UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA,

Plaintiff,

v.

MIAMI-DADE COUNTY; MIAMI-DADE COUNTY BOARD OF COUNTY COMMISSIONERS; MIAMI-DADE COUNTY PUBLIC HEALTH TRUST

Defendants,

1:13-CV- 21570 CIV
The Honorable Beth Bloom

Report No. 11 of the Independent Monitors

October 28, 2019

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This is the eleventh report of the Independent Monitors regarding Miami-Dade County's and the Public Health Trust's compliance with both the Settlement Agreement (effective April 30, 2013) and the Consent Agreement (effective May 22, 2013).

As with the previous ten reports, this findings in this document are based on the evidence, document, and data provided by the Defendants regarding their on-going performance focused on achieving compliance with the provisions of both agreements.

A draft of this report was provided to all parties on October 7, 2019. The Monitor thanks the parties for their expeditious reviews. The nine provisions of the Consent Agreement which the Monitors reported in partial compliance were discussed during the regularly scheduled monthly conference call on October 18th. The Monitors carefully considered the County's submission of October 23rd.

Regarding the Consent Agreement, the Monitors continue to be impressed by the efforts and outcome of the County's work to gain and sustain compliance. The Monitors find that there are no paragraphs in non-compliance at this time.

The County has maintained 100% with the provisions of the Settlement Agreement. As noted in the Introduction to the findings of the Settlement Agreement, there remain several areas requiring on-going attention: inmate classification, sustaining decreases in uses of force and inmate/inmate altercations, and improvements in self-audits.

The leadership of MDCR, Director Daniel Junior, and CHS, Corporate Director Edith Wright is acknowledged. We extend our thanks to: Deputy Mayor Maurice L. Kemp, and, and Chief Operating Officer, Jackson Health System Don Steigman, for their time in meeting with the independent Monitors and their support advice and actions. Many staff in MDCR and CHS contributed significantly to the progress made in the last six year.

The narratives for both the Settlement Agreement and the Consent Agreement provide the analyses of findings, work accomplished to date, and recommendations. [1]

[1] The work of the monitoring team is assisted by subject matter experts: Nancy A. DeFerrari, B.S., CJM, Adam Chidekel, Ph.D., CCHP, Angela Goehring, R.N., M.S.A., C.C.H.P., and Catherine M. Knox M.N., R.N., CCHP-RN.

Consent Agreement - Medical and Mental Health Care

Introduction

The Independent Monitors acknowledge and commend the improvements in the County's compliance with the provisions of the Consent Agreement, with no paragraphs in non-compliance. Improvements are highlighted, decreasing the number of paragraphs in partial compliance from 20 in the last tour, to 9 in this tour, including one paragraph which moved from compliance to partial compliance.

This report examines the County's compliance with the provisions of the Consent Agreement at the time of the on-site tour (September 2019), based on the documentation provided before the tour, and any relevant information provided on-site, and/or immediately after the tour's conclusion. The findings are not a "snap shot" of compliance, rather a thorough review of the historical and trend data, and information provided by the County.

The areas requiring emphasis to achieve or maintain compliance are:

- Retention of a permanent Medical Director of Behavioral Health/Chief Psychiatrist.
- Risk profiles (III.A.2.d).
- Sick call process (III.A.3.a. (2).
- Medication administration and management (III.A.4.d.).
- Improvements in laboratory testing and related processes (III.A.4.e.).
- Discharge planning (III.A.6.a.(1)-(3)).
- Continuing emphases on improving mortality and morbidity reviews (III.A.7.a. b. c.).
- Improved performance for detoxification protocols (III.B.1.a.)
- Referral to mental health care (III.C.1.a.).
- Mental health treatment planning (III.C.2.d.).
- Alignment of screening, assessment, diagnosis, etc. (III.C.2.k.).
- Individualized treatment plans (III.C.3.e.).
- Mental Health Beds assessment in collaboration with MDCR's upcoming revised jail objective classification system (III.C.5.d.).
- Long-term custodial segregation (III.C.6.a.(6)) and III.C.6.a. (11).
- Staffing training on suicide risk assessment protocols (III. C.9.d.).

The Monitors are very encouraged by the progress, and recognize the momentum for improvement. Collaboratively, these improvements have been made, and the Monitors look forward to the time we can report full compliance to the Court.

The Monitors have provided specific recommended actions to achieve and/or maintain compliance. These recommendations are found both within the narrative, and a summary of recommendations found starting on page 64.

U.S. v. Miami-Dade County
Consent Agreement – Compliance Report # 11 - Status of Compliance[1]

Report # Date	Substantial Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total Paragraphs
1 – 11/5/13	1	56	40	22	119
2 – 5/22/14	0	38	73	8	119
3 – 11/28/14	2	19	98	0	119
4 -7/3/15	6	35	75	0	116[2]
5 – 2/15/16	4	50	61	0	115
6 - 9/9/16	10	65	40	0	115
7 – 4/4/17	16	51	48	0	115
8 – 1/18/18	29	70	16	0	115[3]
9 – 8/24/18	48	60	7	0	115
10 – 3/22/19	95	20	0	0	115
11 – 10/7/19	106	9	0	0	115

Defendants shall ensure constitutionally adequate treatment of inmates' medical and mental health needs. Defendants' efforts to achieve this constitutionally adequate treatment will include the following remedial measures regarding: (1) Intake Screening; (2) Health Assessments; (3) Access to Medical and Mental Health Care; (4) Medication Administration and Management; (5) Record Keeping; (6) Discharge Planning; and (7) Mortality and Morbidity Reviews.

Intake Screening

III. A. 1. a. Qualified Medical Staff shall sustain implementation of the County Pre-Booking policy, revised May 2012, and the County Intake Procedures, adopted May 2012, which require, inter alia, staff to conduct intake screenings in a confidential setting as soon as possible upon inmates' admission to the Jail, before being transferred from the intake area, and no later than 24 hours after admission. Qualified Nursing Staff shall sustain implementation of the Jail and CHS' Intake Procedures, implemented May 2012, and the Mental Health Screening and Evaluation form, revised May 2012, which require, inter alia, staff to identify and record observable and non-observable medical and mental health needs, and seek the inmate's cooperation to provide information.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A
Recommendations for Achieving Compliance, if applicable: N/A

III. A. 1. b. CHS shall sustain its policy and procedure implemented in May 2012 in which all inmates received a mental health screening and evaluation meeting all compliance indicators of National Commission on Correctional Health Care J-E-05. This screening shall be conducted as part of the intake screening process upon admission. All inmates who screen positively shall be referred to qualified mental health professionals (psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse) for further evaluation.

Monitor: Johnson

MH Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for continuing Compliance: N/A

III. A. 1. c. Inmates identified as in need of constant observation, emergent and urgent mental health care shall be referred immediately to Qualified Mental Health Professionals for evaluation, when clinically indicated. The Jail shall house incoming inmates at risk of suicide in suicide-resistant housing unless and until a Qualified Mental Health Professional clears them in writing for other housing.

Monitor: Johnson

MH Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

II. A. 1. d. Inmates identified as "emergency referral" for mental health or medical care shall be under constant observation by staff until they are seen by the Qualified Mental Health or Medical Professional.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 1. e. CHS shall obtain previous medical records to include any off-site specialty or inpatient care as determined clinically necessary by the qualified health care professionals conducting the intake screening.

Monitor: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: CHS Behavioral Health (BH) progress notes continue to indicate that they have reviewed prior records contained in the EHR. Medical records for patients returning from competency restoration are routinely reviewed, included in the chart, and utilized in clinical decision making (e.g., medication started at the state hospital during restoration of competency is usually continued when they return to the jail). CHS is requesting previous medical records from inpatient or other outside Mental Health (MH) care at intake based on review of CHS Medical Record Request Log and independent chart review of record requests identified as MH from those identified. However, when records are not requested by the ARNP it is not consistently documented why (e.g., ARNP leaves the area in the progress note blank or writes "N/A" despite document previously that the patient has had outside MH or special needs care). When the requested MH records are received, MH providers rarely note in the EHR that they have reviewed the records and they do not document the impact, if any, the records had on their clinical decision making.

Recommendations for Achieving/Sustaining Compliance, if applicable: Document review of outside medical records once received, and, document the clinically utility of data from outside medical records in diagnostic and clinical decision making.

III. A. 1. f. CHS shall sustain implementation of the intake screening form and mental health screening and evaluation form revised in May 2012, which assesses drug or alcohol use and withdrawal. New admissions determined to be in withdrawal or at risk for withdrawal shall be referred immediately to the practitioner for further evaluation and placement in Detox.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 1. g. (See also III.A.1.a.) CHS shall ensure that all Qualified Nursing Staff performing intake screenings receive comprehensive training concerning the policies, procedures, and practices for the screening and referral processes.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Health Assessments

III. A. 2. a. Qualified Medical Staff shall sustain implementation of CHS Policy J-E-04 (Initial Health assessment), revised May 2012, which requires, inter alia, staff to use standard diagnostic tools to administer preventive care to inmates within 14 days of entering the program. [NB: This requirement is not about diagnostic tools or prevention – it is about the entirety of the health assessment. It was driven by detainees not getting, or getting inadequate initial health assessments.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 2. b. Qualified Mental Health Staff will complete all mental health assessments incorporating, at a minimum, the assessment factors described in Appendix A.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 2. c. Qualified Mental Health Professionals shall perform a mental health assessment following any adverse triggering event while an inmate remains in the MDCR Jail facilities' custody, as set forth in Appendix A.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 2. d. Qualified Mental Health Professionals, as part of the inmate's interdisciplinary treatment team (outlined in the "Risk Management" Section, *infra*), will maintain a risk profile for each inmate based on the Assessment Factors identified in Appendix A and will develop and implement interventions to minimize the risk of harm to each inmate.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The risk profile is created by completing the "Risk for Injury to Self or Others" portion of the "Problem/Target Symptoms Identified" Section of the Interdisciplinary Treatment Plan (IDTP). All sections of the IDTP are completed for each inmate. Appendix A specifically addresses Suicide Risk Assessment Factors. The "Individual Suicide Risk Reduction Factors" in the CAT-RAG portion of the IDTP is now being completed. This reflects progress. The quality of the interventions specified still needs improvement as they address broader mental health goals instead of clearly targeting suicidal ideation; intervening to reduce acute risk factors; and interventions to increase protective factors/coping skills. The Suicide Risk Assessment from the IDTP now consistently populates into subsequent Psychiatry Notes; however, problems with completion of the CSSRS interview portion of the document (i.e. limiting consideration of assessment of suicidal ideation, intent, and behaviors to the current interview instead of the previous 30 days and unclear documentation of review of prior SRAs) limits the utility of the tool. The free text portion of the Suicide Risk Assessments and the IDTPs have greatly improved but this information does not "pull forward" so the reliability of the information pulled through varies. There were occasions where risk was underestimated. Treatment goals in IDTP better address safety. However, interventions to reduce the risk of harm to each inmate and service documentation produced in clinical contacts subsequent to Mental Health Treatment Plans/IDTPs, particularly for Level 1 patients, does not demonstrate performance of the interventions (other than psychiatric medication monitoring) listed in the Mental Health Treatment Plans. Consequently, treatment plans are being developed but not implemented and the services specified to address risk factors and provide the interventions necessary to help patient achieve their goals are not being offered (or clearly documented) in clinical contacts following the IDTPs. When patients are re-levelled there is no continuity of care documented to preserve the gains that enabled the patient to reduce level of care.

In recognition of the improvements made since the last tour, this section will be placed in Compliance but will only remain in compliance if CHS is able to demonstrate they are reliably assessing suicide risk more accurately. This will be demonstrated by reviewing prior suicide risk assessments; taking into account clinical observation and recent clinical presentation, in addition to each patient's current self-report of suicidal ideation, intent, and self-harm behaviors during each assessment; by clearly formulating and explaining the patient's risk and protective factors; by implementing and updating IDTPs as appropriate once an patient's level or treatment needs change; and by providing the services specified in the IDTP as evidenced by subsequent clinical notes (MH-G-03; MH-G-04) .

Recommendations for Achieving Compliance, if applicable: Review IDTP short-term and long-term goals to ensure they are related to the presenting problems described in the IDTP and clinical notes written in days leading up to the IDTP. Review IDTP, Psychiatry Notes, and SW Notes written on day of IDTP to insure consistency across disciplines and document efforts to resolve differences. For inmates who are suicidal target: suicidal ideation, self-harm, and/or suicidal intent in the treatment goals; and, provide interventions specifically designed to reduce risk and increase protective factors/resilience. Review and update IDTP short-term and long-term goals at subsequent IDTPs. Document provision of

interventions consistent with IDTP goals in subsequent clinical notes. Document review and consideration and implementation of interventions and goals made at one treatment level or required changes across changes in MH level or treatment needs.

III. A. 2. e. An inmate assessed with chronic disease shall [be] seen by a practitioner as soon as possible but no later than 24-hours after admission as a part of the Initial Health Assessment, when clinically indicated. At that time medication and appropriate labs, as determined by the practitioner, shall be ordered. The inmate will then be enrolled in the chronic care program, including scheduling of an initial chronic disease clinic visit.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 2. f. (Covered in III.A.1.a.) and (III.A.2.e.) All new admissions will receive an intake screening and mental health screening and evaluation upon arrival. If clinically indicated, the inmate will be referred as soon as possible, but no longer than 24-hours, to be seen by a practitioner as a part of the Initial Health Assessment. At that time, medication and appropriate labs as determined by the practitioner are ordered.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 2. g. All individuals performing health assessments shall receive comprehensive training concerning the policies, procedures, and practices for medical and mental health assessments and referrals.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Access to Medical and Mental Health Care

III. A. 3. a. (1) The sick call process shall include… written medical and mental health care slips available in English, Spanish, and Creole.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 3. a. (2) The sick call process shall include…opportunity for illiterate inmates and inmates who have physical or cognitive disabilities to confidentially access medical and mental health care.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: Pre-tour documentation provided by CHS included data on patients with cognitive disabilities. Since the last tour, CHS has started to test patients who they suspect have cognitive disabilities with the Montreal Cognitive Assessment (MoCA). However, chart review from a list of patients provided prior to the tour demonstrated all testing was completed on August 13th and 14th, 2019. While the actual tests were not scanned into the chart, providers did document completion of the instruments. The provider placed the scores in their progress notes with their tentative findings and documented that the instruments were submitted for scanning into the medical record. Appropriate treatment adjustment and ADA accommodations were not documented or ordered. However, CHS is ordering ADA appropriate accommodations for patients with other ADA disabilities. ADA patients, medical/MH staff, and Correctional Officers report that assistance in completing sick calls is provided to ADA patients by Social Workers or Correctional Counselors.

Recommendations for Achieving Compliance, if applicable: To maintain compliance, continue tracking ADA patients with cognitive disabilities; insure MoCA protocols are scanned into the chart; write the appropriate Special Needs Orders, and clearly document ADA reason for Social Work follow-up visits and intervention.

III. A. 3. a. (3) The sick call process shall include…a confidential collection method in which designated members of the Qualified Medical and Qualified Mental Health staff collects the request slips every day

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 3. a. (4) The sick call process shall include…an effective system for screening and prioritizing medical and mental health requests within 24 hours of submission and priority review for inmate grievances identified as emergency medical or mental health care.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 3. b. CHS shall continue to ensure all medical and mental health care staff are adequately trained to identify inmates in need of acute or chronic care, and medical and mental health care staff shall provide treatment or referrals for such inmates.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Medication Administration and Management

III. A. 4. a. CHS shall develop and implement policies and procedures to ensure the accurate administration of medication and maintenance of medication records.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: Since the last tour, CHS fully implemented the Cerner EHR Medication Administration module.

Recommendations for continuing Compliance: N/A

III. A. 4. b. (1) Within eight months of the Effective Date…Upon an inmate's entry to the Jail, a Qualified Medical or Mental Health Professional shall decide and document the clinical justification to continue, discontinue, or change an inmate's reported medication for serious medical or mental health needs, and the inmate shall receive the first dose of any prescribed medication within 24 hours of entering the Jail;

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 4. b. (2) Within eight months of the Effective Date. A medical doctor or psychiatrist shall evaluate, in person, inmates with serious medical or mental health needs, within 48 hours of entry to the Jail.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving/Sustaining Compliance, if applicable: N/A

III. A. 4. c. Psychiatrists shall conduct reviews of the use of psychotropic medications to ensure that each inmate's prescribed regimen is appropriate and effective for his or her condition. These reviews should occur on a regular basis, according to how often the Level of Care requires the psychiatrist to see the inmate. CHS shall document this review in the inmate's unified medical and mental health record.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 4. d. Medication Administration and Management CHS shall ensure nursing staff pre-sets psychotropic medications in unit doses or bubble packs before delivery. If an inmate housed in a designated mental health special management unit refuses to take his or her psychotropic medication for more than 24 hours, the medication administering staff must provide notice to the psychiatrist. A Qualified Mental Health Professional must see the inmate within 24 hours of this notice.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: CHS has continued to audit this provision with Tool #11. A confounding factor in the audit data is that CHS is reviewing both medical and psychotropic medication refusal and follow-up and it is not always clear in the results which type of medication was refused (e.g., psychotropic or non-psychotropic). The actual results may be worse or better than reported because of this. ARNPs are now assisting with QMHP follow-up after a refusal. The last three audits from March, June, and September 2019 resulted in clinicians being notified of missed doses 50%, 90%, and 70% of the time with the appropriate clinical response 70%, 83%, and 50% of the time, respectively. CHS is averaging ~70% on notification and clinical response in the appropriate time frame. The audit results were found to be reliable when a sample of the audited charts were reviewed by the monitoring team. The Corrective Action Plans focus on both short-term and long-term solutions that are reasonable. While there is a need for continued improvement in notification and response from the QMHP, CHS is aware of the issues and has CAPs that will directly address these issues.

CHS plans to open a Temporary MH Housing unit that will reduce ARNP evaluations in Intake and theoretically allow the ARNPs more time for other clinical tasks (e.g., such as medication refusal follow-up evaluations).

Recommendations for Achieving Compliance, if applicable: Ongoing compliance will be based on consistent referral and timely follow-up for psychotropic medication refusals.

III. A. 4. e. CHS shall implement physician orders for medication and laboratory tests within three days of the order, unless the inmate is an "emergency referral," which requires immediately implementing orders. [NB: Lab tests in this measure are only those related to medications. Email DOJ 8/27/13]

Monitor: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**

Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: Review of audit Tools #21 and 22 indicate that baseline lab orders associated with potentially toxic medications (e.g., Lithium) are being ordered inconsistently (ranging from 10-80% in three measurements in 2019). Further, CHS reliability on these measures is less than optimal. Tools #22 showed low monitoring of lipid profiles and hemoglobin A1c in patients prescribed antipsychotic medication (variable during three 2019 measures, ranging from 0-70%). CHS reliability on these is also less than optimal.

CHS has not developed treatment protocols and instead provided an informal training to psychiatric providers (psychiatrists and ARNPs) that was based on the American Psychiatric Association [APA] clinical guidelines. CHS provided links to the APA clinical guidelines and mention of the psychiatric provider training in the Mental Health Review Committee monthly minutes.

Recommendations for Achieving Compliance, if applicable: Provide access to the summary of the referenced APA clinical guidelines or develop readily accessible and digestible treatment protocols for SMI that include guidance on the psychotropic prescribing and monitoring for these illnesses and commonly prescribed potentially toxic medications. Consider providing quarterly or semi-annual training on the protocols. Continue to audit these measures. Consider methods to institute early ordering of appropriate labs for potentially toxic medications.

III. A. 4. f. (See III.A.4.a.) Within 120 days of the Effective Date, CHS shall provide its medical and mental health staff with documented training on proper medication administration practices. This training shall become part of annual training for medical and mental health staff

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Record Keeping

III. A. 5. a. CHS shall ensure that medical and mental health records are adequate to assist in providing and managing the medical and mental health needs of inmates. CHS shall fully implement an Electronic Medical Records System to ensure records are centralized, complete, accurate, legible, readily accessible by all medical and mental health staff, and systematically organized. [NB: Specific aspects of medical record documentation are addressed elsewhere, e.g. medication administration. This paragraph, then, applies to all aspects of medical records not addressed elsewhere. Thus, these various paragraphs are independent and MDCR may reach compliance with this paragraph, for example, despite non-compliance with other aspects of medical record keeping.]

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: Since the last tour, MH note templates have been updated, the MAR has transitioned to the EHR, training was provided on the APA clinical guidelines for the treatment of SMI diagnoses, and ARNP charts are being audited with feedback by BH leadership on a monthly basis. However, ARNP feedback varies based on who is reviewing the chart and there is room for improvement in this process. Efforts to improve diagnosis of mental illness are noticeable in the chart since the last tour. The IDTT policy, CHS-058A, was updated to reflect CHS' recognition that the rationale for patient treatment decisions, and the role of MH in assessing the rationale, may be required for both psychiatric and medical illness (e.g., decisional capacity evaluations for patients with life endangering medical illness). However, at the time of this report the Monitors had not had the opportunity to review the updated policy and provide feedback.

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 5. b. CHS shall implement an electronic scheduling system to provide an adequate scheduling system to ensure that mental health professionals see mentally ill inmates as clinically appropriate, in accordance with this Agreement's requirements, regardless of whether the inmate is prescribed psychotropic medications.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 5. c. (See III.A.5.a.) CHS shall document all clinical encounters in the inmates' health records, including intake health screening, intake health assessments, and reviews of inmates.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. A. 5. d. CHS shall submit medical and mental health information to outside providers when inmates are sent out of the Jail for health care. CHS shall obtain records of care, reports, and diagnostic tests received during outside appointments and timely implement specialist recommendations (or a physician should properly document appropriate clinical reasons for non-implementation).

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Discharge Planning

III. A. 6. a. (1) CHS shall provide discharge/transfer planning…Arranging referrals for inmates with chronic medical health problems or serious mental illness. All referrals will be made to Jackson. Memorial Hospital where each inmate/patient has an open medical record.

Monitor: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: CHS implemented an excellent process for identifying soon-to-be-released patients. Once identified, CHS staff conducts face-to-face discharge planning including the provision of medication or prescription of medication at a pharmacy convenient to the patient. This program has been in effect for less than a year. Data on success do not appear to be reliable. Though it appears that the absolute numbers have increased, it appears that about 8% of eligible patients have a completed discharge plan with medications on release (CHS reports 248 of approximately 3,000 discharges, of which approximately 1,500 should be eligible).

The County tracks this provision with audit Tools 25 and 40. Discharge planning is happening 100% of the time per the audits and appropriate referrals are being provided prior to discharge, to Jackson Memorial Hospital and other care providers. However, the sampling for these studies was limited to those who had a discharge. This sampling is not representative of the universe of patients with chronic disease or those on the mental health caseload.

Recommendations for Achieving Compliance, if applicable: Continue to implement this new program. Perform a focused study, using appropriate numerators and denominators to determine effectiveness, trended over time. Analyze these data and develop action plans to increase the effectiveness of this program.

III. A. 6. a. (2) Providing a bridge supply of medications of up to 7 days to inmates upon release until inmates can reasonably arrange for continuity of care in the community or until they receive initial dosages at transfer facilities. Upon intake admission, all inmates will be informed in writing and in the inmate handbook they may request bridge medications and community referral upon release.

Monitor: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: See III. A. 6. A (1).

III. A. 6. (3) Adequate discharge planning is contingent on timely notification by custody for those inmates with planned released dates. For those inmates released by court or bail with no opportunity for CHS to discuss discharge planning, bridge medication and referral assistance will be provided to those released inmates who request assistance within 24-hours of release. Information will be available in the handbook and intake admission awareness paper. CHS will follow released inmates with seriously critical illness or communicable diseases within seven days of release by notification to last previous address.

Monitor: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: See III.A.6.a.(1 & 2).

Recommendations for Achieving Compliance, if applicable: See III.A.6.a.(1).

Mortality and Morbidity Reviews

III. A. 7. a. Defendants shall sustain implementation of the MDCR Mortality and Morbidity "Procedures in the Event of an Inmate Death," updated February 2012, which requires, inter alia, a team of interdisciplinary staff to conduct a comprehensive mortality review and corrective action plan for each inmate's death and a comprehensive morbidity review and corrective action plan for all serious suicide attempts or other incidents in which an inmate was at high risk for death. Defendants shall provide results of all mortality and morbidity reviews to the Monitor and the United States, within 45 days of each death or serious suicide attempt. In cases where the final medical examiner report and toxicology takes longer than 45 days, a final mortality and morbidity review will be provided to the Monitor and United States upon receipt.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: Overall, M&M reviews have improved since the last tour. However, it was noted during the onsite review that several key incidents are not reflected in the written report. The consequence of this is that the opportunities for improvement are lost to history, e.g., the annual review. Clinicians are now involved in the reviews; this is an improvement. Follow through on CAPS has lagged in some cases (e.g., shift in assigned personnel for tasks and no indicated target date of completion).

Recommendations for <u>maintaining</u> Compliance: The compliance rating is provisional on improving the rigor of the reviews and improved documentation.

III. A. 7. b. Defendants shall address any problems identified during mortality reviews through training, policy revision, and any other developed measures within 90 days of each death or serious suicide attempt.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III. A. 7. a.

Recommendations for <u>maintaining</u> Compliance: See III. A. 7. a.

III. A. 7. c. Defendants will review mortality and morbidity reports and corrective action plans bi-annually. Defendants shall implement recommendations regarding the risk management system or other necessary changes in policy based on this review. Defendants will document the review and corrective action and provide it to the Monitor.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III. A. 7. a.

Recommendations for <u>maintaining</u> Compliance: See III. A. 7. a.

Medical Care

Acute Care and Detoxification

III. B. 1. a. CHS shall ensure that inmates' acute health needs are identified to provide adequate and timely acute medical care.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for maintain Compliance, if applicable: Revisit and revise the performance measurement tool for detoxification.

III. B. 1. b. (See III.B.1.a.) CHS shall address serious medical needs of inmates immediately upon notification by the inmate or a member of the MDCR Jail facilities' staff or CHS staff, providing acute care for inmates with serious and life-threatening conditions by a Qualified Medical Professional.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. B. 1. c. CHS shall sustain implementation of the Detoxification Unit and the Intoxication Withdrawal policy, adopted on July 2012, which requires, inter alia, County to provide treatment, housing, and medical supervision for inmates suffering from drug and alcohol withdrawal.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour:

Recommendations for Achieving Compliance, if applicable: N/A

Chronic Care

III. B. 2. a. CHS shall sustain implementation of the Corrections Health Service ("CHS") Policy J-G-01 (Chronic Disease Program), which requires, inter alia, that Qualified Medical Staff perform assessments of, and monitor, inmates' chronic illnesses, pursuant to written protocols.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. B. 2. b. (See III. B. 2. a.) Per policy, physicians shall routinely see inmates with chronic conditions to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions. [NB: The Medical Monitor will interpret "see" in this particular requirement as meaning physicians play a leadership and oversight role in the management of patients with chronic conditions; Qualified Medical Staff may perform key functions consistent with their licensure, training, and abilities. This interpretation was approved by DOJ during the telephone conference of 8/19/13.]

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Use of Force Care

III. B. 3. a. The Jail shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15-minute in-person visual observation by trained custody. Qualified Medical Staff shall perform 15-minute checks on an inmate in restraints. For any custody-ordered restraints, Qualified Medical Staff shall be notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. B. 3. b. The Jail shall ensure that inmates receive adequate medical care immediately following a use of force.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. B. 3. c. Qualified Medical Staff shall question, outside the hearing of other inmates or correctional officers, each inmate who reports for medical care with an injury, regarding the cause of the injury. If a health care provider suspects staff-on- inmate abuse, in the course of the inmate's medical encounter, that health care provider shall immediately:

1) take all practical steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence);
2) report the suspected abuse to the appropriate Jail administrator; and
3) complete a Health Services Incident Addendum describing the incident.

Monitor: Greifinger

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

MENTAL HEALTH CARE AND SUICIDE PREVENTION

Referral Process and Access to Care

III. **C. 1. a.** Defendants shall ensure constitutional mental health treatment and protection of inmates at risk for suicide or self-injurious behavior. Defendants' efforts to achieve this constitutionally adequate mental health treatment and protection from self- harm will include the following remedial measures regarding…
CHS shall develop and implement written policies and procedures governing the levels of referrals to a Qualified Mental Health Professional. Levels of referrals are based on acuteness of need and must include "emergency referrals," "urgent referrals," and "routine referrals," as follows:
"Emergency referrals" shall include inmates identified as at risk of harming themselves or others, and placed on constant observation. These referrals also include inmates determined as severely decompensated, or at risk of severe decompensation. A Qualified Mental Health Professional must see inmates designated "emergency referrals" within two hours, and a psychiatrist within 24 hours (or the next Business day), or sooner, if clinically indicated.
"Urgent referrals" shall include inmates that Qualified Mental Health Staff must see within 24 hours, and a psychiatrist within 48 hours (or two business days), or sooner, if clinically indicated.
"Routine referrals" shall include inmates that Qualified Mental Health Staff must see within five days, and a psychiatrist within the following 48 hours, when indicated for medication and/or diagnosis assessment, or sooner, if clinically indicated.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: Evaluation by QMHP and Psychiatrist at Intake continues to be timely. However, CHS has continues to struggle to provide timely follow-up by a QMHP or Psychiatrist after Intake. CHS is no longer using Internal Audit Tool #44, MH Evaluation After Intake. CHS now tracks this provision through monitoring of the MH sick call referral process through Internal Audit Tool #46B, BH Assessments and Access to Care. It is performed on a monthly basis and reported in the Mental Health Review Committee's monthly minutes. Results from the May, June, and July 2019 audits indicated that 63%, 40%, and 75% of consults to the QMHP were completed in the indicated time frame and that follow-up by a psychiatrist was timely in 42%, 53%, and 40% of the time, respectively. The CAP associated with this tool does not address improvement of follow-up by psychiatry.

After the last tour, CHS agreed to continue to audit this provision and to institute appropriate CAPs to improve evaluation within the indicated referral times as well as follow-up by a psychiatrist within the appropriate time after QMHP evaluation. A provisional rating of compliance was given with the shared understanding that they would improve before the next tour. CHS has continued to audit this provision via review of referrals after sick call. Follow-up by the QMHP has improved overall but timely follow-up by psychiatry has not. The absence of a stable BH Medical Director/Chief of Psychiatry until immediately before the September 2019 tour may have impacted opportunities to improve on meeting this provision.

Recommendations for Achieving Compliance, if applicable: Continue to audit this provision quarterly with issue focused CAPs to improve evaluation within the indicated referral time frames as well as timely follow-up by a psychiatrist after QMHP evaluation.

III. C. 1. b. Referral Process and Access to Care
CHS will ensure referrals to a Qualified Mental Health Professional can occur:

1. At the time of initial screening;
2. At the 14-day assessment; or
3. At any time by inmate self-referral or by staff referral.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Mental Health Treatment

III. C. 2. a. CHS shall develop and implement a policy for the delivery of mental health services that includes a continuum of services; provides for necessary and appropriate mental health staff; includes treatment plans for inmates with serious mental illness; collects data; and contains mechanisms sufficient to measure whether CHS is providing constitutionally adequate care.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. b. CHS shall ensure adequate and timely treatment for inmates, whose assessments reveal mental illness and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. c. Each inmate on the mental health caseload will receive a written initial treatment plan at the time of evaluation, to be implemented and updated during the psychiatric appointments dictated by the Level of Care. CHS shall keep the treatment plan in the inmate's mental health and medical record.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: Treatment plans continue to be created by the ARNP as part of patients' initial MH evaluation. It is then updated during subsequent follow-up visits with the Psychiatrist. Psychiatric treatment plans tend to be broad, general, and include a description of the services provided at the level of care the patient is presently being offered. These often pull through to subsequent psychiatry notes and essentially remain the same. The free text portion of the treatment plans have improved and are clearly patient-centered with the most common changes to the treatment plan and interventions being medication adjustments. A minority of psychiatric providers add further specification to the plan. IDTPs have further improved but there is still variance between the Psychiatric Note, Psychiatric Treatment Plan, and the IDTP treatment plan. Combining or linking the IDTPs to the psychiatric treatment plans would essentially meet the need for treatment

plans to contain concrete, measurable, and observable goals that are patient specific and able to be implemented (MH-G-03), and ensure that interdisciplinary differences in care are aligned so that the patient receives the full benefit of the multidisciplinary treatment team approach.

Recommendations for continuing Compliance: Ensure alignment of treatment planning between QMHP (including Psychiatry) Notes, Psychiatric Treatment Plans, and the IDTP treatment plans. Combining or linking the IDTPs to the psychiatric treatment plans would essentially meet the need for treatment plans to contain concrete, measurable, and observable goals that are patient specific and able to be implemented (MH-G-03), and ensure that interdisciplinary differences in care are aligned so that the patient receives the full benefit of the multidisciplinary treatment team approach.

III. C. 2. d. CHS shall provide each inmate on the mental health caseload who is a Level I or Level II mental health inmate and who remains in the Jail for 30 days with a written interdisciplinary treatment plan within 30 days following evaluation. CHS shall keep the treatment plan in the inmate's mental health and medical record.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The IDTT policy, CHS-058A, was updated to reflect CHS' recognition that the rationale for patient treatment decisions, and the role of MH in assessing the rationale, may be required for both psychiatric and medical illness (e.g., decisional capacity evaluations for patients with life endangering medical illness). However, at the time of this report the Monitors had only visualized the changes but had not had the opportunity to formally review the updated policy and provide feedback. The proposed changes are a welcome addition and , once streamlined and operationalized in their final version, will improve the provision of care for patients with life endangering illness.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. e. In the housing unit where Level I inmates are housed (9C) (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care within the next seven days and every 30 days thereafter. In addition, the County shall initiate documented contact and follow-up with the mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. The interdisciplinary team will:

(1) Include the treating psychiatrist, a custody representative, and medical and nursing staff. Whenever clinically appropriate, the inmate should participate in the treatment plan.
(2) Meet to discuss and review the inmate's treatment no less than once every 45 days for the first 90 days of care, and once every 90 days thereafter, or more frequently if clinically indicated; with the exception being inmates housed on 9C (or equivalent housing) who will have an interdisciplinary plan of care at least every 30 days.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. f. CHS will classify inmates diagnosed with mental illness according to the level of mental health care required to appropriately treat them. Level of care classifications will include Level I, Level II, Level III, and Level IV. Levels I through IV are described in Definitions (Section II.). Level of care will be classified in two stages: Stage I and Stage II.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: CHS has continued to audit quarterly the MH Levels using Internal Audit Tools 33-36, for Levels I-IV respectively, to assess if leveling is appropriate. CHS has updated the language in their policy on Leveling, CHS-058B, to reduce ambiguity in the criteria for leveling/releveling patients due to interpretive overlap in some of the level criteria for Level IB and Level II. They now only have Levels I-IV and recently proposed restricting Level I to only those patients who are suicidal and require suicide precautions or suicide smock. Level 1B was removed from use. This will clarify QMHP interpretative overlap between Level 1B and Level II. Audit performance has been high for the majority of measures. There is still improvement to be made for Level I patients on placing an appropriate diagnosis on the diagnosis list (63% in July 2019 down from 70% in April 2019) and entering orders for suicide precautions (0% in June 2019 down from 100% in April 2019). The latter has not impacted care because patients are being placed on suicide precautions based on their assignment to Level, with or without the order based on chart review and the site visit. However, lack of an order may impact tracking of this provision and indicate a need for refresher training.

Recommendations for <u>continuing</u> Compliance, if applicable: Continue to follow through on CAPs for appropriate diagnosis and entry of orders for suicide precautions.

III. C. 2. g. Stage I is defined as the period of time until the Mental Health Treatment Center is operational. In Stage I, group- counseling sessions targeting education and coping skills will be provided, as clinically indicated, by the treating psychiatrist. In addition, individual counseling will be provided, as clinically indicated, by the treating psychiatrist.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: CHS is now tracking individual and group therapy attendance and presenting information during the MHRC monthly meetings where data is

analyzed and appropriate CAPs are instituted. Some psychiatrists have noted in their treatment plans and progress notes that they are providing supportive individual therapy during their follow-up visits. Some LCSWs and Psychologists have also noted provision of supportive therapy during rounding and other services. While clinical notes demonstrate the use of supportive techniques during these services, these are not the same as, and can't substitute for individual and group psychotherapy. These are distinct services which are most effective when they are provided in a planned manner and coordinated with the patient's existing treatment plan. CHS has designated the provision of Psychotherapy to inmates to Psychologists and Social Workers. A review of their documentation revealed a variance between the services offered with some sessions appearing to be offered on a "PRN" (as needed) basis while others offered them in a more planned and deliberate manner. "PRN" counseling is most effective when it is tied to the patient's treatment goals and offered as part of the patient's care plan. Documentation reviewed did not reflect this. There were instances where psychotherapy was provided in conjunction with other services (i.e. Segregation Rounding).

Psychologists and Social Workers are overall clearly articulating their treatment plans including the individualized treatment interventions provided by specifically stating the skills they plan to teach and reinforce (i.e. anger management, assertiveness, medication management, social skills training, etc.). However, chart reviews of progress notes completed after IDTPs did not consistently demonstrate provision of the planned services. Many times subsequent progress notes were restricted to rounding, or other assessments, and not treatment where the provider documented provision of interventions and/or patient response indicating patient progress towards meeting treatment goals. There were many instances where treatment goals are not in-sync between Psychiatrist/ARNPs and Psychologists/Social Workers. While care is adequate, there is room for improved coordination and alignment of the MH services being provided.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. g. (1) Inmates classified as requiring Level IV level of care will receive:
Managed care in the general population; Psychotropic medication, as clinically appropriate; Individual counseling and group counseling, as deemed clinically appropriate, by the treating psychiatrist; and valuation and assessment by a psychiatrist at a frequency of no less than once every 90 days.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County continues to review its mental health population and is considering how best to manage the numbers of patients present at all their psychiatric levels of care. Issues that were discussed during the tour included the frequency of leveling decisions, the amount of time patients spend at the various levels of care, and how to ensure that patients are leveled properly so that they receive adequate treatment. The discussion included both CHS and MDCR and are also impacted by the physical space challenges faced by the County. The County is encouraged to continue

monitoring their patient population and looking at trends in MH Uses of Force, rate, frequency, and location of DRs for MH patients, and rate, frequency, and location of psychiatric emergencies to help manage their mental health population. A review of the Use of Force in the Mental Health Population data indicated that many patients were releveled from Level IV to higher levels of care after being involved in an incident. The County is encouraged to consider factors that are contributing to these incidents (i.e., whether or not premature leveling decisions from III to IV are being made, limited frequency of mental health services at level IV etc.) in their corrective action plans.
Recommendations for Achieving Compliance, if applicable: N/A

III. **C. 2. g. (2)** Inmates classified as requiring Level III level of care will receive:
i. Evaluation and stabilizing in the appropriate setting;
ii. Psychotropic medication, as clinically appropriate;
iii. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days;
iv. Individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist; and
v. Access to at least one group counseling session per month or more, as clinically indicated.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III. C. 2. g. (1).

Recommendations for continuing Compliance: N/A

III. C. 2. g. (3) Inmates classified as requiring Level II level of care will receive:
i. evaluation and stabilizing in the appropriate setting;
ii. psychotropic medication, as clinically appropriate;
iii. private assessment with a Qualified Mental Health Professional on a daily basis for the first five days and then once every seven days for two weeks;
iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and
v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III. C. 2. g. (1).

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. g. (4) Inmates classified as requiring Level I level of care will receive:
i. evaluation and stabilizing in the appropriate setting;

ii. immediate constant observation or suicide precautions;
iii. Qualified Mental Health Professional in-person assessment within four hours,
iv. psychiatrist in-person assessment within 24 hours of being placed at a crisis level of care and daily thereafter
v. psychotropic medication, as clinically appropriate; and
vi. individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. h. Stage II will include an expansion of mental health care and transition services, a more therapeutic environment, collaboration with other governmental agencies and community organizations, and an enhanced level of care, which will be provided once the Mental Health Treatment Center is opened. The County and CHS will consult regularly with the United States and the Monitor to formulate a more specific plan for implementation of Stage II.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. i. CHS will provide clinically appropriate follow-up care for inmates discharged from Level I consisting of daily clinical contact with Qualified Mental Health Staff. CHS will provide Level II level of care to inmates discharged from crisis level of care (Level I) until such time as a psychiatrist or interdisciplinary treatment team makes a clinical determination that a lower level of care is appropriate.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: CHS now tracks this provision with the monthly QMHP 5-Day rounding Assessment Report which is a monthly audit that is reported in the MHRC monthly minutes. Between May, June and July 2019, CHS completed 76% of required 5-Day rounding after a patient's MH Level is changed from I to any other level. Out of the average of 24% of 5-Day Rounds that were not completed, roughly half were attempted but unable to be completed (i.e., the patient was out to court, conflicting appointment, facility

lockdown, etc.); the remaining incomplete 5-Day rounds were missed by the QMHP. The improvement since the last tour is significant.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. j. CHS shall ensure Level I services and acute care are available in a therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling, as clinically indicated.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County's 2019 Q1 MH Bed analysis indicates they required 106% of bed space to manage Level I patients (e.g., they had to create 14 temporary beds). Level I patients continue to be seen as required. CHS believes the number of Level I patients will decrease in the future due to recent changes to the leveling policy, CHS-058B. Access, when clinically indicated, to therapy and counseling has improved based on chart review including IDTTs, and patient interviews. QMHP contact has increased for those patients who are able to benefit from it. However, this continues to be a rare occurrence due to the MH acuity of Level I patients. This population of patients will continue to benefit from focused efforts to ensure access to services to address their psychosocial stressors, reinforce medication adherence, and teach non-pharmacological strategies to address their presenting problems (i.e., impulse control, anger management, sleep hygiene, etc.).

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 2. k. CHS shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County has implemented many individual EHR forms and MH services since the last tour. Their work has been commendable and as consistent with the focus on improving individual processes and procedures the County has not yet had the time to integrate their individual services into a coherent system of care.

While improvement in individual documents was demonstrated across all behavioral health service disciplines, there remains inconsistent alignment among assessment, diagnosis, interventions, and medication management within and across disciplines. Documentation across all disciplines appears to on that particular moment of care with little documented consideration of information from previous notes or assessments.

Psychologists and Social Workers are doing a better job documenting the biopsychosocial signs and symptoms of their patients. They are better articulating the problems to be addressed in their interventions and the individualized treatment interventions specified in treatment plans are better and there was documented conversations therapists had with patients regarding preparation for functioning across levels (i.e., discharge from Level II to level III) which was good. Psychologists and Social Workers are specifically stating the skills they plan to teach and reinforce (i.e., anger management, assertiveness, medication management, social skills training, etc.) and documenting improvement in symptoms to support decisions to change level of care. However, they are not consistently documenting provision of the specified interventions or services in subsequent progress notes and are not clearly or consistently indicating patient progress towards meeting individual treatment goals. There are instances where treatment goals and interventions specified in IDTP or Segregation Treatment Plans are not consistent with the description of problems in previous mental health notes. There were differences in the identified problems and treatment goals of the same patients across Psychiatrist/ARNPs and Psychologists/Social Workers. For example, a psychiatric treatment plan will differ significantly from a psychologist's treatment plan for the same patient on the same day. Lack of integration between the two indicates providers are not reviewing each other's documentation when they are seeing a patient which has led to poor alignment.

Another example is incorrect completion of the suicide risk assessment in conjunction with chart review. QMHPs' suicide risk assessments of risk has underestimated risk on some higher risk patients (e.g., patients who have been the focus of Morbidity and Mortality reviews) due to incorrect completion of the suicide risk assessment tool (e.g., only considering the current presentation and not the past 30-days) and failing to take into account observations from prior notes and prior suicide risk assessments when making an assignment of current risk. This impacted assessment of suicide risk and likely led to an inappropriately early increase in Level (e.g., from Level I to a lower, less restrictive level). The most recent suicide risk assessment populates into the notes of the psychiatrist which could be misleading if incorrectly completed.

Similarly, patients who are refusing care with serious medical and co-morbid SMI have not received robust intervention until they have significantly declined; this in spite of repeated visit with both medical and mental health providers due to failure to align care. CHS updated policy CHS-058A, Interdisciplinary Treatment Team, to include that a Qualified Medical Professional will refer patients who are refusing medical treatment for life-threatening conditions (i.e., wound care, high blood pressure, diabetes, etc.) to the psychiatrist for a medical decisional capacity assessment to decide if they have the ability to make the medical decision to refuse care.

Recommendations for Achieving Compliance, if applicable: Ensure alignment of Treatment Plans across all QMHP (e.g., psychiatrist, psychologist, social workers, etc.) documentation and that patient progress towards meeting treatment goals is consistently updated by the appropriate providers. Incorporate more information from medical and MDCR staff when appropriate.

Suicide Assessment and Prevention

III. C. 3. a. Defendants shall develop and implement a policy to ensure that inmates at risk of self-harm are identified, protected, and treated in a manner consistent with the Constitution. At a minimum, the policy shall:
(1) Grant property and privileges to acutely mentally ill and suicidal inmates upon clinical determination by signed orders of Qualified Mental Health Staff.
(2) Ensure clinical staff makes decisions regarding clothing, bedding, and other property given to suicidal inmates on a case-by-case basis and supported by signed orders of Qualified Mental Health Staff.
(3) Ensure that each inmate on suicide watch has a bed and a suicide-resistant mattress, and does not have to sleep on the floor.
(4) Ensure Qualified Mental Health Staff provide quality private suicide risk assessments of each suicidal inmate on a daily basis.
(5) Ensure that staff does not retaliate against inmates by sending them to suicide watch cells. Qualified Mental Health Staff shall be involved in a documented decision to place inmates in suicide watch cells.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County is now assessing suicide risk on a daily basis when a patient is at risk for suicide (MH Level I). This is reflected in 100% compliance with this measure on Internal Audit Tool #33, Behavioral Health Level I, and from chart review.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 3. b. When inmates present symptoms of risk of suicide and self-harm, a Qualified Mental Health Professional shall conduct a suicide risk screening **and assessment** instrument that includes the factors described in Appendix A. The suicide risk screening and assessment instrument will be validated within 180 days of the Effective Date and every 24 months thereafter.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 3. c. County shall revise its Suicide Prevention policy to implement individualized levels of observation of suicidal inmates as clinically indicated, including constant observation or interval visual checks. The MDCR Jail facilities' supervisory staff shall regularly check to ensure that corrections officers implement the ordered levels of observation.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: MDCR is now producing a quarterly systematic report documenting compliance with this provision entitled, Facility Check Procedures. The audit demonstrates full compliance with this provision.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 3. d. CHS shall sustain implementation of its Intake Procedures adopted in May 2012, which specifies when the screening and suicide risk assessment instrument will be utilized.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 3. e. CHS shall ensure individualized treatment plans for suicidal inmates that include signs, symptoms, and preventive measures for suicide risk.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County has reviewed policy CHS-058A and revised the Interdisciplinary Treatment Plan. The County developed and utilized Audit Tool #23 Mental Health Treatment Planning to review clinical performance. While these steps did produce some improvements, a review of charts of level I inmates did not find individualized treatment plans for suicidal inmates that included signs, symptoms, and preventive measures for suicide risk as described in NCCHC Standards MH-G-03 (Treatment Plans) and MH-G-04 (Suicide Prevention Program). For example, a patient with repeated suicide attempts triggered by returning to jail after harming his father (and the resulting family issues) had his trigger listed in his preventative measures as feeling threatened. In the same patient his protective factors were listed as "reading" and "exercising" but neither was readily available to him as a MH Level I patient. Finally, he noted anger and emotional pain as reasons why he self-harms but there were no suicide reduction interventions to address anger or emotional pain. See III.A.2.d.

Recommendations for Achieving Compliance, if applicable: See III.A.2.d. Tool #23 Mental Health Treatment Planning focuses on the presence/absence of specific information in the document. At least one of the measures was not clearly operationally defined which leaves the County relying heavily on the interpretation of whoever is completing the tool. This tool was reviewed by two different monitors who were unable to substantiate the ratings and found problems with the treatment plans that were not captured by the measuring tool. This limits the utility of the information the tool yields as a source of information for the staff who are completing the work. It is recommended that the County consider operationally defining the key indicators necessary to demonstrate compliance with this measure, training their staff, implementing the expectations, and then measuring with their tools.

III. C. 3. f. Cut-down tools will continue to be immediately available to all Jail staff that may be first responders to suicide attempts.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 3. g. The Jail will keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff shall know the location of this emergency response bag and the Jail will train staff how to use its contents.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 3. h. County shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating*:* (1) adequate suicide screening upon intake, and (2) adequate suicide screening in response to suicidal and self-harming behaviors and other suicidal ideation.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County has continued to Audit Tool #1 to demonstrate their efforts to meet compliance with this provision. The County modified the Suicide Risk Assessment (SRA) so that staff can proceed with utilizing the clinical tool when inmates do not willingly provide information. This has resulted in uniformly better risk assessments and has increased the successful completion of the SRA forms. The County also modified the SRA contained in Social Worker/Psychologist Progress Notes so that if a provider marks a patient as "Refused" the SRA cannot be completed. This prevents the recording of clinical information that could be clinically useful and is captured in the free text portion of the same document. The content of free text notes has improved but this portion of the notes do not pull forward while the CSSR items do. Audit Tool #1 measures the performance of staff utilizing the SRA when a patient is placed on suicide precaution. The tool does not review the performance of staff who utilize the SRA and do not place patients on suicide precaution. A review of records during this tour demonstrated that the prior problems identified with the completion of "Individual Suicide Risk Reduction Factors" in the Cat-RAG Suicide Risk Assessment was addressed. Documents reviewed demonstrated that this field is being completed. The quality of the information provided varied across providers. It is recommended that the County continue to consider using this portion of the tool to identify specific protective factors that can be increased with safety plan interventions.

Recommendations for Achieving Compliance, if applicable: N/A

Review of Disciplinary Measures

III. C. 4.

a. The Jail shall develop and implement written policies for the use of disciplinary measures with regard to inmates with mental illness or suspected mental illness, incorporating the following

(1) The MDCR Jail facilities' staff shall consult with Qualified Mental Health Staff to determine whether initiating disciplinary procedures is appropriate for inmates exhibiting recognizable signs/symptoms of mental illness or identified with mental illness; and

(2) If a Qualified Mental Health Staff determines the inmate's actions that are the subject of the disciplinary proceedings are symptomatic of mental illness, no disciplinary measure will be taken.

b. A staff assistant must be available to assist mentally ill inmates with the disciplinary review process if an inmate is not able to understand or meaningfully participate in the process without assistance.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County has continued to audit this provision with Internal Audit Tool #43. Performance has consistently remained at 100% compliance in all categories of the tool. However, the MH Sub-Monitor reviewed 14 patients from a list of patients provided by the County. A total of 29 Disciplinary Clearance Forms were completed with these patients. The charts revealed that patients who are going to be placed in segregation are brought to nursing for initial evaluation. The nurses are doing a better job identifying SMI and there were some instances where they included patients as SMI who were not. Patients were screened within 24 hours by a QMHP, most of the time. There were problems with how orders were documented and initiated in the chart. Nevertheless this did not appear to significantly impact patient care.

The QMHP completes the Disciplinary Clearance Forms. In 4fourof the assessments, question 9, the "Check ADA List" was left blank which suggests that the County needs continued focus on this area. There was one instance where a patient was identified as having a special accommodation and the specific accommodation was listed. Additionally, questions 8 and 10 on the DR Clearance Form were also frequently left blank. It is unclear if this is due to provider omission or a result of how the questions on the form are interpreted by the providers. While the forced choice section of the form may need some review the vast majority of the free text notes written at the end of the DR Notes were detailed and clear. The SMI patients were correctly identified approximately 90% of the time, and one was relevelled and not cleared for DR. There was one instance where a patient had an SMI diagnosis and it appeared as if the QMHP changed the diagnosis from SMI to non-SMI after clearing the patient for disciplinary placement. While this may have been clinically appropriate if the diagnosis was inaccurate or the symptom presentation was different but this was not explained in the patient's chart. It is strongly recommended that a clear rationale be provided to support such decisions. The monitor was unable to verify if staff assistants are provided to assist with the disciplinary review process if an inmate is unable to understand or meaningfully participate in the process without assistance. The Monitor

does not have access to CJIS (The electronic system used by Custody to track Disciplinary Reviews).

Recommendations for Achieving Compliance, if applicable: N/A

Mental Health Care Housing

III. C. 5. a. The Jail shall maintain a chronic care and/or special needs unit with an appropriate therapeutic environment, for inmates who cannot function in the general population.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 5. b. The Jail shall remove suicide hazards from all areas housing suicidal inmates or place all suicidal inmates on constant observation.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: MDCR continues to retrofit housing units (e.g., showers at MWDC) per its 5-year capitol plan.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 5. c. The Jail shall allow suicidal inmates to leave their cells for recreation, showers, and mental health treatment, as clinically appropriate. If inmates are unable to leave their cells to participate in these activities, a Qualified Medical or Mental Health Professional shall document the individualized clinical reason and the duration in the inmate's mental health record. The Qualified Medical or Mental Health Professional shall conduct a documented re-evaluation of this decision on a daily basis when the clinical duration is not specified.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 5. d. County shall provide quarterly reports to the Monitor and the United States regarding its status in developing the Mental Health Treatment Center. The Mental Health Treatment Center will commence operations by the end of 2014. Once opened, County shall conduct and report to the United States and the Monitor quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds. The Parties will work together and with any appropriate non-Parties to expand the capacity to provide mental health care to inmates, if needed.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County's 2019 Q1 MH Bed Analysis indicates they have been able to provide adequate MH bed space (e.g., providing temporary beds for Level I overages and temporarily housing Level III patients at TGK until bed space opens at Metro West). CHS believes the number of Level I and Level III patients will decrease in the future due to recent changes that include: updating the leveling policy, CHS-058B; a plan to create a MH Temporary Housing Unit at TGK to allow psychiatrists to perform the majority of leveling decisions; and, to reassess the Level III population as CHS believes they may be over utilizing this MH Level instead of more appropriately Leveling patients at II or IV. However, future updates to the MDCR inmate classification process will likely lead to further changes in MH housing. The impact of these changes on MH housing will need to be assessed at the next tour. See also implementation of the objective jail classification system in the Settlement Agreement.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 5. e. Any inmates with SMI who remain on 9C (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care, as per the Mental Health Treatment section of this Agreement (Section III.C.2.e).

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: CHS is now accurately tracking the need for IDTPs. Patients leveled to I and II are tracked by a social worker who insures that IDTPs are scheduled appropriately. The timeliness of the IDTP is also measured by Tool #23. Data provided by the County demonstrated 100% compliance with this provision. Chart review substantiated this finding.

Recommendations for Achieving Compliance, if applicable: N/A

Custodial Segregation

III. C. 6. a. (1) The Jail and CHS shall develop and implement policies and procedures to ensure inmates in custodial segregation are housed in an appropriate environment that facilitates staff supervision, treatment, and personal safety in accordance with the following: (Part a) All locked housing decisions for inmates with SMI shall include the documented input of a Qualified Medical and/or Mental Health Staff who has conducted a face-to-face evaluation of the inmate, is familiar with the details of the inmate's available clinical history, and has considered the inmate's mental health needs and history.

Monitor: Johnson

Compliance Status: **Compliance**

July, and August 2019 demonstrated: documented input from a face-to-face encounter with a QMP prior to a locked housing decision is now occurring 100% of the time; patients were correctly identified as SMI in 70%, 80%, and 70% of the cases in August 2019 (CHS reported that the QMPs are "over identifying SMI" in patients leading to more consults); the QMHP was consulted in 33%, 100%, and 0% of the cases (CHS indicated this is due to the QMHP being called by the QMP and/or MDCR and not solely responding to the consult); and, that QMHPs are performing face-to-face evaluations in 50%, 100%, and 100% of cases. The results indicate: cases are being reviewed in a timely manner; SMI patients are unlikely to be missed and are reportedly being over identified; and QMHP evaluation after consultation is happening on a consistent basis. Appropriate use of the emergent consult process to alert QMHPs needs improvement. However, lack of timely consult does not appear to have had an impact of evaluation and subsequent provision of care. The EHR forms used by QMPs and QMHPs to document their encounters have been updated to reflect their evaluation of factors including whether the inmate has SMI and whether there are contraindications to placement in segregated housing.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (1) (Part b) If at the time of custodial segregation Qualified Medical Staff has concerns about mental health needs, the inmate will be placed with visual checks every 15 minutes until the inmate can be evaluated by Qualified Mental Health Staff.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III.C.3.c.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (2) Prior to placement in custodial segregation for a period greater than eight hours, all inmates shall be screened by a Qualified Mental Health Staff to determine (1) whether the inmate has SMI, and (2) whether there are any acute medical or mental health contraindications to custodial segregation.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III.C.6.a.(1).

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (3) If a Qualified Mental Health Professional finds that if an inmate has SMI, that inmate shall only be placed in custodial segregation with visual checks every 15 or 30 minutes as determined by the Qualified Medical Health Professional.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (4). i. Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes:
i. Qualified Mental Health Professionals conducting rounds at least three times a week to assess the mental health status of all inmates in custodial segregation and the effect of custodial segregation on each inmate's mental health to determine whether continued placement in custodial segregation is appropriate. These rounds shall be documented and not function as a substitute for treatment.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County is monitoring this provision with use of Internal Audit Tool #42 – Disciplinary Segregation. According to data supplied by the County, SMI patients were seen three times per week 100% of the time in each of the three months preceding the tour. The County provided the actual tool from July 2019 where 4 of the 10 patients sampled were SMI while the remainder were SMU and therefore were outcounted from the tally. All of the SMI patients received the appropriate amount of rounding. The County provided a list of SMI patients in Segregation and the patients indicated on the July Tool 42 were reviewed. Both samples contained SMI and SMU patients. Charts revealed completion of Segregation Rounding 3 times per week for SMI patients and once per week for SMU patients. There were many instances where patients refused to participate in confidential services and the provider followed up and evaluated the patient

at the cell door thus insuring the patient was not decompensating. There were patients who also received psychiatric and counseling services. There were instances where a patient received both a clinical service and a disciplinary clearance from the same provider at the same visit. It is strongly advised that the County review MH-I-03 and utilize mental health staff who are not providing therapeutic services to the patient as the one to complete the Disciplinary Review to reduce the risk of undermining the credibility of the mental health service providers. There were at least ten instances where rounds were not completed because of space issues, staff shortages, patient ineligibility, or "movement issues." While this was a small proportion compared to the total number of visits documented, please refer to MH-A-01 and insure patients in segregation have access to care.

Recommendations for obtaining Compliance: N/A

III. C. 6. a. (4). ii. Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes:
ii. Documentation of all out-of-cell time, indicating the type and duration of activity.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: MDCR uses the Black Creek Watch System to document and track out of cell time provided to patients in Segregation. Officers at MWDC demonstrated how the system works and provided an example of the report that can be generated for patients to demonstrate out of cell time. The County also developed a multidisciplinary Segregation Task Force to monitor patients who are not removed from segregation after 14 days. Such patients receive a Segregation Treatment Plan that targets short-term and long-term goals the patient can work on while in segregation. While the treatment plan documents that were reviewed contained clear goals and interventions, implementation of the strategies were not clearly documented in subsequent notes. A review of patient records of current segregated patients revealed that group therapy services, psychotherapy services, and social work rounding was occurring as indicated by staff interviewed.

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (5) Inmates with SMI shall not be placed in custodial segregation for more than 24 hours without the written approval of the Facility Supervisor and Director of Mental Health Services or designee.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The electronic signature for the QMHP is readily identifiable in the EHR as the designee of the Director of Mental Health Services. Once CHS

signs the form electronically it is printed and provided to custody. Custody acknowledges the addendum (in the printed EHR QMHP note) and generates an Incident Report, the addendum is maintained with the Incident Report. The officer completing the incident report is the designee for the Facility Supervisor. Both processes are outlined in CHS (CHS-044, Segregated Patients) and MDCR policy (DSOP 12-002, Inmate Administrative and Disciplinary Confinement).

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (6) Inmates with serious mental illness shall not be placed into long-term custodial segregation, and inmates with serious mental illness currently subject to long-term custodial segregation shall immediately be removed from such confinement and referred for appropriate assessment and treatment.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: Since the prior two tours the number of SMI patients in long-term segregation has slightly increased (17 in June 2018, 18 in February 2019, and 23 in October 2019). Patients' length of time in long-term custodial segregation has significantly decreased (range of 18 to 2050 days in February 2019 to a range of 4 to 245 days in October 2019).

Review of the Safety Cell Review Committee decision forms and inmate lists demonstrated that patients are placed in custodial segregation for various reasons with the top three reasons being "Threat" to Staff or Inmates, "Numerous Keep Separates," and "Media Coverage." They are kept in segregation usually for the same reasons though other reasons stated included: having an "escape" associated charge; court order to be in segregated housing; "recent incident" involving drug use; and, "repeated allegations against staff."

SMI patients are receiving an enhanced level of care through their CHS segregation treatment plans to better support their mental health while in long-term segregation. This includes increased out of cell time. However, while this appears to happen most consistently at MWDC. Review of out of cell time reports on SMI inmates in segregated housing at TGK revealed they were not consistently receiving 2 or more hours of out of cell time on a daily basis.

Review of Safety Cell Reviews from a small sample of inmates at PTDC demonstrated that they were not identified as SMI despite them having SMI MH diagnoses in the EHR (e.g., Major Depressive Disorder and Posttraumatic Stress Disorder). Out of the sample of reviewed Safety Cell Reviews, 80% were correctly identified as SMI or not SMI, and 20% were not correctly identified. Of those correctly identified as SMI: 83% were removed from segregated housing with reason being in all cases a change in MH Level (e.g., MH Level IV to level II) due to mental decompensation; and, of those removed only 20% left within ≤14 days (before the time frame became "long-term"). All SMI inmates were noted to be in

"compliance with requirements" for segregated housing and most were attending psychotherapy groups or unit programming. Despite these positive factors, they were not noted as playing a role in the ultimate decision to remove them from segregated housing. The high frequency of decompensation and the long length of stay are concerning factors and suggest that inmates' best chance of leaving segregated housing occurs if they decompensate.

MDCR, in conjunction with CHS, is in the process of updating the Safety Cell Review forms to include formalized, measurable goals from both CHS and Custody so that when met, can underlie a decision to remove an SMI patient from long-term custodial segregation in lieu of decompensation.

Recommendations for Achieving Compliance, if applicable: Move forward with current plans to develop formalized, measurable goals as a means to track when these patients have reached a point that will allow them to safely transition when appropriate out of segregated housing. Current patients in segregated housing who are not identified as SMI should be studied to ensure that any unidentified SMI inmates can receive the appropriate enhanced services and consideration Custody while decreasing their chances of decompensating.

III. C. 6. a. (7) If an inmate on custodial segregation develops symptoms of SMI where such symptoms had not previously been identified or the inmate decompensates, he or she shall immediately be removed from custodial segregation and referred for appropriate assessment and treatment.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: At TGK the County created a confidential treatment room where patients in segregation can receive medical and mental health care. When an inmate decompensates MDCR calls mental health who comes to the unit to see the patient in the confidential room. This differs from the policy which calls for MDCR to take the patient to nursing who fires as order that summons the QMHP. Since MDCR calls mental health directly there is no order written and it is unclear how this provision is now being measured. According to the last four months data for Tool 42, questions 9 & 10, which track this the results are "N/A." Data from chart review and from staff interview revealed that MDCR calls mental health when they are concerned about their patients. Mental health responds and re-levels the patient when indicated. Chart review demonstrated that inmates who decompensate are identified by both Custody and CHS staff during 30 minute checks, daily RN rounds, or during visits by the QMHP. CHS consistently removes patients in segregation who have decompensated by re-leveling them and moving them to the MHTC until their MH symptoms stabilize and they are appropriate for further level change. Bringing the treatment room to the segregation area was an innovative way to solve a problem and provides increased access to care. Since it resulted in a change in how the actual services are provided the County will need to develop a clear way to track their performance with regard to this provision.

Recommendations for <u>continued</u> Compliance, if applicable: Develop a clear way to reliably and consistently track this provision (e.g., an entry into the custodial computer system that is linked to the CHS EHR).

III. C. 6. a. (8) If an inmate with SMI in custodial segregation suffers deterioration in his or her mental health, decompensates, engages in self-harm, or develops a heightened risk of suicide, that inmate shall immediately be referred for appropriate assessment and treatment and removed if the custodial segregation is causing the deterioration.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III.C.6.a.(7).

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (9) MDCR staff will conduct documented rounds of all inmates in custodial segregation at staggered intervals at least once every half hour, to assess and document the inmate's status, using descriptive terms such as "reading," "responded appropriately to questions" or "sleeping but easily aroused."

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: See III.C.3.c. In addition, MDCR has continued to expand the drop-down menu options of documentation in the Black Creek Watch Tour system to allow for clear explanation of inmate activity during status checks.

Recommendations for Achieving Compliance: N/A

III. C. 6. a. (10) Inmates in custodial segregation shall have daily opportunities to contact and receive treatment for medical and mental health concerns with Qualified Medical and Mental Health Staff in a setting that affords as much privacy as reasonable security precautions will allow.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 6. a. (11) Mental health referrals of inmates in custodial segregation will be classified, at minimum, as urgent referrals.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: The County tracks this provision using Internal Audit Tool #42, question #9. Consults to the QMHP are documented as "Urgent" or "Emergent" when they are actually completed per policy. However, in order for this to be tracked reliably the County will need to revise their procedures so that an order is consistently written in the EHR and tracked. In practice, when an inmate in custodial segregation is referred to mental health it is commonly done by telephone call to which CHS responds. This was demonstrated in chart reviews were it was evident that patients are being seen by the QMHP. However, since the procedure remains "informal" it is not being captured in a manner that allows the County to track and systematically demonstrate their compliance.

Recommendations for <u>maintaining</u> Compliance, if applicable: This is a provisional compliance rating that is based on CHS developing the means to systematically capture this data in audits and appropriate completion of CAPs to demonstrate consistent adherence to this provision. Retraining of RN staff to enter the correct consult even when the QMHP was contacted by phone may be beneficial.

Staff and Training

III. C. 7. a. CHS revised its staffing plan in March 2012 to incorporate a multi-disciplinary approach to care continuity and collaborative service operations. The effective approach allows for integrated services and staff to be outcomes- focused to enhance operations.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 7. b. Within 180 days of the Effective Date, and annually thereafter, CHS shall submit to the Monitor and DOJ for review and comment its detailed mental health staffing analysis and plan for all its facilities.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 7. c. CHS shall staff the facility based on the staffing plan and analysis, together with any recommended revisions by the Monitor. If the staffing study and/or monitor comments indicate a need for hiring additional staff, the parties shall agree upon the timetable for the hiring of any additional staff.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 7. d. Every 180 days after completion of the first staffing analysis, CHS shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If they do not, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 7. e. The mental health staffing shall include a Board Certified/Board Eligible, licensed chief psychiatrist, whose work includes supervision of other treating psychiatrists at the Jail. In addition, a mental health program director, who is a psychologist, shall supervise the social workers and daily operations of mental health services.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 7. f. The County shall develop and implement written training protocols for mental health staff, including a pre-service and biennial in-service training on all relevant policies and procedures and the requirements of this Agreement.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. **C. 7. g.** The Jail and CHS shall develop and implement written training protocols in the area of mental health for correctional officers. A Qualified Mental Health Professional shall conduct the training for corrections officers. This training should include pre-service training, annual training for officers who work in forensic (Levels 1-3) or intake units, and biennial in-service training for all other officers on relevant topics, including:

(1) Training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern);

(2) identification, timely referral, and proper supervision of inmates with serious mental health needs; and

(3) Appropriate responses to behavior symptomatic of mental illness; and suicide prevention.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 7. h. The County and CHS shall develop and implement written policies and procedures to ensure appropriate and regular communication between mental health staff and correctional officers regarding inmates with mental illness.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Suicide Prevention Training

III. **C. 8. a.** The County shall ensure that all staff have the adequate knowledge, skill, and ability to address the needs of inmates at risk for suicide. The County and CHS shall continue its Correctional Crisis Intervention Training a competency-based interdisciplinary suicide prevention training program for all medical, mental health, and corrections staff. The County and CHS shall review and revise its current suicide prevention training curriculum to include the following topics, taught by medical, mental health, and corrections custodial staff:

1. suicide prevention policies and procedures;
2. the suicide screening instrument and the medical intake tool;
3. analysis of facility environments and why they may contribute to suicidal behavior;
4. potential predisposing factors to suicide;
5. high-risk suicide periods;
6. warning signs and symptoms of suicidal behavior;
7. case studies of recent suicides and serious suicide attempts;
8. mock demonstrations regarding the proper response to a suicide attempt; and
9. the proper use of emergency equipment.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 8. b. All correctional custodial, medical, and mental health staff shall complete training on all of the suicide prevention training curriculum topics at a minimum of eight hours for the initial training and two hours of in- service training annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 8. c. CHS and the County shall train correctional custodial staff in observing inmates on suicide watch and step- down unit status, one hour initially and one-hour in-service annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 8. d. CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Risk Management

III. C. 9. a. The County will develop, implement, and maintain a system to ensure that trends and incidents involving avoidable suicides and self-injurious behavior are identified and corrected in a timely manner. Within 90 days of the Effective Date, the County and CHS shall develop and implement a risk management system that identifies levels of risk for suicide and self-injurious behavior and results in intervention at the individual and system levels to prevent or minimize harm to inmates, as set forth by the triggers and thresholds in Appendix A.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 9. b. The risk management system shall include the following processes to supplement the mental health screening and assessment processes:

(1) Incident reporting, data collection, and data aggregation to capture sufficient information to formulate a reliable risk assessment at the individual and system levels;

(2) Identification of at-risk inmates in need of clinical or interdisciplinary assessment or treatment;

(3) Identification of situations involving at-risk inmates that require review by an interdisciplinary team and/or systemic review by administrative and professional committees; and

(4) Implementation of interventions that minimize and prevent harm in response to identified patterns and trends.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. **C. 9. c.** The County shall develop and implement a Mental Health Review Committee that will review, on at least a monthly basis, data on triggering events at the individual and system levels, as set forth in Appendix A. The Mental Health Review Committee shall:

(1) Require, at the individual level, that mental health assessments are performed and mental health interventions are developed and implemented;

(2) Provide oversight of the implementation of mental health guidelines and support plans;

(3) Analyze individual and aggregate mental health data and identify trends that present risk of harm;

(4) Refer individuals to the Quality Improvement Committee for review; and

(5) Prepare written annual performance assessments and present its findings to the Interdisciplinary Team regarding the following:

i. Quality of nursing services regarding inmate assessments and dispositions, and

ii. Access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III. C. 9. d. The County shall develop and implement a Quality Improvement Committee that shall:
(1) Review and determine whether the screening and suicide risk assessment tool is utilized appropriately and that documented follow-up training is provided to any staff who are not performing screening and assessment in accordance with the requirements of this Agreement;
(2) Monitor all risk management activities of the facilities;
(3) Review and analyze aggregate risk management data;
(4) Identify individual and systemic risk management trends;
(5) Make recommendations for further investigation of identified trends and for corrective action, including system changes; and
(6) Monitor implementation of recommendations and corrective actions.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: Sections (2) - (6) of this provision are being met based on review of CQI and FCQI Meeting minutes, and the Biannual Report. However, section (1) remains a work in progress. The County adopted a version of the Columbia Suicide Severity Rating Scale (C-SSRS) for use in many of their progress notes and as a standalone assessment tool. The tool has many versions designed to assess acute and chronic risk for suicide by considering factors within the most recent 30 days and lifetime. Chart review and interview with staff revealed that QMHPs are completing the SRA solely based on their face-to-face interactions with patients on the day of assessment. They are not clearly reviewing prior SRAs in the chart. The County designed the form so that many forced choice questions "pull forward" from one SRA to the next. Since the questions are not reliably being asked as designed by the test publisher the information pulling forward is not reliable and could be misleading. The County addressed the problem of SRA's not being completed when patients refused to answer questions by allowing providers to document patient refusal. This has improved the completion of the tools. The County has designed the form so that if a QMHP indicates the patient refuses the C-SSRS is not able to be completed. This results in blank forms. The quality of the free text version of the SRA's have improved. This is the section at the end of notes where QMHPs write a narrative description of their interaction. In this note information that could be captured in the C-SSRS is captured but it does not pull through. While this decision may have been made with confidentiality in mind the County is advised to weigh the risk/benefits of not being able to capture this data when a patient refuses as these interactions occur in the highest risk (segregation & MHTC) areas.

Recommendations for Achieving Compliance, if applicable: Retrain relevant staff on SRA use and completion with follow through via audits and implementation of CAPs.

Audits and Continuous Improvement
Self-Audits

III.D.1.b. Qualified Medical and Mental Health Staff shall review data concerning inmate medical and mental health care to identify potential patterns or trends resulting in harm to inmates in the areas of intake, medication administration, medical record keeping, medical grievances, assessments and treatment.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: Grievance timeliness and responsiveness have improved.

Recommendations for Achieving Compliance, if applicable: N/A

III.D.1.c. The County and CHS shall develop and implement corrective action plans within 30 days of each quarterly review, including changes to policy and changes to and additional training.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Bi-annual Reports

III.D.2.a. Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi- annual reports regarding the following:
(1) All psychotropic medications administered by the jail to inmates.
(2) All health care delivered by the Jail to inmates to address serious medical concerns. The report will include:
i. number of inmates transferred to the emergency room for medical treatment and why;
ii. number of inmates admitted to the hospital with the clinical outcome;
iii. number of inmates taken to the infirmary for non-emergency treatment; and why; and
iv. number of inmates with chronic conditions provided consultation, referrals and treatment, including types of chronic conditions.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III.D.2.a. (3) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi- annual reports regarding the following:
All health care delivered by the Jail to inmates to address serious medical concerns. The report will include:
(i) All suicide-related incidents. The report will include:
(ii) all suicides;
(iii) all serious suicide attempts;
(iv) list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear);
(v) all restraint use related to a suicide attempt or precautionary measure; and
(vi) information on whether inmates were seen within four days after discharge from suicide monitoring.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III.D.2.a. (4) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi- annual reports regarding the following:
Inmate counseling services. The report and review shall include:
(i) inmates who are on the mental health caseload, classified by levels of care
(ii) inmates who report having participated in general mental health/therapy counseling and group schedules, as well as any waitlists for groups;
(iii) inmates receiving one-to-one counseling with a psychologist, as well as any waitlists for such counseling; and
(iv) inmates receiving one-to-one counseling with a psychiatrist, as well as any waitlists for such counseling.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III.D.2.a. (5) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi- annual reports regarding the following: The report will include:
Total number of inmate disciplinary reports, the number of reports that involved inmates with mental illness, and whether Qualified Mental Health Professionals participated in the disciplinary action.

Monitor: Johnson

Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

III.D.2.a.(6) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following:...
[6] Reportable incidents. The report will include:
i. a brief summary of all reportable incidents, by type and date;
ii. [Joint audit with MH] a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and
iii. number of grievances referred to IA for investigation.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

II.D.2.b. (See also III.D.1.c.) The County and CHS shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Compliance and Quality Improvement

IV. A. Within 180 days of the Effective Date, the County and CHS shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County and CHS shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County and CHS shall send any newly adopted and revised policies and procedures to the Monitor and the United States for review and approval as they are promulgated. The County and CHS shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County and CHS shall document employee review and training in policies and procedures.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

IV. B. The County and CHS shall develop and implement written Quality Improvement policies and procedures adequately to identify and address serious deficiencies in medical care, mental health care, and suicide prevention to assess and ensure compliance with the terms of this Agreement on an ongoing basis.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

IV. C. and D. On an annual basis, the County and CHS shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and the United States for review any changed policies and procedures.

Monitor: Johnson/Greifinger

MH Compliance Status: **Compliance**
Med Compliance Status: **Compliance**

Activities/Analysis Since Last Tour: N/A

Recommendations for Achieving Compliance, if applicable: N/A

Consent Agreement - Recommended Action Steps

III. A. 1. e.: Document review of outside MH records once received, and, document the clinically utility of data from outside MH records in diagnostic and clinical decision making.

III. A. 2.d.: Review IDTP short-term and long-term goals to ensure they are related to the presenting problems described in the IDTP and clinical notes written in days leading up to the IDTP. Review IDTP, Psychiatry Notes, and SW Notes written on day of IDTP to insure consistency across disciplines and document efforts to resolve differences. For inmates who are suicidal target: suicidal ideation, self-harm, and/or suicidal intent in the treatment goals; and, provide interventions specifically designed to reduce risk and increase protective factors/resilience. Review and update IDTP short-term and long-term goals at subsequent IDTPs. Document provision of interventions consistent with IDTP goals in subsequent clinical notes. Document review and consideration and implementation of interventions and goals made at one treatment level or required changes across changes in MH level or treatment needs.

III. A. 3. a. (2).: To maintain compliance, continue tracking ADA patients with cognitive disabilities; insure MoCA protocols are scanned into the chart; write the appropriate Special Needs Orders, and clearly document ADA reason for Social Work follow-up visits and intervention.

III. A. 4. d.: Ongoing compliance will be based on consistent referral and timely follow-up for psychotropic medication refusals.

III. A. 4. e.: Achieve equal to or greater than 90% performance, on a consistent basis, for monitoring for metabolic syndrome for patients on antipsychotic medication and for appropriate serum levels for mood stabilizing medications. Reinforce the use of appropriate guidelines through training and feedback on performance measures. Provide access to the summary of the referenced APA clinical guidelines or develop readily accessible and digestible treatment protocols for SMI that include guidance on the psychotropic prescribing and monitoring for these illnesses and commonly prescribed potentially toxic medications. Consider providing quarterly or semi-annual training on the protocols. Continue to audit these measures. Consider methods to institute early ordering of appropriate labs for potentially toxic medications.

III. A. 6. a. (1, 2, 3.): Continue to implement this new program. Perform a focused study, using appropriate numerators and denominators to determine effectiveness, trended over time. Analyze these data and develop action plans to increase the effectiveness of this program.

III. A. 7. a, b, & c: The compliance rating is provisional on improving the rigor of the M&M reviews and improved documentation.

III. B. 1. a.: Revisit and revise the performance measurement tool for detoxification.

III. C. 1. a.: Continue to audit this provision quarterly with issue focused CAPs to improve evaluation within the indicated referral time frames as well as timely follow-up by a psychiatrist after QMHP evaluation.

III. C. 2. c.: Consider linking the IDTPs to the psychiatric treatment plans treatment plans to assist with inclusion of concrete, measurable, and observable goals that are patient specific and able to be implemented. Ensure that interdisciplinary differences in care are aligned.

III. C. 2. F.: Continue to follow through on CAPs for appropriate diagnosis and entry of orders for suicide precautions.

III. C 2. k.: Ensure alignment of Treatment Plans across all QMHP (e.g., psychiatrist, psychologist, social workers, etc.) documentation and that patient progress towards meeting treatment goals is consistently updated by the appropriate providers. Incorporate more information from medical and MDCR staff when appropriate.

III. C. 3. a.: Demonstrate daily provision of suicide risk assessment (e.g., clinically appropriate focused suicide risk assessment).

III. C. 3. c.: Continue to develop the capacities of the Black Creek System so that reports that demonstrate compliance with Constant Observation of Suicidal Inmates can be demonstrated.

III. C. 3. e.: See III .A. 2. d. Operationally define "patient specific" in Tool #23. Furthermore, consider operationally defining the key indicators necessary to demonstrate compliance with this measure, training staff, implementing the expectations, and then measuring with the tools.

III. C. 6. a. (6): Move forward with current plans to develop formalized, measurable goals as a means to track when these patients have reached a point that will allow them to safely transition when appropriate out of segregated housing. Current patients in segregated housing who are not identified as SMI should be studied to ensure that any unidentified SMI inmates can receive the appropriate enhanced services and consideration Custody while decreasing their chances of decompensating.

III. C. 6. a. (7, 8): Continue to audit this provision to demonstrate patients who have decompensated are being removed from segregation when it is recommended by the QMHP.

III. C. 6. a. (9): Continue to work with the Black Creek Watch Tour System so that reports for this provision can be readily provided and shared.

III. C. 6. a. (11): This is a provisional compliance rating that is based on CHS developing the means to systematically capture this data in audits and appropriate completion of CAPs to demonstrate consistent adherence to this provision. Retraining of RN staff to enter the correct consult even when the QMHP was contacted by phone may be beneficial.

III. C. 9. d.: Retrain relevant staff on suicide risk assessment use and completion with follow through via audits and implementation of corrective action plans.

Settlement Agreement Report of Compliance
October 28, 2019

Introduction

Compliance Report # 11 describes the outcomes of Miami-Dade Corrections and Rehabilitation's (MDCR) initiatives to sustain compliance with the requirements in the Settlement Agreement. This report's findings are informed before and during the on-site tour by review of documents, interviews with staff and inmates, observations of operations, and discussions with the County. Monitor Susan McCampbell and corrections expert Nancy DeFerrari were on site for three days – September 24-26, 2019, with Ms. DeFerrari touring all three jail facilities, including follow-up with inmates who had communicated with the Monitor.

Since compliance report # 10, the County requested, and the Department of Justice approved the request to "sun set" six paragraphs, which have remained in compliance with the language of the Settlement Agreement. These paragraphs addressing fire/life safety have remained in compliance for 18 months.

Chart 1 - Summary of Compliance - Settlement Agreement
As of Compliance Tour # 11

Report # /Date	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total
1 – 11/5/13	1	26	23	6	56
2 – 5/22/14	7	27	22	0	56
3 – 11/28/14	13	31	10	2	56
4 -7/3/15	23	32	0	1	56
5 – 2/15/16	30	26	0	0	56
6 - 9/9/16	30	26	0	0	56
7 – 4/4/17	53	3	0	0	56
8 – 1/18/18	37	19	0	0	56
9 – 8/24/18	42	14	0	0	56
10 – 3/18/19	56	0	0	0	56
11 – 9/27/19	50	0	0	6 ("sun setted")	56

Protection from Harm

The County continues to make progress on three significant, essential issues: objective inmate classification, reduction of inmate on inmate batteries and reductions in use of force, especially uses of force involving inmates on the behavioral health caseload. An additional area of concern is self-audits and corrective action plans. These issues are discussed below.

During the period since the last compliance report the jail's average daily population increased approximately 3%. Comparisons of data regarding uses of force and inmate on inmate batteries are trending downward in year-to-date 2019.

Areas of focus going forward

Classification

A report was received from the subject matter expert, County contractor, Dr. Patricia Hardyman, delivered in March 2019, citing important challenges to the current system; a finding which was anticipated. Her recommendations to improve and then validate the system are in process. The County anticipated that this work would be completed by this tour; but with the amount of work required, this was not possible.

In addition to collecting the data needed to validate the proposed revised system, the County will need to (at a minimum): re-classify on paper all inmates; use this data to assess designation of housing units and reconfigure the housing plan; and develop a plan to move inmates, as necessary, to conform with the housing plan. This plan should include significant staff education, as well as inmate orientation to the potential changes. The County's plan which is expected imminently, will be reviewed by the Monitor, and Ms. DeFerrari, to provide any suggestions.

This classification process major revision is happening alongside the County's initiative to adopt direct supervision principles of inmate management for the three facilities. This is a positive. When Metro West was opened, it was to be a direct supervision facility; but various fiscal and other challenges resulted in the migration away from this model.[2] Direct supervision environments, with properly trained staff and supervisors, are shown to be safer for inmates, and increase employee job satisfaction. Direct supervision requires a validated classification system be operational to insure the appropriate inmates (e.g. minimum, medium, high custody level) are co-housed.

Following the on-site tour, the County provided a plan, Classification Validation Implementation Timeline. The timeline indicates that the activities association with implementation of the new classification system will be concluded in April 2020.

Although the Monitor is unable, at this time, to assess compliance with III. A. a. b.,[3] the Monitor will continue provisional compliance due to the trajectory of the work. The Monitor

[2] See: https://nicic.gov/strategic-inmate-management

[3] Within 90 days of the Effective Date, conduct an inmate bed and classification analysis to ensure the Jail has adequate beds for maximum security and disciplinary segregation inmates. Within 90 days thereafter, MDCR will implement a plan to address the results of the analysis. The Monitor will conduct an annual review to determine whether MDCR's objective classification system continues to accomplish the goal of housing inmates based on level of risk and supervision needs."

will ask that the County update the team monthly about the progress of the initiative, as it is due to be concluded in April 2020, and the Monitor's next tour is scheduled for March 2020.

Inmate/Inmate violence and Uses of Force[4]

Significantly, the County reports that the trends in inmate/inmate violence and uses of force are trending downward for the first six months of 2019 over the same months of 2018. As noted above, this is contrasted against the increase in average daily inmate population. The data reports a 4% decrease in uses of force (3% annualized). There is a reported 17% decrease in inmate/inmate assaults during the first six months (over the same six months is 2018). MDCR is strongly commended for this work, with anticipation that these trends will continue.

As in previous years, the Monitor reviewed a sample of TAAP unit reports to determine if that process identified issues with uses of force. The work continues to be excellent and the Monitor notified MDCR that she will not need to review these samples in the future. The growth in the depth and scope of TAAP reviews has greatly improved, making their reviews an asset to the organization for more than just uses of force.

All the Monitors continue to be concerned about use of force involving inmates on the behavioral health caseload. MDCR and CHS estimate that 54% of the inmate population at any one time is on the behavioral health caseload, with 18% of the population designated to either Level I, II or III status. Data provided by the County reports that inmates on the behavioral health caseload involved in uses of force has remained steady (50/month for the first eight months of 2018 versus 47/month for the first eight months of 2019) while the behavior health caseload is decreasing.

The Monitor strongly recommends that the data regarding uses of force involving inmates on the behavioral health caseload be collected, review, and analyzed regularly, perhaps monthly. Additionally, MDCR and CHS should assure that their sets of data are consistent, as close to the same as possible, and any discrepancies promptly resolved. Action plans to address upward trends should also be developed, and assessed periodically.

[4]Paragraph III. A. 1. a. (11) provides: "MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively."
Paragraph III. A. 5. c. (12) provides: "Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy."

Analysis, Audits and Self-Critical Analysis[5]

Based on the pre-tour reviews by the Monitors, concerns are raised about the need to improve self-critical review. In June 2019, the Monitor requested a sample of 19 of the County's "investigations" into critical incidents reported by the County in the previous six years (a totally of close to 600). The County was able to provide seven reviews. The remaining incidents requested by the Monitor were determined by MDCR, after initial report, to not be critical, therefore not requiring an administrative review. The Monitor's concern is that there is not documentation of how that decision was made, thus identifying a deficiency in the governing policy and procedure.

In addition, a review by the Monitor and Ms. DeFerrari identified quality issues with the reports. These findings were provided to the Director on July 26, 2019.

1. Insufficient self-monitoring – We found in these six investigations there is insufficient attention to critically reviewing the incident. We had more questions about the incident after reviewing the reports. In our view, leads were not followed or documentation provided as part of the file, some materials were contradictory and unresolved, there was an absence of follow-up, and there was a lack of inquisitiveness about the direct and peripheral issues contributing to the incident. The reviews did not seek, nor identify the root cause of the major incidents. In two instances, incidents happened within two weeks in the same cell of PTDC, and the second incident's investigation didn't reference the first.
2. Timeliness – We are very concerned about the time lag between the incident date and the time the Director signed-off. In one case, more than a year passed.
3. Action Plans – None of the six investigations included any corrective actions – either for personnel involved or to address the observations in the reports. There were no summaries of significant issues, although all the investigations enumerated such issues. Between the absence of timeliness and no action plans, this raises serious concerns about how the County will reasonably assure the same type of incident does not re-occur.
4. Accountability – Because of the above – insufficient self-monitoring, timeliness and absence of action plans – we observe an absence of accountability for the quality of the work, and lack of focus on prevention. While there are checklists for materials, in our view, such checklists don't replace thorough supervisory or management review of the reports.

The Monitor also suggests that the analysis of incidents be aligned with the data developed by TAAP to identify trends, such as: days of week, time of day, location, staff involved,

[5]III. D. "MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement.

inmates involved, to assess deployment of resources, programming. The challenge of more data is to consider it as broadly as possible, avoiding silos.

The Monitor and Ms. DeFerrari also reviewed audits conducted by the County, as required by their internal policies, to determine sufficiency and conformance. We provided comments on-site about recommendations to improve quality, and assure that corrective action plans are included in the audits, and concluded.

The County has evolved, over the last six years, the bi-annual report required by the Settlement Agreement (III. D. 2), from pages and pages of unanalyzed charts and graphs, to more succinct reviews of relevant data, findings, and corrective actions. These bi-annual reports are for the use of the County in furthering improvements; and as such should have that focus. Sharing the reports with the entire agency will also highlight the professionalism of these reports, and assure that there is a shared vision for the future.

The Monitor recommends refinement of the data objectives which are realistic, and consider the implications of setting numerical objectives. For example, a well-intended goal of finding 387 unauthorized medications, or less, per quarter, as a benchmark is included in the bi-annual report (first six months of 2019) but this target should be, in the Monitor's view, zero.

Also, comparing trends in Miami-Dade County to other jails in the United States (or even Florida), is spurious, at best. While perhaps interesting, as there are no national or state standards regarding operational philosophies, policies, facility architecture, staffing levels, staff training, and definition of incidents, comparisons invite challenges. The Monitor endorses robust communication with other jails, and dialogue about promising practices.

Regarding the specific requirements of III. D. 2. the County did not produce this information in a consolidated report, but rather, at the request of the Monitor, provided a road map to the location of the information. The list of required reports was developed some time ago, and is not necessarily needed as the County's ability to track, analyze and act on data has improved. For future reports, the Monitor will rely on the County's "cross-walking" of the data to assure the most important data is tracked, for agency use.

Post on-site tour, the County provided to the Monitor a plan to improve self-audits. The corrective action plan projects completion of the work by March 2020. The Monitor will determine a process for assessing if the improvements to the process result in improvements in the outcome/products. This will be after the scheduled March 2020 on-site tour.

The leadership of MDCR should carefully review these reports prior to publication. Assuring reporting meeting generally accepted statistical principles should also be part of the leadership's assessment.

Segregation of Inmates with Severe Mental Illness (SMI) (See Consent Agreement III. C. 6. a. (6))

MDCR and CHS should work to address the number of inmates who are SMI and held in segregation. While all the Monitors appreciate the goal of assuring that inmates do not assault staff, there needs to be a coordinated effort to manage behaviors. The Monitor is concerned that some SMI inmates have been housed in segregation for as long as 242 days (as of 10/3/19). See also CA III. C.6.a. (6).

Investigations

MDCR has worked to establish increased investigative capacity through jail-based, trained, investigators, and re-starting the "gang" unit – to address strategic threat groups (STG). Additionally, an analyst has been hired, and jail-based investigators identified, trained and assigned. This has resulted in improvements, such as the ability to identify the causes of inmate/inmate fights, thus providing critical information to improving inmate and staff safety.

Inmate Grievances

CHS and MDCR's continue to work collaboratively to improve the inmate grievance process. This includes the ability to look at emerging issues in real-time rather than waiting for quarterly trends identification. The related paragraphs in both the Settlement Agreement and Consent Agreement remain in compliance. All the Monitors urge the parties to continue to improve the responses to the inmates to assure effective communication.

Follow-up

The following areas are flagged for follow-up prior to and leading up to the next tour, scheduled for late March 2020.

1. Plan to implement the inmate classification system.
2. Plan to improve internal audit/investigations.
3. On-going work to identify trends in inmate/inmate assaults, uses of force in general, and uses of force involving inmates on the behavioral health caseload.

Improving Jail Facilities

The County presented a summary of a master plan to build a new facility, in the next ten years. It will be on the site of the old "stockade" and provide additional specialized beds, a new booking area, and accommodate the bed needs identified by the operational data from the new inmate classification system. This is highly significant due to the age of the Pre-Trial Detention Center, and the increasing costs to maintain it, as well as its architecture which fails to promote a direct supervision environment. The plan requires final approval by the Mayor and the Board of County Commissioners.

Next Steps – Sustainability

By addressing the critical areas, noted above, on-going compliance with the Settlement Agreement is anticipated. The County has assured the Monitoring team that it has a long-term commitment to sustain the significant improvements made to the County's jails.

MDCR, CHS and the County should be very proud of their hard work. It is a positive reflection of the leadership to look to the future of the organization, rather than just "checking-off" the provisions of the Settlement Agreement. There now is a generation of employees who will know only this positive culture and professional environment.

Settlement Agreement

Review of Provisions

The County shall take all actions necessary to comply with the substantive provisions of this Agreement detailed below. Compliance with the Agreement will be measured both by whether the technical provisions are implemented and whether the conditions of confinement in the Jail meet the requirements of the United States Constitution.

A. PROTECTION FROM HARM

Consistent with constitutional standards, the MDCR Jail facilities shall provide inmates with a reasonably safe and secure environment to ensure that they are protected from harm. MDCR shall ensure that inmates are not subjected to unnecessary or excessive force by the MDCR Jail facilities' staff and are protected from violence by other inmates. The MDCR Jail facilities' efforts to achieve this constitutionally required protection from harm will include the following remedial measures regarding: (1) Safety and Supervision; (2) Security Staffing; (3) Sexual Misconduct; (4) Incidents and Referrals (5) Use of Force by Staff; and (6) Early Warning System.

B. III. A. Safety and Supervision

III. A. 1. a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including:

(1)

(1) Maintain implemented security and control-related policies, procedures, and practices that will ensure a reasonably safe and secure environment for all inmates and staff, in accordance with constitutional standards.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided a memorandum dated August 21, 2019 indicating the policies for which an annual review has been completed.

Recommendations for Sustaining compliance, if applicable: N/A

(2) Within 90 days of the Effective Date, conduct an inmate bed and classification analysis to ensure the Jail has adequate beds for maximum security and disciplinary segregation inmates. Within 90 days thereafter, MDCR will implement a plan to address the results of the analysis. The Monitor will conduct an annual review to determine whether MDCR's objective classification system continues to accomplish the goal of housing inmates based on level of risk and supervision needs.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above, and also Consent Agreement III. C. 5. d. regarding the quarterly mental health bed analysis.

Recommendations for sustaining compliance:

(3) Develop and implement a policy requiring correctional officers to conduct documented rounds, at irregular intervals, inside each housing unit, to ensure periodic supervision and safety. In the alternative, MDCR may provide direct supervision of inmates by posting a correctional officer inside the day room area of a housing unit to conduct surveillance. See also CA III. C. 6. a. (1)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: No additional evaluation was made regarding on-going compliance this tour.

Recommendations for Sustaining compliance, if applicable: N/A

(4) Document all security rounds on forms or logs that do not contain pre-printed rounding times. Video surveillance may be used to supplement, but not replace, rounds by correctional officers.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 1. a. 3.

Recommendations for sustaining compliance, if applicable: N/A

(5) MDCR shall document an objective risk analysis of maximum security inmates before placing them in housing units that do not have direct supervision or video monitoring, which shows that these inmates have no greater risk of violence toward inmates than medium security inmates. MDCR shall continue to increase the use of overhead video surveillance and recording cameras to provide adequate coverage and video monitoring throughout all Jail facilities to include:

(i) PTDC – 24 safety cells, by July 1, 2013
(ii) PTDC – 10B disciplinary wing, by December 31, 2013; kitchen, by Jan. 31, 2014;
(iii) Women's Detention Center – kitchen, by Sept. 30, 2014;
(iv) Training and Treatment Center - all inmate housing units areas and kitchen, by Apr. 30, 2014;
(v) Turner Guilford Knight Correctional Center – kitchen; future intake center; by May 31, 2014; and
(vi) Metro West Detention Center – throughout all areas; by Aug. 31, 2014.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County's audit schedule includes quarterly review of the repairs for equipment in critical areas, including cameras.

Recommendations for sustaining compliance, if applicable: N/A

(6) In addition to continuing to implement documented half-hour welfare checks pursuant to the "Inmate Administrative and Disciplinary Confinement" policy (DSOP 12.002), for the PTDC safety cells, MDCR shall implement an automated welfare check system by July 1, 2013. MDCR shall ensure that correctional supervisors periodically review system downloads and take appropriate action with officers who fail to complete required checks.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 1. a. 3.

Recommendations for sustaining compliance, if applicable: N/A

(7) Security supervisors shall conduct daily rounds on each shift in the inmate housing units, and document the results of their rounds.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County's audit schedule requires quarterly reviews of daily rounds.

Recommendations for sustaining compliance, if applicable: N/A

(8) MDCR shall maintain a policy ensuring that security staff conduct sufficient searches of cells to ensure that inmates do not have access to dangerous contraband, including at least the following:

i. random daily visual inspections of four to six cells per housing area or cellblock;
ii. random daily inspections of common areas of the housing units;
iii. regular daily searches of intake cells; and
iv. periodic large scale searches of entire housing units.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County reported shakedown information in their bi-annual report; however, it did not report the total number of shakedowns conducted, thus not providing a benchmark for the findings or recommendations.

Post on-site tour, the County provided updated data regarding shakedowns, including a differentiation between small and large scale shakedowns. Generally, in terms of larger, planned shakedowns, the County conducted slightly fewer in the first six months of 2019, compared to 2018. At the same time, there appears to be more emphasis, starting in May/June 2019, for more focused searches, as part of the officers' daily work. This i. a positive trend, and the County is urged to assess the

effectiveness of these strategies in terms of what contraband was found, and develop action plans, as necessary.

Recommendations for sustaining compliance: Implement the provisions of the corrective action plan to reduce contraband; focus on credible benchmarks. Analyze the effectiveness of various strategies to insure contraband is not introduced, or circulated in the facility.

(9) MDCR shall require correctional officers who are transferred from one facility to a facility in another division to attend training on facility-specific safety and security standard operating procedures within 30 days of assignment.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR updated an audit of this provision, dated June 30, 2019. The audit noted that some assigned staff required CIT training, which was to be concluded by July of 2019.

Recommendations for sustaining compliance: Continue quarterly audits, develop action plans as needed.

(10) Correctional officers assigned to special management units, including disciplinary segregation and protective custody, shall receive eight hours of specialized training for working on that unit on at least an annual basis.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR updated an audit of this provision, dated June 30, 2019. The audit noted that some assigned staff required CIT training, which was to be concluded by July of 2019.

Recommendations for sustaining compliance: Continue quarterly audits, develop action plans as needed.

(11) MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively. See also Settlement Agreement III. A. 5. c. (12)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See Settlement Agreement Introduction to this report, above.

Recommendations for sustaining compliance: See Settlement Agreement Introduction to this report, above.

III. A. 2. Security Staffing

Correctional staffing and supervision must be sufficient to adequately supervise incidents of inmate violence, including sexual violence, fulfill the terms of this Agreement, and allow for the safe operation of the Jail, consistent with constitutional standards. MDCR shall achieve adequate correctional officer staffing in the following manner:

a. Within 150 days of the Effective Date, MDCR shall conduct a comprehensive staffing analysis and plan to determine the correctional staffing and supervision levels necessary to ensure reasonable safety. Upon completion of the staffing plan and analysis, MDCR will provide its findings to the Monitor for review. The Monitor will have 30 days to raise any objections and recommend revisions to the staffing plan.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR continues to analyze staffing and update plans to provide to the Mayor and Board of County Commissioners.

Recommendations for sustaining compliance, if applicable: N/A

b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.

(2)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County provided an audit of the "no show" reports, dated May 23, 2019, covering the period January 1 – March 31, 2019 for all three facilities. The audit reported that 8% of inmate clinic visits were missed, the causes of which vary by facility. A corrective action plan was referenced, and upon inquiry, MDCR reported it had been completed.

Recommendations for sustaining compliance: Continue to audit as per MDCR's internal audit schedule.

c. MDCR shall staff the facility based on full consideration of the staffing plan and analysis, together with any recommended revisions by the Monitor. The parties shall agree upon the timetable for the hiring of any additional staff.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III. A. a., above

Recommendations for Sustaining compliance, if applicable: N/A

d. Every 180 days after completion of the first staffing analysis, MDCR shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If the level of staffing is inadequate, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III. A. a., above

Recommendations for sustaining compliance, if applicable: N/A

III. A. 3. Sexual Misconduct

MDCR will develop and implement policies, protocols, trainings, and audits consistent with the requirements of the Prison Rape Elimination Act of 2003, 42 U.S.C. § 15601, *et seq*., and its implementing regulations, including those related to the prevention, detection, reporting, investigation, data collection of sexual abuse, including inmate-on-inmate and staff-on-inmate sexual abuse, sexual harassment, and sexual touching.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County provided an audit of PREA documentation dated June 29, 2019 examining volunteer and contractor training, specialized training for investigators, specialized training for medical and mental health staff, and a review of documentation regarding retaliation prevention. There were some findings in which staff needed to be trained as well as corrective action plans to be implemented. The Monitors also reviewed the status and findings of 18 PREA-related investigations and 5 allegations of staff sexual misconduct, all since the beginning of 2019.

Recommendations for sustaining compliance, if applicable: Continue to prepare for the PREA re-audit in 2020.

III. A. 4. Incidents and Referrals

a. MDCR shall ensure that appropriate managers have knowledge of critical incidents in the Jail to take action in a timely manner to prevent additional harm to inmates or take other corrective action. At a minimum, MDCR shall document all reportable incidents by the end of each shift, but no later than 24 hours after the incident. These incidents should include inmate fights, rule violations, inmate injuries, suicide attempts, cell extractions, medical emergencies, contraband, destruction of property, escapes and escape attempts, and fires.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: No review since last on-site.

Recommendations for sustaining compliance, if applicable: N/A

b. Staff shall report all suicides and other deaths immediately, but no later than one hour after the incident, to a supervisor, Internal Affairs ("IA"), and medical and mental health staff.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: No review since last on-site.

Recommendations for sustaining compliance, if applicable: N/A

c. MDCR shall employ a system to track, analyze for trends, and take corrective action regarding all reportable incidents. The system should include at least the following information:

(3) unique tracking number;
(4) inmate(s) name;
(5) housing classification;
(6) date and time;
(7) type of incident;
(8) any injuries to staff or inmate;
(9) any medical care;
(10) primary and secondary staff involved;
(11) reviewing supervisor;
(12) any external reviews and results;
(13) corrective action taken; and
(14) administrative sign-off.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County (in an undated summary) notes it continues to work to implement a jail management information system/offender management system. After attempting through various options to implement this urgently needed system for six years, the process kick-off was July 15, 2019. No schedule was provided for implementation. In the interim, MDCR has been creative

in using existing resources to manage data. It is as troubling to the Monitors, as it is to MDCR that this process *continues*, and has no implementation date.

Recommendations for sustaining compliance, if applicable: N/A

d. MDCR shall develop and implement a policy to screen incident reports, use of force reports, and inmate grievances for allegations of staff misconduct and refer an incident or allegation for investigation if it meets established policy criteria. See also Consent III. A.3. (4)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR and CHS continue to audit the outcomes of the grievance process and focus on corrective actions.

Recommendations for sustaining compliance, if applicable: N/A

e. Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: An updated audit to the one presented in the January 2019 tour was provided (dated 7/11/19). There were issues identified, which were addressed in a corrective action plan.

Recommendations for sustaining compliance, if applicable: Assure that corrective action plans include dates when activities will be completed. "On-going" is not measurable.

f. MDCR shall continue to train all corrections officers to immediately inform a member of the Qualified Medical Staff when a serious medical need of an inmate arises.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: No further review since compliance tour # 10.

Recommendations for sustaining compliance, if applicable: N/A

III. A. 5. Use of Force by Staff

a. Policies and Procedures

a. MDCR shall sustain implementation of the "Response to Resistance" policy, adopted October 2009. In accordance with constitutional requirements, the policy shall delineate the use of force continuum and permissible and impermissible uses of force, as well as emphasize the importance of de-escalation and non-force responses to resistance. The Monitor shall provide ongoing assistance and annual evaluation regarding whether the amount and content of use of force training achieves the goal of reducing excessive use of force. The Monitor will review not only training curricula but also relevant data from MDCR's bi-annual reports.
b. MDCR shall revise the "Decontamination of Persons" policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports.
c. The Jail shall ensure that each Facility Supervisor/Bureau Commander reviews all MDCR incidents reports relating to response to resistance incidents. The Facility Supervisor/Bureau Commander will not rely on the Facility's Executive Officer's review.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County continues to update policies on an annual basis and amend as necessary. Since the last tour MDCR chose to implement the use of conducted energy devises (aka Tasers) as part of their use of force options for trained supervisors. The Monitors and DOJ reviewed the policy prior to implementation.

Recommendations for Sustaining compliance, if applicable: Capture and evaluate data when conducted energy devices are used.

b. Use of Restraints See also Consent Agreement III.B.3.c.

(1) MDCR shall revise the "Recognizing and Supervising Mentally Ill Inmates" policy regarding restraints (DSOP 12-005) to include the following minimum requirements:
   i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances.
   ii. four-point restraints or restraint chairs may be used only as a last resort and in response to an emergency to protect the inmate or others from imminent serious harm, and only after the Jail attempts or rules out less-intrusive and non-physical interventions.
   iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior.
   iv. MDCR shall protect inmates from injury during the restraint application and use. Staff shall use the least physical force necessary to control and protect the inmate.
   v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited.
   vi. any standing order for an inmate's restraint is prohibited.

(2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.

Monitor: McCampbell

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR continues to include de-escalation training in many of the lesson plans, so that staff hear about it in a variety of settings. The Monitor is satisfied that this training is wide-ranging and innovative.

The Medical and Mental Health Monitors found the corresponding requirements of the Consent Agreement to be in compliance.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

c. Use of Force Reports. See also Consent Agreement III. B. 3

(1) MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Remains in Substantial Compliance.

Recommendations for sustaining compliance, if applicable: N/A

(2) MDCR shall ensure that use of force reports:

i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;
ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;
iii. contain an accurate account of the events leading to the use of force incident;
iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;
v. are accompanied with any inmate disciplinary report that prompted the use of force incident;
vi. state the nature and extent of injuries sustained both by the inmate and staff member;
vii. contain the date and time any medical attention was actually provided
viii. include inmate account of the incident; and
ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The TAAP unit continues to evaluate use of force reports, and make recommendations for supervisory intervention and/or remedial training.

Recommendations for sustaining compliance, if applicable: N/A

(15) (3) MDCR shall require initial administrative review by the facility supervisor of use of force reports within three business days of submission. The Shift Commander/Shift

Supervisor or designee shall ensure that prior to completion of his/her shift, the incident report package is completed and submitted to the Facility Supervisor/Bureau Commander or designee.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 5.c. (2)

Recommendations for sustaining compliance, if applicable: N/A

(16) (4) The Facility Supervisor/Bureau Commander or his/her designee shall submit the MDCR Incident Report (with required attachments) and a copy of the Response to Resistance Summary (memorandum) to his/her Division Chief within 14 calendar days. If the MDCR Incident Report and the Response to Resistance Summary (memorandum) are not submitted within 14 calendar days, the respective Facility Supervisor/Bureau Commander or designee shall provide a memorandum to his/her Division Chief explaining the reason(s) for the delay.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 5.c. (2)

Recommendations for sustaining compliance, if applicable: N/A

(17) (5) The Division Chief shall review use of force reports, to include a review of medical documentation of inmate injuries, indicating possible excessive or inappropriate uses of force, within seven business days of submission, excluding weekends. The Division Chief shall forward all original correspondences within seven business days of submission, excluding weekends to Security and Internal Affairs Bureau.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The TAAP Unit continues to review 100% of use of force reports. Since TAAP was formed in 2017 the Monitor has reviewed a sample of each quarter's use of force reports, along with TAAP's assessment. As of July 2019, the Monitor has discontinued her review and the TAAP Unit's work has reached the point where they are skilled at their work.

Recommendations for sustaining compliance, if applicable: N/A

(6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. This criteria should include documented or known injuries that are extensive or serious; injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.); injuries that require treatment at outside hospitals; staff misconduct; complaints by the inmate or someone reporting on his/her behalf, and occasions when use of force reports are inconsistent, conflicting, or suspicious. See also Consent Agreement III. B. 3. b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See (5), above. CHS audit Tool 29 "Individuals on the Mental Health Caseload Involved in Use of Force Incidents", and Tool 30 "Nursing Documentation Following RTR", (response to resistance, aka use of force)/Use of Force Incidents indicate the County is tracking this information, and developing corrective actions.

Recommendations for sustaining compliance: Continue monitoring and develop and implement action plans as necessary.

(7) Security supervisors shall continue to ensure that photographs are taken of all involved inmates promptly following a use of force incident, to show the presence of, or lack of, injuries. The photographs will become evidence and be made part of the use of force package and used for investigatory purposes.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The TAAP Unit reviews 100% of use of force reports.

Recommendations for sustaining compliance, if applicable: N/A

(8) MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: No assessment made since Compliance Tour # 10.

Recommendations for sustaining compliance, if applicable: N/A

(18) (9) Where there is evidence of staff misconduct related to inappropriate or unnecessary force against inmates, the Jail shall initiate personnel actions and systemic remedies, including an IA investigation and report. MDCR shall discipline any correctional officer with any sustained findings of the following:

i. engaged in use of unnecessary or excessive force;
ii. failed to report or report accurately the use of force; or
iii. retaliated against an inmate or other staff member for reporting the use of excessive force; or
iv. interfered with an internal investigation regarding use of force.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: There were three use of excessive force investigations identified by MDCR since the beginning of 2019. The Monitors reviewed these investigations. Two of the three investigation were triggered by a TAAP unit review of a use of force; and one was reported by an LSCW. For the two incidents flagged by TAAP, the Monitor urges that an assessment be made about why the command reviewers did not identify the incidents. It appears to the Monitor that the systems for identifying any excessive uses of force are in place.

Recommendations for sustaining compliance, if applicable: N/A

(10) The Jail will ensure that inmates receive any required medical care following a use of force. See also Consent Agreement III. B. 3. b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.A. 5. c. 6.

Recommendations for sustaining compliance, if applicable: N/A

(11) Every quarter, MDCR shall review for trends and implement appropriate corrective action all uses of force that required outside emergency medical treatment; a random sampling of at least 10% of uses of force where an injury to the inmate was medically treated at the Jail; and a random sampling of at least 5% of uses of force that did not require medical treatment.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County produced an audit of this provision dated July 20, 2019. The audit reported improvement in compliance with MDCR policy. The corrective action plan submitted with the audit had implementation dates in 2018.

Recommendations for sustaining compliance: N/A

(12) Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy. See also Consent Agreement III. B. 3. b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See the Introduction, Settlement Agreement.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

(19) MDCR shall maintain policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County audits security and chemical equipment quarterly.

Recommendations for Sustaining compliance, if applicable: N/A

(20) MDCR shall continue its efforts to reduce excessive or otherwise unauthorized uses of force by each type in each of the Jail's facilities annually. If such reduction does not occur in any given year, MDCR shall demonstrate that its systems for preventing, detecting, and addressing unauthorized uses of force are operating effectively.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III. A. c. (9)

Recommendations for sustaining compliance, if applicable: N/A

d. Use of Force Training

(21) Through use of force pre-service and in-service training programs for correctional officers and supervisors, MDCR shall ensure that all correctional officers have the knowledge, skills, and abilities to comply with use of force policies and procedures.
(22) At a minimum, MDCR shall provide correctional officers with pre-service and biennial in-service training in use of force, defensive tactics, and use of force policies and procedures.
(23) In addition, MDCR shall provide documented training to correctional officers and supervisors on any changes in use of force policies and procedures, as updates occur.
(24) MDCR will randomly test at least 5% of the correctional officer staff annually to determine their knowledge of the use of force policies and procedures. The testing instrument and policies shall be approved by the Monitor. The results of these assessments shall be evaluated to determine the need for changes in training practices or frequency. MDCR will document the review and conclusions and provide it to the Monitor.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of the required testing of the provision requiring random testing of 5% of correctional officer staff annually. A total of 124 staff were tested, representing all levels of rank. Twelve

staff failed the test; resulting in notification to the chain-of-command and a meeting with the Training Bureau staff prior to re-testing. Two staff failed the second time, and were placed in an 8-hour training program.

Recommendations for sustaining compliance, if applicable: N/A

e. Investigations

(25) MDCR shall sustain implementation of comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.

(26) MDCR shall revise its "Complaints, Investigations & Dispositions" policy (DSOP 4-015) to ensure that all internal investigations include timely, thorough, and documented interviews of all relevant staff and inmates who were involved in, or witnessed, the incident in question.

i. MDCR shall ensure that internal investigation reports include all supporting evidence, including witness and participant statements, policies and procedures relevant to the incident, physical evidence, video or audio recordings, and relevant logs.

ii. MDCR shall ensure that its investigations policy requires that investigators attempt to resolve inconsistencies between witness statements, i.e. inconsistencies between staff and inmate witnesses.

iii. MDCR shall ensure that all investigatory staff receives pre-service and in-service training on appropriate investigations policies and procedures, the investigations tracking process, investigatory interviewing techniques, and confidentiality requirements.

iv. MDCR shall provide all investigators assigned to conduct investigations of use of force incidents with specialized training in investigating use of force incidents and allegations, including training on the use of force policy.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See also III. A. 5.c. (2) MDCR provided, as noted in III.C.5.c. (2), an update regarding plans to enhance investigative functions within MDCR.

The TAAP Unit continues to play a vital role in insuring that the requirements are met.

Recommendations for sustaining compliance, if applicable: N/A

III. A. 6. Early Warning System

a. Implementation

(1) MDCR will develop and implement an Early Warning System ("EWS") that will document and track correctional officers who are involved in use of force incidents and any grievances, complaints, dispositions, and corrective actions related to the inappropriate or excessive use of force. All appropriate supervisors and investigative staff shall have access to this information and monitor the occurrences.

(2) At a minimum, the protocol for using the EWS shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit.

(3) MDCR Jail facilities' senior management shall use information from the EWS to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level.

(4) IA will manage and administer the EWS. IA will conduct quarterly audits of the EWS to ensure that analysis and intervention is taken according to the process described below.

(5) The EWS will analyze the data according to the following criteria:

i. number of incidents for each data category by individual officer and by all officers in a housing unit;
ii. average level of activity for each data category by individual officer and by all officers in a housing unit;
iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and
iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of these provisions dated August 1, 2019 seeking to ensure the early warning system process is effective in identifying policy, training, and disciplinary issues. The audit identified a need for supervisors to contact SIB, LUM and/or the TAAP Unit as part of the process.

Recommendations for sustaining compliance, if applicable: N/A

b. MDCR will provide to DOJ and the Monitor, within 180 days of the implementation date of its EWS, and on a bi-annual basis, a list of all staff members identified through the EWS, and any corrective action taken.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The list was provided and reviewed.

Recommendations for sustaining compliance, if applicable: N/A

c. On an annual basis, MDCR shall conduct a documented review of the EWS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 6. a.

Recommendations for sustaining compliance, if applicable: N/A

III. B. FIRE AND LIFE SAFETY

The County requested, and the Department of Justice approved the "sun setting" of the provisions in these six paragraphs as they had remained in compliance for 18 months. The Monitors will not actively review these provisions, unless a finding in a tour, report of inmates or staff, or an investigation raises questions about compliance. The Monitors will review audit reports that address these paragraphs to assess the viability of MDCR's internal audit process.

B. MDCR shall ensure that the Jail's emergency preparedness and fire and life safety equipment are consistent with constitutional standards and Florida Fire Code standards. To protect inmates from fires and related hazards, MDCR, at a minimum, shall address the following areas:

C. 1. Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.

D. 2. MDCR shall ensure that fire alarms and sprinkler systems are properly installed, maintained, and inspected. MDCR shall document these inspections.

E. 3. Within 120 days of the Effective Date, emergency keys shall be appropriately marked and identifiable by sight and touch and consistently stored in a quickly accessible location; MDCR shall ensure that staff are adequately trained in the location and use of these emergency keys.

F. 4. Comprehensive fire drills shall be conducted every three months on each shift. MDCR shall document these drills, including start and stop times and the number and location of inmates who were moved as part of the drills.

G. 5. MDCR shall sustain its policies and procedures for the control of chemicals in the Jail, and supervision of inmates who have access to these chemicals.

H. 6. MDCR shall provide competency-based training to correctional staff on proper use of fire and emergency equipment, at least biennially.

III. C. INMATE GRIEVANCES

MDCR shall provide inmates with an updated and recent inmate handbook and ensure that inmates have a mechanism to express their grievances and resolve disputes. MDCR shall, at a minimum:

1. Ensure that each grievance receives follow-up within 20 days, including responding to the grievant in writing, and tracking implementation of resolutions.
2. Ensure the grievance process allows grievances to be filed and accessed confidentially, without the intervention of a correctional officer.
3. Ensure that grievance forms are available on all units and are available in English, Spanish, and Creole. MDCR shall ensure that illiterate inmates, inmates who speak other languages, and inmates who have physical or cognitive disabilities have an adequate opportunity to access the grievance system.
4. Ensure priority review for inmate grievances identified as emergency medical or mental health care or alleging excessive use of force.
5. Ensure management review of inmate grievances alleging excessive or inappropriate uses of force includes a review of any medical documentation of inmate injuries.
6. A member of MDCR Jail facilities' management staff shall review the grievance tracking system quarterly to identify trends and systemic areas of concerns. These reviews and any recommendations will be documented and provided to the Monitor and the United States.

See also Consent Agreement III.A.3.a.(4) and III. D. 1.b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of the inmate grievance process and on-going improvements (12/3/18).

Recommendations for sustaining compliance, if applicable: N/A

III. D. AUDITS AND CONTINUOUS IMPROVEMENT

1. Self-Audits
MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement.
   a. On at least a quarterly basis, command staff shall review data concerning inmate safety and security to identify and address potential patterns or trends resulting in harm to inmates in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, and grievances. The review shall include the following information:
      (27) documented or known injuries requiring more than basic first aid;
      (28) injuries involving fractures or head trauma;
      (29) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.);
      (30) injuries that require treatment at outside hospitals;
      (31) self-injurious behavior, including suicide and suicide attempts;
      (32) inmate assaults; and
      (33) allegations of employee negligence or misconduct.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See Introduction, Settlement Agreement.

Recommendations for sustaining compliance: The County provided, post-tour, a plan to address the needed improvements in self-assessments. See Introduction.

   b. MDCR shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See IV. D. a., above.

Recommendations for sustaining compliance: Provide examples of work products that meet this provision.

2. Bi-annual Reports See also Consent Agreement III. D. 2.
   a. Starting within 180 days of the Effective Date, MDCR will provide to the United States and the Monitor bi-annual reports regarding the following:
      (34) Total number of inmate disciplinary reports
      (35) Safety and supervision efforts. The report will include:
         i. a listing of maximum security inmates who continue to be housed in dormitory settings;

ii. a listing of all dangerous contraband seized, including the type of contraband, date of seizure, location and shift of seizure; and
iii. a listing of inmates transferred to another housing unit because of disciplinary action or misconduct.

(36) Staffing levels. The report will include:
i. a listing of each post and position needed at the Jail;
ii. the number of hours needed for each post and position at the Jail;
iii. a listing of correctional staff hired to oversee the Jail;
iv. a listing of correctional staff working overtime; and
v. a listing of supervisors working overtime.

(37) Reportable incidents. The report will include:
i. a brief summary of all reportable incidents, by type and date;
ii. data on inmates-on-inmate violence and a brief summary of whether there is an increase or decrease in violence;
iii. a brief summary of whether inmates involved in violent incidents were properly classified and placed in proper housing;
iv. number of reported incidents of sexual abuse, the investigating entity, and the outcome of the investigation;
v. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit;
vi. number of inmate grievances screened for allegations of misconduct and a summary of staff response; and
vii. number of grievances referred to IA for investigation.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Regarding the specific requirements of III. D. 2. the County did not produce this information in a consolidated report, but rather, at the request of the Monitor, provided a road map to the location of the information. The list of required reports was developed some time ago, and is not necessarily needed as the County's ability to track, analyze and act on data has improved. For future reports, the Monitor will rely on the County's "cross-walking" of the data to assure the most important data is tracked, for agency use.

Recommendations for sustaining compliance, if applicable: Continue to track data for internal, agency use.

b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: A bi-annual report is provided along with action plans.

Recommendations for sustaining compliance, if applicable: N/A

IV. COMPLIANCE AND QUALITY IMPROVEMENT

A. Within 180 days of the Effective Date, the County shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County shall send any newly-adopted and revised policies and procedures to the Monitor and DOJ for review and approval as they are promulgated. MDCR shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County shall document employee review and training in policies and procedures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The Monitors reviewed the proposed policy on the use of Tasers in the last six months. There were no other newly proposed policy revisions and/or other operational changes during this period.

Recommendations for sustaining compliance: N/A

B. The County shall develop and implement written Quality Improvement policies and procedures adequate to identify and address serious deficiencies in protection from harm and fire and life safety to assess and ensure compliance with the terms of this Agreement on an ongoing basis.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. D. 1.

Recommendations for sustaining compliance, if applicable: Demonstrate compliance with internal policy by production of a QI plan.

C. On an annual basis, the County shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and DOJ for review any changed policies and procedures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Documentation provided of review process.

Recommendations for sustaining compliance: N/A

D. The Monitor may review and suggest revisions on MDCR policies and procedures on protection from harm and fire and life safety, including currently implemented policies and procedures, to ensure such documents are in compliance with this Agreement.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: No policies reviewed during the last six months.

Recommendations for sustaining compliance: NA

Appendix A - Consent Agreement C= Compliance; PC=Partial Compliance; NC=Non-Compliance; NR= Not Reviewed

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19	Sep-19
A. Medical and Mental Health Care											
1. Intake Screening											
III.A.1.a.	Med-PC MH -PC	Med- NR MH - NR	Med-PC MH -PC	Med - PC MH - C	Med-PC MH -PC	Med-PC MH -PC	Med-PC MH -PC	Med-PC MH -PC	Med-C MH C	Med- C MH C	Med- C MH C
III. A. 1. b.	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - PC	MH - C	MH - C
III. A. 1. c.	MH - NC	MH - NC	MH - NC	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III.A.1.d.	Med - C MH-PC	Med- NR MH - NR	Med - NC MH - NC	Med - C MH - PC	Med - C MH - NC	Med - PC MH - NC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med- C MH C
III.A.1.e.	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH - PC	Med - C MH - PC	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - PC	Med - C MH - PC	Med - C MH - PC
III.A.1.f.	Med - PC MH- PC	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH -C	Med- C MH C
III.A.1.g.	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - NC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med- C MH C
2. Health Assessments											
III. A. 2. a.	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med - NC	Med - NC	Med -PC	Med - C	Med - C
III. A. 2. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C	MH - C
III. A. 2. c.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. A. 2. d.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
III.A.2.e.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NR	MH - C	MH - NC	MH - NC	Med - PC	Med - C	Med - C
III.A.2.f. (See (IIIA1a) and C. (IIIA2e))	Med - PC MH- PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - NC MH - PC	Med-PC MH -PC	Med - PC MH -PC	Med - C MH - C	Med - C MH - C
III.A.2.g.	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH - NC	Med - NC MH - NC	Med-C MH -PC	Med - C MH - C	Med - C MH - C	Med - C MH - C
3. Access to Medical and Mental Health Care											
III.A.3.a.(1)	Med - C MH - PC	Med- NR MH - NR	Med - C MH - C	Med- NR MH - NR	Med- NR MH- NR	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.A.3.a.(2)	Med- NR MH - PC	Med- NR MH - NR	Med - C MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - C MH - NR	Med - C MH - NC	Med - C MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19	Sep-19
III.A.3.a.(3)	Med - PC MH- PC	Med- NR MH - NR	Med - C MH - C	Med- NR MH - NR	Med- NR MH - NR	Med - C MH C	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.A.3.a.(4)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
III.A.3.b.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
4. Medication Administration and Management											
III.A.4.a.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
III.A.4.b(1)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- NC	Med - PC MH - NC	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.A.4.b(2)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH- NC	Med- NC MH -NC	Med- NC MH -PC	Med- PC MH -PC	Med - PC MH - C	Med - C MH - C
III. A. 4. c.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- PC	MH- PC	MH- C	MH- C	MH- C
III. A. 4. d.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- NC	MH- PC	MH- PC	MH- PC	MH- C
IIIA.4.e.	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - PC	Med - NC MH - PC	Med -PC MH - PC	Med -PC MH - PC	Med -PC MH - PC
III.A.4.f. (See (III.A.4.a.)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C
5. Record Keeping											
III.A.5.a.	Med - PC MH - NC	Med - NR MH- PC	Med - PC MH- PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - PC	Med - C MH - C	Med - C MH - C
III.A.5 b.	MH - NC	MH - PC	MH - PC	MH - NR	MH - NR	MH- PC	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III.A.5.c.(See III.A.5.a.)	Med - PC MH- PC	Med- NR MH - NR	Med-PC MH -PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.A.5.d.	Med - PC MH- PC	Med - NR MH- NR	Med-PC MH -PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19	Sep-19
6. Discharge Planning											
III.A.6.a.(1)	Med - NR MH- PC	Med - NR MH- NC	Med - PC MH - PC	Med- NR MH - NR	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III.A.6.a.(2)	Med - NR MH - PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med - NC MH - PC	Med - PC MH - PC	Med - NC MH - PC	Med - NC MH - PC	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III.A.6.a.(3)	Med - NR MH- PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med-PC MH -PC	Med- NR MH - NR	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
7. Mortality and Morbidity Reviews											
III.A.7.a.	Med - PC MH - PC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - C	Med - PC MH - PC	Med - C MH - C
III.A.7.b.	Med - NR MH - NC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH- NC	Med - NC MH - NC	Med - NC MH - NC	Med - C MH - C	Med - PC MH - PC	Med - C MH - C
III.A.7.c.	Med - NR MH - NC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C
B. Medical Care											
1. Acute Care and Detoxification											
III.B.1.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - NC	Med - PC	Med - C	Med - C
III.B.1.b. (See (III.B.1.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - PC	Med - PC	Med - PC	Med - C	Med - C
III.B.1.c.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - C	Med - C	Med - C	Med - C
2. Chronic Care											
III.B.2.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC	Med - C	Med - C
III.B.2.b. (See (III.B.2.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC	Med - C	Med - C
3. Use of Force Care											
III.B.3.a.	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - NR MH- NR	Med - NR MH- NC	Med - C MH - NC	Med-C MH -PC	Med - PC MH -PC	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.B.3.b.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - C	Med - C	Med - C
III.B.3.c. (1) (2) (3)	Med - NR	Med - NR	Med - PC	Med - NR	Med - NR	Med - NC	Med - NC	Med - PC	Med - C	Med - C	Med - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19	Sep-19
C. Mental Health Care and Suicide Prevention											
1. Referral Process and Access to Care											
III. C. 1. a. (1) (2) (3)		MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - PC
III. C. 1. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C
2. Mental Health Treatment											
III. C. 2. a.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. c.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 2. d.	MH - PC	MH - PC	MH - PC	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	MH - C	MH - C	MH - C
III. C. 2. e. (1) (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. f.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. g.	MH - NC	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 2. g. (1)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - C	MH - PC	MH - C	MH - C	MH - C
III. C. 2. g. (2)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C	MH - C	MH - C
III. C. 2. g. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C	MH - C
III. C. 2. g. (4)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 2. h.	MH - PC		MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. i.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	MH - C	MH - C	MH - C
III. C. 2. j.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. k.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
3. Suicide Assessment and Prevention											
III. C. 3. a. (1) (2) (3) (4) (5)	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 3. b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 3. c.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 3. d.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 3. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 3. f.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 3. g.	Med -NR MH - NC	Med - NR MH - NC	Med - NR MH- NR	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C
III. C. 3. h.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC	MH - C	MH - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19	Sep-19
4. Review of Disciplinary Measures											
III. C. 4. a. (1) (2) and b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - PC	MH - PC	MH - C	MH - C
5. Mental Health Care Housing											
III. C. 5. a.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 5. b.	MH - NC	MH - NC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - NC	MH - PC	MH - C	MH - C
III. C. 5. c.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 5. d.	MH - NR	MH - PC	MH - PC	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH -PC	MH - C
III. C. 5. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C
6. Custodial Segregation											
III. C. 6. a. (1a)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH -PC	MH - C
III. C. 6. a. (1b)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH -PC	MH - C
III. C. 6. a. (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH -PC	MH - C
III. C. 6. a. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 6. a. (4) i	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC	MH -PC	MH - C
III. C. 6. a. (4) ii	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - NC	MH - NC	MH - C	MH - C
III. C. 6. a. (5)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 6. a. (6)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH -PC	MH - C
III. C. 6. a. (7)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH - C	MH - C
III. C. 6. a. (8)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH - C	MH - C
III. C. 6. a. (9)	MH - C	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 6. a.(10)	Med - NC MH - PC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - PC	Med - C M - C	Med - C M - C
III. C. 6. a. (11)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH -PC	MH -PC

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19	Sep-19
7. Staffing and Training											
III. C. 7. a.	MH - PC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. c.	MH - NC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. d.	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 7. e.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. f.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. g. (1)(2)(3)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. h.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C	MH - C
8. Suicide Prevention Training											
III. C. 8. a. (1 – 9)	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C	MH - C	MH - C
III. C. 8. b.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C	MH - C	MH - C
III. C. 8. c.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 8. d.	MH - NC	MH - NC	MH - PC	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - PC	MH - C	MH - C
9. Risk Management											
III. C. 9. a.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 9. b. (1)(2)(3)(4)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 9. c. (1)(2)(3)(4)(5)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 9. d. (1)(2)(3)(4)(5)(6)	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
D. Audits an Continuous Improvement											
1. Self Audits											
III. D. 1. b.	Med - NR MH -PC	Med - NR MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
III. D. 1. c.	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH- NC	Med - PC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19	Sep-19
2. Bi-annual Reports											
III. D. 2 .a. (1)(2)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med -NC MH - NC	Med - PC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
III. D. 2. a. (3)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. D. 2. a. (4)			MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. D. 2. a. (5)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. D. 2. a.(6)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - C MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
III. D. 2. b.(See III. D. 1. c.)	Med - NR MH- NR	Med - NR MH- PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
IV. Compliance and quality Improvement											
IV. A	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
IV. B	Med - PC MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - PC	Med - NC MH - NC	Med - NC MH - NC	Med -C MH - C	Med -C MH - C	Med - C MH - C
IV. C	Med - NR MH- NR	Med - NF MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med -C MH - C	Med - C MH - C
IV. D	Med - NR MH- NR	Med - NF MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med -C MH - C	Med - C MH - C

Yellow = Collaboration - Medical (Med) and Mental Health (MH)

Purple = Collaboration with Protection from Harm

Orange = Medical Only

Green = Mental Health Only

Appendix B - Settlement Agreement 9/30/19											
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-17**	**Jul-18**	**Mar-19**	**Sep-19**
Safety and Supervision											
III.A.1.a. (1)	pc	pc	pc	nr	pc	c	c	c	c	c	c
III.A.1.a. (2)	nc	nc	pc	nr	nr	pc	pc	pc	pc	c	c
III.A.1.a. (3)	pc	pc	c	nr	nr	c	c	c	pc	c	c
III.A.1.a. (4)	pc	pc	pc	c	nr	c	c	c	c	c	c
III.A.1.a. (5)	pc	pc	c	nr	nr	c	c	c	c	c	c
III.A.1.a. (6)	pc	c	c	nr	nr	c	c	c	pc	c	c
III.A.1.a. (7)	pc	pc	c	nr	nr	c	c	c	pc	c	c
III.A.1.a. (8)	nc	nc	pc	nr	c	c	c	c	pc	c	c
III.A.1.a. (9)	pc	pc	pc	nr	c	c	c	c	c	c	c
III.A.1.a. (10)	pc	pc	pc	nr	nr	pc	c	c	c	c	c
III.A.1.a. (11)	pc	pc	pc	nr	nr	pc	c	pc	pc	c	c
Security Staffing											
III.A.2. a.	not due	pc	pc	c	nr	c	c	c	c	c	c
III.A.2. b.	nc	pc	pc	c	nr	pc	c	c	pc	c	c
III.A.2.c.	not due	pc	pc	c	nr	c	c	c	c	c	c
III.A.2.d.	NU	not due	nc	not due	c	c	c	c	c	c	c
Sexual Misconduct											
III. A.3.	pc	pc	c	nr	pc	pc	pc	pc	c	c	c
Incidents and Referrals											
III. A.4 a.	pc	pc	c	nr	nr	c	c	c	c	c	c
III.A.4. b.	nc	nc	c	nr	nr	c	c	c	c	c	c
III.A.4.c.	nc	pc	pc	nr	c	c	c	c	c	c	c
III.A.4.d.	not due	nc	pc	c	nr	c	c	pc	pc	c	c
III.A.4.e.	pc	pc	pc	nr	nr	p	c	c	c	c	c
III.A.4.f.	pc	pc	pc	pc	c	pc	c	c	c	c	c

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jul-18	Mar-19	Sep-19
Use of Force by Staff											
III.A. 5 a.(1) (2) (3)	pc	pc	pc	pc	pc	pc	c	pc	c	c	c
III.A.5. b.(1), i., ii, iii, iv, v, vi (2)	pc	pc	pc	pc	nr	c	c	pc	c	c	c
III.A. 5. c. (1)	nc	c	pc	nr	nr	c	c	c	c	c	c
III.A. 5. c. (2)	nc	pc	pc	nr	pc	pc	c	pc	pc	c	c
III.A. 5. c. (3)	pc	pc	pc	c	nr	c	c	c	c	c	c
III.A. 5. c. (4)	pc	NU	c	nr	nr	c	c	c	c	c	c
III.A. 5. c. (5)	pc	c	c	nr	nr	c	c	c	c	c	c
III.A. 5. c. (6)	nc	NU	pc	c	nr	c	c	pc	c	c	c
III.A. 5. c. (7)	pc	c	c	nr	nr	c	c	c	c	c	c
III.A. 5. c. (8)	nc	nc	c	nr	c	c	c	c	c	c	c
III.A. 5. c. (9)	nc	nc	pc	pc	c	c	c	c	c	c	c
III.A. 5. c. (10)	pc	c	c	c	nr	c	c	nc	c	c	c
III.A. 5. c. (11)	nc	nc	nc	pc	nr	pc	pc	pc	c	c	c
III.A. 5. c. (12)	nc	nc	nc	pc	nr	pc	c	pc	c	c	c
III.A. 5. c. (13)	nc	c	c	nr	nr	c	c	c	c	c	c
III.A. 5. c. (14)	nc	nc	nc	pc	nr	pc	c	pc	c	c	c
III.A.5. d. (1) (2) (3) (4)	pc	pc	pc	nr	nr	pc	c	pc	c	c	c
III.A.5. e. (1) (2)	nc	pc	pc	nr	nr	pc	c	pc	c	c	c
Early Warning System											
III.A.6. a. (1) (2) (3) (4) (5)	nc	nc	pc	nr	c	pc	c	c	pc	c	c
III.A.6.b.	nc	nc	not due	pc	c	pc	c	c	c	c	c
III.A.6.c.	nc	nc	NC	pc	c	pc	c	pc	pc	c	c

Section	Jul-17	May-17	Oct-17	May-17	Jan-17	Jul-17	Mar-17	Dec-17	Jul-18	Mar-19	Sep-19
Fire and Life Safety											
III.B.1.	pc	pc	pc	nr	nr	pc	c	c	c	c	"sun setted"
III.B.2.	c	c	c	nr	nr	pc	c	c	c	c	"sun setted"
III.B.3.	pc	pc	pc	nr	nr	pc	c	c	c	c	"sun setted"
III.B.4.	pc	pc	pc	pc	pc	pc	c	c	c	c	"sun setted"
III.B. 5.	nc	pc	pc	nr	nr	pc	c	c	c	c	"sun setted"
III.B.6	nc	nc	nc	pc	nr	pc	c	c	c	c	"sun setted"
Inmate Grievances											
III.C. 1.,2.,3.,4.,5.,6.	pc	pc	pc	c	nr	c	c	pc	pc	c	c
Audits and Continuous Improvements											
PFH III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	pc	c	c	c
FLS III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	c	c	c	c
PFH III.D. 2.a. b.	not due	nc	pc	pc	pc	pc	c	pc	pc	c	c
Compliance and Quality Improvement											
PFH IV. A.	not due	nc	pc	nr	nr	pc	c	c	c	c	c
FLS IV. A.	not due	NU	pc	nr	pc	pc	c	c	c	c	c
PFH IV. B.	nc	nc	pc	nr	nr	pc	c	pc	pc	c	c
FLS IV.B.	nc	nc	pc	nr	nr	pc	c	c	c	c	c
PFH IV.C.	not due	nc	pc	nr	c	c	c	c	c	c	c
FLS IV. C.	not due	nc	pc	nr	pc	c	c	c	c	c	c
PFH IV. D.	pc	pc	c	nr	nr	c	c	c	c	c	c
FLS IV. D.	pc	pc	pc	nr	pc	c	c	c	c	c	c

Legend:
nc = noncompliance
pc = partial compliance
c = compliance
NU = not audited

PFH - Protection from Harm
FLS - Fire Life Safety
nr = not reviewed