UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. COOK COUNTY, ILLINOIS; THOMAS DART, COOK COUNTY SHERIFF (in his official capacity); TONI PRECKWINKLE, COOK COUNTY BOARD PRESIDENT (in her official capacity); COOK COUNTY BOARD OF COMMISSIONERS (in their official capacity), Defendants,	No. 10 C 2946 Judge Virginia Kendall

Monitor Jeffrey L. Metzner, M.D.'s Report No. 12

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MEMORANDUM

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FROM: Jeffrey L. Metzner, M.D.
DATE: May 19, 2016
RE: *U.S.A. v Cook County, et al*
No. 10C2946

I have completed my assessment of the mental health services offered at the Cook County Department of Corrections (CCDOC) through Cermak Health Services of Cook County (CHSCC). I site visited CCDOC from April 18-22, 2016. This final report incorporates suggestions made by the parties regarding my draft report.

Sources of information utilized in compiling this report included the following:

1. review of documents provided in response to my written request for pre-site information, which included the following documents:
    a. status update to the Agreed Order,
    b. Mental Health Quality Improvement Committee meeting minutes,
    c. Suicide Prevention Committee meeting minutes,
    d. numerous mental healthcare quality improvement studies,
    e. root cause analysis reports re: recent suicides within CCDOC,
2. interviews with many inmates in group settings in Division 8 (RTU), Division X,

3. observation of treatment activities in Division 8,
4. information obtained from key administrative and clinical staff that included, but was not limited to, the following persons:

    a. Jay Shannon, M.D. (CEO, Cook County Health and Hospitals System),
    b. Krishna Das, M.D. (Chief Quality Officer),
    c. Claudia Fegan, M.D. (Executive Medical Director),
    d. Agnes Therady, R.N. (Executive Nursing Director),
    e. Christopher Wurth (Chief Operating Officer Hospital Based Services),
    f. Connie Mennella, M.D. (Chair, Department of Correctional Health Services),
    g. Nneka Jones, Psy.D. (First Assistant Executive Director),
    h. Kenya Key, Psy.D. (Chief of Psychology),
    i. David Kelner, M.D. (Chief of Psychiatry), and
    j. Carlos Gomez, Psy.D. (Mental Health Director).

As always, I found the staff from CHSCC and CCDOC to be courteous and helpful throughout my five-day site visit.

In this report the term "inmate" will be used in contrast to "detainee" in order to be consistent with the Agreed Order's terminology, although the vast majority of persons admitted to CCDOC are pre-trial detainees.

Overview

The Cook County Department of Corrections consists of 9 main divisions in a group of buildings covering over 100 acres. The inmate count during April 20, 2016 was 8,282.

Reference should be made to Appendix I for a more detailed summary of population and capacity information.

Findings

As per the June 3, 2010 memorandum regarding the June 2, 2010 meeting that included attorneys from the Department of Justice, attorneys and representatives of the Defendants, and the monitors, my findings relevant to the Mental Health Care section of the Agreed Order are summarized in Appendix IV (5-13-10 Agreed Order Mental Health provisions). Appendix IV includes excerpts from prior site assessment reports if they provide relevant contextual information. Consistent with the June 2, 2010 meeting, I have forwarded my input to the other monitors who have primary responsibility for sections that overlap with various mental health provisions as summarized in the June 3, 2010 memorandum.

Appendix II summarizes the twelve mental health provisions of the Agreed Order that have been in substantial compliance for at least 18 months. My assessment during this site visit did not raise any concerns that these provisions were no longer in substantial compliance. Appendix III

summarizes mental health provisions of the Agreed Order monitored by other monitors.

Information Requests

Appendix V summarizes my revised document request for my next site assessment scheduled for November 14-18, 2016.

Please do not hesitate to contact me if I can answer any further questions.

Sincerely,

Jeffrey L. Metzner, M.D.

Executive Summary—Twelfth Monitoring Report (Mental Health Provisions)

Since the November 2016 site visit, the most significant progress has occurred in the following six areas:

1. Continued improvement in the mental health programming (both in quantity and quality) for inmates in the RTU and Special Care Unit.
2. Continued improvement in the quality improvement process, which remains in substantial compliance.
3. Continued implementation of out of cell structured therapeutic programming for male RTU segregation inmates.
4. Continued implementation of the Intensive Management Unit (IMU) in the RTU.

CCDOC has recently initiated a plan for increased out of cell time for all inmates in segregation units as part of the CCDOC plan to gradually increase the recreational time for segregation inmates to three hours per day. In addition, up to six inmates at a time are allowed to recreate together in the dayroom. This positive change in the milieu related to the increased out of cell time was very apparent. In addition, the custody staff is providing limited correctional programming on a weekly basis to inmates who are willing to participate.

CCDOC has also eliminated administrative segregation, which has contributed to the decreased number of inmates on a segregation status.

There is a total of 118 FTE mental health positions with 18 vacancies that represents a 15.25% vacancy rate. The vacancy rate has continually decreased although the vacancy rate for psychiatrists and psychologists remain problematic.

The leadership of Kenya Key (Chief Psychologist, Ph.D.), David Kelner, M.D. (Chief Psychiatrist) and Carlos Gomez, Psy.D., Christopher Wirth M.D. and Connie Mennella, M.D. remains impressive. The working relationships between CCDOC and Cermak staffs continues to improve and is good.

No additional provisions of the Agreed Order are now in substantial compliance for at least 18 months, which means a total of 12 provisions continue to be in compliance for at least 18 months.

One (1) provision previously in partial compliance is now in substantial compliance, which means there are now six provisions that have substantial compliance for less than 18 months.

A total of eight (8) provisions remain in partial compliance.

The main obstacle related to the provisions in partial compliance center on the following issues:

1. the current vacancies re: psychiatrists and psychologists,
2. the need for increased mental health staffing allocations,
3. current lack of adequate mental health programing for female RTU segregation inmates,

4. current lack of adequate mental health programming for protective custody RTU inmates,
5. the need for increased recreational time for RTU inmates, and
6. the need for increased out of cell time for inmates in the psychiatric special care units.

CCDOC and Cermak leadership staff are actively addressing the above obstacles.

Summary of Compliance Findings

The following provisions were assessed to be in substantial compliance (with the initial date of substantial compliance noted in parenthesis):

Substantial compliance (bolded provisions have been in substantial compliance >18 months)

59. Assessment and Treatment

a. Results of mental health intake screenings (see provision 45.c, "Intake Screening") will be reviewed by Qualified Mental Health Staff for appropriate disposition. (6/12)

b. Cermak shall develop and implement policies and procedures to assess inmates with mental illness; and to evaluate inmates' mental health needs. Said policies shall include definitions of emergent, urgent, and routine mental health needs, as well as timeframes for the provision of services for each category of mental health needs. (10/12)

i. **Cermak shall provide the designated CCDOC official responsible for inmate disciplinary hearings with a mental health caseload roster listing the inmates currently receiving mental health care. (6/12)**

j. **When CCDOC alerts Cermak that an inmate is placed in lock down status for disciplinary reasons, a Qualified Mental Health Professional will review the disciplinary charges against inmate to determine the extent to which the charge was related to serious mental illness. The Qualified Mental Health Professional will make recommendations to CCDOC when an inmate's serious mental illness should be considered as a mitigating factor when punishment is imposed on an inmate with a serious mental illness and to minimize any deleterious effect of disciplinary measures on an inmate's mental health status. (10/12)**

k. In the case of mentally ill inmates in segregation, CCDOC shall consult with Cermak to determine whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on Cermak's assessment. (11/15)

l. Cermak shall ensure that mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained Qualified Mental Health Professionals or by Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, in order to assess the serious mental health needs of inmates in segregation. Inmates who are placed in segregation shall be evaluated within 24 hours of placement and thereafter regularly evaluated by a Qualified Mental Health Professional, or by a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, Cermak shall provide CCDOC with its recommendation regarding whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on the assessment of the Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional. (11/15)

m. Cermak shall maintain an updated log of inmates receiving mental health services, which shall include both those inmates who receive counseling and those who receive medication. Cermak shall create such a log within six months of the date this Agreed Order is executed. The log shall include each inmate's name, diagnosis or complaint, and next scheduled appointment. Each clinician shall have ready access to a current log listing any prescribed medication and dosages for inmates on psychotropic medications. In addition, inmate's medical records shall contain current and accurate information regarding any medication changes ordered in at least the past year. (6/12)

n. Cermak shall ensure that a psychiatrist, physician or licensed clinical psychologist conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. An appropriately credentialed registered nurse may conduct the in-person evaluation of an inmate prior to a seclusion or restraint order that is limited to two hours in duration. Patients placed in medically-ordered seclusion or restraints shall be evaluated on an on-going basis for physical and mental deterioration. Seclusion or restraint orders should include sufficient criteria for release. (4/16)

61. Suicide Prevention Policy

a. CCDOC shall participate with Cermak in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.

b. Cermak shall participate with CCDOC in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.

c. The suicide prevention policy shall include, at a minimum, the following provisions:

(1) an operational description of the requirements for both pre-service and annual in-service training;
(2) intake screening/assessment;
(3) communication;
(4) housing;
(5) observation;
(6) intervention; and
(7) mortality and morbidity review. (11/13)

62. Suicide Precautions

a. CCDOC shall ensure that, where suicide prevention procedures established jointly with Cermak involve correctional personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), correctional personnel perform and document their monitoring and checks.

b. Cermak shall ensure that, where suicide prevention procedures established jointly with CCDOC involve health care personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), health care personnel perform and document their monitoring and checks.

c. CCDOC shall ensure that when an inmate is identified as suicidal, the inmate shall be searched and monitored with constant direct supervision until the inmate is transferred to appropriate Cermak staff.

d. Cermak shall develop and implement policies and procedures for suicide precautions that will set forth the conditions of the watch, including but not limited to allowable clothing, property, and utensils, in accordance with generally accepted correctional standards of care. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergency circumstances. (11/15)

63. **Cermak shall ensure that Qualified Mental Health Staff assess and interact with (not just observe) inmates on Suicide Precautions, and document the assessment and interaction on a daily basis. (11/10)**

64. Suicide Risk Assessments

a. Cermak shall ensure that any inmate showing signs and symptoms of suicide is assessed by a Qualified Mental Health Professional using an appropriate, formalized suicide risk assessment instrument within an appropriate time not to exceed 24 hours of the initiation of Suicide Precautions.

b. Cermak shall ensure that the risk assessment shall include the following:
(1) description of the antecedent events and precipitating factors;
(2) mental status examination;
(3) previous psychiatric and suicide risk history;
(4) level of lethality;
(5) current medication and diagnosis; and
(6) recommendations or treatment plan. Findings from the risk assessment shall be documented on both the assessment form and in the inmate's medical record. (11/13)

65. Cermak shall ensure that inmates will only be removed from Suicide Precautions after a suicide risk assessment has been performed and approved by a Qualified Mental Health Professional, in consultation with a psychiatrist. A Qualified Mental Health Professional shall write appropriate discharge orders, including treatment recommendations and required mental health follow-up. (11/15)

66. Suicide Prevention Policies

a. CCDOC shall ensure that suicide prevention policies established jointly with Cermak include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards.

b. Cermak shall ensure that suicide prevention policies established jointly with CCDOC include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards. (6/12)

67. DFM shall ensure that cells designated by CCDOC or Cermak for housing suicidal inmates shall be retrofitted to render them suicide-resistant (e.g., elimination of protrusive shower heads, unshielded lighting or electrical sockets). Inmates known to be suicidal shall not be housed in cells with exposed bars. (6/12)

68. Suicide Prevention Training

a. Cermak shall ensure that the Facility's suicide prevention curriculum for health care staff members, jointly established with CCDOC, addresses the following topics:
(1) the suicide prevention policy as revised consistent with this Agreed

Order;

(2) why facility environments may contribute to suicidal behavior;
(3) potential predisposing factors to suicide;
(4) high risk suicide periods;
(5) warning signs and symptoms of suicidal behavior;
(6) observation techniques;
(7) searches of inmates who are placed on Suicide Precautions;
(8) case studies of recent suicides and serious suicide attempts (Serious suicide attempts are typically considered to be those that either were potentially life-threatening or that required medical attention);
(9) mock demonstrations regarding the proper response to a suicide attempt; and
(10) the proper use of emergency equipment, including suicide cut-down tools. (12/10)

70. Cermak shall document inmate suicide attempts at the Facility, as defined by the Suicide Prevention Committee's policies and procedure in accordance with generally accepted correctional standards, in the inmate's correctional record in CCDOC's new Jail Management System, in order to ensure that both correctional and health care staff will be aware at future intakes of past suicide attempts, if an inmate with a history of suicide attempts is admitted to the Facility again in the future. Cermak will begin to document this information within six months after execution of this Agreement. (6/12)

86. Quality Management and Performance Measurement

a. Defendants shall each develop and implement written quality management policies and procedures, in accordance with generally accepted correctional standards, to regularly assess, identify, and take all reasonable measures to assure compliance with each of the provisions of this Agreed Order applicable to that Defendant.
b. Defendants shall each develop and implement policies to address and correct deficiencies that are uncovered during the course of quality management activities, including monitoring corrective actions over time to ensure sustained resolution, for each of the provisions of this Agreed Order applicable to that Defendant. (11/15)

The complete list of provisions that were in partial compliance were as follows:

59. Assessment and Treatment

c. Cermak shall ensure that any inmate who screens positively for mental illness or suicidal ideation during the intake screening process, through a mental health assessment, or who is otherwise referred for mental health services, receives a clinically appropriate mental health evaluation in a timely manner, based on

emergent, urgent, and routine mental health needs, from a Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional. Such mental health evaluation shall include a recorded diagnosis section on Axis I, II, and III, using the DSM-IV-TR, or subsequent Diagnostic and Statistical Manual of the American Psychiatric Association. If a Qualified Mental Health Professional, or a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, finds a serious mental illness, they shall refer the inmate for appropriate treatment. Cermak shall request and review available information regarding any diagnosis made by the inmate's community or hospital treatment provider, and shall account for the inmate's psychiatric history as a part of the assessment. Cermak shall adequately document the mental health evaluation in the inmate's medical record.

d. Cermak shall ensure clinically appropriate and timely treatment for inmates, whose assessments reveal serious mental illness or serious mental health needs, including timely and regularly scheduled visits with Qualified Mental Health Professionals or with Qualified Mental Health Staff, with appropriate, on-site supervision by a Qualified Mental Health Professional.

e. Cermak shall ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses.

f. Cermak shall provide 24-hour/7-day psychiatric coverage to meet inmates' serious mental health needs and ensure that psychiatrists see inmates in a timely manner.

g. Cermak shall ensure timely provision of therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate number of Qualified Mental Health Staff to provide treatment, and an adequate array of structured therapeutic programming. Cermak will develop and implement policies and procedures defining the various levels of care and identifying the space, staffing, and programming that are appropriate to each identified level of care.

h. Inmates shall have access to appropriate infirmary psychiatric care when clinically appropriate.

k. In the case of mentally ill inmates in segregation, CCDOC shall consult with Cermak to determine whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on Cermak's assessment.

l. Cermak shall ensure that mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained Qualified Mental Health Professionals or by Qualified Mental Health Staff with appropriate, on-site

supervision by a Qualified Mental Health Professional, in order to assess the serious mental health needs of inmates in segregation. Inmates who are placed in segregation shall be evaluated within 24 hours of placement and thereafter regularly evaluated by a Qualified Mental Health Professional, or by a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, Cermak shall provide CCDOC with its recommendation regarding whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on the assessment of the Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional.

o. Cermak shall ensure an adequate array of crisis services to appropriately manage the psychiatric emergencies that occur among inmates. Crisis services shall not be limited to administrative segregation or observation status.

p. Cermak shall ensure that inmates have access to appropriate acute infirmary care, comparable to in-patient psychiatric care, within the Cermak facility.

60. Psychotherapeutic Medication Administration

a. Cermak shall ensure that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis for appropriateness or adjustment. Cermak shall ensure that changes to an inmate's psychotropic medications are clinically justified and documented in the inmate's medical record.

b. Cermak shall ensure timely implementation of physician orders for medication and laboratory tests. Cermak shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, including movement disorders, and provide treatment where appropriate.

Appendix I

COOK COUNTY SHERIFF'S OFFICE
BUREAU OF INFORMATION AND TECHNOLOGY
BUSINESS INTELLIGENCE UNIT

Sheriff's Daily Report
4/20/2016

Under the Custody of the Sheriff	
TOTAL MALE AND FEMALE	10,484
Jail Population	8,282
Community Corrections	2,202

Jail Population	
TOTAL MALE AND FEMALE	8,282
General Population (Male)	6,940
General Population (Female)	509
VRIC (Court Ordered)	20
PRC (Court Ordered Drug Treatment Program)	583
Women's Residential (Court Ordered Drug Treatment Program)	112
Outside Counties	90
Hospital	28

Community Corrections Population	
TOTAL MALE AND FEMALE	2,202
Electronic Monitoring (Court Ordered)	
Men	1,876
Women	282
Electronic Monitoring (Admin Ordered)	
Men	0
Women	0
M.O.M.s Program (Court Ordered)	8
VRIC Post Release (Court Ordered)	36

COOK COUNTY SHERIFF'S OFFICE
BUREAU OF INFORMATION AND TECHNOLOGY
BUSINESS INTELLIGENCE UNIT

Cook County Department of Corrections Executive Director's Log

Wednesday, April 20, 2016 Prepared by: B. Merle

Totals:	**8,282**	**100%**
Male	7,661	93%
Female	621	7%

	Male	Female	Total	Capacity	No Place To Stay
Div 1	-	-	0	1250	0
Div 2	1923	-	1923	1960	34
Div 3	-	-	0	360	0
3 Annex	659	-	659	749	0
Cermak	104	25	129	148	3
Div 4	-	240	240	552	3
Div 5	-	-	0	992	0
Div 6	976	-	976	992	1
Div 08	628	244	872	979	31
Div 9	960	-	960	1066	1
Div 10	747	-	747	768	6
Div 11	1526	-	1526	1536	0
Div 17 W. Residential	-	112	112	152	0
Div 15 - HP	28	-	28	-	2
VRIC In Camp	20	-	20	-	0
Outlying Counties	90	-	90	-	0
Totals:	7661	621	8282	11504	81

Appendix II

59. Assessment and Treatment

a. Results of mental health intake screenings (see provision 45.c, "Intake Screening") will be reviewed by Qualified Mental Health Staff for appropriate disposition.

Compliance Assessment: Substantial compliance (since June 2012).

Factual Findings:

May 2014 Metzner assessment: Little change from November 2013. Still concerned re: likely false positive screening numbers.

November 2014 Cermak Status Update

From intake referrals by nursing personnel (female intake = RN; male intake = RN or other nursing designees) conducting screening upon all incoming inmates in RCDC, to the secondary mental health assessments, the following referral numbers represent the percentage of referrals to mental health by month from May 2014 through September 2014, which show that the male intake and secondary mental health referrals are remaining essentially constant at this point, while there is a marked increase in female referrals to secondary mental health assessment. Further investigation by the way of a QI study of the Initial Intake Evaluation will need to be conducted.

SECONDARY MENTAL HEALTH REFERRALS GENERATED BY INTAKE NURSING:

Male	%	Referral	Total	Female	%	Referral	Total
May_2014	23.37%	832	3560	May_2014	57.08%	246	431
Jun_2014	22.41%	762	3401	Jun_2014	64.30%	272	423
Jul_2014	24.82%	865	3485	Jul_2014	63.79%	273	428
Aug_2014	22.48%	918	4083	Aug_2014	65.46%	290	443
Sep_2014	22.17%	774	3491	Sep_2014	79.42%	274	345

The chart below looks at the data from all new admissions to the mental health caseload, by month and gender. The charts reflect those inmates identified and classified as P-2, P-3, or P-4 during the secondary mental health assessment at intake or within the three days following admission versus those who were placed on the mental health caseload at some later point during incarceration. The inter-rater reliability study has not yet been conducted for the Mental Health Specialists within RCDC due to staffing levels and other competing priorities. The data reflects continual improvements in identifying mentally ill inmates at the onset of incarceration.

MENTAL HEALTH CASELOAD GENERATED BY INTAKE V. DURING INCARCERATION:

Admit Month	Male Mental Health Classification within 3 day after Admit	Mental Health Classification During Incarceration
9_2014	95.28%	4.72%
8_2014	92.32%	7.68%

7_2014	90.12%	9.88%
6_2014	89.37%	10.63%
5_2014	87.22%	12.78%

Admit Month	Female Mental Health Classification within 3 day after Admit	Mental Health Classification During Incarceration
9_2014	93.68%	6.32%
8_2014	88.09%	11.91%
7_2014	83.73%	16.27%
6_2014	87.20%	12.80%
5_2014	81.95%	18.05%

November 2014 Metzner assessment: Substantial compliance remains.

b. Cermak shall develop and implement policies and procedures to assess inmates with mental illness; and to evaluate inmates' mental health needs. Said policies shall include definitions of emergent, urgent, and routine mental health needs, as well as timeframes for the provision of services for each category of mental health needs.

Assessment: Substantial compliance (since October 2012)

i. Cermak shall provide the designated CCDOC official responsible for inmate disciplinary hearings with a mental health caseload roster listing the inmates currently receiving mental health care.

Assessment: Substantial compliance (since June 2012)

Factual Findings:

October 2012 Cermak Status Update

- Cerner is now able to generate a patient roster for the mental health caseload to provide to the CCDOC; however, it does not yet include the level of care/mental health classification as this is being built within the alert system.

November 2013 Metzner assessment: Substantial compliance continues.

November 2014 Cermak Status Updates

Cerner and CCOMS now have a fully operational, direct interface which makes mental health classification/level of care immediately and accurately available to CCDOC by midnight each day.

November 2014 Metzner assessment: No change

j. When CCDOC alerts Cermak that an inmate is placed in lock down status for disciplinary reasons, a Qualified Mental Health Professional will review the

disciplinary charges against inmate to determine the extent to which the charge was related to serious mental illness. The Qualified Mental Health Professional will make recommendations to CCDOC when an inmate's serious mental illness should be considered as a mitigating factor when punishment is imposed on an inmate with a serious mental illness and to minimize any deleterious effect of disciplinary measures on an inmate's mental health status.

Assessment: Substantial compliance continues (since October 2012).

Factual Findings:

November 2015 Metzner assessment: Substantial compliance continues

m. Cermak shall maintain an updated log of inmates receiving mental health services, which shall include both those inmates who receive counseling and those who receive medication. Cermak shall create such a log within six months of the date this Agreed Order is executed. The log shall include each inmate's name, diagnosis or complaint, and next scheduled appointment. Each clinician shall have ready access to a current log listing any prescribed medication and dosages for inmates on psychotropic medications. In addition, inmate's medical records shall contain current and accurate information regarding any medication changes ordered in at least the past year.

Compliance Assessment: Substantial compliance (since June 2012)

Factual Findings:

June 2012 Metzner assessment: In addition to the above update section, staff demonstrated a capacity to also include dosages of the psychotropic medications in the required log.

October 2012 Cermak Status Update

- The mental health roster has been updated. The roster is being updated routinely. Any inmate on the roster who is identified as missing an ICD 9 code as the result of data entry of a free text or another issue in Cerner is subsequently referred to a psychiatrist for entry of a diagnosis and problem in correspondence to any prescription of a psychotropic medication.

November 2014 Metzner assessment: No change.

61. Suicide Prevention Policy

a. CCDOC shall participate with Cermak in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.

b. Cermak shall participate with CCDOC in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.

c. The suicide prevention policy shall include, at a minimum, the following provisions:

(1) an operational description of the requirements for both pre-service and annual in-service training;
(2) intake screening/assessment;
(3) communication;
(4) housing;
(5) observation;
(6) intervention; and
(7) mortality and morbidity review.

Compliance Assessment: Substantial compliance (11/13)

Factual Findings:

November 2013 Metzner Assessment: Significant improvement is noted in the Mortality & Morbidity Review reports, which are now using a root cause analysis format.

As described elsewhere in this report, problems remain relevant to the intake screening/assessment process, especially in the context of priority referrals and segregation admissions screening. These issues are addressed elsewhere in this report.

November 2015 Metzner assessment: My April 2015 recommendations were implemented. Substantial compliance continues.

63. Cermak shall ensure that Qualified Mental Health Staff assess and interact with (not just observe) inmates on Suicide Precautions, and document the assessment and interaction on a daily basis.

Compliance Assessment: Substantial compliance (since November 2010)

Factual Findings:

November 2013 Metzner Assessment: The EMRs of 10 inmates on suicide observation status were reviewed. Documentation was present in the EMR that mental health staff interacted with (not just observed) these inmates on Suicide Precautions and documented their assessment and interaction on a daily basis with one exception. A patient on 2N while on suicide precautions only received nursing notes one day, 10/20/13, which was a Sunday. There were no mental health assessment notes documented that day.

November 2014 Metzner assessment: No change.

64. Suicide Risk Assessments

a. Cermak shall ensure that any inmate showing signs and symptoms of suicide is assessed by a Qualified Mental Health Professional using an appropriate, formalized suicide risk assessment instrument within an appropriate time not to exceed 24 hours of the initiation of Suicide Precautions.

b. Cermak shall ensure that the risk assessment shall include the following:
- **(1) description of the antecedent events and precipitating factors;**
- **(2) mental status examination;**
- **(3) previous psychiatric and suicide risk history;**
- **(4) level of lethality;**
- **(5) current medication and diagnosis; and**
- **(6) recommendations or treatment plan. Findings from the risk assessment shall be documented on both the assessment form and in the inmate's medical record.** (11/13)

66. Suicide Prevention Policies

a. CCDOC shall ensure that suicide prevention policies established jointly with Cermak include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards.

b. Cermak shall ensure that suicide prevention policies established jointly with CCDOC include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards.

Compliance Assessment: Substantial compliance (since June 2012)

Factual Findings:

November 2014 Metzner assessment: No change

67. DFM shall ensure that cells designated by CCDOC or Cermak for housing suicidal inmates shall be retrofitted to render them suicide-resistant (e.g., elimination of protrusive shower heads, unshielded lighting or electrical sockets). Inmates known to be suicidal shall not be housed in cells with exposed bars.

Compliance Assessment: Substantial compliance (since June 2012)

Factual Findings:

October 2012 Cermak Status Update:

- Inmates known to be suicidal are not housed in cells with exposed bars; rather, they are transported under 1:1 observation by a CO to Cermak and placed into a suicide resistant cell, as ordered by a psychiatrist, when deemed to be a suicide risk, and placed on close or constant observation, as ordered in Cerner.

November 2014 Metzner assessment: No change.

68. Suicide Prevention Training

a. Cermak shall ensure that the Facility's suicide prevention curriculum for health care staff members, jointly established with CCDOC, addresses the following topics:

(1) the suicide prevention policy as revised consistent with this Agreed Order;
(2) why facility environments may contribute to suicidal behavior;
(3) potential predisposing factors to suicide;
(4) high risk suicide periods;
(5) warning signs and symptoms of suicidal behavior;
(6) observation techniques;
(7) searches of inmates who are placed on Suicide Precautions;
(8) case studies of recent suicides and serious suicide attempts (Serious suicide attempts are typically considered to be those that either were potentially life-threatening or that required medical attention);
(9) mock demonstrations regarding the proper response to a suicide attempt; and
(10) the proper use of emergency equipment, including suicide cut-down tools.

Compliance Assessment: Substantial compliance (since December 2010)

Factual Findings:

April 2013 Metzner assessment: Relevant training continues to be provided to staff by the mental health staff.

November 2013 Metzner assessment: No change.

May 2014 Cermak Status Update

DOC Advanced Mental Health Training for In-Service: The DOC has now initiated its second of many scheduled two-week in-service training courses for existing DOC tenured Correctional Officers in Advanced Mental Health Training to include Crisis Intervention Training (CIT) and Cermak Health Services participates in the CIT component through a Correctional Psychologist who describes the Cermak mental health delivery system and the mental health classification

procedure as well. This program is provided at the jail on-site in training facilities within the compound although it is from the Academy curriculum.

Cermak Suicide Prevention Training: The Cermak mental health training in Suicide Prevention for mental health, nursing and medical professionals is ongoing and is offered routinely to ensure that all staff maintain their current status in suicide training according to policy requirements. A Correctional Psychologist provides this training at least twice annually to assure ongoing adherence to requirements in training and also offers Restraint Training as well.

November 2014 Cermak Status Updates

Same as above, training continues for all disciplines as described in May 2014 Cermak Status Update.

November 2014 Metzner assessment: No change

70. Cermak shall document inmate suicide attempts at the Facility, as defined by the Suicide Prevention Committee's policies and procedure in accordance with generally accepted correctional standards, in the inmate's correctional record in CCDOC's new Jail Management System, in order to ensure that both correctional and health care staff will be aware at future intakes of past suicide attempts, if an inmate with a history of suicide attempts is admitted to the Facility again in the future. Cermak will begin to document this information within six months after execution of this Agreement.

Compliance Assessment: Substantial compliance (since June 2012)

Factual Findings:

October 2012 Cermak Status Update:

- All inmate serious suicide attempts are monitored and reported at the Suicide Prevention Committee that occurs on the fourth Friday of each month in Cermak, conducted by the Chief Psychologist, with an agenda and minutes maintained. A detailed report of each serious suicide is completed and reviewed by a Correctional Psychologist at the committee meeting following the attempt and it is treated as a morbidity review for the learning experience. CCDOC incident reports and Cermak medical records as well as court reports are included in the morbidity review. Serious suicide attempts are also reported to the monthly overall CQI committee and to the Sheriff's Office. Any serious suicide attempt also receives an alert in Cerner and in IMACS which is now also passed on to the Courts so that they are aware of any history as well. There had been two instances of serious attempts in court, where the court was not aware of prior attempts. As a result, the Court now participates in the monthly suicide prevention meeting and is now aware of these alerts in Cerner and IMACS, a notable improvement directly attributable to a serious suicide attempt.

October 2012 Metzner assessment: Substantial compliance continues.

May 2014 Cermak Status Update:

Suicide Prevention Committee Review: The Suicide Prevention Committee attempts to meet on the fourth Friday each month and the agenda has a standing item to review any and all serious suicide attempts for patterns that could identify areas for improvement to prevent future occurrences from repeating events. Meeting minutes reflect review of individual cases and ongoing efforts to prevent recurrence by efforts to correct any deficiencies identified. DOC, Cermak, the Sheriff's Office and the Court Officials all participate in this multi-disciplinary meeting.

November 2014 Cermak Status Updates

Suicide Prevention Committee Review: The Suicide Prevention Committee attempts to meet on the fourth Friday each month and the agenda has a standing item to review any and all serious suicide attempts for patterns that could identify areas for improvement to prevent future occurrences from repeating events. Meeting minutes reflect review of individual cases and ongoing efforts to prevent recurrence by efforts to correct any deficiencies identified. DOC, Cermak, the Sheriff's Office and the Court Officials all participate in this multi-disciplinary meeting. Full Root Cause Analyses are completed during these meetings for any completed suicides occurring in the 30 days prior. Root Cause Analyses are also used for other sentinel events as determined by administration. RCAs for two completed suicides since last site visit provided as password protected files under separate cover.

November 2014 Metzner assessment: Substantial compliance continues

Appendix III

Appendix III

Mental health provisions of the Agreed Order monitored by other monitors

H. QUALITY MANAGEMENT AND PERFORMANCE MEASUREMENT

c. CCDOC shall participate with Cermak and DFM in a jointly established Health Care Quality Improvement Committee, to be charged with developing and implementing a joint quality improvement program. CCDOC shall contribute the time and effort of CCDOC staff members who, by virtue of their authority, current responsibilities, and/or past experience, can provide this committee with needed correctional representation.

d. Cermak shall participate with CCDOC and DFM in a jointly established Health Care Quality Improvement Committee, to be charged with developing and implementing a joint quality improvement program. Cermak will work with CCDOC and DFM to identify those CCDOC and DFM staff members who, by virtue of their authority, current responsibilities, and/or past experience, can provide this committee with needed correctional representation. Quality management programs related to medical and mental health care will utilize performance measurements to assess quality of care and timely access to care with quantitative and qualitative data analysis and trending over time.

e. DFM shall participate with CCDOC and Cermak in a jointly established Health Care Quality Improvement Committee, to be charged with developing and implementing a joint quality improvement program. DFM shall contribute the time and effort of DFM staff members who, by virtue of their authority, current responsibilities, and/or past experience, can provide this committee with needed correctional representation.

Compliance Assessment: Refer to the report by Dr. Shansky (initially found to be in substantial compliance during 2011 and again during 2013)

69. CCDOC shall ensure that security staff posts will be equipped, as appropriate, with readily available, safely secured, suicide cut-down tools.

Compliance Assessment: Refer to the report by Susan McCampbell.

Appendix IV

AGREED ORDER

D. MENTAL HEALTH CARE

59. Assessment and Treatment

c. Cermak shall ensure that any inmate who screens positively for mental illness or suicidal ideation during the intake screening process, through a mental health assessment, or who is otherwise referred for mental health services, receives a clinically appropriate mental health evaluation in a timely manner, based on emergent, urgent, and routine mental health needs, from a Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional. Such mental health evaluation shall include a recorded diagnosis section on Axis I, II, and III, using the DSM-IV-TR, or subsequent Diagnostic and Statistical Manual of the American Psychiatric Association. If a Qualified Mental Health Professional, or a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, finds a serious mental illness, they shall refer the inmate for appropriate treatment. Cermak shall request and review available information regarding any diagnosis made by the inmate's community or hospital treatment provider, and shall account for the inmate's psychiatric history as a part of the assessment. Cermak shall adequately document the mental health evaluation in the inmate's medical record.

Compliance Assessment:

Partial compliance with paragraph c.

Factual Findings:

April 2016 Cermak Status Update

March 2016
Total Jail Population as of 04/01/2016: 8,096

P2-Outpatient Mental Health	1550	19.14% (of total)	77.15% (of MH load)
P3- Intermediate Mental Health	394	4.8% (of total)	19.61% (of MH load)
P4- Infirmary Mental Health	65	0.8 % (of total)	3.23% (of MH load)
Mental Health Caseload	**2,009 (24.81%)**		

Total Jail Population as of 10/01/2015: 8,751

P2-Outpatient Mental Health	1571	17.94% (of total)	77.6% (of MH load)
P3- Intermediate Mental Health	382	4.36% (of total)	18.8% (of MH load)
P4- Infirmary Mental Health	69	0.78% (of total)	3.4 % (of MH load)
Mental Health Caseload	**2022 (23.08%)**		

As the total jail population has contracted by 742 detainees, the number of patients on Mental Health Caseload has remained relatively stable. Furthermore, the proportion of detainees in Intermediate Level of Care – P3 has remained constant. Various diversion programs at CCDOC has not diminished the proportion of the seriously mentally ill and the violent offenders, thus the confined population remains as "sick" as it was in 2015.

All Providers, Psychologists, MSW and MHS continue to use their personalized access to the Jail Data Link database allowing them to source data about previous admissions to municipal and state institutions receiving federal grants or directly administered by the State of IL. All Providers, Psychologists, MSW and MHS have personalized access to the Jail Management System (CCOMS) allowing them to review charges, legal and disciplinary history in real time. All the WYSE terminals and desktops that Cermak utilizes across the compound (including RCDC) permit CCOMS access. Mental health staff are routinely seeking releases of information for community providers during the intake process and post intake when needed. Results of the yield in recent month can be found below:

Treatment Records from Community Providers

Oct 2015 to March 2016

MONTH	REQUEST SENT	RESPONSE RECEIVED*	% Return
Oct-15	17	14	82%
Nov-15	49	22	45%
Dec-15	78	37	47%
Jan-16	108	53	49%
Feb-16	212	96	45%
Mar-16	197	73	37%
TOTALS	661	295	45%

The number of records requested from community providers has steadily increased from a low of 17 in October 2015 to a high of about 200 in February and March 2016. MH health professionals working in RCDC/Intake are more conscientious about executing ROIs with patient. Some of the challenges to executing ROIs include: patient refusal, patient is poor historian, patient cannot recall or patient provides wrong/inadequate information.

Medical Records staff indicated that the number of providers from which records are being requested increased. Thus, their effort to focus on a few high-volume providers has not had

much impact on the rate of submission of records from community providers.

As of 3/18/16 every single MHS employee completed the review of all 59 policies, both those that were updated and those that were not.

CCDOC Executive Leadership proposed to introduce additional Mental Health Screening in RCDC (in addition to the pre-bond court screening already conducted by Sheriff's Office for Mental Health Advocacy staff) and the assignment of the CCDOC RCDC MH Referral Alert. CCDOC would like to work with Cermak to identify intake screening questions that would warrant a prompt referral to Cermak and add them to the CCDOC initial intake process. Executive CCDOC Leadership proposed that CCDOC adds the "DOC Mental Health Referral" alert for any detainee:

A. With the charges Cermak previously identified (the idea is to identify the charges that lead to intense guilt, shame and similar feelings that increase the risk of suicide):
    - Predatory Criminal Sexual Assault
    - Abuse of a corpse
    - Sexual relations within families
    - Dismembering a human body
    - Conspiracy to commit murder/solicitation to commit murder
    - Intentional homicide of an unborn child
    - First degree murder when the following aggravating factors are present: killing of a peace officer, murdering two or more individuals, murdered individual was less than 12 years of age, matricide, patricide, the murder involved infliction of a torture, death resulted from exceptionally brutal or heinous behavior or wanton cruelty).
B. Those with affirmative responses to mental health-related questions asked at the lock up by local law enforcement and
C. Any other agreed upon questions (4 sample questions were introduced for further Cermak feedback):

    - *Have you ever been prescribed medication for emotional, behavioral or mental health concerns?*

    - *Have you ever been in the hospital for mental health concerns or on "Suicide Watch" in jail or prison?*

    - *Have you ever been in counseling for an emotional, behavioral or mental health concern?*

- *Do you have thoughts or a plan to hurt yourself or someone else?*

Cermak Leadership met with CCDOC Executive Leadership regarding this matter, in order to gauge the potential for mutual collaboration going forward. Furthermore, Cermak was informed that Northwestern Hospital is in the process of working on a grant designed to create a system allowing identification, tracking, and referral of detainees requiring linkage services in the community. This process would be complementary to already existing Cermak supported process of providing post discharge referrals, access to services, and medications via the e-prescribing pathway. (See Appendix for range of services provided by Cermak Medical Social Work staff). Cermak was informed that the computer based system that is being developed by Northwestern would be relying on self-report and answers to a questionnaire. Cermak recognizes the importance of accurate and comprehensive referral and evaluation of detainees with SMI. Cermak is exploring further venues for collaboration while trying to answer pertinent framework questions:

1. Is addition of yet another self-report based screen (see four sample questions above) seem reasonable or do CCDOC and Cermak need to think about augmenting already existing assessments with observational data from RCDC officers (e.g. bizarre and unusual behavior) while focusing on collateral sources of information (reports from CPD and other arresting Police Departments, available EMR, jail data link, other electronic databases)?

2. Is the introduction of a two tier system – CCDOC Primary screening followed by Cermak Primary screening- justified? The recommended positive combined referral rate ranges from 25 to 33 percent. Present Cermak Primary Screening data are available below. Will there be a compounding of the false positive rate (that is "accepting in" the detainees without true mental health needs and SMI) when it is added to the false positive rate that already comes from the Cermak's Primary Screening? A screening system that accepts high false positive rates may lead to inefficient use of resources that is large numbers of detainees without MH needs receiving assessments possibly delaying assessments and treatments for those who with the highest need.

During the screening process, for rare but severe illnesses (i.e. psychosis and suicidal ideation), a two stage screening process may be acceptable. It may be tolerable to have a high false positive rate at the first stage (Primary Screening), followed by secondary level triage (Secondary Mental Health Assessment). Cermak will continue to discuss the CCDOC proposal while focusing on using already existing validated instruments and processes in order to maximize detection of detainees in need of services and assessment through:

a. minimizing the number of false positives (adequate sensitivity)
b. keeping the false negative rate low under certain threshold (low false negative rate).

On average more than 40% of female detainees and approximately 20% of male detainees are referred for secondary mental health assessment from the initial health screening. Please see Excel Appendix for Intake Referral data. Currently, Dr. Gomez is acting as the clinical supervisor in the RCDC area. During RCDC group supervisions case conferences, including peer review, are conducted to address the quality of secondary mental health assessments and identify outliers among staff. The main focus is to discuss quality of dispositions and risk assessments. Dr. Gomez conducted a thorough audit and analysis of assessments and dispositions made by the Intake QMHP staff. This RCDC QI report can be found in the PDF Appendix.

Dr. Kelner reviewed psychiatry referrals originating in the intake process as per below (also see Excel Appendix for data):

Psychiatry Intake Referrals:

Emergency									
	Seen within 4hrs		Not Seen						Total
Month	#	%	2) Over 4hrs		4) No Note in Intake		#	%	
			#	%	#	%			
2015_10	38	97.4%		0.0%	1	2.6%	1	2.6%	39
2015_11	159	99.4%		0.0%	1	0.6%	1	0.6%	160
2015_12	179	93.7%	4	2.1%	8	4.2%	12	6.3%	191
2016_1	155	82.9%	14	7.5%	18	9.6%	32	17.1%	187
2016_2	169	90.4%	12	6.4%	6	3.2%	18	9.6%	187

In February 2016 90.4% detainees were seen within 4 hours (in keeping with the timeframe) when referred with Psychiatry Emergent Referral. Out of the 9.6% that were not seen timely, 6.4% were still seen in RCDC (Intake) but outside of the 4 hour timeframe. 3.2% were not seen in Intake, as they were either fast tracked, given acuity, prior to Psychiatrists being able to see them, to PSCU and MSCU/detoxification units. Additionally, a small proportion of that cohort had orders for Psychiatry Intake placed in EMR when it was assumed by MHS that Psychiatry would be present on site, but then, due to call offs Psychiatrists did not show up and original orders were not cancelled.

Urgent(P4)	**1) Within 24 hrs**		**2) Over 24 hrs**		**No Note**		Total
2_2016	97	91.%	8	7.%	2	2.%	107
1_2016	76	93.%	5	6.%	1	1.%	82
12_2015	69	84.%	11	13.%	2	2.%	82
11_2015	79	88.%	10	11.%	1	1.%	90

10_2015	71	92.%	3	4.%	3	4.%	77

In February 2016 91% of detainees referred for Urgent Psychiatry Referral were seen within 24 hours (in keeping with the timeframe). The 7% of detainees that were not seen within the next 24 hours were mostly detainees admitted on Fridays and weekend Psychiatrists saw them later in the day and detainees who were assigned P4 level (were "slated" for PSCU admission) and then were diverted to MSCU and detoxification Units, thus delaying their contact with Psychiatry. Nursing and Medical staff in MSCU is still responsible for the identification of P4's and sending these notifications to the Chief of Psychiatry. Since there is no the Scheduling Template, these detainees are frequently missed. See discussion below about the relevance of the new Infirmary Tracker enabling Psychiatry to track these detainees in MSCU/Cermak building and see them timely. The Tracker is anticipated to go live in April of 2016 and would enable Psychiatry to timely locate P4 detainees on the 3 rd. floor/MSCU.

Routine(P2/P3)	1) Within 14 days		2) Over 14 days/within 30days		3) D/C within 15 days		4) D/C over 15 days without Note		5) No Note		Total
2_2016	315	58%	50	9.%	135	25.%	13	2.%	28	5.%	541
1_2016	323	65.%	22	4.%	120	24.%	14	3.%	18	4.%	497
12_2015	365	65.%	23	4.%	139	25.%	15	3.%	19	3.%	561
11_2015	326	55.%	28	5.%	183	31.%	36	6.%	17	3.%	590
10_2015	406	60.%	26	4.%	190	28.%	40	6.%	15	2.%	677

In February 2016 58% detainees referred for Routine Psychiatry referral were seen within 14 days (in keeping with the timeframe). 25% were released from CCDOC within the same time-period before Psychiatry had a chance to see them. 9% were seen by Psychiatry outside of the timeframe (but within 30 days). The last number reflects high vacancy rate in Psychiatry and the fact that many divisional clinics already functioning at their capacity. 2% were released within a month and without being seen by Psychiatry and 5% were either shipped to outside counties or to IDOC. Of note is that that Cerner continues to capture IDOC shipments (most of them were parole holds upon admission to CCDOC) as being physically on campus and, therefore, they are seen as "never having contacts with Psychiatry". Dr. Kelner is addressing this glitch with IT. Additionally, detainees' rate of transfer between divisions/ clinical areas remains significant, as CCDOC transfers patients between divisions VI, II and X for the purposes of bed control/ disciplinary reasons, therefore clinic appointments get missed and , when rescheduled for later time, detainees fall out of the requisite timeframes. CCDOC and Cermak leadership meet regularly to discuss bed control and to identify ways of making the system more efficient.

The following has been introduced to facilitate timely contacts with Providers in Cermak. Mental Health Caseload detainees (P2, P3 and P4) patients that were admitted to MSCU (Medical

Special Care Units) from RCDC/UC w/out a clinic template presented a challenge in terms of tracking. We need a process that supports their timely identification and facilitates their being seen by Psychiatry in keeping with the time frames (Urgent- within 24 hours and Routine - within 14 days). We had to rely on Medical Providers and Nurses identifying these patients and reporting them directly to a single point person - Chief of Psychiatry.

Daily PSCU Mental Health Level of Care Tracker was created by IT and Mental Health. It will enable to track the following metrics:

1. P-level detainees throughout the whole building will appear on the tracker (including staging and MSCU's).
2. Will inform Providers about whether or not Psychiatrist had contact (i.e., wrote a note) with a detainee and if they did, when the contact occurred.
3. Needed follow up for close observation status patients will be indicated.
4. Tracker will prompt Provider to write a note by a specific date to remain in policy compliance (that logic will be built in the tracker).

The creation of the tracker enables mental health to remain aware of patient status throughout the building and addresses the fact that there are no schedulers working on the weekends and that there are no psychiatry clinic templates to schedule detainees on the 3rd floor (MSCU). A sample of the Tracker can be found in the PDF Appendix.

Some challenges have been created by inappropriate requests for Psychiatry Referrals from MHS and PCC Providers for detainees already established on MH caseload, rather than the appropriate follow up with Psychiatry. MH Administration also insists that every detainee who is referred to MH Department for services and evaluation, excluding crisis management, receives a structured Secondary Mental Health Assessment (with the embedded Suicide Risk Screen/Suicide Risk Assessment) prior to ordering Referral to Psychiatry. Additional efforts have been put into educating Mental Health Specialists and PCC providers on the distinction between Referrals to Psychiatry and Follow up to Psychiatry. Mental Health Specialists performing these Secondary MH Assessments will make appropriate referrals to Psychiatry.

Chart audits has revealed an intrinsic problem in RCDC/UC revealing that many MHS allowed the default to the following day when ordering Routine Psychiatric Referrals and not selecting a remote date. MH Administration will continue to work with the Unit Directors and drill down to select appropriately a date within 14 days when MHS schedule Routine Psychiatry referrals. The clerks/AAs responsible for the schedule do not always adhere to the 14 day timeframe for a variety of reasons, some known (i.e. clinic template full) and others unknown (i.e. instances where there are available appointments within the required time frame). Additionally, when detainees have to be rescheduled in divisions (i.e. due to No Shows for a variety of reasons), the rescheduled dates are sometimes outside of routine time frames. Education was provided to scheduling department as a group and individually. (Please see the Excel Appendix for data

reflecting Routine Psychiatry Referrals).

With respect to JSH, EM and outlying county returns, further improvements have been made in tracking detainees returning on CCDOC campus. There is a new daily report generated automatically for hospital returns (15HP). This report is being sent to CHSC 1128A printer in MH Administration area. It lists all the hospital returns over the past 24 hours. The list includes P/M levels and medications pre-transfer. The ones that had not dropped off are listed as "ordered" and the ones that need to be reordered are listed as "discontinued". (A sample of this report can be found in the PDF Appendix.) MH Administration worked with CCDOC Leadership to formalize the way outlying county returns are processed back onto the compound.

Based on the schedule provided by CCDOC, MH administration created a new, standing OT shift to allow Mental Health Specialists to be available to assess returning detainees. Furthermore, Chief of Psychiatry is notified of outlying county returns so that medications can be reordered. Of continued concern is that SPIDOC shipments and outlying county stays continue to show up as "unseen" when the logic used to capture data even though they were not on campus at the time of their scheduled psychiatry appointment. Resolutions for this problem, which adversely affects compliance data is being explored by IT.

Urgent Care Center has introduced a new tracking system (FirstNet) allowing a more efficient control of the flow of detainees in UC. Now PCC Providers and Nurses can move detainees needing a MH assessment to the MH tab, therefore decreasing if not eliminating reliance on verbal hand offs and endorsements that can easily be missed or misinterpreted in a fast paced environment. Additionally, formally incorporating mental health into the flow of the urgent care will serve to minimize miscommunication, minimize missed assessments, and minimize inappropriate discharge from the urgent prior to completion of all needed services.

The stop order medication reports are now generated for Divisions and are designed to identify pt's whose prescriptions are expiring before their regularly scheduled appointments.

The new alert "MH Fit on Medications" is available under "Chronic Disease Alert" order. This alert DOES NOT go into CCOMS/CCDOC System. It will be utilized for detainees who return from DMH restored to fitness on medications or found to be FST on this compound with medications. It will be entered by RCDC Psychiatrists, or whoever conducts the first Evaluation upon their arrival without end dates applied.

The new alert "Authorized Involuntary Medication" is available in Cerner and migrates through the CCOMS interface. It will be utilized for detainees who have court orders for Involuntary Medications (non-emergency basis). Even though court orders have an expiration date, for tactical reasons, Cermak will use this alert without time restrictions. It will be entered by a Provider who serves as a Petitioner and goes to court to argue the petition, in case the ruling authorizes the Involuntary Treatments.

April 2016 Metzner assessment: Significant progress has been made in the following areas as summarized in the April 2016 Cermak Status Update section:

1. Timely assessments by psychiatrists re: urgent and emergent referrals.
2. Requesting and obtaining mental health records from other agencies.

Issues relevant to psychiatrist's timely responses to routine referrals are directly related to the continued significant psychiatrists' vacancy rate.

I discussed issues relevant to the proposal by Northwestern Hospital with staff and made certain nonbinding recommendations since it is not within the scope of the Agreed Order.

Recommendations: Continue addressing the psychiatrists' vacancy issues.

d. Cermak shall ensure clinically appropriate and timely treatment for inmates, whose assessments reveal serious mental illness or serious mental health needs, including timely and regularly scheduled visits with Qualified Mental Health Professionals or with Qualified Mental Health Staff, with appropriate, on-site supervision by a Qualified Mental Health Professional.

Compliance Assessment: Partial compliance

Factual Findings:

April 2016 Cermak Status Update

COMPOUND HOUSING PLAN BY MENTAL HEALTH LEVELS OF CARE (as of April 2016)

Cermak- P4 (Psychiatric Special Care Unit)- 2N acute male, 2W-acute and chronic female, 2S/2SE- male subacute, 2E- male chronic, P4 can also be housed on the third floor in Medical Special Care Unit under special circumstances. Housing on 3S for Mental Health reasons requires Tx orders from PCC/ Dr. Mennella. Patients with M4 and P4 can be housed on the Medical Special Care unit based in interdisciplinary decision.

- Division II: MALE MENTAL HEALTH HOUSING
  - Dorm 2: Mental Health Outpatient P2; **if any Mental Health Intermediates (P3) are placed there, Dr. Gary works transferring them to RTU; CCDOC houses detainees that attend MHTC (Mental Health Transition Center) in Division II Dorm 2
  - Dorm 1: NO MENTAL HEALTH HOUSING
  - Dorm 3: NO MENTAL HEALTH HOUSING
  - Dorm 4: NO MENTAL HEALTH HOUSING
- Division IV FEMALE MENTAL HEALTH HOUSING

□□(Women's Justice- SWJP): FEMALE MENTAL HEALTH HOUSING- 1st Floor

- Mental Health Intermediates P3 (requires clearance from DWJS staff)
- Mental Health Outpatients P2 (requires clearance from DWJS staff)

□□Mental Health Outpatient P2- 2nd floor

- Division V: NO MENTAL HEALTH HOUSING
- Division VI: MALE MENTAL HEALTH HOUSING
  - Westcare tiers – 2A/2B/2C (substance abuse, court ordered treatment program), Mental Health Outpatient P2
  - Protective Custody: 1A, 1B and 1C
    - Mental Health Outpatient P2 (only require mental health clearance prior to placement/ within 24 h if restricted housing rules apply) **No Mental Health Intermediates P3 should be cleared by mental health to transfer to PC in Division VI; they should only be cleared for PC in Division VIII RTU
  - Segregation: Tiers 1N, 1P
    - Mental Health Outpatient P2 (require mental health clearance prior to placement/within 24 h) **No Mental Health Intermediates P3 should be cleared by mental health to transfer to segregation in Division VI; they should only be cleared for segregation in Division VIII RTU
- Division VIII RTU: MENTAL HEALTH HOUSING
  - 5th floor Females
    - Mental Health Intermediates P3 (tiers B, F) Mental Health Outpatients P2 and DETOX (all other tiers)
    - Segregation (tier A) Protective Custody (tier E) (restrictive housing require mental health clearance prior to placement/within 24 h)
  - 4th floor Males
    - Mental Health Intermediates P3 (all tiers)
    - Segregation (tier A) Protective Custody (tier E)
      - Mental Health Intermediates P3 (restrictive housing require mental health clearance prior to placement/within 24 h)
  - 3rd floor Males
    - Medical Intermediate M3s (may also be P2s) with overflow Mental Health Intermediate P3s
  - 2nd floor Males
    - Mental Health Intermediate Overflow P3 (tier 2B)
    - Intensive Management Unit (tier 2A)
- Division IX: MALE MENTAL HEALTH HOUSING
  - Protective Custody (Tiers 3E, 3F, 3G house alone/out alone/ admin. segregation, 3H PC)
    - If conditions of confinement are more restrictive than GP, Mental Health Outpatient P2 require mental health clearance prior to placement/within 24h **No Mental Health Intermediates P3 should be cleared by mental health to transfer to PC in Division IX; they should only be cleared for segregation in Division VIII RTU

  - Segregation- non-administrative segregation (Tier 1E; 1F- enhanced security tier)
    - Mental Health Outpatient P2 (require mental health clearance prior to placement/within 24h) **No Mental Health Intermediates P3 should be cleared by mental health to transfer to segregation in Division IX; they should only be cleared for segregation in Division VIII - RTU
  - General Population (all other tiers in the division)
    - Mental Health Outpatient P2
- Division X: MALE MENTAL HEALTH HOUSING: Mental Health Outpatient P2 **if any Mental Health Intermediates (P3) are placed there, Dr. Gary works on transferring them to RTU
  - Disciplinary Segregation– 1A (require mental health clearance prior to placement/within 24 h or preplacement) **No Mental Health Intermediates P3 should be cleared by mental health to transfer to segregation in Division X; they should only be cleared for segregation in Division VIII RTU
  - Protective Custody -1C (meeting criteria of smart housing) and 2C
    - **No Mental Health Intermediates should be cleared by mental health to transfer to segregation/PC in Division X; they should only be cleared for segregation in Division VIII RTU
- Division XI: NO MENTAL HEALTH HOUSING
- Division XVI (Boot Camp): NO MENTAL HEALTH HOUSING; detainees on dose by dose medications cannot be in Boot Camp (and that excludes any patient on psychotropics)

Compound Housing Discussions:

There has been no further development on the Division XI project and plans to relocate P2 detainees from Divisions II, VI, and IX and X have been tabled indefinitely.

The planned transition to MHTC (Mental Health Transition Center) residential setting has not taken place yet. CCHHS seeded 3 million dollars for additional hiring to staff the transition center program. However, Cermak and CCDOC Executive Leadership staffs have not had discussions with each other regarding the timeline for onboarding of additional staff to accommodate medication management in the residential MHTC.

The Health & Hospital System is partnering with the Cook County Justice Advisory Council and the Chicago Police Department to open a pilot Community Triage Center this year. The community-based center will seek to provide evaluation, crisis stabilization and treatment for patients presenting with psychiatric and/or substance-related emergencies, and will work closely with the local hospitals and outpatient mental health services to best meet patients' needs 24/7/365. Access will be prioritized for police officers to drop off individuals and rapidly return to their patrol areas. The CTC will also provide walk-in services for those released from the Cook County Jail. (See PDF Appendix).

RTU Staffing Levels.

	RTU 5th floor females	RTU 4th floor(+ 2nd and 3rd floors)
Psychiatrist	1.2	1.4+0.2 (PA)=1.6
Psychologist/Unit Director	1.0	1.0
Social workers	1.5+ 1.0 Expressive therapist	1.5+1.0 Expressive therapist
Mental Health Specialists	2MHS III +4MHS II on AM 2MHS III + 2MHSII on PM	4MHS III + 4MHS II on AM 4MHS III + 1MHS II on PM 1MHS III + 1 MHS II on Midnight Shift (for the whole RTU)
Population	P3 76 P2 132 (208)	P3 256 P2 4 (260)+ additional 101 P2 and 40 P3 on the 2nd and 3rd floors

RTU total population 608
P2 237
P3 371
Detainees with medical alerts/detox on the second and third floors -141

Division IV
Proposed movement to Division 4, which was intended to merge Division III and Division XVII (SWJP), took place in January 2016. It consolidated female P2 detainees and enabled Cermak to consolidate services centripetally. Detainees from SWJP remain spatially isolated (on the first floor of Division IV) from other detainees housed on the 2nd floor of the building. Psychiatric Services, Mental Health Services, and community meetings were not interrupted due to coordination of services between CCDOC and Cermak and a series of meetings and walk through sessions that had taken place before the actual move. Psychiatry FTE 03. P2-140, P3-13.

Female RTU
Psychiatric Services in RTU- 5th floor have been unchanged. Cermak continues to provide limited structured out of cell therapeutic programming to detainees on the protective custody tier (5E), group programming is not yet available to patients confined on the segregation tier (5A) as the tier has not been retrofitted to allow detainees to be secured to stationary furniture. CCDOC has expressed concerns that said retrofitting is not gender-responsive; as such safety mechanisms will need to be put in place in order to allow for safe facilitation of group therapeutic programming with this challenging population. Cermak will continue to provide segregation rounds and individual therapeutic contacts for segregated patients and/or aggressive patients.

Executive Summary of Women's Mental Health Services

The team has increased efforts to facilitate individualized group treatment by staffing each P3 patient regularly and using the treatment cards (also to motivate patients). Patients are involved in the treatment planning process and create a problem list with the tier mental health specialist who is familiar with her. All (100%) of P3 treatment plans are initiated and updated on time. The quality of treatment plans drastically improved. Outpatient (P2) treatment plans are created by psychiatrist and have drastically increased in compliance for new P2 patients. P3 patients do receive 10 hours of group on a regular basis. P2 average 2-4 hours of group per month. Protective Custody patients receive 2 hours of group per week. Female Services has a very low self-harm rate. Self-injuries that do occur are usually a few specific patients when housed in segregation. CCDOC escorts all detainees to a mental health provider for assessment prior to placement in segregation and all are escorted for subsequent Cermak mental health assessments if indicators of self-harm are noted by the CCDOC staff.

SMU Rounds are completed twice per week (both in PC although not required and Segregation). Patients are assessed by MH within 24 hours of placement in segregation. PC tiers receive 2 hours of group per week. A significant number of P3 and P2 patients receive individual therapy services in RTU and in Div. 4 for more personalized treatment. There has been improved consultation with CCDOC with respect to identifying what constitutes referral for an urgent psych evaluation, which are completed in a timely manner. RTU provides 24 hour on-site evaluations and consultation. Unit Director periodically attends roll call to discuss psych evaluations and referrals. We continue to focus expressive arts and linkage services on P3 patients. P2's receive linkage services on a selected or referred basis.

We have seen improvement with patients who have poor hygiene. Rise and shine occurs 5 days per week and hygiene supplies and encouragement are provided. Patient's displaying ongoing, serious hygiene concerns (generally psychotic) are discussed in MDT clinical staffing and are admitted to the psychiatric special care unit for increased support and a humanitarian shower. Patients who have marginal hygiene are being encouraged and offered an edible treat or Dove body wash for hygiene compliance. Beauty shop services have increased in RTU and in Div. 4.

Psychiatrists are meeting with patients within 1-3 days if deemed a priority. Routine appointments for new patients are occurring within 14 days. P3 patients are receiving monthly appointments (significant improvement since the last site visit). We are also receiving more records from community providers via ROI for continuity of care.

Div. 3 (Cermak) and Div. 17 (SWJP) have combined to form Div. 4. The results are quite positive. The patients generally prefer the Div. 4 housing better than Div. 3. Cermak and SWJP treatment staff are working well together and have increased communication, providing improved treatment for all Div. 4 patients. Communication between mental health and CCDOC has greatly improved. Enrichment programs have been implemented for P2 and GP patients (Book Club, Theater Group, Anger Management, Yoga, Legal Aid, and sewing workshop). New strategies have been utilized among mental health, nursing, and CCDOC staff to cut down on the number of female patients being moved by CCDOC between RTU and Div. 4. There are very

few moves that are occurring, improving compliance with appointments and decreasing patient stress.

Female services has been working with a shortage of two (licensed) mental health specialists, which poses clinical challenges. Less experienced mental health staff too frequently rely upon showing videos for group, which has resulted in some patient complaints. Such issues have been addressed in individual and group supervision. Facilitating interactive groups has increasingly been discussed in group supervision. While some staff members have shown improvements, others have shown little to no improvement. As a result, there was a change in staff duties in hopes of decreasing patient concerns.

Mental health facilitates a movie discussion group for treatment compliant patients every two weeks. Incentive items (t-shirts, bras, panties) are randomly given to those attending the most groups, takings meds, and following CCDOC rules. We are also providing a standardized letter of participation monthly for patients attending 75% of recommended treatment groups. Few women are receiving the letter of participation due to lack of consistent attendance, which frankly was a surprise as we expected tangible "proof" of compliance with treatment to take to court would be a considerable motivator. Long-term patients (particularly 5F) struggle with the eventual redundancy of the treatment videos and materials often reporting that they are bored.

Patients have also reported becoming bored on the tiers and a desire for increased recreation. In order to increase collaboration in consistency of clinical programming, CCDOC is kept up-to-date with the mental health group schedule to avoid having the recreation schedule conflict with group times. Mental health looks forward to assisting with creative group activities for recreation time (i.e. bowling tournaments, etc.).

Ongoing issues related to patients trying to acquire as much medication as possible, hoarding and abusing the medications is addressed in group and individual treatment. Mental health continues to work with nursing and security to identify and monitor patients engaging in these behaviors. Once patients are identified as engaging in these behaviors, a "Hoards Medication" alert is entered into the medical record. This alert migrates to CCOMS so that all parties are aware and increased monitoring of the patient can take place.

There has been a sharp increase in patients submitting HSR forms making demands for specific medications, often submitting multiple, daily for the same issues. Usually documenting "anxiety" and "I can't sleep", so "I need X medication." Some patients directly inform the mental health staff that they intend to submit the requests daily until they are given what they are requesting. To address this issue community groups, HSR contacts, and psych evaluations are including sleep hygiene, anxiety management, and relaxation/ coping skills, however little impact has been noted.

Mental health staff has expressed concerns related to delays in patient movement and monitoring of clinical activities. Mental health hopes to work toward maintaining consistent officers on

mental health tiers who are advance psych trained and work better with mental health patients. A list of recommendations has been provided to the Superintendent for consideration. The RTU 5th floor periodically experiences issues with housing changes for patients which can be disruptive to programming and patient stability. Recently the Superintendent and Commander have been addressing the issue and indicate that all moves should be done only through classification, hopefully preventing future issues.

Please see PDF Appendix (Monthly Statistics 2016) for group programming statistics.

Male RTU

Psychiatric Services in RTU- 4th floor have been bolstered by the addition of the Part –time Physician Assistant. The relatively small increase in FTE's allocated to the 4th floor reflects ongoing staffing challenges. Due to the preplanned movement of Westcare detainees from Division II Dorm 2 to Division VI, Cermak had to respond to the centrifugal force and fragmentation of services provided on the compound, by assigning FTE 0.1 to Division VI while offsetting that by moving FTE0.1 from Division II Dorm 2 to male RTU, thus, keeping the staffing levels in the high priority area (RTU) constant.

Executive Summary of Male RTU Services

RTU Male Services has continued to implement several changes since November of 2015 to individualize mental health services and to enhance the treatment milieus on 6 dorms, 2 specialized units on the fourth floor (segregation and protective custody), the Intensive Management Unit (IMU), and the P3 overflow dorm on the second floor. The programming on these tiers is described below as well as the strengths and the challenges of each area.
Based upon feedback from detainees and previous DOJ reports, efforts have been made to provide more individualized treatment services for P3 detainees on the fourth floor. In the past, detainees attended group based on bed number. Logistically, this system facilitated scheduling and tracking of groups, but did not necessarily provide detainees with significant input regarding their treatment plan. In August of 2015, several staff members held "voluntary" groups to assess patient interest in signing up for more specialized groups. This format reportedly enhanced motivation and participation in groups per staff and detainees, so was subsequently expanded to the entire fourth floor. In November of 2015, detainees signed up for voluntary groups based upon their interests and perceived treatment needs. Mental health staff also assigned individuals to specific groups given their chart review, clinical presentation, and observed behaviors. In December of 2015, Verification Letters were also introduced as incentives for individuals who attended at least 75% of their groups. Detainee attendance is monitored on individual treatment cards.

Overall, the Verification Letters and voluntary groups seem to have enhanced the motivation and treatment experience for many detainees. Each dorm typically earns between ten to thirteen letters each month (25-30%). Several challenges have emerged with this new system. In

particular, the MH team has had difficulty tracking group enrollment and maintaining a system to orient new detainees. Currently, mental health staff conducts orientation groups to inform new detainees about the structure of RTU program and treatment expectations. At that point, detainees sign up for groups and have initial treatment plans developed. Due to staffing and/or institutional issues, orientation groups may need to be rescheduled, which then delays the onset of group enrollment. Further, some detainees request to sign up for numerous groups while others remain reluctant to participate altogether. This discrepancy potentially limits the opportunity detainees have to enroll in groups and to earn verification letters. These factors along with staff absences, both planned and unplanned, often interfere with the consistency and efficiency of treatment programming. Staff assignments have been changed to increase the number of mental health specialists conducting orientation groups, developing treatment plans, and monitoring group enrollment. The treatment team will continue to make adjustments to streamline these processes.

In August of 2015, treatment groups were initiated on the segregation tier of RTU (4A). At that time, groups were co-facilitated on three mornings of the week with three detainees at a time. After a trial period without significant problem or incidents, group programming was expanded to five of days of the week (Monday through Friday), during both morning and evening shifts. Up to six detainees can now participate in on tier sessions. In addition to group programming, MH staff conducts segregation rounds once per week as well as individual follow up with detainees. Our goal is to provide ten hours of programming per week; however, MH staff has struggled to consistently increase and maintain treatment hours for several reasons. When the program was developed, the mental health team and CCDOC agreed two officers would be necessary to hold and supervise the group. Due to institutional needs, two officers have not always been available for the group, which occasionally interfered with total hours provided. To avoid repeated disruptions in programming, the safety plan was eventually adjusted to include at least two officers present for the transport of detainees and one officer present for the group. With respect to other obstacles, groups are sometimes difficult to hold on the unit when detainees are engaging in highly disruptive behaviors (throwing urine and feces, making threats, etc.). Moreover, MH staff has had difficulty engaging detainees who refuse to participate in groups. Some detainees are highly symptomatic and prefer to isolate in their cells while others are resistant to have group in a setting where other detainees can hear personal discussions. Although the segregation unit on the fourth floor previously housed only P3 detainees, recent institutional changes resulted in this tier serving as the only segregation unit in RTU. As a result, the tier is now mixed with intermediate care, outpatient care, and general population detainees. This environment is not always conducive to on tier programming and seems to contribute to group refusals on occasion. After consultation with security, MH staff was granted permission to hold off tier groups when necessary. MH staff attempt to do so whenever room space is available. The treatment team will continue to consult with CCDOC about incentives for group participation in segregation. The following have been discussed as potential alternatives to food incentives: supervised time on the patio as well as participation in on tier activities such as bowling, music, and art. Although decreased segregation time has been proposed, this option has been more controversial.

Detainees housed in protective custody are not permitted to attend off tier groups with other P3 detainees. Consequently, on tier group programming was originally scheduled for this tier (movie discussion, chair yoga, and emotional management). These sessions were ultimately discontinued due to low participation. Staff resources were refocused to other dorms, with individual follow up and crisis intervention as the main mental health services provided to protective custody detainees. Recently, some of the newer detainees have expressed interest in participating in the aforementioned groups, which have now resumed.

A P3 overflow dorm was opened on the second floor of RTU to reduce the number of P3 patients displaced to other areas of the compound. This dorm was intended to provide temporary housing for detainees awaiting space on the fourth floor. Since its creation, the P3 overflow dorm has varied in overall size and population. To illustrate, the dorm houses P3, P2, as well as general population medical patients. At times, the dorm has been dominated by P3 detainees; at other times, the dorm is mostly medical patients. For several weeks, 2B was closed altogether due to low population. Detainees were initially expected to move up to the fourth floor within two to three weeks. Consequently, the mental health services provided to P3 detainees on this dorm included wellbeing checks twice a week. Periodic community meetings were added in February of 2016 due to the increased number of P3 detainees housed on 2B at that time as well as the increased length of stay for those individuals. Mental health services were again increased following the completed suicide of a P3 detainee on this dorm. Currently, staff is scheduled to provide wellbeing checks twice a week, community meetings once a week, and on tier groups two days a week.

Presently, detainees in need of hygienic procedures (excluding, thus far, haircutting) are to be admitted in a preplanned way to the psychiatric special care unit where Cermak MH leadership and the Superintendent have developed the hygiene protocol allowing for the coordinated administration of hygienic services. When warranted, detainees displaying disorganization of behavior (along with the other salient criteria) are considered and petitioned for the nonemergency administration of psychotropic medications.

Intensive Management Unit (IMU)

The Intensive Management Unit (IMU) is on the second floor or RTU. This specialized program is designed to provide increased structure and support for mentally ill detainees who have demonstrated significant problems in their functioning. The program consists of three successive phases (Assessment and Admission Phase-minimum 2 weeks; Stage 1- minimum 4 weeks; and Stage 2-minimum 4 weeks) which offer increased incentives as the detainee progresses. All of the detainees selected for the program thus far incurred notable segregation time due to severe behavioral problems (e.g. assault against others; property damage; sexual misconduct; threats and noncompliance). These detainees were informed their participation and successful completion of the program could result in absolution of segregation time for previous disciplinary tickets. The first three detainees moved into the IMU unit in October of 2015. MH and CCDOC staff were selected and trained to participate in the IMU unit. To date, the program has housed a maximum of four detainees, two of whom have successfully graduated

and have returned to a dorm setting without behavioral incidents to date. One detainee has progressed to Stage 2 and is eligible to graduate at the end of April, 2016. The last detainee has remained in the Assessment and Admission Phase since October due to his repeated noncompliance with treatment and behavioral expectations. The IMU team meets for weekly staffings and holds on tier meetings with the detainees every other week to review treatment progress and expectations. The collaboration and communication amongst this disciplinary team has been essential to facilitate the progress of detainees.

Currently, the team continues to work on maintaining consistency across shifts and personnel, as lapses in rules and regulations have periodically jeopardized the integrity of the program. The recent departure of one Commander and addition of two new Commanders to the building highlighted the need for a clear and thorough description of the program. A joint manual for both MH and CCDOC staff is being developed to address the issues and questions that have arisen over the past six months. Another training session will then be scheduled for new and existing staff to discuss strengths, weaknesses, and recommended adjustments to the program. For example, the team is considering the IMU for mentally ill detainees who would benefit from celled housing, but have not accrued segregation time.

Since the last DOJ visit, RTU MH staff has focused on individualizing treatment services and expanding the groups offered to male detainees. In addition, staff has increased individual follow up for detainees who demonstrate poor hygiene and significant symptoms of mental illness. Regarding challenges, MH staff absences continue to impact programming, as does problems with supervision of CCDOC staffing allocations. Further, limited space and computers make it difficult to conduct all clinical activities and charting on days when all staff is present. Requests have been made to activate the computers on the second floor to allow access to Cerner and for mental health staff to be able to utilize computers in the medical triage rooms on the tier, particularly as MH presence increases on 2A and 2B.

Please see PDF Appendix (Monthly Statistics 2016) for group programming statistics.

Division II Dorm 2/P2

Houses O, R and P housing Westcare patients have been moved to Division VI. MHTC detainees are housed in the V house. Overflow P3 are still housed in Division II Dorm 2 until a bed opens in RTU and Cermak staff transfers them immediately using bed control tools. Within the past few months there has been a concerted effort to conduct community groups in all ten tiers on a weekly basis. At times, these groups have not occurred due to security issues, employee absence, and employee vacation. There is a MHS III assigned during the evening (3-11) shift on Tuesday, Wednesday, and Thursday. Telepsychiatry Clinic continues to provide reliable coverage for this Division and remains the strongest assignment in terms of productivity and meeting expectations. The initiative is meeting expectations. Dr. Marri's clinic, due to growing demand in RTU, has been limited to mornings on Tuesday. The mental health staff is working well with security. Supt. Martinez has been very open to the needs of mental health. As

mentioned elsewhere, Dr. Kaniuk functions as a Unit Director for Divisions X and II. FTE for Psychiatry is 1.1. Population: P2-392.

Division 2 Dorm 2 Executive Summary

Division Two – Dorm Two houses P-2 and M2 (outpatient level of care) patients. Recently, the population changed somewhat by the influx of many more "medium" security detainees from Division Ten, after the Westcare substance abuse program was transferred to Division Six. These individuals can be more problematic at times. Thus, this means more referrals to mental health through HSRF, mental health clinic, or emergency evaluations.

Staff absenteeism has been a significant problem in this area. There are two employees assigned during the 7-3PM shift but due to vacation and sick time, they are often absent. Also, the MHS III (on both shifts) is occasionally reassigned to the Cermak building or Division Ten due to operational need. Thus, community groups are significantly impacted. At this point, there is one MHS III assigned during the 3-11PM shift on Tuesdays, Wednesdays, and Thursdays. Employees are rotated periodically from Division Two to Division Ten (and vice versa) in order to avoid burnout.

Mental health staff works well with security. They refer individuals who request an evaluation or have a question, as well as those who display behavior problems. This is done formally (Inter-Agency Health Inquiry) and informally. The mental health staffs, along with the CRW's, meet with Supt. Martinez on a weekly basis.

The telepsychiatry clinic is working very well. There are only minor problems with the computer equipment (on site and with Dr. Ward). The detainees receive these services with very few complaints. She sees approximately 14 (10 in the morning, 4 in the afternoon) patients on a daily basis, with a combination of new evaluations and followups. Dr. Marri is only in Division Two – Dorm Two for one-half day per week, which makes telepsychiatry even more critical. Dr. Marri must see detainees who need translation services.

The nursing staff processes HSRF forms before giving them to mental health staff. On occasion, there is a delay in processing the forms. The detainees who write these requests are seen by the mental health staff in a timely manner. In general, the mental health staff works well with the nursing staff.

There is a medical social worker assigned full-time to work in the building. He addresses family issues, discharge medications, and provides linkage services to community agencies.

Division VI/P2 Executive Summary

Westcare patients formally housed in 2D2 were moved to Division VI, which significantly changed the culture and demand for the full range of health services in a division primarily accustomed to housing majority general population detainees. Division VI continues to have a segregated population on the tiers 1N and 1P, as well as a recent addition of a third segregation

tier, 1Q. Psychiatry FTE was increased to 0.2 to accommodate the increased population (P2-174). Additionally, in response to the population change, a second mental health specialist (QMHP) was assigned to the division resulting in 7 day coverage on the 3p-11p shift. Mental health staff conducts segregation rounds, responds to HSRF, and facilitates mental health clinic 6 days each week. A schedule is currently being developed to begin community meetings on six designated tiers which house the majority of the P2 patients. The Chief Psychologist is currently acting as the Unit Director for the division due to psychology staffing vacancies. The weekly psychology clinic for the division is facilitated by one of the Cermak Unit Directors. Cermak and CCDOC divisional leadership meet weekly to discuss divisional concerns. CCDOC divisional leadership has been very responsive to requests and feedback from Cermak supervisors, a very good working relationship is being established. With the significant culture change, which is accompanied by novel issues for the current staff, continued dialogue will need to occur with respect to urgency of action related to mental health and health needs. The Chief Psychologist and Nurse Manager will continue to provide feedback as needed around these issues at the divisional meetings. A medical social worker is assigned to the division to address linkage needs and discharge medications for selected or identified patients.

Division IX/P2 Executive Summary

In the fall of 2015 more than one hundred detainees with P2 alerts from non SMU tiers were transferred to Division 10. It led to less fragmentation of Psychiatric Services and transfer of 1 FTE MHSIII from Div. IX to Div. X). The remaining detainees with P2 alerts are either on the Enhanced Security tier, Segregating tiers, and Protective Custody tiers. Very few of them are remaining on non SMU tiers. The Level System of Administrative Segregation has been dismantled. Special Incarceration Unit has been closed. Remaining Segregation tier is 1E. Tier 1F is converted into "Enhanced Security Parameters" tier. Detainees identified as institutional threat and engaging in actions designed to disrupt operations are concentrated on the above tier with enhanced movement and security precautions. It was clarified by CCDOC Leadership that the qualifying behaviors must not be rooted in or related to mental illness. Those with serious staff assaults, serious inmate assaults and those that repetitively disrupt CCDOC operations are considered. Placement is at the discretion of the executive leadership. In the beginning all security/custodial functions were carried out by ERT (Emergency Response Team) but, eventually CCDOC was trained in these duties and presently manages this tier. See full CCDOC Memorandum stipulating pertinent objectives and means in the PDF Appendix.

The following are Patient Safety and Enhanced Security Guidelines for patients who present with self-harm (Foreign Body-ingestion, insertion and pill ingestion) in Division 9 & 10 designed to complement the enhanced security parameters and reduce the amount of disruption of operations: CCDOC staff presents patient to the Divisional Dispensary for triage and evaluation by the Nurse, as is the current process. A referral to the Urgent Care is made, if advised by the Nurse. Nursing indicates on the transfer envelope the type of self-harm (i.e. pill ingestion, foreign body ingestion, etc.) the patient has presented with. Nursing notifies the CCDOC transporting officer who notifies Admissions at extension 5802 to notify them anticipated transfer of inmate to

Urgent Care. Nursing determines the appropriate timeframe for transfer and will notify DOC of timeframe. (Please see PDF Appendix)

The following is a guideline for transfer: Pill Ingestion: transfer to Urgent Care within 60 minutes. Foreign Body Ingestion/Insertion: transfer to Urgent Care within 4 hours. If there is an inmate in Division 9 who states that he's ingested "pills or medication" and there is a wait time to be seen in the Urgent Care, he will then be taken to Division 10 (if nurse available) for initial triage and taken back to Division 9 (if stable) to wait for transfer to Urgent Care. Suggested Guidelines for Management of Patients after Foreign Body Ingestion have been developed as a result of a collaborative effort between CCDOC, Department of External Operations, Cermak Administration, John Stroger Hospital Risk Management Department, JSH Emergency Room staff, and JSH GI/ Internal Medicine Department. These guidelines operationalize transfers, observation, alimentation, and treatment of patients engaging in frequent self-injurious behavior, for non-suicidal reasons. All the above measures have been developed in response to the formation and rise of a jail gang named "Savage Life". This organization openly professes their mission as designed to disrupt operations and inflict chaos through acts of self-injury and noncompliance with orders/rules. Cermak Mental Health started limited structured out of cell therapeutic programming on 1F utilizing the services of two staff Psychologists. 1F has been retrofitted to allow detainees to be secured to stationary furniture during group therapy. Protective Custody tiers remain on 3E, F, G, H. Cermak staff is working with corrections to understand the role differentiation of Cermak Mental Health providers and Sheriff's Mental Health staff. Ongoing role clarification will assist in smooth coordination of patient care when differing clinical opinions exist between the two agencies. Following the resignation of Dr. Rogers, Dr. Key had to assume the role of the Unit Director. Psychiatry FTE 0.2. P2-61. Mental health staff conducts segregation rounds, responds to HSRF, and facilitates mental health clinic 6 days each week.

Division X/P2
In the winter of 2016 1-D was closed as a segregation unit and presently serves as non SMU housing tier (as of October 30th, 2015 1D was disciplinary segregation). 1A remains a disciplinary housing tier. Retrofitting 1A furniture to allow securing detainees to stationary furniture during out of cell structured therapeutic programming (planned at this time) was identified as priority during the last Interagency Compound wide planning monthly meeting and Department of Facilities Management is going to start the project. Elsewhere in the division, on non SMU tiers, Cermak continues provide community meetings supplemented by CRW programming provided by CCDOC staff. Below is a snapshot of the community group activity for the month of March 2016:

Community Groups conducted = 15
Community Group Cancellations = 30

Detainee behavior = 11
Mental health staff absence = 8

Security reassignment for other duties = 5
Emergencies in the building = 2
Mental health staff needed to conduct emergency evaluations = 2
Milieu issues (power washing tier) = 1
Milieu issues (nurse passing meds) = 1

Division X received a large number of non SMU detainees from Division 9 as a onetime transfer in the fall of 2015. Following the implementation of the new PC criteria by CCDOC, Division X now houses two PC tiers – 1C (clean, where more stringent criteria are applied for entry) and 2C (where criteria are not as stringent). Dr. Kaniuk (Unit Director) still manages Division II Dorm 2 and Division X (both housing P2) and his workload is substantial due in part to the distance between those two divisions and overall patient population. Overflow P3 (minimal most of the time) are still housed in Division X when necessary until a bed opens in RTU and Cermak staff transfers them immediately using established bed control tools. Telepsychiatry Clinic's opening and preparation took many months to implement. Cermak Administration had assisted in identifying and training Administrative Assistants who were to function as Clinic's Attendants. Dr. Kelner created a tutorial for JSH Providers. Dr. Kulik committed two JSH Providers to staff the clinic on a part time basis. The Clinic was eventually opened in February 2016 and remained operational until March 2016. Then one of the JSH Providers resigned from CCHHS and the other Provider was replaced by a Locums Physician. The clinic can be reopened, when operational demands arise. FTE for Psychiatry is 0.9. MH population: P2-530. Utilization of Division X as P3 overflow has decreased with the opening of RTU 2B as a P3 overflow tier in September 2015.

Div. X Executive Summary

Division Ten houses M2, P2, and some General Population (GP) detainees. There have recently been an influx of detainees from Division Nine, replacing the medium-classified individuals who were transferred to Division Two – Dorm Two. This has created an even more challenging patient population. There are SMU tiers for Disciplinary Segregation and Protective Custody. There were initially two disciplinary segregation tiers (1-A and 1-D) but now only one (1-A). The cell windows have been covered over with thick plastic within 1-A, in order to stop the detainees from throwing containers of bodily fluids or feces on staff members. The tier has an average census of about 40 detainees. The demands for mental health evaluations in this tier are quite significant. Also, many of these evaluations are for suicide risk assessment. There is a special tier for detainees who are exposing themselves to staff (3-D).

The mental health staff work well with security staff, who is very receptive to our concerns. The mental health staff, along with nursing staff and CRW staff meet with Supt. Walsh on a weekly basis. There have been some difficulties, specifically on the 3-11 shift, with presentation of multiple detainees to be evaluated who may not be in need of an emergency assessment which presents challenges for staff with respect to completing routine duties (clinics, HSR, rounds, etc.).

Psychiatry has two providers assigned most of the week. Telepsychiatry was instituted for a brief time but discontinued. There is a problem on Thursdays for psychiatry due to PC's being seen in the dispensary. Unless the psychiatry schedule contains PC detainees that day, the psychiatrists often are delayed for about one hour or so.

There are four mental health workers assigned to the 7-3 shift. Absenteeism is somewhat of a problem. Also, MHS III's are reassigned to Cermak or RCDC whenever there is a clinical need. Thus, the shortage of staff is pronounced from Friday through Monday. The detainees in Division Ten are very challenging in regard to programming. There are three group therapies (community meeting with a psycho-educational component) scheduled on Tuesdays, Wednesdays, and Thursdays. There is an assigned security officer, who escorts the mental health worker on to the various tiers. The television is turned off which upsets many detainees. Other detainees are taking showers or some just voice their displeasure at a mental health worker on the tier, disrupting their daily routine. In a few instances, detainees are exposing themselves in front of female mental health workers. Thus, it is not easy conducting groups in Division Ten.

It is not always easy to see detainees who write HSRF. This is due to the logistics of the building (i.e. getting people out of cells, commissary day, emergencies where all available are needed in a certain location) and lack of MHS III, due to reassignment. As a result, many evaluations are done cell front or on the tier with as much privacy as possible.

Employees are rotated periodically from Division Ten to Division Two (and vice versa) in order to avoid burnout.

CCDOC Submitted Updates

Compound Housing: DOC, Cermak and Facilities collaborated on the closures of 3 divisions since the last site visit. On 1/31/16 inmates from Divisions 3 and 17 were transferred to Division 4, which had been temporarily closed and undergoing renovations for the past two years. The Division 3 population comprised all security classifications – minimum, medium and maximum. The Division 17 population, home to the Sheriff's Women's Justice Program, traditionally housed minimum security females, with a strong emphasis on vocational programming, drug treatment and mental health counseling. Females taking part in the Women's Justice Program maintained access to the same programming in Division 4.

While Division 17 typically operated at full capacity (approximately 140 women), Division 3 had been running at about 56% capacity (about 195 inmates with available bed capacity of 346). Redistributing the female population from two aging buildings into the refurbished Division 4 will save significantly in jail operational costs moving forward.

On 2/8/16, DOC, Cermak and Facilities initiated the closure of maximum security Division 1, with those inmates being redistributed to other divisions throughout the jail. The closure was completed on 2/13/16. Division 1 had only been functioning at 44% capacity (about 550 inmates

with available bed capacity of 1248), so the redistribution will result in a significantly more cost-effective utilization of Cook County Jail's buildings. Division 1's correctional staff were assigned to new divisions across the compound, allowing for increasingly efficient staffing structures and reduced overtime costs.

Mental Health Transition Center: The Sheriff's Office Mental Health Transition Center (MHTC) doubled its participant caseload in January 2016. The program now averages 100 participants. It remains a day treatment program at this time.

Correctional Programming in Disciplinary Segregation: Effective January 2016, the DOC discontinued the use of administrative segregation. All segregation units are now considered disciplinary segregation. Additionally, in January 2016 the DOC identified inmates that had been causing the most disruption to the compound and moved them to one tier in Division 9 (Tier 1F). Many of these inmates were affiliated with the newly formed 'Savage Life' gang. The DOC staffed the unit with staff from the Emergency Response Team. Expectations, unit rules and consequences of rule-breaking behavior were articulated in writing to each detainee. In March 2016, the enhanced segregation concept was expanded to include Division 10 Tier 1A. In February and March 2016, the DOC was able to reduce the number of detainees in disciplinary segregation, reducing the general population segregation units (those in Divisions 6, 9 and 10) from 8 to 5 living units.

In an effort to minimize role issues between the Sheriff's Office and Cermak mental health staffs, the Sheriff's Office mental health staff ended their provision of group programming on the segregation tiers January 2016. DOC non-mental health program staff now provide correctional programming in the segregation units in Divisions 9 and 10 at least once each week.

Inmate Hygiene: Inmates housed in Division 08 RTU continue to have access to sanitation kits, which are maintained on the living unit. The living unit showers in RTU continue to be power washed on a regular schedule to manage the soap scum.

Recreation: Detainees in Division 08 RTU have access to patio recreation. The mental health units typically go to recreation on the patio at least once weekly. Recreation was minimal in the month of February due to the weather conditions.

Recreation is offered to Cermak 2nd floor detainees on Thursdays, Fridays and Saturdays. Female detainees in Cermak are allowed to go to indoor and outdoor recreation in Division 4, but they often refuse. Male detainees in Cermak are allowed to go to indoor and outdoor recreation in Division 10.

April 2016 Metzner assessment: Male and female P3 RTU inmates continue to be offered at least ten hours per week of structured therapeutic activities. Female RTU inmates were offered access to the patio during March 2016 on a once per week basis for one hour each week. They will soon have limited access to the Division 4 recreational yard.

During the morning of April 19, 2016 I interviewed inmates in a community meeting-like setting within two RTU female units (5B & 5F) and two male RTU units (4B 7 4G). The female inmates were with many more complaints regarding the RTU that focused on issues of limited access to group treatments and the quality of some of the groups. However, many of the complaints voiced by them were not substantiated after obtaining information from other sources (e.g., staff and medical records). The male inmates were much more appreciative regarding the quality of the groups offered. Inmates confirmed that they were being offered at least 10 hours per week of structured therapeutic activities. Discharge planning services were available. In general, medication continuity issues were not present. Limited access to the psychiatrist was present although most inmates reported seeing a psychiatrist on a monthly basis.

Male and female inmates indicated that during the past several weeks they had begun to have access to the patio and nearby recreational yards. Their access had been very limited during the winter months due to the cold weather.

Female inmates who had previously been treated on 2W reported their experiences were very unfavorable. The male inmates generally voiced more favorable reports regarding their experiences on 2N, 2E, 2S or 2SE.

Appendix VI is a summary of review of randomly selected mental health caseload inmates' medical records that focused on progress notes written from November 2015-April 2016. This review was performed by my fellow in forensic psychiatry under my supervision. Findings included the following:

> **Frequency of Psychiatry Visits:** With few exceptions, patients were seen within the recommended timeframe (maximum of every four weeks while in RTU and maximum of every three months as P2s). Some notes did not indicate a recommended time to return to clinic so this metric was difficult to track. However, psychiatric follow-up for inmates transferred from the PSCU to the RTU was not timely.
>
> **Consistency/Continuity of Plan of Care:** The plan and assessment aspect of documentation was variable. Some clinicians were specific in their targets of intervention and indications for medication changes while other notes made no or limited mention of rationale for therapies. With one patient, it appeared that hospital notes (upon return) were not reviewed or at least incorporated into the plan of care, at least not within a timely manner. Several patients had a myriad of providers throughout their course, but this usually appeared to be a function of location (i.e., moved between units or different levels of care) rather than a function of provider availability.
>
> **Diagnosis:** Diagnoses largely remained unchanged from visit to visit and were carried over when seen by a new provider. The diagnoses remained consistent. When a patient was seen by a new provider, it often was unclear whether the new

> provider had reviewed the chart and/or done a new, independent assessment of the patient in order to arrive at their diagnosis and plan.

RTU male segregation inmates (4A) are currently being offered about eight hours per weeks of out of cell structured therapeutic activities. RTU male segregation inmates are not all classified as mental health P3 inmates—some are P2 and some are M3. However, P3 inmates are given priority in the context of being offered out of cell structured therapeutic activities. P3 inmates are housed in 4A for up to 10 days per rule infraction ticket.

Female segregation RTU inmates are not being provided out of cell structured therapeutic activities related to CCDOC concern re: the use restraints from a gender sensitive perspective. After discussion with Dr. Jones, Dr. Kelner and Dr. Keys, it was decided that female RTU segregation inmates will be provided out of cell structured therapeutic activities without restraints but with the presence of two correctional officers during the structured therapeutic activities. These officers will receive enhanced mental health training

Protective custody RTU inmates are only receiving two hours per week of out of cell structured therapeutic activities due to mental health staffing issues.

IMU inmates in 2A are offered eighteen hours per week of out cell of structured therapeutic activities. These inmates also receive additional out of cell recreational dayroom time. I interviewed one IMU inmate during the morning of April 19, 2016, who described his experiences on this unit in a very favorable terms. Another IMU inmate indicated a similar experience during a 'group" therapy session that I observed. Two inmates have "graduated" from the IMU and are now residing in a RTU living unit.

Significant improvement is noted relevant to providing out of cell structured therapeutic activities for IMU inmates and male RTU inmates in the segregation unit.

The decision by CCDOC to discontinue the use of administrative segregation is very encouraging as is the plan to increase the out of cell time in all segregation units and allow up to six inmates to recreate together. There were 217 inmates in disciplinary segregation in the various segregation units throughout CCDOC during April 18, 2016. Data provided by CCDOC included the following:

> As recommended, we took a random date of March 15 and determined how long those who were in these seg units on that date had served disciplinary seg time. Please note that there were two people on 4a who stayed for over 48 days, one of whom was an M3, not a P-3, who had multiple write ups, and the other was a P-3 who had two write ups for a total of 36 days, but his time in seg was miscalculated and he spent an extra 12 days in seg. This was addressed with our staff in a meeting on 3/17/16, where we made the expectation of 14 days or less for P3 inmates in segregation clear for our staff. That inmate was removed from

segregation on that day. This situation will not be repeated because our Disciplinary Unit will not issue more than 14 days for P-3's. However, it should be noted that Cermak did not mitigate his 26 day and 10 day seg orders.

RTU 4a : 14.6 avg days, but if you take out outliers, 9.2 days (mixture of all classes)
RTU 5a: 9.2 days (mixture of all classes)
Div.6 1P: 7.125 days (Min's and Med's)
Div.6 1N: 9.04 days (Min's and Med's)
Div.10 1A: 7 days (Max)
Div. 91E: 16.5 days (Max)
Div.91F: 17.04 days (Max)

Recommendations: Implement the plan for structured out of cell therapeutic activities for female RTU segregation inmates. Access to the patio and recreational yards should be significantly increased. It was my understanding that plans are being considered to winterize the patio area, which will provide for more access during the winter months to outdoor recreation.

RTU inmates continue to be offered at least 10 hours per week of structured therapeutic activities. The quality of some of these groups could be improved if new psychoeducational videos could be obtained in order to supplement the current videos being used which have been viewed by many of the inmates in the past. The mental health services should have an annual budget for therapeutic programming materials.

Mental health staffing vacancies and allocation issues are directly related to inadequate mental health programming for protective custody RTU inmates

e. Cermak shall ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses.

Compliance Assessment: Partial compliance

Factual Findings:

April 2016 Cermak Status Update

Please see Appendix for Treatment Plan QI Audits for each level of care.

Additionally, multiple comprehensive interagency behavioral management plans have been developed by the Chief Psychologist, the Chief Psychiatrist, Unit Directors in concert with the full multidisciplinary team, when needed for more complex or difficult cases. The majority of interagency plans continue to be generated in PSCU, followed by the RTU.

April 2016 Metzner assessment: QI studies relevant to treatment plans for the various levels of mental health care were reviewed. The treatment plans for inmates receiving a P2 mental health level of care, which are completed by the psychiatrists, have demonstrated significant improvement during the past 12 months. The audit of treatment plans for inmates receiving a P4 level of care included the following summary:

> The database of special care patients was reviewed by the PSCU Unit Director for compliance with the treatment plan policy. Thirty patient charts were selected at random representing patients housed in various units within Cermak (acute care, chronic care, medical). 93% of charts reviewed had P4 ordered within 72 hours of admission to PSCU. Of the 30 treatment plans reviewed, 28 reflected multidisciplinary representation at MDT, 30 included psychiatry in all P4 and P3 plan development, 29 of the treatment plans were completed by a QMHP, and in 23 cases it was documented that the patient was informed of the plan. PSCU plans will continue to be completed by a QMHP and involving the patient (either by being present during plan development or by informing the patient of the plan) will be increased. Treatment plan updates are an area for improvement. 13% of P4 Acute plans were updated within 7 days. 6% of P4 Chronic plans were updated within 90 days. QMHP will improve the consistency with which treatment plans are developed/reviewed/updated. P4 patients will be classified as high, medium, or low with regards to acuity and treatment plans will be reviewed/updated according to the corresponding level of care (every 7 days for high, every 30 days for medium, every 90 days for low). Staff will be trained on these expectations and supervisors will regularly monitor compliance.

The audit of treatment plans for inmates receiving an RTU level of care included the following summary:

> The database of all intermediate treatment plans was reviewed for compliance with the treatment plan policy. All 90 (100%) intermediate mental health treatment plans were completed within 30 days of admission and all updated plans were completed on time. Intermediate mental health treatment plans have maintained compliance for an extended period. All treatment plans were completed by a QMHP, in conjunction with the multidisciplinary team and the patient's input. Intermediate treatment plans will continue to be completed by one QMHP who will utilize the excel database for completed treatment plans and due dates to ensure ongoing compliance with due dates. All intermediate mental health patients are reviewed in the MDT staffings and specific problem items with corresponding treatment groups are indicated for each patient on an ongoing basis. The quality of intermediate mental health treatment plans has improved consistently by individualizing each treatment plan and treatment groups to each patient's needs, with input from the patients. Each intermediate mental health patient receives a "Treatment Card" indicating recommended treatment groups and attendance based

on patient specific needs. Incentives are provided to encourage participation in treatment, such as movie incentives and undergarments. Patients who attend 75% of recommended treatment groups receive a treatment attendance letter for court (8% on average receive a letter).

Recommendations were made relevant to revising the policies and procedures regarding the frequency of treatment plan reviews based on an inmate's acuity level and level of care. The revisions will be sent to me for review prior to being submitted to the pertinent policy committee within Cermak for consideration.

The current process for developing treatment plans for RTU inmates (i.e., one licensed mental health specialist is assigned to write all initial comprehensive treatment plans for female inmates and two licensed mental health specialists are assigned to write all initial comprehensive treatment plans for male inmates) has been developed due to the licensed mental health specialists' allocation issues. This process includes involvement with the mental health specialists assigned to the particular RTU unit. There was agreement that this process is better than not having treatment plans but will be changed once the mental health specialists' allocation issues (i.e., allocating more licensed mental health specialists positions) are resolved.

I observed a treatment team meeting on 2W during the afternoon of April 19, 2016. Due to a leak in the ceiling, which was located where the computer drop-down cable came through the ceiling, the staff did not have access to the medical record via a computer. Unfortunately, this issue was identified during previous site visits and despite pending work orders it has not been resolved.

Recommendations: Change this process once the licensed mental health specialist positions have been increased so that the assigned mental health specialists develops a treatment plan in conjunction with the inmate and the multidisciplinary treatment team.

It is not acceptable that treatment plans are being developed during treatment team meetings without access to the electronic medical record. This issue needs to be resolved immediately by either fixing the leak, providing computer access via another drop-down cable or meeting in a different conference room.

f. Cermak shall provide 24-hour/7-day psychiatric coverage to meet inmates' serious mental health needs and ensure that psychiatrists see inmates in a timely manner.

Compliance Assessment: Partial compliance

Factual Findings:

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		Vacant	Filled	Sum	% Vacant
Divisional Chief of Psychiatry	110	0	1	1	0%
FT Psychiatrist	110	8	7	15	53%
PT Psychiatrist	133	0	5	5	0%
PT Psychiatrist Consultant	155	1	1	2	50%
Chief Psychologist	110	0	1	1	0%
Psychologist	110	5	5	10	50%
Physician Assistant	110	1	1	2	50%
Social Worker	110	1*	6	7	14%
Director of Mental Health	110	0	1	1	0%
Art Therapist	110	0	3	3	0%
MHS III	110	2	52	54	3.7%
MHS II	110	0	3	3	0%
MHS Senior	110	0	13	13	0%
Administrative Assistant	110	0	1	1	0%
Locums Psychiatrist			1		
Mental Health		18	100	118	15%

The main task remains attracting full time Correctional Psychiatrists through assertive national search and advertisement campaigns. There are presently two Providers in credentialing (Drs. Bednarz and Haq). Please see PDF Appendix.

2 FTE for Psychiatric PA. Current vacancy rate for this group is 50%. It is noted that the starting salary for this group pays less than what constitutes industry average in this market.

Compensation for the PA position seems to remain the main factor hindering recruitment at this point.
There are 5 part-time Psychiatrists and in that group all the vacancies have been filled. The majority of part-time (Account 133) Psychiatrists are committed to working between 8 (Lassen) to under 20 hours (Dr. Kartan and Ramic). One part-time position of Consulting Physician (Account 155) remains vacant. Dr. Binius started as a Consulting Physician in March 2016. The rate of compensation for that position is made sufficiently attractive. RCDC coverage remains rather fragmented and services of full-time attendings are sought (on a voluntary basis) to provide evening coverage at the moonlighting rates.

In June 2015 Cermak Mental Health submitted paperwork necessary for the creation of the new non-union position of the Associate Chairman/Divisional Chair for Psychiatric Special Care to

assist the Chief of Psychiatry in clinical and administrative duties. As of April 2016 the creation of this position has not been cleared.

One Locums Tenens Psychiatrist joined the Department in February 2016.She provides FTE 0.3/ week in Division X Clinic.

Our experience with Telepsychiatry in various clinical locations on this campus demonstrated that Mental Health Department needs a position of a Clinic Attendant for diverting Mental Health Specialists (even unlicensed ones) to the duties of the Clinic Attendant, given their other tasks in RCDC and Divisions, is not sustainable. Dr. Gomez created a functional description of that position in 2015 and further effort will be put in promoting the creation of this job to sponsors at the CCHHS level. An example of productivity and exceeding expectations can be found in the Division 2 Clinic. Division X Telepsychiatry Clinic was opened in February 2016 but, subsequently, had to be closed in March 2016 due to the resignation one of the JSH Providers. Physical layout in Division X does not allow for the intermittent presence of a clinic attendant, as officer in that area supervises, at the same time, a busy HCR clinic and the Psychiatry Clinic, consequently, constant presence of an attendant is necessary to ensure safety. An Administrative Assistant/ Ward Clerk from Division X was assigned to watch the clinic, but it was eventually realized that a Cermak staff overseeing the clinic must be present in that location as long as the Clinic remains open and Administrative Assistants have other duties to perform and could not be dedicated to the Clinic 100%. RCDC Telepsychiatry Clinic remains open and serves an important function, even though there had been some concerns about Telepsychiatry in the acute/triage setting.

Cermak has contracts with 3 (three) staffing agencies to provide Locum Tenens Psychiatrists: Medical Doctor Associates (MDA), Maxim Physicians Resources and Columbus Organization. Cermak is at various stages in the onboarding process for candidates from each of these agencies. Dr. Garb, furnished by Columbus, is the only psychiatrist who has completed the credentialing and HR "purple form" process and is deployed (FTE 0.3) at Cermak. The contracts for the three locum tenens agencies will end in 11/30/2016. Based on present clinical needs and recruitment yield, Cermak Mental Health Department projects that we will continue to need staffing assistance. To help address the critical need for psychiatry coverage, Cermak proposes the following two-pronged strategy:

1. Seeking an extension of the contracts for 1-2 years. Recently, all the contracts have been synchronized. So far, the funds seeded in the financing of the Maxim, MDA, and Columbus contracts have not been exhausted. The extension would not result in any net costs to the system.
2. Have all three staffing agencies recruit psychiatrists with subsequent buy out by CCHHS. Columbus has a clause that allows Cermak to hire one of their employees. MDA and Maxim do not have similar clauses. Amending their contracts may need to be pursued by Purchasing Department at CCHHS.

One potential caveat is to allow Vendor's recruitment which would have to be reconciled with the Shakman Monitor first. Cermak Mental Health Leadership has submitted these proposals to Cermak Leadership.

Ongoing current recruitment efforts by CCHHS are detailed in the PDF Appendix.
The hiring of Providers at Cermak is currently under modified purview of Shakman Monitors. In October 2015 CCHHS informed Cermak leadership that the County will be piloting a new process for recruitment and hiring of Advanced Clinical Providers. The project has been utilized since November 2015. This is the first step in the decoupling of Psychiatric hiring from the Monitors. The Advanced Clinical Position (ACP) Hiring Process resulted in less paperwork, more opportunities for individualized treatment of candidates, and fewer delays. Psychiatry, Psychology and PA Positions at Cermak are eligible.

Vacancy Rates, FTE's and Net changes in vacant positions for Psychiatry is available in the PDF Appendix.

There is a total of 10.0 FTE psychologist positions (excluding the Chief Psychologist position) with a current vacancy rate of 50% (5 FTE). One Correctional Psychologist resigned. Cermak has lost several candidates in later stages of their hiring process due to the fact that their internships were not APA approved. Efforts are made to vet candidates early on to identify candidates whose internships would disqualify them from receiving clinical privileges at Cermak.

There is a total of 70 MHS Specialist Positions with a current vacancy rate of 2.8 % (2FTE for MHS III). Currently we 16 unlicensed staff (3 recently achieved licensure and are awaiting reclassification), 52 licensed staff (1 had an administrative hearing and adjudicated). Cermak is currently working with Labor Relations Department to upgrade the staff who recently achieved their licensure in their respective disciplines. All the unlicensed MHS were informed that they needed to get the credentials/education necessary to move to MHS III positions as the MHSII/Senior positions were to be eliminated. Local 73 filed the EEOC complaint with the federal government and the unfair labor complaints with the IL Labor Board. The EEOC complaints were determined to be unfounded and eventually the unfair labor issue ended in arbitration. In January 2016 the issue was decided in favor of the County. The 16 affected staff were to supply County Labor Relations Department with the information regarding their current academic standing, whether enrolled full time or part time, where they were enrolled, anticipated graduation date from the Master's program and anticipated licensure date. Three (3) of these completed all requirements to transition to Mental Health Specialist III positions as they've earned their Master's degree and are licensed as an LPC, LCPC, LSW or LCSW. Cermak plans to give notice to six (6) of them that their position is being eliminated in accordance with the arbiter's decision. Cermak's goal is to post positions to replace the 6 individuals whose positions are to be eliminated so that we can hire already licensed staff to replace them. There are those who are presently enrolled in a Master's program and expected to be eventually licensed. They will be expected to complete their degree/licensure by specific, individualized dates (based on

current status and anticipated licensure date). If these employees do not achieve licensure by their specified dates, their position will be eliminated.

There is a total of 7 Medical Social Workers Positions; the 7th position was recently filled with an anticipated start date in May.
Positions of the Chief of Psychiatry, Chief Psychologist and Mental Health Director are filled.

Staffing Plan for FE 2017 has been developed by Cermak Mental Health Leadership and can be found in the Excel Appendix.

April 2016 Metzner assessment: My November 2015 report included the following:

> During July 2014 there were a total of 9.70 functional FTE psychiatrists working at CCDOC as compared to the 11.7 FTE psychiatrists during April 2015. There were 2.0 PA's employed at Cermak during April 2015.
> There is now a total of 16.0 FTE psychiatrist positions (including the chief psychiatrist position) and 2.0 FTE psychiatric physician assistant positions with 10.4 FTE psychiatrists and 1.0 FTE PA currently employed at Cermak. The current vacancy rate is 49% for psychiatrists/physician assistant positions. There are now 1.3 FTE more psychiatrist/physician assistant vacancies as compared to 2015. However, there are the equivalent of 4.0 FTE locum tenens psychiatrists who are currently in the credentialing process. The locum tenens contract was recently modified to include telepsychiatry, which significantly increase the applicant pool. In addition, two psychiatrists working at Stroger Hospital will be providing a morning per week of Telepsychiatrist clinic time in the near future.
>
> There is a total of 11.0 FTE psychologist positions (including the chief psychologist position) with a current vacancy rate of 37% as compared to 45% vacancy rate during April 2015. In other words, there is an additional 1.0 FTE psychologist employed at Cermak as compared to the last site visit.
>
> The recently approved salary increase and the Shakman pilot hiring project summarized in the current status section are very positive signs and should significantly assist in recruiting psychiatrists.
>
> During the April 2015 site visit, I reported the following:
>
> There is a total of 118 FTE mental health positions with 25 FTE vacancies that represents a 21% vacancy rate
>
> As of the November 1, 2015 site visit there was total of 20 vacancies, which represents a 16.94% vacancy rate.

During April 2016 there were 11.2 FTE psychiatrists' positions filled (which represented a loss of 0.5 FTE psychiatrists as compared to the last site visit) and 5.0 FTE psychologist positions filled (which represented a loss of 1.0 FTE psychologist position). The total mental health staff vacancy rate has decreased somewhat to 15% since the last site assessment.
2.0 FTE psychiatrists have been hired with start dates of May 1 and July 1, 2016 and 1.0 FTE psychologist has been hired, who will be starting May 1, 2016.

There still appears to be issues with the hiring process, including the credentialing process. Refer to the report by Dr. Porsa for more detailed information.

I discussed with the administrative staff the importance of resolving the issue with the loss of the 0.5 FTE telepsychiatrist and issues relevant to arranging for independent forensic psychiatric examinations in the context of nonemergency involuntary medication petitions.

The psychologists' salaries were reported to be equivalent with those available in the community, which was problematic because they did not provide an incentive for working in a correctional environment. In other words, to really be competitive, the salary needs to exceed the average salary available in a public community setting.

Recommendations: As per Dr. Porsa's report. Take steps to make the psychologist' salaries more attractive for hiring and retention purposes.

I also strongly support the creation of the proposed Associate Chair of Psychiatry, Director of Infirmary Psychiatry position.

g. Cermak shall ensure timely provision of therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate number of Qualified Mental Health Staff to provide treatment, and an adequate array of structured therapeutic programming. Cermak will develop and implement policies and procedures defining the various levels of care and identifying the space, staffing, and programming that are appropriate to each identified level of care.

Compliance Assessment: Partial compliance

Factual Findings:

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Please see Update in 59f. Also see Excel Appendix.

April 2016 Metzner assessment: A staffing proposal is in the process of being submitted that will include a request for additional mental health staff with an emphasis on additional licensed

mental health specialist positions. Although it is clear that additional psychiatry and psychology staff are needed the emphasis will be on the mental health specialist positions due to the issues involved with the current psychologists' and psychiatrist' vacancies. The need for more license mental health specialists is particularly acute within the RTU as evidenced in the sections relevant to treatment plans and services being provided to RTU inmates who have a protective custody status.

The problems associated with the significant vacancies relevant to psychiatrists and psychologists impact inmates access to care and quality of care issues. It is clear that there has been a direct correlation with a significant decrease in the total mental health staff vacancy rate and significant improvement in the quality of care offered to inmates.

Recommendations: I agree that the emphasis should be placed on the mental health specialist positions for the reason summarized above.

h. Inmates shall have access to appropriate infirmary psychiatric care when clinically appropriate.

Compliance Assessment: Partial compliance

Factual Findings:

Cermak Male Acute, Subacute and Chronic Mental Health Unit Descriptions

The Cermak male psychiatric units are comprised of 60 beds distributed among 3 units – 2North (acute unit), 2South (subacute unit) and 2East (chronic unit). The purpose of the units is to provide extended observation, stabilization and structured/unstructured therapeutic activities. Services are provided by a multidisciplinary team, which includes psychology, psychiatry, mental health specialists, nursing, social workers, correctional rehabilitation workers and custody staff.

Male detainees may be admitted to 2North, the 24-bed acute psychiatric unit, from intake, general population or other mental health units. Primary reasons for admission include an acute risk for harm to self or others, acute psychosis, and an inability to care for self or marked decompensation that poses as a risk for victimization in other living units. Detainees housed on 2North are scheduled to see a psychiatrist 5-7 times per week. Detainees are typically housed on 2North for a brief period of time before transitioning to a less restrictive setting.

The subacute mental health unit, 2South, is a 26-bed unit for detainees that have demonstrated a decrease in the severity of psychiatric symptoms but continue to evidence symptoms that cannot safely and adequately be treated in a division with mental health services. Some detainees exhibit chronically severe symptoms that necessitate long term sheltered housing. They may be housed

on 2South or 2East, a 12-bed unit that houses detainees that demonstrate severe negative symptoms of psychosis, chronically severe depression and/or significant cognitive delays.

Discharge Planning

Cermak male mental health units are staffed with 1 Medical Social Worker who maintains regular contact with detainees diagnosed with serious mental illness to coordinate post-release treatment services in the community. Due to the severity of their mental illness, all detainees released to the community from these units must be assessed by a Qualified Mental Health Professional prior to discharge to determine the need for hospitalization. If community hospitalization is not warranted based on the clinical assessment, the Medical Social Worker can assist the detainee with referrals to community agencies for continued treatment and shelters for housing. The Medical Social Worker can also arrange for the detainee to be given a 2-week supply of his current medications.

Cermak Female Acute and Chronic Mental Health Unit Description

The Cermak female acute and chronic mental health unit, 2West, is a 20-bed unit devoted to the psychiatric stabilization of detainees whose presentation warrant stabilization and/or extended observation. Detainees may be admitted to 2West from intake, general population or other mental health units. Primary reasons for admission include an acute risk for harm to self or others, acute psychosis, and an inability to care for self or marked decompensation that poses as a risk for victimization in other living units. Detainees housed on 2West are scheduled to see a psychiatrist 5-7 times per week. Detainees are typically housed on 2West for a brief period of time before transitioning to a less restrictive setting unless they present with symptoms that warrant chronic care services. Chronically mentally ill detainees that require continued housing on 2West demonstrate severe negative symptoms of psychosis, chronically severe depression and/or significant cognitive delays that cannot safely and adequately be treated in a division with mental health services.

Discharge Planning

The Cermak female mental health unit is staffed with 1 Medical Social Worker who maintains regular contact with detainees diagnosed with serious mental illness to coordinate post-release treatment services in the community. Due to the severity of their mental illness, all detainees released to the community from this unit must be assessed by a Qualified Mental Health Professional prior to discharge to determine the need for hospitalization. If community hospitalization is not warranted based on the clinical assessment, the Medical Social Worker can assist the detainee with referrals to community agencies for continued treatment and shelters for housing. The Medical Social Worker can also arrange for the detainee to be given a 2-week supply of her current medications.

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Psychiatric coverage of the Psychiatric Special Care Units has been without changes. 2N is covered by 1 FTE Psychiatrist and 1 FTE Psychiatric PA. 2W/2S/2SE are covered by 1 FTE. 2E is covered by 01.FTE. Treatment Compliance Incentive Program has also positively impacted the overall milieu Dr. Waxler (Unit Director for 2N/2W) continues to provide supervision to staff. Dr. Nunez provides supervision to staff on 2S/2E. Increase in efficiency and better adherence to the statutory deadlines for UST removal to the DMH has led to fewer delays for 2S/2SE detainees awaiting their turn to go to the DMH. Supt. Jones continued to facilitate hygienic procedures in coordination with Nursing and MH staff.

PSCU Executive Summary

2N (males) and 2W (females) are Special Care Units within Cermak Health Services that provide psychiatric/mental health services to a population of acute, sub-acute, and chronic individuals. A psychiatrist meets with each patient within 24-hours of admission and then daily thereafter. Structured group programming is delivered daily to patients, which ranges from a "Rise and Shine" group focusing on hygiene/ADLs, to "Community Meeting/Unit Orientation," as well as more clinically focused groups.

Clinical groups take place both in the day room and in the small group room and generally engage patients in discussing topics such as Anger Management, Coping Skills, Patient Rights, Understanding Mental Illness, etc. The Rise and Shine Programming typically runs from 0830-1000. Two clinical groups are generally conducted between 1000-1230, or until patients are returned to their rooms. Groups resume after patients are allowed out of their room for the afternoon, typically between 1730-2000. An expressive art therapist also spends between 6-8/week providing small group sessions to patients on both units Mondays- 2W, Thursdays 2N). All services are provided by licensed Mental Health Specialists (MHS-III). Patients housed on the Special Care Units are seen by a Mental Health Specialist during rounds on each shift, and they have access to a licensed Mental Health Specialist 24 hours a day. Mental health staff engages patients either in their room or in the milieu (dayroom or interview room). Patients also have access to psychiatric services while housed on the Special Care Unit. They typically meet with a psychiatrist or physician's assistant daily.

Since October 2015, patients on 2N have been receiving an average of 4.67 hours of structured group programming per day; while patients on 2W have been receiving an average of 26.37 hours of structured group therapy per week, per patient. These numbers are quite high when patient access is considered. There are many factors that negatively impact the access mental health specialists have to work with patients. For 2N, patients are being engaged in structured group programming an average of 84.8% of the time they are out of their room over the last six months (October 2015-March 2016). The percentage of large group room therapy versus small group room therapy has remained steady at about 90% to 10%, respectively. The majority of small group room therapy has been expressive art therapy groups where patients have the opportunity to listen to music of their choosing, write letters with a provided stamped envelope, create art with markers, write poetry, and look up words in a dictionary.

Another challenge to providing groups in the small group room is the creation of a secure environment by having a proximate officer. This is not always possible in such a dynamic environment (examples of conflicting activities include: medication pass, psychiatry evaluations, crisis interventions, and movement off unit). Staff is working towards increasing the amount of small group room therapy provided each month by collaborating with CCDOC partners in order to have the groups properly supervised.

Access to patients has been tracked on 2 North as our group therapy hours were appearing deflated if it was assumed that staff had 12-14 hours of access to patients. Over the past six months (October 2015-March 2016) the average access staff has to engage patients in groups is 5.5 hours/day. [It should be noted that CCDOC review of out of cell time found that the majority of the detainees were out of cell for 7-8 hours per day. This discrepancy appeared to be related to CCDOC including inmates on walk-alone status being counted in the out of cell time average.] With the Cermak metric taken into account, our average of 4.67 hours/day of structured group therapy constitutes the utilization of 85% of available time. The remaining 15% of out-of-cell time is used for meals and unstructured recreation (television, phones).

The percentage of group programming on 2N has shown a slight decrease over the past four months which may be related to several factors. One hypothesis is that the MHS staff has been trained to be more consistent with what can be counted as actual clinical group programming. In the past, there was more inconsistency with reporting activities such as socialization/unstructured recreation time as group programming which may have inflated our numbers slightly (October- 92% and December- 94%). In addition to this hypothesis, we have been seeing an increase in situations that prevent group programming from taking place, such as: patients who have a House Alone/Out Alone or P.C. status, incidents in the milieu (Use of Force, FLR deployment, flooding cell), and maintenance/construction on the unit. The group programming hours will continue to be monitored within the context of how many hours Mental Health staff has access to patients. One proposed solution is to engage patients in groups in the small group room while a P.C. detainee is using the dayroom area.

In addition to providing assessment/treatment planning, milieu therapy, rounds, individual sessions, and group sessions, the mental health staff also meets daily in a "morning huddle" to discuss new admissions and any concerns or questions from the previous day(s). Staff will also regularly engage in multidisciplinary treatment team meetings held twice a week on both units to discuss patient progress, update the patients' treatment plan, and address any other pertinent items/issues. The restraint and seclusion log for the previous week is reviewed twice weekly (am and pm shifts) at staffing, and staff is given the opportunity to discuss any issues or questions they have with the process of utilizing therapeutic restraint/seclusion. Multidisciplinary Treatment Team (MDT) meetings are scheduled regularly and consist of psychiatrists, psychologists, physician's assistants, mental health specialists, nurses, and correctional officers.

The two main challenges to the Special Care Units have been related to: 1) lack of patient motivation in the recovery process and 2) maintaining a routine schedule for service delivery.

Examples of patients with low motivation towards treatment might include patients admitted due to the nature of their charge or patients who are admitted to the Special Care Unit who upon admission deny any symptoms, stating that they manipulated the system for secondary gain (i.e. movement, preferential housing). Patients who are not invested in the recovery process can be disruptive to those who would benefit from a low environmental-stimulation therapeutic milieu.

Maintaining a routine for service delivery is also challenging in an environment with individuals who are labile and more likely to become physically aggressive. Aggressive behaviors by one patient can lead to all patients being directed back to their rooms. Multiple admissions can happen on the same shift which also has the ability to disrupt the ability to deliver group therapy on that shift depending on single room availability and the security status of the new admission. In addition, building maintenance and environmental services can diminish patient access to services as some rooms can be decommissioned for issues such as plumbing, painting, waxing floors, etc. Maintenance can be both routine, as well as in response to property or physical plant destruction or for the removal of biohazardous material.

With regards to the milieu and therapeutic environment on the psychiatric special care units, staff works towards developing rapport with each patient and providing a sense of physical and emotional safety. This is especially the case on 2 West (females), where staff provides a more trauma-informed approach to working with patients. Staff encourages patient compliance with treatment while also respecting patients' rights. Mental health staff spends time describing patient rights with regards to medical/mental health treatments (i.e. right to refuse medications).

The incentive program is utilized on 2 West to encourage patients to participate in health-promoting activities, such as hygiene, group therapy, and medication compliance. Mental health staff tallies points and provides incentives for patients who engage in these activities. Mental health staff will modify the incentive program for patients with special circumstances (such as out alone/house alone status) to make it possible for all patients to participate in the program. A recent rotation of mental health specialist staff has taken place on the 2nd floor of Cermak. The current placement of mental health specialists was initiated on April 1, 2016. This was done to decrease/prevent staff burnout and to increase staff's ability to work in various clinical areas. So far the rotation has been met with mixed reviews by mental health staff. Some staff members were opposed to moving, while others welcomed the change. There are normal personnel issues that can be expected in a fast-paced and emotionally charged environment. Burnout-related absenteeism is an issue that is addressed both in individual and group supervision. Since the beginning of 2016 one group supervision session per month has been dedicated to self-care/burnout prevention.

An area that has been improving is cooperation across disciplines. This has periodically been a challenge, but generally has been moving in a positive direction. Mental health specialists are more likely to communicate/collaborate with medical, nursing, and the officers. This collaboration can be challenging at times due to discrepancies between professional perspectives and opinions, but has been improving. The increased collaboration amongst leadership may be

driving this improvement (i.e. regular interagency management meeting and multidisciplinary staffing). In all, the Cermak Psychiatric Special Care Units (2 North and 2 West) provide patient-centered multidisciplinary treatment to a diverse and challenging population.

Please see PDF Appendix (Monthly Statistics 2016) for group programming statistics, which includes the following:

Inpatient Weekly Programming Hours

INPATIENT WEEKLY PROGRAMMING HOURS BY UNIT 2016													
LOC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVE
2N*	4.9*	5.1*	4.4*										4.8*
2S	18.9	20.1	19.6										19.5
2E	15.3	18.2	17.4										17.0
2W	25.2	22.5	23.6										23.8

**Calculated as DAILY PROGRAMMING HOURS*

INPATIENT WEEKLY PROGRAMMING HOURS BY UNIT 2015													
LOC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVE
2N*	4.5*	4.5*	3.9*	3.3*	3.7*	4.2*	4.5*	4.7*	3.9*	3.6*	4.9*	5.1*	4.9*
2S	14.3	14.8	15.6	23.1	21.8	19.8	18.0	11.7	19.1	18.8	15.0	16.6	17.3
2E	13.9	12.8	11.7	15.2	14.1	12.2	7.1	7.5	14.1	13.8	13.6	12.6	12.4
2W	23.0	26.0	22.5	27.7	26.2	25.0	23.6	21.8	29.5	31.7	26.8	28.4	26.1

**Calculated as DAILY PROGRAMMING HOURS*

Cermak Medical Social Workers continue to provide linkage and aftercare planning for SMI detainees and P2 detainees not participating in the Mental Health Transition Center Program (CCSO employs its own discharge planners). The Medical Social Workers also continue to be an integral part of the response to calls received by the Sheriff's Care Line. All information related to mental health issues continues to be forwarded to our two senior medical social workers for follow up and/or delegation to divisional social workers if indicated. Since the last visit, our social work staff has addressed 61 calls/referrals. Of those referrals, (64%) had already been identified, evaluated, placed on the MH caseload and were receiving treatment. (8%) of the referrals yielded new additions to the MH caseload, and the remaining (28%) referrals were determined to not be in need of continued follow up from the MH department. This collaborative community outreach effort has resulted in increased access to collateral information and opportunity for improved care and clarification of needs. Please see the PDF Appendix for the broader scope of services provided by Cermak Medical Social Work staff.

Detainees meeting criteria for involuntary admission by petition and certificate are transported to one of two area hospitals (Mt. Sinai and St. Anthony) upon release from Cermak by the court system. All detainees with P4 alert are evaluated at the moment of court release, and those anticipated to meet criteria for involuntary admission in the community are also 'flagged' ahead of time in EMR to ensure that their need for continued inpatient treatment is not overlooked if they are released in the overnight hours. There has been no indication of 'missed' evaluations at discharge recently, and the program continues to be very efficient.

In 2014 and 2015, an average of 3.8 patients per month were transported to community hospitals for involuntary admission by petition and certificate upon release from CCDOC. For the first quarter of 2016, the rate is 3.0. This decline may be accounted for, in part at least, by the reduction in jail census over the past two years. The average daily population in the jail for 2014 was 9,351. For 2015, the ADP was 8,204. For the first quarter of 2016, it is 7,996. This represents a 16% reduction in census, which is close to the 22% reduction in post-detention petitioned and certified hospital admissions during the same period.

INVOLUNTARY HOSPITALIZATION BY PETITION & CERTIFICATE UPON RELEASE 2014-16													
YEAR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2016	3	2	4	1									
2015	3	7	2	2	3	10	0	3	2	4	6	3	32
2014	3	5	4	4	4	5	5	4	3	4	3	4	48

INVOLUNTARY HOSPITALIZATION Q1-Q4 2014-16					
YEAR	Q1	Q2	Q3	Q4	TOTAL
2016	9	1			
2015	12	15	5	13	32
2014	12	13	12	11	48

Detainees meeting criteria for the administration of involuntary medications (non –emergency basis) continue to be evaluated for filing of the Petition. Some patients refuse to accept psychotropic medications, sometimes even in cases when their safety and survival depends on their receiving treatment. In those cases, judges are petitioned to authorize involuntary treatment. Typically our petitions for the administration of involuntary treatments are heard by the judges at the Circuit Court of Cook County. Cermak's petitions for the involuntary administration of psychotropic medications undergo vigorous judicial review and are not afforded the administrative review process. While preparing these petitions requires many hours of medical research and clinical data analysis, this painstaking process is made even more difficult by the fact that Psychiatric Providers have to travel to the Daley Center for the hearings. It was suggested that petitions for the involuntary administration of psychotropic medications be heard by Criminal Court Judges at the Leighton Center, thus reducing Cermak's travel and time expenditures. A letter to one of the Judges at CCB was written by Dr. Kelner seeking assistance in the matter. Furthermore, Dr. Kelner contacted ASA Office seeking additional information and guidance in finding out if the Harper Procedure afforded to detainees in IDOC (Administrative review) can be applied to CCDOC detainees in lieu of the Judicial Review that we currently use to petition for the administration of involuntary medications (non-emergency basis).

See PDF Appendix for Correspondence from Dr. Kelner.

CCSO facilitated, 3 joint sessions of CIT training for Cermak clinical staff and custody staff. The first was a 7 hour overview, the others the full 5 day training. Staff persons selected for this initial training are currently assigned to the psychiatric care units or the residential treatment unit. Staff selected to attend reported finding the training extremely useful. So far 12 Cermak mental health staff completed the full CIT training, while an additional 7 attended the initial CIT overview.

Following a sentinel event on 2N on 12/01/2015, a staff safety checklist was developed in MH CQI committee meetings and shared with CCDOC and Cermak Leadership. Findings were further discussed in CQI Suicide Prevention Committee meeting. One of the recommendations developed in CQI meetings was to install a retractable physical barrier to separate clinical areas/nurse's stations in PSCU's from the space available to detainees for roaming and programming. Presently the project is still in the cost estimation phase and has not resulted in a decision to proceed with the installation. Several caveats were also demonstrated, the main being that physical separation of staff from detainees might lead to staff's decreased motivation to participate in therapeutic milieu. It was noted that earlier and more aggressive pursuit of the Petition for the Involuntary Administration of Medications (non-emergency basis) would have been a more viable strategy, given the relative infrequency of similar sentinel events in PSCU. As a follow up to the said sentinel event and other incidents throughout the compound, civilian's staff safety was discussed in Mental Health CQI Meetings. Concerns voiced by front line staff were incorporated in the discussion and relayed to CCDOC Leadership. A checklist of safety issues (some of them impacting delivery of services, including, but not limited to crisis services and therapeutic programming in segregation) to be addressed in clinical areas was generated and can be found in the Appendix. The checklist was additionally discussed in Mental Health CQI meeting in April 2016.

CCDOC Submitted Updates

Inmates in Cermak (excluding 2North, the acute male unit) are recreated on Thursdays, Fridays and Saturdays outside of programming hours.

2North

The General Population detainees/patients receive time out of cell for a minimum of 7-8 hours per day. Due to the census and high turnover it is hard to state with accuracy how many hours a day Out Alone/House Alone detainees/patients receive. Due to the damage that some inmates cause to the rooms, hours may be minimized by the need to complete facility repairs. At minimum, Out Alone/House Alone and Protective Custody detainees receive 1 hour out of cell each day and are encouraged to participate in programming for additional hours out of cell. All activities in regards to security are notated in the Officer's log book.

2South

The General Population detainees/patients are out of their cells for a minimum of 7-8 hours per day. Protective Custody and Out Alone/House Alone detainees receive 1 hour out of cell each day and are encouraged to participate in programming for additional hours out of cell. All activities in regards to security are notated in the Officer's log book.

2East

The census on 2East is usually 8-12. Most individuals come out of their cells for a minimum of 8-10 hours a day. Because the unit is smaller in size and much more manageable, they are allowed the freedom to return to their cells. All activities in regards to security are notated in the Officer's log book.

2West

The census fluctuates considerably on this living unit but usually houses 14-21 detainees/patients. Most of them come out of their cells for a minimum of 7-8 hours a day. All activities in regards to security are notated in the Officer's log book.

Inmate Hygiene

DOC, nursing, environmental services and mental health staff continue to be proactive with managing inmates with poor hygiene in Cermak. Once a humanitarian shower is requested, all staff work together to accomplish the task.

April 2016 Metzner assessment: Access to patients by clinical staff, especially on 2N, is limited related to most inmates being locked down generally from 12:30 PM-to about 4:30 PM or 5:30 PM related to out of cell time for walk alone status inmates. Inmates on this unit generally are out of their cells for 5.5 hours per day. The discrepancy with the CCDOC report of inmates being out of their cell 7-8 hours per day appears to be related to counting hours out of cell for "walk alone" inmates. There was agreement with key correctional and mental health staff that the out of cell hours per day will be increased and will be spot checked on all Special Care Unit patients.

During the morning of April 20, 2016 I observed patient activity in all of the Psychiatric Special Care Units. I was impressed with the quality of the activities being offered and the inmate participation. I discussed with Dr. Jones and Dr. Kelner an agreeable process to monitor the amount of out of cell activities generally be offered to all inmates on these units, with a particular focus on Unit 2N.

As in the past, I emphasized the following principles:

1. Out of cell time unstructured time is much better than being locked down.
2. Out of cell structured therapeutic activity is better than unstructured time

3. There should be a reasonable balance of both out of cell structured therapeutic activity and out of cell unstructured time.

Recommendations: The number of out of cell structured therapeutic activities and out of cell unstructured time on all of these units needs to be increased and monitored.

i. **Cermak shall provide the designated CCDOC official responsible for inmate disciplinary hearings with the mental health caseload roster listing the inmates currently receiving mental health care.**

Assessment: Substantial compliance (since June 2012)

November 2015 Metzner assessment: Substantial compliance continues.

April 2016 Metzner assessment: No change

j. **When CCDOC alerts Cermak that an inmate is placed in lock down status for disciplinary reasons, a Qualified Mental Health Professional will review the disciplinary charges against inmate to determine the extent to which the charge was related to serious mental illness. The Qualified Mental Health Professional will make recommendations to CCDOC when an inmate's serious mental illness should be considered as a mitigating factor when punishment is imposed on an inmate with a serious mental illness and to minimize any deleterious effect of disciplinary measures on an inmate's mental health status.**

Assessment: Substantial compliance continues (since October 2012).

Factual Findings:

<u>April 2016 Cermak Status Update</u>

Based on the results of interagency collaboration, the 14 day stipulation was removed, DOC understands that if mitigating factors are identified and there is no contraindication for continued placement in disciplinary segregation they will limit disciplinary segregation time for P3 and P4 detainees to 14 days or less.

Following the dismantlement of the Levels System, a combined huddle meeting for Compound Disciplinary Segregation/ Restrictive Housing Units analogous to The Levels System Meeting (for Administrative Segregation) takes place on a weekly basis. It was decided that these discussions are to occur at the Leadership Level/ Cermak MH Administration level and not during local divisional management meetings. Cermak MH Leadership (Drs. Key and Kelner)

discontinued reviewing the cases of detainees housed in Special Incarceration Unit to provide the higher level of review. The said Unit is no longer a part of the Levels System.

Please see PDF Appendix for Mitigation Report.

CCDOC Submitted Updates

	Division 1	Division 2	Division 3/4	Division 6	RTU	CHS	Division 9	Division 10	Division 11	Division 17	Totals
January											
Total Written	9	61	26	355	122	22	268	163	11	10	1047
Psych Consults	0	0	0	0	38	39	0	0	0	0	77
Mitigations											32
February											
Total Written	48	38	36	349	82	63	206	246	57		1125
Psych Consults	0	0	0	0	33	24	0	0	0		57
Mitigations											29
March											
Total Written		41	28	319	166	50	230	223	53		1110
Psych Consults		0	0	0	27	26	0	3	0		56
Mitigations											26

Of the total number of disciplinary reports written, approximately 5-7% are referred for mental health mitigation review. Of those referred for mitigation review, approximately 45% of them are deemed to have mitigating factors. From January to March 2016, the typical consequence given by the hearing board was time in disciplinary segregation, much of which was less than 15 days. All of the detainees with mitigating mental health factors were either housed in Cermak or Division 08 RTU. Detainees housed in the Cermak mental health units do not complete disciplinary segregation time. They are allowed out of their cells for programming, so they typically engage with mental health staff and/or other detainees on the unit for 7-8 hours each day. Detainees housed in Division 08 RTU segregation units receive regular programming from Cermak mental health staff.

April 2016 Metzner assessment: Substantial compliance continues

k. In the case of mentally ill inmates in segregation, CCDOC shall consult with Cermak to determine whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on Cermak's assessment.

l. Cermak shall ensure that mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained Qualified Mental Health Professionals or by Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, in order to assess the serious mental health needs of inmates in segregation. Inmates who are placed in segregation shall be evaluated within 24 hours of placement and thereafter regularly evaluated by a Qualified Mental Health Professional, or by a Qualified Mental Health Staff with

appropriate, on-site supervision by a Qualified Mental Health Professional to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, Cermak shall provide CCDOC with its recommendation regarding whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on the assessment of the Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional.

Compliance Assessment: Substantial compliance (11/15)

Factual Findings:

April 2016 Cermak Status Update

CCDOC Administration brought in the State of IL statutory compliance their disciplinary segregation process and, presently, detainees' stay in disciplinary segregation cannot exceed 29 days, whereupon, they are removed from segregation and undergo additional review in order to determine whether they need to be put back in segregated setting. Mental Health Department continues to provide 24 hour segregation screening for this cohort of detainees reentering restrictive settings.

Mental health staff continues to conduct rounds on restrictive housing units at minimum weekly. Dr. Key and Dir. Lyles collaborated to update the currently used SMU notification sheet to include originating in addition to proposed housing change to address what is suspected to be an artificial lowering of screening compliance. Detainees moving from one segregation tier to another are not in need of additional screening, however are documented on the notification sheet for institutional purposes. Mental health, unable to differentiate between those who were in need of a screen from those who are not, count the compliance rates at face value. As such, both agencies are confident that the screening compliance rates are higher than the data currently reflects. The new notification sheet will be distributed and used by all divisions. Please see Excel Appendix SMU Screen.

CCDOC Submitted Updates

The Department of Corrections has been 100% compliant with the daily notifications to Cermak of detainees placed in disciplinary segregation since January 2016. In December 2015, the CCDOC Executive team increased the accountability of divisional Superintendents by requiring divisions housing disciplinary segregation tiers to maintain monthly calendars noting the staff member that made the daily notification to Cermak. If notification was not made, disciplinary action was initiated. In October 2015, the DOC initiated the Placed in Segregation alert in CCOMS as an additional method to notify Cermak of all detainees placed in segregation. In

March 2016, the centralized classification unit took responsibility of entries and discharges to segregation units. This measure increases the oversight of the process and maximizes consistency across divisions.

April 2016 Metzner assessment: Substantial compliance continues

n. **Cermak shall ensure that a psychiatrist, physician or licensed clinical psychologist conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. An appropriately credentialed registered nurse may conduct the in-person evaluation of an inmate prior to a seclusion or restraint order that is limited to two hours in duration. Patients placed in medically-ordered seclusion or restraints shall be evaluated on an on-going basis for physical and mental deterioration. Seclusion or restraint orders should include sufficient criteria for release.**

Compliance Assessment: Substantial compliance (4/16)

Factual Findings:

April 2016 Cermak Status Update

A restraint audit QI report, completed by the Cermak nurse manager, Madonna Mikaitis, R.N. was reviewed and demonstrated compliance with the relevant policy and procedure.

An audit regarding Notifications to the Facility Director was undertaken that demonstrated issues in the reporting process, which hare in the process of being corrected.

April 2016 Metzner assessment: Substantial compliance has been achieved.

Recommendations: Continue with the current QI process.

o. **Cermak shall ensure an adequate array of crisis services to appropriately manage the psychiatric emergencies that occur among inmates. Crisis services shall not be limited to administrative segregation or observation status.**

p. **Cermak shall ensure that inmates have access to appropriate acute infirmary care, comparable to in-patient psychiatric care, within the Cermak facility.**

Compliance Assessment: Partial compliance

Factual Findings:

April 2016 Cermak Status Update

The collection of the HSRF response data reflects face to face evaluations conducted by mental health specialists by level of ordered priority (see Excel Appendix). Compliance with responding to all HSRF with a face-to-face evaluation within the required timeframes has continued to show improvements, specifically in response to Urgent and Priority health services requests. Currently approximately 95% of the Urgent HSRF are seen on the same day that the request is received and close to 90% of requests deemed a priority are seen within 48 hours of receipt of the request. While this trend is encouraging, response to routine requests continues to fall below expectations with approximately 70% of routine requests for services being seen within 72 hours of receipt of the request. One known factor continues to be delayed scheduling of appointments related to staff allocation and staff attendance. The second full-time mental health specialist that was previously assigned to Div. 9, one of the problematic areas, had to be reassigned to Div. 10 due to compound housing changes and reassignment of mental health patients. Unfortunately, despite the decrease in mental health patients in Div 9, mental health has not noticed a decrease in HSRF needing a mental health response. Female services has been short two licensed mental health specialists for an extended period of time, which has made adherence to HSRF timeframes more challenging. Other areas are impacted by staff absenteeism and sheer volume of HSRF submitted. There are just far more patient requests for services than we have the staff to respond to in the required time frames. As such, clinics fill up quickly and appointments are scheduled further and further back. We incorporated these issues into our proposed staffing plan for the 2017 budget cycle, as expect that that we would see improvements in response time with increased staff numbers. As a department we continue to discuss ways in which to address the challenges associated with responding to repetitive and misused requests (i.e. detainees who fill out numerous requests for secondary gain). We also expect that as the protocols and procedures for the processing of HSRF becomes more fluid within Cermak as a whole; the mental health response time will improve. Patient Care Services staff continues to be provided education as to the appropriate handling of HSRF for mental health services. Cermak leadership is also engaged in discussion with the IT department about updates to the documentation of mental health HSRF in the medical record that would allow more efficient documentation of face to face triage by the QMHP and minimize "missed data" that is interpreted as a patient not being seen when that may not have been the case.

There is diminished concern regarding the number of HSRF that were classified as "not seen" by absence of documentation reflecting an evaluation in the medical record. The number in this category has not only significantly decreased in comparison to prior visits, but review of the records reflect that most of the HSRF had either been responded to by a QMHP, however the response was documented within the HSRF ad hoc document in the EMR which is not currently captured by the data . This is being addressed with IT. Remaining "not seen" were due to patient refusals and erroneous referrals to mental health that were not mental health related and did not warrant a mental health evaluation. The Chief Psychologist will monitor "Not Seen" patients to ensure access to care is consistently and appropriately provided.

To expand the availability of crisis response to divisions, additional telehealth equipment was installed in the urgent care. With this additional equipment, when there are two mental health providers scheduled to the urgent care, divisional services needs have increased access. This has been of specific benefit with regard to screening the often high numbers of individuals that enter segregation on a daily basis.

April 2016 Metzner assessment: QI data documents issues in meeting timelines for responses to routine mental health referrals related to the current policy and procedure that requires a face to face triage for routine referrals within 72 hours and periodic delays in receiving the referral from nursing staff in a timely manner. I discussed with staff potential revisions to the pertinent policy and procedure that will significantly decrease the lack of compliance. In addition, the process involved with the sending of the mental health referrals from the nursing staff to mental health services needs to be improved.

Recommendations: As above. Refer to the medical monitor's report.

60. Psychotherapeutic Medication Administration

a. **Cermak shall ensure that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis for appropriateness or adjustment. Cermak shall ensure that changes to an inmate's psychotropic medications are clinically justified and documented in the inmate's medical record.**
b. **Cermak shall ensure timely implementation of physician orders for medication and laboratory tests. Cermak shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, including movement disorders, and provide treatment where appropriate.**

Compliance Assessment: Partial compliance

Factual Findings:

April 2016 Cermak Status Update

Periodic monitoring of blood levels of Lithium and Depakote is important for the safe administration of the said medications. It is suggested that blood levels are checked at least every 6 months, even if a patient remains asymptomatic and the dosage remains unchanged. A new Cerner alert was created. The logic now exists in EMR and, when Providers (both Medical and Psychiatric) try to order and, more importantly, reorder Lithium and Divalproex, a new rule fires. If no Li and VPA levels have been ordered over the past 6 months, it prompt the system to order Li and VPA levels. Presently, Chief of Psychiatry proposed that a similar alert be created to ensure timely monitoring of blood glucose levels and lipids against the backdrop of the

administration of second generation antipsychotics. As demonstrated by the chart, the frequency of medication monitoring has reached levels above 90%.

AS of 4_7_2016	# of Med Order(person)	# of Lab Order	Ratio
Lithium	20	20	100%
Divalproex Sodium/ Valproic Acid	193	180	93.26%
Risperidone/ Ziprasddone/ Olanzapine	539	240	44.53%

April 2016 Metzner assessment: As above.

Recommendations: Develop and implement the careset for blood glucose levels and lipids studies.

E. SUICIDE PREVENTION MEASURES

61. Suicide Prevention Policy

a. CCDOC shall participate with Cermak in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.

b. Cermak shall participate with CCDOC in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.

c. The suicide prevention policy shall include, at a minimum, the following provisions:

(1) an operational description of the requirements for both pre-service

and annual in-service training;
(2) intake screening/assessment;
(3) communication;
(4) housing;
(5) observation;
(6) intervention; and
(7) mortality and morbidity review.

Compliance Assessment: Substantial compliance (November 2013)

Factual Findings:

November 2013 Metzner Assessment: Significant improvement is noted in the Mortality & Morbidity Review reports, which are now using a root cause analysis format.

As described elsewhere in this report, problems remain relevant to the intake screening/assessment process, especially in the context of priority referrals and segregation admissions screening. These issues are addressed elsewhere in this report.

April 2016 Cermak Status Update

Four reports were submitted for review, following initial Root Cause Analysis. One RCA was following staff assault (patient's initials are PD). Two RCA's followed completed suicides (JS and DL). One RCA followed a critical incident on 2N unrelated to suicide and self-harm (AC). Cermak created narratives with a summary of relevant findings for the RCA related to the staff assault, two completed suicides and the critical incident. It is of note that, according to the IL statute, presently, deaths in custody are investigated as potential crimes by IL State Police Task Force and no results of their investigations have been made available to Cermak. As of the submission of this report the following data/ action items and relevant findings have been reviewed in Suicide Prevention CQI: staff assault (PD). The following RCAs were reviewed in Mental Health CQI (JS, DL, and AC). Final autopsy results for all RCAs were unavailable at the time of this report. Two RCAs following staff assault, completed suicides and the critical incident in Cermak were conducted with CCDOC participation according to the timeframes (10 days).

CCDOC Submitted Updates

In 2015, the Illinois General Assembly passed SB1304, the Police and Community Relations Improvement Act. The Act requires law enforcement agencies to employ an outside law enforcement agency to investigate all deaths involving officers. In January 2016, the DOC began utilizing the Illinois State Police Public Integrity Task Force (PITF) to investigate all in-custody deaths, including detainee suicides.

April 2016 Metzner assessment: Substantial compliance continues

62. Suicide Precautions

a. CCDOC shall ensure that, where suicide prevention procedures established jointly with Cermak involve correctional personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), correctional personnel perform and document their monitoring and checks.

b. Cermak shall ensure that, where suicide prevention procedures established jointly with CCDOC involve health care personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), health care personnel perform and document their monitoring and checks.

c. CCDOC shall ensure that when an inmate is identified as suicidal, the inmate shall be searched and monitored with constant direct supervision until the inmate is transferred to appropriate Cermak staff.

d. Cermak shall develop and implement policies and procedures for suicide precautions that will set forth the conditions of the watch, including but not limited to allowable clothing, property, and utensils, in accordance with generally accepted correctional standards of care. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergency circumstances.

Compliance Assessment: Substantial compliance (11/15)

Factual Findings:

April 2016 Cermak Status Update

The language in Cermak Policy G05 A#10 was amended in order to clarify Cermak's Suicide Prevention Program:

A#8. It was confirmed via CCHHS Risk Management and legal research that the original Policy language allowing QMHP (including licensed MHS III's) to increase level of observation and order close observations was consistent with NCCHC standards and IL Nurses Practice Act.

A#10. The following rules now apply to renewing and downgrading suicide precautions: Psychiatrists and a doctoral –level Mental Health Clinicians (Psychologists) may downgrade or discontinue suicide precautions after an in-person evaluation. A physician, other than a psychiatrist, may downgrade or discontinue suicide precautions only after conferring with a psychiatrist. Hitherto, only Psychiatrists had been able to downgrade/discontinue the level of

observation. Interagency CCDOC/ Cermak Suicide Detection and Prevention 64.9.22.0 D-2 also asserts that Psychiatrist and *Psychologists* may downgrade or discontinue observation status.

See PDF Appendix for Suicide Detection and Prevention QI Report Qtr. 4 2015 and Qtr. 1 2016 and Self- Injury Data (Mental Health Monthly Statistics).

April 2016 Metzner assessment: Substantial compliance continues

64. Suicide Risk Assessments

a. Cermak shall ensure that any inmate showing signs and symptoms of suicide is assessed by a Qualified Mental Health Professional using an appropriate, formalized suicide risk assessment instrument within an appropriate time not to exceed 24 hours of the initiation of Suicide Precautions.

b. Cermak shall ensure that the risk assessment shall include the following:

(1) description of the antecedent events and precipitating factors;
(2) mental status examination;
(3) previous psychiatric and suicide risk history;
(4) level of lethality;
(5) current medication and diagnosis; and
(6) recommendations or treatment plan. Findings from the risk assessment shall be documented on both the assessment form and in the inmate's medical record.

Compliance Assessment: Substantial compliance (11/13)

Factual Findings:

November 2013 Metzner assessment:

The 15 charts in the EMR of patients, who had screened positive on the suicide screen, were reviewed by my fellow in forensic psychiatry. These charts were randomly selected among approximately 40 patients who had screened positive on the suicide screen. Every patient chart reviewed had a secondary suicide risk assessment completed. In 12 of the 15 assessments, the form was completed and the narrative summary was consistent with the checked items. In three of the assessments, the narrative summary was thorough, but risk factors highlighted in the narrative summary were not checked as risk factors in the body of the assessment form. This was likely an error because the narrative summary assessed those patients as a risk for suicide.

April 2016 Metzner assessment: Review of relevant QI data demonstrated continued substantial compliance.

65. Cermak shall ensure that inmates will only be removed from Suicide Precautions after a suicide risk assessment has been performed and approved by a Qualified

Mental Health Professional, in consultation with a psychiatrist. A Qualified Mental Health Professional shall write appropriate discharge orders, including treatment recommendations and required mental health follow-up.

Compliance Assessment: Substantial compliance (11/15)

Factual Findings:

November 2015 Metzner assessment: Review of the relevant QI results were consistent with the presence of substantial compliance.

April 2016 Cermak Status Update

Please refer to QI reports referenced in provision #62.

April 2016 Metzner assessment: Review of the relevant QI results were consistent with the presence of substantial compliance.

H. QUALITY MANAGEMENT AND PERFORMANCE MEASUREMENT

86. Quality Management and Performance Measurement

a. **Defendants shall each develop and implement written quality management policies and procedures, in accordance with generally accepted correctional standards, to regularly assess, identify, and take all reasonable measures to assure compliance with each of the provisions of this Agreed Order applicable to that Defendant.**

b. **Defendants shall each develop and implement policies to address and correct deficiencies that are uncovered during the course of quality management activities, including monitoring corrective actions over time to ensure sustained resolution, for each of the provisions of this Agreed Order applicable to that Defendant.**

Compliance Assessment: Substantial compliance (11/15)

Factual Findings:

April 2016 Metzner assessment: The pre-site information packet, which included the QI appendix, was well done and extremely helpful. The QI studies were methodologically sound, well written and very relevant.

Additional Information

April 2016 Cermak Status Update

Use of Force Task Force and Tracker.

The CCDOC and Cermak are committed to ensuring that uses of force against the seriously mentally ill are rare and consistent with our UOF standards. To this end, we have:

- continued to emphasize to CCDOC and Cermak staff the need for effective de-escalation attempts;

- sent over 60 correctional and mental health staff working with these populations to state-certified Crisis Intervention Training (with plans to send more in May and then throughout the year);

- continued to provide over two weeks of Advanced Mental Health and Crisis Intervention Training to all correctional officer recruits;

  There has been a relatively significant decrease in the collective monthly average uses of force by those who attended the training.

- required that all CCDOC staff take the on-line "Advanced Mental Health Training" course by April 3, 2016 (will provide copy during site visit upon request);

- modified the interagency daily huddle format so that CCDOC has consistent representation and tracks relevant UOF information more quickly and uniformly;

- since December, Cermak and CCDOC representatives have met monthly as an interagency group specifically to assess the individual and collective uses of force against P-3's and P-4's and resolve UOF issues;

- ensured that there is 24/7 Mental Health staffing in Cermak and RTU

- submitted a staffing plan to CCHHS that calls for increased mental health staffing.

- continued to refine and improve upon the sharing of pertinent medical documentation between Cermak and the UFRU -- there have been no issues or problems reported for several months;

- created an electronic Dashboard of all uses of force to better detect key trends;

- added staff and resources to the UFRU to ensure quicker assessments of UOF's involving p-3's and P-4's; and

- remained committed to expanding the Intensive Management Unit for some of the most problematic P-3 inmates.

In addition, Superintendent Jones and Cermak Leadership have helped usher in an improved culture of sensitivity and accountability within all disciplines working the 2nd Floor of Cermak. Last month, there were 8 uses of force, which was the lowest since November, and 4 of those 8 involved one patient, JH. We recognize that Dr. Metzner cautioned that any time O/C spray is used more than 5 times a month, there might be underlying problems. This relatively high number of uses of force involving O/C has occurred in two successive months. JH was involved in 4 O\C uses. However, at this point, the CCDOC can say with confidence that officers and sergeants assigned to the 2nd floor of Cermak understand that O/C should be used as a last resort after de-escalation efforts proved ineffective and when it's the safer alternative to going hands-on.

To decrease uses of force and improve operations in the RTU, CCDOC added a Commander and Lieutenant to the evening shift, when a majority of uses of force occur. In addition, CCDOC added an additional sergeant to each shift. This supervisory staffing increase will help with the consistency of leadership in the division and communication among supervisors from the 7-3 and 3-11 shifts. Supt. Brown and RTU leadership have regular meetings with the psychologists assigned to the 4th and 5th floors to develop behavioral plans for problematic inmates. Looking at patients like MC and WK, these meetings and plans have proven successful in reducing uses of force. Further, CCDOC Executive staff recently met with daytime supervisors in RTU to hear and act upon their recommendations for improving operations. One result is that RTU now has radios playing during non-program hours on the living units. The patients appreciate this, and more analysis needs to be completed to determine if this has been at least partially responsible for a decrease in incidents.

Additional Quality Materials available in the Appendix or During Site Visit:
Telepsychiatry Utilization and chart audit
Intake Psychiatry Referrals chart audit
Facility Director Notifications chart audit
CQI Frequency of contact with Providers in Cermak
Quality of RCDC Mental Health Assessments
Treatment Plan Audits for each Level of Care

April 2016 Metzner Assessment: I discussed issues with key mental health and correctional staff re: the above information. I recommended that they talk with Kathleen Allison (Director Division of Adult Institutions, California Department of Corrections & Rehabilitation) regarding the CDCR response to similar issues.

During the afternoon of April 21, 2016, I observed the mental health rounds in the two segregation units within Division IX. They were well performed by the mental health specialist. Six inmates were in the dayroom at a time for 90 minutes with increased correctional officer

present. The inmates were also handcuffed.

This increased out of cell time in segregation units is part of the CCDOC plan to gradually increase the recreational time for segregation inmates to three hours per day. The positive change in the milieu related to the increased out of cell time was very apparent. In addition, the custody staff is providing limited correctional programming on a weekly basis to inmates who are willing to participate. The plan for increased out of cell time for all segregation inmates and the opportunity to recreate with other inmates are very progressive measures and will contribute to less health care issues for these inmates. Mental health services are planning to also provide programming to segregation unit inmates if increased staffing allocations are obtained.

AppendixV

Please have the following information available in hard copy at the time of the site visit, and sent to me one week prior to the site visit in electronic form (but not in PDF) unless indicated otherwise. *Each* piece of information should cover the period since the last site visit.

Note: If any of the requests are too burdensome to produce, please contact me before attempting to produce such information.

Appendix I Agreed Order 5/13/10 MH provisions revised

Using the word version of Appendix IV in my last submitted report, after each of the "recommendations" section add the following section: **[date of site visit] Cermak status update:** and complete a narrative with proof of practice as available. This document request is the most crucial document. *Please do not delete my April 2016 findings or recommendations except for provisions that have been found in substantial compliance for at least 18 months..*

Some of the following requests may be in the above document and only need to be referenced—it does not have to be provided twice.

Mental Health System

1. The mental health system organization chart (with both position and name of person filling the position and his/her credentials- e.g., degree).
2. Any new policies and procedures relevant to mental health services.
3. Any new program descriptions of the current mental health system.
4. Any other reports (i.e., internal or external reviews) relevant to the mental health system at CCDOC.

Institutional Program Status

1. Narrative summary of program status

Staffing

1. List authorized mental health staff positions by discipline (psychiatrists, psychologists, social workers, nursing staff, clerical staff, etc.) and by program/area (intake, crisis stabilization, mental health housing units, etc.). For each position, indicate the person's name, professional degree, start date, and percent of FTE if not full-time. If the position is vacant, provide the date it became vacant. For any staff on leave, indicate the date the leave began.

2. List any newly allocated mental health positions and the dates they were established.

Census/Mental Health Roster

1. The total number of inmates in the jail, total number in segregation units, total number of mental health caseload inmates, and total number of inmates in each program area (crisis observation, mental health housing, general population, etc.).

2. Statistical information pertinent to the reception center screening of inmates (i.e., number of persons on a daily, weekly, or monthly basis for the past six months, percentage of inmates who have positive screens from a mental health perspective, percentage of inmates with positive screens who enter the continuum of mental health services, percentage of all newly admitted inmates who enter the continuum of mental health services).

Access to Higher Levels of Care

1. Number of inmates admitted to the infirmary on a monthly basis and the median length of stay in such beds.

Disciplinary Reports

1. The total number of disciplinary reports written in the jail.

2. The total number of disciplinary reports written for mental health caseload inmates in the jail. Please list by mental health housing wings by Division.

3. The percentage of disciplinary reports that assessed mitigating circumstances to be present.

4. An analysis of the impact of positive mental health assessments re: mitigation.

Quality Improvement

1. Agenda and minutes of all CQI meetings.
2. Agenda and minutes of all Mental Health Subcommittee of the CQI meetings
3. A copy of each relevant QA/QI audit conducted, preferably in electronic forms. For each audit provided, a description of:

    a. Statement of the issue being studied
    b. Methodology used
    c. Results
    d. Assessment of results
    e. Plan of action based on the assessment

Medication management

1. List of inmates and/or logs or other documentation of inmates receiving medications on an involuntary basis.*
2. Audits or other documentation of timeliness of medication delivery to inmates who arrived at the institution with current psychotropic medication orders or adequate verification of current psychotropic medication usage.
3. Audits or other documentation of timeliness of medication delivery upon expiration of prior psychotropic order.
4. Audits or other documentation of practices identifying patients noncompliant with their psychotropic medication (as defined in policy), timeliness of referral to mental health, and timeliness and adequacy of psychiatric response.
5. Audits or other documentation of laboratory testing orders as per standards for psychotropic medications, timeliness of results, timely notice regarding abnormal results, and appropriate medication adjustments.
6. The total number of mental healthcare caseload inmates prescribed medication.

Suicide Prevention

1. For any completed suicide, a copy of the mortality and review report.

2. Agenda and minutes of Suicide Prevention team meetings

Additional Items

1. Schedule of group therapies/structured out of cell therapeutic activities offered to inmates in the mental health housing units.*

2. Logs showing the use of restraints and seclusion, including the dates and times the orders were initiated, renewed, and discontinued, and the timing of nursing checks conducted.*

3. Audits relevant to the mental health screening and rounds in the segregation units.

4. Description of the status of any new construction or remodeling for mental health treatment space.

Does not need to be sent in advance of site visit.

Appendix VI

P3 (RTU) Charts and Patient Data

Patient #1: R.W.
Identifying Information: Patient is a 46 y/o F with history of psychosis, previously a P4 while incarcerated in 2015, and history of treatment at Elgin, re-incarcerated on March 18, 2016.

Interval History: Patient was seen by mental health on March 19, 2016. She was transferred to the PSCU because of paranoia. She was discharged from 2W to Intermediate Psych on April 1st.

Psychiatry Visits:
March 19th: Dr. Howard saw her and patient refused medications. He ordered Zyprexa 10 mg bid and prn Ativan, Haldol and Benadryl. He diagnosed her with Psychosis. This remained her diagnosis in subsequent encounters.
March 22nd: She continued to refuse medications and refused to interact with Dr. Howard.
March 24th: Patient observed to interact with peers many hours of the day and continued to refuse to speak to staff. Dr. Howard changed her to P3 and discharged to RTU.
March 25th: Returned to 2W given an error in classification. She was taking 50% of medications.
March 28th: Remained on 2W but was now medication compliant. She continued to be uncooperative with Dr. Howard and staff.
March 29th: Seen by Dr. Howard, med compliant about 80% of the time
March 30th: Taking Zyprexa 10 mg only in the morning.
March 31st: No changes
April 1: Discharged to RTU.
No other psych appointments noted.

Group and Individual Counseling:
Notes were in EMR for April 6, 8,10,12,14,17,18,19.
Pt refused a community meeting and psychoeducation on April 6.
Pt refused individual counseling on April 8.
She attended Rise and Shine and Medications on April 10.
She refused coping skills group the afternoon of April 12.
Off the tier on April 14.
Went outside for recreation on April 17.
Attended Rise and Shine/Medications group on April 18.
Refused groups on April 19.

Assessment:
In general, patient received an appropriate level of psychiatric and mental health treatment since her arrival to the Cook County system. However, the lack of psychiatric follow-up since transfer to the RTU is very problematic.

Patient #2: A.V.

Identifying Information: Patient is a 51 y/o F with h/o remote inpatient psychiatric hospitalization, past outpatient psychiatric contact but unclear diagnosis, incarcerated on November 8, 2015. This was her first incarceration.

Interval History:
Patient was first assessed by mental health on 11/10/15. She had submitted an HSRF while housed in Division 3. She stated that she was depressed and wanted medications. She was seen by MH again on 11/15 after patient submitted HSRF asking when she would see MH again. She was assessed by Dana Laughlin on 11/17 and reported increased depression, SI and past psychiatric outpatient treatment and psychotropic trials. Ms. Laughlin referred patient to psychiatry. She was seen by Dr. Menezes and he referred patient to RTU. Patient was subsequently transferred to 2W on 1/8 after disclosing a recent overdose with hoarded medications. She was discharged back to RTU on 1/11. She was re-admitted to 2W on 3/4- after ingesting shampoo and lotion after an upsetting court date. She was discharged on 3/9 back to RTU. She was readmitted to 2W on 3/30 after cutting herself with a metal piece of handcuffs while in court. She was subsequently transferred back to RTU on 4/1.

Mental Health Contact:
11/19: Seen by Ms. Laughlin again in response to HSR and patient asked when she would see psychiatry.
11/23: Seen by Ms. Adame in response to HSR in which patient asked when she would see psychiatry.
11/25: Seen by Ms. Laughlin in response to HSR. Pt noted to be odd, disorganized and with poor hygiene.
12/1: Seen by Linkage.
1/3: Seen by Ms. Adame after security requested contact because pt endorsed SI.1
1/4 Seen by Ms. Adame for follow up.
1/6: Seen by Ms. Adame after submitting HSR in which patient said she was slowly dying from a suicide attempt. Ms. Adame agreed to meet with patient the following day.
1/7: Patient told Ms. Adame that she had hoarded medication and overdoses on 1/5. This information was relayed to the unit director/tier officer.
3/3: Seen by MH after observed drinking lotion and shampoo in the bathroom and making suicidal statements.
3/16: CCDOC requested a MH Assessment because patient was upset about "fraud" in police report.
4/10: Seen by MH because patient stated she was going to kill herself. She had gauze in her mouth and threatened to swallow it. She subsequently calmed with therapeutic interventions.

Psychiatry:
11/25: Seen for first visit by Dr. Menezes. Reported increasing depression since early November after suffering multiple psychosocial stressors. Her first incarceration and recently lost job as paralegal. She was diagnosed with Anxiety Disorder and Depression and started on Zoloft 50 mg daily and Benadryl 50 mg at bedtime. She was referred to intermediate psych.

12/1: Dr. Menezes saw patient. She stated that she felt calmer and more relaxed. Current meds were continued. No change in diagnoses.
1/8: Seen by Dr. Howard upon admission to 2W due to recent OD on hoarded medications. Patient's diagnoses and medications were unchanged.
1/11: Discharged from 2W.
2/22: Seen by Dr. Menezes. Patient reported doing well. Diagnoses unchanged. Medications continued.
3/3: Admitted to 2W after ingesting lotion/shampoo with SI.
3/4 Seen by Dr. Howard. He believed that patient also showed evidence of thought disorder and exhibited overvalued ideas. He added Geodon 40 mg at bedtime to her Zoloft/Benadryl.
3/7: Seen by Dr. Kelner. Patient improving, increased Geodon.
3/8: Seen by Dr. Kelner. Noticed ongoing signs of thought disorder. Continued medications.
3/9: Seen by Dr. Kelner, discharged to RTU.
3/30: Seen by Dr. Howard upon admission to 2W. Was agitated and tried to harm self while at court. She received emergency medications.
3/31: Patient refused to speak with Dr. Howard.
4/1: Patient more interactive. Discharged back to RTU.

Groups and Individual Counseling:
11/27: Attended exercise and medications groups
11/28: Attended medications.
11/29: Attended Rise and Shine, Medication Compliance and Healthy Living.
12/1: Attended multiple groups.
12/2-9: Attended daily groups.
12/31: Individual counseling.
12/10-1/7: Attended daily groups.
1/8-/11: On 2W
1/12-1/30: consistently attended groups
2/9: Seen for individual counseling with Ms. Adame
2/1-2/29: Attended groups consistently.
2/23: Individual counseling.
3/21: Individual counseling
3/9-4/20: Attended most groups, intermittent refusals.
3/24: Seen by psychology clinic.
4/14: Seen for individual session.

Assessment: Overall, patient received an adequate level of mental health services except for untimely psychiatric appointments. Groups and individual sessions were offered routinely. She was seen numerous times by mental health in response to requests from staff and/or patient herself. However, there was at least one time in which she was not seen by psychiatry within a 4 week period. She was seen in 5 weeks vs. 4 weeks by psychiatry after her first discharge from 2W to RTU (1/11 discharge and seen on 2/22). She was last discharged from 2W on 4/1 and has not yet seen psychiatry (20 days ago) but has been seen for an individual session. One suggestion would be for patients who are

recent discharges from 2W to be seen by psychiatry within 2 instead of 4 weeks upon their transition back to RTU. If that is not feasible, perhaps they could have an individual session within 7 days of their discharge from RTU. This may decrease the return rate back to an inpatient level of care. RTU psychiatry notes did not note when a patient was expected to return to clinic. Minimal rationale included in the plans, so it was difficult to follow the course of treatment and targets of intervention.

Patient #3: D.F.
Identifying Information: Patient is a 46 y/o M with history of mood disorder, intermittently taking psychotropic medication in the community, incarcerated on November 4, 2015.

Interval History: Patient was seen by Dr. Ramic in psychiatry upon intake into the jail on 11/4. She referred him to the RTU and started him on self-reported meds of Prozac and Risperdal, which he had not been consistently taking as an outpatient.

Psychiatry:
11/4: Saw Dr. Ramic on intake into jail and restarted on meds and referred to the RTU.
12/24: Seen by Dr. McNeal. Diagnosis of mood disorder and cannabis abuse. Follow up for 4 weeks. Continued medications as prescribed. To consider P2.
2/3: Seen by Dr. McNeal. Ongoing diagnoses of Mood Disorder and Cannabis Abuse. Increased Risperdal to 2 mg. and Benadryl added.
3/10: Seen by Dr. Marri. Recommended f/u in 4-5 weeks. No med changes.
4/14: Seen by Dr. Marri. Prozac increased. Recommended f/u in 4-5 weeks.

Groups and Individual Counseling:
11/16: Individual session.
11/15-12/15: Attended groups routinely.
12/16-1/16: Attended groups routinely.
2/24: Individual session.
2/24-present: Continued to attend groups routinely.

Assessments:
Overall, patient received an adequate level of mental health care. Although he was referred to the RTU upon intake into the jail, he was not again seen by psychiatry for approximately 7 weeks. One recommendation would be to ensure that patients who are re-starting or new to psychotropic medication be seen within a minimum of 4 weeks when at an RTU level of care. Otherwise, patient had a consistent level of follow-up. Some psychiatric notes did not indicate reasons/indications for med changes and targets for these medication changes. Some statement about the patient's course of treatment, interval findings, and focus of interventions would be helpful in determining their response to treatment.

Patient #4: J.B.

Identifying Information: Patient is a 53 y/o M with h/o mood disorder, alcohol use d/o,

multiple past inpatient psychiatric hospitalizations, suicide attempts (at least once while in custody, in 2013), taking psychotropic medication and incarcerated on 11/5/15.

Interval History:
Patient was referred for MH assessment on intake. He was incarcerated on 11/5/15 and seen by MH on the following day. He was transferred to 2N at that time due to "risk of decompensation." He was transferred to 2S on 11/9 and transferred to RTU on 11/16.

Psychiatry:
11/7: patient seen by PA (Ms. Balawender) on 2N. He was started on Depakote, Risperdal and Trazodone (meds verified in his property). He was diagnosed with Mood D/o and Alcohol Dependence.
11/8: Seen by PA. Continued on current meds.
11/9: Seen by Dr. Paschos. Continued on current medications, Mood NOS vs. SIMD along with alcohol dependence. Not tending to hygiene and isolative. Transferred to 2S for subacute obs/chronic care.
11/16: Seen by Dr. Howard on 2S. Discharged to intermediate psych.
1/19: Seen by Dr. McNeal on RTU. Continued diagnoses of mood disorder and alcohol dependence. No med changes. F/u in 4 weeks.
2/22: Seen by Dr. McNeal. Reporting AH so increased Risperdal. ROI signed for past psych inpatient. F/u in 4 weeks.
3/23: Seen by Dr. McNeal. Continued present management, status improving. f/u in 4 weeks.

Group and Individual Sessions:
12/16-present: routinely attended group sessions offered.
1/30: Individual session.
2/6: Individual session.
2/27: Individual session.

Assessment:
Patient received an adequate level of mental health care except for untimely appointments with the psychiatrist related to psychiatrists 'allocation issues. He was seen routinely by psychiatry within the time frame specified in the psychiatry notes. Plan of care was appropriately documented, patient's progression and rationale for medication changes.

Patient #5: P.M.
Identifying Information: Patient is a 42 y/o M with h/o PTSD, depression and Xanax use disorder, incarcerated on September 26, 2015.

Interval History: Patient was admitted to detox on intake given his reported history of Xanax use (unprescribed). He was designated a P2 and seen by Dr. Ward for medication management. He was seen by MH several times upon request, often asking for new meds or medication changes. On 11/24, was referred to P3 level of care for further observation of his reported symptoms and admitted to RTU. He was sent to Stroger 12/5 due to reported symptoms of stroke, but stroke was not confirmed on imaging. Psychiatry and

neurology believed that patient's tremor and dysarthria was secondary to EPS and Haldol administration. He was transferred back to the jail and the infirmary on 12/9. He was admitted to RTU on 2/2. It appeared he went back to the infirmary from 2/7-3/2. Neurology saw patient in mid-March and noticed bradykinesia and other symptoms. They noted that he had a d/o schizophrenia.

Psychiatry:
10/6: Dr. Ward saw patient as a consult while patient was in detox. Patient reported AH in addition to PTSD symptoms. Dr. Ward diagnosed him with Undifferentiated Schizophrenia and PTSD. She started him on Remeron and Thorazine and recommended f/u in 6-8 weeks.
11/5: Seen by Dr. Ward. Stated his medication did not work and cannot sleep. Continued to endorse AH. Dr. Ward confirmed d/o schizophrenia. She changed medications to Haldol and Trazodone. F/u for 8-12 weeks.
11/24: Seen by Dr. Ward. Increased Haldol and Trazodone due to subjective complaints. Referred to P3 level.
12/7: Seen at Stroger by Dr. Watts as a psychiatric consultation. Dr. Watts noted that patient's presentation was not consistent with psychosis. Dr. Watts reviewed multiple past outpatient notes for patient. He recommended that all antipsychotics be stopped, stopped Trazodone and started Doxepin. His primary diagnoses were PTSD and Alcohol Dependence. Haldol had been stopped while at Stroger due to possible EPS.
12/10: Seen by Dr. Paschos as a consultation after patient returned from Stroger. Medications had been restarted by Dr. Kelner. Patient was restarted on same regimen as he received prior to Stroger transfer-which included Haldol and Trazodone. Patient asked for Doxepin but was not aware he was receiving Trazodone. Benadryl added for sleep, diagnoses were carried over from pre-Stroger evaluation (Schizophrenia, PTSD, Alcohol Abuse).
12/22: Seen by Dr. Paschos as a consultation. Patient continued to c/o insomnia. Dr. Paschos noted recent eval at Stroger and subjective c/o EPS in the past. He did not believe that patient showed signs of EPS on exam and he increased patient's Haldol. No change in diagnoses.
2/1: Seen by Dr. McNeal. Patient stated that he is drooling and feels sedated. He asked for Haldol to be stopped. Dr. McNeal reviewed patient's course including his stay at Stroger. She noted that patient's symptoms were atypical and his main focus has been sleep. He was not showing objective signs of psychosis. She decreased both Haldol and Trazodone. Carried over diagnoses. He was to return for f/u in 2 weeks.
3/22: Seen by Dr. McNeal. Patient complained of potential restless legs. Dr. McNeal noted that his psychotic disorder diagnosis is questionable. She diagnosed him with primary dx as alcohol abuse. She switched him from Haldol to Risperdal and increased Trazodone per patient request.

Group and Individual Sessions:
2/1-/2/6: Only attended a few groups. Refused 3 days in a row.
3/2-4/1: Intermittently attended groups.
3/9: Individual session.
4/1-present: It appeared that patient intermittently attended groups.

Assessment: Documentation by Dr. McNeal was very good and noted the patient's course, charts reviewed, and assessment which was integrated into his plan of care. One potential area of improvement was related to diagnosis. It appeared that patients diagnosis and medications were carried over after his Stroger assessment, though neurology and psychiatry at Stroger had raised concern about patient's antipsychotic medication and the need for this given ? of EPS. Would recommend that for continuity purposes, a patient's notes and discharge summary is reviewed and noted in documentation upon return from medical hospitalization. Patient was also seen by a number of different psychiatric providers and it appeared his diagnoses was carried over from encounter to encounter, though questions remained whether he experienced true psychosis. If patients are unable to be seen by a recurring provider, would recommend that increased collaboration occur between providers or more detailed thought process in notes so that when the subsequent provider evaluates the patient, he/she may review the chart and be alerted as to the prior provider's concerns and focus of treatment.

P2 Charts and Patient Data

Patient #1: C.C.
Identifying Information: Patient is a 42 y/o M with h/o heroin abuse and h/o psychotropic medication while in prison but unclear psychiatric diagnosis, incarcerated on March 26, 2015.

Interval History: Patient seen by MH for intake on 12/17, unclear source of referral. He reported taking Haldol and Remeron when at the prison and he was referred to psychiatry. He was seen initially by psychiatry on 12/23.

Psychiatry:
12/23: Dr. Advani saw patient. Patient stated he did not want medications and had no issues. Dr. Advani stated he would try to get records from DOC, no meds at that time and RTC in 3 months. Designated as P2.
2/2: Seen by Dr. Ward. Started on Remeron for anxiety. F/u in 8-12 weeks. Diagnoses of Anxiety and Heroin Abuse.
3/15: Seen by Dr. Ward. Continued on Remeron. F/u for 8-12 weeks.

Group Sessions:
12/31: Coping Skills, attended.
1/27: Seen in MH clinic by Ms. Thigpen.

Assessment: Patient received an adequate, timely level of mental health services. He saw psychiatry on a routine basis, even more frequently than indicated in the notes.

Patient #2: L.T.
Identifying Information: Patient is a 55 y/o M with h/o depression and multiple medical problems, incarcerated on October 29, 2014.

Interval History:

Patient initially seen by MH on 12/1/15 in response to HSR in which he stated he was depressed. He was referred for supportive counseling and consistently saw MH for sessions in December and the early part of January. He saw psychiatry twice as noted below.

Psychiatry:
1/1/16: Seen by Dr. McNeal. She diagnosed him with depression and started Remeron. F/u for 8-12 weeks. Diagnosed with Heroin Abuse and Depressed Mood.
2/9: Seen by Dr. Ward. Remeron renewed. Diagnoses carried over.

Group/Individual Sessions:
12/8, 12/17, 12/24, 1/8, Individual Sessions
2/4: Anger Mgt group-attended
3/17: Music therapy-attended.

Assessment:
Patient received an adequate level of MH services. He was seen by psychiatry in a routine manner, albeit by different providers. It was unclear if he was to continue with individual sessions, as his therapy notes did not indicate when he was next to follow up.

Patient #3: J.H.
Identifying Information: Patient is a 38 y/o M with referral to MH due to reported history of taking psychotropic medication but unclear psychiatric diagnosis. He was incarcerated on November 11, 2014.

Interval History: Patient seen by MH on 11/13/14 and was referred to psychiatry. He was first seen by psychiatry on 11/8/14 and has consistently seen psychiatric providers since that time and remained on a P2 level.

Psychiatry:
11/18/14: Seen by PA Ms. Kalman. Diagnosed with schizophrenia and noted that she would restart medications but note does not indicate what meds were started. Noted that patient was to go out on EM that week.
12/9: Seen by Dr. McNeal. Continued Effexor and Thorazine. Continued d/o schizophrenia.
1/2-Seen by PA Kalman. She increased Effexor.
1/22: Seen by Dr. Ward. Increased Effexor and started Benadryl. RTC in 2 months.
3/2: Seen by Dr. Ward. Noted depressed mood. Stopped Benadryl and started Remeron. Continued Effexor. RTC in 2 months.
6/9: Seen by Dr. Marri. Diagnosed him with depression, continued meds and RTC in 8 weeks.
8/11: Seen by Dr. Marri. Dx of depression and insomnia. Sleep hygiene. RTC 8 weeks.
10/13: Seen by Dr. Ward. Discontinue Effexor and raised Remeron. RTC 6-8 weeks.
11/20: Seen by Dr. Ward. Diagnosed with Mood Disorder and Geodon added to Remeron.
1/7: Seen by Dr. Ward. Meds renewed. RTC in 8-12 weeks.

3/9: Seen by Dr. Ward. Increased Geodon. RTC 8-12 weeks.
4/15: Seen by Dr. Ward. No med changes. RTC 8-12 weeks.

Mental Health/Group/Individual Contacts:
11/25/14: Seen by MH to discuss SW needs.
11/26: Seen in MH clinic.
12/7: Seen by MH for clearance for seg.
1/20: Asked to see psychiatrist about Benadryl.
4/9: Seen for clearance to seg.
7/1: Music therapy-attended
7/3: Community mtg-attended
7/11: Seg clearance.
9/8: Community mtg
9/26: allegedly throwing Effexor in the trash.
10/27: Group
11/17: group
12/2: Group
12/22: Group
2/8: Group
3/7: Anger mgt
3/14: Anger mgt
4/4: Anger mgt

Assessment: Patient received an adequate level of care. He received psychiatric services in a timely and routine manner-often seeing a psychiatrist well before the recommended follow up times.

Patient #3: E.S.
Identifying Information: Patient is a 41 y/o M with reported h/o psychotic and/or bipolar disorder, incarcerated since January 17, 2015.

Interval History: Patient referred to MH on intake due to his reported history of psychiatric issues. He was reported a hospital takeover but not seen in RCDC. He was deemed safe for Division 6 when in intake but while there he became disorganized and agitated and was transferred to 2N on 1/20 or 1/21. He was eventually transferred to 2S and deemed safe for discharge on 2/17 to P3 status. Patient remained in RTU until 10/6 at which point he was deemed appropriate for transition to P2 status.

Psychiatry:
1/23-2/17/: Dr. Paschos saw patient while he was on 2N. Diagnosed with psychosis and started prn and scheduled Thorazine. Patient seen consistently by psychiatric providers while on 2N and then 2S. Medications at discharge were Thorazine prn and Depakote scheduled.
3/31: Dr. Advani saw patient. Obtained Depakote level, started Zyprexa. Continued d/o psychosis.

4/30: Seen by Dr. McNeal. Ongoing AH and anxiety, increased Zyprexa. F/u in 4 weeks.
6/1: Seen by Dr. McNeal. Added Hydroxyzine. RTC 4 weeks.
7/2: Seen by Dr. Advani. Increased Zyprexa.
8/10: Seen by Dr. McNeal. No changes, consider P2. RTC 4-6 weeks.
9/18: Seen by Dr. McNeal. Increased Zyprexa, to check lipids at next apt. F/u 4 weeks.
10/28: Seen by Dr. Ward. Started Trazodone. RTC 4-6 weeks.
1/7: Seen by Dr. Ward. Med renewal. RTC 8-12 weeks.
4/8: Seen by Dr. Ward. Diagnosis of schizophrenia made this visit. Increased Zyprexa.

Group Contacts:
Attended groups throughout RTU stay.
November 2015: Offered and attended 2 groups
December 2015: Offered and attended 1 group
February 2016: Offered and attended 1 group
April 2016: Offered and attended 1 group

Assessment:
Patient received an adequate level of mental health care. One psychiatry note recommended f/u within 4-6 weeks and patient was next seen in 9 weeks, which would still be within a 3 month time frame.

Patient #4: M.U.
Identifying Information: Patient is a 43 y/o F with h/o opioid dependence and anxiety with h/o outpatient psychiatric treatment, incarcerated on November 15, 2015.

Interval History: Upon intake into the jail, the patient was referred to outpatient psychiatry. It appeared she left the jail and returned on 1/30. She was seen by MH again on 1/30 for intake and referred to psychiatry given h/o recent heroin use and reported anxiety symptoms. Designated a P2.

Psychiatry:
2/17: Seen by Dr. Advani. Diagnoses of Benzo Dependence, Opioid Dependence and Adjustment D/o. Started Zoloft and Trazodone. RTC 8-12 weeks.
4/11: Seen by Dr. Menezes. Stopped Trazodone due to headache. Increased Zoloft and added Remeron. Diagnosis unchanged.

Group Contact:
February: 2016: Offered and attended 3 groups.
March 2016: Offered and attended 4 groups.
April 2016: Offered and attended 1 group.

Assessment: This patient was receiving an appropriate level of mental health care.

Summary of Observations:

Frequency of Psychiatry Visits:

With few exceptions, patients were seen within the recommended timeframe (maximum of every four weeks while in RTU and maximum of every three months as P2s). Some notes did not indicate a recommended time to return to clinic so this metric was difficult to track. However, psychiatric follow-up for inmates transferred from the PSCU to the RTU was not timely.

Consistency/Continuity of Plan of Care: The plan and assessment aspect of documentation was variable. Some clinicians were specific in their targets of intervention and indications for medication changes while other notes made no or limited mention of rationale for therapies. With one patient, it appeared that hospital notes (upon return) were not reviewed or at least incorporated into the plan of care, at least not within a timely manner. Several patients had a myriad of providers throughout their course, but this usually appeared to be a function of location (i.e., moved between units or different levels of care) rather than a function of provider availability.

Diagnosis: Diagnoses largely remained unchanged from visit to visit and were carried over when seen by a new provider. The diagnoses remained consistent. When a patient was seen by a new provider, it often was unclear whether the new provider had reviewed the chart and/or done a new, independent assessment of the patient in order to arrive at their diagnosis and plan.