

## **Introduction**

Our 5th onsite review of the Muscogee County Jail (MCJ) under the 2015 Memorandum of Agreement (MOA) occurred April 27-28, 2017. Pre-site information including the data matrix (Appendices 1 & 2), policies and CQI materials were reviewed in advance. All elements of the MOA were reviewed during this visit.

Ms. Marlysha Myrthil, Senior Trial Attorney with the Special Litigation Section of the Civil Rights Division of the USDOJ, and I met with the following persons and appreciated their collaboration in this process and commitment to providing quality mental health services to the inmates in their care:

1. Donna Thompkins, Sheriff
2. John L. Fitzpatrick, Jr., Deputy Chief (Corrections)
3. Larry Mitchell, Major (Warden)
4. Cynthia Pattillo, Psychologist, New Horizons (MCJ's Mental Health Services vendor)
5. Jeremy Hattaway, Corporal (Data\Intel)
6. Lucy Sheftall, Assistant County Attorney
7. Kimberly Rayburn, Director of Nursing

There have been no changes since our last site visit in mental health staffing, physical plant, clinical processes, policies, or committee structure. A new sheriff was elected and took office January 20, 2017. Commander Collins is no longer at the jail. Instead, Warden Mitchell has been promoted and assumed those roles. His direct supervisor is Mr. Fitzpatrick. Currently Ms. Rayburn is the Acting Health Services Administrator until the newly hired person is trained and assumes those responsibilities.

2017:

The average daily census since October 2016 is slightly below 1000. In March 2017, the average daily population was 935, with 663 male inmates received and 218 female inmates received that month. The monthly average of inmates housed on specialty mental health units for March 2017 was 46, with an average of 385 inmates on psychotropic medications. 69 inmates or 7.4% of the population are designated as having an SMI. There is no back log in 14 day medical assessments.

2016:

*The electronic health record, new kiosk and sick call request systems remain in place and continue to be useful. Sick call requests and responses are tracked by the kiosk system and enable better and more accurate review than the prior process. There have been no major physical changes or mission changes since our last visit. It was reported that there is a much higher gang presence in the jail than in prior years resulting in a tougher population. Staff have observed an increase in medication hoarding which is attributed to the latter and the use of medications as a commodity.*

*The census remains below 1000 due to implementing software to process non-violent felony cases faster. Census on the male mental health units has been slightly lower. Female census fluctuates between 10&14% of the total jail population.*

*The mental health service is shifting to contracting for weekend staff to conduct groups and respond to any urgent sick call requests on the weekend. We learned that until now staff were granted compensation time for their weekend service which had the net effect of increasing the work coverage*

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*the other employees had to perform during the work week. The MD and PhD weekend coverage has always been covered by contract pay.*

*Correctional Care Solutions (CCS) still provides the medical, nursing, dental, and pharmaceutical coverage at the jail. New Horizons remains the mental health provider.*

**Compliance Assessment Methodology**

Per Section VI.2 of the MOA, the following terms will be used when rating compliance:

- a. **“Substantial Compliance”** indicates that Columbus has complied with all or most components of the relevant provision of the MOA and that no significant work remains to accomplish the goal of that provision.
- b. **“Partial Compliance”** indicates that Columbus has complied with some components of the relevant provision of the MOA and that significant work remains to reach substantial compliance.
- c. **“Noncompliance”** indicates that Columbus has not complied with most or all of the components of the relevant provision of the MOA and that significant work remains to reach partial compliance.
- d. **“Unratable”** shall be used to assess compliance of a provision for which the factual circumstances triggering the provision’s requirements have not yet arisen to allow for meaningful review. Provisions assessed as “unratable” shall not be held against Columbus in determining overall substantial compliance with this MOA in accordance with the termination procedures outlined below.

Furthermore, as defined in the MOA, the term **“Sustained Substantial Compliance”** means to achieve and maintain a prolonged and continuous practice consistent with a level of “substantial compliance,” as that term is defined above.

**Instructions to the Reader:**

- All text from the MOA provisions and the headings of Compliance Ratings, Findings, Recommendations, and Suggestions by this reviewer appear in **bolded** font.
- Many of the provisions, especially those referring to policies, have multiple subsections. In general, an overall compliance rating for each provision will be given at the beginning of each main section heading. Findings, recommendations, and suggestions will be listed under the main section heading. When there are detailed findings, recommendations, or suggestions specific to certain subsections, they will be broken out and recorded under each subsection with the relevant heading.
- Findings from the previous reporting period are provided where necessary for a complete understanding of current findings and/or recommendations and are in *italic* font.
- Recommendations from the previous reporting period are provided for each provision and are

in *italic* font.

- “Recommendations” refer to such corrective action that this reviewer will expect MCJ to complete to move towards substantial compliance.
- “Suggestions” refer to additional action that MCJ may, but is not required to, take to further implement a provision in accordance with best practices. These suggestions are offered to assist MCJ in their ongoing efforts to improve facility conditions.

## **MOA Compliance Review of Substantive Provisions**

### **I. SUBSTANTIVE PROVISIONS**

#### **A. Mental Health Care and Suicide Prevention**

**Columbus shall provide adequate mental health services to inmates at the Jail, in accordance with constitutional standards. To that end, Columbus agrees to the following:**

- 1. *Policies, procedures, and training:* Jail Staff shall develop and implement adequate mental health policies, procedures, forms, and training regarding the following areas:**

**COMPLIANCE RATING: Substantial Compliance – for all subsections under Substantive Provisions I. (Only pertinent comments will be added to this section under the separate provisions.)**

*FINDINGS (OCTOBER 2016 Tour) for this entire provision:*

*Policies were finalized after the last tour and remain in effect. The minor recommendations listed below have been added and training sign-in sheets were provided pre-site. Specific comments appear only in sections “n” and “q”.*

**FINDINGS (April 2017 tour):**

There have been no policy revisions. All policies have been approved and were deemed adequate on prior visits.

We again discussed the concept of clinical seclusion as it relates to disciplinary sanctions. I will discuss this under that section.

**RECOMMENDATIONS (April 2017 Tour): None**

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a. **mission and goal of the Jail’s mental health program;**

b. **administrative structure of the Jail’s mental health program;**

c. **staffing, including staff-to-inmate ratios, job descriptions, credentials, and privileging;**

d. **training of mental health staff regarding correctional or security procedures that are necessary for the delivery and accessibility of mental health care;**

e. **Crisis Intervention Team (CIT) training of correctional staff that includes training on (1) understanding and recognizing psychiatric signs and symptoms to identify inmates who have or may have SMI, (2) using de-escalation techniques to calm and reassure inmates who have or may have SMI before resorting to use of force, discipline, or isolation, and (3) making appropriate referrals of such inmates to mental health staff;**

*FINDINGS (April 2016 Tour):*

*Training records were provided as requested and demonstrated compliance with this provision. The county only offers 2 CIT training classes of 35 attendees per year for all public safety agencies. MCJ only is allotted a few slots. All 90 supervisors and all mental health officers have been CIT trained. Anyone assigned to the mental health units receives priority in attending these classes.*

*Attendance at the required 40 hour annual training is 100% for the facility.*

**FINDINGS (April 2017 Tour):**

MCJ is now participating in a statewide program, Question Persuade Respond, which was described as similar to CPR training but focused on suicide prevention. The State of Georgia mandates that staff be trained on an annual basis. Mental health staff is 100% trained at this facility. The Sheriff’s Department, New Horizons, and CCS continue to maintain the same training schedule with no changes in curriculum.

**RECOMMENDATIONS (April 2017 Tour): None**

f. **strategies for effective communication with inmates with SMI in a respectful and supportive manner to promote pro-social behavior;**

**g. collaboration between mental health staff and correctional staff in the classification, housing, use of force, and discipline of inmates with SMI;**

**h. reliable and valid methods for identifying inmates with SMI, including mental health screening, assessments, evaluations, and appropriate timeframes for completion;**

**i. housing of inmates with SMI, including limits on the use of segregation;**

**FINDINGS (April 2017 Tour):**

Two behavioral management plans have been completed since our last tour in October 2016. Both were well documented, highly descriptive and more than adequate.

**j. daily management of inmates with SMI and related safety and security procedures, including protection from inmate-on-inmate violence, constant direct supervision of actively suicidal inmates, and close supervision of special needs inmates with lower levels of risk;**

**k. treatment planning;**

**FINDINGS (April 2017 Tour):**

Two behavioral management plans have been developed since our last tour in October 2016. Both were well documented, highly descriptive and more than adequate.

**l. sick call, including**  
**i. availability of written or electronic sick call request slips without advance charges;**

**FINDINGS (October 2016 Tour):**

*Inmates on several units were interviewed and they continue to harbor the belief that there are sick call charges for mental health requests. However, almost all the inmates on these units had never read the orientation materials on the kiosk. All inmates on specialized mental health units stated that was not a deterrent to their making such requests.*

**FINDINGS (April 2017 Tour):**

The jail continues to improve on their communication with inmates, developing unit posters especially addressing issues around suicide prevention. All inmates that I spoke with during this

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tour in the segregation units were aware of how to use the kiosk to notify mental health if they had concerns.

**RECOMMENDATIONS (April 2017 Tour): None**

**ii. a collections method where the requests are directly sent to a qualified health or mental health professional;**

**iii. daily review of inmate requests by a qualified health or mental health professional to determine level of urgency;**

**iv. appropriate timeframes for responding to sick call requests depending on level of urgency;**

**v. logging procedures to record the date, time, and nature of each sick;**

**vi. documentation of the nature and response to each sick call request in an inmate's medical or mental health record;**

**m. suicide prevention and treatment;**

**n. use of psychotropic medications, including verification, continuity, and medication non-compliance;**

**o. involuntary treatment, including the use of seclusion, restraints, forced medications, and involuntary hospitalization;**

**p. medicolegal issues, including confidentiality, informed consent, and the right to refuse treatment;**

**q. collaboration with community services and discharge planning;**

**r. maintenance of medical and mental health records; and**

**s. quality assurance measures to regularly assess and ensure compliance with the terms of this MOA.**

**SPECIFIC PROVISIONS OTHER THAN REQUIRED POLICIES:**

- 2. *Mental Health Services (generally):* The Jail Staff shall ensure that qualified mental health professionals provide adequate 24-hour on-call consultation as well as adequate in-person intervention and evaluation. The Jail Staff shall provide adequate evaluation, therapy, counseling, and array of other programs; adequate staff levels; and adequate space for programming consistent with other requirements of this MOA.**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (April 2016 Tour)*

*There has been no change in the staffing levels at MCJ. A complete psychiatric inmate case list is maintained by the mental health administrative assistant. Currently there are 314 inmates on this list including those with as needed follow up, no follow up appointments and non-SMI inmates refusing treatment. The list contains inmate identifiers, whether the inmate's classification is SMI (seriously mentally ill), the date last seen and the next scheduled appointment. There are 58 inmates classified as SMI at MCJ. Those inmates only seen by mental health counselors and not ever referred to psychiatry are not being tracked on the master list.*

*RECOMMENDATIONS (October 2016 Tour):*

- 1. The jail is planning an annual staffing review which was last completed one year ago. It is my recommendation that the line staff be included in developing the list of tasks required by the service and the average time to complete so that the most reliable estimate of required staff can be reached. It is likely that additional professional staff may be required.*
- 2. For now I will continue a Compliance Rating of Substantial Compliance pending review of the adequacy and findings of the upcoming staffing analysis. I will also want to review the quality of documentation by the counseling staff on the next site tour to ensure that it reflects adequate staff hours to complete not only the clinical service but the recording of the service and plan.*

**FINDINGS (April 2017 Tour):**

Recommendations from the October 2016 tour have been incorporated and are now being tracked by New Horizons. 24-hour coverage is in place and is provided by the psychiatrist and physician's assistant. Private interviewing spaces are available on all housing units and are utilized for individual contacts other than rounds. There have been no changes in staffing allocations. One master's level counselor was replaced by a new person with similar credentials in December 2016. Programming remains the same with the addition of a sleep hygiene group in the chaplain's programming dorm.

With the assistance of Mr. John Redmond, CMA, CIA and internal auditor with the Mayor's Office, a comprehensive staffing analysis was completed. We had the opportunity to meet with him on the first day of our tour for a presentation of the methodology and results. Dr. Pattillo assigned time values for each clinical task. Mr. Redman's determined, after studying the statistical information maintained on the mental health data matrix for 2016 and the first quarter of 2017, that there has been an increase in population resulting in added work requirements for

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the prescribers and PhD providers. Based on his review, he would recommend an increase in a half time position to give these providers more latitude. I am satisfied with the methodology of this review and confident that the jail has now demonstrated its capability in completing a reliable staffing analysis.

Mental health staff are also now tracking ongoing counseling services for the small percentage of people requiring that level of care regardless of SMI status; thereby, fulfilling the recommendation of the October 2016 tour.

**RECOMMENDATIONS (April 2017 Tour): None**

**3. *Psychology and Psychiatry Hours:* The Jail Staff shall ensure that at least one psychiatrist or nurse practitioner with prescriptive authority will provide at least thirty hours of services every week, and that a psychologist shall provide at least twenty hours of services at the Jail every week. These hours shall be clearly documented and logged. The psychologist hours may be averaged over a four week period to determine compliance. The Jail Staff shall include an adequate number of qualified mental health professionals and mental health staff—as determined by an annual staffing analysis—to enable it to address the serious mental health needs of all inmates with timely and adequate mental health care.**

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

New Horizons provided detailed timesheets for all of the doctorate level providers. The requirements of this provision are consistently met.

**RECOMMENDATIONS (April 2017 Tour): None**

**4. *Psychiatry-Psychology Collaboration:* The psychiatrists and nurse practitioners shall collaborate with the psychology staff in mental health services management and clinical treatment, and both psychologists and psychiatrists shall communicate problems and resource needs to the Commander and Director of Mental Health Services.**

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

Collaboration between Mental Health, Medical, and Security staff continues to demonstrate excellent cooperation between all entities. Special management treatment team meetings continue to occur regularly each week. There continues to be a close relationship between the prescribing psychiatric staff, mental health staff and security.



**RECOMMENDATIONS (April 2017 Tour): None**

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| <p><b>5. Screening:</b> The Jail Staff shall utilize qualified mental health staff or a qualified health professional with documented mental health screening training to administer a mental health/suicide screen for all inmates upon arrival at the Jail. The screening form shall provide for the identification and assessment of the following factors:</p> <ul style="list-style-type: none"><li>a. <b>past suicidal ideation or attempt;</b></li><li>b. <b>current suicidal ideation, threat, or plan;</b></li><li>c. <b>prior mental health treatment or hospitalization;</b></li><li>d. <b>recent significant loss such as the death of a family member or close friend;</b></li><li>e. <b>history of suicidal behavior by family members or close friends;</b></li><li>f. <b>suicide risk during any prior confinement;</b></li><li>g. <b>any observations by the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk or mental health;</b></li></ul> |
| <ul style="list-style-type: none"><li>h. <b>substance(s) or medication(s) used, including the amount, time of last use, and history of use;</b></li><li>i. <b>any physical observations, such as shaking, seizing, or hallucinating; and</b></li><li>j. <b>history of drug withdrawal symptoms, such as agitation, tremors, seizures, hallucinations, or delirium tremens;</b></li><li>k. <b>history or serious risk of delirium, depression, mania, or psychosis.</b></li></ul>  |

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

All required elements are now contained in the electronic health care template. There has been no change in the process. Intake screening is still performed by a registered nurse.

**RECOMMENDATIONS (April 2017 Tour): None**

- 6. Assessments:** Upon admission to the Jail, based on the results of the initial screening set forth in paragraph 5 above, the Jail Staff shall provide mental health assessments to inmates and refer inmates to qualified mental health professionals for treatment in accordance with the following:
- a. **Emergent/Urgent Referrals:** These referrals will be held in the clinic or HD area and a mental health assessment shall be provided by a qualified mental health professional for each inmate within 4 hours if during normal business hours, but no later than within 24 hours if outside of normal business hours, after the following triggering events:
- i. signs and symptoms of acute mental illness;
  - ii. disorientation/confusion;
  - iii. jail history of placement on mental health units;
  - iv. inability to respond to basic requests or give basic information;
  - v. recent suicide attempt; and
  - vi. inmates who report any suicidal ideation or intent, or who attempt to harm themselves, or the arresting officer indicates threats or attempts to harm themselves, or who are so psychotic they are at imminent risk of harming themselves.

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (October 2016 Tour):*

*New Horizons completed a study of all inmates placed in HD from the intake area between 5/6/16 – 6/6/16. The study demonstrated that 87% of these individuals were seen within the 4 hour requirement of the provision. The design of the study was good as was the narrative of the obstacles to achieving 100 % compliance within the time frame. The study lacks a description of the follow up methodology and time frame to demonstrate improvement based on the interventions under the “Action” section. Dr. Patillo does have plans to revisit this study.*

*RECOMMENDATIONS (October 2016 Tour):*

- 1. Repeat the study with a description of the follow up methodology and the results. If the results do not demonstrate improvement then a new set of interventions and subsequent follow up are needed to show adequate capacity to self-monitor systems.*
- 2. I am assigning a Compliance Rating of Substantial Compliance because the facility has demonstrated the capacity to carry out a reasonably well designed study, but the feedback loop demonstrating improvement of interventions must be demonstrated to sustain this rating.*

**FINDINGS (April 2017 Tour):**

The number of referrals is being tracked on the data matrix (See Appendices 1 & 2). Tracking of urgent and emergent nursing referrals has a 24 hour completion requirement with the 100% quality threshold. Inmates placed on that triage status are consistently being held in the HD (psychiatric observation) area until a mental health evaluation is completed within 24 hours.

Dr. Pattillo did complete the previously recommended quality improvement study focused on timeliness of evaluation for inmates moved to psychiatric observation (HD) following their intake screening. This was the second look at this population using a larger sample size. All of these evaluations occurred within the required time frames and the methodology and discussion were well done.

**RECOMMENDATIONS (April 2017 Tour): None**

- b. **Routine Referrals: Mental health assessments shall be provided by a qualified mental health professional within 5 business days for each inmate whose mental health/suicide screening triggers the following assessment factors:**
- i. **any past suicide attempt;**
  - ii. **any suicidal ideation, with intent or plan within the past 30 days;**
  - iii. **any combination of the following:**
    - 1. **suicidal ideations within the past year, with or without intent or plan;**
    - 2. **suicidal gestures, current or within the last year;**
    - 3. **a diagnosis of one or more of the following: bipolar disorder, depressed, major depression with or without psychotic features, schizophrenia, schizoaffective disorder, any diagnosis within the pervasive developmental disorder spectrum, and any other factor(s) contributing to suicide risk (e.g., recent loss, family history, etc.)**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (October 2016 Tour):*

*Evidence of recent training was provided pre-site. Chart review of 15 randomly selected cases showed adequate documentation that evaluations were occurring on new intakes and appropriate referrals were initiated.*

**FINDINGS (April 2017 Tour): No Change**

The mental health staff are averaging approximately an 80% timely completion for routine referrals. Should an 80% compliance with the routine referral indicator continue then time frames on the staffing analysis may have been underestimated and should be recalculated, if applicable.

Completion of assessments is being tracked on the statistical matrix, and the facility has instituted peer review. In studying the statistics for 2016 through 2017, it is evident that there is improved compliance on the peer review indicators as staff become familiar with the matrix. This is a good indication that the peer review process is working, in that it reinforces quality indicators for documentation, timeliness and other policy-driven requirements.

**RECOMMENDATIONS (April 2017 tour):** Continue to monitor timeliness for routine assessments.

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| <p><b>c. All other inmates shall receive an initial mental health assessment within 14 days of admission conducted by a qualified mental health professional or qualified health professional with mental health training.</b></p> |
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**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (October 2016 Tour):*

*The initial intake screen is completed by an LPN or RN and the 14 day health assessment is completed by an RN or PA. Correct Care Solutions is generating a report of "Active Patients in Need of a Health Assessment" which was provided for review. Only 1 of 124 (.008%) inmates was 14 days out from intake on 4/18/16 when the report was generated. That person was on work detail when he was scheduled for his health assessment. CCS provides 4 courses for qualified health professional training in performing screenings.*

**FINDINGS (April 2017 Tour):**

Completion of 14 day assessments is now being tracked on the statistical matrix and has had almost perfect compliance in 2016 and 100% compliance in 2017. Screenings are completed by three registered nurses, two of whom have had additional training from Dr. Pattillo.

**RECOMMENDATIONS (April 2017 Tour):**

1. Complete additional mental health training for the third registered nurse.

- d. Mental health assessments shall include a structured, face-to-face interview with inquiries into the following:**
- i. a history of**
    - 1. psychiatric hospitalization, psychotropic medication, and outpatient treatment,**
    - 2. suicidal behavior,**
    - 3. violent behavior,**
    - 4. victimization,**
    - 5. special education treatment,**
    - 6. cerebral trauma or seizures, and sex offenses;**
  - ii. the current status of**
    - 1. mental health symptoms and psychotropic medications,**
    - 2. suicidal ideation,**
    - 3. Drug or alcohol abuse, and**
    - 4. orientation to person, place, and time;**
  - iii. emotional response to incarceration; and**
  - iv. a screening for intellectual functioning (e.g., mental retardation, developmental disability, learning disability).**

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):** All elements of this provision have been implemented.

**RECOMMENDATIONS (April 2017 Tour):** None

- 7. Referrals: Any jail staff member may refer an inmate to Mental Health based on observed changes in behavior, increase or appearance of psychotic symptoms, or other concern and these referrals shall be seen as follows:**
- a. An inmate designated “Emergent/Urgent Referral” will be held in the clinic or HD area where they can be directly observed and supervised and be seen for assessment or treatment by a qualified mental health professional within 4 hours if during normal business hours, and within 24 hours if outside of normal business hours. The on-call qualified mental health professional must be notified within one hour of an Emergent Referral and advise with regard to course of treatment, housing, observation, medication, property restriction, and other appropriate care. Emergent Referrals will remain in the clinic/HD until seen and cleared by a qualified mental health professional. Triggering events for emergent/urgent referrals shall include the following:**
    - i. increase or emergence of psychotic symptoms;**
    - ii. inability to care for self appropriately;**
    - iii. signs and symptoms of acute mental illness;**
    - iv. disorientation/confusion; and**
    - v. inability to respond to basic requests or give basic information.**
  - b. An inmate designated as a “Routine Referral” will be seen for assessment or treatment by a qualified mental health professional within 5 business days, and a psychiatrist, when clinically indicated (e.g., for medication and/or diagnosis assessment). Routine referrals may include individuals who previously refused mental health treatment or medication or exhibit concerning but not emergent increases in symptoms, or raise concerns about medication compliance. The written policies and procedures governing referrals will include criteria for determining if a referral is not subject to this timeline requirement (e.g., a face-to-face contact is not clinically indicated).**

**COMPLIANCE RATING: Substantial Compliance**

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**FINDINGS (April 2016 Tour):**

*The process of referral has not changed. Data tracked on the Quality Management Matrix demonstrates 100% completion of routine referrals within 5 days. 24 hours completion of Urgent/Emergent referrals ranged from 87.5% (28/32 inmates), 83.3% (33/36 inmates) and 93.4% (57/61 inmates) for the months of January, February and March 2016 respectively.*

**FINDINGS (April 2017 Tour): No Change**

Compliance regarding referrals for urgent/emergent nursing referrals ranges from 77 to 84% (with a quality indicator of 100 %) in 2017. Dr. Pattillo reported that the staff have tried multiple strategies to improve their performance. For those people requiring emergency evaluation, all are placed in HD, and are seen 100% of the time within the expected time frame.

**RECOMMENDATIONS (April 2017 Tour): None**

**SUGGESTIONS (April 2017 tour):**

Tracking urgent and emergent response times separately in the matrix will give a more accurate picture of which portion of the process may fall below the desired indicators. I would also suggest tracking urgent referrals based on weekday versus weekend timeframes for easier identification regarding glitches in the system. The CQI committee should continue to study opportunities to improve response times for urgent referrals.

**8. Mental Health Sick Call: The Jail Staff shall ensure inmates' access to adequate care in accordance with the following:**

- a. **Inmates submitting sick call requests shall be seen for assessment or treatment by a qualified health or mental health professional in a timely and adequate manner, as clinically appropriate.**
- b. **Inmates with emergent/urgent mental health needs shall be seen for assessment or treatment by a qualified mental health professional or a qualified health professional with documented mental health screening training within 24 hours, and shall be placed in a setting with adequate monitoring pending the evaluation. Inmates with routine mental health needs shall be seen for assessment or treatment within 5 business days.**
- c. **Jail Staff shall permit inmates who are illiterate, non-English speaking, or otherwise unable to submit written or electronic sick call requests to verbally request care. Such verbal requests shall immediately be documented by the staff member who receives the request on an appropriate form and transmitted to a qualified medical or mental health professional for response in the same priority as those sick call requests received in writing or electronically.**
- d. **The Jail Staff shall develop and implement an effective system for documenting, tracking, and responding to all sick call requests.**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (April 2016 Tour):*

*Sick call requests are handled expeditiously with the new kiosk system. Mr. Lattimore continues to handle most of the requests. With the new system he can email responses to the inmate if the request does not require a face to face contact. Anyone on the mental health staff can see what sick call requests are open. On Saturdays Dr. Pattillo checks all sick call requests to look for any urgent/emergent requests and another counselor looks for these every Sunday. A chart review was completed on site and did not reveal significant problems with this process. (See Appendix I). Grievances are now received by the mental health service remedying the problems identified in November 2015.*

*FINDINGS (October 2016 Tour):*

*The data matrix and review of 15 randomly selected medical charts indicates compliance with this provision. Appropriate referrals are made and usually seen within the established time frames. All indicators on the data matrix now have a compliance threshold. The timeliness of response to referrals and has been maintained at rates of 100% completion for urgent, emergent and routine referrals.*

**FINDINGS (April 2017 Tour):**

Information on the kiosk is in English and Spanish. Translation services and accommodations for hearing impaired and deaf inmates is also available. The kiosk system is working well. Inmates are knowledgeable about accessing the system. Requests are reviewed by licensed mental health professionals in a very timely manner. New Horizons is tracking timeliness to completion. Requests triaged as emergent are seen 100% of the time within 24 hours. Routine requests are seen 100% of the time within five days.

While on site 14 sick call requests were reviewed, as well as others from medical records forwarded pre-site. Inspection of these records raised concerns that some records were not identified as urgent and did not precipitate a face-to-face evaluation.

In order to complete a larger sample review I requested that Cpl. Hattaway provide me with copies of the first two weeks of sick call requests for the month of March 2017. Many of the 45 requests were reviewed with Dr. Pattillo the next morning on site. The significant portion of the communications to the inmates was sufficient and addressed the concerns raised by the inmate. All requests received a prompt written response from the reviewer. I had some concerns which I discussed with Dr. Pattillo regarding complaints of medication side effects. Dr. Pattillo will provide in-service training to the counselors completing the triage function so that any complaint of medication side effects or significant medication issues will be referred either to a registered nurse or a psychiatric clinician expeditiously for assessment.

**RECOMMENDATIONS (April 2017 Tour): None**

**SUGGESTIONS (April 2017 Tour):**

Complete additional in-service training regarding triage and referral of sick call requests.



- 9. *Treatment Plans:* The Jail Staff shall ensure that each inmate on the mental health caseload receives a comprehensive, individualized treatment plan developed by a clinician with participation from the inmate and from others, as appropriate (e.g., mental health, medical, or correctional staff) within 10 days of his/her initial intake evaluation. Generally all treatment plans will meet the following requirements.**
- a. **Each individual treatment plan shall direct the mental health services needed for every patient on the mental health caseload and includes the treatment goals and objectives.**
  - b. **The Director of Mental Health provides guidelines for individual treatment plan review, which shall occur per the following frequency:**
    - i. **For inmates on a designated mental health unit, every 30 days;**
    - ii. **For all other inmates, every 6 months, or whenever there is a substantial change in mental health status or treatment.**
  - c. **Individual treatment planning is initiated on referral at the first visit with a qualified mental health professional.**
  - d. **Mental health treatment plans include, at a minimum:**
    - i. **Frequency of follow-up for evaluation and adjustment of treatment modalities;**
    - ii. **Adjustment of psychotropic medications, if indicated;**
    - iii. **Referrals for psychological testing, medical testing and evaluation, including blood levels for medication monitoring as required;**
    - iv. **When appropriate, instructions about diet, exercise, personal hygiene issues, and adaption to the correctional environment; and**
    - v. **Documentation of treatment goals and notation of clinical status progress (stable, improving, or deteriorating).**
  - e. **All aspects of the standard shall be addressed by written policy and defined procedures.**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (April 2016 Tour):*

*New Horizons has implemented the revised treatment plan form. Staff has been entering the same therapeutic modality/group for each problem creating a plan that could be misinterpreted as providing far more contact hours than actually provided by the available treatment menu. Ten treatment plans are peer reviewed each month, and this data is entered on the MCJ Mental Health Quality Management Data matrix. However, this indicator only tracks the presence or absence of the plan and if updates are timely. It is not a quality review of the content. My review of treatment plans and the tracking of programming hours provided on the specialty units is consistent with this agreement and track at a minimum of 10 hours a week. The lowest % of groups held vs. offered was 80% in June 2015 and since July 2015 have run at 100% or greater.*

*FINDINGS (October 2016 Tour):*

*Sample treatment plans were reviewed. These samples did follow the electronic health care record template and were completely filled out with additional patient specific information.*

*Minutes of the semimonthly special needs meetings were also reviewed and reflected discussion of inmates presenting with difficult management issues.*

*Review of a small sample of charts (n=15) demonstrated that appropriate medication laboratory studies are not routinely performed. For example, an inmate with a lithium level <0.1 (essentially undetectable) had no repeat study and continued to receive the medication despite the psychiatrist noting non-compliance with 100% of all his morning doses. This same inmate was on a tricyclic antidepressant (TCA) and compliance by serum blood levels was not done. Lithium can be lethal in an overdose situation and non-compliance can also result in life threatening depression or a manic psychosis. TCA overdoses can also be lethal. Dr. Patillo is aware of this problem. Prescribing staff also reported that on occasion when a lab study is ordered it is not performed by the nursing staff.*

*RECOMMENDATIONS (October 2016 Tour):*

- 1. Prior to the next site visit please conduct a review of use of medications requiring laboratory monitoring and demonstrate significant compliance with laboratory monitoring. Also, address the report that orders for studies are reported as not completed by the medical staff. I am happy to review the methodology in advance if that would be helpful.*
- 2. For now I will retain the compliance rating of Substantial Compliance but this could be downgraded if there evidence of difficulties in either ordering or drawing lab studies persists.*

**FINDINGS (April 2017 Tour):**

Treatment plans are routinely being completed by the mental health professionals on the treatment plan form. Dr. Pattillo and I reviewed 10 to 12 plans together. It is my opinion that the staff continue to need additional training on how to generate more specific and measurable problems and goals. As an example, several of the plans identified a diagnosis of a serious mental illness as an issue with the phrasing of the goal similar to, “the patient will learn about their illness.” There was no clarification as to how this education would express itself in benefits to the patient in measurable outcomes and no specific intervention regarding an educational program other than the general group menu

The 2017 data matrix (Appendix 2) demonstrates a significant improvement in 2017 for peer review regarding the ordering of policy required laboratory studies of 90-100%.

**RECOMMENDATIONS (April 2017 Tour):**

Learning how to generate good treatment plans is a difficult task and requires continued on-the-job training, which Dr. Pattillo plans to provide. The current plans are understandable but could be improved with training.

**10. Medication Administration: The Jail Staff will develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws and through the following:**

- a. **ensuring that initial doses of prescribed medications are delivered to inmates within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner;**
- b. **ensuring that inmates entering the Jail continue to receive previously prescribed medications or acceptable alternate medications, within 48 hours of entry, unless the facility physician makes an alternative clinical judgment;**
- c. **ensuring that medical staff who administer medications to inmates document in the inmate's Medical Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, and (3) the date and time for any refusal of medication; and**
- d. **ensuring that the inmate's unified health record is updated within one week of the end of each month to include a copy of the inmate's Medical Administration Record for that month.**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (April 2016 Tour):*

*There is evidence of medication verification at the time of intake and medications being initiated within 48 hours by chart review. However, the sample size reviewed onsite was too small to reach any conclusions regarding the reliability of this process. Unfortunately this provision is currently not tracked on the data matrix.*

*Dr. Pattillo recently completed a preliminary, draft small study looking at everyone who entered the jail over a one week timeframe to determine if medication was verified and administered. Five inmates claimed to be on psychiatric medication: 4 had medications started within 48 hours, and the 5<sup>th</sup> inmate was seen by the psychiatrist within the 48 hour*

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*timeframe for an assessment. Dr. Pattillo plans to repeat this study over a longer time period and with a larger sample size.*

*All medication administrations are entered into a laptop computer by the nurse and uploaded into the electronic health record at the end of the medication pass. In addition, staff run a report twice weekly of any prescriptions that will expire within 5 days so the providers can renew the medication and avoid lapses in dose delivery between visits.*

**RECOMMENDATIONS (April 2016 Tour):**

1. *Please provide proof of practice for this provision either through a chart review process or by a report from the electronic health record.*
2. *Please complete a study of the intake process with a focus on medication verification and administration including a full methodology, data collection and interpretation of the data prior to the next site visit.*

**FINDINGS (October 2016 Tour):**

*The jail has documented an increase in diverted medications in their special management minutes and developed a change in medication administration (calling inmates out one at a time to administer medications rather than dispensing through a pass through in the unit wall) to try and decrease this practice. We did discuss that this would be a good CQI study, measuring how often medications are discovered on the units, etc. to determine if this intervention is a sufficient remedy. All medication administrations are entered into the electronic health record. Chart review of 15 randomly selected records did demonstrate medication bridging and prescriptive practices in line with the clinical diagnoses.*

**FINDINGS (April 2017 Tour):**

There has been no change in the process for medication verification and bridging. A psychiatric prescriber is available 24\7 to provide bridging orders for inmates booked into the facility after hours and on weekends.

The jail has documented an increase in diverted medications in their special management minutes and developed a change in medication administration (calling inmates out one at a time to administer medications rather than dispensing through a pass through in the unit wall). When there are specific concerns regarding diversion, the clinician can order crushed and floated or liquid medications to help minimize mishandling of the prescription by the inmate. We did discuss that this would be a good CQI study, measuring how often medications are discovered on the units, etc. to determine if this intervention is a sufficient remedy.

All medication administrations are entered into the electronic health record. Chart review of 15 randomly selected records did demonstrate medication bridging and prescriptive practices in line with the clinical diagnoses.

**RECOMMENDATIONS (April 2017 Tour): None**

**11. *Psychiatric Hospitalization/Crisis Services:* Jail Staff shall ensure that inmates requiring emergency psychiatric hospitalization or who are acutely mentally ill receive timely and adequate treatment either on site or by agreement with a hospital offering the needed services.**

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

No change since November 2015. MCJ and New Horizons maintain contact with the courts, DA, and public defender whenever inmates are identified as being in need of diversion or restoration to competency. Inmates with misdemeanors can be sent to the Bradley Center. For those with felony charges, the mobile crisis team can come and certify that the person requires hospital level of care. Unfortunately, there is no secure unit available to accept these individuals. Dr. Pattillo does go to the probate court to get an involuntary treatment order following a petition with the treatment plan. An outpatient 12 month commitment can be granted allowing the psychiatrist/mid-level provider to administer the medications they feel will be most effective. Access for felony convicted inmates to state hospitals remains problematic statewide. Inmates found Incompetent to Stand Trial or Not Guilty by Reason of Insanity and in need of restoration can be placed in a hospital bed within 2 to 3 weeks.

**RECOMMENDATIONS (April 2017 Tour): None**

**12. Housing: Inmates shall be housed in an appropriate environment that ensures adequate staff supervision, mental health care and treatment, and personal safety in accordance with the following:**

- a. **Housing options for inmates with SMI shall include general population, a secure mental health unit, and a step-down unit for inmates with serious mental illness that is similar to a general population unit in which inmates are out of their cells during the day by default. Jail staff shall develop and implement these housing options with the technical assistance of the United States and its expert consultant(s).**
- b. **Jail Staff shall ensure that segregation is not used as an alternative to adequate mental health care and treatment.**
- c. **All locked housing decisions for inmates with SMI shall include the input of a qualified mental health professional who has conducted a face-to-face evaluation of the inmate in a confidential setting, is familiar with the details of the available clinical history, and has considered the inmate's mental health needs and history.**
- d. **Segregation shall be presumed contraindicated for inmates with SMI.**
- e. **Within 24 hours of placement in any form of segregation, all inmates on the mental health caseload shall be screened by a qualified mental health professional to determine whether the inmate has a SMI, and whether there are any other acute mental health contraindications to segregation.**
- f. **If a qualified mental health professional finds that an inmate has a SMI or other acute mental health contraindications to segregation, that inmate shall not remain in segregation absent extraordinary and exceptional circumstances.**
- g. **Inmates who are placed in a secure mental health unit or a step-down unit shall be offered a minimum of:**
  - i. **at least 10 hours of out-of-cell structured time each week, with every effort made to provide two scheduled out-of-cell sessions of structured individual or group therapeutic treatment and programming Monday through Friday and one session on Saturdays, with each session lasting approximately one hour, with appropriate duration to be determined by a qualified mental health professional and detailed in that inmate's individualized treatment plan, and**
  - ii. **at least 14 hours of out-of-cell unstructured time each week.**
- h. **All out-of-cell time in the secured mental health or step-down units shall be documented, indicating the type and duration of activity.**

- i. Policies and procedures shall detail the criteria for admission into the secure mental health housing or step-down units and levels of care provided to inmates in those units.**
- j. Any determination not to divert or remove an inmate with SMI from segregation shall be documented in writing and include the reasons for the determination.**
- k. Inmates with SMI who are not diverted or removed from segregation shall be offered a heightened level of care that includes the following:**
  - i. If on medication, shall receive at least one daily visit from a qualified health care professional.**
  - ii. Shall be offered a face-to-face, therapeutic, out-of-cell session with a qualified mental health professional at least once per week.**
  - iii. Qualified mental health professionals shall conduct rounds at least once a week to assess the mental health status of all inmates in segregation and the effect of segregation on each inmate's mental health to determine whether continued placement in segregation is appropriate.**
  - iv. Rounds shall not be a substitute for treatment and shall be documented.**
- l. Inmates with SMI who are placed in segregation for more than 24 hours shall have their cases reviewed by the Commander or the presiding Captain and the Director of Mental Health Services on a weekly basis at the critical management meeting.**
- m. Inmates with SMI shall not be placed into long-term segregation absent extraordinary and exceptional circumstances, and inmates with SMI currently subject to long-term segregation shall immediately be referred for appropriate assessment and treatment from a qualified mental health care professional who will recommend appropriate housing.**
- n. If an inmate on segregation develops signs or symptoms of SMI where such signs or symptoms had not previously been identified, or decompensates, the inmate shall immediately be referred for appropriate assessment and treatment from a qualified mental health care professional who will recommend appropriate housing.**
- o. If an inmate with SMI on segregation suffers a deterioration in his or her mental health, engages in self-harm, or develops a heightened risk of suicide, that inmate shall immediately be referred for appropriate assessment and treatment from a qualified mental health care professional who will recommend appropriate housing.**
- p. Muscogee County shall document the placement and removal of all inmates to and from segregation.**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (April 2016 Tour):*

*Mental health rounds are now occurring on all segregation units. This information is tracked on the data matrix with current completion ratings of 90%. However, staff was counting missed rounds if an inmate was out to court, etc. rather than simple counting whether rounds were performed on the required units. With this correction, rounds were offered weekly.*

*All inmates on the SMI medication list placed in segregation are referred for a mental health review.*

*Specialty mental health units continue to sustain the required programming and this is tracked on the monthly quality matrix. Group offerings have exceeded the expected minimum on all units. Inmates on these units are out of cell from 3:30 p.m. until 11 p.m.*

*Inmates on the segregation unit were visited during this tour. No one with an apparent serious mental illness was observed and all the inmates reported only being in the unit for 2-3 days.*

**FINDINGS (April 2017 Tour):**

All services continue to be provided with no changes since 2016. Delivery of group services continues to be tracked for all specialty mental health units on the data matrix (see appendix 1 and 2). The jail continues to employ recreation officers on the mental health units and a specialty officer and therapy dog, Beethoven.

The maximum disciplinary sanction is set at 14 days. A tour of the segregation unit revealed that very few inmates are housed in disciplinary segregation and most reported they had only been there for a day but certainly less than 14 days. No inmates interviewed in the segregation units appeared to have an unstable mental condition. Mental health rounds are conducted on a regular basis, confirmed by the inmates. Review of input into the disciplinary process by mental health reveals a healthy collaboration between custody and mental health leadership. Inmates on specialty mental health units received sanctions on that unit and are not transferred to a segregation unit.

**RECOMMENDATIONS (April 2017 Tour): None**

**13. Collaboration between Mental Health and Security Staff: Within six months of the effective date of this Agreement, the Jail Staff shall develop adequate training curricula, and within twelve months of the effective date of this Agreement, all relevant staff shall receive documented adequate training, regarding security and supervision issues specific to inmates with mental illness, including but not limited to**

- a. use of force on inmates with mental illness;**
- b. pill call procedures to prevent inmates with serious mental illness, inmates on the mental health units, and inmates with mental illness in segregation units from hoarding or hiding pills;**
- c. safe shaving procedures to prevent inmates with serious mental illness, inmates on the mental health units, and inmates with mental illness in segregation units from hiding or misusing razor blades; and**



- d. proper procedures in instances in which one inmates threatens to harm another with whom he/she is being placed in a suicide watch cell or a cell in a mental health unit, i.e., the need for officers to immediately consult with the classification unit for a determination, based on a review of the inmates' history and interviews, as to whether such placement should occur.**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (October 2016 Tour):*

*Electric shavers are provided on all mental health units, observation units and the annex. Those inmates on the observation unit (suicide watch included) are supervised when out for showers. As mentioned previously, medication administration practices have been improved throughout the jail to increase scrutiny of medication ingestion by inmates.*

*Communication practices between Mental Health and classification/disciplinary officers remain timely and excellent.*

**FINDINGS (April 2017 Tour):**

There has been no change since the last tour. All provision components are implemented.

**14. Disciplinary Action: The Jail Staff shall ensure that disciplinary charges against inmates with a SMI are reviewed by a qualified mental health professional to determine the extent to which the charge was related to mental illness or a developmental disability and to ensure that an inmate's mental illness or developmental disability is used as a mitigating factor, as appropriate, when punishment is imposed and to determine whether placement into segregation is appropriate. The amount of time since a previous placement in segregation and any history of decompensation in segregation also shall be considered in determining whether placement is appropriate or would have a deleterious effect on the inmate's mental health. Prior history of decompensation in segregation shall be a contraindication to placement in such confinement.**

- a. **Jail Staff shall consider suggestions by mental health staff for minimizing the deleterious effect of disciplinary measures on the mental health status of the inmate. Any punishment must work within the inmate's mental health treatment plan.**
- b. **The hearing officer shall document the participation of mental health staff and the hearing officer's consideration of the mental health staff's recommendations, including treatment alternatives considered in the disciplinary process.**
- c. **Disciplinary measures taken against specially housed inmates with SMI shall be reviewed on a quarterly basis.**
- d. **Inmates shall not be subject to discipline for refusing treatment or medications or for engaging in self-injurious behavior or threats of self-injurious behavior.**

**COMPLIANCE RATING: Substantial Compliance**

*FINDINGS (October 2016 Tour):*

*Uses of force incidents are tracked on the data matrix and only 2 such events this calendar year have occurred (1 in August and 1 in September). Mental health continues to complete a form sent to the disciplinary officer with their input which is routinely taken into account when sanctions are or are not issued.*

**FINDINGS (April 2017 Tour):**

There has been no change since the last tour. MCJ is tracking the incidents on the Health Services Units, including use of force (only one use of force has occurred this quarter). Examples of mental health input into the disciplinary process forms were provided for review and continue to demonstrate an effective process. On line 46 of Appendix 1, no SMI inmates were moved to segregation without a screening by mental health. Mental health continues to round on all disciplinary and administrative segregation units by report and as confirmed via my interviews with inmates on these units.

Mental health provides input into the disciplinary process via a form that indicates whether there is a mitigating circumstance and whether the disciplinary officer adjusted sanctions on that basis. One observation in the use of these forms pertains to be specialty mental health units. All inmates on these units who received disciplinary sanctions were not moved to segregation, but rather, received cell restriction or commissary restrictions as a result of the disciplinary sanction. I once again discussed with the jail and mental health leadership consideration of using clinical seclusion rather than a disciplinary process for those instances where the infraction was clearly a result of significant alterations in judgment and reality testing. This does not represent a change in the actual practices, but rather restructures what they are doing under a mental health driven policy rather than a custody policy. The policy would then specify the frequency of contacts with psychiatric and counseling services, etc. Any inmate that falls under this type of restriction would be managed similarly to someone on suicide watch, in that it would be the clinical team that reviews the sanctions at least weekly and controls the order to release the individual back into the milieu of the treatment unit. In addition, the clinical team can allow out of cell time to attend all treatment programming, etc.

A second possibility is to have the disciplinary officer refer to a behavior management plan, prepared by the mental health professionals, rather than have security apply restrictions under the disciplinary process. This plan would be prepared by the mental health professionals and specify what types of restrictions or interventions should be utilized for specifically identified behaviors. This process would require notification of the mental health department when the plan is implemented so that they can provide additional review, clinical management and support to the inmate.

**RECOMMENDATIONS (April 2017 Tour): None**

- 15. Suicide Prevention: Jail Staff shall ensure that suicide prevention measures are in place at the Jail and shall also develop and implement adequate written policies, procedures, and training on suicide prevention and the treatment of special needs inmates.**
- a. **These procedures shall include provisions for constant direct supervision of actively suicidal inmates when necessary and close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks). Officers shall document their checks.**
  - b. **Suicide prevention policies shall include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs.**
  - c. **Jail Staff shall develop and implement an adequate suicide screening instrument that includes adequate screening for suicide risk factors and assessment triggers.**
  - d. **A risk management system shall identify levels of risk for suicide and self-injurious behavior that requires intervention in an adequate and timely manner to prevent or minimize harm to inmates. The system shall include but not be limited to the following processes:**
    - i. **Incident reporting, data collection, and data aggregation to capture sufficient information to formulate reliable risk assessment at the individual and system levels regarding inmates with mental illness and developmental disabilities.**
      1. **Incidents involving pill hoarding or razor blades and injuries involving pills or razor blades shall be tracked and analyzed by the Jail Staff on a quarterly basis.**
      2. **Incidents involving weapons, self-harm, use of force, suicide, suicide attempts, or inmate-on-inmate assaults shall be tracked and analyzed by the Jail Staff on a quarterly basis.**
      3. **All such incidents shall be reviewed, including a psychological reconstruction for suicides, as part of a regularly scheduled suicide prevention committee composed of security, nursing, medical staff, and qualified mental health staff. Jail Staff shall develop a corrective action plan where appropriate, and the Staff's response shall be clearly documented.**

- ii. Identification of at-risk inmates in need of clinical or multidisciplinary review or treatment.**
  - iii. Identification of situations involving at-risk inmates that require review by a multidisciplinary team and/or systemic review.**
  - iv. A hierarchy of interventions that corresponds to levels of risk.**
  - v. Mechanisms to notify multidisciplinary teams and the risk management system of the efficacy of interventions.**
  - vi. Development and implementation of interventions that adequately respond appropriately to trends.**
- e. Jail Staff shall ensure that placement on suicide precautions is made only pursuant to adequate, timely (within four (4) hours of identification, or sooner if clinically indicated), and confidential assessment and is documented, including level of observation, housing location, and conditions of the precautions.**
- f. Inmates requiring crisis level of care will be seen by qualified mental health care professional within 4 hours of being placed on suicide precautions or crisis level care if during normal business hours, or within 24 hours if outside of normal business hours. The on-call qualified mental health professional must be notified within one hour of being placed on suicide precautions or crisis level care and advise with regard to course of treatment, housing, observation, medication, property restriction, and other appropriate care. Inmates on suicide precautions shall be provided out-of-cell time for clinically appropriate structured activities and showers.**
- g. Jail Staff shall develop and implement an adequate system whereby inmates, upon evaluation and determination by a qualified mental health professional, may, where clinically appropriate, be released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precautions. Step-down placements should continue to be suicide-resistant and located in such a way as to provide full visibility to staff. Jail Staff shall ensure that inmates are placed on a level of observation that is not unduly restrictive.**
- h. Inmates on suicide precautions shall be provided out-of-cell time for clinically appropriate structured activities and showers.**
- i. Qualified mental health staff shall assess and interact with (not just observe) inmates on suicide precautions on a daily basis and shall provide adequate treatment to such inmates.**

- j. Jail Staff shall ensure that inmates are discharged from suicide precautions or crisis level care as early as possible. Jail Staff shall ensure that all inmates discharged from suicide precautions or crisis level of care continue to receive timely and adequate follow-up assessment and care, specifically at a minimum of within 24 hours and 7 days following discharge. A qualified mental health professional may schedule additional follow-ups within the first 7 days of discharge if clinically indicated. A qualified mental health professional will develop a treatment plan within 7 days following discharge.**

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

The basic monitoring and set up of the suicide prevention cells remains the same. However, since the time of our last visit, staff report it is rare that inmates have been housed more than two to a cell. Inmates are housed in suicide resistant cells and allowed only suicide resistant property at all times. A member of the medical staff is assigned to complete the staggered 15-minute observations for everyone housed at this level of care. Clinical oversight is provided through daily review by either Dr. Pattillo or Dr. Nandamora. Only a mental health licensed professional can move someone on or off any mental health unit. Only the doctorate level providers move people on and off the HSP/HD (High Suicide Precautions/ Psychiatric Observation) unit.

All mental health units, including HD, provide safe shaving via use of electric razors under direct supervision by the officer.

Regularly scheduled special management meetings review cases confined to this unit and special management plans are implemented when needed. The quality improvement committee closely monitors incidents of assaults, contraband, injuries and use of force on this unit. Timeframes for evaluation of inmates placed on this unit are tracked and comply with the memorandum of agreement. Staff has the capacity to gradually release inmates and even step them down to psychiatric observation or a residential treatment unit when clinically indicated.

All inmates on these units are seen either by Dr. Nan or Dr. Pattillo daily for reassessment. A suicide risk assessment process is in place and is being utilized. Appendices 1&2 track not only the number of placements on HSP, but also the number of individuals who were repeatedly placed within the same month as well as average length of stay. The latter is three or fewer days. Tracking of the percent of people seen at one day and seven days post release is also in place with 97% to 100% compliance.

CCS provides a suicide awareness educational program each month. As mentioned previously all of the mental health staff have been trained by the Question Persuade Respond program. There has been no change in the training curriculum or training schedule for custody.

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One death in early 2017 was ruled a suicide and shortly after our April 2017 tour we were informed a second death had just occurred. The former death occurred in an inmate well known to the mental health department who had been seen frequently by the psychiatrist and psychologist prior to his death. The suicide prevention policy was not applicable to this case. A timely review was done by the facility and well documented. The psychological autopsy completed by Dr. Patillo was comprehensive. Suggested actions to decrease risk in the future are appropriate and demonstrate reasonable self evaluation by the system.

**September 11, 2017 Addendum:**

Prior to the finalization of this report additional material on the mortalities at the facility were received and reviewed.

Regarding the death mentioned above, copies of the entire record and incident reports were sent for my review. My comments will focus on whether the requirements of the current Mortality and Morbidity Policy and Procedure and this provision were followed.

Many of the provisions of the Agreement are not applicable because the inmate was not identified as suicidal but we know from our experience that once that identification is made the facility implements the appropriate levels of observation and professional monitoring. Data reviewed also indicates that suicide prevention training is provided per policy. Once the inmates in the housing unit notified the officers of their discovery of the inmate, the emergency response was immediate, including AED assessment and appropriate.

Mental Health contacts, especially via the kiosk system, were frequent. Contacts between the inmate by trained professionals, including a psychologist and psychiatrist, repeatedly documented that he denied being suicidal and was not demonstrating any evidence of serious impairment in thought, mood, judgement or impulse control. Segregation monitoring logs were complete and documented policy appropriate checks for the first several days of incarceration. He was moved to general population several weeks before his death. Comprehensive discharge referrals were completed shortly before the death. Critical reviews were completed in a timely fashion and identified recommendations that were responsive to the detailed review of the death. In my opinion, the review process was robust, self-critical and meets the elements of this provision.

Attendance records for the Critical Incident meetings included excellent representation from the Sheriff's' department, jail administration, New Horizons, and CHC medical services. The 2 reviews sent were self-critical. The final autopsy reports were not available at the time of the documented review and were not attached for my review. We were notified of two other inmate deaths in July and August 2017, which will be reviewed at the time of our next site visit.

**RECOMMENDATIONS (April 2017 Tour): Continue the current practices and monitoring**

**16. Morbidity/Mortality Reviews: Jail Staff shall conduct a written interdisciplinary review (critical incident report) of any suicide, serious suicide attempt or other sentinel event within thirty (30) days of the incident. The Morbidity/Mortality Review shall include a corrective action plan with timetables for completion.**

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

The first mental health related death in many years occurred in the first half of 2017. The medical records and critical incident reports were provided for review. An appropriate multidisciplinary committee was assembled and completed a comprehensive analysis of the death and self-analysis resulting in generation of appropriate improvements to the MCJ system. MCJ has demonstrated that they and their health vendors are capable of critical self-analysis. The final autopsy and toxicology reports have not yet been returned to the facility.

**RECOMMENDATIONS (April 2017 Tour):**

1. It is recommended that a final review occur within 30 days of the time the autopsy and toxicology reports return.
2. The critical incident report should have recommendations in a Corrective Action Plan (CAP) format identifying the issue, action to be taken, person responsible to facilitate the action, expected date of completion, and date of review by the committee.

**SUGGESTIONS (April 2017 tour):**

1. Another useful tool is to schedule an annual review of all deaths by the multidisciplinary Quality Improvement Committee or Morbidity and Mortality Committee (if the membership varies) in order to ensure that all elements of any corrective action plan developed earlier in the year has been completed and to observe for any trends in morbidity and mortality that might indicate the need for systemic intervention.

**17. Discharge Planning: Inmates on the mental health caseload shall be provided adequate discharge planning, including a sufficient amount of prescribed medications and appropriate referrals to community mental health services. The Jail shall develop relationships with and solicit input from community mental health organizations and providers regarding inmates' mental health needs in the Jail and upon discharge from the Jail.**

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

There has been no change in the discharge planning process. Most inmates continue to be referred to New Horizons for their follow-up care. Other appropriate community referrals including housing are in place and inmates are receiving discharge medications.

**RECOMMENDATIONS (April 2017 Tour): None**

**18. Confidentiality:** Jail Staff shall ensure that discussion of patient information and clinical encounters are conducted with adequate sound privacy in an office-like setting and carried out in a manner designed to encourage subsequent use of health services. All assessments shall be confidential. Because it may be necessary that Custody staff be present during clinical encounters, the Jail Staff shall ensure that Custody staff receives adequate and documented training on how to maintain patient confidentiality.

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 Tour):**

Access to the electronic medical records is restricted to clinical personnel. The officer training in mental health does cover the elements of this provision. MCJ continues to provide adequate and appropriate individual and group programming space for clinical encounters other than segregation rounds.

**RECOMMENDATIONS (April 2017 Tour): None**

**19. Health Records:** The Jail Staff shall maintain complete, legible, confidential, and well-organized mental health records as part of the medical records at the Jail, separate from the inmate record.

- a. Access to individual inmate mental health records shall be restricted to medical and mental health personnel, and mental health information shall be shared with jail officers only when the medical or mental health staff believes this is necessary or in the event of investigation of a critical incident.
- b. Jail Staff shall be instructed not to divulge inmate mental health information to other inmates.

**COMPLIANCE RATING: Substantial Compliance**



**FINDINGS (April 2017 Tour):**

MCJ continues to use the CCS electronic health record. All forms have previously been reviewed and found to be adequate. The record records the timestamp and name and credentials of the individual generating the entry.

**RECOMMENDATIONS (April 2017 Tour): None**

**20. Quality Assurance:** Muscogee County shall develop and implement, with the technical assistance of the United States and its expert consultant(s), a quality assurance plan to regularly assess and take all necessary measures to ensure compliance with the terms of this MOA. The quality assurance plan shall include, but is not limited to, the following:

- a. creation of a multi-disciplinary review committee;
- b. periodic review of screening, assessments, use of psychotropic medications, emergency room visits and hospitalizations for inmates with SMI,
- c. periodic review of housing of inmates with SMI;
- d. periodic review of the use of segregation;
- e. tracking and trending of data on a quarterly basis;
- f. morbidity and mortality reviews with critical analyses of causes or contributing factors, recommendations, and corrective action plans with timelines for completion; and
- g. corrective action plans with timelines for completion to address problems that arise during the implementation of this MOA and prevent those problems from reoccurring.

**COMPLIANCE RATING: Substantial Compliance**

**FINDINGS (April 2017 tour):**

MCJ is consistently using a data matrix which provides a year to glance review of critical processes such as intake screening, referrals to mental health, suicide prevention, use of seclusion, cell restriction on mental health treatment units, involuntary medications and hospitalization, use of restraint chair, morbidity and mortality, psychiatric management and mental health peer review, and group programming on all mental health units.

Under Dr. Pattillo's facilitation, multiple staff quality improvement projects have been designed and completed with the appropriate follow-up. MCJ has demonstrated the

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capacity to design, gather data and implement corrective actions is a critical component of itself monitoring and quality improvement program.

**RECOMMENDATIONS (April 2017 Tour): Continue the current efforts.**

Respectfully submitted this fifth day of May, 2017,<sup>1</sup>



Roberta E. Stellman, MD

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<sup>1</sup> As reviewed and updated through September 11, 2017.