Executive Summary

Roberta Stellman, M.D., DABPN

Review of Mental Health Services Currently Provided by the

Santa Barbara County Jail System

Review Conducted between April 12-14, 2017

TABLE OF CONTENTS

An independent mental health review was requested by the Santa Barbara County and Sheriff's Office (SBC) under a Structured Negotiations Agreement with Disability Rights California (DRC), Prison Law Office (PLO), and King & Spalding (KA).

Definitions of Abbreviations:

General standards relied upon for this report are the NCCHC Jail Standards, the American Psychiatric Association guidelines both for correctional facilities and the general practice of psychiatry, US Federal case law where applicable, and accepted peer practices.

Abbreviations/Acronyms Used In This Report	**Definition**
Be Well	Department of Behavioral Wellness
CFMG	California Forensic Medical Group
CARES	Mental Health Crisis Mobilization Unit
DON	Director of Nursing
DPH	Department of Public Health
DRC	Disability Rights California
HSA	Health Services Administrator
ITP	Individualized Treatment Plan
K & S	King and Spalding
LMFT	Licensed Marriage and Family Therapist
LMHP	Licensed Master's Level Mental Health Professional
LVN	Licensed Vocational Nurse
MD or doctor	A psychiatrist
PLO	Prison Law Office
QI	Quality Improvement
RN	Registered Nurse
SBCJ	Santa Barbara County Jail (unless specified otherwise refers to the Main Jail Facility)
SC	Safety Cell
SMI	Seriously Mentally Ill
Recommendation	Those additions that are required to meet current expected minimum services for a jail
Suggestions	Non-required practices that are considered "Best Practice"

A. ORGANIZATIONAL STRUCTURE OF THE MENTAL HEALTH SERVICE:

Findings:

On April 1, 2017 CFMG became the new health services provider after a 20 year relationship with PHS/Corizon.

Under the new health services provider, the Health Services Administrator is responsible for leading the mental health team. Consultative services are available from the regional

office to provide guidance for developing mental health programming. There is no lead mental health supervisor on site.

The health services administrator orchestrates a monthly Medical Administration Committee (MAC). The sign in sheets for Corizon's MAC meetings, that were available for review, indicate attendance by the administrative assistant, grievance officer, commander, Lieutenant, and the health services administrator. Meeting minutes were reviewed and their content will not be included in this summary but some recommendations below are related to the meeting minutes.

Recommendations:

1. If the jail is to successfully develop treatment programs to meet the needs of the seriously mentally ill it is strongly recommended there be an on-site mental health coordinator rather than a health services administrator, independently licensed mental health professional with prior experience in program development, familiarity with correctional mental health practices and management skills, who can plan, integrate, and oversee treatment programming that meet the needs of the inmate population and individualized treatment plans. This person should also be capable of supervising the counseling staff and providing in-service training in the development of measureable treatment plans and adequate medical record documentation.

2. Any programming provided by mental health agencies other than CFMG should be approved and monitored by CFMG's on-site mental health coordinator so that all services provide a cohesive program based on the individual's treatment plan.

3. The standing membership for the MAC meetings should have a broad representation and at a minimum should always include the Director of Nursing, Chief Medical Officer and a Representative from the Mental Health Service and the appropriate custody leaders. When appropriate, (for example, when the agenda has topics such as medical diets), a representative from the appropriate service should be included in the meeting.

4. Whenever considering utilizing trainees, such as psychiatric interns, it is essential for the jail to have a memorandum of agreement with the University that stipulates requirements for supervision of those clinicians. Usually interns are unlicensed practitioners, practicing under an institutional license. There should be sufficient psychiatric hours to monitor the care provided by an intern.

5. The jail should consider developing quality indicators with their own independent expert that should be included in any future contracts to monitor compliance with those guidelines and impose penalties for failures in

performance by private contractors along with required periods for remedies to improve compliance.

B. POLICIES AND PROCEDURES:

Currently all policies and procedures are the property of the current health services vendor as of April 1, 2017. The previous vendor, Corizon, left on the last day of March. Corizon medical\mental health policies were provided electronically at the completion of my site visit but were not reviewed since those documents are no longer pertinent to the current mental health operation. The CFMG policies were produced on June 13, 2017. The CFMG policies are IMQ (California based) and for the past year NCCHC compliant.

In general the policies and procedures provided by CFMG are aligned with the standard NCCHC Jail standards. The policies submitted for review are not site specific and need additional clarifications regarding credentialing and privileging.
Recommendations:

1. It is strongly recommended that the SBCJ develop its own system and site specific policies and procedures. The private health provider should be bound by contract to the current and future SBCJ policy manuals. Such a practice allows for continuity in processes and requirements regardless of which company provides services at the jail. Many correctional systems have all their policies on line and can serve as templates which can be tailored to the SBCJ system. (CDCR, New Mexico Department of Corrections, Delaware Department of Correction, etc.). Relying on jail\prison systems outside of the State of California will also help align policies with national standards such as National Commission on Correctional Healthcare Jail Health Standards (NCCHC) or American Correctional Association (ACA). I would also recommend contacting the larger jail systems in California because they may readily share their policies with Santa Barbara County.

2. Terminology is inconsistent between policies.

3. The grievance policy is inadequate because it lacks an appeal process.

4. Suicide prevention training should be done at least annually.

5. Policies should include a detailed, site specific procedure to increase uniformity in implementation of the policy by all staff.

6. A policy and practice allowing mental health input into the disciplinary process for inmates with serious mental illness should be developed and implemented.

7. The policy on the use of safety cells needs significant modification and must include mandatory frequencies of observation, sanitization practices(including inspection of the cell prior to placement for quality of ventilation and frequencies of sanitization of the cell), property restrictions communicated to security by a mental health professional, access to bathroom facilities, etc.

8. The basic mental health treatment policy should include requirements for individualized treatment plans and update timeframes.

9. Minimum requirements for adequate re-entry planning for inmates with a serious mental illness should be specified in policy.

10. Management of medically/mentally ill inmates requiring restraint needs to be developed with greater attention to the role of de-escalation and medical monitoring for those individuals.

11. All policies and procedures should be reviewed annually and updated as necessary.

12. In the future, Jail Mental Health Policies and proposed changes to adopted policies should be reviewed and approved by the subject matter expert under a remedial plan.

13. Policies and procedures should specify the minimum timeframes to complete specific tasks, quality requirements such as documentation guidelines, laboratory and examination requirements, triage systems, etc.

14. Policies regarding committees should describe the committee structure as well as the required membership and minimum meeting frequencies.

15. Specificity regarding the procedures should easily enable the development of measurable quality indicators that can be employed to monitor the implementation of policies.

C. STAFFING:

Findings:

Based on the observed levels of acuity and chart reviews, staffing levels at the current time are deemed inadequate despite the facility being fully staffed for contracted allocations.

No comprehensive staffing analysis has been completed to determine the actual needs of the service

Recommendations:

1. Develop a vision of what the adequate service should provide in order to add any additional staff requirements into the analysis, such as additional services for the seriously mentally ill inmates. Include alternative treatment areas for the SMI inmates unable to be placed in general population. Currently the system is relying on segregation as the housing alternative but this is not a treatment setting. It should only be a rare exception that a seriously mentally ill individual should be placed in segregated housing with well-documented justifications, supervision, and treatment. Proper treatment areas should allow for day room space for programming such as community meetings, social skills training, recreation therapies, etc.

2. A comprehensive staffing analysis should be completed in order to determine the actual staff needs of the service. In order to be accurate, the service will need to divide referrals into intake, inmate generated and crisis contacts since each requires a different time to complete. Crisis calls can be very time-consuming because of the need to attempt de-escalation and other techniques to attempt to resolve the crisis.

3. An analysis should be based on accurate data that reflects the expected number of contacts for each contact type (Much of this detail is not readily accessible at the current time and will require at least a couple of months of data collection). Realistic estimates (not the time it currently takes since this is deemed inadequate) regarding the average amount of time to complete an adequate contact should be developed including time to travel to and from the site of contact and documentation time. Relief factors for vacation and other leave needs to be included.

D. INTAKE SCREENING:

Findings:

SBJ utilizes a two-step intake process conducted in a private office outside of the main booking area. A registered nurse completes a prescreening assessment and determines whether someone needs to be diverted from the jail to the hospital for medical clearance. The nurse requests the hospital provide reasons for clearance as well as x-

rays and other diagnostic tests prior to accepting the inmate into the jail. Mentally ill inmates needing emergency treatment for danger to self or will wait until a CARES LSCW assesses them for potential hospitalization at PHF. The hospital will not complete a 5150 on inmates. Should CARES complete a 5150, the inmate will be diverted to PHF. If a bed at PHF is not available the inmate is booked into the main jail and placed in a safety cell or observation cell until a transfer can be effected.

An RN completes a full intake for those inmates not diverted out of the facility. The nurse will determine if a referral to mental health is considered urgent or routine. Urgent referrals can be managed after 11 PM by an on-call mental health provider from the crisis mobilization team (CARES) or can wait until the next morning when mental health on-site coverage resumes at 7 AM. During the tour several cases were uncovered where inmates refused an intake screening and there was no follow up.

Medication verification can be done by the nurse by calling the pharmacy, calling the provider, inspecting medication bottles brought by the inmate, or information from the medical record. This process can take hours or days. If medications cannot be verified the reported practice is that the inmate will be seen by a psychiatrist within seven days. The previous practice was for medications to be bridged within 30 days or for the inmate to be seen within 30 days (One month is an unacceptably long period of time before assessment.). It is too early into the contract to determine whether the current reported practice has been implemented. Mental health staff said that if medications cannot be verified the inmate is placed on a priority wait list to see a psychiatrist within one to two weeks.

When an inmate requests medications they are screened to see if they should be referred to the psychiatrist. Inmates who repeatedly request to see a psychiatrist will be referred by the mental health counselor. No data was provided to offer proof of practice.

Recommendations:

1. Periodic quality improvement reviews of the intake process should be done to ensure that this most critical function is done with accuracy and that the appropriate referrals are initiated. The review of the intake referrals to mental health should monitor the level of triage, time for mental health to complete the referral, the adequacy of the plan by the mental health counselor based on the clinical presentation of the patient, etc.
2. Whenever an inmate refuses the intake screening there should be a process to include a follow up review to ensure serious mental health issues are not overlooked. The intake nurse should also make every effort to provide a detailed record of the inmate's general presentation and an opinion regarding their capacity to refuse evaluation. Those who demonstrate observable

impairment should be considered for referral for further evaluation prior to the 14 day intake history and physical.

3. Any positive finding on the intake mental health screen should generate a referral to a mental health professional. This is consistent with CFMG's policy and a quality improvement process can confirm compliance with the policy.

4. Referrals to mental health should be triaged as urgent/emergent/routine. The criteria for the triage system should be incorporated into the jail health screening policy. This is consistent with CFMG's policy and a quality improvement process can confirm compliance with the policy.

5. Quality reviews should monitor whether the practice meets the requirements of the jail's policy, timeliness, effective triage, appropriate diversion, etc.

E. RESPONSE TO REFERRALS TO MENTAL HEALTH FROM INTAKE:

Findings:

There is no current statistical information demonstrating the timeliness of psychiatric assessments following referral from the initial mental health evaluation. Chart reviews did demonstrate that mental health staff see people referred to them within one to two days.

Recommendations:

1. Inmates requesting to see a psychiatrist should receive a comprehensive initial mental health assessment before it is determined that they do not have a clinical need for medication.

2. Documentation by mental health should to be expanded to include detailed descriptions of signs and symptoms of conditions which justify the assignment of a DSM[1] diagnosis.

3. A log of inmates referred to mental health from booking should be maintained in order for auditors to complete randomized studies of the process either via the quality improvement committee or the assignment of a subject matter expert under a legal agreement.

[1] Diagnostic and Statistical Manual of Mental Disorders, Current Edition, American Psychiatric Association

F. PSYCHIATRIC MANAGEMENT:

Findings:

Referrals to psychiatry are generated by the licensed mental health professionals. The mental health professionals have a triage system whereby people are either placed on a priority list to be seen within one to two weeks, or on a nonpriority list within a 30 day window for completion of the review.

Psychiatric hours had been 24 per week but recently, with the new contract, this allocation was increased to 40 hours a week. At the current time coverage is split among several psychiatrists with approximately 75% of the services being delivered on site and 25% via tele-psychiatry. Psychiatrists see patients with a registered nurse in a non-contact booth on the housing units. Patients in safety cells are generally seen by the psychiatrist at the request of mental health staff and otherwise the psychiatrist has little involvement in the management of inmates in those settings.

Follow up laboratory studies were appropriate and appeared to be consistently ordered. Psychiatric appointments often are not scheduled early enough. Those individuals who received significant changes in prescriptions or initiation of new medications should be seen within 2 to 3 weeks for follow-up or sooner. There was little evidence in the medical records that such a practice is in place.

Recommendations:

1. As part of the staffing analysis, data should be collected on time of referral to time seen by the psychiatrist so that the staff is not relying on anecdotal material to determine the required psychiatric hours for these facilities.

2. There is a clear need for additional psychiatric time and involvement in the development of referral criteria and policies regarding management of the seriously mentally ill inmates. The role of the psychiatrist needs to be expanded to provide greater leadership and a multidisciplinary approach to the treatment of the seriously mentally ill patient, greater participation in the management of SMI inmates and those inmates in safety cells an observation cells.

3. Data concerning prescriptive practices should be collected and available for review by the subject matter expert. This should include a sortable spreadsheet containing at a minimum, the inmate's name, jail number, medication name, milligram size, Sig (e.g. ii BID), mode of delivery, and name of prescriber.

4. A policy and procedure regarding pharmacy practices including non-formulary medication requests and patient refusals should be produced for review by the subject matter expert.

5. At the time of any future site visit, the subject matter expert should receive information summarizing the number of non-formulary drug requests that were made and the number that were denied. For the latter group inmate identifiers shall be made available in the event the subject matter expert wishes to do a chart review.

6. The frequency of psychiatric follow-up appointments should be monitored as a quality measure to ensure that inmates have adequate access to the prescriber and clinically appropriate for review of their response to medications.

G. PHARMACY:

Findings:

The Sheriff's Department pays for all pharmacy costs. Maintenance of a spreadsheet allows for a weekly query of prescriptions which are about to expire.

The current contract with the health provider (page 2, H.) states:

> Where medication is verified, the RN may dispense "bridge" medication from the current medication order of record until the inmate has a face-to-face appointment with medical or psychiatric provider. Psychotropic bridge medication should be the same medication as the inmate received in the community, regardless of its formulary status.

The current contract also requires that non-verified medications require the nurse to confer with the psychiatrist within 24 hours of the detainee's arrival at the jail reception area.

However, The CFMG policy, received after the site visit, does require the nurse to contact the on call provider for an order.

> "If the nurse verifies the medication with the prescribing physician or pharmacy, ***the nurse will provide the medication after contacting the on-call provider for an order***. During this consultation, the on-call provider, based on clinical judgment, will schedule a date for a provider to see the patient face-to-face at the next available sick call. The date of the appointment will be reflected in the record of the order."

Recommendations:

1. Initiation of verified and non-verified medication practices should be monitored to ensure the requirements of the contract is met. Based on interviews with inmates, the inmates state that medication is often not available in a timely fashion following intake.

3. Sedating medications ordered for bedtime should be administered late evening.

4. CFMG needs to monitor the medication administration process to ensure that prior prescriptions did not lapse with the change in health vendors.

H. INMATE GENERATED SERVICE REQUESTS:

Findings:

The current practice is to lump all referrals to mental health into the same tracking category. The disadvantage of doing this is that it does not give clear data necessary for annual staffing analysis review. Of all of the referral types it is probably the crisis call from custody that is the most time-consuming, followed by intake referrals and then inmate generated health services requests. The second level of classification of requests is via their triage status of emergent, urgent or routine. In general emergent requests should be handled within four hours, urgent requests within one work shift and routine within 1 (referrals from intake) to 5 (health service requests) business days depending on the nature of the referral and the policies and procedures that are adopted by the system.

The inmates interviewed during the tour frequently commented that there were delays in being seen in response to their requests. However, others said that they received prompt responses. Without effectively tracking this process the system cannot establish whether or not people are being seen within established guidelines and determine the health of each of these processes.

Inmate generated requests should always be handled in a manner that ensures the confidentiality of the materials submitted. Systems can achieve this via the practice of request collections being done daily by nursing staff during medication passes, lockboxes for housing units that only medical staff can open, a confidential electronic system, etc.

Recommendations:

1. Health service requests should be handled in a confidential manner unless the inmate chooses to communicate directly to non-health staff. Communications back to inmates from health staff by mail should be sealed in an envelope with the inmate's name, number and location on the front.
.
2. Develop a triage system with documentation on the form for the triaging licensed professional (RN or MHCS) to enter the level of urgency and a tracking system to accurately monitor the efficacy of the process. This data will also be necessary for staffing analyses.

3. Develop a system to log inmate requests so that periodic quality reviews can be done to assess whether:

    a. health service requests are retrieved timely manner
    b. health service requests are triaged within the established timeframe
    c. by the nature of the complaint a proper level of triage is assigned
    d. mental health staff appropriately resolve the complaint
    e. mental health staff resolve the complaint in a timely fashion

I. BASIC MENTAL HEALTH SERVICES:

Findings:

Basic mental health services should include, at a minimum, the following systems of care and self-monitoring:

1. Intake screening by qualified health professionals and an adequate screening tool to identify individuals with mental illness, at risk of self-injury, vulnerable to predation secondary to a mental illness, and risk factors and or medication that require referral to mental health professional
2. An effective and adequate system to complete timely initial mental health evaluations and make recommendations regarding housing and referrals based on the individual's diagnosis, strengths and weaknesses
3. The ability to effectively respond to requests for service/referrals from inmates, custody, case management\classification and medical professionals
4. The capacity to provide brief evidence-based counseling services
5. An effective system of suicide prevention training for custody and health staff and treatment by mental health professionals.

6. Intensive services for inmates in psychiatric observation and suicide prevention status
7. Develop and enhance policies that drive the mental health service including clinically ordered seclusion, restraint and emergency medications
8. Timely access to psychiatric services for evaluation, treatment, and follow up based on clinical necessity
9. Safe and appropriate housing for the seriously impaired mentally ill inmate. Segregation is not a substitute for a health services treatment setting
10. Provide a minimum of 10 hours per week of out of cell structured therapeutic group and individual programming for the seriously mentally ill inmate in specialized or segregated housing and 10 hours a week of out of cell unstructured time.
11. Segregation rounds for all inmates to identify any signs of decompensation or new onset mental health symptomatology at least weekly.
12. Management of mental-health crises including referrals for inpatient and emergency department care
13. Discharge planning including release medications and follow-up appointments
14. Collateral contacts with family, community agencies, and legal representatives
15. Advocacy with the District Attorney and public defender's office for any inmate deemed incompetent to give consent or in need of a compassionate release
16. A quality improvement process to monitor the effectiveness of the basic mental health services and to identify and intervene whenever necessary to demonstrate effective self-monitoring
17. Demonstrate critical assessments for instances of morbidity and mortality
18. Strive to provide all mental health services in the appropriate clinical environment

Most of these systems are currently not in place or are insufficient to meet the clinical needs of inmates with a mental illness, most notably discharge planning, treatment planning, quality improvement, morbidity and mortality reviews, delivery of mental health group and individual counseling, and private confidential evaluation of inmates on an ongoing basis. Suicide prevention training is offered during the initial orientation.

The recent contract with CFMG was provided and reviewed following the site visit. In general the new contract does cover the required clinical processes well including implementing a confidential sick call request process. At the time of my site visit many of these were not in place and I cannot offer an opinion regarding whether these have successfully been implemented.

Some concerns I have regarding the contract and minimum standards and best practice are as follows:

1. Page 2 allows an RN to administer verified medications without an order by a CFMG prescribing provider. Since inmates may enter with new medical concerns or detoxification issues, it is prudent for their current medical status to be reviewed by a practitioner prior to previous medication continuation since that could exacerbate or mask current medical/mental health issues. (Best Practice)
2. Timeframes for the triage and completion of sick call requests are too lengthy (page 8) with the general minimum standards being triage within 24 hours, completion within 24 hours for emergent/urgent and 5 business days for routine mental health requests (The latter is not a written standard but is based on the verbal communication between myself and NCCHC (Scott Chavez) several years ago.) (NCCHC 2014 Jail standards p. 83).
3. The contract requirements for mental health interventions for inmates in restrictive housing or for those with a serious mental illness housed on specialty mental health units are not specified (see the body of this report).
4. 4.2 Suicide Prevention: The review requirements do not specify what level of training and credentialing are required for the q 4 hours review and should specify the minimum number of hours of training to be provided by the Contractor.
5. 4.3 Psychotropic Medications: See item 1: above.
6. 11.0 Continuous Quality Improvement and Accreditation: the “behavioral health staff member” lacks the specificity to provide continuity and oversight and does not include the facilities’ medical director.

Problematic areas in the delivery of mental health services include:

1. All inmates with a positive finding on the mental health intake screen should receive a mandatory referral to a mental health professional.
2. If an inmate refuses to give consent for treatment at the time of intake that does not imply that they have refused all future offers of treatment. The intake nurse still has an obligation to make the appropriate referrals to psychiatry and mental health professionals. This is addressed in CFMG’s policy but this will need to be demonstrated going forward.
3. Inmates demonstrating significant psychopathology with placement in a safety cell should always be referred urgently to the on-site psychiatrist.
4. Inmates with severe personality disorders resulting in frequent placement on suicide precautions should have a comprehensive behavioral management plan in their record and be receiving regularly scheduled stabilizing counseling services in an attempt to maintain the individual in regular housing.

5. Decreasing time spent in safety cells can be an admirable goal. However, releasing people from suicide watch without a reasonable period of observation (48 to 72 hours) in step down may be precipitous and increase the risk of an adverse outcome.
6. Inmates entering the facility on verified medications should have a routine referral to psychiatry issued at the time of intake rather than impose a delay by waiting for the completion of the mental health professional's evaluation. The LCSW evaluation can then prioritize the psychiatric appointment is clinically indicated.
7. There appears to be too high a threshold for initiating referrals to psychiatry. Because jail settings are high-volume, high turnover, high stress there should be as few barriers to referral to mental health and psychiatric services as possible to decrease the risk of unidentified and untreated mental health conditions.

There is currently no classification system to designate inmates SMI (Seriously Mentally Ill). Current mental health services provided to inmates in segregation with a mental illness consist of administrative segregation checks, psychoeducation, brief counseling and mental status exam almost always conducted through the cell door. The mental health department currently has no input into the disciplinary process that is formally documented.

Individualized treatment plans were not found in any of the reviewed medical records.

It should be noted that the prior contract's scope of work section was essentially what appears to be Corizon's response to the bid for proposal. The contract stated, "Corizon recognizes the importance of individual and group therapy that is tailored to the unique needs of the inmates being treated… Specifics of these and other programs will be developed and customized with the County." No such services were ever provided. The current contract scope of work is County driven and more tightly constructed.

Currently no structured programming is provided by the mental health staff. The 4 LCSW's have a rotating workload covering seven days per week. There is a shortage of officers to provide escort services for mental health services staff. Mental health professionals attempt to see people in a noncontact booth but anecdotally this occurs only 50% of the time for follow-ups and 75% of the time for initial assessments. (All inmates interviewed disagreed with that report. They uniformly stated that they saw the psychiatrist in a privacy booth but all other mental health contacts were at the door front.) If an inmate refuses a psychiatry appointment they are seen at their cell door. The medical service has treatment rooms available on the units but these are rarely available for mental health use.

The current practice for treatment planning is to use the "P" in the SOAP note.

CFMG has not yet trained to and implemented the definition for SMI.

There is a small dorm setting for men (S Tank) that is considered mental health housing. An interview was conducted on this unit. Most all of the residents appeared capable of participating in a residential treatment setting. The unit consists of a small day room that had 2 boats on the floor for overflow placement. There was a fixed table with eight seats and a television in that area. The dormitory area had bunkbeds (3 high) placed on three walls with the fourth being an open barred wall opening onto the hallway. Total occupancy was 24. Natural lighting filtered from the dormitory across the hall into this area. Upon entering the unit all inmates were in bed. The men complained that there were no structured activities provided to them and little to occupy their time. One man complained that the only treatment was coloring papers. One man reported it took over a week for him to receive bridge medications even though he had signed release of information waivers. Another man appeared actively psychotic with impairment in maintaining appropriate social boundaries.

Mental health professional contacts occur through the barred grill at the front of the unit. The psychiatrist and registered nurse see them in a private booth for less 5-10 minutes or an initial evaluation. The men estimate that follow-up mental health visits are shorter than that. Intake assessments were estimated at 2 to 5 minutes and their initial mental health evaluation at approximately 10 minutes. The men all reported that when a mental health professional sees them in the intake area they are seen and interviewed in the open. The only programming they receive is when the chaplain comes to the unit on Sundays for services. Men complained that the safety cells were unsanitary and one man stated, “You get so sick of it, you shut up.” Sick call in conducted through the food port.

Inmate stated there was no discharge planning unless you submitted a request. Several stated they received no medication upon release from the jail. They can seek services at CARES clinics but it can take one week so they may be off medications for that period of time. They reported that they were in their tank 24\7 with access to the yard on Tuesdays and Saturdays for an hour and half.

Recommendations:

1. The County needs to implement a detailed tracking form that parallels the scope of work requirements in order to ensure that the current vendor is meeting the requirements of the contract.

2. Policies, procedures and staffing allocations need to be considered to develop multidisciplinary treatment programs for the most seriously ill inmates. Currently these individuals are only receiving medications in isolation and cell front review

by mental health professionals. Treatment programs for both male and female individuals should be developed. A minimum of 10 hours per week of structured out of cell therapeutic activities and 10 hours of unstructured out of cell time be provided to any seriously mentally ill inmate in segregated housing (See the Section labelled "Segregation of the Seriously Mentally Ill" below)

3. Those people who are extremely unstable and unsafe to mix with other programming inmates should be isolated based on a clinical seclusion policy and procedure. Such a process would require an order by a physician to isolate an individual and would dictate the nature and frequency of professional contacts insuring a higher level of observation and intervention that is currently provided. (See Appendix 12 – Sample policy on restraint and seclusion to aid in better conceptualizing this recommendation)

4. Train and implement an SMI classification and track the mental health caseload by total number open and total # SMI.

5. Track the number of SMI housed in restrictive housing by housing units.

6. Develop a multidisciplinary treatment plan form for all seriously mentally ill inmates incapable of functioning in a general population setting or who are housed on a specialty mental health treatment unit.

7. Demonstrate that training on the right to refuse care and its implications is completed.

8. All inmates with a positive finding on the mental health intake screen should receive a mandatory referral to a mental health professional.

9. When an inmate refuses to give consent for treatment during the intake process the appropriate clinical referrals should still be generated.

10. Inmates demonstrating significant psychopathology with placement in a safety cell or observation cell should always be referred urgently to the on-site psychiatrist for evaluation.

11. Inmates with severe personality disorders who frequently require placement in a safety cell should receive a behavioral management plan and regularly scheduled counseling services to aid them in maintaining function in regular housing.

12. Inmates entering the facility on verified medications should routinely be referred to psychiatry at the time of intake.

General Information

It should be evident to everyone that in recent decades the number of seriously mentally ill people incarcerated in jails and prisons has risen for many reasons including the loss of long-term residential\hospital beds. Inmates with SMI, when incarcerated, frequently have longer stays in jails; the reasons for this are multifactorial. In California with the advent of A.B. 109 jail facilities are now housing long-term inmates many of whom suffer from an SMI. The burden of providing treatment programming for this population is increasingly falling on the shoulders of community jails.

Addressing the treatment needs of this population requires several elements:

1. An identification system -the jail needs to have an operative definition of seriously mentally ill. Once this is in place it is possible to develop a classification system that can divide this group into different levels of care or health needs determined by the mental health treatment team. Such subdivisions may include categories such as acute care, subacute care, residential treatment, incompetent to stand trial, incompetent to give consent to treatment, etc.

2. A policy describing and defining the menu of services should be developed by health services, custody, and classification input and design.

3. In an ideal situation, different levels of functional capacity determine which housing unit people would be placed on. These specialized units should be classified as health services units and are under the direction of the psychiatric team. Therefore, it is the clinical team that determines who will be admitted to these units and when someone can be discharged from the units. Operation of these units require strong collaboration between the members of the multidisciplinary treatment team (classification, case management, custody, psychiatric clinician, psychiatric nurse, unit LMHP coordinator) with regularly occurring multidisciplinary team meetings to discuss the management of each inmate from health, mental health, classification and discharge perspective.

   Once units are designated as health services units there can be a policy which allows for the mixing of security\classification levels, making these units unique when compared to the rest of the facility. Direct supervision by custody is essential in supporting the therapeutic milieu and maintaining order on these units. Officers working on these units should receive enhanced training by the mental health staff to aid them in the daily management of inmates designated as seriously mentally ill.

All individuals on specialty units should receive an enhanced individualized treatment plan. Other requirements for inmates on the specialty units are an enhanced discharge plan that is also documented in the medical record on a dedicated form. Privileges and property are determined by the multidisciplinary treatment team for those inmates who are not cell restricted. The psychiatric clinician should have ultimate authority over privileges and property for those people maintained on psychiatric observation\clinical seclusion or suicide watch. The jail should have the capacity to appropriately house and treat inmates with mental illness in emergent, sub-acute, residential treatment and general population housing units.

J. SHERIFF'S DEPARTMENT PROGRAMMING:

Findings:

Under the leadership of Sheriff Brown, SBCJ has adopted the Stepping up Initiative, a national initiative for mental illness diversion. The Council of State Governments, the American Psychiatric Association, and the National Association of Counties has partnered to provide resources for this initiative. At the Santa Barbara County level involvement includes the District Attorney's Office, Be Well, Sheriff's Department, and National Alliance for the Mentally Ill, CLUE (a local agency), Community Service Board, and Families Act.

Santa Barbara County is also planning the construction of the new jail facility which may enable them to redesign some parts of the main jail which could improve housing for inmates with special needs. Sheriff Brown has expanded STP (Sheriff's Treatment Program) with an evidence-based curriculum. His next budget proposal will ask to expand this program and add a screening tool to assess for the likelihood to re-offend. Santa Barbara County Jail uses custody deputies who do not rotate into the community. The system is also considering using security technicians to manage control room functions thereby freeing up custody deputies for other assignments.

The Inmate Programs Supervisor provided me with the following information:

1. The Sheriff's Treatment Program which is housed in three different units, protective custody unit 400, one male unit and one female unit. Under an NIC grant experts were sent to collaborate with community agencies, the district attorney and the public defender. The prior Sheriff's Treatment Program was redesigned from a drug offenders program which was 12-step-based to a CBT evidence-based program. Inmates are selected who

have a high risk for recidivism. Curricula utilized are New Direction, Thinking for Change, SAMSHA Anger Management and Helping Women Recover. The jail plans to expand this program and partner with probation Department for the evaluation of outcome data.

2. The County is hoping to update its jail management system and risk\need case management system to create a case plan for inmates. This will focus on a risk\need assessment which will aid in guiding the selection of interventions in the facility and community for inmates with a high risk of recidivism based on criminogenic factors.

3. Sanctuary Centers of Santa Barbara are funded through the Community Corrections Partnership (CCP) in cooperation with the Probation Department as are other community partners. They will be piloting the BRACE program which looks at mental health issues as well as criminogenic risks and needs.

Recommendations:

1. Continue participation in what sounds like excellent services for the targeted population.

2. Should the jail expand programming for the SMI inmate by utilizing community agencies rather than its mental health care vendor; it is strongly recommended that these efforts be supervised and directed by the CFMG lead mental health professional. Periodic review of the group curricula and focus of programming should be overseen and approved by CFMG to ensure that services are congruent with the efforts of the CFMG multidisciplinary team and to prevent staff splitting.

K. SHERIFF'S DEPARTMENT SUICIDE PREVENTION TRAINING:

Findings:

All Sheriff's officers complete Academy training which includes CIT certification and eight hours of suicide prevention training. CFMG will do annual suicide prevention training. All Sheriff's officers are receiving training on direct supervision models of observation. The Sheriff's Office is also undergoing a new CIT Team program. In this program all custody deputy staff will receive 8 hours of crisis intervention training. In addition, participants in this program will undergo an additional 40 hours of training.

Recommendations:

1. The suicide prevention training curriculum including any pre-and post-test materials should be reviewed and approved by mental health subject matter expert under the terms of any remedial plan.

2. Suicide prevention training data should be tracked by total number of officers\percentage officers who have received the training each year with parallel data maintained on health services staff as well.

L. EMERGENCY CARE:

Findings:

Individuals who do require emergency care are transferred to a psychiatric health facility. The Behavioral Wellness Department (Be Well) operates a 16 bed LPS (commonly referred to as PHF, Santa Barbara County Psychiatric Health Facility). For the past 6 to 7 months one bed has been designated for a jail inmate who might require safety cell placement for more than 24 hours. Any inmate who is deemed to require emergency hospitalization for danger to self or others is evaluated by the CARES Mobile Crisis Unit which will come to the jail 24/7 to complete an evaluation. They are the only clinical providers who are authorized to complete a 5150 evaluation for hospitalization. Santa Barbara County is working to develop a facility for diversion if the individual does not meet 5150 requirements.

During my jail tour I observed several inmates who were acutely mentally ill and would benefit from placement in an LPS or psychiatric hospital; although, based on California state law they may not meet the requirements for placement at an LPS.

The Justice Alliance is contacted when mentally ill inmates refuse medications. They report to the court and can request a Riese hearing. Should the court order medication the inmate is transferred to PHF which has 4 beds for that class of patient. PHF also has 4 beds for misdemeanants who are incompetent to stand trial.

Recommendations:

1. Continue the current efforts to establish community resources for acute care hospitalization, LPS and restoration services.

2. Establish policy guidelines for timeframes of mental health face to face clinical review for all inmates returning to the jail from different levels of community care, ED, LPS, State Hospitals, etc. to ensure appropriate classification and housing and continuity of medications and follow-up evaluations.

3. Develop relationships with the DA and PD offices to expedite court referrals to the State Hospital system or other treatment facilities.

4. Track patient lists of all inmates referred to a higher level of mental healthcare with sufficient identifiers to be able to complete periodic quality reviews.

M. SUICIDE PREVENTION:

Findings:

SBJ has 4 safety cells and 2 observation cells. These cells are sometimes used as step down cells for people released from safety cells/suicide watch. LMHPs assess for danger to self or others or if someone is gravely disabled (defined as not eating, drinking, or showering, etc.). Inmates moved to safety cells from intake are also assessed by the mental health staff for signs of drug or alcohol withdrawal.

Any jail staff member can place somebody in a safety cell pending a mental health evaluation. Once placed, medical and mental health are contacted to see the patient within one hour except after 11 PM when mental health staff are not on-site. In the latter situation the inmate will be assessed by a mental health professional at the beginning of the next work shift. Nursing staff can call the CARES to assess for a 5150 hold. If the hold is issued and no hospital bed is available the inmate will remain in a safety cell until a bed opens up. In acute situations the inmate can be referred to the emergency department where they can be held for up to 72 hours. In the event the one PHF bed is available the inmate can be transferred to that psychiatric facility.

It is reported that a new mental health evaluation is completed if one has not been done within the prior 90 days. A suicide risk assessment form has recently been implemented. Licensed mental health professionals, including the psychiatric RN, can release someone from suicide watch. Staff reported that all mental health professional contacts in the safety cell occur through the food port. Chart review did indicate that mental health staff are making brief contact with individuals in the safety cell multiple times per day.

Inmates placed in a safety cell receive a suicide resistant smock, but no mattress or blanket. Meals are prepared on a paper tray with an eco-friendly spork.

Once released from safety cell precautions inmates are to be seen one day and seven days post release. Staff reported that if they determine it is not clinically appropriate the inmate is not seen. This practice deviates from the customary national practices of seeing people at least at one day and seven days, and often 28 days post watch and in some situations monthly until discharged.

Some isolation cells were noted to have prominent metal rungs to provide a ladder to the upper bunk. Suicide rates are much higher for inmates in segregated housing, and these protuberances make it possible to easily secure ligature. It was also noted that several isolation cells had grills that make it quite difficult to see into the cell, again an additional risk factor that should be reviewed by the jail.

Recommendations:

1. Unless patients are physically aggressive or highly agitated they should be offered use the bathroom facilities on a periodic basis (every 4 hours per the restraint chair policy) while housed in a safety cell.

2. Written property restrictions while on suicide watch should be issued by a mental health professional and should allow all inmates to be issued a suicide resistant mattress, smock and blanket unless there are documented reasons requiring the removal of that or any other item from the cell.

3. Inmates on watch should be allowed access to bathroom facilities and showers and group and unstructured activities whenever possible if approved by the mental health team based on safety issues.

4. Safety cells should be sanitized after every use and the sewer grate inspected prior to placement to ensure there are no foul odors emanating from the opening.

5. The suicide risk assessment form should document the clinicians' rating of low moderate or high suicide risk.

6. Therapeutic services, especially psychiatric services, need to be increased for those people on suicide precautions. Depressed nonaggressive suicidal patients should be receiving brief cognitive behavioral therapy in a confidential setting and be evaluated for the initiation of antidepressant medications.

7. A copy of the suicide prevention training curriculum should be provided to the subject matter expert for review to ascertain whether it incorporates correctional risk factors.

8. A behavioral management plan or treatment plan form should be developed for use with inmates with frequent safety cell placements.

9. All inmates should be seen at customary frequencies of post suicide prevention observation. Post suicide prevention follow-up should not be left

to the discretion of the staff but be driven by measurable policy requirements.

10. A quality improvement study needs to be performed to ensure that people are being seen for post suicide watch assessments per the requirements of the facility policy.

11. At least one daily licensed mental health professional contact for any inmate in a safety cell or identified as a current suicide risk should be conducted in a sound private interview space unless there are documented reasons why the safety of the patient or the therapist cannot be maintained.

12. A mental health assessment leading to the release of someone from suicide precautions should always be conducted in a sound private interview space in order to fully assess the individual's preparedness for release.

13. Isolation cells should be inspected to ensure that they are as suicide resistant as possible since the majority of jail suicides occur at this level of housing.

14. Inmates in psychiatric observation should be monitored in a health services setting and not in isolation cells. This ensures closer monitoring and access to medical/mental health services and focused custody observation. It also creates less stigmatization for the patient and identifies their issues as health related and not simply a behavioral problem. This practice also better protects the confidentiality of the patient's need to be placed on special observation.

N. USE OF RESTRAINTS:

Findings:

The Santa Barbara Sheriff's Custody Operations provided a 2016 monthly data summary for the use of force (UOF). Total use of force for the year was a fairly low number. Of these 56% inmates were showing signs and behaviors of mental illness with use of force scattered throughout the year with no general trend.

The restraint chair is not utilized at SBCJ. However, the UOF is disproportionately utilized for inmates with signs of a mental illness and physical restraint may be safer than the use of electronic restraint, particularly in aroused inmates or those on medications that can effect cardiac conduction.

Recommendations:

1. Develop a policy on the use of clinically ordered restraints, especially given the shortage of inpatient psychiatric beds for incarcerated individuals. (See Appendix 11)

2. CFMG should track any use of restraint for SMI inmates and this data should be regularly reviewed by the Quality Improvement Committee and the subject matter expert.

3. Use of de-escalation techniques and early involvement by a mental health professional when restraint of an SMI inmate is being considered is best practice. In my input into the policy manual I discussed the consideration of having two categories of restraint, custody and medically ordered. Please refer to that document.

O. SEGREGATION HOUSING OF THE MENTALLY ILL INMATE

Findings:

Most of the inmates with overt psychiatric symptomatology are housed in restrictive/segregated housing. Concerns identified during the site visit included delayed access to a psychiatric evaluation and initiation of medication treatment, difficulties in medication continuity upon intake, issuance of new medications without a face to face evaluation, an absence of treatment programming for inmates with serious mental illnesses who cannot tolerate placement in general population due to their illness, overtly psychotic inmates housed in segregation due to a lack of developed mental illness treatment units, and a pervasive lack of mental health contacts conducted in sound private settings.

The New East ISO-unit cells 25-38 was also visited. Although a physically more pleasant segregation unit, the inmates here are all single celled and essentially in isolation. Several of the cells had negative airflow making it completely impossible to conduct any kind of conversation through the doors since the inmates' verbalizations were inaudible.

There is a provision on page 9 of the CFMG contract that the contractor will collaborate in developing delivering appropriate service levels in staffing models if the Sheriff determines in the future that subacute or acute inpatient psychiatric services should be provided at the jail.

Based on my tour of the jail and interviews with inmates in restrictive housing, the jail is currently housing acutely and sub acutely mentally ill individuals, almost without exception, in restrictive housing or in a few cases, extreme isolation. All of those inmates are in need of greater services than are currently being provided. In recent years the American Psychiatric Association, the Society of Correctional Physicians, and

NCCHC have adopted position statements to restrict the use of segregated housing for inmates with serious mental illnesses.

> "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/ psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals."[2]

The American Psychiatric Association publication[3] further outlines essential mental health services for inmates in segregation housing paraphrased as follows:

1. Inmates should not be placed in segregation housing solely because of symptoms of the mental illness unless there is immediate and serious danger for which there is no reasonable temporary alternative.
2. When an inmate is placed in segregated housing for appropriate correctional reasons, the facility remains responsible for meeting all of the serious medical and psychiatric needs of the inmate.
3. Inmates in segregation who decompensate and experience a psychiatric crisis should be removed from segregation and transferred to an acute psychiatric setting. If they are returned to segregation should be a unit that provides adequate structured and unstructured activities.
4. "If an inmate with SMI is placed in segregation, adequate unstructured out-of-cell time should be scheduled (at least 10 hours per week), as must adequate out of cell structured therapeutic activities (i.e., mental health\psychiatric treatment). Such treatment should be responsive to the level of care clinically required and occur in appropriate programming space.

Currently the only essential mental health services provided to the mentally ill inmate in segregated housing are a three times weekly administrative segregation rounds and psychiatric appointments for those on medications as infrequently as every 90 days. Rounds are documented on a log form. No out of cell structured activities are provided. During rounds each inmate, regardless of mental health history, should be visited briefly so that any emerging problem can be assessed."

---

[2] Position Statement on Segregation of Prisoners with Mental Illness; Approved by the American Psychiatric Association Board of Trustees, December 2012 Approved by the Assembly, November 2012

[3] Psychiatric Services in Correctional Facilities, third edition, American psychiatric Association 2016

Recommendations:

1. The current contract requires that mentally ill inmates in restrictive housing receive appropriate interventions at least three times per week. The contract does not specify what appropriate interventions are. Seriously mentally ill inmates confined to restrictive (non-isolation areas) housing settings should be provided with a minimum of 10 hours per week of structured out of cell cycle therapeutic activities and 10 hours of unstructured out of cell time. In addition, a minimum of weekly rounds by a mental health professional or psychiatric registered nurse should be completed. Inmates in these settings should be seen with greater frequency by psychiatry whether the inmate is currently compliant with medications or not. These inmates should also all have an individualized treatment plan (ITP) and the structured out of cell activities should be driven by the ITP. No inmate with a serious mental illness should be housed in isolation (ISO 20-21 and C7-8 (cells with minimal contact with other human beings).

2. Minimum programming and out of cell time should be driven by policy.

3. Admitting criteria for any mental health housing units should be developed.

4. Once a unit is designated as a health services unit movement to and fro is based on recommendations by mental health professionals as opposed to custody or classification. Management of these units is a combined collaboration between those three areas of the jail. Comparable and separate services should be developed for male and female inmates. I am attaching an older generic policy that may aid the facilities in conceptualizing how programming and housing can be structured with specified mental health and psychiatry interventions (See Appendix 12). Implementation is dependent on the development of a concept for these units and an adequate staffing plan for both health services professionals and custody.

5. It has become customary for larger jails to provide a minimum of 10 hours per week of structured therapeutic activities provided by health services to those individuals housed in specialized areas.

6. Segregation should not be used as an alternative to providing mental health housing. These housing units are essentially comparable to a sheltered housing unit or infirmary provided for general medical services.

7. Tracking of completion of segregation rounds as well as any special programming provided to the seriously mentally ill in segregation should be

maintained as proof of practice and reviewed by the Quality Improvement Committee.

8. During mental health rounds, if an inmate shows evidence of decompensation or reports significant mental health issues a private out of cell appointment should be scheduled within clinically appropriate time frames for a face-to-face evaluation.

P. MENTAL HEALTH INPUT INTO THE DISCIPLINARY PROCESS

Findings:

There is currently no policy or process (shared with me) for mental health clinicians to have input into the disciplinary process. It is important for inmates identified as having a serious mental illness and receiving major disciplinary reports for behavioral disruptions to be evaluated by a licensed mental health professional as close to the incident as possible. The role of the licensed mental health professional is to determine whether or not there were mitigating factors (such as mania, delirium, delusions, etc.) leading to the infraction; can the individual can tolerate the conditions of confinement if they are moved to segregated/isolated housing; and, should the inmate be diverted to a hospital or other health setting. A concise and briefly written form forwarded to the classification or disciplinary officer from the mental health professional should be issued. This input should be considered prior to any disciplinary action being imposed. It is not the role of the mental health professional in this practice to determine competency. There should also be a concomitant health review to ensure the inmate is medically clear for whatever placement custody is imposing.

Recommendations:

1. Develop a policy on mental health input into the disciplinary process (See Appendix 14).

2. Develop an accompanying form (See Appendix 15) to be completed by the mental health professional and filed in the medical record with a copy forwarded to the disciplinary officer\committee. This form should also have an area where the disciplinary officer can indicate whether the sanctions were mitigated based on the input by the mental health professional.

3. The quality improvement committee should periodically track this process and determine what percent of the time input has a positive impact, either diverting the individual from isolations\segregation or diversion to a hospital or mental health treatment unit.

Q. RE-ENTRY

Findings:

The role of discharge planning seems to fall to the Sheriff's Department. There are two discharge planners (one recently retired) who follow up with any inmate who submits a discharge application or assist inmates not capable of completing the application. The discharge planners go throughout the jail inquiring as to whether inmates want re-entry planning.

The mental health service primarily provides medication as their portion of the discharge plan. Inmates who are released Monday through Friday receive instructions on how to go to a Be Well or CARES walk-in clinic and a brief supply of medications in their property. Under Corizon, on Saturday and Sunday a nurse calls a seven-day supply medication to a local pharmacy. A discharge planner can also pick up the medication for the inmate and place it in their property. CFMG's policy is to place a medical hold in the jail information system so that inmates are seen by a registered nurse prior to release. That nurse will obtain a 30 day prescription for medications.

There is a data tracking the reentry efforts. In 2015 there were 16,899 bookings to the County jail. The percentage of inmates with a serious mental illness to receive discharge planning cannot be determined from the data provided. From previous calculations earlier in this report approximately 20% of the population receives psychiatric medication. 20% of the 2015 bookings represents 3380 people, more than twice the number reentry assistance offered in 2016.

The discharge planning team consists of 2 rehabilitation specialists (one position is currently vacant) through the public defender's office and 2 probation officers station at the jail. Discharge planners will assist the inmate in filling out the questionnaire form. Inmates can easily be reconnected with Social Security Administration because their

offices are down the street and readily accessible to discharging inmates. Discharge planners also connect people with medical services in the community. Those people who are designated "dress for release" and are known to be leaving at the next court date will have a discharge planner ensure that their insurance is activated on their day of release and will ask the health services provider to call a prescription in to the pharmacy.

A copy of an individual discharge plan was reviewed. Elements of housing, medical and mental health aftercare, probation, and release medications are covered in a discharge plan for the inmate. Both staff and the inmate sign the plan. The plan is well documented and comprehensive. The target population for discharge planning includes inmates with high mental health issues.

Recommendations:

1. The discharge plan should include directions on how to reinstate Social Security Administration benefits when applicable and access to social service benefits such as health insurance, temporary assistance, etc.
2. The facility should track the elements of discharge planning for the seriously mentally ill in order to provide proof of practice in the event of future reviews. Data should include at least the following:
    a. The total number of mentally ill inmates eligible for discharge planning per month.
    b. How many of that subset received referrals for outpatient appointments, discharge medications, 5150 referrals, etc.
    c. What percent of the seriously mentally ill inmates discharged required housing referrals versus the percent that received placements?
3. The staffing analysis should include discharge/re-entry staff once completed.

R. MEDICAL RECORD

Findings:

In the contract agreement with CFMG on page 3 the County shall be the owner of all data collected and all documents of any type whatsoever.

The records reviewed on site were paper documents maintained by Corizon HealthCare. CMFG was implementing an electronic health record at the time of my visit and I have no knowledge of how that process has gone.

Recommendations:

1. The County should review all of the templates in the health record and make recommendations for modifications to customize forms to the needs of a correctional setting.

2. All health forms should be County forms that also indicate the contractor's name.

3. Record entries should indicate the housing location of the patient, the type of service (segregation rounds, initial mental health assessment, response to sick call requests, crisis contact, psychiatric initial or follow-up appointments, etc.) and where services were delivered (such as, at the cell front, attorney's booth, etc.).

4. Records should always indicate the time of the encounter as well as the time the note is generated since there may be significant lapses in the two events.

5. As requested, I am also including Appendix 10, Documentation Guidelines as a reference. Please bear in mind that these are guidelines and not standards.

Suggestions:

1. It is always to the advantage of the County to own the medical record so that there are fewer impediments to changing health care vendors. If the vendor owns the record and their contract is terminated or not renewed, then the jail only has access to read only documents and staff must be retrained on a new system which is disruptive and time consuming.

S. PRIVACY OF CARE

Findings:

There are serious inadequacies in providing essential sound privacy of care throughout the entire facility to inmates identified as mentally ill. Individuals seen by mental health on referral from intake, more often than not, are seen in an open non-private setting in the intake area. Thereafter, contact with the licensed mental health professionals invariably occurs at the cell front with in ear shot of other inmates and correctional staff. The only sound private contacts are conducted by the psychiatrist, and even then, inmates report a security officer is always present as is a psychiatric nurse. The lack of privacy significantly hampers the development of confidence and trust between the inmate and the mental health professional. Without sound privacy individuals are unlikely to confide material that they believe will reveal weakness or for which they feel shame. Oftentimes inmates will request placement on suicide watch for reasons other

than intent to harm themselves. Without a private setting they will not reveal the vulnerabilities which caused them to request that placement.

The second issue regarding the privacy of care is the maintenance of inmate health service requests remaining confidential throughout the process of submission until receipt by health services. Emergency mental health needs and when an inmate chooses to hand their requests to an officer are the usual exceptions.

Recommendations:

1. Patient\clinician contacts, other than rounds, should occur in a sound private setting unless there are well founded documented security justifications restricting this practice.

2. Sufficient escort officers and private interviewing spaces are essential to allow proper mental health encounters.

3. Inmates housed in a safety cell should be seen in a sound private interview space which may include a fixed table and chairs. Inmates considered a safety risk may need to be shackled and secured so they can be seen safely by the clinician.

4. Mental health staff delivering services in high security areas should have a security radio for emergency contacts.

5. A confidential health service request system should be implemented.

T. MORTALITY AND MORBIDITY REVIEWS:

Findings:

A verbal description of the morbidity and mortality process is as follows:

1. An internal affairs investigation is completed by a Risk Assessment Unit (RAU) (patrol and custody). A review of all video, the autopsy, and staff interviews including EMS are completed.
2. RAU works for the County Council and reports directly to the Sheriff and the undersheriff.
3. Upon completion of the autopsy and toxicology studies the final coroner's review includes the Chief of Corrections, Commanders, Lieutenant, the health services leadership, physician, and Public Health Department physician.
4. CFMG stated that they do a 24 hour review with a report to the corporate office and within 30 days meet with custody to review the death.

The adequacy of the suicide death review is deficient because there is no formal follow up at the site level to ensure that corrective actions were developed, completed by an assigned facilitator and done in a timely fashion.

Recommendations:

1. Add a process defined by policy creating a final documented mortality review, interventions and root cause analysis, when indicated, at the facility level. Develop any necessary corrective action plans based on this final review looking for systems issues that were identified and correct physical or procedural issues uncovered by the mortality review process and track the outcome of applied interventions.

Suggestions:

1. It is useful for the mortality and morbidity committee to schedule an annual review of all deaths in the facility to ensure that all elements of the corrective action plans have been completed and are sustaining themselves. The second purpose of such a meeting is to attempt to identify if there are any trends in the nature of the deaths that might require an intervention. Examples of this might be an uptick in the number of heroin related deaths resulting in the facility we studying policies around contraband etc.

U. QUALITY IMPROVEMENT:

Findings:

CFMG plans to do specific studies each month including outcome and process studies that are site specific.

No studies performed by the prior contractor, Corizon, were available for review.

Recommendations:

1. A policy modeled after J-A-06 Continuous Quality Improvement Program Standard [4] or a similar standard be reviewed and approved by the subject matter expert.

[4] Standards for Health Services in Jails 2008, Essential Standard J-A- 06 Continuous Quality Improvement Program, p.10. National Commission on Correctional Healthcare 2008

2. A minimum requirement for process and outcome studies should be established by policy.

3. The Quality Improvement Committee should meet monthly with facilitation until all members are knowledgeable about the principles of continuous quality improvement and are capable of facilitating project teams. Ultimately, the quality of healthcare is the responsibility of the County and key leadership from the Sheriff's Jail Staff should be integral members of the Quality Improvement Committee. (In the case of this County, I would also include the two monitors from the Departments of Public Health and Behavioral Health). The latter are responsible to communicate back the County key concerns regarding poor performance relying on aggregate, non protected data to address concerns regarding outcomes and vendor work efforts.

4. Develop a Corrective Action Plan format to track the elements of any future remedial plan and send the recommended data to the subject matter expert at least two weeks prior to any monitoring tour.

Respectfully submitted,

March 2, 2018