

## **Introduction**

Our fourth onsite review of the Muscogee County Jail (MCJ) under the new Memorandum of Agreement (MOA) occurred October 12-13, 2016. Pre-site information including the data matrix, policies and CQI materials were reviewed in advance. All elements of the MOA were reviewed during this visit.

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

1. **Dane Collins**, MCJ Commander
2. **Cynthia Pattillo**, Psychologist, New Horizons (MCJ's mental health services vendor)
3. **Jeremy Hattaway**, Corporal (Data Collections)
4. **Lucy Sheftall**, Assistant County Attorney
5. **Glenda Hall**, Captain (Custody Operations)

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

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

The mental health service is shifting to contracting for weekend staff to conduct groups and respond to any urgent sick call requests on the weekend. We learned that until now staff were granted compensation time for their weekend service which had the net effect of increasing the work coverage the other employees had to perform during the work week. The MD and PhD weekend coverage has always been covered by contract pay.

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

### **Compliance Assessment Methodology**

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

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

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

**RECOMMENDATIONS OCTOBER 2016:**

Please provide copies of the curriculum or agenda outline for the two training sign in sheets provided in the pre-site packet for October 2016.

Please provide copies of the curriculum or agenda outline with all training sign in sheets on all future tours.

**SUGGESTIONS (October 2016 Tour):**

As discussed on site, currently inmates are placed on “psych eval” status in HSP (“High Suicide Precautions”) (essentially psychiatric observation with 15 minute watches) by *any* staff person in the facility until they are seen and evaluated by a mental health professional. Should the mental health professional choose to continue the observation, the inmate remains in clinical seclusion on watch. It might be a helpful tracking tool to label the latter “Clinical Seclusion” so that when tracking, one can easily distinguish between the different statuses (the first is a placement by non-mental health staff and the second is by order of a mental health professional). This also helps non-mental health staff, appreciate who is on suicide watch and who is under observation for other reasons. I leave it to the facility to determine if their current process works well for them or if they might prefer to review the NCCHC standard on seclusion and consider whether they wish to develop a policy and procedure for that separate from the suicide prevention policy.

***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*

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*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**

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| <ul style="list-style-type: none"><li>a. <b>mission and goal of the Jail's mental health; program;</b></li><li>b. <b>administrative structure of the Jail's mental health program;</b></li><li>c. <b>staffing, including staff-to-inmate ratios, job descriptions, credentials, and privileging;</b></li><li>d. <b>training of mental health staff regarding correctional or security procedures that are necessary for the delivery and accessibility of mental health care;</b></li></ul> |
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**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**

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| <ul style="list-style-type: none"><li>e. <b>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;</b></li></ul> |
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**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**

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| <ul style="list-style-type: none"><li>f. <b>strategies for effective communication with inmates with SMI in a respectful and supportive manner to promote pro-social behavior;</b></li></ul> |
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**FINDINGS (April 2016 Tour):**

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

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**RECOMMENDATIONS (April 2016 Tour):** *None*

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| <p>g. <b>collaboration between mental health staff and correctional staff in the classification, housing, use of force, and discipline of inmates with SMI;</b></p> |
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**FINDINGS (April 2016 Tour):** *No change*

**RECOMMENDATIONS (April 2016 Tour):** *None*

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| <p>h. <b>reliable and valid methods for identifying inmates with SMI, including mental health screening, assessments, evaluations, and appropriate timeframes for completion;</b></p> |
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**FINDINGS (April 2016 Tour):** *No change.*

**RECOMMENDATIONS (April 2016 Tour):** *None*

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| <p>i. <b>housing of inmates with SMI, including limits on the use of segregation;</b></p> |
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**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*

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| <p>j. <b>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;</b></p> |
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**FINDINGS (April 2016 Tour):**

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

**RECOMMENDATIONS (April 2016 Tour):** *None*

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| <p>k. <b>treatment planning;</b></p> |
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**FINDINGS (April 2016 Tour):**

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

**RECOMMENDATIONS (April 2016 Tour):** *None*

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| <p>1. <b>sick call, including</b><br/>i. <b>availability of written or electronic sick call request slips without advance charges;</b></p> |
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***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 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.*

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| <p>ii. <b>a collections method where the requests are directly sent to a qualified health or mental health professional;</b></p> |
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***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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| <p>iii. <b>daily review of inmate requests by a qualified health or mental health professional to determine level of urgency;</b></p> |
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***FINDINGS (April 2016 Tour): No change***

***RECOMMENDATIONS (April 2016 Tour): None***

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| <p>iv. <b>appropriate timeframes for responding to sick call requests depending on level of urgency;</b></p> |
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***FINDINGS (April 2016 Tour): No change***

***RECOMMENDATIONS (April 2016 Tour): None***

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- 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 (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 (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.*

**FINDINGS (October 2016 Tour)**

This recommendation was completed (see Appendix I).

**RECOMMENDATIONS (October 2016 Tour)**

None

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

***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.*

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

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

*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 (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 (April 2016 Tour):***

*Policy 1392 was not modified to specifically address a procedure for discharge planning.*



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*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.*

**FINDINGS (October 2016 Tour):**

Policy 1392.04.7 was modified per the above suggestions.

**RECOMMENDATIONS (October 2016 Tour):**

None

r. maintenance of medical and mental health records; and

**RECOMMENDATIONS (April 2016 Tour):** None

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

**FINDINGS (April 2016 Tour):**

*The current policy has the required specificity.*

**RECOMMENDATIONS (April 2016 Tour):** None

**SPECIFIC PROVISIONS OTHER THAN REQUIRED POLICIES:**

**NOTE:** We were provided with proof of training for the new policy changes in medication administration and suicide prevention prior to our October 2016 Tour.

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.

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***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.*

***FINDINGS (October 2016 Tour):***

Staffing levels remain unchanged since our previous visits. During this visit I was able to meet with the professional counseling staff without supervisors present. I am impressed by the positive moral of the staff and their good relationships with their supervisors, psychiatrist and physician's assistant. The current employee non-supervisory staff consists of 2 master's level counselors and 1 administrative assistant/certified peer counselor. The two counselors provide, at a minimum:

1. Required group therapies to the specialized mental health units which consists of 6 hourly groups daily (2 per unit). (The Certified Peer Counselor does contract for weekend groups).
2. Suicide assessments prior to the inmate being moved to suicide watch
3. Case management for the entire caseload
4. Inmate release and discharge plan coordination
5. Monthly individual visits on the mental health units
6. Treatment planning for all inmates on the 3 specialty mental health housing units
7. Sick Call and Referral responses not covered by Mr. Lattimore, their supervisor
8. Some Intake assessments, although the bulk of these are done by Dr. Patillo

There are many organizational tasks they perform in addition to delivering clinical services such as ensuring CCS nurses administer all the ordered injectable medications, tracking to ensure the prescriber's have successfully completed the orders for non-formulary agents, track and ensure that if the prescriber missed a medication renewal it is done.

Currently only one of the professional counselors and the certified peer counselor are under contract for weekend services. So, weekend referrals and groups have only been done by that individual resulting in her working 5 full days and two partial days every week. Mr. Lattimore received comp time for any additional hours he worked which provides no respite for the other two counselors because they have to pick up his assignments during his comp time absences.

The graduate students who rotate through the service generally provide any required individual brief counseling. They also have their own special projects that may not be related to the daily needs of the service but provide assistance in performing CQI studies.

Please see the following section for the current staffing levels.

**RECOMMENDATIONS (October 2016 Tour):**

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

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

**COMPLIANCE RATING:** Substantial Compliance

***FINDINGS (April 2016 Tour):***

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

*New Horizons staff currently consists of:*

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| 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 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

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**FINDINGS** (October 2016 Tour):

Staffing remains unchanged from the prior visit except for some rotation in psychology students but no change in the employed staff and meets the minimum requirement of this provision; but without a detailed analysis it may not meet the adequacy of staffing in the prior provision. Line staff report that Mr. Dehner is usually scheduled to see 18-25 patients per day, which includes new assessments and follow ups. Dr. Nandamuru usually works 4 hours in the evenings and sees about 5-8 inmates in the HSP area on suicide watch and observation and new inmates. It is the opinion of the line staff that the prescribers do not have enough time to track what inmates needs medication renewals, and they often do not complete the final input into the electronic health record to ensure non-formulary orders actually get sent to CCS for approval. This current staffing may be less than needed supported in part in my observations that the documentation is somewhat thin although adequate.

The monthly average number of inmates on psychotropics in September, 2016 (See Appendix III, Data Matrix) was 31.83% of an ADP of 1029, or 327.53 inmates. Seventy eight inmates were on HSP. If we subtract that number then the caseload generally followed by the PA is roughly 249.5 inmates (which is probably an underestimate given the rapid turnover in a jail). That may be a manageable caseload in an outpatient community practice 20 hours per week but may not be sufficient in a high acuity jail setting to complete comprehensive initial assessments and follow up visits.

**RECOMMENDATIONS** (October 2016 Tour):

1. As per the prior provision, a detailed staffing analysis with input by the clinical staff is necessary to establish whether there is adequate time for prescribing staff to complete their own detailed history and observations in order to develop a meaningful diagnosis and treatment plan.
2. For now, as above, I will continue a Compliance Rating of Substantial Compliance pending review of the adequacy and findings of the upcoming staffing analysis. I will also continue to review the quality of documentation by the prescribing staff on the next site tour to ensure that it reflects adequate staff hours to complete not only the clinical service but also the recording of the service and treatment plan.

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| <p><b>4. <i>Psychiatry-Psychology Collaboration:</i> 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.</b></p> |
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**COMPLIANCE RATING:** Substantial Compliance

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**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

**FINDINGS (October 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 and the minutes of these meetings since our last tour were reviewed on site.

**RECOMMENDATIONS (October 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 (April 2016 Tour):**

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

**RECOMMENDATIONS (April 2016 Tour):** None

**FINDINGS (October 2016 Tour):**

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

**RECOMMENDATIONS (October 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:** Substantial Compliance

***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 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.*

***FINDINGS (October 2016 Tour):***

New Horizons completed a study of all inmates placed in HD from the intake area between 5/6/16 – 6/6/16. The study demonstrated that 87% of these individuals were seen within the 4 hour requirement of the provision. The design of the study was good as was the narrative of the obstacles to achieving 100 % compliance within the time frame. The study lacks a description of

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the follow up methodology and time frame to demonstrate improvement based on the interventions under the “Action” section. Dr. Patillo does have plans to revisit this study.

**RECOMMENDATIONS (October 2016 Tour):**

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

- 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 (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.

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**FINDINGS (October 2016 Tour):**

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

**RECOMMENDATIONS: (October 2016 Tour):** 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 (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.*

**FINDINGS (October 2016 Tour):**

The data matrix and review of 15 randomly selected medical charts indicates compliance with this provision since April 2016 when tracking was initiated.

**RECOMMENDATIONS (October 2016 Tour):** None



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

**COMPLIANCE RATING:** Substantial Compliance

***FINDINGS (April 2016 Tour):***

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

***RECOMMENDATIONS (April 2016 Tour):*** None

***FINDINGS (October 2016 Tour):***

Review of 15 randomly selected medical charts indicates continued compliance with this provision.

***RECOMMENDATIONS (October 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:** Substantial Compliance

***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.*

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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%.*

*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.*

**FINDINGS (October 2016 Tour):**

The data matrix and review of 15 randomly selected medical charts indicates compliance with this provision since April 2016 when tracking was initiated. Appropriate referrals are made and usually seen within the established time frames. All indicators on the data matrix now have a compliance threshold.

A new kiosk system went into effect January 2016 and there was a spike in referrals supposedly explained by the inmates' increased access to communications. Routine and Emergent kiosk requests have all been addressed within the expected timeframes.

Staff reported that the nursing staff was marking all referrals as urgent, even those inmates requesting clearance for work assignments. Ten days ago Mental Health discovered that not all the referrals had been cleared out and are working on that now. Lower performance on the matrix is attributed to both of these issues and staff hope that going forward the timeframes will be met as expected. Dr. Patillo spoke with the health services administrator and training for the nurses was completed.

**RECOMMENDATIONS (October 2016 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.***

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**COMPLIANCE RATING:** Substantial compliance

***FINDINGS (April 2016 Tour):***

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

***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.*

***FINDINGS (October 2016 Tour):***

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

A review of 15 sick call requests indicated appropriate triage for all but on case which was triaged as routine but because of the nature of the complaint should be triaged as urgent. However, the inmate was seen within an urgent timeframe as documented in the medical record.

***RECOMMENDATIONS (October 2016 Tour):*** None

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

**COMPLIANCE RATING:** Substantial Compliance

***FINDINGS (April 2016 Tour):***

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

***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.*

**FINDINGS (October 2016 Tour):**

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

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

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

**RECOMMENDATIONS (October 2016 Tour):**

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

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

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

**COMPLIANCE RATING:** Substantial Compliance

***FINDINGS (April 2016 Tour):***

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

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

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

***RECOMMENDATIONS (April 2016 Tour):***

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

***FINDINGS (October 2016 Tour):***

The jail has documented an increase in diverted medications in their special management minutes and developed a change in medication administration (calling inmates out one at a time to administer medications rather than dispensing through a pass through in the unit wall) to try and decrease this practice. We did discuss that this would be a good CQI study, measuring how often medications are discovered on the units, etc. to determine if this intervention is a sufficient remedy.

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

***RECOMMENDATIONS (October 2016 Tour):*** None

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

**COMPLIANCE RATING:** Substantial Compliance

***FINDINGS (April 2016 Tour):***

*No change from November 2015*

***RECOMMENDATIONS (April 2016 Tour):*** None

**FINDINGS (October 2016 Tour):**

No change.

**RECOMMENDATIONS (October 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 (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.*

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*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.*

**FINDINGS (October 2016 Tour):**

Inmates are tracked by a case list now. The data matrix indicated that weekly rounds are conducted in units 4G, 148/149 and 150 but there was a 25% drop in rounds during July and August when one staff member was out on maternity leave in July and another was on medical leave in August. Some elements of this provision are not currently tracked on the matrix.

Inmates on segregated mental health housing (4F) have their out of cell time tracked by the officer swiping an inmate specific card into the jail management system.

Inmates on the mental health caseload who might be moved to disciplinary segregation are instead placed on HD (psychiatric observation) until they can be assessed (within 24 hours) by a mental health professional who then makes housing recommendations if the inmate needs to be diverted from segregated housing for mental health purposes. Any such inmate who is placed in 4F is seen daily by the LPN, weekly by a QMHP and offered an out of cell contact. There are no inmates with an SMI in 4G (administrative segregation).

Inmates in mental health housing continue to be offered more than 10 hours a week of group activities. However, groups such as yoga, pet therapy and HIV groups fall into the current tracking figures. Groups not conducted by health/mental health professional staff should be tracked separately for a clearer picture of what services are being provided by the mental health staff.

Out of cell time for inmates in 4E meets general population guidelines and does not need to be tracked individually.

**RECOMMENDATIONS (October 2016 Tour):**

1. All elements of this provision should be tracked on the data matrix to provide a form of proof of practice.
2. Please be prepared to allow DOJ review of the out of cell logs at the time of the next site review.
3. Add critical elements of the policies to the matrix for a better view of when a process may

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not be working as it should. This is especially useful for high risk policies such as seclusion, restraint and suicide watch.

4. Tracking for mental health groups should be broken out into MH and health staff run groups vs. volunteer or non-health staff run activities.
5. Data of proof of practice for segregation/seclusion rounds, offering of out of cell contact, completed face to face out of cell interviews and the number of SMI inmate placements in 4G and 4H should be added to the matrix.

**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 (April 2016 Tour):**

*There has been no change since the last tour.*

**RECOMMENDATIONS (April 2016 Tour):** None

**FINDINGS (October 2016 Tour):**

Electric shavers are provided on all mental health units, observation units and the annex. Those inmates on the observation unit (suicide watch included) are supervised when out for showers.

As mentioned previously, medication administration practices have been improved throughout the jail to increase scrutiny of medication ingestion by inmates.

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

**RECOMMENDATIONS (October 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

**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

**FINDINGS (October 2016 Tour):**

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

**RECOMMENDATIONS (October 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:** Substantial Compliance

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

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*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.*

**FINDINGS (October 2016 Tour):**

There have been no deaths by suicide in 8 years. Inmates in suicide resistant cells receive suicide resistant blankets, mattresses and smocks. While on site we had several discussions concerning differentiating clinical seclusion from “Psych Eval.” MCJ staff prefer to use the latter term but this makes it difficult for them to track who is placed in HD by someone other than mental health staff and who is ordered to remain there under psychiatric observation or clinical seclusion. However, they are seeing everyone in this area per policy so this is more a data tracking issue than a clinical practice one.



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There has been no change in the actual supervision and clinical practices since our last tour. There was an uptick in the number of women placed in HSP in April and May 2016 when 5N was relocated to a maximum security dormitory (which the women did not like) while renovations were being done.

During May 2016 there was an increase in assaults (usually 0-1) to 10 attributed to a single aggressive inmate.

Staff is utilizing a suicide risk assessment template with an estimated risk entered by the QMHP.

**RECOMMENDATIONS (October 2016 Tour):** None

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

**COMPLIANCE RATING:** Substantial compliance

**FINDINGS (April 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

**FINDINGS (October 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 (October 2016 tour):** None

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

**COMPLIANCE RATING:** Substantial Compliance

**FINDINGS (April 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.*

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*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

**FINDINGS (October 2016 Tour):**

Discharge planning remains the same as that reported in April 2016.

**RECOMMENDATIONS (October 2016 tour):**

Please keep a list of all inmates released from jail who are on the mental health case list for the month of March, 2016 for review during the next site visit and any proof that the discharge plan was actually implemented.

**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 (April 2016 tour):** None

**FINDINGS (October 2016 Tour):**

Clinical encounters continue to be conducted in private and confidential locations. The facility has adequate space for this function.

**RECOMMENDATIONS (October 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.

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*(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.*

**FINDINGS (October 2016 Tour):**

The electronic health record is in place and available to all clinical staff. New Horizons retains the capacity to also access their community records for inmates previously followed in their system.

**RECOMMENDATIONS (October 2016 tour):** None

**SUGGESTION (October 2016):**

Other versions of this electronic medical record divide mental health encounters by discipline or type. The version at MCJ is cumbersome because one must open each and every mental health encounter to determine if it was a progress note, response to a sick call, prescriber encounter, etc. I would suggest CCS request a modification as described above.

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

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

**COMPLIANCE RATING:** Substantial Compliance

***FINDINGS (April 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.*

***FINDINGS (October 2016 Tour):***

A complex study regarding factors influencing suicidal statements has been undertaken and results are currently being tabulated by a statistician. The methodology for the study was presented and was sound. The sample size is everyone released from suicide watch in the month of September.

The prior study on timeliness of evaluation of inmates placed on “Psych Eval” was completed in May 2016 and the study was good but needs a follow up snapshot to monitor the interventions taken by staff.

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The Commander and 2 captains have also undertaken doing a “Problem of the Month” in June 2016 and have looked at clean walls and wrist bands. Presently they are reviewing medication pass.

MCJ has demonstrated their capacity to develop a CQI study, include useful and diverse project team membership and appropriate documentation of the CQI effort; therefore, the compliance rating is advanced to Substantial. However, MCJ will need to complete the following recommendations to sustain Substantial Compliance.

**RECOMMENDATIONS (October 2016 tour):**

1. Present pertinent Problem of the Month findings in the CQI Committee.
2. Repeat the timeliness to assessment study with a description of the follow up methodology and the results. If the results do not demonstrate improvement then a new set of interventions and subsequent follow up are needed to show adequate capacity to self-monitor systems.
3. Please provide the results of the suicide prevention study when available.
4. Complete at least 2 process and 2 outcome studies per year for mental health.

I am assigning a Compliance Rating of Substantial Compliance because the facility has demonstrated the capacity to carry out a reasonably well designed study. The feedback loop demonstrating improvement of interventions, and ongoing studies going forward must be demonstrated to sustain this rating.

Respectfully submitted this 21st day of December, 2016,



Roberta E. Stellman, MD