannot access psychotherapy while housed on the Fremont (intake) unit, typically for 90 days.
    - This 90-day treatment gap is particularly dangerous because the intake period represents a very high-risk time for psychiatric decompensation, suicide, and adjustment disorders when inmates most urgently need therapeutic support.

Finding 2: The USCF is violating Utah Code § 64-13-39, which requires NCCHC accreditation.

Specific Deficiencies:

- The USCF has not been accredited since it moved to its new location.[4]

[4] Again, USCF has operated without required NCCHC accreditation for over three years. The facility lost accreditation during its July 2022 relocation and became eligible to reapply in July 2024 after completing the required 12-month documentation period under new healthcare management. Despite this eligibility, an accreditation review was not scheduled until September 2025.

Finding 3: The USCF is not identifying suicidal inmates and appropriately intervening.

NCCHC Standards Violated: P-B-05, MH-G-04, and O-G-01.

Specific Deficiencies:

- Acutely suicidal inmates are not under constant observation, violating compliance indicators P-B-05(2), MH-G-04(1), and O-G-01(1).
- Non-acutely suicidal inmates in isolation cells lack required constant observation.
    - Standards require continuous staff monitoring, with technological aids (closed-circuit television) as supplements only, never substitutes for staff monitoring.[5]
    - In one case, despite documented "every 15-minute" checks, an inmate was not found deceased until over an hour after his death by suicide.
- Cells housing suicidal inmates are not maximally suicide-resistant. They contain known protrusions that enable hanging.
    - In one particularly egregious case, it is this consultant's opinion that staff displayed deliberate indifference to excessive and grave risks to the inmate's health and safety by not providing a suicide attempt-resistant cell. The inmate was actively suicidal and had previously cost the State tens of thousands of dollars in healthcare costs from previous suicide attempts.

[5] National Commission on Correctional Health Care. (2015). Standards for mental health services in correctional facilities.

Finding 4: USCF inmates are unable to receive inpatient psychiatric hospitalization services.

NCCHC Standards Violated: P-D-08 and MH-D-05.

Specific Deficiencies:

- The psych hall is used instead of transferring inmates to local inpatient psychiatric hospitals, but care quality is not comparable to community standards.
    - The psych hall and Currant unit are not licensed as psychiatric facilities. They are not following psychiatric facility regulations. This licensing gap has enabled inadequate care for the most severely ill inmates. Multiple profoundly psychotic inmates received grossly inadequate treatment
        - Required assessments under Utah Admin. Code R432-101-20(2) (physician assessment within 24 hours) are not being conducted.
        - Required activity therapy under Utah Admin. Code R432-101-31 is not provided; Inmates remain in total isolation without psychotherapy, receiving only brief, perfunctory visits.
        - Examples of this inadequate care include the following:
            - An inmate became suicidal due to persistent psychotic hallucinations and was admitted to the psych hall for two weeks. During this admission, providers made no diagnostic attempt and implemented no treatment changes. Two days after discharge, he was readmitted for continued suicidality. Throughout both psych hall admissions, his medications remained unchanged, no therapy was provided, and he was maintained in complete isolation—receiving no therapeutic intervention for the very symptoms driving his suicidal ideation.
            - An inmate transferred from Utah State Hospital—indicating chronic, severe mental illness requiring

intensive psychiatric care—had a documented history of catatonia and schizophrenia. Despite his clinical complexity, facility policy mandated tapering his essential catatonia medication over two weeks rather than the clinically appropriate months-long process, significantly increasing his risk of potentially life-threatening catatonic episodes. Compounding this dangerous decision, he discontinued his antipsychotic medication entirely. During his psych hall stay, providers never recognized or addressed that he had stopped taking his antipsychotic medication.

Finding 5: USCF inmates lack reliable access to care for their serious mental health needs.

NCCHC Standards Violated: P-A-01, MH-A-01, and O-A-01.

Specific Deficiencies:

- Multiple psychotic patients with severe cognitive impairments were instructed to follow up via "health care request" despite remaining psychotic and out of touch with reality. This violates standards which require flexible access-to-care procedures to accommodate inmates that lack the ability to recognize emerging health needs.

Finding 6: USCF policies violate clinician autonomy.

NCCHC Standards Violated: P-A-03, MH-A-03, and O-A-03.

Specific Deficiencies:

- Practitioner judgment for medication-assisted treatment programs for opioid use disorder is being overridden by prison policy.
- Multiple inmates were denied medication-assisted treatment due to policy restrictions rather than clinical assessment.

- While Utah Code 64-13-25.1 permits inmates with active medication-assisted treatment plans within six months prior to custody to continue treatment, it does not prohibit treatment for other individuals.

- At least one inmate with a significant catatonia history was unable to continue receiving necessary medical treatment (a benzodiazepine) because of facility policy.

Finding 7:. The USCF is not providing medication services in a timely, safe, and sufficient manner.

NCCHC Standards Violated: P-D-02, MH-D-02, and O-D-02.

Specific Deficiencies:

- Medications were not bridged on admission for multiple inmates (approximately 10% of the sample reviewed) within an acceptable time frame.
- Medication-assisted treatment policies prevent clinicians from prescribing to appropriate patients.
  - 100% of prescribers interviewed reported that facility policy at times prevented them from prescribing the medications they believed to be indicated.
- Ordering clinicians are not notified when orders expire, resulting in inmates frequently losing access to their prescription medications.

Finding 8: Inmates at the USCF are not receiving evidence-based care consistent with national clinical practice guidelines.

NCCHC Standards Violated: P-F-01, MH-E-05, and O-E-01.

Specific Deficiencies:

- The USCF will not provide inmates on the Fremont unit psychotherapy.
- The USCF does not provide robust, effective therapy. Therapy currently provided is infrequent and generally is not of an evidence-based modality.
- The USCF restricts medication-assisted treatment beyond clinical criteria.

Finding 9: USCF clinicians are not providing interventions consistent with current practice standards.

NCCHC Standards Violated: P-E-09, MH-E-09, and O-E-09.

Specific Deficiencies:

- Inmates on the inpatient psychiatric unit are not always seen at least five times weekly as required by current practice standards.
- One-to-one supervision is not provided when clinically indicated.[6]
- APA Guidelines for psychiatric evaluations are not followed.[7]
- Documentation, especially on the psych hall, is often absent or contradictory, suggesting inadequate clinical consideration.
- In suicide cases, retrospective documentation was added to at least one patient chart after death, representing a severe violation of medical ethics.
- Most inmates on the inpatient psychiatric unit never see a psychiatrist, contrary to Medicare and Joint Commission requirements[8,9] and a violation of NCCHC guidelines.

Finding 10: The USCF is not providing the range of mental health services required.

NCCHC Standards Violated: P-F-03 and MH-G-01.

Specific Deficiencies:

- Very few patients are seen at least every 90 days, the absolute minimum required by NCCHC guidelines.
- Individual and group counseling, while available, is infrequent and often is not of the evidence-based modality required for the inmate's specific condition.

---

[6] The Joint Commission. (2024). "Standard FAQs." https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/national-patient-safety-goals-npsg/000002265/

[7] American Psychiatric Association. (2015). The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults.

[8] Centers for Medicare & Medicaid Services (CMS). (2020). "Medicare Benefit Policy Manual, Chapter 2 - Inpatient Psychiatric Hospital Services." CMS.gov. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf

[9] The Joint Commission, Oakbrook Terrace, IL. https://staff.codman.org/wp-content/uploads/sites/2/2021/06/JC-Accreditation-Manual-2021.pdf)

Finding 11: The USCF is not meeting inmates' serious mental health needs and providing appropriate infirmary-level care when indicated.

NCCHC Standards Violated: P-F-02 and MH-G-02.

Specific Deficiencies:

- The acute mental health residential unit lacks daily patient evaluation by mental health staff and appropriate programming and therapies, violating NCCHC guidelines.
- Treatment plans are absent. Medication providers' assessments and plans are frequently substandard without thoughtful assessment.
- The psych hall environment is not a therapeutic environment, as required, and lacks required "individual and group therapies and psychosocial activities."[10]
- Patients requiring daily monitoring are not always within sight or hearing of a facility staff member, violating NCCHC compliance indicator P-F-02(2).

Finding 12: The USCF is not creating or following mental health individual treatment plans.

NCCHC Standards Violated: MH-G-03.

Specific Deficiencies:

- Meaningful treatment plans are absent from almost all inmates' medical records, including on the psych hall. The examiner was unable to locate a single treatment plan in the 55 cases he reviewed.
- Treatment plans should follow appropriate practice guidelines from the American Psychiatric Association or American Psychological Association.[11]

[10] National Commission on Correctional Health Care. (2015). Standards for mental health services in correctional facilities. Page 106.
[11] National Commission on Correctional Health Care. (2015). Standards for mental health services in correctional facilities. Page 108.

Finding 13: The USCF is not providing appropriate medication-assisted treatment.

NCCHC Standards Violated: P-A-03, MH-A-03, O-A-03, O-A-01, O-E-01, and 2025 Jail Guidelines.

Specific Deficiencies:

- The USCF restricts access to medication-assisted treatment (MAT) for opioid use disorder through facility policies that override clinical judgment.
    - Nearly all incarcerated individuals with opioid use disorder history qualify for MAT under current medical criteria due to high recurrence risk in correctional settings.
    - The USCF's current policy is likely to contribute to the following:
        - Inmates sharing needles and engaging in unsafe drug practices, spreading hepatitis C and HIV.
        - Inmates overdosing upon release.
        - An increase in the "street value" of buprenorphine in prison, spurring medication diversion and fostering a black market.
        - An increase in both healthcare costs (i.e. preventable infections requiring treatment) and security costs (i.e. personnel trying to prevent diversion)

Finding 14: The USCF is not following required procedures when inmates die.

NCCHC Standards Violated: P-A-09, MH-A-10, and O-A-10.

Specific Deficiencies:

- NCCHC standards require that a clinical mortality review be conducted by an independent physician following an inmate's death. Results of this review, as well as those of administrative review, must then be communicated with health staff, so everyone can learn from these cases. Staff generally seem to be unaware of these reviews if they are being performed.

Recommendations

Based on the review findings, the following recommendations are organized by priority level and implementation timeline to address the critical deficiencies identified at USCF.

Immediate Priority Recommendations (0-30 days):

Recommendation 1: Implement suicide prevention emergency measures.

- Establish continuous observation protocols for all suicidal inmates.
- Replace technological monitoring with direct staff observation for acutely suicidal inmates and non-acutely suicidal inmates who are isolated.
- Modify cells to remove suicide-enabling protrusions.
- Implement true 15-minute safety checks with documented verification.

High Priority Recommendations (30-90 days):

Recommendation 2: Recruit and hire adequate mental health staff.

- Request additional funding from legislature.
- Develop competitive compensation packages and expedited hiring processes.
- Improve staffing. I suggest attempting to follow APA staffing guidelines.
- Increase mental health professional staff (i.e. therapists) to enable 90-day maximum intervals between appointments.
- Establish psychotherapy services on Fremont and the psych hall.

Recommendation 3: Revise policies to ensure clinical decisions rest solely with qualified mental health professionals.

- Remove policy-based restrictions on medication-assisted treatment to enable clinicians to prescribe MAT based on individual clinical assessment.

Recommendation 4: Establish medication bridging protocols.

- Implement systematic medication bridging for all psychiatric medications pending clinician review.
- Establish automatic notification system for medication order expirations.
- Create emergency protocols for medication continuity.

Medium Priority Recommendations (90-180 days):

Recommendation 5: Either obtain psychiatric facility licensure for the psych hall and Currant unit or establish transfer agreements with community psychiatric hospitals.

Recommendation 6: Establish comprehensive evidence-based mental health programming.

- Create diagnosis-specific group therapy programs.
- Implement structured therapeutic activities on residential units.

Medium-Term Recommendations (6-12 months):

Recommendation 7: Initiate formal NCCHC accreditation processes as statutorily mandated.

- Phase 1: NCCHC Health Services Accreditation.
- Phase 2: NCCHC Mental Health Services Accreditation.
- Phase 3: NCCHC Opioid Treatment Program Accreditation.

Long-Term Recommendations (24 months):

Recommendation 8: Initiate a review audit by the Office of the Legislative Auditor General to ensure changes have been completed.

The implementation of these recommendations will require significant financial investment in staffing, infrastructure, and systems upgrades. However, the costs of non-compliance include:

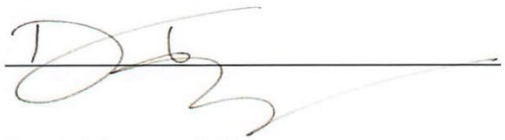
- Increased inmate morbidity and mortality
- Violation of Utah statutory requirements

The facility should prioritize immediate safety concerns while developing a comprehensive implementation plan that addresses systemic deficiencies over the recommended timeline.

Conclusion

These recommendations address fundamental deficiencies that pose significant ethical and safety risks at USCF. The current state of mental health services at the USCF falls substantially below acceptable standards and requires immediate, sustained intervention to protect inmate welfare and institutional integrity.

Sincerely,



Daniel Inouye, MD
Diplomate, American Board of Psychiatry and Neurology

Agency Response Plan

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

DR. STACEY BANK
Executive Medical Director

TONYA HALES
Deputy Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

November 6, 2025

Mr. Kade Minchey
Utah Legislative Auditor General
Utah Capitol Complex
P.O. Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Minchey,

Thank you for the opportunity to respond to the recommendations in *A Performance Audit of the Correctional Health Services Behavioral Healthcare in State Prisons* (Report No. 2025-23). This letter includes the response from the Utah Department of Health and Human Services (department) and Correctional Health Services (CHS). We appreciate the work of the Office of the Legislative Auditor General in conducting this audit and agree that providing effective, high-quality behavioral healthcare within the prison system is a paramount responsibility. We are encouraged that the review noted the overall dedication and commitment of our correctional health staff and management. We fully concur that the identified deficiencies and critical issues in the delivery of behavioral health services require immediate and focused action.

We value the professionalism and direct engagement of your staff throughout this process. On behalf of the department, we agree with the recommendations in this report and we stand ready to implement them, as we collectively strive to strengthen our operations and ensure the delivery of comprehensive and appropriate behavioral health services to all those in our care.

Sincerely,

Tracy S. Gruber
Executive Director

State Headquarters: 195 North 1950 West, Salt Lake City, Utah 84116
telephone: 801-538-4001 | email: dhhs@utah.gov | web: dhhs.utah.gov

Recommendation 1.1. Division of Correctional Health Services Management should review practice and policy that are designed to adhere to best practices when classifying inmates as acutely or non-acutely suicidal. The policies when implemented should improve the care and outcomes of behavioral health services.

Department Response: The Department of Health and Human Services (department or DHHS) concurs with this recommendation.

What: Admission to the psychiatric infirmary provides immediate risk mitigation through environment controls. The setting itself, which removes access to means, is a primary factor in reducing risk. CHS is updating its policies and practices for suicidal inmates to meet the the National Commission on Correctional Health Care (NCCHC) standards effective 2026, focusing on the classification of suicidal inmates and ensuring individuals are monitored according to their clinical risk. Documentation gaps during admission, stay, and discharge have been noted, and efforts to correct these are underway.

How: CHS will clarify policy by clearly defining 'acutely' and 'non-acutely' suicidal and standardizing the process for psychiatric infirmary admissions. The Division will formalize the standard operating procedure (SOP) to guide mental health providers on documenting admissions, evaluating risk, and determining required supervision levels. Following policy and SOP updates, CHS will provide corresponding training to address documentation deficiencies, clarify levels of supervision required, and provide instruction on the continuous assessment of risk.

When: Ongoing, and fully implemented July 2026.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist; Amanda Alkema, CHS director of behavioral health

Recommendation 1.2. The Division of Correctional Health Services Management should review practices and policies that are designed to adhere to best practices when tracking step-down visits to ensure patient

safety classifying inmates as acutely or non-acutely suicidal. The policies when implemented should improve the care and outcomes of behavioral health services.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: When inmates are admitted to the psychiatric infirmary for suicidal ideation or self-harm, they receive a safety plan prior to discharge. While safety plans are being provided to inmates, CHS has become aware that a more extended treatment strategy may be needed. CHS is updating its policies and procedures pertaining to step-down visits and working to integrate individualized care before inmates are discharged. CHS therapists are being trained to utilize a validated assessment tool, the Collaborative Assessment and Management of Suicidality (CAMS), to develop treatment plans focused on underlying issues leading to suicidality. This tool aids in conducting a suicide risk assessment and formalizing a risk management treatment plan, with a core focus on identifying drivers of suicidal ideation and behaviors.

How: CHS is updating the Suicide Prevention and Intervention SOP to clarify assessments, standardize individualized treatment plans, and create a consistent process for documenting and scheduling step-down visits for inmates discharged from the psychiatric infirmary. CHS will integrate training on step-down visits into its comprehensive suicide prevention framework and develop a tracking system to ensure post-discharge policies are implemented effectively, thereby improving the quality and outcomes of behavioral health services.

When: Ongoing, and fully implemented January 2027.

Responsible Staff: Amanda Alkema, CHS director of behavioral health

Recommendation 1.3. The Division of Correctional Health Services should establish a systematic process for defining, identifying, tracking, and

reviewing all suicide attempts to improve the quality of care and patient outcomes.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: During OLAG's review of current practices, it was discovered that CHS lacked a system for tracking suicide attempts. CHS subsequently began a process to identify suicide attempts for inmates admitted to the psychiatric infirmary. CHS updated Fusion to allow for various admission order types, including orders for suicide attempts. CHS is developing a SOP for the psychiatric infirmary to define suicide attempt and standardize how admissions are identified and tracked.

How: CHS will clearly define suicide attempt, clarify admission order types, and standardize how admissions are identified and tracked. CHS will collaborate with the Utah State Hospital (USH), Office of the Medical Examiner (OME), and Utah Department of Corrections (UDC) to establish a systematic process for defining, identifying, tracking, and reviewing suicide attempts. By analyzing data to assess risk patterns and prevention efforts, CHS aims to enhance the quality of care and patient outcomes.

When: Ongoing, and fully implemented July 2027.

Responsible Staff: Amanda Alkema, CHS director of behavioral health; Emily Shuman, CHS compliance officer

Recommendation 1.4. The Division of Correctional Health Services should review their existing prevention and intervention standard operating procedures and design and implement a systemwide comprehensive suicide prevention program to improve the quality of care and patient outcomes.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: CHS and UDC are collaboratively involved with the Zero Suicide Institute, which unites facilities across various states to implement a Zero Suicide program. The Zero Suicide framework serves as a pragmatic structure for the transformation of organizational culture and clinical practice. CHS and UDC receive ongoing support from the Zero Suicide Institute to implement a systemwide suicide prevention program.

CHS established a Zero Suicide Initiative workgroup which is tasked with overseeing the process of transforming the CHS and UDC culture and clinical practices to prevent suicide among inmates. This workgroup is designed to be a comprehensive, proactive, systemwide suicide prevention and quality improvement program implemented over a period of several years to improve the quality of care and outcomes. As part of this initiative, staff were identified and trained on the Collaborative Assessment and Management of Suicidality (CAMS) which is being implemented across both agencies. CAMS provides a therapeutic framework that guides collaborative suicide risk assessment and treatment. This approach facilitates improved identification of individuals exhibiting patterns of suicidal behaviors or self-harm throughout the continuum of care shared between CHS and UDC.

How: The Zero Suicide Initiative workgroup, a multi-year initiative, will continue to work toward the implementation and sustainability of a comprehensive systemwide suicide prevention program by conducting a system wide assessment. This assessment will help identify and prioritize system deficiencies and areas of focus. Initially, the workgroup will prioritize updating policies and procedures, providing necessary staff training, reviewing suicide attempts, completed suicides, and establishing a system for oversight and accountability.

When: Ongoing, and full implementation expected within 3-5 years.

Responsible Staff: Dr. Marcus Wisner, CHS director; Amanda Alkema, CHS director of behavioral health

Recommendation 2.1. The Division of Correctional Healthcare Services should establish a structured review process to ensure that providers are prescribing medications as clinically indicated, and that medications are provided in a timely, safe, and sufficient manner.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: Advanced practice registered nurses (APRNs) and physician assistants (PAs) can legally practice independently once they are certified and licensed. An experienced, independently practicing APRN is employed by CHS in a supervisory capacity. This individual is responsible for the periodic review and quality oversight of the mental health services delivered by APRN and PA providers. CHS hired a board certified forensic psychiatrist (.8 FTE) and two University of Utah forensic psychiatry fellows, who began rotation at CHS, to provide clinical leadership. These psychiatrists carry a caseload and care for high acuity and complex patients, as well as serve in a supportive and consultative role to APRNs managing a similar caseload. CHS has implemented ongoing education and training for mental health providers that includes case review.

How: CHS will continue to provide education and training regarding evidence-based best practices and treatments for mental illnesses. Training by a psychiatrist will include pharmacological guidance for psychiatric providers which will align with evidence-based practice and cost effectiveness. CHS will create a structured review process for prescribing practices, aimed at enhancing patient safety and ensuring medications are clinically justified and delivered appropriately.

When: Ongoing, and fully implemented July 2026.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist

Recommendation 2.2. The Division of Correctional Healthcare Services should review standards and policies pertaining to intake and implement practices that meet standards to ensure an appropriate level of care.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: All inmates are seen for a mental health screening when they enter the correctional facility. CHS adheres to the NCCHC standards of care, which require that inmates who screen positive for mental health concerns are referred for a mental health evaluation. This evaluation is completed within 30 days, or sooner if clinically indicated.

Upon completion of the initial screening process and transfer to the intake housing unit, inmates may access routine mental health services by submitting a healthcare request (HCR). CHS acknowledges variations and challenges in the access to routine mental health services through the HCR process for inmates housed within the intake unit. CHS is developing standard operating procedures (SOPs) for mental health staff conducting HCR triaging and evaluations, focusing on identifying high-risk situations, particularly suicide risk within the intake unit.

How: CHS will implement standard procedures that identify high-risk situations, particularly those with increased risk for suicide within the intake unit. CHS will evaluate current resource allocation for routine mental health services and assess the patient population to determine the feasibility of offering therapeutic interventions within the intake unit. CHS will work to prioritize high-risk situations or inmates at increased risk for suicide.

When: Ongoing, and fully implemented January 2027.

Responsible Staff: Amanda Alkema, CHS director of behavioral health; Jon Butterfield, CHS chief operating officer.

Recommendation 2.3. The Division of Correctional Healthcare Services should ensure appropriate follow-up is conducted to provide inmates with behavioral health care that is adequate and appropriate.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: Appointments for follow-up visits are scheduled either through an inmate submitted HCR or by an internal referral placed by a provider. Typically, in the mental health housing sections, the mental health provider schedules follow-up appointments prior to mental health medications expiring. In the most acute and restrictive mental health housing sections, referrals for ongoing therapy are initiated by the mental health provider once a patient's level of functioning and medication stability increase to a point where they can appropriately engage with a mental health therapist. CHS is reviewing and updating its follow-up care processes to ensure high-risk individuals receive adequate, clinically appropriate care.

How: CHS will strategically assess the inmate population to prioritize high-need cases for follow-up care, while simultaneously updating existing SOPs with clear guidelines. A new system will then be implemented based on these revised procedures to ensure inmates receive clinically appropriate follow-up care.

When: Ongoing, fully implemented January 2027.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist and Amanda Alkema, CHS director of behavioral health

Recommendation 2.4. The Division of Correctional Healthcare Services should ensure that the frequency and duration of appointments is sufficient to meet the mental health needs of the population.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: The psychiatric infirmary concentrates on stabilization and individualized safety plans to facilitate appropriate step-down care. CHS mental health providers conduct brief daily rounds in the psychiatric infirmary after the inmate has been admitted. Within 24 hours of admission, a psychiatric assessment is completed by a

mental health provider. The length of appointments is determined by factors such as the location of the visit, the patient's clinical requirements, and their willingness to participate. Group therapeutic interventions present significant logistical and safety challenges. The primary considerations are the population's unpredictable acuity levels, physical or spatial constraints, and the security protocols required for inmate movement.

How: The Division is committed to maintaining adequate provider coverage in the psychiatric infirmary to ensure each patient receives appropriate, clinically indicated evaluation and treatment. CHS is also evaluating its procedures for the infirmary to ensure they include ongoing evaluations and appropriate therapeutic interventions for inmates housed for more than seven days.

When: Ongoing, fully implemented July 2026.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist; Amanda Alkema, CHS director of behavioral health

Recommendation 2.5. Division of Correctional Healthcare Services management should periodically review inmate behavioral health records for adequacy, thoroughness, and completeness and document these reviews to ensure appropriate care.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: An experienced, independently practicing APRN is employed by CHS in a supervisory capacity. This individual is responsible for the periodic review and quality oversight of the mental health services delivered by APRN and PA providers. CHS hired a board certified forensic psychiatrist (.8 FTE) and two University of Utah forensic psychiatry fellows, who began rotation at CHS, to provide direct clinical care and to serve in a supportive and consultative role. CHS has implemented ongoing education and training to the mental health providers that includes case review. Chart documentation has been of inconsistent quality, particularly

documentation surrounding psychiatric infirmary admissions. CHS is aware this is an area for improvement and is reviewing the process to ensure documentation accurately reflects clinical decision-making and appropriate diagnoses.

How: CHS is committed to maintaining adequate provider coverage in the psychiatric infirmary to ensure each patient receives appropriate, clinically indicated evaluation and treatment. CHS will implement a two-pronged approach: develop staff training focused on documentation standards (adequacy, thoroughness, and completeness) and establish a structured review process to ensure documentation accurately reflects clinical decision-making and appropriate diagnoses.

When: Ongoing, fully implemented January 2027.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist; Amanda Alkema, CHS director of behavioral health

Recommendation 3.1. The Division of Correctional Health Services should review involuntary medication administration processes and address barriers associated with staff not administering these medications. This should ensure that staff administer involuntary medications as prescribed.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: CHS will review the processes associated with involuntary medications. This review will include the processes associated with ordering medications, administration, documentation, and ongoing monitoring for compliance.

It should be recognized that the current electronic health record (EHR) has been identified as a barrier to compliance. The EHR does not provide a mechanism for the easy identification of involuntary medications during the bar code medication administration process. Furthermore, the EHR lacks the functionality to filter or identify those involuntary medications that have not been administered at the

conclusion of a medication pass. CHS is working proactively to address these issues within the EHR and is working to develop alternative solutions for nursing personnel to ensure that involuntary medications have been administered.

How: CHS will continue to address any barriers or issues that contribute to the lack of compliance with involuntary medications. CHS will maintain its work with the current EHR vendor, Fusion, to develop processes and functionality within the EHR that provide identification of involuntary medications along with the reporting to monitor compliance. CHS will develop a required training module that addresses involuntary medication administration and the importance of compliance for all staff administering medication. Staff will receive this training at onboarding and annually.

When: Ongoing, fully implemented July 2027.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist; Jon Butterfield, CHS chief operating officer

Recommendation 3.2. The Division of Correctional Health Services leadership should set a clear expectation that staff must administer involuntary medications. This should ensure that staff understand the importance of administering these medications and that leadership will hold staff accountable.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: CHS leadership will establish clear expectations that staff must comply with mandatory duties for administering involuntary medications. The critical nature of this task will be emphasized, and strict accountability will be enforced.

How: CHS will implement a mandatory training module for all staff involved in the administration of involuntary medication. This module will explicitly address involuntary medication procedures, emphasize policy compliance, and set clear

expectations that all such medications must be administered. The training will be provided during employee onboarding and repeated annually. Additionally, CHS will establish a system of oversight and accountability to guarantee that involuntary medications are properly documented and administered.

When: Ongoing, fully implemented January 2027.

Responsible Staff: Jon Butterfield, CHS chief operating officer

Recommendation 3.3. The Division of Correctional Health Services should establish a system of oversight and accountability to ensure that involuntary medications are properly documented and administered.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: CHS acknowledges inconsistent documentation and administration of involuntary medications. To address this, CHS will review existing oversight and accountability processes to ensure medications are properly documented and administered. This comprehensive review will examine the entire process, including the ordering, administration, and documentation phases of involuntary medication management.

How: CHS will review and update processes regarding provider monitoring of inmates receiving involuntary medications. This is to ensure the treating provider adequately reviews, monitors, and documents the inmate's progress during treatment. Additionally, CHS will establish a system of oversight and accountability to ensure that involuntary medications are properly administered and documented.

When: Ongoing, fully implemented July 2027.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist; Jon Butterfield, CHS chief operating officer

Recommendation 3.4. The Division of Correctional Health Services should review and adhere to effective involuntary medication prescription safeguards. This should ensure that inmate prescriptions are reviewed in a way that reflects qualified medical judgments.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: The current three-person involuntary medication hearing committee determines if an inmate meets criteria for involuntary medications. It is composed of a psychiatrist and two other qualified mental health professionals, none of whom are involved in the inmate's current treatment. The CHS model is consistent with the standard established by the correctional facility referenced in *Washington v. Harper.* CHS is reviewing the current structure of the involuntary medication hearing committee.

How: In consultation with the USH, CHS will continue to evaluate the current structure of the involuntary medication hearing committee including the renewal hearing process. CHS will review and update current policies and procedures to ensure the involuntary medication process, including renewals, is clearly outlined.

When: Ongoing, fully implemented January 2027.

Responsible Staff: Dr. Alexandra Audu, CHS psychiatrist; Amanda Alkema, CHS director of behavioral health.

Recommendation 3.5. The Division of Correctional Health Services should develop policies and procedures to standardize the process of prioritizing (triaging) inmate healthcare requests for mental health services and monitor its implementation. These should ensure that inmates are seen according to the urgency of their request.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: CHS has policies and SOPs for the HCR process, including collection, review, face-to-face assessments, and triage. Currently, inmates who submit HCRs receive a face-to-face assessment within 24 hours. Following this, the HCR is routed to mental health staff for triaging. CHS is developing a SOP and training to clarify this assessment and triage procedure. This training will also cover emergent situations (e.g., suicidal ideation, self-harm, psychosis) and the required crisis call response. This is in addition to the annual crisis call response training CHS currently provides healthcare staff.

How: CHS will continue to train healthcare staff on the criteria for crisis response (e.g., suicidal or homicidal ideation). Additionally, CHS will develop and implement a standardized procedure and training for triaging HCRs, establishing a structured review to ensure accuracy. CHS will also create a system for regular follow-up appointments of inmates unable to self-submit HCRs.

When: Ongoing, fully implemented July 2026.

Responsible Staff: Jon Butterfield, CHS chief operating officer; Amanda Alkema, CHS director of behavioral health

Recommendation 3.6. The Division of Correctional Health Services leadership should establish a system of oversight and accountability to ensure that inmate healthcare requests for mental health services are prioritized (triaged) appropriately.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: CHS leadership acknowledges the need to establish a well designed system of oversight and accountability to ensure that HCRs are triaged appropriately. The CHS nursing staff will continue to train on the importance of identifying HCR's

during the face-to-face assessments that are emergent and the need to initiate a crisis response when indicated.

How: CHS leadership will ensure all mental health staff are trained on the process of triaging HCRs. CHS will establish a structured review process to ensure that mental health staff are triaging appropriately. CHS will also ensure healthcare staff receive training on crisis call responses.

When: Ongoing, fully implemented January 2027.

Responsible Staff: Amanda Alkema, CHS director of behavioral health; Jon Butterfield, CHS chief operating officer

Recommendation 3.7. The Division of Correctional Health Services should prioritize the creation of standard operating procedures for individualized treatment plans and monitor its implementation. This should improve behavioral health outcomes for inmates.

Department Response: The Department of Health and Human Services concurs with this recommendation.

What: CHS is reviewing the current safety, behavior, and treatment plan process to align with NCCHC standards of care and recommendations in this report. CHS is focusing on treatment plans that address suicidality at time of discharge from the psychiatric infirmary and for inmates who are participating in ongoing therapy. CHS now has a functional treatment plan in Fusion and will continue to train on this process and implement a treatment plan when clinically appropriate.

Additionally, UDC and CHS therapists are being trained to utilize a validated assessment tool, the Collaborative Assessment and Management of Suicidality (CAMS), to develop treatment plans focused on underlying issues leading to suicidality. Inmates admitted to the psychiatric infirmary for suicidal ideation and self-harm will receive individual treatment plans prior to discharge from the psychiatric infirmary. UDC and CHS are working together to operationalize CAMS

throughout the continuum of care at USCF, CUCF, and UDC treatment programs in the community.

How: CHS will develop a standard operating procedure and training for the safety and treatment plan process. CHS will also establish a structured review process to ensure that treatment plans are implemented and address the long-term needs of patients leaving the psychiatric infirmary.

When: Ongoing, fully implemented July 2027.

Responsible Staff: Amanda Alkema, CHS director of behavioral health

THE MISSION OF THE LEGISLATIVE AUDITOR GENERAL IS TO

AUDIT · LEAD · ACHIEVE

WE HELP ORGANIZATIONS IMPROVE

olag.utah.gov