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Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail

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Abstract

Dual loyalty is an omnipresent feature of correctional health. As part of a human rights quality improvement committee, and utilizing the unique advantage of a fully integrated electronic health record system, we undertook an assessment of dual loyalty in the New York City jail system. The evaluation revealed significant concerns about the extent to which the mental health service is involved in assessments that are part of the punishment process of the security apparatus. As a result, dual loyalty training was developed and delivered to all types of health staff in the jail system via anonymous survey. Six clinical scenarios were presented in this training and staff members were asked to indicate whether they had encountered similar circumstances and how they would respond. Staff responses to the survey raised concerns about the frequency with which they are pressured or asked to put aside their primary goal of patient care for the interests of the security mission. The online training and follow-up small group sessions have revealed widespread support for more training on dual loyalty.

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Introduction

The US has the highest rate of incarceration in the world, with approximately 11.6 million people cycling through jails (in New York State: locally operated, short-term facilities that hold people awaiting trial and/or sentencing, as well as those found guilty and sentenced to a term of one year or less) and prisons (long-term facilities run by a state or the Federal government that hold people serving sentences of longer than one year) annually.[1] Approximately 95% of these incarcerations occur in jails, which are chaotic settings given the short stay of the incarcerated and the lack of established programs that exist in most prison settings.[2] Health providers in these settings care for patients with high rates of substance use, mental health, and chronic medical concerns.[3] In addition, incarcerated patients experience new morbidity and mortality related to their incarceration, ranging from medication interruption to injury to worsening mental health during solitary confinement. Dual loyalty—the impact of the security setting on the health mission—is a central challenge for health providers in these settings.

In the New York City (NYC) jail system, the Bureau of Correctional Health Services (CHS) of the NYC Department of Health and Mental Hygiene (DOHMH) is responsible for all aspects of health care for the incarcerated, while the NYC Department of Correction (DOC) is responsible for security. This division of duty and responsibility for incarcerated people in NYC provides both an opportunity to improve the level of care from the national standard and a chance for tensions to arise as two separate city agencies work within one system towards divergent goals. As part of this mission, CHS formally integrated human rights into the overall health care mission in 2012.[4] This integration involved several levels of initiatives. A high-level forum called the CHS Human Rights Collective was established to bring together jail administrators and clinicians with community experts in policy, clinical care, and human rights around specific issues that bear on the CHS mission, such as solitary confinement, human trafficking, and traumatic brain injury. The recommendations of the Human Rights Collective flow into the operational arm of the human rights work, the human rights quality improvement (QI) committee. This committee is part of the overall QI process that directs all aspects of health services in the NYC jail health system and this committee develops initiatives and tracks specific QI projects related to the findings of the human rights collective. The first such project was an assessment of dual loyalty concerns in our health system. We then embarked on a project to develop and implement dual loyalty training for all health staff.[5] Feedback from this training has informed our most recent human rights QI committee priority: elimination of the CHS role in clearing patients for solitary confinement.

Phase 1: Assessing dual loyalty

Dual loyalty is an omnipresent force in correctional health settings.[6] The moment doctors, nurses, pharmacists, mental health providers, and other health staff members begin their first day of work, they are constantly reminded that they practice their trade in a setting consecrated to security. In some settings, such as the US Federal Bureau of Prisons, health staff members undergo security training, including firearms certification, before they can begin seeing patients.[7] In most jails and prisons, it is readily apparent that the health mission is used for security purposes. The most prominent example of dual loyalty is the 'clearance' of patients for punishment in solitary confinement. Security staff members assess whether an inmate has broken the rules of the jail or prison and then presents the inmate to health staff for confirmation that the inmate is physically and mentally sound enough to be placed in solitary confinement, generally described as 23 hours per day in a small cell, with an hour per day of recreation and some nominal services such as showers and occasional phone calls. Solitary confinement is also used widely in

state prison systems as a 'preventive' measure (for example, to separate inmates deemed dangerous away from others). Security staff members often refer to these two types of solitary confinement as punitive segregation and administrative segregation. Whatever the security reasoning for placement in such units, the participation of health staff in this process is cumbersome, time intensive, of questionable value, and does not reflect a patient-health provider interaction that is in the patient's best interest. In fact, many institutions employ health and mental health services expressly to maintain the practice of solitary confinement.[8]

Other situations also generate issues around dual loyalty. Medical providers may be asked to alter their assessments of patient injuries based on security staff reports about 'what actually happened.' Health staff may also be asked to change prescribing practices or other clinical plans based on security concerns about patients going to off-site specialty care or emergency departments. In addition, staff may be pressured to divulge protected health information to security staff for reasons unrelated to provision of care. Our approach to assessing dual loyalty was not to establish whether or not these issues were present; we were confident that they were. Instead, we sought to characterize how dual loyalty concerns were reflected in patient care and also to quantify the extent of dual loyalty challenges in certain high-risk settings. Accordingly, we focused on settings and encounters we knew to be rife with dual loyalty concerns: solitary confinement housing areas and patients who self-harm. Beginning in November 2012, CHS undertook review of three sources of data to conduct a formal assessment of dual loyalty. Review of electronic health record (EHR) records among 24 patients housed in solitary confinement (total patient encounters = 5,604); data from three focus groups with 24 mental health staff members; and qualitative interviews with 19 patients who committed acts of self-harm while in jail. For the EHR review, we assessed encounters for the presence of dual loyalty concerns. Dual loyalty concerns were defined as parts of patient assessments or plans that suggested efforts made in service of the security mission as opposed to work done on behalf of the individual patient. The frequency of these types of assessment was recorded, as well as the specific language used in the medical record supporting the presence of dual loyalty concerns. For mental health staff focus groups, an independent consultant met with a convenience sample of mental health staff and assessed themes regarding ethical challenges in their work. The focus groups were announced in advance, and staff members were free to attend the sessions without leadership or management present. Comments were recorded in writing and aggregated into common themes. For qualitative interviews with patients, one CHS staff member met individually with 19 patients who had injured themselves while in jail. A structured set of interview themes was used in these encounters, including discussion of self-harm history, interactions with DOC staff, interactions with mental health staff, and specific discussion of dual loyalty. This project was exempted from DOHMH Institutional Review Board (IRB) evaluation after it was assessed to constitute public health surveillance.

Among 5,604 written comments that were studied during the EHR review, 651 (12.2%) included a dual loyalty concern. The most common type of concern was notation that a patient was 'goal directed' or exhibiting 'secondary gain' to influence their housing status (n=312). The following note is a typical example: "Inmate is well known to mental health and all recent notes indicate he is threatening to harm himself if put in a cell. He owes 109 punitive segregation days and wants to be placed in C71. He has reported that he will swallow a razor, batteries, cut himself, etc., if placed in a cell. He is at high risk for repeating self-injurious gestures to get himself moved, but low risk for actual suicide."

Focus groups with mental health staff yielded several important themes related to dual loyalty. First, more than one-third of mental health staff felt that their ethics were regularly compromised in their work setting. This exceeds the rate for other staff, as we have learned from recent staff satisfaction surveys.[9] In addition, mental health staff reported that they cannot adequately ensure confidentiality with their patients in the security setting and that their patients have lower levels of trust as a consequence. Third, mental health staff reported that the work done to round on patients

in solitary confinement is different than real mental health work, which is aimed at improving the mental status of the patient; rounding on patients in solitary confinement is aimed at ensuring that patients are mentally and physically sound to remain in solitary confinement without posing an immediate threat to themselves. Finally, mental health staff reported that some security staff felt free to agitate and abuse both patients and staff, further impairing their ability to care for patients.

Qualitative interviews with patients who had harmed themselves revealed one common theme: a perception that mental health staff were part of the security apparatus and were not there to serve patients' needs. Specifically, patients commented on the role of mental health staff in clearing them for solitary confinement as an impediment to trusting them. One patient reported: "the doctor is not for us, they [security staff] influence them [mental health staff] to clear people who are not supposed to be cleared." In addition, patients did not view the clearance process as protective. One patient told his interviewer he was "afraid of being in a cell alone and says his fear of being alone in his cell…will lead him to try to cut and hang himself as well as ingest soap whenever possible…even after he expressed this fear to DOC and Mental Health staff and began engaging in self-mutilation they still put him back in a cell."

Dual loyalty concerns were evident in all three data sources and focused on the role of clinicians interacting with patients who seek to avoid solitary confinement. The tension between protecting patients from harm and participating in punishment is a clear ethical dilemma for medical and mental health service providers. An additional difficulty for mental health staff is that their clinical training in assessing suicide risk is based on suicidality as a feature of mental illness, whereas self-harm in the NYC jail system is seen largely as a product of patients seeking to avoid solitary confinement, a seemingly adaptive behavior. Finally, patients interpret the health service to have lost independence from the security staff in some settings.

Phase 2: Training staff to recognize and report dual loyalty

After assessing issues of dual loyalty, the human rights QI committee developed training for all 1,400 health service staff members. Approximately 250 of these employees work directly for CHS, and the rest work for one of two vendors who provide health services in the jails. The goals of this online training were to orient staff to the concept of dual loyalty, to present teaching scenarios focused on a range of dual loyalty concerns, and to elicit feedback and information about these issues. The human rights subcommittee designed the training based on the dual loyalty assessment, and considered a large number of scenarios before settling on six that reflected situations staff had encountered. Vignettes based on jail scenarios were presented, followed by a series of questions about how a provider might react. Despite the voluntary nature of participation, more than 600 staff members completed the module, representing nearly 50% of our workforce. After the primary deployment of the module, we integrated it into new employee training, so all incoming staff members complete the module, though their responses are not included in this analysis.

Description of the six scenarios included in the survey

After each vignette, respondents were asked whether or not they had ever encountered anything like the scenario in their work setting. Affirmative responses ranged from 16% to 93% (Appendix 1). The first scenario involved a high-security patient who reports asthma but who, when escorted from place to place by security officers, has his hands cuffed behind his back rather than in front, as required by medical policy to ensure that he may access his inhaler. Thirty-seven percent of respondents indicated that they had encountered or heard of this type of situation. Responses to the first scenario were encouraging in that almost all respondents (94%) said they would make an effort to grant the wishes of the patient in requesting an order for front cuffing or make an effort to establish the presence of asthma in making this decision. This leaves only 6%

who would refuse, essentially leaving the patient's concerns unaddressed. One provider summed up the difficulty of this scenario by stating: "This can be impossible to assess because the appropriate evaluation of asthma relies on patient report. When the history of present illness is unreliable, it puts doctors in a difficult or impossible situation. When the doctor has to serve as the arbiter of security issues like this, it destroys the doctor-patient relationship."

The second scenario, in which a transgender patient requested a condom in order to practice safer sex in jail, revealed complex beliefs and practices on the part of health staff. Provision of condoms in jail is permissible by CHS policy and approximately 75,000 are distributed each year, either as part of re-entry kits or from health staff. When asked about how to handle this situation, 4.4% responded that patients should never receive condoms and 27% responded that they would report the patient to security staff for infraction purposes. These responses indicate that staff may not widely understand or adhere to preventive health measures. The qualitative responses to this scenario gave some context to the quantitative data. One provider suggested "Remind the [patient of] the disastrous consequences of her irresponsible behavior." While another responded "providing condoms promotes the act of having sex. Although giving condoms will prevent other inmates from being infected; might issue condoms and report inmate for having sex while incarcerated."

For the third scenario, in which a provider walks away from a patient requesting help, 50% of respondents indicated that they had encountered or heard of this type of situation and 100% indicated that they would take measures to address the patient's needs. Any health staff member who ventures outside the confines of the jail or prison clinic will encounter inmates with requests or concerns. The stated intention of all respondents to address such concerns is reassuring.

In the fourth scenario, in which mental health staff are asked to approve or 'clear' a patient for transfer into solitary confinement despite recent self-harm, only 7% of respondents indicated that they had no concerns for the welfare of the patient in returning to solitary confinement. Most respondents (93%) indicated that this patient required a higher level of care, either in a non-punitive intensive mental health treatment area within the jail or an inpatient psychiatric setting. The qualitative responses for this question, however, revealed the difficult realities of our setting. One respondent wrote: "In the case of personality disorder, it may be difficult to simply remove the patient from the segregated setting. The patient may have been down this path many times before and may be manipulative and predatory in an MO unit [mental health unit], while receiving little benefit from the increased MH [mental health] services offered there. Similarly, removing the patient to general population for this act of self-harm may reinforce the behavior pattern which led to it in the first place. Even though I am not a believer in solitary confinement as punishment, I sometimes feel that the least harmful path is to return a personality disordered person to solitary in this scenario. This is very personally distressing to me and situations like this leave me with a negative impression of the work I do and my workplace."

In the fifth scenario, a patient disputes the account of events that security staff members have written on an injury report and 93% of respondents indicated that they had encountered or heard of this type of situation. Responses to this question were split between 34% who indicated that they would ask security staff to either leave the area or correct the form, and 45% who reported that they would seek guidance from a supervisor. The resolution of this case in real life involved asking the patient to sign the injury encounter as presented, but then correctly documenting the patient's account in the electronic health record and reporting it later to senior security staff. Thirteen percent of respondents chose this option. One respondent wrote that their action would "Depend on how intimidating the DOC officer is," while another indicated, "This decision is a difficult one considering that we are considered guest [sic] in the DOC facilities, I believe I would call for advise [sic] from my supervisor before I take any action on this matter." One staff member reported, "It is important that upper management

define 'ethics' and clarify what their core values are. To date, I am not aware that this has been done. Does 'Moral Space' exist in this organization? If not, how can we create? Patients need to feel safe in the clinic area and free from intimidation and abuse by DOC staff."

The sixth scenario presented the starkest and most threatening form of dual loyalty: security staff members assaulting patients within the clinic. Almost 16% of respondents indicated that they had encountered or heard of this type of event. The most common response (76.5%) to this scenario was to try and get security staff to stop beating the patient. Respondents were split in their ideas about who should be contacted in such a situation, with 23% indicating security leadership, 29% indicating facility medical staff, and 44% indicating leadership of CHS or oversight agencies. One staff member reported: "Tell DOC staff this is highly inappropriate and threaten to report this to all higher authorities in which their jobs may be in jeopardy. Such beatings (if done at all) should never take place in public."

Overall, staff responded very positively to the dual loyalty module. Ninety-one percent of respondents described the training as helpful, and 95% reported that more energy and time should be dedicated to identifying and addressing dual loyalty concerns. One respondent noted that this training did not go far enough, stating, "This is not addressing the dual loyalty issues in a serious way. Very superficial and not reflecting reality of my work environment where I'm not treated as a professional that even deserves decent discussion on the issue and some power to change the way things are run in my work place." Multiple respondents expressed concern that security staff might retaliate if health staff reported patient abuse. One respondent reported, "Part of dual loyalty is threats from DOC if we go above and beyond to protect a patient. We are then in a position that the officer may take 'extra-long' to respond to medical staff being assaulted by patient due to medical staff reporting human rights violations. We have to bear in mind the safety of the patient as well as our own safety." Another staff member gave a more grim assessment: "People don't feel supported here so they have a mentality of 'if I don't see anything then I don't know anything and that protects me.'"

Discussion

Dual loyalty is an indelible feature of correctional health care. The goal of these quality improvement projects was to raise awareness and strategize on ways to mitigate the impact of dual loyalty on the health care we deliver to our patients. In assessing dual loyalty, we learned from patients and providers alike that participation in the punishment apparatus of the jail results in harm to the therapeutic alliance between us and our patients, ultimately damaging our capacity to deliver care. Of particular note, our assessment confirmed long-standing concerns that staff members' work in solitary confinement settings revolves around responding to the stress these housing areas cause patients, and the efforts they make to avoid them.

We have embarked on follow-up sessions in each of our jail facilities with small groups of clinical providers around dual loyalty. While many of them understand the goal of reporting human rights concerns so that other systems may address them, the clinicians also remind us of the real world consequences of alienating the security apparatus and staff on which they rely for protection. Recent increases in assaults on health staff have been concentrated among patients in solitary confinement settings and have led to a great deal of concern by staff for their safety.[10] We plan to continue these small group sessions not only as a means to hone our training program, but to serve as a surveillance mechanism for dual loyalty concerns and how these concerns relate to both staff and patient safety.

The dual loyalty training module has served as a valuable tool for engaging with staff and discussing strategies to deliver care and protect patients. The provider in the real-life case described in the fifth scenario took a creative approach to defuse the confrontation, while ensuring proper reporting of the patient's account of events. This approach is possible because of the significant adaption of the

EHR to the human rights concerns we have in our health mission.[11] CHS is able to generate regular reports that reflect injuries stemming from all causes, including fights or assaults committed by other patients, use of force exacted by security staff, and self-injury and suicide attempts. We can then match these reports with reporting produced by the security staff that track uses of force, and inmate injuries.

We are alarmed that almost 16% of respondents reported encountering or hearing of the type of event described in the sixth scenario (security staff assaulting patients in clinic). It is difficult to contemplate any successful aspect of the health mission, from medication prescription and administration, to chronic care and emergency response, in a setting where health staff are aware of and exposed to the violent abuse of their patients. In addition, more than three-quarters of respondents indicated that they would try to get security staff to stop beating the patients, an intervention for which they are not trained and which is unlikely to succeed. Especially given the aforementioned fears of retaliation, this response seems honorable but unrealistic. Although the health mission should require zero tolerance for all forms of patient abuse or neglect, this cannot be accomplished by delivering unsupported mandates to staff that they report incidents at their own peril. Instead, jail managers and staff must take the difficult steps towards building a culture of transparency and patient welfare.

Our next step in operationalizing remedies to these dual loyalty concerns will be to reform our participation in clearing patients for transfer to solitary confinement. The harmful impact of this participation is one of the most consistent themes to emerge from the survey. The path to becoming an integral part of supporting solitary confinement spanned a decade in which concern for the welfare of mentally ill patients who might be vulnerable to the effects of this practice led to the clearance process, with some alternate pathway for those who were not cleared. Ultimately, it has become apparent that these alternate pathways may not be protective for those patients and that the clearance process was unsupported by scientific evidence and harmful to the patient/provider alliance. This entanglement of the health service with the punishment apparatus is common in the US, where solitary confinement is a routine form of punishment and where health services are largely part of or subordinate to the security authority.[12] While it may be routine practice in US correctional settings, participation in punishment of inmates violates basic ethical standards for health staff.[13] NYC is set apart from many settings in that it is written into the City Charter that the DOHMH provide for the health and well-being of those incarcerated. As it is our duty to maintain a high level of ethical standards in the care of our patients, we have initiated a review of our existing policies and plan to work with partner agencies to end the use of solitary confinement in NYC jails, or at least, our involvement in the practice.

Conclusion

Throughout this process, we have struggled with the tension between the traditional focus of health systems on identification and treatment of pathology and the human rights imperative of documenting problems that may be beyond the capacity of the health service. Except in special circumstances, physicians, nurses, and other health staff are generally trained to work within a fairly well-ordered structure; clinical problems are identified and addressed while other issues requiring social work, legal, or benefits assistance are directed elsewhere. In correctional health settings, all health staff members need to understand the potential for patient abuse as well as the impact of dual loyalty on their individual jobs. In addition, administrators in these settings need to modify their surveillance, reporting, and health information systems so as to enable staff to accurately reflect the reality they and their patients face. Ultimately, the health systems in correctional settings are best-suited to promote the health and welfare of their patients. Without a commitment to human rights, including assessing dual loyalty and addressing fault lines, this obligation is unlikely to be met.

Appendix 1. Dual loyalty training and results

Scenario 1: Asthma front cuff

While being seen for an asthma visit, a patient tells a provider that DOC staff don't ever front cuff him while being escorted, despite a medical order to do so for access to his asthma inhaler. The patient is young and doesn't appear to be having any asthma symptoms during this visit. In addition, the provider is aware that the patient has a high security classification and has been in multiple fights. The patient asks the provider to reprint the medical order for front cuff and give copies to him and to DOC.

1. Have you ever encountered or heard of anything like this in your work setting?

Yes	No	Total
240	417	657
36.5%	63.5%	100.0%

2. How would you respond if you were the provider?

Give the orders to the patient and DOC	Refuse to give the orders to the patient and DOC	Try to assess whether or not the patient really has asthma	Total
274	38	328	640
42.8%	5.9%	51.3%	100.0%

Scenario 2: Condoms

A transgender client housed in [a male jail facility] is living with HIV and indicates that she is having unprotected sex in the housing area with those she is interested in. She asks you for a condom.

3. Have you ever encountered or heard of anything like this in your work setting?

Yes	No	Total
192	455	647
29.7%	70.3%	100.0%

4. Do you:

Hand 3 wrapped condoms to the inmate as provided by DOHMH	Put a box of condoms in a drawer or file bin with the DOC policy posted on top, and let the inmate take what she needs	Never provide condoms to inmates, it's just not worth the grief from DOC	Report the inmate for security violations for having sex with another inmate while incarcerated.	Total
339	76	27	167	609
55.7%	12.5%	4.4%	27.4%	100.0%

Scenario 3: Help requested

You briefly visit a high security setting to see one patient and ask a few questions before moving on to the rest of your day. While there, multiple other patients call out to you from their cells requesting help with medical, mental health, medication and other issues they are having. After jotting down the names and concerns of several patients, you turn to leave the unit. As you approach the gate, another patient yells out "I'm not getting my medicine, I really need my medicine, these officers won't let me have my medicine!" You hear a DOC officer yell at the patient and you leave the unit. As you exit the unit, you become worried that you should have stopped and spoken with the patient.

5. Have you ever encountered or heard of anything like this in your work setting?

Yes	No	Total
314	311	625
50.2%	49.8%	100.0%

6. Having left the unit, what are some things you might do to address your growing worries?

Contact the facility clinic, describe the location and concerns of the patient and ask them to check on the patient	Call operations to report	Email DOHMH at CHS. HUMANRIGHTS@ health.nyc.gov	Other (please specify)	Total
512	64	82	106	764
67.0%	8.4%	10.7%	13.9%	100.0%

Scenario 4: Solitary confinement

A patient in solitary confinement has become increasingly withdrawn on daily rounds. The patient has a history of adjustment disorder, multiple self-harm gestures and recent assessments of 'goal-oriented behavior to influence housing area'. The patient now begins to bang his head on the walls of his cell, causing laceration(s). After brief transfer to Urgicare for suturing, he returns to the solitary unit.

7. If this patient appears to be escalating the lethality of his self-harm, do you have any concerns about him returning to solitary confinement?

Yes	No	Not sure	Total
573	46	45	664
83.3%	6.9%	6.8%	100.0%

8. What are alternative areas for this patient to be housed in?

Mental observation unit	Hospital	General population	Other (please specify)	Total
563	180	10	49	802
70.2%	22.4%	1.2%	6.1%	100.0%

9. Do you feel confident in your ability to advocate for a different housing placement for this patient?

Yes	No	Not sure	Total
431	42	138	611
70.5%	6.9%	22.6%	100.0%

Scenario 5: Patient disputes an injury report

A patient is presented to a physician with an injury report. The injury report states the patient was in a fight with another inmate. As the physician examines the patient, he states that the injury report is wrong and that he was assaulted by DOC staff, not in a fight. DOC staff are standing at the entrance to the cubicle and dispute the patient's account. The patient refuses to sign the injury report but the DOC staff say they will not take the patient out of the cubicle until he signs the injury form.

10. Have you ever encountered or heard of anything like this in your work setting?

Yes	No	Total
573	46	619
92.6%	7.4%	100.0%

11. How would you respond if you were the provider?

Ask DOC staff to leave the cubicle	Call Operations (x5200) for guidance	Ask DOC staff to change the injury form	Ask the patient to sign the form but document your discussion in eCW	Discuss with your supervisor	Total
294	139	34	126	387	980
30.0%	14.2%	3.5%	12.9%	39.5%	100.0%

Scenario 6: Abuse of a patient

During the overnight tour, DOC staff bring a patient into the clinic in restraints. Both DOC staff and the patient are yelling at each other and struggling physically. The patient is brought into a cubicle and DOC staff ask the physician to see the patient for an injury encounter. As the physician approaches the cubicle, several DOC staff enter the cubicle and begin to strike the restrained patient, causing injuries to the face. A DOC Captain then turns to the provider and says 'you need to get in here and do your job so we can get him back to the housing area.'

12. Have you ever encountered or heard of anything like this in your work setting?

Yes	No	Total
94	509	603
15.6%	84.4%	100.0%

13. How would you respond if you were the provider?

Do what DOC says	Refuse to see the patient	Try to get the DOC staff to stop beating the patient	Total
63	74	447	584
10.8%	12.7%	76.5%	100.0%

14. Who could you contact for help?

Clinic staff (for example, an SMD or HSA)	Corizon Operations	DOC Tour Commander	BOC	DOHMH	Other (please specify below)	Total
401	329	315	56	242	30	1373
29.2%	24.0%	22.9%	4.1%	17.6%	2.2%	100.0%

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