Introduction

Our second onsite review of the Muscogee County Jail (MCJ) under the new Memorandum of Agreement (MOA) occurred November 16–18, 2015. Information was received from the leadership team, including a response to the first report, from the May 2015 tour. All elements of the MOA were reviewed during the November 2015 visit.

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

1. **John Darr**, Sheriff
2. **Dane Collins**, MCJ Commander
3. **Cynthia Patillo**, Psychologist, New Horizons (MCJ's mental health services vendor)
4. **Jeri Johnson**, Captain
5. **Jeremy Hattaway**, Corporal (Data Collections)
6. **Gary Deperro**, Sergeant (Specialized Mental Health Units)
7. **Robert Trombley**, Lieutenant (Training)
8. **Charles Shafer**, Captain
9. **Paul Morris**, Health Services Administrator, Correct Care Solutions (CCS) (MCJ's medical services vendor)
10. **Sai Nandamuru**, MD ("Dr. Nan"), Psychiatrist
11. **Lucy Sheftall**, Assistant County Attorney

A pre-site request for documentation was submitted, and the facility again did an excellent job in providing a detailed response (See Appendix 1). Assistance by all staff is much appreciated. I would like to especially thank Commander Collins, Dr. Patillo, and Cpl. Hattaway for ensuring their availability throughout the tour to assist both myself and Ms. Myrthil.

We were informed at the opening of our tour that County computers had been down for the last 10 days impeding the facility's capacity to check warrants on people that were discharging from the jail. However, the kiosk system (ASK) for sick call and grievances by inmates and the electronic medical record were unaffected.

Positive changes since our last visit included an increase in the number of group therapies offered on the special mental health units. One of the sergeants had completed training with a homeless deaf dog, Beethoven, who was certified as a therapy dog. They are now working on the specialized mental health units, and we were able to observe the warm interaction between the male inmates and canine therapy team on 4E. A yoga class was just beginning. Mr. Mike Dahner, nurse practitioner, has been brought on board to work as a full time clinician For New Horizons at MCJ.

The drafts for most policies and procedures regarding mental health were submitted for review in September 2015, and the USDOJ submitted this monitor's final response and feedback to these

drafts in November 2015. Additional feedback on these drafts was provided during the November onsite tour. This process unfortunately delayed the facility's capacity to incorporate and train to recommendations and suggestions previously made by this monitor. The new mental health input into the disciplinary process form was reviewed and modifications were completed during the time of the tour. The process, however, has been functioning in the facility since at least the time of the May 2015 visit.

The kiosk software system will change after the New Year and the staff anticipates this will make it easier to generate reports and track requests. Case lists are currently generated from Diamond Pharmacy but the staff only relies on these for prescription monitoring and not for appointment scheduling. Rather, they generate a spreadsheet based on a completed work list by the psychiatric providers that indicates when the patient should return to clinic and whether they are considered seriously mentally ill or not. During the course of our visit we saw one of these forms in use by Dr. Nan.

Compliance Assessment Methodology

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

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

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

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

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

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

Instructions to the Reader:

- All text from the MOA provisions and the headings of Compliance Ratings, Findings, Recommendations, and Suggestions by this reviewer appear in **bolded** font.

- Many of the provisions, especially those referring to policies, have multiple subsections. In general, an overall compliance rating for each provision will be given at the beginning of each main section heading. Findings, recommendations, and suggestions will be listed under the main section heading. When there are detailed findings, recommendations, or suggestions specific to certain subsections, they will be broken out and recorded under each subsection with the relevant heading.

- Findings from the previous reporting period are provided where necessary for a complete understanding of current findings and/or recommendations and are in *italic* font.

- Recommendations from the previous reporting period are provided for each provision and are in *italic* font.

- "Recommendations" refer to such corrective action that this reviewer will expect MCJ to complete to move towards substantial compliance.

- "Suggestions" refer to additional action that MCJ may, but is not required to, take to further implement a provision in accordance with best practices. These suggestions are offered to assist MCJ in their ongoing efforts to improve facility conditions.

MOA Compliance Review of Substantive Provisions

I. SUBSTANTIVE PROVISIONS

A. Mental Health Care and Suicide Prevention

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

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

COMPLIANCE RATING: Partial Compliance

FINDINGS (May 2015 Tour):

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

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

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

RECOMMENDATIONS (May 2015 Tour):

*We discussed each specific requirement under this provision, and recommendations were made accordingly. With the permission of the Bernalillo County Metropolitan Detention Center's Administrator, Phillip Greer, I was able to provide MCJ with a complete copy of the health/mental health policies as a reference in modifying this site's policies. Also, several prison systems do list all of their health policies online, including the New Mexico Department of Corrections and the Delaware Department of Correction. Both of these systems policies, as well as the Bernalillo County Metropolitan Detention Center's policies, comply with both the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) standards. It is strongly recommended that MCJ rely on the ACA and NCCHC standards and any Georgia State Jail standards as helpful guidelines in developing a mental health policy manual. Another excellent reference is the soon to be published third edition of the American Psychiatric Association's publication, Psychiatric Services in Jails and Prisons due out in July, 2015 (*Disclaimer, this reviewer is a co-author of this publication.).*

FINDINGS (Nov. 2015 Tour):

The current policies have been modified based on our recommendations but training and implementation has not yet occurred.

RECOMMENDATIONS (Nov. 2015 Tour):

Specific feedback was provided on MCSO's response to the May 2015 tour compliance report and will be reiterated under each of the following policy sections as applicable.

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

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

This recommendation has been incorporated into the policies.

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

FINDINGS (May 2015 Tour):

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

This recommendation has been incorporated into the policies.

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

FINDINGS (May 2015 Tour):

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

In October 2015, MCJ completed an initial staffing analysis based on that month's data which was reviewed and discussed with the leadership team. It is recommended that future staffing analyses should contain a narrative description of the methodology including a detailed description of how each staffing component of the plan is calculated. The staffing plan should include totals by professional category, as well as a total monthly calculation of functionally filled positions versus full-time employee positions allocated. It was further suggested that the plan also include supervisory time allocated for oversight of the graduate students providing individual therapy in the facility.

RECOMMENDATIONS (Nov. 2015 Tour):

Additional assistance can willingly be provided upon request.

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

FINDINGS (May 2015 Tour):

This provision was adequately covered in Appendix 2 of MCSO document production and continues to be incorporated into current practice.

RECOMMENDATIONS (May 2015 Tour): *None at this time*

FINDINGS (Nov. 2015 Tour): No change since previous tour

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour): None.

SUGGESTIONS (Nov. 2015 Tour): MCJ may wish to consider adding procedures to this policy which would allow some people to be temporarily classified as seriously mentally ill (without changing the current definition), such as those entering with drug-induced paranoid

psychoses. The procedure could specify what level of privileging and credentialing is required for that classification to be changed and also specify the nature of the documentation in the electronic health record to justify changes in classification.

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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;**

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

k. **treatment planning;**

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

FINDINGS (May 2015 Tour):

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 (May 2015 Tour): *None*

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour): *None*

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

FINDINGS (May 2015 Tour):

Please see the above provision and provision 8 of the MOA. We were told on-site that mental health sick call requests are triaged Monday through Friday by a mental health professional.

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

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

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

FINDINGS (May 2015 Tour): See above discussion of sick call.

RECOMMENDATIONS (May 2015 Tour):

An established timetable for triage and resolution of each level of sick call request (emergent/urgent versus routine) should be codified in this policy.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour): None

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

RECOMMENDATIONS (May 2015 Tour): *None*

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour): None

m. **suicide prevention and treatment;**

RECOMMENDATIONS (May 2015 Tour):

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.*

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

   Addendum: On December 17, 2015, Corporal Hattaway emailed an overview of the Suicide Prevention Training by Relias. The curriculum is a good one for the general community. However, MCJ should incorporate discussions specific to a correctional

environment for a fully pertinent training. For example, the presentation lists firearms as the most common method of suicide; however, hanging is the primary method of death in a jail. There are different risk factors for jail suicides not addressed in the Relias training. Therefore, this curriculum is not adequate for training security or medical/mental health staff in correctional institutions because some of the facts provided are incorrect for your environment. However, in the course list there are two references to suicide in jails and prisons. A curriculum pertinent to those topics was not provided.

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

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

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

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour): None other than monitoring the implementation of this policy.

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

Policy 13921 mental health services was revised and reviewed.

RECOMMENDATIONS (Nov. 2015 Tour):

This policy does address treatment services and treatment plans provided at MCJ. Transfer to community resources is acknowledged. However, the policy does not specifically address routine efforts at discharge planning. The discharge planning form has been developed by New Horizons but is primarily a discharge needs assessment. I will be providing a copy of a sample format that the facility may modify or use as an aid to the development of a form to address both needs assessment and the indication of the finalized referral. (See appendix 2).

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

Policy 1416 was submitted and reviewed and is adequate.

RECOMMENDATIONS (Nov. 2015 Tour): None

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

SPECIFIC PROVISIONS OTHER THAN REQUIRED POLICIES:

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

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

COMPLIANCE RATING: Substantial Compliance

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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.*

FINDINGS (Nov. 2015 Tour):

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

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

1. Inmates reported that they were being seen in private interview rooms off of the housing units or in a practitioner's office in the clinic.

2. The actual inmate case list was not reviewed at the time of this visit. Dr. Patillo did report that such a case list is being maintained and <u>I would request that it be provided at the time of the next site visit.</u>

3. The actual inmate case list was not reviewed at the time of this visit. Dr. Patillo did report that such a case list is being maintained and <u>I would request that it be provided at the time of the next site visit.</u>

4. This information has successfully been added to the kiosk.

6. Private office space remains sufficient for the services provided and staff size.

Addendum: Materials provided in December 2015 demonstrate that community resources have been added to the Kiosk. MCJ also has a very useful Re-Entry packet developed in September 2015 for inmates to help prepare them in finding housing, employment, and substance recovery resources. Information regarding who receives this packet and how it is used was not made available to this reader but can be discussed at the next site visit.

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

FINDINGS (May 2015 Tour):

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 (May 2015 Tour): *See A.1.c.*

FINDINGS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour): *Continue a process that seems to be working well.*

FINDINGS (Nov. 2015 Tour):

There is no change since the last report. 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 HSP. 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.

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

6. *Assessments*: Upon admission to the Jail, based on the results of the initial screening set forth in paragraph 5 above, the Jail Staff shall provide mental health assessments to inmates and refer inmates to qualified mental health professionals for treatment in accordance with the following:

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

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

ii. **disorientation/confusion;**

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

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

v. **recent suicide attempt; and**

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

COMPLIANCE RATING: Partial compliance

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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.*

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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: Substantial Compliance

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour): Continue tracking the timeliness of this process.

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

RECOMMENDATIONS (May 2015 Tour):

Develop a method to prove compliance through data collection.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

Develop a method to prove compliance through data collection.

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

MCJ will request this addition to the health record.

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

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

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

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

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

        iv. **disorientation/confusion; and**

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

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

COMPLIANCE RATING: Substantial Compliance

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour): None

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

a. **Inmates submitting sick call requests shall be seen for assessment or treatment by a qualified health or mental health professional in a timely and adequate manner, as clinically appropriate.**

b. **Inmates with <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

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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.*

FINDINGS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

CCS does not currently have the ability to generate a report tracking time to first dose administered. The facility will need to devise a methodology to study this provision (10.a) as a CQI study. Dr. Nan did report that there is no formulary for New Horizons so there is no delay because of a non-formulary drug request process. He does receive calls from the site when inmates are booked and report being on psychotropic medications. His procedure is to order a short prescription until the inmate can be seen and the clinician can determine the ensuing course of treatment. STAT medications not in stock will be obtained from a local pharmacy. Since New Horizons out patient records are accessible to MCJ New Horizons staff verification of treatment in easy and are scanned into ERMA. Often times these records also contain discharge summaries from the Bradley Center. Obtaining records from the VAMC remains problematic.

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

COMPLIANCE RATING: Substantial Compliance

RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

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

Inmates in need of acute mental health treatment can be housed in the HSP area where they are seeing daily and observed by nursing staff at least every 15 minutes. Those inmates who require less supervision but are still demonstrating significant

symptomatology are housed on 4F. Inmates with chronic persistent mental health needs and cannot tolerate housing in general population can be stepped down to 4E.

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

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 qualif ied 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

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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.*

FINDINGS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

a. **use of force on inmates with mental illness;**

b. **pill call procedures to prevent inmates with serious mental illness, inmates on the mental health units, and inmates with mental illness in segregation units from hoarding or hiding pills;**

c. **safe shaving procedures to prevent inmates with serious mental illness, inmates on the mental health units, and inmates with mental illness in segregation units from hiding or misusing razor blades; and**

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

COMPLIANCE RATING: Substantial compliance

RECOMMENDATIONS (May 2015 Tour):

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.*

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

a. **Jail Staff shall consider suggestions by mental health staff for minimizing the deleterious effect of disciplinary measures on the mental health status of the inmate. Any punishment must work within the inmate's mental health treatment plan.**

b. **The hearing officer shall document the participation of mental health staff and the hearing officer's consideration of the mental health staff's recommendations, including treatment alternatives considered in the disciplinary process.**

c. **Disciplinary measures taken against specially housed inmates with SMI shall be reviewed on a quarterly basis.**

d. **Inmates shall not be subject to discipline for refusing treatment or medications or for engaging in self-injurious behavior or threats of self-injurious behavior.**

COMPLIANCE RATING: Substantial Compliance

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

FINDINGS (May 2015 Tour):

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 (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

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

The HSP unit has 13 available cells. Three of these have higher windows and remain a last resort for housing inmates on suicide watch. These 3 cells are commonly used for non-HSP inmates who need to be kept NPO prior to surgery or for observation prior to transfer. The rest of the cells have large windows both at the top and bottom of the cell for good observation. At the time of our inspection all inmates were asleep in the unit. Two inmates were observed to have smocks and blankets but no mattresses and were sleeping on the concrete floor. Inmates are generally housed with a cellmate unless there are safety and security overrides. Residents are issued suicide resistant smocks and blankets.

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

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

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

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

COMPLIANCE RATING: Substantial Compliance

RECOMMENDATIONS (May 2015 Tour):

Complete additions to the Kiosk system

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

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

COMPLIANCE RATING: Substantial Compliance

RECOMMENDATIONS (May 2015 Tour):

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.

FINDINGS (Nov. 2015 Tour):

Access to the medical records is restricted to clinical personnel. Officers' training in mental health does cover the elements of this provision. Inmates reported that individual encounters do occur in sound private areas. This provision will be reviewed again via inmate interviews to monitor compliance.

RECOMMENDATIONS (Nov. 2015 Tour): None

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

a. **Access to individual inmate mental health records shall be restricted to medical and mental health personnel, and mental health information shall be shared with jail officers only when the medical or mental health staff believes this is necessary or in the event of investigation of a critical incident.**

b. **Jail Staff shall be instructed not to divulge inmate mental health information to other inmates.**

COMPLIANCE RATING: Substantial Compliance
RECOMMENDATIONS (May 2015 Tour):

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

FINDINGS (Nov. 2015 Tour):

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

RECOMMENDATIONS (Nov. 2015 Tour): None

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

RECOMMENDATIONS (May 2015 Tour):

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.*

FINDINGS (Nov. 2015 Tour):

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

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

RECOMMENDATIONS (Nov. 2015 Tour):

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

Respectfully submitted this 2nd day of March, 2016,

Roberta E. Stellman, MD