Kerry C. Hughes, M.D.
1579 Monroe Dr., Suite F Box 612
Atlanta, GA 30324
Phone: 404-277-4912
Fax: 404-364-9708
Email: dockc99@aol.com

Doña Ana County Jail Mental Health Consultant's Report

April 2015

Overview

The Doña Ana County Detention Center (DACDC) was visited from April 27, 2015 to April 30, 2015 at the request of the County. This was the third yearly visit to the jail after the resolution of the Stipulated Settlement Agreement regarding the Bravo litigation. The purpose of the visit was to review, evaluate and make recommendations regarding the mental health services provided at the facility.

This visit included tours of the various housing units at the facility, including the mental health housing units and office space on the Delta unit, the women's mental health and segregation units, the Fox, Shu, Echo and Bravo segregation units, general population units as well as the booking and medical units. The visit also included interviews with detainees and facility staff, as well as review of medical records and provided documents regarding quality assurance, suicide prevention and mental health care at the facility. Lastly, various mental health related activities were also observed, including segregation rounds, group therapy on the mental health units and the mental health treatment team meeting.

This visit indicated that the jail continued to provide quality mental health services for the detainees housed at the facility. Prior improvements that occurred during the litigation were maintained, and in some cases expanded and augmented. The mental health and custody staff

also remained open to additional recommendations and concerns noted during this visit. The D2 and D4 mental health areas appeared to be working very well. Clinical contacts were timely and therapeutic. Group therapy remained available for male and female detainees housed in some segregation units and in the mental health units. Segregation rounds also continued, and were even expanded for general population detainees who had been placed on lockdown with restricted programming.

It should also be noted that the mental health staff remained stable, dedicated, competent and knowledgeable regarding the detainees that they treated. There was also good leadership in place, including custody, mental health and medical which helped to maintain and improve upon past recommendations.

There were some recent changes that occurred at the facility that impacted the mental health services that were provided. There was a significant decrease in population from the mid-700s to approximately 632 detainees at the time of the visit. For this and other reasons, plans were underway to move juvenile detainees to the main jail facility in the Fox 2 unit. Modifications were underway at the time of the visit to accommodate the juveniles on this unit. This move also resulted in the movement of other units within the jail, including movement of the Fox Halcyon unit to Fox 1. Additionally the men's mental health units were condensed into one unit, Delta 4.

Current obstacles in the provision of mental health services at the jail included the custody staffing, which was at times insufficient and led to some decreases in evening and weekend programming. In addition, the size of the medical unit has been a long-standing issue. The current number of beds on this unit has been insufficient in the housing of medical and mental health detainees in need of increased monitoring and stabilization. This has resulted in daily

movement of individuals into and out of the unit to make way for more acute individuals. Lastly, a review of records and observations at this visit indicated that detainees with serious mental illness were being housed in the Bravo segregation units. As part of the prior litigation, the jail attempted to prevent housing of detainees with a history of current serious mental illness on these units due to the unit configuration which included limited social interactions and cells with limited visibility. This type of sensory deprivation and isolation on such units may lead to decompensation and worsening of mental health symptoms in vulnerable individuals.

Staffing

The level of mental health staffing remained constant during the past year. Information provided indicated that the mental health staffing was as follows:

1.00 FTE Psychiatrist

1.00 FTE Psychiatric Nurse Practitioner

2.00 FTE Mental Health Registered Nurses

4.00 FTE Mental Health Counselors

- Three counselors were in place at the time of the visit, and one of the mental health technicians would occupy the fourth position within several weeks of the visit.

3.4 FTE Mental Health Technicians

Dr. Castillo, the psychiatrist continued to function as the team leader. Previous workload issues (backlogs) appeared to be significantly improved, and clinicians were up to date with clinical contacts. It appeared that the overall mental health staffing was sufficient, and the detainees interviewed during the visit appeared to be receiving appropriate mental health treatment. Group

therapy continued on Saturdays, but some evening and weekend programming was decreased due to custody staffing limitations.

Detainees who were interviewed denied problems with access to or delays in obtaining mental health care. The current level of mental health staffing appeared to be adequate for the provision of mental health care at the facility.

Intake

The facility maintained the achievements in this area that were accomplished during the litigation and improved in some areas. Detainees who arrived at the facility continued to be housed in the intake area until intake processing was completed and more permanent housing was secured. The intake assessment form utilized in screening was included in the Catalyst electronic system and incorporated many of the components identified in the Settlement Agreement. Medical records also included a form that was completed by the transport officer regarding information about detainees, including mental health/medical symptoms, intoxication and suicidal behavior. It also appeared that detainees were processed through booking in less than 72 hours. This was an area of improvement. Although there did not appear to be formal audits performed to monitor the time in booking, this issue appeared to be much improved with timely movement of detainees out of booking.

Access to mental health services also appeared to be much improved in booking for several reasons. Kiosks were placed in the booking cells, allowing for immediate access to custody and medical/mental health services. Additionally, mental health technicians provided daily rounds in the booking areas.

There continued to be separate areas for male and female detainees in booking. At the last visit, there were detainees without beds sleeping in temporary boats. This issue was not observed at this visit.

Post-Intake Mental Health Services

The jail continued to have a good system in place for comprehensive mental health assessment after booking. The system for mental health referral and triage also remained in place, with a mental health nurse responding to referrals and mental health counselors providing triage on weekends.

Mental Health Units

The decision was made to discontinue transfer of inmates to Mesilla Valley Hospital (MVP) for mental health stabilization, with instead movement of mental health inmates into the Delta unit. This process appeared to be working very well. The D2 unit was modified into mental health offices, and the D4 unit was modified into the male mental health housing unit. Fencing was installed in D3 and D4 to deter jumping from the second tier. A waiting area was developed in D2 so detainees could be transferred to this area by custody staff to be seen by their clinicians, and this process greatly improved the efficiency of providers. This setting provided a positive and professional environment for detainees and staff for clinical appointments. Custody staff assisted with security as well as in efficient movement of detainees for clinical appointments.

Mental health programming for male inmates continued in the D4 unit. As the mental health unit had close proximity to the mental health offices, this allowed for timely access to clinical services.

Echo 2 remained as the mental health unit for women, and Echo 4 continued as the segregation unit for women. New fencing was installed on the second level and stairs of the female mental health unit, allowing for increased safety and deterrence from jumping.

Group therapy

Male and female detainees who were housed in the mental health units and some segregation units were provided group therapy daily Monday to Friday with some weekends, depending upon custody staffing. The expert observed group therapy in all of the program areas; the groups were well run and appeared to be very beneficial for the detainees who participated.

Individual therapy

Mental health counselors scheduled detainees for individual therapy and follow-up evaluation. This therapy was provided to detainees who were housed in the mental health and segregation units as well as for some individual who were housed in general population. This appeared to be a very beneficial and necessary service for those detainees who were identified as needing this type of therapy.

Mental health technicians provided daily mental health rounds in male and female mental health housing units. These rounds were observed, and they provided additional clinical contact and assessment. Detainees were asked to develop daily goals which were discussed later during the day by the mental health technicians.

Weekly treatment team meetings continued and included clinical discussions of all inmates in the mental health units, disciplinary and administrative segregation, SHU and the medical unit. The expert attended this meeting; the meeting continued to show improvement. The staff was well

acquainted with the detainees staffed during the meeting, and treatment planning was discussed. There was very good interdisciplinary discussion during the meeting, including active and consistent custody involvement. Topics during the meeting included discussion regarding movement into and out of the above units, discussion about patients for whom the staff had concerns and other related clinical issues. The routine presence of higher level custody staff at this meeting greatly benefitted this process.

Segregation units

Daily rounds were conducted by the mental health techs in all of the segregation units (including Fox 1, Bravo, SHU, Echo 2 and general population units on lockdown). The nurse practitioner also conducted rounds with the mental health technicians weekly. The psychiatrist and mental health nurse practitioner continued to provide evaluations of detainees who were initially placed into segregation.

Group therapy was provided for mental health detainees who were housed in the Fox1 Halcyon segregation unit. This therapy was very beneficial for these individuals, as it helped to mitigate the isolation of placement in segregation for these male segregation detainees. Patients in the segregation units continued to be seen for individual sessions with the psychiatrist, nurse practitioner and counselors.

As was previously mentioned, I have significant concerns regarding the placement of severely mentally ill inmates in the Bravo segregation units. There were some very ill inmates with active psychosis that have routinely been placed in the Bravo unit. The sensory deprivation of that unit is not beneficial for these detainees, and in fact can exacerbate their illness. I would strongly discourage the placement of severely mentally ill detainees in the Bravo unit.

Correctional systems are increasingly examining their practice of placement of severely mentally ill individuals in these segregated settings. Colorado and California state prisons have already placed restrictions against this type of placement. The facility should examine alternatives to the placement of these detainees in this setting

Since the last visit, kiosks were placed in the Bravo cells allowing for contact with custody, medical and mental health for grievances, requests and referrals.

The facility should be commended for the mental health rounds in general population units that were placed on limited programming. These rounds may not; however, be necessary in the X unit, where detainees were housed in four man dormitories, had intercom systems to contact custody in cell, and were provided with daily contact with medical via medication passes. Daily rounding should; however, continue for those units where detainees were single-celled and had limited programming.

Medical Unit

Detainees were seen Monday to Friday by the mental health nurse and psychiatrist while housed on the medical unit. These patients were also seen daily for mental health technician rounds in medical unit. There was good documentation of clinical contacts and the treatment provided on this unit. Kiosks and televisions had been installed in the medical cells allowing for immediate contact with staff and alleviating boredom for long term occupants.

Since the last visit, the facility had implemented a daily medical/mental health debriefing. This meeting included participation by the mental health nurse, psychiatrist and medical staff in the medical unit. During this meeting, all patients were discussed with emphasis on patients with combined medical and mental health concerns.

Although several detainees housed in unit exhibited symptoms of severe mental illness, none appeared to be in need of inpatient care at the time of the visit.

The size of the medical unit provided challenges, requiring constant determination of what patient could be moved out so that a more acute individual could be placed on the unit. The limited size of the medical unit also appeared to result in pressure on the mental health staff to move mentally ill individuals to less optimal and potentially unsafe settings, such as the Bravo segregation unit.

Seclusion and restraint use

Since the last visit, the facility implemented a new authorization and removal form for restraint chair usage. The facility also began monitoring the use of the restraint chair and seclusion in the padded cell.

Regarding restraint chair usage, audits from December 2014 to March 2015 indicated that there were between two and four instances of restraint chair usage for all months with the exception of December when there were eight incidents. Despite the increased usage of the restraint chair during December, seven of the incidents involved the same detainee. A review of the duration of restraint chair use indicated that the incidents were brief and were primarily for self-injurious behavior.

Regarding seclusion in the padded cell, the facility reported that there were a total of 62 incidents during the same four month period, averaging 15.5 incidents per month. The duration of seclusion ranged from less than one hour to as long as three days. The rationale for placement into the padded cell was overwhelmingly reported as "ideation"; in only two of the incidents was the reason for placement listed as "ideation/gesture". The use of the padded cell and seclusion

for suicidal ideation only and not actual behavior or threats might be possibly interpreted as punitive. The lack of needed observation cells in the medical unit may have resulted in the placement of individuals in the padded cell as no other cell was available in the medical unit. The facility should better document the rationale for placement into the padded cell, and ensure that individuals are not secluded if they do not pose acute risk of self-harm or pose acute risk of harm to others.

Access to Inpatient care

This expert was concerned regarding access to higher levels of care (inpatient mental health treatment) even with the completion of the Delta units and the other positive developments that have occurred at the DACDC. It did appear that the facility had aggressively pursued the identification of treatment guardians when indicated to improve timely transfer of detainees for inpatient care.

There remains a need for more adequate treatment space and/or inpatient care for a segment of the population who are severely mentally ill, who may be dangerous to themselves or others and for whom the jail is unable to adequately manage with the current resources available. The issue of the placement of severely mentally ill individuals in Bravo may be a result of this lack of access to appropriate treatment space and/or inpatient mental health services.

Training

All officers were provided with yearly in-person refresher training that included suicide prevention; in addition they reportedly received on-line training that occurred yearly that also included suicide prevention training.

There was a need for additional mental health training for custody officers in light of many new custody staff hired and turnover. Training should include suicide prevention, recognition of signs and symptoms of mental illness and the indicators for mental health referral which would be greatly beneficial and would also make general population rounding for dormitories with limited programming less necessary.

This training should also utilize mental health staff to better facilitate team building. Corizon, the medical/mental health contractor, has a correctional staff training module that might be utilized that includes the necessary topics for mental health custody training.

Suicide Prevention

There was a serious suicide attempt that occurred on 3/20/15. There was no formal mortality and morbidity review that occurred after this incident that included jail custody, medical and mental health staff to review the incident and to make coordinated recommendations for corrective action. A formal mortality and morbidity review should occur with all completed suicides as well as with all serious suicide attempts. Although a formal meeting did not occur, it appeared that discussions occurred on an informal basis, as evidenced by the placement of fencing in the female unit second floor and stairway which was a good suicide prevention measure.

Facility supervisory staff also reported that modifications were underway to loosen the hooks in the cells in the Fox 1 Halcyon segregation unit to prevent ligature tie-off opportunities with plans to eventually remove the hooks. These were also good suicide prevention measures.

Quality Improvement

Minutes were provided that indicated that the Medical Audit Committee and the Quality Improvement meetings occurred every other month and were active. A recommendation that was made at the last visit included the performance of site specific audits in addition to the Corizon mandated quality improvement audits that occurred. The facility followed this recommendation and has since audited the use of the padded cell and restraint usage. The facility should be commended for instituting these additional audits which have reportedly been beneficial in the management of these issues.

Grievances

Grievances were reviewed for January 2015 to March 2015. There were few, if any mental health grievances submitted. No systemic mental health concerns were noted. None of the justified grievances were mental health related. Grievances were responded to by the triage nurse and were reviewed by the Director of Nursing, and subsequently by the healthcare administrator.

The low number of justified mental health grievances implied satisfaction with mental health services that were provided at DACDC.

Summary and Recommendations

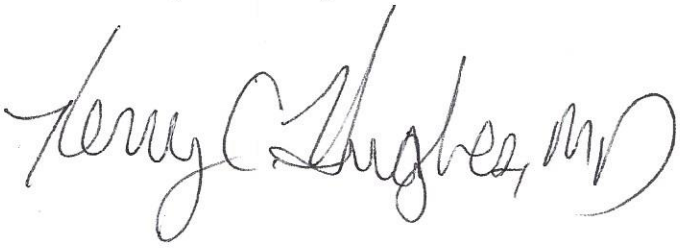
I want to thank the County and jail administrative staff for again allowing me the opportunity to return to the DACDC for this annual review of mental health services. The leadership at the jail remains committed to providing quality mental health services, and they have been open and receptive to recommendations for improvement.

There are several areas of needed improvement and focus that were identified at this visit. Recommendations include the following:

1. The facility should examine alternative placement of severely mentally ill individual other than the Bravo segregation unit.
2. The facility should continue to work to better obtain access to inpatient mental health services.
3. The facility should better document the rationale for placement into the padded cell, and ensure that individuals are not secluded if they do not pose acute risk of self-harm or pose acute risk of harm to others.
4. The County should investigate options for increasing the size of the medical unit to allow for better and expanded monitoring of severely ill detainees.
5. The facility should implement a mortality and morbidity review process that includes review of critical incidents such as serious suicide attempts and provides critical analysis and corrective action.
6. The facility should continue to assess suicide prevention measures and work to minimize and eliminate (as much as possible) in-cell issues that can result in self-harm, such as hooks in Fox segregation cells.
7. It would be beneficial for the facility to resume the tracking of length of stay in intake to ensure that detainees do not remain in this area for extended periods of time.
8. The facility should expand custody and staff training to include the areas outlined and to provide this training on an ongoing basis.
9. The local quality improvement committee should continue to identify issues for ongoing auditing and quality assurance.
10. The facility should continue to examine custody staffing availability to ensure that the effect on mental health programming is minimized.

Please feel free to contact me should you have any questions or concerns regarding this report.

Respectfully submitted,



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