

Introduction

Our 6th onsite review of the Muscogee County Jail (MCJ) under the 2015 Memorandum of Agreement (MOA) occurred October 30-31, 2017. Mortality review materials were provided prior to the visit and were reviewed in detail. Information including the data matrix, policies, and CQI materials were reviewed on site. All elements of the MOA were reviewed during this visit. I again appreciated the assistance offered by all staff in my efforts to complete this review.

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

1. Donna Tompkins (Sheriff)
2. Larry Mitchell, Major (Warden)
3. Cynthia Pattillo, PhD (Psychologist), New Horizons (MCJ's Mental Health Services vendor)
4. Jeremy Hattaway, Corporal (Data\Intel)
5. Glenda Hall, Captain (Security)
6. Lucy Sheftall, Columbus Assistant City Attorney
7. David Benoit III, Health Services Administrator

There have been no structural, policy, or other changes since our last site visit in mental health staffing, physical plant, clinical processes, policies, or committee structure except for the addition of a medically driven Quality Improvement Committee and the addition of a new health services administrator. Mr. Benoit began work as the health administrator for CCS in June 2017 and has been working diligently to improve processes and training on the medical side. He has addressed some issues which arose in the M&M reviews with his staff and recently initiated a monthly Quality Improvement (QI) Committee for medical and mental health which will then report to the facility quarterly QI Committee.

October 2017

The average daily census has risen from 985 in April 2017 to the current number of 1076 for September 2017. The number of monthly intakes is essentially the same, probably indicating an increase in the length of stay. Currently there are 649 male and 210 female inmates at the facility. The monthly average for inmates on psychotropic medication hovers around 400. The current number of individuals designated as having a serious mental illness is 76, representing approximately 7% of the total population of the jail. This is consistent with the percentage observed in April 2017.

The electronic health record, kiosk and sick call request systems remain in place. Sick call requests and responses continue to be tracked by the data matrix and the kiosk system enables accurate review of the process. The gang presence continues to rise in the jail. In an effort to control predatory practices by these inmates, the jail gang leaders are being separated and housed in the Annex in multi-man cells. It was also reported that recent gang related deaths in the community has increased the number of inmates seeking protection by requesting placement in the observation cells in HD.

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April 2017:

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

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

Compliance Assessment Methodology

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

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

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

Instructions to the Reader:

- Please refer to Appendix A for summary of compliance ratings through December 2017.
- All text from the MOA provisions and the headings of Compliance Ratings, Findings, Recommendations, and Suggestions by this reviewer appear in **bolded** font.

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- Many of the provisions, especially those referring to policies, have multiple subsections. In general, an overall compliance rating for each provision will be given at the beginning of each main section heading. Findings, recommendations, and suggestions will be listed under the main section heading. When there are detailed findings, recommendations, or suggestions specific to certain subsections, they will be broken out and recorded under each subsection with the relevant heading.
- Findings from the previous reporting period are provided where necessary for a complete understanding of current findings and/or recommendations and are in *italic* font.
- Recommendations from the previous reporting period are provided for each provision and are in *italic* font.
- “Recommendations” refer to such corrective action that this reviewer will expect MCJ to complete to move towards substantial compliance.
- “Suggestions” refer to additional action that MCJ may, but is not required to, take to further implement a provision in accordance with best practices. These suggestions are offered to assist MCJ in their ongoing efforts to improve facility conditions.

MOA Compliance Review of Substantive Provisions

I. SUBSTANTIVE PROVISIONS

A. Mental Health Care and Suicide Prevention

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

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

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

FINDINGS (October 2017 Tour):

There have been no policies revisions since the last tour. Currently the jail has not implemented an annual review of their health policies.

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April 2017 Tour:

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

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

SUGGESTION (October 2017 Tour):

1. The jail should review all mental health policies on an annual basis to ensure that the procedures align with the current needs and practices within the facility. It is also helpful to have a process whereby the Health Services Administrator/Medical Director and the Mental Health Director can request policy modifications throughout the year and programs, processes, etc. change to meet the needs of the inmate population. Reliance on the data matrix will also aid the jail directors in monitoring critical elements of jail health policies evidenced in the delivery of health services to ensure that the required services are being provided.

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

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

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

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

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

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

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

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

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

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

k. treatment planning;

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

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

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

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

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

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

m. suicide prevention and treatment;

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n. use of psychotropic medications, including verification, continuity, and medication non-compliance;
o. involuntary treatment, including the use of seclusion, restraints, forced medications, and involuntary hospitalization;
p. medicolegal issues, including confidentiality, informed consent, and the right to refuse treatment;
q. collaboration with community services and discharge planning;
r. maintenance of medical and mental health records; and
s. quality assurance measures to regularly assess and ensure compliance with the terms of this MOA.

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SPECIFIC PROVISIONS OTHER THAN REQUIRED POLICIES:

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017):

No change since April 2017. Sheriff Thompkins did not receive a copy of Mr. Redmond's staffing analysis report presented during the last tour. Ms. Sheftall's office will provide that document to the Sheriff for review and action as she sees fit. An ongoing increase in gang-related inmates continues to put pressure on the mental health staff due to a steady increase in the number of individuals requesting placement in the high-security area (suicide watch) primarily for protective custody reasons, although they initially claim they are suicidal. This will be discussed further under section 2.12.

Twenty-four hour coverage continues to be provided by two psychologists, a psychiatrist, and a nurse practitioner. Programming efforts remain consistent and unchanged.

(April 2017 Tour):

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

With the assistance of Mr. John Redmond, CMA, CIA and internal auditor with the Mayor's Office, a comprehensive staffing analysis was completed. We had the opportunity to meet with him on the first day of our tour for a presentation of the methodology and results. Dr. Pattillo assigned time values for each clinical task. Mr. Redman's determined, after studying the statistical information maintained on the mental health data matrix for 2016 and the first quarter of 2017, that there has been an increase in population resulting in added work requirements for the prescribers and PhD providers. Based on his review, he would recommend an increase in a half time position to give these providers more latitude. I am satisfied with the methodology of this review and confident that the jail has now demonstrated its capability in completing a reliable staffing analysis.

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

RECOMMENDATIONS (October 2017 Tour):

The jail needs to review Mr. Redmond’s staffing analysis and formally respond to his recommendations. There is some evidence in my review of medical records that inmate follow-up appointments with prescribers is further out than expected, and this may correlate with Mr. Redmond’s report to me last visit that the facility does need another 0.5 FTE in prescriber time. I did not find evidence of harm that would justify a change in compliance level at this time. I would not recommend eliminating any mental health professional positions to accommodate an increase in prescribers since that would adversely affect the programming and other counseling functions within the jail.

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 Tour):

New Horizons provided detailed timesheets for all of the doctorate level providers. The requirements of this provision are consistently met with no change from the prior visit in April 2017.

RECOMMENDATIONS (October 2017 Tour): None

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 Tour):

Collaboration between Mental Health, Medical, and Security staff continues to demonstrate excellent cooperation between all entities. Special management treatment team meetings continue to occur regularly each week to jointly review all inmates on suicide precautions, SMI in disciplinary settings, restraint chair use, predatory inmates, etc. There continues to be a close relationship between the prescribing psychiatric staff, mental health staff and security.

RECOMMENDATIONS (October 2017 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 (October 2017 Tour):

All required elements are now contained in the electronic health care template. Intake screening is currently being performed by a registered nurse. The Health Services Administrator is planning on moving the registered nurses (RNs) back to the clinic after intake training and placing licensed practical nurses (LPNs) in intake. His current nursing staffing includes 5 RNs, 13 LPNs and 4 medical assistants.

RECOMMENDATIONS (October 2017 Tour): None

SUGGESTIONS (October 2017 Tour):

At the time of the exit review, I discussed the nursing staffing ratios. In general, it is recommended that RNs to do sick call triage, sick call evaluations, and intakes because of their higher level of training and ability to assign nursing diagnoses and implement clinical pathways. Sheriff Thompkins was interested in looking at these needs with CCS to determine the best staff ration for the service.

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 Tour)

The mental health department continues to follow policy recommendations for this provision. Data provided on the tracking matrix (Appendix 1). Chart review (see Appendix 2) corroborated the presented data regarding timeliness and psychiatric and mental health professional valuations for emergent and urgent referrals from the screening registered nurse. The facility reported a 90% rate of compliance for urgent and emergent nursing referrals and 100% compliance for routine referrals. Their established threshold is 100% and the matrix has shown steady improvement in reaching this goal since January 2017.

(April 2017 Tour):

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

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

RECOMMENDATIONS (April 2017 Tour): None

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

COMPLIANCE RATING: Substantial Compliance

Findings (October 2017 tour):

Timeliness and completing routine kiosk requests were 100% as were routine referrals from intake. The electronic medical record template provides prompts for documentation of current and prior suicidal ideation and attempts, and current and past history of mental health symptoms and treatment. Charts reviewed during the current tour substantiated the data reported on the quality assurance matrix as did Cpl. Hattaway's additional spreadsheet tracking the timeliness in psychological assessment of those inmates placed in the high-security area by intake. His data supports the finding that 100% of these inmates are seen by the appropriate mental health professional within 24 hours of placement.

FINDINGS (April 2017 Tour): No Change

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

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

RECOMMENDATIONS: None

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 (October 2017 tour):

There has been no change since April 2017. Current chart reviews substantiates data reported on the statistical matrix.

FINDINGS (April 2017 Tour):

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

RECOMMENDATIONS: None

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 (October 2017 tour): All elements of this provision have been implemented and remain incorporated in the electronic medical record template.

RECOMMENDATIONS (October 2017 Tour): None

7. Referrals: Any jail staff member may refer an inmate to Mental Health based on observed changes in behavior, increase or appearance of psychotic symptoms, or other concern and these referrals shall be seen as follows:

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

COMPLIANCE RATING: Substantial Compliance

Findings (October 2017 tour): No change in practice. Compliance with current policies and statistical data matrix were verified by chart review (see appendix 2).

FINDINGS (April 2017 Tour): No Change

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

RECOMMENDATIONS (October 2017 Tour): None

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

COMPLIANCE RATING: Substantial Compliance

Findings (October 2017 Tour):

Current practice was reviewed by randomly selecting cases from the kiosk system for review and remains compliant with the requirements of the memorandum of agreement and facility policies.

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FINDINGS (April 2017 Tour):

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

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

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

RECOMMENDATIONS (October 2017 Tour): None

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9. Treatment Plans: The Jail Staff shall ensure that each inmate on the mental health caseload receives a comprehensive, individualized treatment plan developed by a clinician with participation from the inmate and from others, as appropriate (e.g., mental health, medical, or correctional staff) within 10 days of his/her initial intake evaluation. Generally all treatment plans will meet the following requirements.

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 tour):

Since the time of our last visit, Dr. Pattillo reports having completed in-service training for her staff on the recommendations made at the time of our last visit. Individual treatment plans were reviewed with Dr. Pattillo while on site. The electronic health record template was completed in its entirety by mental health professionals for SMI (seriously mentally ill) inmates in each of the mental health dormitories. The available objectives were reasonable, but the electronic record only allows selection of canned choices. One mental health professional has added greater specificity with descriptions of the inmate's behavior and anticipated goals in a final comment box on the form. The treatment plans were routinely generated on inmates housed in the three mental health units and timely updates were documented on the plans that were reviewed.

SUGGESTIONS (OCTOBER 2017 TOUR):

1. Dr. Pattillo will continue to provide periodic in-service training to her team regarding individualizing the plans such that a more detailed description of the person and their needs is documented.
2. Dr. Pattillo and I discussed adding comment boxes under each of the plan's objectives so that staff can enter more detailed and descriptive information regarding the inmates needs and progress towards the specified goals.

FINDINGS (April 2017 Tour):

Treatment plans are routinely being completed by the mental health professionals on the treatment plan form. Dr. Pattillo and I reviewed 10 to 12 plans together. It is my opinion that the staff continue to need additional training on how to generate more specific and measurable problems and goals. As an example, several of the plans identified a diagnosis of a serious mental illness as an issue with the phrasing of the goal similar to, "the patient will learn about their illness." There was no clarification as to how this education would express itself in benefits to the patient in measurable outcomes and no specific intervention regarding an educational program other than the general group menu. The 2017 data matrix (Appendix 2) demonstrates a significant improvement in 2017 for peer review regarding the ordering of policy required laboratory studies of 90-100%.

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

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

COMPLIANCE RATING: Substantial Compliance

Findings (October 2017 tour):

During the performed chart reviews there was documentation of attempts to verify and bridge medication in a timely manner.

FINDINGS (April 2017 Tour):

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

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

All medication administrations are entered into the electronic health record. Chart review of 15

randomly selected records did demonstrate medication bridging and prescriptive practices in line with the clinical diagnoses.

RECOMMENDATIONS (October 2017 Tour): None

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

COMPLIANCE RATING: Substantial Compliance

Findings (October 2017 Tour):

No change in the current practice or availability within the community psychiatric beds for this population. Access for inmates committing felonies still remains difficult unless a judge orders them to a state facility. For those with the city ordinances or misdemeanors, the staff continues to work with the local court for orders to the Bradley Center on an involuntary basis for up to 72 hours. Upon release from the crisis stabilization unit, charges would be dropped. The Bradley Center has the capacity to request an extension in detention as clinically indicated. When the Bradley Center is full, the patient can be deferred to another crisis stabilization unit within the state of Georgia. Once someone is hospitalized, the New Horizons liaison is notified and begins working with the hospital to relay treatment recommendations from the New Horizons staff at the jail. This person also works with the Bradley Center to relay information back to the treating staff at the jail with discharge plans once the person is released. Referrals to the ACT team require 2 hospitalizations as a criteria for acceptance. However, incarceration counts as a hospitalization making it somewhat easier for inmates to be referred to the ACT team.

FINDINGS (April 2017 Tour):

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

RECOMMENDATIONS (October 2017 Tour): None

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

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

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017):

Placement in the administrative segregation unit remains unchanged. Mental health routinely has been conducting rounds in this area and has been doing brief evaluations on inmates identified as having a serious mental illness prior to their placement in segregation.

Due to the increased number of gang-related inmates in the jail, the jail has begun using several cells in the Annex to isolate gang leaders from the general population. While on site we toured this area. Men are housed 3-4 per cell. They reported limited access to out of cell time and recreation. Mental health staff do not conduct segregation rounds in this area because they were under the impression that segregation refers only to disciplinary and administrative segregation in the upper floors of the jail. Inmates in these Annex units reported they only come out of their cell for showers and occasional recreation.

Mental health professionals have been conducting fitness for placement in segregation for those inmates designated as SMI, but not for other inmates followed by mental health.

FINDINGS (April 2017 Tour):

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

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

RECOMMENDATIONS (October 2017 Tour):

1. The Memorandum of Agreement specifically states that anyone on the mental health caseload will be screened prior to placement in segregation by a mental health professional. The mental health staff has consistently been evaluating only those people identified with a SMI and unintentionally overlooked the broadness of the language in this agreement requiring a screening for anyone on the mental health caseload. Going forward they will need to evaluate anyone on the mental health case list prior to segregation placement. Given the fact that the use of segregation is limited in number and time at this facility, this probably does not represent a significant deficiency. So the recommendation is that going forward a full case list be utilized when addressing this provision but there be no change in the compliance rating at this time.
2. In the past, the Annex cells have not been considered segregation by jail staff. However, given the fact that cells 148-150 have additional restrictions and limited

movement, they should be considered segregation, the MOA's and provisions to monitor and complete weekly rounds also should be implemented in this unit. Up until now, the jail has interpreted the definition of segregation to refer to disciplinary segregation as opposed to all forms of administrative segregation. However, any 23/24 hour restriction cells should be treated as segregation, which is in line with the MOA's definition of segregation. Again, because we're only talking about a dozen or so inmates, staff should easily be able to accommodate the requirements of this provision.

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

- a. **use of force on inmates with mental illness;**
- b. **pill call procedures to prevent inmates with serious mental illness, inmates on the mental health units, and inmates with mental illness in segregation units from hoarding or hiding pills;**
- c. **safe shaving procedures to prevent inmates with serious mental illness, inmates on the mental health units, and inmates with mental illness in segregation units from hiding or misusing razor blades; and**
- d. **proper procedures in instances in which one inmates threatens to harm another with whom he/she is being placed in a suicide watch cell or a cell in a mental health unit, i.e., the need for officers to immediately consult with the classification unit for a determination, based on a review of the inmates' history and interviews, as to whether such placement should occur.**

COMPLIANCE RATING: Substantial Compliance

Findings (October 2017 Tour):

There has been no change in practice. All requirements of this provision continue to be met. The relationship between jail staff and mental health staff remain collaborative and supportive.

FINDINGS (April 2017 Tour):

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

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

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

COMPLIANCE RATING: Substantial Compliance

Findings (October 2017 tour):

All documented records of mental health input into the disciplinary process were reviewed from April 2017 to the present time. Clearly evidenced in this review was that in several circumstances the mental health professional providing the input did not request mitigation despite documenting the presence of such factors. In discussing this with Dr. Patillo, what was apparent was the fact that the jail has been relying on disciplinary sanctions to restrict people on the mental health units to their cells to meet immediate safety concerns because their behavior was unstable secondary to their mental illness. Yet, by relying on the disciplinary process, the established number of days per infraction becomes the sanction, rather than the clinical staff utilizing a clinical model whereby mental health professionals—as opposed to security staff—regulate the amount of time in cell to stabilize behavior from a treatment perspective. Under a clinical seclusion model, inmates with mental illness who are separated from the general population to stabilize behavior would retain privileges, such as canteen, whereas currently, under the disciplinary process they do not.

*Memorandum of Agreement between the U.S. Department of Justice and Columbus, Georgia
Regarding the Muscogee County Jail
Mental Health Monitoring Report October 2017 Tour
Roberta Stellman, MD*

FINDINGS (April 2017 Tour):

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

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

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

RECOMMENDATIONS (October 2017 Tour):

1. For those inmates who have behavioral issues related to an acute or subacute manifestation of their illness, clinical seclusion is the appropriate means to isolate them from the unit population for both their safety and the safety of those around them rather than the disciplinary process. For example, one inmate did not have their sanctions mitigated because they were manic and unpredictable. By having a clinical seclusion policy, the psychologist or psychiatrist could have placed this person on cell restriction until such time as the *clinician* felt the person could safely be returned to the unit's milieu. Having such an option would allow both the psychologist and the disciplinary officer to dismiss disciplinary charges when appropriate.
2. The jail should develop a policy for clinical seclusion which would dictate who has the authority to place people on and take people off this housing status. The policy would also drive the frequency of contacts with a variety of mental health professionals, thereby increasing contact with mental health professionals and hopefully allowing for rapid stabilization through medication adjustment and decreased external stimulation.

15. Suicide Prevention: Jail Staff shall ensure that suicide prevention measures are in place at the Jail and shall also develop and implement adequate written policies, procedures, and training on suicide prevention and the treatment of special needs inmates.

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

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

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 Tour):

All mental health staff continue to participate in the Question Persuade Respond Program for the State of Georgia. New Horizons also uses Relias online training and Dr. Pattillo does and in-service training that is corrections oriented. Mental health staff are currently reading an article by Lindsay Hayes regarding suicide in jails which will be followed by a team discussion. Correctional Care Solutions staff are 100% trained online in suicide prevention, and the health services administrator also conducted a discussion during staff meetings. Since April 2017, comprehensive training records provided by the jail indicate that all deputies have completed suicide prevention training through their online program. All medical staff have done suicide prevention training except for a contract obstetrician who works a few weekend hours.

Mental health staff routinely complete a suicide risk assessment at the time of release from suicide watch. All inmates on watch continue to receive suicide resistant garments and are observed by a medical staff member at least on a staggered 15 minute watch. All inmates at this level of care are seen daily by either a psychologist, psychiatrist or nurse practitioner. The statistical matrix tracks 24 hour and 7 day follow up, currently at 97% for both. There is a very low rate of self harm, also tracked on the matrix, averaging 1.5 incidents per month for the past 9 months.

FINDINGS (April 2017 tour):

All of the mental health staff have been trained by the Question Persuade Respond program. There has been no change in the training curriculum or training schedule for custody.

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

RECOMMENDATIONS (October 2017 Tour):

1. Suicide Risk Assessments should be completed prior to placing the inmate on watch in order to justify the level of observation and other precautions. The documented assessment should also be completed prior to release from observations (which is the current practice).

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 tour):

While on site we discussed the three deaths at the facility in 2017. Of these, only one appears to be a suicide. The psychological review was timely, self-critical and comprehensive. A critical incident committee meeting did occur for all three deaths in a timely manner with participation by the appropriate clinicians and security representatives. A mental health review was completed by Dr. Pattillo for the three deaths. Staff reported that the Georgia Bureau of Investigation does not routinely release the autopsy reports to the treating clinicians at the jail. However, that was not correct in that following our tour and per Georgia state law these reports can and have been received by the jail. Not routinely reviewing these reports hampers the jail’s internal process of developing a corrective action plan because the final findings of the official inquiry may not be incorporated into the jail’s review process.

FINDINGS (April 2017 Tour):

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

RECOMMENDATIONS (October 2017 Tour):

1. A medical death was discussed extensively in the exit meeting and concerns were expressed by this reviewer regarding some of the medical processes. Details of that discussion remain confidential.

SUGGESTIONS (October 2017 Tour):

1. Obtain the autopsy and toxicology reports for all in-service deaths for review by

the facility's Mortality Committee in drafting the final corrective action plan.

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 tour): No change

FINDINGS (April 2017 Tour):

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

RECOMMENDATIONS (April 2017 Tour): None

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 tour): No change. Adequate clinical space is provided for confidential encounters between staff and inmates.

FINDINGS (April 2017 Tour):

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

RECOMMENDATIONS (October 2017 Tour): None

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

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 tour): No change, an electronic record remains in place.

FINDINGS (April 2017 Tour):

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

RECOMMENDATIONS (October 2017 Tour): None

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

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (October 2017 tour):

Since the time of our last visit another collaborative CQI study was performed between the mental health and medical departments. Staff looked at nursing referrals to the mental health service to determine if appropriate referrals were made and if the level of urgency was clinically appropriate. The methodology was well selected and clearly documented in the quality improvement report. Recommendations from the study were appropriate.

Staff are using the data matrices on a monthly basis to track performance and have demonstrated proficiency in selecting appropriate processes for study by multidisciplinary quality improvement teams and the capacity to perform a review and interpret data from the studies.

Mr. Benoit has implemented a Medical Quality Improvement Committee and has included mental health and custody staff in the membership. The plan is to meet monthly and maybe change to quarterly once the committee has matured. This committee will look at issues such as clinical processes, infection control, medication administration, etc. Problems identified by this committee will be filtered into the facility QI Committee quarterly. The jail committee focuses on multidisciplinary processes and Cpl. Hattaway's studies.

FINDINGS (April 2017 tour):

MCJ is consistently using a data matrix which provides a year to glance review of critical processes such as intake screening, referrals to mental health, suicide prevention, use of seclusion, cell restriction on mental health treatment units, involuntary medications and hospitalization, use of restraint chair, morbidity and mortality, psychiatric management and mental health peer review, and group programming on all mental health units. Under Dr. Pattillo's facilitation, multiple staff quality improvement projects have been designed and completed with the appropriate follow-up. MCJ has demonstrated the capacity to design, gather data and implement corrective actions is a critical component of itself monitoring and quality improvement program.

RECOMMENDATIONS (October 2017 Tour): None

Respectfully submitted this day 29th of December, 2017,



Roberta E. Stellman, MD