Vera INSTITUTE OF JUSTICE

A Sentinel Events Approach to Jail Suicide and Self-Harm

Final Summary Overview

Leah G. Pope and Jason Tan de Bibiana

June 29, 2019

NIJ Award Number: 2014-IJ-CX-0030

PI: Jim Parsons, MSc

Contact: Leah Pope, PhD
Email: lpope@vera.org
Phone: 212-376-4029

Grant Manager: Laurie Bright
Email: lbright@usdoj.gov

This project was supported by Award No. 2014-IJ-CX-0030, awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect those of the Department of Justice. Additional support was provided in part by a grant from The Clifford Chance Foundation, Inc.

Purpose of the Study

Suicide is the leading cause of death for people incarcerated in jail in the United States, accounting for more than 30 percent of deaths.[1] In 2014, the rate of suicide in local jails (50 per 100,000) was the highest observed since 2000 and remained more than three times higher than rates of suicide in either prison (16 per 100,000) or in the community (13 per 100,000).[2] Despite the fact that jail suicide is increasingly recognized as a serious public health problem, the relatively stable rate of jail deaths by suicide across the last 20 years suggests that progress in jail suicide prevention has stalled.[3] The majority of jails in the United States (63 percent) do not conduct mortality reviews following a jail suicide.[4] Further, review processes in the criminal justice system traditionally have been adversarial, driven by an approach that assumes a "bad apple" operator is responsible for error and responds by ascribing blame rather than seeking out the underlying system weaknesses that may more accurately be responsible for the bad outcome.[5] The lack of a system-wide approach inhibits an honest assessment of what happened in these cases and, in turn forecloses opportunities for staff and corrections leaders to learn from mistakes and prevent future incidents of suicide and self-harm.

Since 2016, the Vera Institute of Justice (Vera) has been studying the potential for addressing the problem of jail suicide—as well as the problem of serious self-harm in detention—through "Sentinel Event Reviews."[6] Recognizing that jail suicide and self-harm is rarely cause by a single event or the actions of an individual person, Vera has been exploring what might be gained by understanding jail suicide as a sentinel event: a significant negative outcome that signals underlying system weaknesses, is likely the result of compound errors, and may provide, if properly analyzed and addressed, important keys to strengthening the system and preventing future adverse outcomes.[7] Many high-risk fields like aviation and medicine have long

responded to known errors by implementing review processes characterized by an *all-stakeholder*, *non-blaming*, and *forward-looking* examination of the error. These sentinel event reviews move away from a view of error as solely the product of individual negligence and instead encourage an institutionalized approach that identifies root causes and underlying systems failures.[8]

The current study draws on research in four county jail systems to answer the following research questions: (1) How do the selected jail systems currently review incidents of suicide and self-harm? (2) What challenges and successes have they experienced in developing multi-stakeholder reviews and corrective action plans in response to incidents of suicide and self-harm? And (3) How does the legal and policy landscape in each jurisdiction impact the feasibility of conducting sentinel event reviews in response to incidents of suicide and self-harm? The findings presented below build the evidence base for the feasibility of sentinel event reviews in the criminal justice system and also provide rich data on both why the problem of jail suicide remains so intractable and how some jurisdictions are trying to innovate their responses.

Methodology

Vera's study included four jail systems: the Middlesex Office of Adult Corrections and Youth Services (MCDOC) in Middlesex County, New Jersey; the Middlesex Sheriff's Office (MSO) in Middlesex County, Massachusetts; the Pinellas County Sheriff's Office (PCSO) in Pinellas County, Florida; and Spokane County Detention Services (SCDS) in Spokane County, Washington. For each system, Vera researchers reviewed administrative documents and policies, conducted site visits and interviews with jail and health leadership and staff, and analyzed the legal landscape for jails and sentinel event reviews.

Study Sites

Vera selected the four jail systems after outreach to 16 sites about the study and conversations with six sites. The four systems were selected due to their diversity in geographic location, size, and model of healthcare delivery (see Table 1). Each of the jails had had at least one suicide in custody in the two years leading up to the study and two of the jails experienced a suicide during the study period.

Table 1. Characteristics of Sentinel Event Study Sites

Site	Region	2015 Jail Population	2015 Jail Admissions	2015 County Incarceration Rate (per 100,000)
MCDOC	Mid-Atlantic	803	7,933	141
MSO	Northeast	1,183	5,634	109
PCSO	South	2,528	37,931	427
SCDS	Northwest	834	19,521	259
Source: Vera Institute of Justice, "Incarceration Trends," http://trends.vera.org/incarceration-rates?data=pretrial (accessed March 12, 2019).				

Study Activities

All research procedures were approved by Vera's Institutional Review Board and NIJ's Human Subjects Protection Office. Researchers obtained informed consent from all interview participants. Study activities included the following:

Administrative Document and Policy Review: Researchers requested and reviewed a variety of administrative documents from each site, including: policies related to suicide prevention and response, staff training, staff support, and review processes; training materials; and anonymized investigative reports and mortality and morbidity reports for the most recent suicide in custody. In total, Vera reviewed 85 documents. Policies were compared to review process standards recommended by the American Correctional Association and the National Commission on Correctional Healthcare.[9]

Qualitative Data Collection and Analysis: Between April and June 2018, Vera visited each study site and conducted 42 interviews with 56 individuals, including leadership (n = 32)

and staff from health (n = 26) and corrections (n = 20), legal counsel (n = 3), and internal affairs and investigation team members (n = 7) (see Appendix A). Interview recruitment and scheduling was facilitated by corrections leadership at each jail. Interviews were conducted by one or two Vera researchers, using a semi-structured interview guide with questions exploring the issue of suicide and self-harm at the jail, the types of review processes currently in place to respond to suicide and self-harm, staff training, relationships between corrections and healthcare staff, staff support, and perspectives on the feasibility of implementing sentinel event reviews.

Interviews were audio-recorded and transcribed verbatim for analysis, with the exception of one participant who did not wish to be audio-recorded but agreed to have detailed notes taken. A team of four Vera researchers used Dedoose, an application that allows researchers to organize, analyze, and identify major themes from qualitative data.[10] The team reviewed interview transcripts and defined codes capturing themes through an iterative process during regular team meetings. Once a complete code list was developed, researchers coded all interviews, with 10 percent of interviews independently coded by two researchers to ensure reliability. Coding discrepancies were subsequently resolved through consensus discussions. Researchers then reviewed code reports to develop consensus around the primary themes and findings from the interview data.

Legal Landscape Analysis: With pro-bono assistance from attorneys at the law firm Clifford Chance, Vera researchers conducted a legal review of the four study jurisdictions and potential facilitators or barriers for conducting sentinel event reviews. Specifically, Vera researchers analyzed the legal landscape of liability, discovery, public record requests, and confidentiality in each jurisdiction.

Creating the Conditions for Sentinel Event Reviews

At the time of this study, all four jails were already taking important steps to prevent suicide and self-harm and to respond comprehensively when an incident did occur. Each jail had a Suicide Prevention Plan in place, for example, and three of the four jails were accredited by the National Commission on Correctional Health Care and/or the American Correctional Association, demonstrating that their Suicide Prevention Plans met criteria for these accrediting bodies. However, current review processes did not always involve stakeholders across all levels of corrections and health staff and leadership struggled to effectively communicate the outcomes of reviews to line staff. Also, most reviews focused on incidents of suicide, and sometimes suicide attempts, with less clear criteria on when cases of self-harm warrant a review. Overall, Vera's analysis identified variability across the sites in terms of readiness to mobilize the "routine, culture-changing practice" that is at the heart of the sentinel event review process and several key themes emerged as being critical to the success of a future sentinel event review around jail suicide and self-harm: (1) the model of healthcare delivery; (2) the nature of collaboration and communication; (3) the organizational culture; and (4) the legal landscape.[11]

Healthcare Delivery Model

An increasing number of jails contract with vendors to provide at least some healthcare services.[12] Private vendors can provide access to greater expertise, allow for greater budget predictability and financial risk sharing, and free up jail administrators from the routine activities of running a health system. However, private vendors can also add complexity for sentinel event reviews that intend to bring together a range of stakeholders.

The jails in this study have a variety of organizational models to deliver healthcare to people in custody (see Appendix B). Three of the four jails had gone through a recent transition. One site returned to providing services through the sheriff's office (having had a private vendor

for several years), a second changed private vendors, and a third entered into a private contract for the first time. Three of the jails managed relationships with outside organizations and the integration of employees with different management structures. This introduced different systems of accountability, different training requirements, and different review processes—all of which complicated the possibilities for a robust review process after incidents of suicide.

Collaboration and Communication

Strong collaboration and effective communication are vital for creating conditions that prevent incidents of suicide and self-harm and can also foster space for sentinel event reviews and corrective action when an event occurs.[13] However, collaboration and communication within a jail are not easily written as policy directives. Two themes emerged as key in this regard: the relationship between corrections staff and health staff and the extent to which information is communicated across disciplines as well as both up and down the chain of command.

There was consistency across sites in highlighting the importance of the relationship between corrections and health staff. Healthcare staff and leadership at each of the jails described being reliant on corrections staff for suicide prevention, given that corrections officers are in most regular contact with incarcerated people. The necessary collaboration across corrections and health does not mean that such collaboration is always easy. Corrections and health staff were cognizant they had different roles, different training, and different professional cultures that sometimes put them at odds with each other. Even so, staff largely described a relationship of respect, recognizing their interdependence as they work across the treatment and custody divide.

The nature and extent of communication across disciplines and within the hierarchy of the jail emerged as a key theme in considering the necessary conditions for a non-blaming, all stakeholder review process. The jails use a wide range of approaches to communicate

information in verbal or written from, including through informal conversations, roll calls, shift reports, regular team meetings, and formal review processes. This range of strategies is necessary given the practicalities of working in a jail, including shiftwork and the lack of electronic communication for corrections officers in many jails. For the most part, the strategies being used are effective and are in line with the spirit of collaboration discussed above. At the same time, the default to a top-down communication style presents particular challenges in the context of more formal, critical incident review processes. The primary theme reflected across sites when discussing existing review processes was that line staff are generally not included in the reviews and that there are few or no mechanisms for communicating the outcomes of reviews or plans for corrective action. In particular, jails had difficulty balancing sharing and protecting information and discussed having room for improvement around developing truly collaborative reviews.

Organizational Culture

At their core, sentinel event reviews are mechanisms for cultivating a culture of safety, committed to addressing system weaknesses to prevent future adverse outcomes, instead of a culture of blame, fixated on identifying bad apples. The organizational culture of the jail itself also plays a critical role in the feasibility and success of sentinel event reviews. Three aspects of organizational culture emerged as particularly relevant to creating the conditions for sentinel event reviews of jail suicide and self-harm: the way blame operates, openness or resistance to change, and attitudes around mental health and suicide prevention efforts.

In the four jails Vera studied, many staff described a culture of passing around and placing blame on individuals. This culture of blame could be compounded by a resistance to change among many staff, although some were able to cite a few specific examples of tangible changes that had been made prevent suicide and self-harm in their jails. Finally, staff reflected on

the significant ways that beliefs and attitudes about mental health have changed in the corrections field over time—both in terms of increased recognition about the extent of mental illness among people in jail and efforts to increase access to and quality of care. All of these aspects of organizational culture were seen as being tied to the success of suicide prevention efforts as well as the feasibility of all-stakeholder, non-blaming, forward-looking reviews.

Legal Landscape

Beyond the local jail and its institutional arrangements, the feasibility of conducting sentinel event reviews also depends on the complex legal landscape in each jurisdiction. Vera's analysis focused on liability, discovery, public records requests, and confidentiality.[14]

Liability: Incidents of suicide and serious self-harm may give rise to legal liability for jails, based on deprivation of individuals' constitutional or statutory rights or the failure of the jail to act with reasonable care towards the individuals in their custody.[15] Conducting a sentinel event review does not give rise to additional liability itself, but the review process could increase litigation exposure by aggregating details about the incident into documents that could ultimately be obtained by either plaintiffs, through discovery during litigation, or the public, through freedom of information requests. This fear of liability and litigation was intense for many leadership and line staff, and emerged as a potential barrier for robust review processes.

Discovery: Documents produced from a sentinel event review could be obtained by plaintiffs during litigation through discovery, unless they are deemed to be privileged.[16] These privileges vary across states. Two of the four states Vera studied had some protections in place for documents produced during formal medical review boards and hospital quality improvement committees—spaces and processes similar to sentinel event reviews in jails. It is plausible that these privileges could be extended to sentinel event reviews for jail suicide in these states. In one

of the other states Vera studied, discoverability was assessed by the courts on a case-by-case basis and in the other, medical committee meeting minutes and similar review reports have been deemed discoverable.

Public Records Requests: Freedom of information laws provide citizens access to government records and information, which provides an important channel to hold governments accountable. These laws are another way that internal documents from a review could be made public. At the state level, the provisions of freedom of information laws can vary widely. Many states have enacted specific statutory or inter-agency exemptions for their laws to ensure that honest and frank communication pertaining to policymaking within the government is not stifled by the threat of public disclosure. Such exemptions existed in only two of the four study sites and some staff disclosed reluctance to fully document incidents and opportunities for improvement, knowing the likelihood of public records requests. Arguably, however, if sentinel event reviews take place and documents are made public, the extent to which they demonstrate evidence of a thoughtful and regular review process may rebuke accusation of "deliberate indifference" to the care of people who are incarcerated.

Confidentiality: Finally, jails undertaking sentinel event reviews must consider issues that arise around sharing and disclosing confidential, personal health information during the review process. This is important as sentinel event reviews usually aim to bring together stakeholders of different disciplines, and sometimes, different agencies. Depending on how jails administer their healthcare and how sentinel event review boards are organized, health information privacy laws (e.g. the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) may limit access to personal health information pertaining to incidents of suicide and self-harm for some review team members.[17] However, HIPAA's Privacy Rule does recognize that correctional facilities

have legitimate reasons to use and share personal health information and allows for health providers and other covered entities to share personal health information with correctional institutions having lawful custody of an inmate if it is necessary for a) the health and safety of the individual or other people incarcerated in the or b) the maintenance of safety, security, and good order of a facility. In practice, considerations about confidentiality and HIPAA may necessitate that not everyone participating in a review have access to personal health information, but should not prevent reviews from taking place at all.

Conclusion

The success of sentinel event reviews in other industries like medicine and aviation provides evidence that it is possible to learn from error and to strengthen overall system reliability by understanding the root causes of negative outcomes. Vera's research demonstrates that it is also possible in the criminal justice system, notwithstanding the many implementation challenges stakeholders may face. The jails in this study all have review processes in place for critical incidents, but were also open to considering how their current processes might be improved through expanding the types of staff included, for example, or making review findings and recommendations transparent. To be sure, no single sentinel event review process will look the same. The results of this study suggest that the design and implementation of any sentinel event review process will depend on multiple factors ranging from how healthcare is delivered, to the communication processes in place, to the organizational culture of the jail and the legal landscape of the state where the jail is located. Thankfully, there is emerging guidance to help jurisdictions walk through the myriad factors to consider in designing a sentinel event review and implement the steps of a review process.[18] A forthcoming Vera report will also provide concrete recommendations for jail-based sentinel event reviews of suicide based on the results of this

study. Jails that adopt sentinel event reviews will not only demonstrate leadership and commitment to advancing the field, but will also help instill a new culture in their facilities that helps ensure the safety and well-being of those in their custody and those who work for them.

Reports and Upcoming Scholarly Products

1. Jason Tan de Bibiana, Therese Todd, and Leah Pope. *Preventing Suicide and Self-Harm in Jails: A Sentinel Events Approach* (New York: Vera Institute of Justice, *forthcoming 2019*).

2. Vedan Anthony-North, *Addressing Suicide and Self-Harm in Jails: A Sentinel Events Approach.* Presented at the American Correctional Association 148th Congress of Correction (Minneapolis, MN: 2018).

3. Leah Pope and Ayesha Delany-Brumsey, *Creating a Culture of Safety: Sentinel Event Reviews for Suicide and Self-Harm in Correctional Facilities* (New York: Vera Institute of Justice, 2016).

Appendix A: List of Interview Participants

Site	Interview #	Leadership Level	Role Type	Role Description
MCDOC	33	Leadership	Legal Counsel	Senior Deputy County Counsel
MCDOC	34	Leadership	Health	Director of Nursing
MCDOC	35	Leadership	Health	Mental Health Director
MCDOC	36	Line	Corrections	Officer
MCDOC		Line	Corrections	Officer
MCDOC	37	Leadership	Health	Health Services Administrator
MCDOC	38	Mid-Level	Internal Affairs and Investigations	Chief Investigator, Internal Affairs
MCDOC		Mid-Level	Internal Affairs and Investigations	Officer/Investigator, Internal Affairs
MCDOC	39	Leadership	Corrections	Chief of Staff
MCDOC	40	Leadership	Corrections	Warden
MCDOC	41	Line	Health	Social Worker
MCDOC	42	Leadership	Corrections	Operations Captain
MSO	23	Leadership	Corrections	Superintendent
MSO	24	Leadership	Legal Counsel	Chief Legal Counsel
MSO	25	Leadership	Corrections	Special Sheriff
MSO	26	Leadership	Health	Health Services Administrator
MSO	27	Leadership	Corrections	Assistant Deputy Superintendent, Policy Advisor
MSO	28	Leadership	Health	Mental Health Director
MSO		Leadership	Health	Doctor and CEO of Contract Healthcare Provider

MSO	29	Leadership	Internal Affairs and Investigations	Internal Investigations Unit Director
MSO	30	Line	Health	Medical Clinician
MSO		Line	Health	Medical Clinician
MSO	31	Mid-Level	Corrections	Lieutenant
MSO		Mid-Level	Corrections	Sergeant
PCSO	1	Leadership	Corrections	Colonel
PCSO		Leadership	Corrections	Major
PCSO	2	Line	Health	Licensed Mental Health Counsellor
PCSO	3	Line	Health	Licensed Mental Health Counsellor
PCSO	4	Leadership	Health	Nursing Director
PCSO	5	Line	Health	Charge Nurse
PCSO	6	Mid-Level	Corrections	Sergeant
PCSO	7	Leadership	Health	Health Services Administrator
PCSO	8	Leadership	Health	Medical Director
PCSO	9	Leadership	Health	Psychiatrist
PCSO	10	Mid-Level	Corrections	Shift Commander
PCSO	11	Leadership	Legal Counsel	General Counsel
PCSO	12	Mid-Level	Internal Affairs and Investigations	Corporal, Detention Investigation Unit
PCSO		Mid-Level	Internal Affairs and Investigations	Sergeant, Detention Investigation Unit
SCDS	13	Leadership	Corrections	Director of Detention Services
SCDS	14	Leadership	Health	Health Services Administrator
SCDS		Leadership	Health	Health Contract Administrator

SCDS		Leadership	Health	Chief Legal Officer for Contract Healthcare Provider
SCDS		Leadership	Health	Chief of Operations for Contract Healthcare Provider
SCDS	15	Mid-Level	Corrections	Sergeant, Training
SCDS		Mid-Level	Internal Affairs and Investigations	Sergeant, Internal Affairs
SCDS	16	Leadership	Health	Mental Health Manager
SCDS		Leadership	Corrections	Lieutenant
SCDS		Leadership	Corrections	Lieutenant
SCDS	17	Leadership	Internal Affairs and Investigations	Director of Risk Management
SCDS	18	Line	Health	Psychiatric Nurse Practitioner
SCDS	19	Line	Health	Physician Assistant
SCDS	20	Line	Corrections	Officer
SCDS	21	Mid-Level	Corrections	Sergeant
SCDS	22	Line	Health	Mental Health Professional
SCDS		Line	Health	Mental Health Professional
SCDS	32	Leadership	Health	Medical Director

Appendix B. Healthcare Organizational Models

Site	Organizational Model	Explanation	Recent Transition
MCDOC	Contracted out	Jail procures all health services (physical and mental health) from a single, private vendor.	Changed contracted providers (2016)
MSO	Hybrid of in-house and contract providers	Jail provides the majority of health care services through a private vendor. However, some mental health staff are employed through the sheriff's office.	N/A
PCSO	In-House	Jail provides all services using staff employed by the sheriff's office.	Brought services in-house after a period of contracting them out to a private vendor (2014).
SCDS	Hybrid of in-house and contract providers	Jail provides physical health care through a contracted private vendor. Mental health services are provided through a private vendor in collaboration with in-house positions, funded by a partnering county agency (the regional behavioral health organization).	Contracted with a private vendor for the first time after a history of providing services in-house (2015).

[1] Margaret E. Noonan, *Mortality in Local Jails, 2000-2014 – Statistical Tables* (Washington, DC: Bureau of Justice Statistics, 2016, NCJ250169), https://www.bjs.gov/content/pub/pdf/mlj0014st.pdf
[2] Noonan, 2016; Margaret E. Noonan, *Mortality in State Prisons, 2001-2014 – Statistical Tables* (Washington, DC: Bureau of Justice Statistics, 2016, NCJ 250150), https://www.bjs.gov/content/pub/pdf/msp0114st.pdf; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, *Web-based Injury Statistics Query and Reporting System (WISQARS) [online],* www.cdc.gov/injury/wisqars, (accessed November 30, 2018).
[3] Notably, the rate of jail suicide dropped dramatically between 1986 (107 per 100,000 people) and 2006 (38 per 100,000 people). However, since 2006, the rate has fluctuated between 29 per 100,000 to 50 per 100,000. Lindsay M. Hayes, "Suicide prevention in correctional facilities: Reflections and next steps," *International Journal of Law and Psychiatry*, 36, 188-194 (2013); Margaret E. Noonan, *Mortality in Local Jails, 2000-2014 – Statistical Tables* (Washington, DC: Bureau of Justice Statistics, 2016, NCJ250169), https://www.bjs.gov/content/pub/pdf/mlj0014st.pdf
[4] Lindsay M. Hayes, *National Study of Jail Suicide: 20 Years Later* (Washington, DC: U.S. Department of Justice, National Institute of corrections, 2010).
[5] James M. Doyle, "Learning from Error in the Criminal Justice System: Sentinel Event Reviews," in *Mending Justice: Sentinel Event Reviews* (Washington, DC: U.S. Department of Justice, National Institute of Justice, 2014, NCJ 24714).
[6] Leah Pope and Ayesha Delany-Brumsey, Creating a Culture of Safety: Sentinel Event Reviews for Suicide and Self-Harm in Correctional Facilities (New York: Vera Institute of Justice, 2016).
[7] Doyle, 2014.
[8] Institute of Medicine, *To Err is Human: Building a Safer Health System,* edited by Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (Washington, DC: Institute of Medicine, 1999).
[9] National Commission on Correctional Health Care. 2014. *Standards for Health Services in Jails*. Chicago: National Commission on Correctional Health Care.
[10] Kathy Charmaz, *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* (London: SAGE Publications, 2006); Dedoose Version 8.1.8, web application for managing, analyzing, and presenting qualitative and mixed method research data (Los Angeles, CA: SocioCultural Research Consultants, LLC, 2018), www.dedoose.com.
[11] Katharine Browning, Thomas Feucht, Nancy Ritter, Katherine Darke-Schmitt, Maureen McGough, and Scott Hertzberg, *Paving the Way: Lessons Learned in Sentinel Event Reviews* (Washington, DC: National Institute of Justice, 2015, NCJ 249097), 1.
[12] The Pew Charitable Trusts, *Jails: Inadvertent Health Care Providers: How county correctional facilities are playing a role in the safety net* (Washington, D.C.: Pew Charitable Trusts, 2018).
[13] Doyle, 2014
[14] Vera and Clifford Chance conducted analysis across four states but each agency should consult its own counsel in considering what its obligations are and how best to meet them.
[15] 42 U.S.C. § 1983 (2012); Restatement (Third) of Torts: Physical and Emotional Harm § 40 (Am. Law Inst. 2012).
[16] Some states have enacted self-critical analysis and deliberative process privileges that protect records pertaining to confidential internal investigations and pre-decisional policy-making from discovery.
[17] Goldstein, Melissa M. 2014. "Health Information Privacy and Health Information Technology in the US Correctional Setting." *American Journal of Public Health* 104 (5): 803–9. https://doi.org/10.2105/AJPH.2013.301845.l; In addition to HIPAA, federal or state privacy laws providing more stringent privacy protection also apply, especially in the case of mental illness and substance abuse. For example, 42 CFR Part 2 is a federal statute governing confidentiality for people seeking treatment from substance use disorders and, with limited exceptions, requires patient consent for disclosure of patient records.
[18] Pope and Delany-Brumsey, 2016; Doyle 2014; Browning et al., 2015; The Joint Commission. Root Cause Analysis in Health Care: Tools and Techniques, Fifth Edition. (Oakbrook Terrace, IL: The Joint Commission, 2015).