Introduction

During May 4-7, 2015, a review of the Muscogee County Jail (MCJ) was begun under the new Memorandum of Agreement (MOA) entered in January 2015. During the first two days, this reviewer met with the MCJ leadership team and reviewed all elements of the MOA while concomitantly discussing recommendations for improvement. Specifically, we reviewed submitted documents, policies, forms, and data collection in detail.

While on site, I had the opportunity to meet 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. **Jeri Johnson**, Administrative Lieutenant
4. **Jeremy Hattaway**, Deputy (Data Collection)
5. **Larry Mitchell**, Captain (Security)
6. **Gary Deperro**, Sergeant (Mental Health)
7. **Paul Morris**, Health Services Administrator, Correct Care Solutions (CCS) (MCJ's medical services vendor)
8. **Lucy Sheftall**, Assistant City Attorney

The primary goal of this initial site visit under a newly accepted MOA was to aid the facility in modifying policies forms, data entry tools and other materials in order to meet the exacting demands of the MOA. The hope, in this effort, is that the facility will be able to meet substantial compliance for the majority, if not all, of the provisions by the next monitoring cycle.

A pre-site request for documentation was submitted, and the facility did an excellent job in providing all the materials requested. (See Appendix 4)

Ms. Myrthil (Senior Trial Attorney, Special Litigation Section, USDOJ) and I received a tour of the housing units and treatment areas, including the special treatment units, mental health offices, suicide prevention areas, the annex, and segregation units. There have been no construction changes since the time of our last visit in 2012; however, mental health does have an additional office in the health clinic. The Jail continues to use specially trained officers on the mental health units with good success. Utilization of segregation cells has markedly decreased since the time of our last visit in 2012 due to changes in disciplinary practices on-site.

Staff were extremely helpful and responsive during our visit.

Compliance Assessment Methodology

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

a. **"Substantial Compliance"** indicates that Columbus has complied with all or most components of the relevant provision of the MOA and that no significant work remains to accomplish the goal of that provision.

b. **"Partial Compliance"** indicates that Columbus has complied with some components of the relevant provision of the MOA and that significant work remains to reach substantial compliance.

c. **"Noncompliance"** indicates that Columbus has not complied with most or all of the components of the relevant provision of the MOA and that significant work remains to reach partial compliance.

d. **"Unratable"** shall be used to assess compliance of a provision for which the factual circumstances triggering the provision's requirements have not yet arisen to allow for meaningful review. Provisions assessed as "unratable" shall not be held against Columbus in determining overall substantial compliance with this MOA in accordance with the termination procedures outlined below.

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

Instructions to the Reader:

- All text from the MOA provisions and the headings of Compliance Ratings, General 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. General 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.

- "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: Partial Compliance

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

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

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

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

American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) standards. It is strongly recommended that MCJ rely on the ACA and NCCHC standards and any Georgia State Jail standards as helpful guidelines in developing a mental health policy manual. Another excellent reference is the soon to be published third edition of the American Psychiatric Association's publication, Psychiatric Services in Jails and Prisons due out in July, 2015 (*Disclaimer, this reviewer is a co-author of this publication.).

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

GENERAL FINDINGS: Policy 1394, *Housing Inmates in Mental Health Units*, does describe a general approach to providing treatment and housing for the seriously mentally ill. However, there is no overall mental health policy provided describing the mission and goal of a comprehensive jail mental health program.

RECOMMENDATIONS: MCJ should develop a general policy on basic mental health services which would include a mission and goal statement.

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

GENERAL FINDINGS: There is no policy on the administrative structure of the mental health service.

RECOMMENDATIONS: MCJ should develop a policy outlining the administrative structure of the mental health service including definitions for each provider type as defined on pages 3, 4 and 5 of the MOA.

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

GENERAL FINDINGS: The MCJ policy manual lacks an administrative mental health policy which would require periodic staffing analyses.

RECOMMENDATIONS: MCJ should complete a detailed staffing analysis for submission prior to the next site visit and develop a policy requiring an annual review of the mental health services, both staffing and treatment needs.

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

GENERAL FINDINGS: While on-site, we were told that new mental health employees are getting the above specified training. Current employees have not yet received training in applicable security procedures.

RECOMMENDATIONS: MCJ should complete the training of all mental health employees regarding correctional or security procedures 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;**

GENERAL FINDINGS: MCJ provided the Core Elements of CIT by the University of Memphis, September 2007. An attendance roster for the most recent training was e-mailed by Deputy Hattaway while we were on-site as well as the spreadsheet sent prior to the site visit were reviewed. (See Appendices 1&2) The PowerPoint in Appendix 2 provided was comprehensive and presented in an interesting format. It was reported that all security staff on the special management units have received this training.

RECOMMENDATIONS:
Please provide a training record at the time of the next site visit which includes a breakout of the percentage of total staff by type (supervisors, officers, medical and mental health staff and specialty housing unit staff in particular) that has received the training in Appendix 2.

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

GENERAL FINDINGS: This provision was adequately covered in Appendix 2.

RECOMMENDATIONS: none at this time

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

GENERAL FINDINGS: We once again observed an excellent and collaborative relationship between security, mental health, and medical leadership. Policy 1452 on penalties for violations has decreased the penalty for major violations to loss of privileges for 7 days as opposed to 14. In addition, policy 1438 on disciplinary procedures has added the following paragraph, "Jail staff will collaborate with mental health staff when discipline is considered for an inmate that is classified as seriously mentally ill. The goal of that collaboration is to reach an appropriate level of discipline and accountability, based on the inmate's ability to comprehend and tolerate the discipline without negatively impacting their ability to receive and benefit from prescribed treatment." Combining both of these measures the jail has successfully decreased the number of people and disciplinary segregation from 30-40 to half a dozen. A form has been created that contains a signature stamp for the psychologist indicating verbal input into the disciplinary

process. In addition, mental health staff upon completing an initial referral will make recommendations as to appropriate housing to classification submitted on an internal form.

Policy 1138, *Inmate Classification System*, has clarified that mentally disordered inmates will be separated from the general population on the written order from a licensed mental health professional. This policy also specifies that mental health staff will be advised and will collaborate with custody staff regarding appropriate discipline for inmates who are classified as severely mentally ill.

Appendix 4, pp. 125–261 has a protocol for initial housing pending a mental health review by Lt. Johnson.

RECOMMENDATIONS: A process should be developed whereby the reviewing mental health professional receives a copy of the incident report and then performs a timely chart and a face to face review of the seriously mentally ill inmate assessing for the presence of mitigating factors. The input into the disciplinary process form should be enhanced to allow for a documented description by the evaluating mental health person regarding what mitigating factors may exist and other comments that can be utilized by the disciplinary officer in making a decision regarding sanctions. The form should also include documentation as to whether the sanctions were modified based on input from the mental health professional. These forms can then be tallied as part of the quality improvement process to determine the frequency with which input from the mental health professional has resulted in a modification of the disciplinary sanction. A sample policy and form were provided on site to assist in this process.

It is further recommended that the policy and procedure incorporate the elements in Lt. Johnson's protocol for the initial housing of inmates at the start of the disciplinary process.

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

GENERAL FINDINGS: The mental health service created a list of inmates identified as seriously mentally ill off of the daily psychiatric log tracks 6 to 8 months ago. However, this practice is not detailed in the form of a policy. Dr. Patillo informed me that any inmate who has been housed on the specialized mental health lists will always remain on the SMI list regardless of functional capacity. In addition, any inmate who has been placed on the SMI list will always remain on that list regardless of functional capacity. The list provided lists 34 inmates as identified as SMI. 261 inmates are on psychotropic medication. Therefore, 13% of the psychiatric case list has an SMI. (See Appendices 13 & 14)

RECOMMENDATIONS: MCJ should develop a policy defining "seriously mentally ill" based on the definition in the MOA as well as additional qualifications provided by the mental health professionals. The current process of maintaining an ongoing list of inmates classified as SMI should be be continued and updated weekly to ensure accurate identification of these individuals,

particularly when security issues, such as possible disciplinary actions or planned use of force, are at plan.

SUGGESTIONS: Despite the fact that the MOA does not specify specific diagnostic categories, it is recommended that MCJ consider the addition of chronic persistent disorders known to be biologically based as serious mental illnesses. Examples of such conditions are illnesses such as, paranoid schizophrenia, schizoaffective disorder, bipolar affective disorders which are well known to result in serious decompensations under stress, physical illness, noncompliance with medication, etc. and carry an elevated lifetime risk of suicide.

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

GENERAL FINDINGS: MCJ does not have a policy or forms specific to this provision. However, MCJ clearly has a practice of not placing seriously mentally ill inmates in disciplinary segregation, but rather, retaining them on special mental health units. These inmates may be held in cell restriction.

RECOMMENDATIONS: MCJ should have a policy that not only describes the diversion of SMI inmates away from disciplinary segregation but also specifies the detailed practice of cell restriction on a mental health unit. This process is frequently referred to as a behavior management plan and usually is detailed on a form, similar to a treatment plan form, that would specify property, privilege, and out of cell restrictions as well as the anticipated duration of the plan. Please refer to the following link for one example of a policy and form: http://cd.nm.gov/policies/docs/CD-180300.pdf

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;**

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

RECOMMENDATIONS: Treatment on specialized mental health units should be defined regarding frequency and the nature of documentation. The current policy does outline the minimum requirement for group activities provided by mental health counselors. The policy should also specify the minimum frequency with which inmates on these units receive psychiatric review and access to individual mental health professional counseling (examples of such requirements are contained in the sample policies given to the facility with an excerpt in Appendix 3). Minimum documentation requirements for all activities on these units should be specified within the policy.

k. **treatment planning;**

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

RECOMMENDATIONS: A copy of the treatment plan form was reviewed on site and recommendations were made to modify the form better reflect measurable holes and objectives, the nature of the treatment provided, and the staff member accountable for delivering the service.

l. **sick call, including**

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

GENERAL FINDINGS: All housing areas within the jail are equipped with kiosks allowing the inmates to make electronic requests to medical and mental health. The inmates we spoke with on multiple units were aware of how to use the kiosks to access mental health services. However, inmates repeatedly told us that their fear of being charged limited their utilization of this system.

On May 19, 2015, Commander Collins emailed a directive that stated, "The MCJ will no longer charge a co-pay for Mental Health Treatment. This is effective immediately. Please discontinue any charges that are pending but have not yet posted to an inmate's account."

RECOMMENDATIONS: None

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

GENERAL FINDINGS: Policy 1392, Mental Health Services, does address a time frame by which referrals are resolved. However, I did not receive the policy specific to the triaging and resolution of sick call requests by inmates unless that policy is #1406 which is inadequate partly because it fails to identify what level of health professional completes the triage and the timeframes for resolution of the various levels of clinical urgency.

RECOMMENDATIONS:

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

GENERAL FINDINGS: Please see Provision 1.l.ii. above and Provision 8 (Mental Health Sick Call) below. We were told on-site that mental health sick call requests are triaged Monday through Friday by a mental health professional.

RECOMMENDATIONS: While on site we discussed a process for triaging mental health sick call requests received after hours and on weekends so that any urgent and emergent request can be identified in a timely manner and the on-call mental health provider can be notified if they are

not on-site. This process will need to be detailed in a mental health policy. If the general sick call policy does not specifically address how mental health requests are handled then it is recommended that MCJ developed a separate mental health sick call policy.

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

GENERAL FINDINGS: See above discussion of sick call.

RECOMMENDATIONS: Please provide the sick call policy.

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

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

RECOMMENDATIONS: none

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

GENERAL FINDINGS: Each sick call request and its response are logged into the electronic medical record.

RECOMMENDATIONS: none

m. **suicide prevention and treatment;**

GENERAL FINDINGS: This essential policy needs revision.

RECOMMENDATIONS: Areas for revision at a minimum include the following:

1. Training needs to specify the number of hours for new hires.
2. Identification does not specify the timeframe in which an inmate is placed on High Suicide Precautions (which should be defined) and what level of precautions they are maintained at until evaluated by a mental health staff.
    a. The policy does not define what level of training the mental health staff member must have to evaluate the inmate. Follow up is done by a licensed mental health provider and it is recommended this should be the same minimum level of training necessary to perform the initial risk assessment.
    b. Referral - The policy does not set a minimum timeframe within which the mental health staff must complete their assessment.

3. Evaluation – The risk assessment tool does not have a determination of the level of suicide risk, generally high, medium, low, and none.
4. The policy does not specify criteria for different levels of observation.
5. Treatment - There is no provision for a treatment plan or treatment other than isolation and observation.
6. Monitoring – The policy should specify who does the monitoring (constant v. staggered 15 minute).
7. Intervention should describe who is the first responder and how do they communicate with security or medical for assistance.
8. Reporting – Recommended documentation should be defined in policy. Currently inmates on High Suicide Precautions have daily documentation which too often has absolutely no narrative description of the inmate or their progress. The current progress note is simply a checklist for a mental status exam with no requirements that further information be added.

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

GENERAL FINDINGS: No policy on use of psychotropic medication, verification, continuity and non-compliance was submitted for review.

RECOMMENDATIONS: Please forward the policy for review and comment. The policy should include how a prescribing clinician is notified for orders, who transcribes the orders, how are issues of medication non-compliance defined and communicated with the treating clinician, etc.

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

GENERAL FINDINGS: MCJ uses the restraint chair as the only form of psychiatric restraint.

RECOMMENDATIONS: The policy should state what happens if there is no improvement after 6 hours.

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

GENERAL FINDINGS: No policy was submitted, only the refusal form.

RECOMMENDATIONS: Please submit a policy that addresses this provision for review and comment.

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

GENERAL FINDINGS: No policy was submitted that addresses discharge planning.

RECOMMENDATIONS: Please submit a policy that addresses this provision for review and comment.

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

GENERAL FINDINGS: No policy was submitted that addresses discharge planning.

RECOMMENDATIONS: Please submit a policy that addresses this provision for review and comment.

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

GENERAL FINDINGS: No policy was submitted that addresses discharge planning.

RECOMMENDATIONS: Please submit a policy that addresses this provision for review and comment.

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: Partial Compliance

GENERAL FINDINGS: Currently New Horizons is searching for a nurse practitioner. Since April 2015, Sai Nandamuru, MD (Dr. Nan) has been taking all of the after-hours call and providing all the psychiatric medication monitoring.

The jail did submit a copy of the MCJ Hybrid Staffing Matrix.

The mental health staff consists of the following:

1. 2 FTE QMHP (One is primarily assigned to the female mental health unit and assists with intakes, referrals and crisis calls. The other two MHP's assess new intakes and respond to all kiosk requests, and suicide watches and follow up.)
2. 1 FTE MHP (this person provides programming to the two male mental health units and also helps with crisis calls.)

3. 1 mental health technician
4. 0.5 FTE psychologist (Dr. Patillo, Mental Health Director)
5. New Horizons also has some students who provide assistance. Currently two students are providing one day per week each, and both are PhD candidates. One is scheduled to leave the jail at the end of May 2015. A third student as a Master level student who is currently at the jail two days per week.
6. Dr. Nandamuru provides .35 FTE of psychiatry time 2 evenings a week, and a NP position covers an additional partial FTE time (the latter position is currently vacant) for a total combined time of 30 hours per week.

In addition to three specialized mental health units (See MOA 12 Housing) there are programming units, primarily under the direction of the jail chaplain, in the North tower consisting of a fatherhood dorm (parenting skills), a faith-based substance-abuse program, and a United States veterans unit.

Clinic space consists of three interviewing offices in the medical clinic and attorney visiting offices and program rooms which are available on every floor of the south tower. The North tower does not have program rooms. However, sick call is often done in the hallway space between the inmate units and the officers' security bubble and with an officer present. Any services that require the inmate to disrobe are performed in a private setting. Intake screening is performed in a two-person office with a partial wall that separates the two screening areas to create some privacy for the inmates.

New Horizons is developing a discharge planning form and a sample form was shared with them. Lt. Johnson has been working on adding a community resources tab to the inmate handbook on the kiosks. We did have a discussion on what areas would be useful once the kiosk has been updated. Mental health services for the general population remains limited.

19 medical records were reviewed (not in their entirety) and revealed the following:

1. Initial psychological evaluations appear to be fairly descriptive and complete.
2. Psychiatric progress notes are almost uniformly selections in checkbox options on the medical record template and lack any narrative description or formulation supporting a diagnosis. A common complaint among inmates interviewed who were currently being followed for psychiatric medications was that there psychiatric visits were extremely brief. The quality of the documentation in the medical record would appear to substantiate the inmate's claims. It is recognized that MCJ is down a partial FTE MENTAL HEALTH provider and this may account for the brevity in the documentation.
3. Intake screening forms were generally complete.

An after hour call schedule was provided.

RECOMMENDATIONS: Most national standards recommend an annual review that would enable the leadership of the facility to determine whether the staffing is adequate to meet the existing tasks required by the service. We were provided with a list of full-time employee positions at the facility. Elements of the staffing analysis, at a minimum, should include the following:

1. data detailing each function (annual numbers of intake and referral comprehensive assessments, follow-up counseling visits, suicide prevention and close observation daily encounters, group programming hours, etc.)
2. an expectation of a reasonable average amount of time required to competently perform each clinical and administrative function including adequate documentation
3. a calculation of the total number of hours required to complete the above functions
4. a calculation of the total number of necessary staff positions, including a relief factor for vacation, CME, and sick call absences

In regards to the delivery of general mental health services it is recommended:

1. Whenever possible, all face-to-face clinical encounters other than rounds should be performed in the sound private environment. Doors should remain open only when security or clinical staffs suspect that there is a safety risk for that individual or group encounter. It is not a violation of privacy for specially trained officers to be in attendance cheering group therapies on the specialized mental health unit but in general officers should not be present inside of the room during group services offered on general population units.
2. New Horizons should maintain an updated case list of all inmates followed by psychiatry. The case should include the medical record number, inmate's full name, and date of birth, housing location, last psychiatric visit, next psychiatric visit, and whether the inmate has the designation of SMI.
3. New Horizons should also maintain an active list of all inmates who were being followed by mental health counselors regardless of whether they are on medications or not. Such a list should also reflect time frames of the required treatment plan updates and follow-up services.
4. The kiosk should have information on community resources including housing/shelters, mental health outpatient and inpatient clinics, obtaining benefits such as SSRI/SSD, health insurance, and food stamps, jobs training resources, faith-based supports and parenting resources, and general medical clinics.
5. Appendix 9 contains suggested documentation guidelines which may be of assistance in improving the quality of the medical record documentation. In the future the adequacy of documentation will be assessed based on whether a diagnosis and treatment is substantiated by the documentation of DSM 5 criteria. Laboratory guidelines are a suggestion and may be modified based on current professional recommendations (this document was originally generated in 2010).
6. Private office space is deemed sufficient for the services provided and staff size.

SUGGESTIONS: The National Institute of Corrections (NICIC.gov) will assess correctional facilities in developing staffing plans and may be a good resource for MCJ in meeting this requirement.

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: Partial Compliance

GENERAL FINDINGS: MCJ currently has a 0.35 FTE psychiatrist who is the only prescribing practitioner which fall short of the minimum of 30 hours of service per week requirement. Prior to April there was also a nurse practitioner on-site but she has relocated. New Horizons will try and get a locum tenens between now and July at which time they have a candidate for a full-time position that they are hoping to hire. Licenses were provided where applicable by email and all were current.

RECOMMENDATIONS: See A.1.c.

SUGGESTIONS: See A.1.c.

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

GENERAL FINDINGS: Dr. Patillo continues to maintain an excellent working relationship with Commander Collins and the supervising officers overseeing disciplinary segregation and all specialized mental health housing units including High Suicide Precautions. She also sits on the Quality Assurance Committee and the Weekly Special Management Meeting. Dr. Patillo remains in regular contact with Dr. Nan, who works evenings and also schedules an MHP/QMHP to work at least two evenings a week so that Dr. Nan can remain better contact with the service.

During this visit we were unable, due to time constraints secondary to a detailed review of the MOA, tour of the facility, and inmate interviews, to meet with the mental health staff. Such a meeting will be scheduled during the next site visit.

RECOMMENDATIONS: Continue a process that seems to be working well.

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: Partial Compliance

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

RECOMMENDATIONS: Item A.5.d. and a.5.k. are not specifically addressed by the receiving screen and should be included to meet the requirements of the MOA.

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. **<u>Emergent/Urgent Referrals</u>: These referrals will be held in the clinic or HD area and a mental health assessment shall be provided by a qualified mental health professional for each inmate within 4 hours if during normal business hours, but no later than within 24 hours if outside of normal business hours, after the following triggering events:**

        i. **signs and symptoms of acute mental illness;**

        ii. **disorientation/confusion;**

        iii. **jail history of placement on mental health units;**

        iv. **inability to respond to basic requests or give basic information;**

        v. **recent suicide attempt; and**

        vi. **inmates who report any suicidal ideation or intent, or who attempt to harm themselves, or the arresting officer indicates threats or attempts to harm themselves, or who are so psychotic they are at imminent risk of harming themselves.**

COMPLIANCE RATING: Partial compliance

GENERAL FINDINGS: In April 2015, MCJ began using an electronic medical record developed by CCS, called ERMA (Electronic Record Management Application). The template for the initial mental health evaluation in the electronic record covers all of the required elements of the MOA except for a specific prompt for jail history of placement on mental health units. The screening tool prompts for history of psychiatric hospitalization or outpatient mental health treatment.

Current data concerning the percentage of intake screening within four hours but no later than 24 hours was not provided by the facility. It is my understanding that the electronic health record does have the capacity to generate specific reports that would provide this data.

RECOMMENDATIONS:

1. A specific prompt can be added to the MCJ screening tool in order to meet this specific requirement of the MOA. It is recommended that a request be made of the CCS IT department by MCJ to modify the template for the receiving screening mental health form for this site.
2. MCJ should promptly collect data that would generate an absolute number and percentage of inmates who are screened within four hours as well as those who are

screened within 24 hours when booked after normal business hours. Several months' worth of this information should be provided prior to the next site visit.

b. **<u>Routine Referrals</u>: 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: Non-Compliance

GENERAL FINDINGS: Data demonstrating compliance with the specific elements of this provision was not of available for review. The facility does track timeliness regarding emergent and urgent referrals, but as yet, has not developed a tracking tool or a screening instrument with the specific details of this MOA requirement.

RECOMMENDATIONS: In order to obtain data in the most efficient fashion possible for every element in this MOA requirement, the facility will need to ensure that each specific prompt is contained in the various forms within the electronic health record so that at least quarterly reports can easily be generated to track compliance.

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: Non Compliance

GENERAL FINDINGS: Data specific to this requirement was not available.

RECOMMENDATIONS:

1. Develop a method to prove compliance through data collection.

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: Partial Compliance

GENERAL FINDINGS: The electronic health record contains prompts to all of the specific elements of the MOA except for 6. seizures and sex offenses.

RECOMMENDATIONS: In order to obtain data in the most efficient fashion possible for every element in this MOA requirement, the facility will need to ensure that each specific prompt is contained in the various forms within the electronic health record so that at least quarterly reports can easily be generated from ERMA to track compliance.

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

    a. **An inmate designated "Emergent/Urgent Referral" will be held in the clinic or HD area where they can be directly observed and supervised and be seen for assessment or treatment by a qualified mental health professional within 4 hours if during normal business hours, and within 24 hours if outside of normal business hours. The on-call qualified mental health professional must be notified within one hour of an Emergent Referral and advise with regard to course of treatment, housing, observation, medication, property restriction, and other appropriate care. Emergent Referrals will remain in the clinic/HD until seen and cleared by a qualified mental health professional. Triggering events for emergent/urgent referrals shall include the following:**

        i. **increase or emergence of psychotic symptoms;**

        ii. **inability to care for self appropriately;**

        iii. **signs and symptoms of acute mental illness;**

        iv. **disorientation/confusion; and**

        v. **inability to respond to basic requests or give basic information.**

    b. **An inmate designated as a "Routine Referral" will be seen for assessment or treatment by a qualified mental health professional within 5 business days, and a psychiatrist, when clinically indicated (e.g., for medication and/or diagnosis assessment). Routine referrals may include individuals who previously refused mental health treatment or medication or exhibit concerning but not emergent increases in symptoms, or raise concerns about medication compliance. The written policies and procedures governing referrals will include criteria for determining if a referral is not subject to this timeline requirement (e.g., a face-to-face contact is not clinically indicated).**

COMPLIANCE RATING: Partial Compliance

GENERAL FINDINGS: MCJ policy requires all emergent/urgent referrals from intake be held in the HD area until evaluated by a mental health professional. Data demonstrating compliance with the requirement that an inmate be placed in HD was not presented for review.

RECOMMENDATIONS: MCJ should provide data tracking the number of people referred, by policy, for placement in HD as emergent/ urgent referrals and compare this to the time

evaluated by mental health professional. A similar tracking of routine referrals should also be demonstrated in a database.

SUGGESTIONS: A copyrighted data matrix developed by this reviewer for large metropolitan jail (see Appendix 6) was given to MCJ. MCJ has my full permission to modify this tool in any way the facility sees fit should it aid them in being able to develop an instrument that will allow them to better monitor the essential processes such as intake, initial assessments, suicide watch, clinical seclusion, use of restraints, special mental health unit programming, response to sick call requests, etc. An accompanying medical matrix is included as Appendix 7 and a power point on use of the matrices as Appendix 8. Both these tools are also useful in preparing for a staffing analysis.

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 <u>emergent/urgent</u> 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 <u>routine</u> 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: Partial compliance

GENERAL FINDINGS: New Horizons does track and presented data regarding timeliness of response to urgent/emergent versus routine referrals. However the reliability of these numbers is questionable based on a review done on site. With the aid of Dr. Patillo and Deputy Hattaway I reviewed 41 kiosk referrals for the last week of April 2015. Of those requests nine were not handled adequately. 3/9 (~10%) should have been triaged as urgent but rather were handled in a routine fashion and one was never seen at all.

Another trend that was identified appeared to be a significant issue regarding access. For example, one the inmate requested treatment from New Horizons and received the response, "at this time you don't qualify for mental health services." with no explanation to the inmate or an accompanying progress note explaining why services would be denied. Another inmate requested help with his drinking and reported hearing bells and was told to see New Horizons when he was released. That inmate was never seen in evaluated by mental health despite the report of possible auditory hallucinations. A third inmate requested to speak with the psychologist about their mental illness and received a response that the doctor at MCJ does not prescribe medications for sleep. Another inmate requested to be seen for PTSD and was told the doctor does not prescribe medications for sleep and was not seen.

On a positive note, inmates received responses that they would be seen soon by the doctor and in several cases they were seen within 24 hours.

Currently charges for sick call are determined by a single QMHP who reviews the daily kiosk requests. As mentioned previously, MCJ will no longer charge inmates for mental health sick call.

RECOMMENDATIONS: Self-referrals remain a major avenue of access for incarcerated individuals. This is especially true for jails where detainees have a greater amount of uncertainty in their daily lives and live with a higher level of stress. In a jail setting much of the mental health staff time can be spent in responding to the large number of sick call requests from the inmate population and completing initial assessments. While on site inmates on non-mental health units were interviewed and consistently reported problems regarding access. 11 inmates on 4D, 10 inmates on 4 C4 inmates on 4G were interviewed. Some of the complaints concerning responses to kiosk requests were verified by electronic medical record review and included being charged for mental health sick calls without actually receiving the service and being seen and referred for counseling but never actually receiving the service.

1. It is recommended that MCJ design and quality improvement studying monitor the call process. Such a study should include parameters, or quality indicators, that would aid in determining whether the process is effective.
2. Given a high number of inadequate responses in a one-week review of kiosk requests, I would further recommended that criteria for triaging and completing a face-to-face assessment be developed, trained to and implemented. Then follow up through peer and supervisory review should demonstrate the effectiveness of the implementation.
3. The jail should anticipate that improving access to sick call and follow-up treatment will result in an appropriate higher utilization of mental health services requiring a staffing analysis review.
4. Currently New Horizons tracks all referrals including sick calls on a data cell. It is recommended that referrals from intake versus staff versus sick call requests should be logged separately to improve the specificity of data collection.

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: Partial Compliance

GENERAL FINDINGS: New Horizons does utilize a treatment planning form and by policy specifies the frequency with which these are completed. While on site we reviewed the form and suggestions were made for modifications.

RECOMMENDATIONS:

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

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

a. **ensuring that initial doses of prescribed medications are delivered to inmates within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner;**

b. **ensuring that inmates entering the Jail continue to receive previously prescribed medications or acceptable alternate medications, within 48 hours of entry, unless the facility physician makes an alternative clinical judgment;**

c. **ensuring that medical staff who administer medications to inmates document in the inmate's Medical Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, and (3) the date and time for any refusal of medication; and**

d. **ensuring that the inmate's unified health record is updated within one week of the end of each month to include a copy of the inmate's Medical Administration Record for that month.**

COMPLIANCE RATING: Partial Compliance

GENERAL FINDINGS:

Examination of a variety of medical records while on-site demonstrated the presence of current and past medical administration records in the electronic medical record. Inmate screening positive for medications signed consent form with the nurse for treatment and a release of information. The release is then sent to the doctor and pharmacy for confirmation of the medication. If the psychiatric provider is on site the inmate will be seen that day or a verbal order will be issued by the doctor to continue medications.

RECOMMENDATIONS:

1. MCJ will be expected to provide proof from the electronic medical record of compliance with the components of this provision prior to each site visit.

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

COMPLIANCE RATING: Partial Compliance

GENERAL FINDINGS: MCJ does have an agreement with a local hospital for medical treatment of its inmates. Inmates in need of acute psychiatric hospitalization can be referred to public forensic facilities but as with most jails, this is a difficult and often fruitless process.

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

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

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

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: Partial Compliance

GENERAL FINDINGS: MCJ has several specialized housing units delivering programming to seriously mentally ill inmates. Women are housed on the general population unit (419N) and can be placed on room restriction if they demonstrate assaultive behavior. There currently is no female disciplinary segregation unit in the jail. When on cell restriction the officer will document checks in the security log and allow inmates out a minimum of one hour a day for general population females and two hours a day for women housed on 419 N. The jail maintains an SMI list generated by New Horizons. Inmates on that list will not go to disciplinary segregation but rather will be placed in an HD cell until seen by mental health, which occurs within 24 hours. By practice, inmates on a mental health unit will not be moved but rather placed on cell restriction or some other sanction until assessed by a mental health professional, and there is input into the time limits on the restriction by that provider (usually 24-48 hours).

There are two male units for seriously mentally ill inmates, 4F which houses more behaviorally symptomatic inmates and for E which is comparable to a residential treatment population.

Programming on the three specialty mental health unit has been averaging approximately 6 to 7 groups per week and therefore do not meet the requirement for substantial compliance (a minimum of 10 hours) under this provision. Inmates report they are receiving two groups per day. However, tracking information provided by the jail indicated the following:

Actual/expected	1/2015	2/2015	3/2015
4F	13/45	28/45	24/45
4E	30/44	30/44	29/44
419	22/48	24/48	28/48

Staff are trying to tighten the specificity of the group schedule and also are exploring additional options for creating other types of structured therapeutic activities. Inmates on these units are seen at least monthly by a psychiatric clinician and receive discharge and treatment planning from the mental health counselors. The jail also recently implemented psychiatric follow-up for SMI in general population on a monthly basis. The mental health professional documents progress notes on every individual attending group therapy.

The use of disciplinary segregation has dropped dramatically in jail for all classifications of inmates and MCJ is commended for this achievement. We were told that there were no inmates in segregation who had an SMI. However when we rounded in the segregation unit one inmate on the mental health caseload, had a documented diagnosis of a major chronic persistent affective disorder but was not deemed to have a serious mental illness because his functional capacity was assessed as being good. He did have a history of being in a restraint chair for six hours and easily became agitated just in conversation with this reviewer. He reported he does not ask to speak with the mental health doctor because he will be charged.

RECOMMENDATIONS:

1. To achieve a rating of substantial compliance the jail will need to demonstrate reliability in its ability to deliver the expected number of structured therapeutic activities on a special mental health housing units.
2. Enhance the definition of SMI to include major chronic persistent mental illnesses, as Dr. Patillo and I discussed during the tour.
3. The policy should codify the practice of using cell restriction on the mental health units and specify the maximum amount of time this practice may be utilized, in accordance with the limitations set forth in the MOA. It is suggested that if the inmate requires restriction beyond 48 hours that there be the consideration of ordering clinical seclusion rather than indefinite segregation, and documented consideration for transfer to a higher level of care at another facility, if necessary and available. The policy should also specify the amount of unstructured time out of cell offered to these inmates, equal to or greater than 10 hours per week, as set forth in Sections 12.g and 12.k of the MOA.

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: Partial compliance

GENERAL FINDINGS: During the course of our tour medication administration was observed for several housing units. Neither the nurse nor the correctional officer completed mouth checks. In one instance an inmate was observed to break up the pills, stick out his tongue with pill fragments on the tip of his tongue and then was allowed to walk away from the administration area without evidence of actually swallowing the pills.

MCJ does have a policy on safe shaving and tracking forms used by the officers.

No reports of use of force were produced for review.

RECOMMENDATIONS:

1. In-service training updates with medical and correctional staff regarding proper technique and consistency in performing mouse tracks should be performed and proof of practice should be demonstrated at the time of the next site visit via training sign in sheets and/or distributed directives.
2. Please provide use of force data tailored to respond to the elements of the MOA prior to the next site visit. If data is produced for the 6 months prior to the tour and review of the supporting documentation (incident reports, etc.) establishes good practices per the MOA then a compliance rating of substantial compliance can be assigned.

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: Partial Compliance

GENERAL FINDINGS: Currently security supervisors do consult with Dr. Patillo regarding imposition of disciplinary sanctions for those inmates on the SMI list. However, a rating of partial compliance can only be given at this time since there needs to be some modification in the policy and practice as well as the development of an interdisciplinary form. The reason that a form is essential is because it will enable the jail to do quality improvement reviews to ensure that this process works consistently, appropriately, and effectively.

RECOMMENDATIONS: MCJ will continue to modify the policy and develop an input into the disciplinary process form. A sample policy was provided for guidance.

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 a qualified mental health care professional within 4 hours of being placed on suicide precautions or crisis level care if during normal business hours, or within 24 hours if outside of normal business hours. The on-call qualified mental health professional must be notified within one hour of being placed on suicide precautions or crisis level care and advise with regard to course of treatment, housing, observation, medication, property restriction, and other appropriate care.**

g. **Jail Staff shall develop and implement an adequate system whereby inmates, upon evaluation and determination by a qualified mental health professional, may, where clinically appropriate, be released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precautions. Step-down placements should continue to be suicide-resistant and located in such a way as to provide full visibility to staff. Jail Staff shall ensure that inmates are placed on a level of observation that is not unduly restrictive.**

h. **Inmates on suicide precautions shall be provided out-of-cell time for clinically appropriate structured activities and showers.**

i. **Qualified mental health staff shall assess and interact with (not just observe) inmates on suicide precautions on a daily basis and shall provide adequate treatment to such inmates.**

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

COMPLIANCE RATING: Partial Compliance

GENERAL FINDINGS: Inmates on suicide precautions and close observation are housed in HD which currently has 12 inmates. A member of the nursing staff is assigned to this area and that staff person completes the staggered 15 min. watches. Whenever constant observation is required we were told that an officer sits at the door. They have not utilized constant observation more than 2 to 3 times per year. There have been no suicides.

Length of stay for suicide watch is quite brief averaging less than two days, and the use of the restraint chair is uncommon and brief. However, there is one inmate who has been housed on High Suicide Precautions for months at a time and has 5 volumes of paper charts with page after page of daily suicide check progress notes with almost no narrative description of his progress. Staff have provided him with individual psychotherapy, but his therapist left quite some time ago. While on site I did interview the man with Dr. Patillo present. We did discuss options to management including developing a behavioral management plan and disclaimer of risk due to his life-long history of self-injury. Both actions might enable moving him to a programming unit rather than essentially isolating him in HD.

We also inspected 2 cells on 4G (Disciplinary Segregation) that were suicide resistant. These cells are equipped with only a combination sink/commode. Neither was occupied.

RECOMMENDATIONS: The current practices are effective. The primary reason for a rating of partial compliance is due to the need to add a suicide risk rating to the daily progress notes and improved tracking of follow up care and treatment planning upon release as well as more effective programs for managing high risk but not acutely suicidal inmates.

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: Partial compliance

GENERAL FINDINGS: We were made aware of one serious suicide attempt within the last year, yet there was no report of a Morbidity and Mortality ("M&M") process.

RECOMMENDATIONS: MCJ should develop an M&M committee to review all aspects of the case (security, medical, mental health, etc.) to develop a facility corrective action plan and track the completion and maintenance of each element of the plan. The committee should consider an annual meeting as well to review the outcome of all morbidities and mortalities and determine if there are trends. For example, if a fair number of emergency room send outs are due to psychotropic overdoses, then medication administration and possible diversion might be studied as a Continuous Quality Improvement project.

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: Partial Compliance

GENERAL FINDINGS: As previously discussed, discharge planning materials will be added to the kiosk. Most inmates follow up with New Horizons upon release.

RECOMMENDATIONS: Complete additions to the Kiosk system

Suggestions: Since New Horizons is the primary provider of in-jail and community treatment, it would be possible to conduct a review to determine what percentage of released inmates actually follow up on their discharge plans to enable to providers at the jail to monitor the effectiveness of discharge planning and attempt changes in the process to make it more successful in decreasing recidivism and relapse.

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: Partial Compliance

GENERAL FINDINGS: Access to the medical records is restricted to clinical personnel. Officers' training in mental health does cover the elements of this provision. Issues around lack of sound privacy were discusses in an earlier section

RECOMMENDATIONS: Brief encounters such as sick call, etc. still should be conducted in sound private settings and officers should be in ear shot only if there are documented safety risks.

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

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

New Horizons is using the medical vendor's electronic health record. It is noted that many of the entries reviewed did not have adequate narrative entries, but rather, relied almost solely on the check boxes provided by the electronic form.

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

These guidelines represent minimal requirements for documentation of clinical encounters.

GUIDELINES APPLICABLE TO ALL MEDICAL RECORD ENTRIES:

1. All entries shall be legible
2. Each entry shall list the inmate's name and MDC number
3. Each entry shall be signed by the clinician and indicate their professional degree
4. All entries shall be dated and timed
5. Current housing location, such as special housing or isolation, should be apparent by reading the chart.
6. Every assessment and clinical visit notation shall follow the SOAP format (unless the documentation is on a required template that is structured differently) and make every effort to provide the narrative information necessary for another clinician to understand the writer's assessment.

THE INITIAL ASSESSMENTS:

SUBJECTIVE/ OBJECTIVE:

1. The subjective portion of the entry shall contain critical elements required by the DSM (current version) to support the differential diagnosis and global assessment of function.
2. Past history will note pertinent findings such as prior hospitalizations, commitments, periods of outpatient psychiatric treatment and substance abuse treatment, any episodes a self-injury, suicidal ideation are intent and/or significant aggression. In addition, a history of victimization or perpetration of abuse should be noted. Significant medical illnesses and history of traumatic brain injury should be listed.
3. Inquiry into previous work history, military history, prior incarceration, and other significant psychosocial information should be provided.

4. Family history should include any history of psychiatric or substance abuse disorders as well as suicidal behavior in close family members.
5. Substance abuse history including current use and previous symptoms when withdrawing should be entered in the chart.
6. Current medications as well as response to prior treatment regimens should be listed.
7. The mental status examination will contain appropriate corroboration in a narrative form to the symptom checklist. Thus, should the clinician check a box indicating hallucinations, it is appropriate to describe the content and nature of the reported symptom.

ASSESSMENT:

8. All assessments completed by psychiatrists, independently licensed mental health professionals, or nurse practitioners shall contain a full five axis diagnosis based on the American Psychiatric Association's DSM (current version) unless a template form does not require this information.

PLAN:

9. The plan will include medications (or referral for a medication evaluation) if indicated. Referrals for appropriate psychosocial interventions, comments on discharge planning, and a follow-up for general health needs will also be indicated in the plan. In addition, a risk assessment, if indicated, as well as the clinician's professional opinion as to the degree of risk will be entered. All records will indicate the date (or approximate date (e.g., return in 3 weeks) of the next clinically appropriate follow-up visit. Medical practitioners will indicate laboratory studies, obtain and file the appropriate consent forms, and perform clinically appropriate tests such as the AIMS and the MMSE.

10. Primary Axis I and Axis II diagnoses should be entered on the master problem list by psychiatrists, psychologists and advance practice nurses. Other disciplines may initially list the symptom deficits such as cognitive deficits and thereafter defer to the diagnosis provided by the above specified disciplines.

<u>THE PSYCHIATRIC PROGRESS NOTE:</u>

SUBJECTIVE/OBJECTIVE:

1. Comments should be entered concerning any reports of side effects or relevant clinical symptoms presented by the patient.
2. The clinician should comment on any recent PAC admissions, or transfers to segregation and the impact of those status changes as reported by the inmate.
3. The clinician should indicate the clinical response by the patient to the current treatment plan and the presence of medication side effects.
4. Significant additions and deletions in diagnostic categories should be substantiated by DSM (current version) criteria recorded in the subjective portion of the note.
5. The reasons prompting significant changes in medications or the patient's treatment plan should be explained by history or findings

ASSESSMENT:

6. Provide an assessment pertinent to the data documented.

PLAN:

7. The appointment designated as the return to clinic time should be clinically appropriate.
8. Laboratory studies should be ordered as clinically appropriate.
9. Any planned interventions are documented

<u>THE INDIVIDUALIZED TREATMENT PLAN:</u>

1. Treatment plans should follow a problem-oriented format.
2. Problems listed should be descriptive and meaningful with measurable goals.

3. The plan should indicate time frames to complete the above goals.
4. Planned interventions are documented
5. A date of the scheduled review of the individual treatment plan will be listed on the chart.
6. All members of the treatment team in attendance shall sign the treatment plan and indicate their professional degree.
7. A notation by the team will also indicate progress made towards previous goals.
8. The patient shall also sign the treatment plan indicating participation and awareness of the established goals.

THE GENERAL POPULATION AND SEGREGATION MENTAL HEALTH PROGRESS NOTE:

SUBJECTIVE/OBJECTIVE:

1. The subjective portion of the note should contain descriptions of any current problems, the inmate's level of activity and function, programs participation, job assignments, family issues, and any other pertinent information.
2. Documentation of any reports of medication issues or side effects
3. A brief mental status examination unless the template does not require that information.

ASSESSMENT:

4. A DSM (current version) diagnostic list as well as an estimate of the current global assessment of function
5. An assessment pertinent to the data documented

PLAN:

6. A clinically appropriate follow-up appointment
7. A description of the recommended, if any, appropriate psychosocial intervention and an estimate of the timeframe to complete such treatment. For example, "The inmate will be seen weekly for four visits focusing on cognitive behavioral therapy for bereavement counseling."

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

a. **creation of a multi-disciplinary review committee;**

b. **periodic review of screening, assessments, use of psychotropic medications, emergency room visits and hospitalizations for inmates with SMI,**

c. **periodic review of housing of inmates with SMI;**

d. **periodic review of the use of segregation;**

e. **tracking and trending of data on a quarterly basis;**

f. **morbidity and mortality reviews with critical analyses of causes or contributing factors, recommendations, and corrective action plans with timelines for completion; and**

g. **corrective action plans with timelines for completion to address problems that arise during the implementation of this MOA and prevent those problems from reoccurring.**

COMPLIANCE RATING: Partial Compliance

GENERAL FINDINGS: MCJ has developed some tracking tools and recently implemented some special needs multidisciplinary committees but still needs to develop a Continuous Quality Improvement Committee driven by policy to oversee this component of the MOA.

A summary of the number of inmates receiving psychotropic medication was emailed on 5/13/15 and is 261 out of a total number on medications of 571. A Health Service Statistical Report (See Appendix 11) also tracks this number monthly with a range of 270-345 for the first three months of 2015. Also tracked are the number of mental health screens, follow up contacts, special needs contacts, segregation rounds, individual psychotherapy contacts, group therapy sessions, the # of patients in group and discharge planning contacts. All this data should be utilized in creating a staffing analysis and in tracking the availability of services provided.

Also included are data for self-harm, sentinel events, mental health sick call requests and referrals. However, the data we received (Appendix 11) is only current through March, 2015.

RECOMMENDATIONS:

1. See attached Appendix 10 that is provided as a reference in beginning this process. Policies related to Continuous Quality Improvement have also been provided.
2. The jail should develop a stable membership to the committee and meet at least quarterly to review any Continuous Quality Improvement studies and data matrices.
3. 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 Continuous Quality Improvement techniques to facilitate the team.
4. A Continuous Quality Improvement manual should be maintained that contains all the current project data and corrective action plans in a central location for easy access.
5. Accurate minutes should be maintained.
6. Demonstrations via Quality Assurance/ Improvement Committee minutes and documented assessments of variation in the data would be helpful in documenting that the information gathered is actual used to track trends and stimulate further quality improvement processes.
7. Check with you local experts to determine if you can protect your Continuous Quality Improvement materials from discovery as part of a peer review process.

Respectfully submitted this 26th day of June, 2015,

Roberta E. Stellman, MD