

*Memorandum of Agreement between the U.S. Department of Justice and Columbus, Georgia
Regarding the Muscogee County Jail
Mental Health Monitoring Report April 2016 Tour
Roberta Stellman, MD*

Introduction

Our third onsite review of the Muscogee County Jail (MCJ) under the new Memorandum of Agreement (MOA) occurred April 21–22, 2016. Information was received from the leadership team, including a response to the second report, from the November 2015 tour. 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. **John Darr**, Sheriff
2. **Dane Collins**, MCJ Commander
3. **Cynthia Pattillo**, Psychologist, New Horizons (MCJ's mental health services vendor)
4. **Jeri Green**, Captain
5. **Jeremy Hattaway**, Corporal (Data Collections)
6. **Gary Deperro**, Sergeant (Specialized Mental Health Units)
7. **Charles Shafer**, Captain
8. **Paul Morris**, Health Services Administrator, Correct Care Solutions (CCS) (MCJ's medical services vendor)
9. **Lucy Sheftall**, Assistant County Attorney
10. **Glenda Hall**, Lieutenant

A pre-site request for documentation was submitted, and the facility again did an excellent job in providing a detailed response (This material was divided over many documents that are too numerous to attach but which will be referred to in the body of this report.). Assistance by all staff is much appreciated. I would like to especially thank Commander Collins, Dr. Pattillo, and Cpl. Hattaway for ensuring their availability throughout the tour to assist both myself and Ms. Myrthil.

Information systems changes since our last visit were primarily focused on installation of a new kiosk system in January 2016. Inmates can now receive emails from family and staff. No information is dropped out of the queue so it can always be tracked. Grievances and sick call requests are now directed to the mental health staff and delays in response or lack of responses have been corrected. Grievance appeals are done by Capt. Johnson or the Commander. Group therapies continue to be offered on the special mental health units. The certified therapy dog continues to visit the mental health units, and this service has been expanded to some of the other programming units under the Chaplain's oversight.

The drafts for most policies and procedures regarding mental health were submitted for review in September 2015, and the USDOJ submitted this monitor's final response and feedback to these drafts in November 2015. Additional feedback on these drafts was provided during the November onsite tour. A final policy manual was completed in 2016 and reviewed by this monitor. All policies were adequate and implemented following directives from the Commander to all staff for review. Samples of actual forms accompanying the policies were also sent in the pre site materials.

The current census has decreased due to the implementation of a rapid resolution track by the courts, especially for female inmates. The current average inmate count is 990 with 58 inmates with SMI (Serious Mental Illness) (52 reside on specialty mental health units). There is no change in the units

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utilized to house inmates requiring specialty mental health housing and observation. One unit on the west side is closed for renovations.

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

FINDINGS (May 2015 Tour):

Policies required in this MOA, in general, lack specificity particularly in describing detailed procedures necessary to codify those steps necessary to implement the intent of the policy. For an effective service, a policy manual needs to be more robust and comprehensive in its scope as discussed in the recommendations for this section.

One important reason for MCJ to have specific requirements within each policy is to aid the facility in its ability to oversee its contract with the mental health provider. Requirements such as timeliness, documentation requirements, frequency of treatment services, etc. allow the jail to monitor services in a quantitative manner and hold the private vendor accountable for those services; the contract binds the vendor to MCJ policies and procedures. In the absence of a professional contract compliance monitor, the advantage of quantitative measures is that it allows for a non-mental health professional to at least monitor a significant number of performance measures.

In the future, should the jail wish to acquire the services of a health/mental health professional with correctional experience that person would be able to assist the data collections Deputy in overseeing both quantitative and qualitative aspects of the external contractor's performance. While on-site, Commander Collins and I were able to discuss different configurations that might be able to provide the jail with cost-effective contract monitoring by health professionals preferably with correctional experience.

RECOMMENDATIONS (May 2015 Tour):

We discussed each specific requirement under this provision, and recommendations were made accordingly. With the permission of the Bernalillo County Metropolitan Detention Center's Administrator, Phillip Greer, I was able to provide MCJ with a complete copy of the health/mental health policies as a reference in modifying this site's policies. Also, several prison systems do list all of their health policies online, including the New Mexico Department of

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*Corrections and the Delaware Department of Correction. Both of these systems policies, as well as the Bernalillo County Metropolitan Detention Center's policies, comply with both the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) standards. It is strongly recommended that MCJ rely on the ACA and NCCHC standards and any Georgia State Jail standards as helpful guidelines in developing a mental health policy manual. Another excellent reference is the soon to be published third edition of the American Psychiatric Association's publication, Psychiatric Services in Jails and Prisons due out in July, 2015 (*Disclaimer, this reviewer is a co-author of this publication.).*

FINDINGS (April 2016 Tour):

The current policies (Appendix II) have been modified based on our recommendations, and the Commander has issued all staff emails to direct staff to review changes to the current policies rather than schedule classroom training for minor changes. This method is an acceptable interim practice in addition to the ongoing annual MSCO training schedule on this topic. On 4/19/16 an email was sent regarding the changes in the restraint chair policy requiring mental health professional staff intervention should restraint be required beyond 6 hours. (Appendix III) The facility provides annual in-service training on the restraint chair under Use of Force training as well. Dr. Pattillo provides training updates in staff team meetings on Tuesdays.

RECOMMENDATIONS (April 2016 Tour): None

- 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;**

FINDINGS (Nov. 2015 Tour):

Copies of the current initial and annual training curricula for suicide prevention and identification and intervention with mentally ill inmates were requested for review to determine adequacy. Also since the initial training is 3 1/2 hours and the annual training is four hours this monitor would like to understand what materials were provided and why there was a discrepancy with the initial training being shorter than the follow-up training. While on site Lieut. Trombley did provide attendance records that indicate the mental health staff, except for the newest hire, Mr. Dahner, have received training.

On December 17, 2015, Corporal Hattaway emailed an overview of the Suicide Prevention Training by Relias. The curriculum is a good one for the general community. However, MCJ should incorporate discussions specific to a correctional environment for a fully pertinent training. For example, the presentation lists firearms as the most common method of suicide; however, hanging is the primary method of death in a jail. There are different risk factors for jail suicides not addressed in the Relias training. Therefore, this curriculum is not adequate for training security or medical/mental health staff in correctional institutions because some of the facts provided are incorrect for your environment. However, in the course list there are two references to suicide in jails and prisons. A curriculum pertinent to those topics was not

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provided.

Review of the Relias training records indicates the last 1.25 hour course on Suicide In Jails and Prisons Part 1 was completed on 1/24/15 and a 1.5 hour training on Suicide Prevention Part 2 was completed 1/25/15.

RECOMMENDATIONS (Nov. 2015 Tour):

1. *MCJ should continue to complete the training of all mental health employees regarding correctional or security procedures necessary for the delivery and accessibility of mental health care.*
2. *Copies of the actual curriculum should be provided for review to ensure the materials sufficiently cover all critical components of these high risk areas.*

FINDINGS (April 2016 tour):

Copies of the Relias suicide prevention training curricula was reviewed and was found to be comprehensive and sufficient to meet this provision.

RECOMMENDATIONS (April 2016 Tour): None

- 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 (Nov. 2015 Tour):

A CIT training roster was provided which demonstrated that staff who attended CIT training at the current time is 42% of the total.

RECOMMENDATIONS (Nov. 2015 Tour):

Please provide a training record at the time of the next site visit which includes a breakout of the percentage of total staff by type (supervisors, officers, medical and MH staff and specialty housing unit staff in particular) that has received the training. Hopefully a significant number of untrained staff will be able to complete the training by the time of the next site visit.

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.

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (April 2016 Tour):

Consistent with previous findings, this provision was adequately covered in Appendix 2 of MCSO document production and continues to be incorporated into current practice.

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (Nov. 2015 Tour):

The excellent and collaborative relationship between security, mental health, and medical leadership continues. While we were on-site, a new form for mental health input into the disciplinary process was reformatted per this Monitor's recommendations. The reorganization of this form will hopefully make it clearer what mental health is responsible for and also aid the facility in easily being able to obtain tracking data for the mental health matrix regarding mitigation of disciplinary sanctions based on mental health input. Mental health is receiving copies of the incident report and should add this to the data matrix for easy tracking and analysis.

FINDINGS (April 2016 Tour): No change

RECOMMENDATIONS (April 2016 Tour): None

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

RECOMMENDATIONS (May 2015 Tour):

MCJ should develop a policy defining "seriously mentally ill" based on the definition in the MOA as well as additional qualifications provided by the mental health professionals. The current process of maintaining an ongoing list of inmates classified as SMI should be continued and updated weekly to ensure accurate identification of these individuals, particularly when security issues, such as possible disciplinary actions or planned use of force, are at plan.

FINDINGS (Nov. 2015 Tour):

New Horizons creates a list of inmates identified as seriously mentally ill based on the clinician worksheet handed in at the end of each clinic by either a psychiatrist or nurse practitioner. Currently there are 58 inmates identified as having a serious mental illness which is 5.5% of the average daily population.

FINDINGS (April 2016 Tour): No change.

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (Nov. 2015 Tour):

MCJ continues its practice of not placing seriously mentally ill inmates in disciplinary segregation, but rather, retaining them on special mental health units. These inmates may be held in cell restriction. An SMI disciplinary recommendation form has been generated which does include a determination by the mental health professional whether contraindications to segregation housing exists.

A behavior management plan form has been generated but has not yet been implemented.

RECOMMENDATIONS (Nov. 2015 Tour):

Behavior management plans will be provided for review at the time of the next site visit should any be implemented. Dr. Pattillo should provide inservice training for her staff regarding the implementation of such a form and provide data for the next visit regarding the completion of the training.

FINDINGS (April 2016 tour):

An example of a behavioral management plan was provided for review and was appropriately completed. The inmate was released prior to this tour.

RECOMMENDATIONS (April 2016 Tour): None

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;

FINDINGS (Nov. 2015 Tour):

Policy 1394 describes housing for inmates on mental health units. The basic policy is adequate except for recommendations below.

RECOMMENDATIONS (Nov. 2015 Tour):

Treatment on specialized mental health units should be defined regarding frequency and the nature of documentation. Policy 1394.0 5.06 should specify the minimum frequency with which inmates will access individual mental health professional counseling services.

FINDINGS (April 2016 Tour):

Recommendations from November 2015 have been incorporated into the policy manual.

RECOMMENDATIONS (April 2016 Tour): None

k. **treatment planning;**

FINDINGS (Nov. 2015 Tour):

Policy 1392 does contain a paragraph addressing the frequency of treatment plans which are updated monthly on the special mental health housing units and every six months for inmates in the general population.

RECOMMENDATIONS (Nov. 2015 Tour):

A copy of the treatment plan form was reviewed on site and recommendations were made to modify the form to better reflect measurable goals and objectives, the nature of the treatment provided and the staff member accountable for delivering the service. Specifically the plan should specify the frequency of the recommended interventions. Dr. Pattillo and I reviewed the form which she will modify and implement with the aid of IT from CCS, the medical contractor.

FINDINGS (April 2016 Tour):

Recommendations from Nov. 2015 have been incorporated into the current form.

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (Nov. 2015 Tour):

Inmates were interviewed on a variety of General Population and Special Housing units. Multiple inmates expressed their concern and belief that they would be charged for mental health sick call. Despite the Commander's alteration in this policy there is an opportunity for ongoing education of the inmate population.

RECOMMENDATIONS (Nov. 2015 Tour):

There remains a disconnect between written policy/procedure and practice regarding the cost of a sick call request to the mental health service. To fully implement this important policy change, there needs to be communication to the inmate population, not just staff alone. Otherwise, inmates will continue to operate under the old policy and not engage the kiosk system under the mistaken belief that they will be charged for submitting mental health sick calls.

FINDINGS (April 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

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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.

RECOMMENDATIONS (April 2016 Tour): None

SUGGESTIONS (April 2016 Tour):

Inmates on the specialized programming units should receive ongoing orientation via community meetings to improve their capacity to access benefits provided in the kiosk system. Perhaps, mental health professionals can inform inmates regarding the sick call process and the absence of charges when initial contacts are made to ensure that false beliefs do not serve as barriers to accessing services.

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

FINDINGS (Nov. 2015 Tour):

Mental health sick call requests are sent through the kiosk system and are received electronically by the mental health staff. Inmates interviewed demonstrated on the kiosks that some of their requests for services, particularly when labeled as a grievance, were closed without any action. Further investigation by Cpl. Hattaway revealed that all mental health grievances, many of which are simply sick call requests and other communications, were being electronically sent to a “black hole.” Mental health had never received any of these. Review of the reports of the last three months indicated a total of 108 mental health grievances being filed. Most of these, as stated previously, were really requests for service. 17 complaints from October 29, 2015 until November 16, 2015, were reviewed in the electronic medical record. All of these requests had been ruled unfounded by the kiosk system without any face-to-face evaluation. A copy of this report will be given to Dr. Pattillo so that she can have her staff retroactively address the inmate needs expressed in these “grievances.”

RECOMMENDATIONS (Nov. 2015 Tour):

Cpl. Hattaway was able to reroute future mental health requesting grievances to the mental health department in the kiosk system. We will review this at the time of the next site visit to ensure there are no further access issues.

FINDINGS (April 2016 Tour):

The new kiosk system has corrected this issue and the process is working reliably. Leadership tracks this on the Quality Improvement data matrix.

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (Nov. 2015 Tour):

Mental health sick call requests are being reviewed on a daily basis by a qualified health or mental health professional.

RECOMMENDATIONS (Nov. 2015 Tour): Continue the current practice.

FINDINGS (April 2016 Tour): No change

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (Nov. 2015 Tour):

The kiosk system does generate a log containing all the elements of this provision.

RECOMMENDATIONS (Nov. 2015 Tour): None

FINDINGS (April 2016 Tour): No change

RECOMMENDATIONS (April 2016 Tour): None

**v. logging procedures to record the date, time, and nature of each sick call request and responsive action; and
vi. documentation of the nature and response to each sick call request in an inmate's medical or mental health record;**

FINDINGS (April 2016 Tour):

Each sick call request and its response are logged into the electronic medical record whenever a face to face contact is made. If the issue is resolved by electronic communication the complete transcript is retained and accessed through the kiosk system.

RECOMMENDATIONS (April 2016 Tour): None

m. suicide prevention and treatment;

FINDINGS (Nov. 2015 Tour):

This essential policy was revised and is adequate pending implementation of the following recommendations.

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RECOMMENDATIONS (Nov. 2015 Tour):

1. *Please provide actual training materials electronically for review by this monitor. A screenshot of the Overview of Suicide Prevention for Corrections Professionals was provided but lacks the detail to determine the adequacy of this program. As mentioned previously in section 1396.0 5.1 - Training, 3 1/2 hours of suicide prevention training is part of the orientation yet the annual review is scheduled for four hours. The question raised is whether the initial training includes other hours focused on the approach to the mentally ill inmates and if so those should be specified in this policy to provide the reader with enough clarity to understand the breadth and scope of the initial training.*

Addendum: On December 17, 2015, Corporal Hattaway emailed an overview of the Suicide Prevention Training by Relias. The curriculum is a good one for the general community. However, MCJ should incorporate discussions specific to a correctional environment for a fully pertinent training. For example, the presentation lists firearms as the most common method of suicide; however, hanging is the primary method of death in a jail. There are different risk factors for jail suicides not addressed in the Relias training. Therefore, this curriculum is not adequate for training security or medical/mental health staff in correctional institutions because some of the facts provided are incorrect for your environment. However, in the course list there are two references to suicide in jails and prisons. A curriculum pertinent to those topics was not provided.

Please provide any additional training materials pertinent to the incarcerated population prior to the next site visit for review. If no such material exists, then it is recommended that MCJ develop training materials that can be added to the Relias curriculum.

Review of the Relias training records indicates the last 1.25 hour course on Suicide In Jails and Prisons Part 1 was completed on 1/24/15 and a 1.5 hour training on Suicide Prevention Part 2 was completed 1/25/15.

2. *Entry 1396.0 5.4-Treatment should document the recommended interventions and frequencies as well as focus provided to inmates on the HSP unit.*

FINDINGS (April 2016 tour):

The current policy is adequate and complete.

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (Nov. 2015 Tour):

The policy on inmate medication was revised to address psychotropic medication.

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RECOMMENDATIONS (Nov. 2015 Tour):

Policy 1414.0 3.11 discusses the inmate signing a medical release when refusing medications. However the policy still does not address how the clinician is notified when a patient refuses medication and what the requirements are for the provider to deal with these situations. Notifications for refusal of medication should be issued whenever there are three consecutive refusals, a pattern of refusal, or a significant refusal parentheses such as a single dose of injectable long-acting agent).

FINDINGS (April 2016 Tour):

The medical policy on missed or refused doses has not been altered. Based on my discussions with the jail psychiatrist at the last visit, a reasonable practice of verbal communication between the nurse and doctor does occur. This process should be codified in policy.

RECOMMENDATIONS (April 2016 Tour):

Please modify the policy to comply with NCCHC standards which better reflect monitoring when inmates with serious mental illnesses refuse significant medication administrations.

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|---|
| <ul style="list-style-type: none">o. involuntary treatment, including the use of seclusion, restraints, forced medications, and involuntary hospitalization; |
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FINDINGS (Nov. 2015 Tour):

Policies on the use of involuntary medication were good. MCJ uses the restraint chair as the only form of psychiatric restraint. This policy was revised to state that should an inmate require more than six hours of restraint the mental health provider will seek alternative treatment solutions to include emergency hospitalization, mobile crisis team evaluation, and/or emergency medication administration.

RECOMMENDATIONS (Nov. 2015 Tour):

None other than monitoring the implementation of this policy.

FINDINGS (April 2016 Tour):

Recommendations from November 2015 have been incorporated into the current policy. New Horizons keeps a list of inmates referred to the Bradley Center upon release. If an incarcerated inmate requires hospitalization they must call the mobile crisis team and they determine if a referral is indicated to a forensic facility. This process does not work smoothly for the jail and only 1 inmate has been sent out since November 2015.

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Use of the restraint chair is tracked on the quality data matrix.

	Jan 2016	Feb 2016	Mar 2016
# episodes of restraint chair use	3	6	3
Average length of time in minutes	128	168	174
Checks performed by health trained security	100%	100%	100%
Nursing checks done every 15 minutes	100%	100%	100%

During the Tuesday Special Management meetings any inmate suspected of hoarding medication, sent to the emergency department, or requiring any special review or services are discussed and minutes are kept. These were reviewed prior to the site visit

RECOMMENDATIONS (April 2016 tour): None

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

FINDINGS (Nov. 2015 Tour):

A policy on the confidentiality of the health record was reviewed.

RECOMMENDATIONS (Nov. 2015 Tour):

The policy was adequate with the only recommendation being a clarification in section 1458.0 4.1 to specify when non-healthcare staff members are instructed regarding confidentiality of inmate health information.

FINDINGS (April 2016 Tour):

Recommendations from the last tour are incorporated into the Sheriff's code of ethics which was provided for review.

RECOMMENDATIONS (April 2016 Tour): None

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

FINDINGS (Nov. 2015 Tour):

Policy 13921 mental health services was revised and reviewed.

RECOMMENDATIONS (Nov. 2015 Tour):

This policy does address treatment services and treatment plans provided at MCJ. Transfer to community resources is acknowledged. However, the policy does not specifically address routine efforts at discharge planning. The discharge planning form has been developed by New Horizons but is primarily a discharge needs assessment. I will be providing a copy of a sample format that

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the facility may modify or use as an aid to the development of a form to address both needs assessment and the indication of the finalized referral. (See appendix 2).

FINDINGS (April 2016 Tour):

Policy 1392 was not modified to specifically address a procedure for discharge planning. However resource information is on the kiosk and a discharge form is in place. Inmates may request the kiosk packet upon release but that information is not widely disseminated.

SUGGESTIONS (April 2016 Tour)

At the next policy manual revision it is suggested that Policy 1392 be modified to add language addressing the discharge planning process for specialty units and general population.

r. maintenance of medical and mental health records; and

RECOMMENDATIONS (Nov. 2015 Tour): None

RECOMMENDATIONS (April 2016 Tour): None

s. quality assurance measures to regularly assess and ensure compliance with the terms of this MOA.
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FINDINGS (Nov. 2015 Tour):

The new policy, 1148 Administrative Meetings, was reviewed. The policy outlines five types of meetings pertaining to the review of mental health caseload inmates. These meetings are:

- 1. Special Management Meeting*
- 2. Quality Assurance Meeting*
- 3. Suicide Prevention Meeting*
- 4. Mental Health Treatment Team Meeting*
- 5. Critical Incident Meeting*
- 6. Morbidity/Mortality Review*

The policy describes the purpose of each meeting and its frequency. See recommendations.

RECOMMENDATIONS (Nov. 2015 Tour):

The policy is good but it is recommended that when discussing the standing members of each committee, greater specificity for the title of each member should be added. In general, the standing members should represent leaders in each field or their designee should that person not be able to attend the meeting.

FINDINGS (April 2016 Tour):

The current policy has the required specificity.

RECOMMENDATIONS (April 2016 Tour): None

SPECIFIC PROVISIONS OTHER THAN REQUIRED POLICIES:

Note (Nov. 2015 Tour): Despite the current policies remaining in draft form until the time of this visit, when a practice has been in place since the time of our last visit and complies with the intent of the MOA, I have advance compliance rating. However at the time of our next visit should there be evidence that policies have not been trained and implemented causing any decline in the practice a rating of substantial compliance will be reduced to partial compliance at that time.

- 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 (Nov. 2015 Tour):

A staffing matrix was provided and remains unchanged except for the positive addition of a psychiatric nurse practitioner. During this visit I was able to meet with Dr. Nan who has been working at MCJ for almost 20 years. Currently he provides 15 to 20 hours a week Tuesday through Saturday. He and Dr. Pattillo usually are the ones that complete suicide watch follow-up at one and seven days. On Tuesdays Dr. Nan is at the facility both in the morning and evening. We discussed the process for medication refusals and he stated that usually the nurses verbally inform him when someone has refused medications. He does get a list of weekly injections which are usually performed in the clinic on Tuesday while Dr. Nan is on-site. Psychiatric progress notes were observed to have more narrative during the time of this visit when compared to May 2015.

As it relates to the prior recommendations (see numbers above), the following was found:

- 1. Inmates reported that they were being seen in private interview rooms off of the housing units or in a practitioner's office in the clinic.*
- 2. The actual inmate case list was not reviewed at the time of this visit. Dr. Pattillo did report that such a case list is being maintained and I would request that it be provided at the time of the next site visit.*
- 3. The actual inmate case list was not reviewed at the time of this visit. Dr. Pattillo did report that such a case list is being maintained and I would request that it be provided at the time of the next site visit.*
- 4. This information has successfully been added to the kiosk.*
- 6. Private office space remains sufficient for the services provided and staff size.*

Addendum: Materials provided in December 2015 demonstrate that community resources have been added to the Kiosk. MCJ also has a very useful Re-Entry packet developed in September 2015 for inmates to help prepare them in finding housing, employment, and substance recovery

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resources. Information regarding who receives this packet and how it is used was not made available to this reader but can be discussed at the next site visit.

RECOMMENDATIONS (Nov. 2015 Tour):

Recommendations #2 and #3 from the May 2015 tour are still applicable. Please provide case lists prior to next visit.

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 (April 2016 Tour):

Case lists should also track those inmates receiving ongoing counseling services so that inmates requiring a pre-segregation MH review can be identified.

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| <p>3. <i>Psychology and Psychiatry Hours:</i> 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.</p> |
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COMPLIANCE RATING: Substantial Compliance

FINDINGS (Nov. 2015 Tour):

A staffing analysis was completed in October 2015. The psychiatrist and nurse practitioner are present for 30 hours per week. The psychologist provides 25 hours per week. There is one full time licensed counselor. There are two full-time master level counselors, a full-time mental health technician, and 16 hours of graduate student time provided. Allocations with relief factor include 0.85 FTE M.D./LNP, .68 FTE PhD, 2.39 FTE LPC/Masters, 1.12 technician, .14 graduate student.

New Horizons has also adopted a data matrix which will be used to track timeliness of a variety of services delivered. This information should also be helpful in calculating staffing requirements and trending any difficulties in the service meeting those time frames. There is insufficient data currently to indicate if timeliness issues on the matrix are a result of staffing levels or efficiency in performance.

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RECOMMENDATIONS (Nov. 2015 Tour):

Currently the data matrix only tracks whether the psychologist has met the required hours per month. It is recommended that this matrix include much more specific information as to the functional hours completed by all categories of professional service. This information is helpful especially in interpreting data concerning timeliness of service. Further trending and QI reviews will better substantiate whether staffing allocations sufficiently meet the needs of the service.

FINDINGS (April 2016 Tour):

Detailed weekly staffing information is tracked by the service and meets the requirement of this agreement.

New Horizons staff currently consists of:

- | | |
|-------------------------------------|----------------------|
| 1. Cynthia Pattillo, PhD | 20+ hours per week |
| 2. Sai Nandamuru, MD | 10-20 hours per week |
| 3. Michael Dehner, NP | 20 hours per week |
| 4. Cicero Latimore, LPC | 40 hours per week |
| 5. Diana Ezell, MS | 40 hours per week |
| 6. Shannon Nihiser, MS 4 | 0 hours per week |
| 7. Cynthia Thompson, MH Tech | 40 hours per week |
| 8. Daniel Fry, MS, PhD candidate | 8-12 hours per week |
| 9. Daniel Stabin, MA, PhD candidate | 8 hours per week |
| 10. Gigi Guerra, PsyD | 12 hours per month |

RECOMMENDATIONS (April 2016 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 (Nov. 2015 Tour):

There is no change since the last report. Dr. Pattillo continues to maintain an excellent working relationship with Commander Collins and the supervising officers overseeing disciplinary segregation and all specialized mental health housing units including HSP. She also sits on the Quality Assurance Committee and the Weekly Special Management Meeting. Dr. Pattillo remains in regular contact with Dr. Nan, who works evenings and also schedules an MHP/QMHP to work at least two evenings a week so that Dr. Nan can remain better contact with the service.

Minutes from special management meetings were reviewed from May, June, and November 2015. These minutes reflect discussion on inmates receiving disciplinary reports and accommodation by the facility for those inmates demonstrating abnormal behaviors related to mental illness.

RECOMMENDATIONS (Nov. 2015 Tour):

Continue a process that seems to be working well. Please provide copies of all special management meeting minutes prior to the next site visit.

FINDINGS (April 2016 Tour):

Collaboration between Mental Health and Security staff continues to demonstrate excellent cooperation between the two entities. Special management treatment team meetings occur regularly each week.

RECOMMENDATIONS (April 2016 Tour): None

- 5. Screening:** 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:
- a. past suicidal ideation or attempt;
 - b. current suicidal ideation, threat, or plan;
 - c. prior mental health treatment or hospitalization;
 - d. recent significant loss such as the death of a family member or close friend;
 - e. history of suicidal behavior by family members or close friends;
 - f. suicide risk during any prior confinement;
 - g. any observations by the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk or mental health;
 - h. substance(s) or medication(s) used, including the amount, time of last use, and history of use;
 - i. any physical observations, such as shaking, seizing, or hallucinating; and
 - j. history of drug withdrawal symptoms, such as agitation, tremors, seizures, hallucinations, or delirium tremens;
 - k. history or serious risk of delirium, depression, mania, or psychosis.

COMPLIANCE RATING: Substantial Compliance

FINDINGS (Nov. 2015 Tour):

The MCJ receiving screen does contain almost all elements of the MOA provision.

RECOMMENDATIONS (Nov. 2015 Tour):

Revisions in the electronic form were completed; however, screening for sex offenses was not added. Hopefully, CCS can incorporate that into the mental health assessment form in the near future.

FINDINGS (April 2016 Tour):

All required elements are now contained in the electronic health care template.

RECOMMENDATIONS (April 2016 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: Partial compliance

FINDINGS (Nov. 2015 Tour):

New Horizons is currently tracking the percentage of psychological evaluations that are seen within 24 hours of referral from intake on the data matrix. 100% of the inmates referred over the last year have been seen within that timeframe. As noted at the time of our last visit the electronic medical record is unable to generate a report at this time of those people seen within four hours of booking for their initial health and mental health screening. Dr. Pattillo completes the majority of these evaluations. When she is unable to schedule an assessment, the licensed mental health professional will perform the evaluation.

RECOMMENDATIONS (Nov. 2015 Tour):

New Horizons might be able to collect data that would generate an absolute number and a percentage of inmates who are screened within four hours by adding this category to the provider worksheet and meet the requirements of the MOA.

FINDINGS (April 2016 Tour):

New Horizons has a draft CQI study (received with the pre-site materials Appendix IV) to determine if they are completing evaluations within the required timeframes stipulated in the MOA. MCJ/New Horizons continues to perform well in documenting completion of assessments within 24 hours but there is no proof of practice that they are meeting the 4 hour requirement

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during working hours. Dr. Pattillo will add this element to the data matrix for ongoing tracking of compliance.

RECOMMENDATIONS (April 2016 Tour):

Initiate and complete the CQI process.

- 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 (Nov. 2015 Tour):

Dr. Pattillo is completing the majority of initial referrals within 5 business days and this is now being tracked on the data matrix.

RECOMMENDATIONS (Nov. 2015 Tour):

Continue tracking the timeliness of this process.

FINDINGS (April 2016 Tour):

Our findings are unchanged from November 2015 except for the observation that when a prescribing practitioner is the first contact for the inmate only a follow up type progress note is most often recorded. As a result, these inmates may never receive a comprehensive assessment.

RECOMMENDATIONS (April 2016 Tour):

1. Provide training updates to staff (and document by use of a sign in sheet) that whoever has the first contact with the inmate documents a complete evaluation including the inmate's present and past history.
2. Monitor effectiveness of the training by chart review as part of the CQI process.

- 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.**

COMPLIANCE RATING: Substantial Compliance

FINDINGS (Nov. 2015 Tour):

Data specific to this requirement was not available. The MCSO Response to Compliance Report states this is tracked on the data matrix. It is not.

RECOMMENDATIONS (Nov. 2015 Tour):

Develop a method to prove compliance through data collection.

FINDINGS (April 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%) inmate 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.

RECOMMENDATIONS (April 2016 Tour):

New Horizons will need to demonstrate that all medical staff performing mental health screenings do receive enhanced training on identification of mentally ill inmates as a routine procedure in order to move to substantial compliance for this provision.

- 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 (Nov. 2015 Tour):

The electronic health record was modified and contains prompts to all of the specific elements of the MOA except for sex offenses.

RECOMMENDATIONS (Nov. 2015 Tour):

MCJ will request this addition to the health record.

FINDINGS (April 2016 Tour):

The omission for sex offense history has now been incorporated into the health record.

RECOMMENDATIONS (April 2016 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: Partial Compliance

FINDINGS (Nov. 2015 Tour):

New Horizons is now tracking completion of referrals and timeliness is demonstrated.

RECOMMENDATIONS (Nov. 2015 Tour): None

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.

RECOMMENDATIONS (April 2016 Tour):

1. Indicators of this nature should have a threshold of compliance established on the monthly matrix so that all reviewers are clear when the facility is in or out of compliance with its own standards. For clarity, the methodology and thresholds can be entered into the shaded headers for each category of review.
2. Areas of high risk for adverse outcomes should have a very high requirement at or near 100%. Ideally the response to urgent and emergent referrals should be at 100% given the higher risk of adverse outcome for these persons. More routine processes can have a threshold closer to 85-90%.
3. Tracking the exceptions for urgent/emergent referrals would help determine whether a CQI study should be done. For example, if some of these inmates were in court or bonded out of jail then the statistics are skewed but do not indicate a problem with the process.

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.**

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COMPLIANCE RATING: Substantial compliance

FINDINGS (Nov. 2015 Tour):

Partial Compliance is given based on the current malfunction in the electronic delivery of mental health grievances and communications. (See p.8 A.I.ii)

Data tracking indicates timely responses to sick call requests based on triage levels. On chart review we also noted a pleasant improvement in the nature of the responses to the inmates. Responses are courteous, clinically appropriate and helpful. There are no charges for mental health sick call since the Commander's directive in May 2015. Once the ASK system operates more efficiently the data will reflect the services ability to deal with an increase in the number of requests it triages and responds to.

RECOMMENDATIONS (Nov. 2015 Tour):

Continue the current tracking methods and consider periodic quality reviews to ensure the health of the system.

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.

RECOMMENDATIONS (April 2016 Tour): None

SUGGESTIONS (April 2016 tour):

Continue to track data and perform occasional chart reviews to confirm the health of the new system.

- 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

RECOMMENDATIONS (May 2015 Tour):

1. Treatment goals and objectives should be specific, measurable, contain time frames for completion and list the staff or clinical team responsible for overseeing that portion of the plan.
2. At the time of the next site visit it would be very helpful to be able to see data on the number of mental health treatment plans developed on special mental health units versus general population and proof that the plan update time frames are met. In addition, if a list of names is maintained, random charts can be selected to verify the data submitted.

FINDINGS (Nov. 2015 Tour):

New Horizons does utilize a treatment planning form and by policy specifies the frequency with which these are completed. While on site we reviewed the form and suggestions were made for modifications. Treatment plans were present in all the charts of inmates on every specialized mental health units that were randomly selected.

RECOMMENDATIONS (Nov. 2015 Tour):

Dr. Pattillo and I discussed improvements to the proposed plan to include frequency of interventions and increased specificity to the problems and nature of the interventions so they are measureable and improvement can be determined at the time of updates. In-service training may help staff enhance their ability to individualize the plans.

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.

RECOMMENDATIONS (April 2016 Tour):

Dr. Pattillo was able to devise a plan during this visit to improve the documentation by the mental health professionals to better reflect the actual services provided. She plans on adding a better list of topics for groups and the frequency of groups for the staff to choose from. The actual plans submitted for review were descriptive and complete and therefore. I am applying a rating of substantial compliance with review at the next visit.

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: Partial Compliance

FINDINGS (Nov. 2015 Tour):

CCS does not currently have the ability to generate a report tracking time to first dose administered. The facility will need to devise a methodology to study this provision (10.a) as a CQI study. Dr. Nan did report that there is no formulary for New Horizons so there is no delay because of a non-formulary drug request process. He does receive calls from the site when inmates are booked and report being on psychotropic medications. His procedure is to order a

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short prescription until the inmate can be seen and the clinician can determine the ensuing course of treatment. STAT medications not in stock will be obtained from a local pharmacy. Since New Horizons out patient records are accessible to MCJ New Horizons staff verification of treatment is easy and are scanned into ERMA. Often times these records also contain discharge summaries from the Bradley Center. Obtaining records from the VAMC remains problematic.

Dr. Nan believes medications ordered are usually administered within 48 hours.

RECOMMENDATIONS (Nov. 2015 Tour):

MCJ will be expected to provide proof of compliance with the components of this provision prior to each site visit.

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 5th inmate was seen by the psychiatrist within the 48 hour 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.

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

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RECOMMENDATIONS (May 2015 Tour):

Inmates housed in High Suicide Precautions for acute mental illness and not suicidal behavior should be offered out of cell time and out of cell 1:1 counseling whenever feasible based on their condition and level of aggression. Daily mental health notes and psychiatric notes should reflect counseling efforts designed at assisting the inmate in understanding behavioral controls necessary to advance them to 4F and updated documentation of progress made and treatment plan changes.

FINDINGS (Nov. 2015 Tour):

Same as previous site tour. MCJ does have an agreement with a local hospital for medical treatment of its inmates. Inmates in need of acute psychiatric hospitalization can be referred to public forensic facilities but as with most jails, this is a difficult and often fruitless process. Dr. Pattillo and Dr. Nan work closely with the court system and whenever possible can petition for minor charges to be dropped so that an inmate can be transferred to a local hospital for treatment. When inmates have more serious charges but exceed the treatment capacity at the jail they are sent to the local emergency room where they can receive acute treatment. The jail can also request a review by the local mobile crisis team who can set in motion a process to get the inmate accepted into a forensic hospital. But, it was explained, that often the hospitals all decline acceptance.

On 5/13/15 a list of 1013/Order to Apprehend to Bradley Center was emailed and demonstrated 26 requests for treatment between 12/2013 and the present by MCJ. 22 inmates on the list accepted for treatment.

Inmates in need of acute mental health treatment can be housed in the HSP area where they are seeing daily and observed by nursing staff at least every 15 minutes. Those inmates who require less supervision but are still demonstrating significant symptomatology are housed on 4F. Inmates with chronic persistent mental health needs and cannot tolerate housing in general population can be stepped down to 4E.

RECOMMENDATIONS (Nov. 2015 Tour): *Same as May 2015*

FINDINGS (April 2016 Tour):

No change from November 2015

RECOMMENDATIONS (April 2016 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 two hours of unstructured out-of-cell recreation with other inmates each day, including exercise, dining, and other leisure activities that provide opportunities for socializing, for a total of 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 (Nov. 2015 Tour):

Segregation rounds are performed in a unit for aggressive high risk inmates but not disciplinary segregation. During this tour we interviewed all inmates in 4H (disciplinary segregation), 4G (Isolation due to assaultive or predatory behavior), and the Annex isolation. No inmates demonstrated signs of a serious mental illness. Inmates in the Annex and 4G all reported weekly rounds by the licensed mental health professional. Inmates in 4H all reported no mental health rounds.

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The three special mental health units (2 male, 1 female) continue to operate well. Group programming has increased and inmates on 419 (female) and 4E (male step down) reported group therapy 7 days a week. Group services have increased on all of these units and the inmates found the hour long groups helpful.

RECOMMENDATIONS (Nov. 2015 Tour):

To achieve a rating of substantial compliance weekly mental health rounds will need to be implemented on 4H.

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.

RECOMMENDATIONS (April 2016 Tour):

All inmates with an SMI, on or off medications, should be tracked on the mental health case list, as previously mentioned, in order to ascertain who requires a referral for mental health review when placed in segregation.

- 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 (Nov. 2015 Tour):

Commander Collins provided the files on all uses of force involving inmates with an SMI designation. All files were reviewed. The use of the restraint chair was appropriate in all cases and frequent required checks were completed. When an inmate is placed in a restraint chair they are moved to the medical clinic where video monitoring and medical monitoring are available. In several cases the use of a restraint chair occurred on more than one occasion, frequently within the same 24 hour period. An opportunity for mental health intervention prior to the use of force was not likely since most occurred after hours and shortly upon intake. In all but one instance, restraint was initiated by security and not Dr. Nan.

RECOMMENDATIONS (Nov. 2015 Tour):

Elements of this provision should be tracked on the data matrix for trending, identification of potential opportunities for intervention, and % of cases ordered by a mental health provider vs. security, etc.

FINDINGS (April 2016 Tour):

There has been no change since the last tour.

RECOMMENDATIONS (April 2016 Tour): None

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

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FINDINGS (Nov. 2015 Tour):

The actual form is near completion and as mentioned above was reformatted during this tour. However, the process has been in place for quite some time now and the minutes of the Special Management Meeting do reflect inmates with SMI being retained on special housing units for their disciplinary time, rather than being placed in segregation.

RECOMMENDATIONS (Nov. 2015 Tour):

Implement the new form and begin tracking data pertaining to this process. Data should reflect the number of incidents per month, whether New Horizons received and reviewed the incident report and whether mitigating factors were present. I would also recommend tracking when mitigating circumstances were considered in adjustments in sanctions.

FINDINGS (April 2016 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.

RECOMMENDATIONS (April 2016 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.**
 - vii. **Development and implementation of interventions that adequately respond appropriately to trends.**

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- f. **Inmates requiring crisis level of care will be seen by a 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.**
- 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: Partial Compliance

FINDINGS (Nov. 2015 Tour):

A rating of Partial Compliance was given because one high risk individual was placed on HSP on 8/19/15 but did not receive a suicide risk assessment until 9/2/15. Since this area is such a high risk for harm provision such a delay is not acceptable. He also reported to me that he did not receive a suicide resistant mattress. Also, the Suicide Prevention Committee just met last month and will meet quarterly.

MCJ has sustained its suicide prevention program with no evidence of slippage. Levels of suicide risk assigned by the evaluating mental health professional and now been incorporated into the suicide risk assessment form. Language changes were recommended to the policy; however, the current process is sufficient. Inmates on the HSP unit are seen daily either by Dr. Pattillo or Dr. Nan seven days a week. Nursing staff remains position on the unit and completes the required safety checks 24 hours a day.

The HSP unit has 13 available cells. Three of these have higher windows and remain a last resort for housing inmates on suicide watch. These 3 cells are commonly used for non-HSP inmates who need to be kept NPO prior to surgery or for observation prior to transfer. The rest of the cells have large windows both at the top and bottom of the cell for good observation. At the time of our inspection all inmates were asleep in the unit. Two inmates were observed to have smocks and

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blankets but no mattresses and were sleeping on the concrete floor. Inmates are generally housed with a cellmate unless there are safety and security overrides. Residents are issued suicide resistant smocks and blankets.

We were also told by inmates not currently housed on the HSP unit that not everyone receives a suicide resistant mattress. I discussed this omission with Cmdr. Collins and hopefully this will be remedied.

The inmate who had been on HSP for months and was interviewed again at cell front and has been progressed to attending programming on a specialized mental health unit during the day and returns to HSP after hours. I did have the opportunity to speak with him again and he reported that the goal is for him to advance to full residence on a specialized mental health unit as soon as he is able to tolerate that level of socialization without becoming self-injurious. I commend the mental health staff for using creativity and providing additional structured activities for this individual. I would also like to acknowledge and complement the security and classification staff for making it possible for this inmate to be able to attend programming in an area where he is not housed.

MCJ is also studying the possibility of relocating the HSP unit away from the intake and booking area. Staff believes that many inmates claim to be suicidal in order to be housed in an area where they can potentially have limited interaction with fellow gang members, members of the opposite sex, or greater stimulation because of the increased activity in this area of the facility.

RECOMMENDATIONS (Nov. 2015 Tour):

The current practices are effective. Recommendations from May 2015, such as adding a suicide risk rating to the daily progress notes and improved tracking of follow up care and treatment planning upon release, as well as more effective programs for managing high risk but not acutely suicidal inmates, are now in practice.

Minutes from the Suicide Prevention quarterly meetings should be provided for review prior to the next site visit.

FINDINGS (April 2016 Tour):

Inmates on suicide prevention and close observation remained housed in the same area as during previous tours. Medical personnel continue to provide the staggered 15 minute checks and daily contacts occur with an advanced practice mental health provider. There is an increasing demand for suicide watch as the gang influences increase in general population. Many inmates are claiming to be suicidal despite the mental health staff assessing them as not self-injurious but rather seeking asylum and safety. This has been a topic in the special management meetings as the jail seeks an alternative method of safely housing these inmates. We did discuss using this as a CQI project because it is complex and multidisciplinary. The jail has designated two sheriff's deputies to go on all units and do something similar to a community meeting to try and decrease gang activity and bullying.

However, we observed three cells housing 4 inmates per cell. Only one of 12 inmates had a mattress. All had a suicide resistant smock and blanket. 2 mattresses were in the laundry waiting cleaning. 5 new mattresses were able to be located in the quartermaster's storage room. Of the

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12 inmates on HSP, Dr. Pattillo stated none were actually determined to be suicide risks by mental health.

Not all inmates receive a suicide risk assessment when initially placed on suicide watch. On occasion it was observed that the assessment may be completed several days into the placement. These instruments are also not utilized when there are repeated placements on watch.

New Horizons is completing chart reviews on psychiatric management and measures if a suicide assessment is completed at each visit for individuals with depression (100% compliance but the sample size was not indicated).

In reviewing the matrix we observed some confusion in how inmates were assigned as “seclusion” instead of “segregation”. And there needed to be further clarification for those on “time out” on the specialty mental health units.

RECOMMENDATIONS (April 2016 Tour):

1. HSP inmates should not be housed more than two to a cell.
2. Suicide Risk Assessments should be done on or about at the time of placement on watch and prior to release from watch to document changes in status allowing the discontinuation of the watch. They should be utilized every time an inmate is placed on watch.
3. All inmates should have a mattress issued to them especially since they have little or no access to chairs while on watch. If an inmate is not considered a suicide risk they should be housed as someone on clinical seclusion, keep away, step-down status, etc. which enables staff to order property such as a non-suicide resistant mattress, reading materials, etc. Such provisions should be codified in policy along with a written method of communicating with security what property and privileges these lower level inmates may have as ordered by mental health.
4. Alternative solutions should continue to be sought for safely house inmates in a less restrictive area if they are not suicidal.
5. When performing chart reviews please specify the sample size.
6. Seclusion should be used as “Clinical Seclusion” which is a therapeutic intervention initiated by medical or mental health staff to use rooms designed to safely limit a patient’s mobility, decrease stimulation, and facilitate rapid stabilization. Clinical seclusion is ordered by a mental health professional and is not used for security purposes. When clinical seclusion is used, it is employed for the shortest time possible (usually not more than 12 hours -5 days). Clinical seclusion should not be used as a substitute for administrative or disciplinary segregation for behaviors not related to a mental illness.

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.

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FINDINGS (Nov. 2015 Tour):

There were no reported deaths since the last monitoring tour. A mortality\morbidity committee meeting has not occurred. The policy was discussed and will be implemented following this tour.

RECOMMENDATIONS (Nov. 2015 Tour):

Please provide copies of all meeting minutes prior to the next tour for review.

FINDINGS (April 2016 Tour):

There, fortunately, have been no suicides or serious morbidities at the jail since the new MOA was adopted. The mortality committee has been defined by policy.

RECOMMENDATIONS (April 2016 tour): None

<p>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.</p>

COMPLIANCE RATING: Substantial Compliance

FINDINGS (Nov. 2015 Tour):

Discharge planning materials have been added to the kiosk. Most inmates follow up with New Horizons upon release. Dr. Pattillo and I have discussed modifications to the proposed Discharge Planning Form (See Appendix II). A rating of Substantial Compliance is given because inmates interviewed all reported receiving discharge instructions and medications when released in the past and the discharge options have been added to the kiosk.

RECOMMENDATIONS (Nov. 2015 Tour):

Implement a new needs assessment and discharge plan form and provide a list of inmates who have received discharge planning at the next site visit so a chart review can be performed.

FINDINGS (April 2016 Tour):

Inmates can access discharge materials on the kiosk and request a printed reference when released. Inmates receive more extensive planning if they are on a specialized mental health unit. During chart reviews there was documentation of discharge planning by the prescribing practitioners too. The jail does have a very helpful reentry workbook.

Discharge planning in general population relies upon the inmate accessing the kiosk and the outpatient prescriber/counselor providing planning during scheduled visits. On the health units a discharge planning form is completed by the inmate with guidance from the mental health staff. Inmates do receive information on how to get social security and other entitlements. The county covers all indigent people for medical care so inmates who have had social security benefits/medical benefits suspended while in jail still have access to services on a sliding scale. Hospitalizations are completely covered by the county for indigent patients.

RECOMMENDATIONS (April 2016 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

RECOMMENDATIONS (Nov. 2015 Tour): None

FINDINGS (April 2016 Tour):

Inmates continue to be seen in private and confidential locations for services other than rounds. Officers have been instructed to keep inmate information confidential as part of their ethics code and training.

RECOMMENDATIONS (April 2016 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: Partial Compliance

RECOMMENDATIONS (May 2015 Tour):

The entries in the medical record need to also document a complete history of the present illness and past history so that any reviewer can see the DSM V criteria utilized to reach the diagnostic conclusions and also to chart the improvement or exacerbation in symptom complaints and level of functional capacity.

FINDINGS (Nov. 2015 Tour):

Access to the medical records is restricted to clinical personnel. Officers' training in mental health does cover the elements of this provision. Please note that this section only addresses confidentiality and not privacy which was discussed earlier.

RECOMMENDATIONS (Nov. 2015 Tour): None

FINDINGS (April 2016 Tour):

Documentation is driven by the templates in the CCS electronic health record. A rating of partial compliance is given because the majority of psychiatric records reviewed lacked any or a current DSMV diagnosis. There is no way of judging if the treatment is appropriate if one cannot determine what exactly the practitioner is treating.

RECOMMENDATIONS (April 2016 tour):

1. Please refer to documentation guidelines provided in the May 2015 report, pages 34-36.
2. I suggest that New Horizons request CCS provide copies of the psychiatric progress notes and initial assessment forms in place at the Bernalillo County Metropolitan Detention Center as possible additions to the MCJ program since these also include a prompt for assigning a classification of SMI if that would be useful to the providers. Each note should have an area that allows the practitioner to enter a diagnosis and also a formulation justifying a change in the prior diagnosis, etc.

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: Partial Compliance

FINDINGS (Nov. 2015 Tour):

MCJ has developed some tracking tools and recently implemented some special needs multidisciplinary committees. A Continuous Quality Assurance/Improvement (CQI) Committee driven by policy to oversee this component of the MOA met for the first time on 7/16/15. The policy revisions were reviewed and recommendations submitted. Dr. Pattillo and MCJ utilized materials provided and now have a quality improvement manual to help guide the process of quality review. A data matrix has been implemented for quality assurance purposes. Several potential quality improvement projects were discussed on site.

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The Quality Assurance Matrix is now tracking various clinical processes and we reviewed the document on site. Several suggestions were made to improve the document.

RECOMMENDATIONS (Nov. 2015 Tour):

- 1. The jail should develop a stable membership to the committee and meet at least quarterly to review any CQI studies and data matrices.*
- 2. Complicated studies may need to be designed and implemented by sub-committees composed of staff who know the processes being studied first hand and at least one member knowledgeable in CQI techniques to facilitate the team.*
- 3. A CQI manual should be maintained that contains all the current project data and corrective action plans in a central location for easy access.*

FINDINGS (April 2016 Tour):

Two studies were provided pre-tour for reviews that are promising. A committee has been established per policy. It is too early to see the outcome of the studies and the effectiveness of the Quality Improvement Committee. Therefore, I am rating this provision as Partial Compliance with the hope that this will move to Substantial at the time of the next visit. I would also like to see evidence that the jail can conduct a complex CQI project that is multidisciplinary and driven by more than just Dr. Pattillo.

RECOMMENDATIONS (April 2016 tour):

Complicated studies may need to be designed and implemented by sub-committees composed of staff who know the processes being studied first hand and at least one member knowledgeable in CQI techniques to facilitate the team.

Respectfully submitted this 16th day of May, 2016,



Roberta E. Stellman, MD