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 Final Report December 11, 2016

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MEMORANDUM

TO: Donald J. Pechous, Esq.
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P.O. Box 66400
Washington, DC 20035-6400

FROM: Jeffrey L. Metzner, M.D.
DATE: December 11, 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 November14-18, 2016.

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,
2. interviews with many inmates in group settings in Division 8 (RTU and the Cermak units) and Division 2,
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. Linda Follenweider, R.N., N.P. (Acting Chief Operating Officer Hospital Based Services),
    c. Connie Mennella, M.D. (Chair, Department of Correctional Health Services),
    d. Nneka Jones, Psy.D. (First Assistant Executive Director),
    e. Kenya Key, Psy.D. (Chief of Psychology),
    f. David Kelner, M.D. (Chief of Psychiatry).

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 November 15, 2016 was 8,029

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 seventeen 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.

The psychiatric vacancies were all filled during August 2018 via full-time employees, part-time employees and contract employees. Attachment B provides a summary of the current staffing

allocations and vacancy rate.

Information Requests

Appendix V summarizes my revised document request for my next site assessment scheduled for April 10-14, 2017.

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

Sincerely,

Jeffrey L. Metzner, M.D.

Executive Summary—Thirteenth Monitoring Report (Mental Health Provisions)

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

1. Since August 2016, there been no functional vacant psychiatrists' positions.

2. Compliance has been achieved re: meeting timeframes by psychiatrists in response to emergent, urgent and routine referrals.

3. Compliance has been achieved with the provisions of the Agreed Order regarding infirmary psychiatric care.

4. Continued improvement in the mental health programming (both in quantity and quality) for inmates in the RTU.

5. Continued implementation of the Intensive Management Unit (IMU) in the RTU.

6. Continued improvement in the quality improvement process, which remains in substantial compliance.

7. An additional 14.0 FTE mental health specialists' positions have been funded.

CCDOC has continued to implement 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 at least three hours per day. In addition, the custody staff is providing increased correctional programming on a weekly basis to inmates who are willing to participate.

The leadership of Kenya Key (Chief Psychologist, Ph.D.), David Kelner, M.D. (Chief Psychiatrist) and Carlos Gomez, Psy.D., Linda Follenweider, R.N., N.P (Acting Chief Operating Officer Hospital Based Services), and Connie Mennella, M.D. is impressive. The working relationships between CCDOC and Cermak staffs continues to improve and is good.

An additional four provisions have now been in compliance for at least 18 months, which means a total of 16 provisions have been in compliance for at least 18 months.

Three (3) provision previously in partial compliance are now in substantial compliance, which means there are now four (4) provisions that have substantial compliance for less than 18 months.

A total of five (5) provisions remain in partial compliance, although three of these provisions are essentially related to staffing vacancies and/or allocation funding issues. Mental health leadership will be working with me to complete a staffing needs analysis by January 1, 2017.

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

1. Mental health staff vacancies and/or allocation issues, which impact both the RTU and

outpatient levels of mental healthcare services.
2. The need for increased structured therapeutic time for RTU inmates as well as unstructured time in the recreational areas.
3. The current lack of adequate mental health programing for SMU RTU segregation inmates.
4. The current lack of adequate mental health programming for protective custody RTU inmates.

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):

Bolded provisions indicate that the provisions have been in substantial compliance for more than 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)

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. (11/16)

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. (11/16)

h. Inmates shall have access to appropriate infirmary psychiatric care when clinically appropriate. (11/16)

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.**

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 is as follows:

59. Assessment and Treatment

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.

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.

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 ANALYTICS AND RESEARCH
BUSINESS INTELLIGENCE UNIT

Sheriff's Daily Report
11/15/2016

Under the Custody of the Sheriff	
TOTAL MALE AND FEMALE	10,274
Jail Population	8,029
Community Corrections	2,245

Jail Population	
TOTAL MALE AND FEMALE	8,029
General Population (Male)	6,759
General Population (Female)	534
VRIC (Court Ordered)	13
PRC (Court Ordered Drug Treatment Program)	488
Women's Residential (Court Ordered Drug Treatment Program)	115
Outside Counties	107
Hospital	13

Community Corrections Population	
TOTAL MALE AND FEMALE	2,245
Electronic Monitoring (Court Ordered)	
Men	1,931
Women	288
Electronic Monitoring (Admin Ordered)	
Men	0
Women	0
M.O.M.s Program (Court Ordered)	2
VRIC Post Release (Court Ordered)	24

COOK COUNTY SHERIFF'S OFFICE
BUREAU OF ANALYTICS AND RESEARCH
BUSINESS INTELLIGENCE UNIT

Cook County Department of Corrections Executive Director's Log

Tuesday, November 15, 2016 — Prepared By: F. Khan

Totals:	8,029	100%	
Male	7,380	92%	
Female	649	8%	

	Male	Female	Total	Capacity	No Place To Stay
Div 1	0	-	0	1,250	0
Div 2	1,732	-	1,732	1,960	64
Div 3	0	-	0	360	0
3 Annex	666	-	666	768	11
Cermak	105	24	129	148	46
Div 4	-	281	281	552	2
Div 5	0	-	0	992	0
Div 6	913	-	913	992	6
Div 08	675	229	904	979	7
Div 9	912	-	912	1,066	2
Div 10	738	-	738	768	2
Div 11	1,506	-	1,506	1,536	6
Div 17 W. Residential	-	115	115	152	0
Div 15 - HP	13	-	13	-	0
VRIC In Camp	13	-	13	-	0
Outlying Counties	107	-	107	-	0
Totals:	7,380	649	8,029	11,523	146

COOK COUNTY SHERIFF'S OFFICE
BUREAU OF ANALYTICS AND RESEARCH
BUSINESS INTELLIGENCE UNIT

Sheriff's Daily Report
11/15/2016

Under the Custody of the Sheriff	
TOTAL MALE AND FEMALE	10,274
Jail Population	8,029
Community Corrections	2,245

Jail Population	8,029	100%
Male	7,380	92%
Female	649	8%

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

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:

November 2016 Cermak Status Update

CCDOC Administration brought in the State of IL statutory compliance their disciplinary SMU process and, presently, detainees' stay in disciplinary SMU cannot exceed 29 days, whereupon,

they are removed from SMU 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 SMU screening for this cohort of detainees reentering restrictive settings. Mental health staff continues to conduct rounds on restrictive housing units at minimum weekly (in addition to the rounds conducted by Nursing/PCS). New updated universal SMU placement notification sheet has been created and implemented. 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. Please refer back to Div. IX updtaes for discussion. Please see PDF Appendix for SMU Screening Compliance data.

To centralize the notification to Cermak mental health and nursing staff of detainees placed in Special Management Units, both agencies agreed upon a revised process that mimics the successful bed control notification process. Cermak leadership will be creating an SMU Notification email address that will be used by the DOC Classification unit to provide daily notifications.

November 2016 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.

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 Metzner assessment: Substantial compliance continues

November 2016 Cermak Status Update

See PDF Appendix for Suicide Detection and Prevention QI Report Qtr. 1-3 2016

November 2016 Metzner assessment: Results of the above referenced QI report were consistent with continued compliance.

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)

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 2016 Cermak Status Update

Please refer to QI reports referenced in provision #62.

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

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

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:

November 2016 Cermak Status Update

Several additional QI projects have been undertaken since the last site visit, referenced throughout this report and/or found in the PDF Appendix.

Mental Health Disposition at Intake
Psychiatric Diagnoses, Self-Injury, and Disciplinary Status of "High Disruption" Detainees
Disciplinary Beds in Segregation & Self-Injury
Cermak Dayroom Hours
HSRF Reason for Delay/Not Seen

November 2016 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. 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: Compliance (11/16)

Factual Findings:

November 2016 Cermak Status Update

October 2016
Total Jail Population as of 10/13/2016: 8,226

P2-Outpatient Mental Health	1711	20.7% (of total)	76.62%9(of MH load)
P3-Intermediate Mental Health	436	5.3% (of total)	19.5% (of MH load)
P4-Psych. Special Care Units	86	1.05% (of total)	3.85% (of MH load)
Mental Case Caseload	**2,233 (27.14%)**		

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%)**

The number of patients on Mental Health Caseload has remained relatively stable. Furthermore, the proportion of detainees in Intermediate Level of Care and Outpatient Level of Care– P3 and P2, respectively, has remained constant. Various diversion programs at CCDOC has not diminished the proportion of the seriously mentally ill and the violent offenders.

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

Cermak has been requesting records from community providers, primarily from Intake/RCDC. In June 2016, a system-wide employment displacement took place that resulted in Cermak losing the Health Information Management Department staffer that was coordinating this process. It took several months to identify a new individual to take on this process and to catch up with the back log. Data for October 2016 was used to conduct a review of this process as the data for this month was the most complete and accurate.

Once an ROI is executed, it is forwarded to Dr. Gomez for review to ensure all fields are completed and that it is valid. Dr. Gomez then forwards the requests to the coordinator who logs the ROI in an Excel database and sends the ROI to the community provider. All records are send back to the coordinator. Upon receipt, the coordinator logs the return date in the same Excel database and forwards the records to the MH department administrative staff. The mental health department administrative staff determine whether the pt is still in custody and forwards the records for those in custody to the requester or the supervising psychologist of the Housing Unit where the patient is currently housed. Upon receipt, the requester enters a brief summary of the records into Cerner, shares the information with the clinical team—including the psychiatrist—and forwards relevant records to HIMD for scanning into Cerner. Reviewed medical records are scanned to the initial date of admission to CCDOC. If a patient is no longer in custody, the records are forwarded to Dr. Gomez who then includes the summary in Cerner and forwards relevant records to HIMD for scanning into Cerner.

In October 2016, 173 requests were sent out for behavioral health records to community providers. As of 11/2/16, 83 (48%) of the records had been received within an average turn-around time of 7.3 calendar days. The 90 records that have not been received have been

outstanding for an average of 17.3 days. The coordinator contacts all providers who have not sent records within 20 calendar days. A review of the agencies that have not returned records revealed only that these agencies are very diverse but almost all of them are private hospitals or clinics.

As of October 2016 all MH Department employees completed the review of all annually reviewed/updated policies.

Cermak met with DOC Leadership and representatives of Northwestern Memorial Hospital to discuss the introduction of Computerized Adaptive Testing (CAT) in RCDC (Intake). Presently, Cermak's role is still being defined. Further meetings between CCHHS Institutional Review Board and Northwestern are pending. Issues of interface and compatibility between the research project and already existing Intake flow are to be discussed. CAT has less proven results in terms of detecting several important domains of psychopathology such as psychotic disorders and addictive disorders. It is understood that the Northwestern project will not replace already existing validated process in RCDC.

On average more than 40% of female detainees and approximately 24% of male detainees are referred for secondary mental health assessment from the initial health screening. Additionally, appropriate identification of mental illness and placement on the mental health caseload at intake remains consistently over 90%. Please see Excel Appendix for Intake Referral data.

Dr. Gomez continues 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 an ongoing audit and analysis of assessments and dispositions made by the Intake QMHP staff, find excerpts below. The full RCDC QI report can be found in the PDF Appendix.

The table and figure below reflect the disposition made by the QMHP based on the results of a comprehensive mental health assessment for both the spring and summer samples. At first glance, the data suggests two significant shifts, a marked decrease in the number of referrals to the intake psychiatrist and a subsequent increase in the number of individuals dispositioned to every level of care. However, these changes may be due the way that mental health staff document their disposition. Based on conversations with the QMHPs affected, they currently document their clinical impressions and anticipated disposition even when they referred to the intake psychiatrist—whereas in the past the staff would simply document a referral to the intake psychiatrist without noting their recommended level of care. The decision of the intake psychiatrist during the spring period was not captured in the data set. If that data were available, it is suspected that it would look very similar to the summer 2016 disposition pattern.

Table – Disposition

	Spring 2016	Summer 2016

DISPOSITION	COUNT	PERCENT	COUNT	PERCENT2
BONDED OUT	3	0.1%	0	0%
RELEASED	1	0.0%	0	0%
REFUSED	9	0.3%	0	0%
MISSING	26	0.9%	15	1%
GP	911	31.0%	353	31%
P2	1048	35.7%	492	43%
P3	279	9.5%	166	14%
P4	108	3.7%	101	9%
INTAKE PSYCH	552	18.8%	30	3%
TOTAL	2937	100%	1157	100%

Psychiatry face to face visits reflected a steady trend in the second and third quarters of 2016.

April	May	June	July	August	September
1,344	1,049	1,143	1,080	1,117	1,148

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

Order Priority	Emergency								
Status	Seen		Not Seen						Total
Month	#	%	2) Over 4hrs		4) No Note		#	%	
			#	%	#	%			
2016_9	165	97.06%	2	1.18%	3	1.76%	5	2.94%	170
2016_8	186	98.41%	1	0.53%	2	1.06%	3	1.59%	189
2016_7	172	97.18%	3	1.69%	2	1.13%	5	2.82%	177
2016_6	165	90.66%	13	7.14%	4	2.20%	17	9.34%	182
2016_5	191	97.45%	4	2.04%	1	0.51%	5	2.55%	196
2016_4	213	94.25%	11	4.87%	2	0.88%	13	5.75%	226
2016_3	210	93.33%	10	4.44%	5	2.22%	15	6.67%	225

In September 2016 97.6% detainees were seen within 4 hours (in keeping with the timeframe) when referred with Psychiatry Emergent Referral. Out of the 2.94% that were not seen timely, 1.18% were still seen in RCDC (Intake) but outside of the 4 hour timeframe. 1.76% 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.

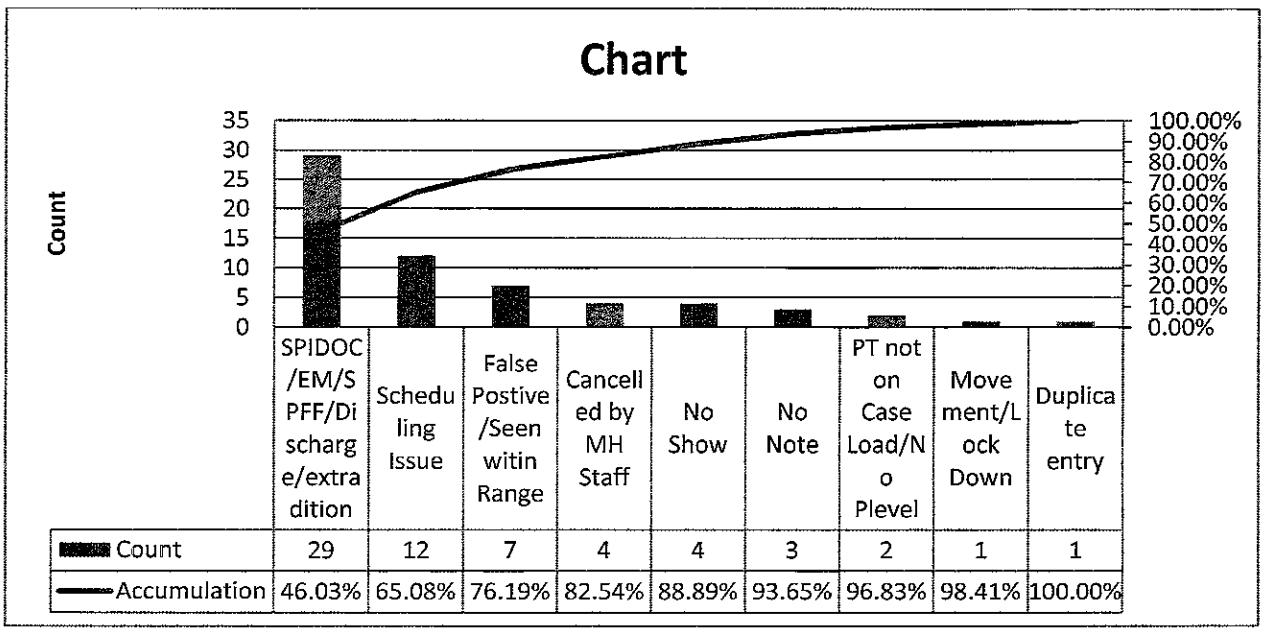
Urgent(P4)	1) Within 24 hrs		2) Over 24 hrs		No Note		Total
9_2016	93	94.%	4	4.%	2	2.%	99
8_2016	98	95.%	2	2.%	3	3.%	103
7_2016	100	89.%	10	9.%	2	2.%	112
6_2016	100	94.%	5	5.%	1	1.%	106
5_2016	93	92.%	8	8.%			101
4_2016	112	92.%	10	8.%			122
3_2016	97	90.%	8	7.%	3	3.%	108

In September 2016 94% of detainees referred for Urgent Psychiatry Referral were seen within 24 hours (in keeping with the timeframe). The 4% 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. The identification of P4s that are admitted from Intake to locations other than PSCU has been improved following an introduction of Daily PSCU Mental Health Level of Care Tracker which allows Providers review lists of patients with P-alerts in MSCU and see when notes are due. The tracker assists in identification of detainees requiring Psychiatry Consults ordered by Medical Providers in MSCU. Conversely, the tracker enables Medical Providers to identify and track detainees in PSCU who are in need of medical evaluations and follow up. The remaining detainees who did not have any notes written within the required timeframe were transferred to John Stroger Hospital due to medical problems and detox and could not be seen within 24 hours by Cermak Psychiatrists. There is a system of notifications between JSH Consultation and Liaison Psychiatrists and Cermak Providers to alert JSH C/L Service to their arrival. Furthermore, JSH belongs to/shares the same EMR so there is full access to Cermak's notes at JSH.

Routine(P2/P3)	**1) Within 14 days**		**2) Between 15-21 days**		**3) Between 22-30 days**		**4) D/C within 15 days**		**5) D/C over 15 days without Note**		**6) No Note**		**Total**
9_2016	356	58.%	19	3.%	6	1.%	162	26.%	9	1.%	62	10.%	**614**

8_2016	344	57.%	28	5.%	17	3.%	169	28.%	21	3.%	23	4.%	**602**
7_2016	324	56.%	31	5.%	4	1.%	184	32.%	21	4.%	19	3.%	**583**
6_2016	339	53.%	35	5.%	12	2.%	183	28.%	48	7.%	28	4.%	**645**
5_2016	399	59.%	17	3.%	19	3.%	175	26.%	43	6.%	25	4.%	**678**
4_2016	425	65.%	14	2.%	8	1.%	167	25.%	24	4.%	17	3.%	**655**
3_2016	485	71.%	21	3.%	4	1.%	142	21.%	24	3.%	11	2.%	**687**

Reason for No Note (6)	**Count**	**Accumulation**
SPIDOC/EM/SPFF/Discharge/extradition	29	46.03%
Scheduling Issue	12	65.08%
False Positive/Seen within Range	7	76.19%
Cancelled by MH Staff	4	82.54%
No Show	4	88.89%
No Note	3	93.65%
PT not on Case Load/No P level	2	96.83%
Movement/Lock Down	1	98.41%
Duplicate entry	1	100.00%
Grand Total	63	100.00%



In September 2016 58% detainees referred for Routine Psychiatry referral were seen within 14 days (in keeping with the timeframe). 26% were released from CCDOC within the same time-period before Psychiatry had a chance to see them. 4% were seen by Psychiatry outside of the

timeframe (but within 30 days). Chart audit for the cases that did not have Provider's notes in EMR in September 2016 revealed that, when all the false positives and discharges from custody are subtracted, the actual number of detainees not seen as Routine Psychiatry Referrals in September was 23 (3.74% of the total number of Routine Psychiatry Referrals made).

In addition to existing vacancies in Psychiatry, the following major trends have been identified as a result of the 62 chart audit/review:

- Cerner continues to capture many IDOC transfers (most of them were parole holds upon admission to CCDOC)/Electronic Monitoring releases/Furloughs/15SFFP/, and extraditions as being physically on campus and, therefore, they are seen as "never having contacts with Psychiatry". Dr. Kelner is addressing this glitch with IT.
- Scheduling and scheduling related errors remain an area of vulnerability. Cermak MH Leadership address scheduling issues with the Scheduling Supervisors.
- Some of the "No notes" were actually due to the fact that Cerner's logic was not timely updated and did not recognize one of the Locums' Providers name.

The interface between Cerner and CCOMS has been a standing agenda item in the monthly Interagency Coordinating Committee (IACC) meeting. A task list was created in August regarding discharge reactivations, which will resolve the issue of Cerner capturing transfers and facility releases. The CCSO and Cermak IT are finalizing the work contract with the third-party vendor. The interface will continue to be addressed in the IACC until the issues have been resolved.

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". Dr. Kelner submitted a request to the JSH EMR committee to introduce a discern rule/change the referral careset in order to disallow non MH staff to order Psychiatry Referrals directly. A new power form has been built to accommodate that request. 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. Ultimately, the goal is to enable only Mental Health Specialists to make appropriate referrals to Psychiatry.

MH Administration will continue to work with the Unit Directors and drill down the process so that MHS select appropriately a date within 14 days when MHS order Routine Psychiatry Referrals. The clerks/AAs responsible for the scheduling tasks do not always adhere to the 14 day timeframe. Education was provided to scheduling department as a group and individually. (Please see the Excel Appendix for data reflecting Routine Psychiatry Referrals).

Daily reports for P Level detainees returning on the compound after hospital stays (15HP) are automatically generated and available to staff. They allow providers to identify detainees who reenter CCDOC and are in need of having their medications restarted as well as those who need to be assessed for MH stability by MHS so that appropriate housing is chosen.

Urgent Care Center continued to utilize their focal 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 reliance on verbal hand offs and endorsements. Formally incorporating mental health into the flow of the urgent care will serve to minimize miscommunication, minimize missed assessments and minimize inappropriate discharge from UC.

Cermak and CCDOC has developed a collaborative process for the receipt of detainees returning from outlying counties:

1. Specific reception/processing time was designated: Saturdays 1.30PM as the start of screening in RCDC
2. If Friday is a holiday, returns are back on the compound on Saturdays; if Monday is a holiday, returns are back on Mondays
3. MH commits a MHS III to start the screening; at this point supported with OT
4. When the rest of the RCDC team arrives at 3PM, they assist in processing outlying county returns if needed
5. Every return to CCDOC must be screened by paramedics ("primary screening")
6. All detainees previously with P levels must have face to face ("seen"), some M levels will have medications renewed by Providers w/out being seen, if stable; additionally, new changes in clinical condition/new MH changes , need to have face to face
7. The following order will be followed MP's>P's>M's
8. Under certain circumstances, Medical can start seeing returns before MH, with the understanding that they may need to change orders from KOP to Dose x Dose later, in case detainees go into MH housing
9. CCDOC will assist in having PCs seen at the same time
10. Outlying Counties notify DOC liaison and RCDC Unit Director about upcoming arrivals and the list is distributed among RCDC MH staff
11. Outlying Counties provide medical records that arrive with the returning detainees
12. Chief of Psychiatry is notified of outlying county returns so that medications can be reordered.

Cermak mental health leadership previously identified several charges that warranted a DOC referral to intake mental health services. The charges included:

- 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 behavioral or wanton cruelty

DOC and Cermak mental health staff has historically had a process by which intake correctional staff verbally informed Cermak mental health staff of any detainees charged with high profile crimes. In November 2016, the DOC formalized the process by creating an alert for a "DOC Intake Mental Health Referral" for all detainees with charges related to those mentioned above. The alert is entered by DOC RCDC staff and is communicated to the Cerner electronic medical record. Due to expressed concerns regarding the interface and the possibility of the alert not transferring to Cerner, DOC will continue to notify Cermak mental health staff of such referrals verbally and through use of the alert until the interface issues are resolved.

November 2016 Metzner assessment: Significant improvement is noted re: meeting the required timeframes by the psychiatrists for completion of mental health referrals, which is the result of better tracking processes and supervision. In addition, processes have been implemented that have facilitated reviewing and obtaining relevant collateral information for mental health assessment purposes. The QI processes reported pertinent to this provision were very well conceptualized and very useful.

Recommendations: Continue to monitor the relevant timeframes specific to this provision.

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 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

November 2016 Cermak Status Update

COMPOUND HOUSING PLAN BY MENTAL HEALTH LEVELS OF CARE (as of October 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 transfer orders from PCC/ Dr. Mennella. Patients with M4 and P4 can be housed on the Medical Special Care unit based on interdisciplinary decision.

- Division II: MALE MENTAL HEALTH HOUSING
    - Dorm 2: Mental Health Outpatient P2; **if any Mental Health Intermediates (P3) are placed there, MH staff works on 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
- 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)
        - SMU (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)
        - SMU (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. SMU, 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 SMU in Division VIII RTU
    - SMU- non-administrative SMU (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 SMU in Division IX; they should only be cleared for SMU 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, MH staff works on transferring them to RTU
    - Protective Custody -1C (meeting criteria of SMU housing) and 2C
        - **No Mental Health Intermediates should be cleared by mental health to transfer to SMU/PC in Division X; they should only be cleared for SMU in Division VIII RTU
    - Mental Health Intermediate Overflow P3 (2B); MH staff/Bed Control teams from Cermak and CCSO works on transferring them to RTU once bed space becomes available
- 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:
The planned transition to MHTC (Mental Health Transition Center) residential setting has not taken place.

On May 18, 2016, the DOC transferred the disciplinary segregation units in Divisions VI and X to Division IX in an attempt to centralize the restrictive housing units. Following this transfer, the units holding detainees that were found guilty of disciplinary infractions were truncated from four divisions to two (Divisions 08 RTU and 9), allowing for a centralization of services.

CCHHS partnered with the Cook County Justice Advisory Council and the Chicago Police Department in the opening of a pilot Community Triage Center in the Roseland neighborhood. The community-based center provide evaluation, crisis stabilization and treatment referrals 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 in order to prevent detentions and hospitalizations. Access will be prioritized for police officers to drop off individuals and rapidly return to their patrol areas. A primary goal is to reduce a number of detainees admitted to jail who have an identifiable behavioral health condition by providing a treatment oriented alternative to detention. The CTC will also provide walk-in services for those released from the Cook County Jail.

Updates: RTU Male Services
Psychiatric services in Male RTU have been constant. Staffing levels in the high priority area (RTU) constant are maintained for P3 detainees. In response to concerns about the frequency of follow up in Divisions after PSCU discharges, Psychiatry has introduced a new paradigm when detainees dispositioned to P3 and P2 Levels of care are followed by MHS in one week, and by Psychiatry in 2 and 4 weeks.

Cermak continues to strive to modify conditions of confinement for those who are housed on 4A (SMU tier). A random sampling established that of October 17th, 2016 RTU 4A (mixed tier/some are M level patients/all classes) average length of stay was 5.15 days, without two outliers; with the outliers it is 14.93. One of the outliers is M3 and had 69 days of continuous disciplinary time (he was not sent to Cermak for mitigation) and the other one, a P3 was housed on the tier for 88 days with two tickets sent for mitigation (last one in August) and was mitigated to 7 days of SMU. Further investigation revealed that he was no longer being considered a disciplinary segregation detainee by custody, but rather a house alone individual.

Modification of conditions of confinement for those individuals with Serious Mental Illness whose time in SMU exceeds 14 days would consist of providing more out of cell time to them, however, DOC Disciplinary Unit continues to issue tickets for P3 that do not exceed 14 days. Cermak continues to provide structured therapeutic programming for SMI detainees in SMU - 4A, further described in the updates. Detainees remain tethered to stationary furniture during out

of cell group structured therapy/activities. As more staff allocations become available, Cermak will continue to target 10 hours of structured activities /10 hours unstructured activities provided to these detainees.

Since April of 2016, RTU Male Services has made several changes to the treatment program based upon DOJ recommendations, feedback from detainees, and the clinical needs of P3 overflow. An overview of programming is outlined below.

Over the past year, efforts have been made to provide more individualized treatment for P3 detainees housed on the fourth floor of RTU. While detainees previously attended group by bed number, adjustments were implemented in November 2015 to offer voluntary groups. This system allowed detainees to sign up for specific groups based upon clinical need. As mentioned in the summary outlined in April of 2016, this format seemed to increase motivation for many detainees. However, ensuring equal participation in groups across dorms became challenging. To illustrate, some detainees attended numerous groups, while others only signed up for a few. Further adjustments to the schedule were made in May of 2016 to address imbalances in group participation and the logistical issues of tracking attendance as detainees transferred from dorm to dorm.

Currently, the RTU male treatment program blends voluntary groups with those conducted by group number. The mental health team identified three core clinical areas that benefit all of the population referred for intermediate care: emotional management, communication/interpersonal skills, and problem solving skills. Detainees on five of the P3 dorms are therefore scheduled to attend these three groups based upon bed number. Each detainee was then asked to rank order their preference for voluntary groups, with the understanding they would attend at least two additional groups ideally of their highest rank ordered choices. Based upon feedback from detainees and clinical staff, the following groups were offered as voluntary groups on five of the dorms: MISA/Recovery, Positive Psychology, Community Re-entry, Young Men's Group, Progressive Relaxation, Grief and Loss, Intrusive Thoughts/Mindfulness, Book/Journaling Club, and Chair Yoga/Meditation. The sixth P3 dorm (4B) is designated for lower functioning patients who largely participate in on tier programming focused upon hygiene, medication compliance, and basic life skills. Progressive Relaxation and Emotional Management are offered as off tier groups for this dorm. All detainees are also encouraged to attend on tier groups (Rise and Shine, Community Meetings, and Movie Group) as well as off tier art therapy sessions. Verification letters are given to detainees on all dorms who attend at least 75% of their groups. In the past few months, 17-30% of detainees on dorms have earned letters for their participation. The variety of clinical services offered is a strength of the blended treatment program. Detainees benefit from the opportunity to participate in structured sessions as well as experiential practice of breathing, stretching, reading, and journaling. Mental health staff were asked to choose modules of their own interest, which seemed to enhance their motivation and sense of accountability. In the future, the mental health team will focus upon developing uniformity in content and structure of modules.

MH staff continue to provide group programming on 4A, a Special Management Unit. This tier remains the only SMU unit for all males in Division 8, which results in periods of mixed housing for P3, P2, and general population detainees. At times, the unit has no P3 detainees. As a result, interest and participation in group varies, often depending on who is housed on the unit. Further, behavioral incidents on 4A increased for several months, largely due to the housing of detainees who were usually placed in Division 9 and were temporarily receiving medical care in RTU. Those particular detainees repeatedly engaged in problematic behaviors (flooding, climbing the shower, refusing to lock up, etc.) to obtain secondary gains. These incidents often interfered with group programming. Another issue that caused some complication was the increase in out of cell time for detainees in SMU. When this positive change initially occurred, some groups could not be conducted as detainees were frequently completing hours out throughout the day. MH staff have since collaborated with tier officers and adjusted group times, which has been more successful on the 3 to 11 shift. Day shift staff tend to encounter multiple competing activities (law library, CRW, hearing board, movement, etc.) and have been working to make up groups whenever possible.

A significant challenge to consistent group programming on all tiers has been mental health staffing. Prior to August of 2015, the RTU treatment team comprised of thirteen MH staff (both MHS IIs and MHS IIIs) who provided group programming for six P3 dorms in addition to other clinical activities (MH clinic, HSRF's, P3 rounds, SMU rounds, individual contacts, and crisis intervention/psych evals). Since November of 2015, the RTU treatment team has been responsible for programming on four additional tiers including 4A (Special Management Unit), 2A (Intensive Management Unit), 4E (Protective Custody), and 2B (P3 overflow). Providing these additional services with the same number of staff has been challenging. Further, the mental health team has been short three staff since July 2016 due to displacements, turnover, and extended absences for health issues/bereavement. Consequently, the team has not been able to fulfill projected goals for group programming. Staff absences have additionally impacted the consistency of clinical programming. To illustrate, only two MH staff are currently assigned for RTU-Males on Fridays and Saturdays (both AM and PM shifts). In the event of a planned or unplanned absence on either shift, the remaining MHS often has to cancel group in order to attend to psych evals, emergent HSRFs, and SMU clearances for all three floors. MH staff frequently express concerns about prioritizing clinical demands with fewer staff available.

CCDOC staffing has also impacted group programming on the 3 to 11 shift over the past few months. In April of 2016, a trend of evening group cancellations emerged. In particular, MH staff noted they were not able to conduct off tier sessions due to lack of movement officers to supervise groups. There are four to eight off tier groups scheduled from 4pm to 6pm on most nights depending on the number of MH staff assigned to the shift. During that time period, movement officers are often pulled for recreation, tier searches, and other duties. Periodically, movement officers return and staff are able to conduct group as scheduled. At other times, movement officers return as other activities on the tiers begin including dinner trays, barber shop, and on tier movies, all of which further interfere with group programming. Although staff are encouraged to make up groups on the tier whenever possible, evening staff are typically left

with large numbers of HSRFs (between 20-50). Consequently, they usually begin attending to HSRFs and psych evals, which then potentially interfere with their availability to return to group even when officers become available. The lack of movement officers and CCDOC staffing has been discussed in several interagency meetings over the past few months.

In recent months, several conflicting activities seemed to contribute to group cancellations and/or diminished participation in group sessions. Specifically, tiers being taken to recreation during group time and on tier movies being played during scheduled groups on the evening shift. Detainees were understandably less motivated to participate in group sessions when choosing between these activities, which ultimately resulted in increased cancellations. These conflicts have been discussed in interagency meetings. Fortunately, cancellations due to recreation have decreased with "real time" communication of these instances. Most recently, MH and CCDOC partners agreed to collaborate on a joint schedule to outline time periods for group sessions, recreation, tier searches, etc.

Bed space remains a significant issue for P3 males. Although an overflow dorm was created on the second floor of RTU (2B), this housing is shared with medical patients and is not sufficient for the number of P3 males awaiting a space on the fourth floor. Consequently, the number of detainees placed on 2B and other tiers within RTU typically varies between 20 to 40 detainees. In addition, Division 10-2B has opened an overflow dorm for P3 males, which also houses anywhere between 15 to 20 detainees.

During weekly MDT meetings, staff attempt to identify detainees who are stable to transition out of RTU. Several issues arise during those discussions. The level of functioning amongst P3 detainees vary widely. Many males are referred to intermediate care due to chronic mental illness. These detainees often require assistance with basic self-care, medication compliance, and symptom management. Other detainees are otherwise higher functioning with histories of mental health treatment in the community or demonstrated difficulties adjusting to incarceration. MH staff often struggle with treatment planning for detainees who are mentally ill yet unresponsive to and noncompliant with clinical intervention. Alternatively, some detainees are quite high functioning and are stable for less restrictive environments, but seem to benefit from participation in treatment. Ideally, higher functioning detainees will have shorter lengths of stay and can be transferred out of RTU more quickly. However, many of the detainees become comfortable in the dorm setting and resist being transferred to what they perceive as less desirable, celled housing. For example, several detainees openly admit to exaggerating or feigning symptoms and to acting out to remain in RTU. As a result of these efforts, many P3 detainees successfully obtain preferential housing and remain in or immediately return to RTU. Consequently, the P3 detainees in overflow housing are then delayed in their transfer to the fourth floor. MH staff is scheduled to provide follow up, community meetings, and/or rounds for overflow detainees at least three times per week, which helps to monitor patients and identify those in need of immediate transfer to the fourth floor. However, aforementioned staffing issues impacts this oversight.

To address challenges with overflow, the MH team will need to develop greater clarity and consensus on the clinical needs of P3 versus P2 detainees. Additionally, the RTU MH team will begin focusing more heavily upon treatment plan review in MDT meetings to identify detainees who have completed group modules and have made sufficient progress on outlined goals. This type of review will ensure that all detainees are systematically assessed for step down. Moreover, MDT staffing with Div 102B will help to identify detainees who may have stabilized and may not need transfer to RTU. The team has also discussed that Div 102B can eventually serve as P3 housing for detainees who are not appropriate for a dorm setting. In this way, Div 10 can function less as overflow and instead provide the appropriate treatment setting for more labile and aggressive detainees. This will also be resource and staff allocation dependent. Ongoing collaboration with CCDOC will be also important to manage bed space issues. In the past few months, the newly developed system of directly contacting classification has been effective to expedite requested movements.

Updates: Intensive Management Unit

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. Recently the 3rd Phase (Residential) was introduced to accommodate program graduates who have lower functioning/significant deficits and expected to do poorly in the dormitories in RTU. 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. The program continues to offer more than 15 hours of structured out of cell therapeutic programming. Dr. Kaniuk is the Unit's Director. Dr. Kelner temporarily served as a Psychiatrist. Effective October 2016, Dr. Haq is the new Unit Psychiatrist.

The IMU team meets for weekly MDT meetings and holds on tier meetings with the detainees every week to review treatment progress and expectations. The collaboration and communication amongst this disciplinary team has been essential to facilitate the progress of detainees. 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. Currently, the team continues to work on maintaining consistency across shifts and personnel. Security personnel who are assigned to IMU must have knowledge of the program because participants have entitlements that are consistent with their level in the program, including how they are secured in the dayroom. Their level in the program also dictates which commissary products they can purchase. The first shift is fairly consistent and the officers work well with the program detainees. On other shifts, the same officers are not assigned to the unit, which creates inconsistency. Unfortunately, many of the

behavioral problems occur on the second and third shifts. Mental health staff work well with security. A walk around tour with Facilities Management and DOC leadership identified physical plant inefficiencies. In order to repair those structural defects additional modifications and caulking are pending.

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 continues on 2A and 2B. Overflow is sometimes placed in IMU overnight (mostly due to bed shortages in RTU). Issues pertaining to overflow include:

1. Confidentiality issues. When detainees participate in therapeutic out of cell programming, there is an expectation of privacy, very much similar to the instances when individual therapy is conducted. When Cermak staff programs in spite of the overflow presence, lack of privacy has a chilling effect on detainees and inhibits their ability to participate in therapeutic activities.

2. Group disruption/ cancellation due to overflow detainees needing to have their time out.

3. Detoxification cases placed in IMU are rather labor intensive in terms of Nursing protocols (COWS and CIWA) and disrupt out of cell programming.

4. When overflow detainees are housed in IMU by DOC, an effort is made by CCSO Bed Control and Classification staff to move them off IMU as early as possible and, preferably, before group activities are scheduled to start around 9am.

Currently, two groups are held Monday through Friday mornings. Another group is held in the evening when staff is available. Group content includes positive psychology, anger management, communication, DBT, etc. CRWs come to the tier on a daily basis.

Staff availability is a significant problem. There are employees assigned to do groups from the fourth floor of RTU during the 7-3PM shift but due to vacation and sick time, they are often absent. In addition, groups may be cancelled due to medication pass, overflow detainees being transferred, power washing of cells, or other behavioral issues. If there are any emergencies, mental health workers assess the patients on the tier, either cell front or at the nursing medication window. When staff are unavailable onsite, all emergencies are seen in Urgent Care. At times, the detainees engage in behaviors with the goal of going to the Urgent Care area or outlying hospitals for a variety of secondary gains. These issues include self-injurious behavior, suicide hanging, foreign body insertion/ingestion, jumping off ledges, slipping in shower, eating magic shave foam, and banging head.

The medical social worker in the building addresses family issues, discharge medications, and

provides linkage services to community agencies.

Updates: Female Services

Cermak continues to provide Psychiatric Services to the mix of P3, P2, and SMU populations. Psychiatrists continue to provide services to the SWJP participants (remanded to the program by the Courts) and the remainder of the female detainees with mostly P2 and some with P3 level of care. Clinics are run separately as detainees are separated in terms of housing. Most of the clinical services for SWJP participants are provided by a Contractor - "Salina and Associates". Division IV did not have not have SMU until recently when a PC unit was opened. Dr. Briney is the Unit Director. Psychiatry FTE is 0.5. MH Population: P2-182 and P3-7.

Currently averaging 7.2 hours per patient per week for intermediate level of care due to the reduction in staff. 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). Superintendent Baker has been instrumental in improving multidisciplinary communications and increasing enrichment programs. P2s continue to be spread among the second floor rather than on two tiers. Lists of P2s/GPs who need to move are provided to security approximately every two weeks, but moving patients in div. 4 seems to occur more slowly now that they are not handled at the local level. However, there are very few moves that are occurring between divisions, improving compliance with appointments and decreasing patient stress. Div. 4 provides a helpful daily list of all patient moves in an effort to ensure appointments are rescheduled. Patients generally prefer tier housing. Housing units in RTU are being regularly power washed. No recent temperature complaints. Ongoing religious services are provided and CCDOC provides weekly Enrichment groups for P2 patients. Patient in the two divisions make some attempts to move to the other division to obtain preferential housing, but patient moves have been minimized greatly.

Patients meet with their tier mental health specialist to create a treatment goal list. Each P3 patient is discussed in MDT staffing on a regular basis. Patients receive treatment cards (also to motivate patients) and to ensure they are aware of their treatment plan. Both the patients and the entire treatment team are involved in the treatment planning process, resulting in individualized treatment plans for each P3 patient. Nearly all (99%) of P3 treatment plans are initiated and updated on time. The quality of treatment plans has improved. Outpatient (P2) treatment plans are in compliance, as they are created by psychiatrist the treating psychiatrist during clinic appointments. P2s average 2 hours of group per month in Div. 4 and RTU.

Patients receive a face to face assessment generally within 48 hours of receipt of the HSR by a MHS III. When staffing is low, there are some HSR that are completed outside of the 48 hour range. Patients have increasingly demonstrated misuse/abuse of the HSR process. There has been a large increase of patients making demands for specific medications. They are submitting

multiple requests daily for the same issues. Usually, "anxiety" and "I can't sleep." Many patients make statements like, "I'm going to keep putting these in every day until you give me what I want." Community groups, HSR contacts, and psych evaluations are frequently including sleep hygiene, anxiety management, and relaxation/ coping skills, but many of the patients are hyper-focused on receiving specific medications.

Cermak continues to strive to modify conditions of confinement for those who are housed on 5A (SMU tier). A random sampling established that of October 17th, 2016 RTU 5A (mixed tier/some are M patients/all classes) average length of stay was 8.17 days. Average number of disciplinary tickets from January 2016 to date was 5.75. Modification of conditions of confinement for those individuals with Serious Mental Illness whose time in SMU exceeds 14 days would consist of providing more out of cell time to them, however, DOC Disciplinary Unit continues to issue tickets for P3 that do not exceed 14 days. Since the last site visit, patients in SMU and protective custody have received one hour of mental health programming per week. In non-PC SMU, the unit director facilitates weekly group. Patients are blue boxed for safety purposes and there is an expectation that there will always be two officers present on the tier during group. Patients have generally been receptive and ask for more programming. More programming has not been possible due to current staffing challenges. Although P3s are the priority for SMU groups, others are permitted to attend. We have learned this creates a more challenging situation given that SMU ranges from general population to intermediate mental health. There have been issues of higher functioning patients targeting and taunting lower functioning P3 patients. This interaction has not been avoidable given that females only have one non-PC SMU on the compound. The higher functioning GP and P2 patients also have difficulty benefitting from group because their peers are lower functioning in terms of mental health. This was also previously an issue with protective custody, in addition to a lack of SMU bed space.

Since the opening of a protective custody in Div. 4, we are seeing more cohesive mental health groups and interactions on the PC tiers, as well as less manipulations for preferred housing between divisions. With the planned increase in mental health staff moving to female treatment divisions, we are scheduling 10 hours of structured mental health treatment activities and additional time out of cells in both disciplinary SMU and protective custody beginning 12/1/16. The tier mental health specialist will also be responsible for ensuring P3 patients receive a monthly individual contact and treatment plans will be entered by the tier MHS, just as on intermediate mental health dorms. The mental health team will continue to stress the need for increased number of security staff to provide observation and security, which has been challenging, particularly on the 3-11 shift. Rounds are completed once per week (PC and SMU). Patients are assessed by MH within 24 hours of placement in SMU. There have been recent challenges with security not referring patients to mental health when they are to be housed in SMU, resulting in delayed mental health assessments. Patients in both Protective Custody and SMU receive an average of 1 hour of group per week due to current staffing allocations.

A significant number of P3 and P2 patients receive individual therapy services in RTU and in Div. 4 for more personalized treatment. Due to current staffing allocation, there are fewer slots

and longer wait times. Each P3 patients is assigned to meet with her tier mental health specialist monthly for an individual mental health contact. Approximately half of the P3 patients regularly receive the monthly contact. The discrepancy appears to be a function of limited mental health staff, staff motivation/time management (addressed in individual supervision) and lack of security on the evening shift to provide security during individual contacts. The RTU provides 24 hour on-site psych evaluations and consultation. We are trying to improve consultation with CCDOC to refer appropriate psych evaluations according to policy (emergent issues, use of force, placement in special management unit, suspected or confirmed physical or sexual abuse). Unit Director periodically attends roll call to discuss psych evaluations and referrals and to remind all staff of the existing interagency agreements and policies. Mental health is putting a flow chart together with the assistance of our program analysts to provide a simple visual reminder of policies for appropriate referral for psych evals.

We continue to focus expressive arts and linkage services on P3 patients. An additional expressive arts group has been added for tier 5B. P2s receive limited linkage services and discharge medications. Overall, we have seen improvement with patients who have poor hygiene. Currently, the rise and shine program occurs one day per week rather than the previous five days per week. Hygiene supplies and encouragement are provided. Patients displaying ongoing, serious hygiene concerns are discussed in MDT clinical staffing and are admitted to the psychiatric special care unit for increased support and a humanitarian shower. Female Services has a very low self-harm rate. Self-injuries that do occur are most often housed in disciplinary segregation. Female services has seen some increase in self-injury in segregation (P3 and very stable P2s), as they believe it will get them out of segregation and placed back on a tier. Patient motivation continues to poses challenges. Mental health facilitates a movie discussion group for treatment compliant patients every two weeks. We are also providing a standardized letter of participation monthly for patients attending 75% of recommended treatment groups. Few women (10-15%) are receiving the letter of participation due to lack of consistent attendance. Long-term patients (particularly 5F) want new treatment videos and materials, reporting that they are bored. Despite ongoing and prior efforts and external motivators, the staff finds that only the women who are intrinsically motivated to participate in treatment are attending groups. The remaining patients enjoy sleeping and socializing on the tier.

There have been some informal complaints and formal grievances received about specific mental health staff with patient reports that they too frequently show videos for group or are not as respectful as they feel they should be. Such issues have been addressed in individual and group supervision. Mental health administration has also been made aware. Facilitating interactive groups has been discussed in group supervision. Concerns specific to CCDOC, specifically about the availability of officers and/or consistent presence at identified posts, has been raised at divisional meetings with CCDOC leadership. Additionally, CCDOC has been informed of specific security staff who have displayed patterns of inability to work effectively with mentally ill patients or mental health treatment staff. Patients will sometimes report being bored on the tiers to the mental health staff. Patients have periodically complained to mental health staff about being unable to have recreation in RTU when the weather is cool or have complained that

is recreation inconsistent. Additionally, to address clinical programming conflicting with recreation, mental health periodically resubmits the schedule of group times to CCDOC supervisory staff.

Updates: Division 2 Dorm 2

Division Two – Dorm Two houses P-2 and M2 (outpatient level of care) patients within a dorm setting. There are ten dorms over three floors, with a census of approximately 44-48 detainees in each tier. It includes detainees with minimum and medium security classification. Services are maintained without significant changes. MHTC detainees are housed in the V house. Overflow P3 are rarely housed in Division II Dorm 2 until a bed opens in RTU and Cermak staff facilitates transferring detainees to RTU with the help of CCSO Bed Control/Classification staff.

Telepsychiatry Clinic continues to provide reliable coverage for this Division and remains the strongest assignment in terms of productivity and meeting departmental expectations. Dr. Ward sees patients on a daily basis, with a combination of new evaluations and follow-ups. Dr. Marri is in Division Two – Dorm Two for one-half day per week and usually sees detainees who need translation services.

Supt. Martinez has been very open to the needs of mental health. Dr. Kaniuk functions as a Unit Director for Divisions VI and II. Dr. Kaniuk is the Unit Director. Psychiatry FTE is 1.1. MH Population: P2-409.

A dorm setting makes it easier for detainees to talk to the staff, since they are often within proximity of the detainees. Because detainees have immediate access to staff in the open setting, many of the requests made are not related to mental health. Thus, the limited staff could become overwhelmed. In addition, security will often refer detainees for non-emergency requests to mental health staff for immediate evaluation using interagency health inquiry forms. The physical plant also poses challenges. There are only two interview rooms on the second floor, one is being used by telepsychiatry Monday through Friday. As such, it becomes more difficult to see detainees in a private setting. Quite often staff have to interview detainees outside the tier in any available space.

Staff availability is also a challenge. There are two employees assigned during the 7-3PM shift, but due to vacation and sick time, they are often absent. All mental health requests during the 3-11PM shift or 11PM-7AM shift are seen in Urgent Care.

Groups are scheduled on a weekly basis in all ten tiers. It is composed of two parts: community issues and therapeutic intervention. The types of groups conducted are anger management, substance abuse, domestic violence, criminogenic thinking, and depression. However, due to absenteeism and other issues (nursing staff passing medication, security passing out supplies, linen exchange, commissary, emergency evaluations), it has been difficult to meet the target of one group in each tier per week.

Security refers 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 staff, along with the CRWs, meet with Supt. Martinez on a weekly basis.

There is a psychology clinic scheduled for Tuesday mornings. There are no problems seeing detainees in this clinic. Mental health clinic occurs on Wednesday and Thursday mornings. One mental health specialist is assigned to this clinic and it runs rather smoothly.

The nursing staff processes HSRF forms before giving them to mental health staff. However, on occasion, there is a delay in processing the forms. The detainees who write these requests are seen by the mental health staff (MHS III or psychologist) in a timely manner. Mental health staff or the medical assistant will inform nursing staff when a "STAT" order has been written by psychiatry.

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.

Updates: Division 6

Division Six houses P-2 and M2 (outpatient level of care) patients, along with GP (General Population) detainees. The Protective Custody tiers (1-A, 1-B, 1-C) and the Westcare substance abuse program (2-A, 2-B, 2-C) P-2 detainees. Division VI no longer houses Special Management Units (Non PC), they were moved to Division IX . The PC population includes detainees with special accommodations. As the population of P2 detainees grew, Psychiatry allocations were increased to accommodate the increased need. Dr. Kaniuk is the Unit Director. Psychiatry FTE 0.3. MH Population: P2-202.

There is one mental health specialist assigned during the 3-11PM shift (Sunday through Thursday), but due to vacation and sick time, she is occasionally absent. Also, the MHS III may be reassigned to the Cermak building or RCDC, should the need arise. Community meetings have resumed with the allocation of a security escort and are scheduled for Tuesday and Wednesday. The meetings contain two components: community milieu issues and clinical topic. The group topics include substance abuse, anger management, criminogenic thinking, domestic violence, and depression.

Security refers 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 unit director (psychologist) and other disciplines meet with Supt. Beachem on a weekly basis.

There is a psychology clinic scheduled on Monday mornings. Security brings the detainees on a timely basis. Mental health clinic occurs during the 3-11PM shift on Sunday, Monday, and Thursday. There have been no difficulties reported about this clinic.

The nursing staff processes HSRF forms before giving them to mental health staff. During the morning shift, the forms are faxed to Urgent Care and emergencies are seen as soon as possible. The non-emergency requests are processed by Urgent Care and scheduled for mental health clinic in Division Six.

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

Updates: Division 9 & 10

Since the last visit a new Unit Director/Correctional Psychologist has taken over leadership of the Div. 9 & 10, Dr. Elma Augustine. The following services continue to be provided in Division 9, Super Maximum, and in Division 10, Maximum by Mental Health Specialists and a psychologist: evaluations and treatment for mental health conditions, psychological evaluations and assessments for suicidal risks. This clinical team provides therapeutic services which includes mental health clinics, group therapy and the following: treatment planning for intermediate level detainees, community meetings for outpatient detainees, segregation clearance for Special Management Unit admittance, weekly Special Management Unit Rounds, crisis intervention and processing of detainees mental health needs that are documented via Health Service Requests and Inter-Agency Health Inquiries forms.

Special Management Units for non P3 detainees are now exclusively concentrated in Division IX. SMU Units from (Non PC) from Divisions VI and X have been moved to Division IX. SMU housing includes special managements tiers (Non PC) and Protective Custody tiers. P2 detainees are diffusely housed also on non SMU tiers throughout the building. Detainees identified as institutional threat and engaging in actions designed to disrupt operations are concentrated on 1F and 1E where enhanced security parameters are enacted 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 housed there.

The Patient Safety and Enhanced Security Guidelines for patients who present with self-harm (Foreign Body-ingestion, insertion and pill ingestion) in Division IX was designed to complement the enhanced security parameters and reduce the amount of disruption of operations. Analogous 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.

In SMU new measures have been added to further improve security and staff safety while modifying conditions of confinement: a. moving Dose by Dose Patients to the first level of those

tiers. b. having 5 officers and a sergeant working on those tiers at all times c. CCDOC staff completing rounds every 30 minutes on those tiers d. Cermak Patient Care Services (PCS) staff completing medication pass at the cell front e. Cermak PCS staff having a CCDOC escort and medication pass officer with them at all times. f. no detainees are out of their cells when Cermak staff is on the tier. g. Cermak PCS staff will complete the morning/evening passes medication pass by certain time to give DOC more certainty and preparation for adequate staffing/including supervisory staff.

Cermak MH Department will furnish SMU detainees with the services, as elsewhere described in this report:

a. SMU rounds weekly (in addition to weekly PCS rounds)
b. Psychiatry appointments (regularly scheduled and walk ins)
c. Individual Behavioral Management Treatment Plans
d. Other essential services –individual supportive counseling , access to emergency and routine care as per DHCR process, crisis intervention, etc. (commensurate with their level of care)

Cermak Mental Health started limited structured out of cell therapeutic programming on 1E utilizing the services of one staff Psychologists. 1E has been retrofitted to allow detainees to be secured to stationary furniture during group therapy. Dr. Augustine is the Unit Director. Psychiatry FTE 0.2. MH Population: P2-178.

Special Management Units (Non PC) have been moved out of Division X. 1C and 2C continue to house Protective Custody Inmates. Elsewhere in the division, on non SMU tiers, Cermak continues provide Psychiatric Services to P2 populations. 2B remains an overflow tier housing P3 patients until a bed becomes available in RTU. Utilization of Division X 2B as P3 overflow has decreased with the opening of RTU 2B as a P3 overflow tier in September 2015, however consistently maintains a census that fills half of the tier. Telepsychiatry clinic is open in Division X three days a week utilizing 0.6 FTE of a Locums Provider and a Locums Telepsychiatry Clinic Attendant. In a significant development, DOC staff now supervises afternoon Psychiatry clinics 3 additional days a week with the resultant improvement in access to care:

Monday	8.30AM- 12.00N (both classrooms)	
Tuesday	8.30AM- 12.00N (both rooms)	1.00PM-3.00PM (one room)
Wednesday	8.30AM- 12.00N (both rooms)	12.30PM-4.00PM (both rooms)
Thursday	8.30AM- 12.00(both rooms)	
Friday	8.30AM- 12.00(both rooms)	1.00PM-3.00PM (one room).

Physical Plant changes have been undertaken: DOC Facilities management installed walls rings in the rooms that host Psychiatry clinics and now detainees are secured to stationary object during the session. Detainees with CCOMS and Cerner alerts denoting dangerousness and affiliation with the Savage Life jail gang now presented to Psychiatry Clinics with enhanced

supervision by DOC staff. Environmental Services extended the cables of landlines and computer terminals in those rooms and that enabled reorientation of Provider's desks so that more efficient escape routes were opened to Providers. Unit Director: Dr. Augustine. Psychiatry FTE is 1.3. MH population: P2-495.

There are currently two Mental Health Specialists in Division 9, one on the am shift and one on the 3-11 pm shift. They provide services to 24 Tiers. In Division 10 there are five Mental Health Specialists, three on the am shift and two on the 3-11 pm shift. They provide services to 16 Tiers, one of which is an intermediate level of care tier functioning as overflow for P3 patients awaiting bedspace in the RTU. One psychologist is assigned to both divisions.

Accomplishments are reflected in weekly provision of the above listed services and weekly provision of: Mental Health Specialist Clinics six days per week in Division 10 and five days per week in Division 9, weekly Psychology Clinic on Mondays in Division 9 and on Wednesdays in Division 10.

Groups are conducted by Dr. Waxler on Division 9/1E on the first and third Tuesdays of the month. In Division 10 the group/community meeting schedule is nine groups weekly, (3 on Tuesdays, Wednesdays and Thursdays) with an expected total of 32 groups per month. Groups were previously held on the living units. It should be noted that groups in Division 10 were suspended by mental health administration effective August, 2016 due to acute security concerns following a sentinel event. However, since then a plan reflecting increased safety during the facilitation of services was able to be agreed upon and groups were resumed on October 19th. The groups are now help off-tier in the division chapel. Initial restart of programming was marked by some miscommunication of expectations, however with the assistance of divisional correctional leadership groups did occur as scheduled on 10/19 and 10/20 and a total of 37 detainees participated in off-tier groups during these two days. Moving forward, in an effort to ensure that all staff are informed and participants are prepared for groups, Supt. Walsh and Director Reyes agreed to have the group schedule announced daily in roll call. Additionally, Mental Health staff posted a scheduled of the groups on all Tiers.

The following challenges impact the delivery of mental health services in Divisions 9 and 10. The historical presence of Mental Health Specialist staff available for 11 pm to 7 am shift for both Divisions was beneficial in addressing overnight crises onsite and in minimizing the need for movement out of the building, which can serve secondary gain. With the current allocation of two mental health staff for Division 9 (one on the 7 am- 3 pm shift and one on the 3 pm to 11 pm shift) it is difficult to meet the high demands of a population that includes special management units, behavioral issues and enhanced security tiers.

The current provision of care is being impacted by current staffing allocation. Following displacement of and subsequent reassignment of staff in June 2016, the division lost the mental health specialists responsible for morning clinics in Division 10 and intensive supportive services to intermediate level of care detainees/ P3's housed on Tier 2B Division 10.

The physical plant in both divisions is also a challenge for mental health staff. There have been ongoing challenges with securing designated clinic office space for Mental Health Specialist or Psychologist to consistently utilize in Division 9. This impacts the provision of mental health services on a weekly basis. There is an office space available for Mental Health in Division 10. However, the space is extremely small and results in an uncomfortable and potentially unsafe space between staff and detainees. Mental Health administration continues to work with Cermak and CCDOC administration to rectify space issues.

In Division 9 a challenge for mental health is clearance of detainees for Special Management Unit Admissions (SMU). Mental Health Specialists (MHS) have encountered difficulties in ensuring 100% compliance in Segregation Clearance due to the following: MHS are not always informed in real time when a detainee is being sent to SMU or when the detainee is removed and returned after 30 days/24 hours out compliance. Another challenge is that mental health is often not informed that detainees are being placed in SMU housing when they are returned from outlying counties.

Correctional Programming

In an effort to minimize role issues between the Sheriff's Office and Cermak mental health staffs, the Sheriff's Office mental health staff discontinued their provision of group programming on the special management units in January 2016. The DOC has significantly increased the amount of enrichment programs that are offered to other detainees across the compound (see Attachment A).

DIVISION 2

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. In October 2016, detainees housed in Division 08 RTU reported inconsistent access to hygiene items between weekly distributions. To minimize continued issues, Superintendent Brown informed all divisional staff that detainees housed in RTU are allowed access to hygiene supplies as needed and issued a notification to staff identifying the storage areas for the items.

The DOC continues to assist seriously mentally ill detainees housed in Cermak that consistently demonstrate an inability to complete their daily living skills through the facilitation of compassionate showers. An interagency team of DOC and nursing staff typically complete 1-2 compassionate showers monthly.

Recreation

All detainees across the compound have access to recreation. Detainees housed in Cermak typically had access to indoor and outdoor recreation in the Division 4 gymnasium or yard every other week. There was difficulty in coordinating schedules across disciplines for movement

outside of the building. Thus in October, the DOC and Cermak collaborated to reconfigure an uninhabited living unit in Cermak to a recreational space. The space includes group games (i.e., bean bag toss, plastic table tennis, plastic floor darts for wheelchair-bound detainees, etc.), board games and activities. Additionally, the agencies installed two televisions to the 2Southeast unit, an area that houses detainees with serious mental illness and histories of violence. We utilize the space to allow increased hours out of cell. Detainees that were previously allowed one hour out of cell each day due to their level of violence now typically receive 3 hours out of cell to watch television, engage with the staff and complete their hygiene. Most recently, the Cermak Superintendent and DOC staff facilitated a talent show for the detainees housed in 2South. All of the detainees were allowed out of their cell to participate and enjoy cheering on about 7 of their tier mates who sang, danced, recited history and poetry. Such activities are planned periodically. Detainees identified as seriously mentally ill and housed in RTU had access to recreation 1-2 times each week. Access to recreation in RTU is expected to increase as it was recently assigned to a correctional supervisor. The DOC has been working with our County partners to weatherize the RTU patios to allow for continued use during the winter months. We received confirmation that at least one out of four patios will be weatherized in FY2017.

November 2016 Metzner assessment: The status update section provides a comprehensive summary of the P2 and P3 levels of mental healthcare being offered in the CCDOC.

Division 2 P2 inmates were reported by custody staff to have access to the indoor recreational area on the first floor on a once per month basis and to the outdoor recreational yard 1-2 times per week. However, inmates uniformly reported during my community meeting with them during the afternoon of November 16, 2016 that access to the outdoor recreational area during the past month was once every two weeks. This appeared to be confirmed by review of the custody logbook. Inmates continued to report the lack of recreational materials in the first floor indoor recreational area.

Division 2 P2 inmates had many complaints about medications they were not receiving, which were primarily non-formulary medications. Continuity of medications did not appear to be problematic except following housing moves. The scarcity of mental health programming was a significant complaint by these inmates. However, as compared to prior site visits, the focus of the inmates' complaints were on conditions of confinement in contrast to mental health system issues. For example, several inmates did not have access to hygiene materials such as toothbrushes and several did not have access to towels due to apparent shortages that was confirmed by custody leadership staff. Other verified issues included or access to the barber, except when going to court, and issues with being able to use their telephone cards.

Information was obtained relevant to the special management unit as follows:

- Compound Census 11/14/16: 8,046
- SMU Census 11/14/16: 175 (31 in RTU; 144 in Division 9)
- Thus, 2.2% of the detainee population are currently housed in SMU

  - This is a reduction in the percentage of individuals in SMU from the last site visit.
  - During the last site visit (4/18/16), there were 217 individuals in the SMU tiers and a total compound census of 8318 (= 2.6% of the detainee population was housed in SMU)
- Approximately 77% of the detainees currently in the RTU SMU have been there for less than 14 days
  - All detainees that have been housed in RTU SMU for longer than 14 days are identified as M3 and/or P2
- 16% of the current RTU SMU detainees are identified as P3
- Median length of stay in RTU SMU tiers is 5.7 days
- On an average day, 84% of people in RTU SMU had been there for less than 14 days
- On an average day, 36% of people in RTU SMU had a P3 alert at the time

The above statistics are encouraging for the following reasons:

1. The percentage of detainees housed in a SMU is low and continues to decline.
2. The percentage of P3 detainees in a SMU and their length of stays are relatively short.

RTU SMU inmates are offered two hours per day of unstructured out of cell time as compared to Division 9 SMU inmates, who were reportedly offered three hours per day of unstructured out of cell time. The offered structured as therapeutic time was as follows:

Outpatient and SMU programming hours have been monitored as of July of this year. These are shown by area below.

OUTPATIENT & SMU PROGRAMMING HOURS 2016													
LOCATIONS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOT
RTU 4A							31/32	27/32	21/28	19/28			98/120
RTU IMU							78/90	50/74	61/86	38/58			227/308
RTU F/4 P2							8/8	6/8	5/8	6/6			25/30
RTU F 5A							8/8	8/8	8/8	8/8			32/32

The structured therapeutic out of cell time offered to RTU SMU inmates is significantly less than the time offered to RTU IMU inmates directly related to the more adequate mental health staffing allocations assigned to the IMU. The 10 cell IMU program has been successful in providing needed treatment to very difficult inmates, who had previously essentially been locked down in the 2SE unit within Cermak. Increased staffing allocations are necessary for the RTU SMU to provide adequate treatment. During November 15, 2016, there were 33 mental health caseload inmates housed in the RTU SMU and the IMU. It is recommended that a 0.25 FTE psychiatrist be allocated to cover both of these units, which are currently covered by multiple psychiatrists. A mental health unit director is needed to cover for both of these units.

I briefly observed that mental health rounding process in Unit H of Division 9 during the morning of November 17, 2016. Inmates uniformly reported that they were receiving only one hour per day of dayroom time in contrast to the previously reported 3 hours per day. Subsequent

review of custody logbooks and videotapes indicated that the amount of dayroom time being offered to these inmates varied from 1 to 3 hours per day, which was related primarily to custody staffing on the unit on a particular day in addition to other factors including on unit incidents. It was clear that they were not receiving three hours of dayroom time on a daily basis. However, the out of cell time being provided to all SMU inmates continues to be very progressive and is indicative that CCDOC is on the verge of being on the cutting edge nationwide in the context of improving conditions of confinement within a SMU environment

Out of cell structured therapeutic activities for the male RTU detainees were as follows:

MALE INTERMEDIATE WEEKLY PROGRAMMING HOURS 2016													
LOC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVE
ON	2.7	2.4	2.1	2.5	2.3	3.6	2.7	3.2	3.2	3.2			2.8
OFF	8.4	9.0	6.1	6.3	6.2	4.1	3.6	3.0	3.1	2.8			5.3
TOT	11.1	11.4	8.2	8.8	8.5	7.7	6.3	6.2	6.3	6.0			8.1

Cancellations of such programming was related to the following:

MENTAL HEALTH MONTHLY STATISTICS 2016 CCHHS

For male programming in RTU, groups were canceled, on average, 43 times per month, which clinical staff scheduling conflicts and lack of security accounting for 26 cancelations per month.

MALE INTERMEDIATE CANCELED PROGRAMMING HOURS 2016													
REASONS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOT
REC, BARBER					6	18	13	4	7	5			53
CLIN STF CONFL	16	11	27	9	9	27	13	6	6	13			137
CLINICAL MTGS	8	4	13	6	5	6	5	2		3			52
LACK SECURITY	4		9	15	10	18	15	20	18	16			125
SEARCHES	4	4	10			4		4		13			39
FIGHTS, UOF				2	3	4		4					13
PT REFUSALS		3	1	2		2		3					11
ENVTL ISSUES													
TOTAL	32	22	60	34	33	79	46	43	31	50			430

Similar statistics for the female RTU were as follows:

FEMALE INTERMEDIATE MENTAL HEALTH PROGRAMMING HOURS IN RTU

Female programming hours in RTU have also moved in the direction of 'off-tier' group programming in accordance with departmental goals, and have maintained a proportion similar to that of male programming for 2016. In addition, canceled group hours have averaged 9.1 per months during this period. As in the case of male programming in RTU, decreases in programming hours have been attributable to a developing staff shortage during this period.

FEMALE INTERMEDIATE WEEKLY PROGRAMMING HOURS 2016													
LOC	*JAN*	*FEB*	*MAR*	*APR*	*MAY*	*JUN*	*JUL*	*AUG*	*SEP*	*OCT*	*NOV*	*DEC*	*AVE*
ON	*5.3*	*4.8*	*3.0*	*2.5*	*4.7*	*4.3*	*1.2*	*0.3*	*0.3*	*0.5*			*2.7*
OFF	*6.2*	*5.7*	*7.2*	*6.3*	*5.5*	*5.7*	*4.5*	*4.5*	*4.3*	*4.7*			*5.5*
TOT	*11.5*	*10.5*	*10.2*	*8.8*	*10.2*	*10.0*	*5.7*	*4.8*	*4.6*	*5.2*			*8.2*

FEMALE INTERMEDIATE CANCELED PROGRAMMING HOURS 2016

REASONS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOT
REC, BARBER								2	1				3
CLIN STF CONFL	1	6	3	3	14	12	7	2	4	1			53
CLINICAL MTGS	1	2	2	2	2	2	2	2					15
LACK SECURITY									2				2
SEARCHES		1											1
FIGHTS, UOF									1	1			2
NO DOCU								8	4	1			13
ENVTL ISSUES	3					1	1						5
TOTAL	5	9	5	5	16	15	10	14	12	3			94

As evidenced in the above tables, the two major barriers for achieving compliance with the number of hours per week of out of cell structured therapeutic activities for RTU male detainees are mental health clinical staffing issues (i.e., vacancies and/or staffing allocations) and correctional staff use of resources. It is expected that the latter issue will be resolved in the very near future.

The major barrier for achieving compliance with the number of hours per week of out of cell structured therapeutic activities for RTU female detainees is mental health clinical staffing issues (i.e., vacancies and/or staffing allocations).

Male RTU inmates were reported to have access to the outdoor patio area on a twice per week basis (1 hour each time) as compared to the female RTU inmates' access of 3 to 4 times per week. However, inmates continued to report very limited access to the outdoor patio areas. Plans are being made to winterize one of the outdoor patio areas.

As stated in the status update section:

> Bed space remains a significant issue for P3 males. Although an overflow dorm was created on the second floor of RTU (2B), this housing is shared with medical patients and is not sufficient for the number of P3 males awaiting a space on the fourth floor. Consequently, the number of detainees placed on 2B and other tiers within RTU typically varies beween 20 to 40 detainees. In addition, Division 10-2B has opened an overflow dorm for P3 males, which also houses anywhere between 15 to 20 detainees.

P3 inmates in Division 10 has an average length of stay of 60 days in Division 10. They are only offered two therapeutic groups per week.

The current RTU staffing allocations were as follows:

	RTU 5th floor females	RTU 4th floor(+ 2nd and 3rd floors)
Psychiatrist	1.2	1.6+0.2 (PA)=1.8
Psychologist/Unit Director	1.0	1.0
Social workers	1.5+ 1.0 Expressive therapist	1.5+1.0 Expressive therapist
Mental Health Specialists (cover RTU5th floor and Div. 4 for female services)	3 MHS III in am 2 MHS III + 2 MHS II in pm	3 MHS III + 3 MHS II on AM 4 MHS III's on PM
Population	P3 84 P2 137 (221)	P3 317 P2 99 (416)

RTU total population 637; P2- 236; P3- 401

In addition to the mental health specialists' vacancies and/or allocation issues that negatively impact providing adequate access to inmates for out of cell structured therapeutic activities, the allocations of psychiatrists' positions to the RTU are not sufficient. Currently ~2.0 FTE psychiatrists provide services to a residential treatment level of care population of 401 inmates and 1.0 FTE psychiatrist provides mental health services to an outpatient population of 236 P2 inmates housed in the RTU. On average, 415 inmates have had a P3 designation on any given day during the past 11 months. In general, 1.0 FTE psychiatrist position is needed for 80 – 100 RTU level of mental health care inmates.

The average daily census of inmates with a P2 designation throughout CCDOC during the past 11 months has been 1605 with an average of ~180 inmates per day in the SMU and 502 inmates per day with a maximum custody level in Division 10. I have significant concerns re: the current allocation of psychiatrists' positions for inmates requiring a P2 level of mental healthcare. The psychiatric staffing allocations for general population medium or minimum custody level P2 inmates will be less than the allocation required for higher security P2 inmates due to access issues. I discussed at length my concerns and recommendations with mental healthcare leadership staff, who agreed to submit to me a draft by January 1, 2017 re: a staffing needs analysis that may include relevant QI studies and/or management reports.

Information was obtained from line psychiatrists regarding the amount of time allotted to initial psychiatric examinations. They reported that the amount of time required for such examinations, which included review of relevant records, clinical interview, documentation and waiting time for the inmate to arrive for the examination generally required a total 20-45 minutes. Psychologists indicated that their initial comprehensive mental health assessments generally involved 30 to 60 minutes in duration.

I reviewed three initial psychiatric evaluations that were selected on a random basis. These evaluations were not adequate based on documentation, which lacked support for the diagnosis and/or a reasonable review of systems specific to the inmates' presenting complaint and/or reason for referral. Psychosocial history, family history and substance abuse history were poorly documented. In addition, the planned follow-up for inmates initially started on psychotropic medications was not timely (generally 8-12 weeks). Discharge planning was not addressed, which was problematic because two of the inmates were discharged prior to the planned psychiatric follow-up. These issues appeared to be related to large caseloads and limited time available for such assessments.

Recommendations:

1. Address the staffing vacancy and or allocation issues as summarized above, along with a staffing needs analysis as previously referenced.

2. More RTU beds are needed as evidenced by the P3 overflow units.

3. Various conditions of confinement, such as access to basic hygiene items, towels, outdoor recreation, etc. need to be more closely monitored, and remedied when needed, by custody staff

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:

November 2016 Cermak Status Update

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

The Unit Director for the Intensive Management Unit (IMU) in consultation with the Chief Psychiatrist developed a behavioral custody report that is submitted to the courts upon successful completion of the IMU program. Please see Appendix for a sample of report.

Additionally, comprehensive Interagency Behavioral Management Plans continue to be developed as needed by Unit Directors in concert the Chief Psychologist, the Chief Psychiatrist, and the full multidisciplinary team for more complex or difficult cases. The majority of interagency plans continue to be generated in PSCU, followed by the RTU.

New proposed language for policy G.04.1 (redlined version) was forwarded to Dr. Metzner for

review.

- P4 (Psychiatric Special Care Units): Psychiatric Special Care Units patients will have completed treatment plans within 72 of admission to the Psychiatric Special Care Unit (PSCU) by QMHP and the Treatment Team with a review and update triggered by changes in acuity (such as placement in therapeutic restraints or administration of emergency medications) and failure to achieve goals, but no less frequently than weekly.

Once patients within PSCU's are determined to require subacute level of care, with regard to the frequency of Treatment Plan reviews, they will have their Plans reviewed by QMHP and the Treatment Team every 30 days for two months. After that, patients within PSCU's requiring chronic level of care will have their treatment plans reviewed no less frequently then every 90 days by QMHP and the Treatment Team from that point forward.

- P3(Intermediate Care): Mental Health Intermediate/residential level of care patients will have completed treatment plans by a QMHP within 30 days of admission, with review and update at least every 90 days thereafter.

- P2(Outpatient Care): Mental Health Outpatient level of care patients will have completed treatment plans by a QMHP within 45 days of admission, with review and update at least annually thereafter.

November 2016 Metzner Assessment: As per status update section. Results of the Treatment Plan QI Audits for each level of care were summarized as follows:

> Executive Summary The database of special care patients was reviewed 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, 28 included psychiatry in all P4 and P3 plan development, 28 of the treatment plans were completed by a QMHP, and in 15 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 continue to be an area for improvement. 45% of P4 Acute plans were updated within 7 days. 100% of P4 Chronic plans were updated within 90 days. QMHP will improve the consistency with which treatment plans for Acute patients 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 overall percentage of compliance measured by the Cermak Treatment Plan Audit Tool was 81% (average of all quality indicators). This increased from 68% when the treatment plans were first audited in April 2016.

Significant improvement is noted.

Recommendations: Repeat the QI following the planned training.

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: Compliance (11/16)

Factual Findings:

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

> 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 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.

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

November 2016 Cermak Status Update

See Attachments B & C.

November 2016 Metzner Assessment: As summarized earlier in this report, psychiatrists are now meeting time for frames relevant to emergent, urgent, and routine referrals. Related to salary increases, streamlining of the hiring process, success of the Shakman pilot hiring project and an aggressive recruitment process there have been no functional vacancies relevant to the 14.9 FTE allocated psychiatrists' positions since August 2016.

As was summarized in provision 59 d., I think it is very likely that the total funded psychiatrists' allocations are not sufficient to meet the inmates' serious mental health needs. However, for reasons discussed in that provision, mental health leadership staff will work with me to jointly develop a needs assessment relevant to this issue by January 1, 2017. Compliance is found because all of the current funded psychiatrists' positions are functionally filled. I will reassess this provision during the next site visit in the context of the plan need assessments and subsequent assessment specific to provision 59 d.

Recommendations:

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:

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 licensed 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.

November 2016 Cermak Status Update

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

November 2016 Metzner Assessment: Refer to Attachments B & C for staffing allocations and vacancies. It is very encouraging that 14.0 FTE additional mental health specialists' allocations was just recently funded. Refer to provision h regarding the planned needs assessment. This needs assessment will help determine whether the staffing issues identified in provision 59 d. are due to vacancy issues, performance issues and/or staff allocation issues.

Recommendations: Complete the staffing needs analysis.

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

Compliance Assessment: Compliance (11/16)

Factual Findings:

April 2016 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.

November 2016 Cermak Status Update

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.

<u>Discharge Planning</u>

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 an e-script for 30 days of medication in the community as a bridge until their next provider appointment.

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 prescription for discharge medications.

Psychiatric coverage of the Psychiatric Special Care Units has been strengthened: 2N is covered by 3 Psychiatrists and 1 Psychiatric PA (Balawender). Dr. Bednarz and Haq joined Dr. Paschos on the PSCU team in May 2016 and October 2016 respectively. They also have clinical assignments outside of the PSCU setting. 2W covered by Dr. Howard. 2S/2SE is covered by Drs. Howard and Bednarz. 2E is covered by Dr. Moreno. Please see PDF Appendix for QI related to frequency of contact of PSCU patients.

2 North: 3 Psychiatrist +1 PA with 7-day Coverage-2.4 FTE
2 South/Southeast: 2 Psychiatrist with 5-day Coverage-0.6 FTE
2 West: 1 psychiatrist with 7 day coverage-0.8 FTE
2 E: 1 Psychiatrist Once a month coverage-0.1FTE

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.

Upon request from Cermak Mental Health Leadership, the DOC continues to supply snack items to be used for incentives for treatment compliance.

According to the Interagency PSCU Policy, bed assignment is a collaborative task between DOC, Nursing, and Mental Health. Striving to maintain the integrity of ongoing out of cell structured therapeutic programming and recognizing the importance of having dayroom available for therapeutic programming, Cermak supports using every appropriate space/accommodation for patients in need of single rooms, including, but not limited to:

- Temporarily holding 2N detainees on 2S and 2E. When there is a new admission(more unstable) to 2N in need of a single room, more stable 2N patients occupying a single room may be transferred to 2S and 2E on a temporary basis.
- Using existing single rooms on 2N (putting new detainees in need of single room in the rooms of established (stable) single room patients who are having their "hour" out).
- Using group rooms (when group room detainees are out for therapeutic and unstructured activities) to temporarily insert new admissions in.
- Temporarily keeping new detainees in other appropriate clinical/non clinical space on 2N (for instance, the long hallway and the small group room). DOC is requested to provide direct observation of these detainees if they are kept in clinical areas.
- Keeping new detainees who need a single room in the big dayroom will be used only as the last resort.

Providers, Unit Directors, and MHS will collaborate with DOC Supervisors and front line staff identifying accommodations designed to avoid any disruption in therapeutic programming

2S/2SE concentrates the most recalcitrant and treatment refractory detainees with serious mental illness on the compound. In order to preserve a safe, sanitary, and therapeutic milieu in the area where adherence to hygiene and personal self care is oftentimes a challenge for many of those detainees, Cermak MH, Environmental Services, and DOC staff collaborate in maintaining:

1. Cleaning schedule- twice a day (am and pm) including the weekends on both 2S and 2SE. The pm cleaning is for selected cells that need extra attention. Power washing

frequency is to be determined. Supt. Hays is asked to provide staff to assist the cleaning of 2S/2SE.

2. Additionally, DFM Plumbing foreman have been requested to have a plumber come to 2S/2SE every morning Monday through Friday.
3. Environmental inspection detected no present mold contaminated surfaces on vinyl chairs in the dayroom and nurses' station.
4. One ceiling tile with mold has been replaced
5. A/C issues have been corrected.
6. The fruit flies infestation has been reduced. DOC will avoid, if possible, feeding detainees in their cells, when practicable, in order to minimize the resurgence of fruit flies' population.
7. " Humanitarian showers" on the 3-11Pm shift will be available as needed in close coordination between DOC, PCS, MHS, and Psychiatry. MH will submit the lists of detainees requiring hygiene to Supt. Hayes and Shift Commanders. MH will secure OT, if need be, to assist in coordinated preplanned hygiene.
8. Cleaning and environmental maintenance should not interfere with ongoing out of cell therapeutic programming.

Updates: PSCU

2N (males) and 2W (females) are the Psychiatric 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.

Programming

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. Dayroom hours and structured programming are calculated most closely on the 2 North Unit. Through an interagency directive, both dayroom hours and programming hours have been increased on 2 North and 2 West. 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.

Because 2 North calculates both daily programming hours and dayroom hours, the following data was derived from 2 North. The dayroom hours have increased beginning in May 2016 from an average of 5.9 hours per day (January-April) to an average of 7.9 hours per day (May-September). This increase of access to care has allowed for an increase of mental health programming from an average of 4.8 hours per day (January- April) to an average of 6.5 hours

per day (May-September).

Since May 2016, patients on 2N have been receiving an average of 6.5 hours of structured group programming per day; while patients on 2W have been receiving an average of 41.04 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 82% of the time they are out of their room over the last five months (May 2016-September 2016).

The percentage of large group room therapy versus small group room therapy has decreased slightly over the past five months. 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. The expressive arts therapist assigned to the second floor of Cermak has been given additional responsibilities one day a week which has taken his ability to provide a "floating day" which traditionally allowed him to make up for services that were cancelled due to holidays, unit closures, etc. Approximately 95% of group programming takes place in the large group room. We will be working towards increasing small group room programming by 2-3 hours/week by assigning each mental health specialist to conduct one small room group session per week.

An ongoing challenge to providing groups in the small group room is difficulty with obtaining proper CCDOC supervision. In order to run these groups, a secure environment must be maintained by having a proximate officer. This is not always possible in such a dynamic environment where there are conflicting activities to supervise, which 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.

The unit schedules aspire to provide 12 hours of open dayroom time each day where patients have access to care and are provided with 8 hours of structured programming. The newly disseminated interagency unit schedule is attached in the PDF Appendix). Although the schedule provides 6 hours of dayroom time in during the 7-3 shift and another 6 hours during the 3-11 shift, the highest daily average of dayroom hours for a month was just under 10 hours/day (June 2016). There are several factors that can impact the availability of dayroom time. The most frequent reason over the past six months has been for the challenge of detainees requiring single cells versus the number of single cell housing available in the PSCU. Once admitted patients are often housed in the dayroom for several hours which precludes other patients from utilizing the dayroom area. As a result, structured group programming can be interrupted, delayed, or cancelled. For example, the month of August had a total of 12 shifts in which structured programming was either postponed or cancelled due to "patients housed in the dayroom."

Several approaches/solutions have been proposed to prevent dayroom closure including: 1) placing a newly admitted patient who requires a single cell in a room while group takes place and then after the dayroom hours return the patient to the dayroom, 2) situating the patient in the back hallway with security supervision, and 3) boarding more stable patients on other second floor units if there is available space.

A QI study was initiated in May 2016 to ensure that dayroom hours are being accurately tracked, but the results of this study are limited. The data comparing the reported dayroom hours from mental health specialists with CCDOC video is attached to this document (PDF Appendix). We will need to continue to closely monitor dayroom access as it is directly related to group programming.

Treatment Planning

An area of improvement that was identified during the last audit was treatment plan development, review, and update. Procedures have been initiated on both 2 North and 2 West to ensure that treatment plans are updated within the specified timeframes of our policies. The attached treatment plan audit will describe improvements in this area over the last five months. Once consistency is achieved with the review and update of treatment plans, the quality and effectiveness of the treatment plan should be assessed. Outcome studies may help to better understand the impact our services have on our patients' mental health and wellbeing. The treatment plan audit and summary is provided in the PDF Appendix.

Additional Activities

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. With regards to the milieu and therapeutic environment on the psychiatric special care units, staff work 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.

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. An area that has been improving is cooperation/collaboration across disciplines. This has traditionally been a challenge, but 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). We will continue to hold multidisciplinary clinical staffings to ensure that all disciplines are represented and that all varying perspectives are taken into account.

Areas for Improvement

The key areas identified for improvement are:

1. Monitor dayroom closures more closely and develop interagency procedures to minimize dayroom closures
2. Increase small group room programming by scheduling one small group per clinician per week
3. Continue to encourage full multidisciplinary participation at clinical staffings
4. Continue to monitor compliance with treatment plan policy

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 (and some with P3 alerts) are evaluated by Mental Health Staff 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. The numbers of involuntarily hospitalized patients continue to be relatively stable in spite of overall reduction in jail census.

Cermak Male Sub-Acute and Chronic Mental Health Units Description

The Cermak male sub-acute mental health unit, 2 South, is a 26-bed unit devoted to psychiatric stabilization and maintenance of detainees suffering from severe psychiatric illness whose condition warrants weeks or months of extended inpatient care. Detainees are transferred to 2 South from 2 North, the acute care and triage unit. Primary reasons for transfer are severity of illness or symptom presentation, inability to achieve successful adjustment at a lower level of care, treatment refusal and need for emergency involuntary medication or nonemergency medication by court order, pending forensic evaluation for Fitness to Stand Trial (BCX), or

finding of Unfit to Stand Trial (UST) with pending transfer to a forensic state psychiatric facility for fitness restoration. The table below summarizes the status of 2 South patients on November 7, 2016.

*STATUS OF 2 SOUTH PTS**			
STATUS	# PTS	INV MEDS ORDERED	INV MEDS PENDING
UST	7	2	0
BCX	11	3	0
NO BCX	8	1	2
TOTAL	26	6	2

**on 11/07/16*

Many 2 South patients are at acute risk for harm to self or others, are unable to care for self, or suffer marked decompensation which could create vulnerability in less intensive levels of care. Patients housed on 2 South see a psychiatrist a minimum of once a week, and have twenty or more hours of mental health programming during that period. All 2 South patients are considered for linkage planning and community reintegration services provided they are to be released to the community. A number of patients are petitioned and certified for involuntary admission to area psychiatric hospitals when released by the court.

2 East is a 12-bed chronic care unit adjacent to 2 South. It houses patients who are not expected to be able to adjust successfully elsewhere in the jail, and many of these detainees are considered clinically frail and susceptible to exploitation. Patients housed on 2 East see a psychiatrist a minimum of once a month, and share the other services found on 2 South.

Significant progress has been made relevant to the use of involuntary administration of psychotropic medications on a nonemergency basis, which is well summarized in Attachment D. The need to initiate civil commitment procedures at the time of discharge from CCDOC has decreased, which is likely a reflection of improve mental health services being offered within Division 8 (see Attachment D).

CCSO facilitated sessions of Crisis Intervention Training (CIT) training for Cermak clinical staff and custody staff. 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. There have been 4 full 40 hour classes and 1 one day training. Cermak's involvement is as follows:

13 unique staff completed the 1 day training (3 of those individuals are no longer with us).
17 unique staff completed the full 40 hour training (1 of those individuals is no longer with us).

DOC Administration initiated multidisciplinary Crisis Intervention Training (CIT) in November 2015. The initial training consisted of a one-day introductory course. Thirty staff members from

Cermak and the DOC completed the 8-hour CIT course. Subsequent training consisted of a 40-hour curriculum. To date, 120 DOC and Cermak employees have completed the 40-hour CIT course.

Staff safety checklist was developed in MH CQI committee meetings and shared with CCDOC and Cermak Leadership (please see PDF Appendix). Findings are further discussed in CQI Suicide Prevention Committee meeting and the MH CQI meeting. 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. Medical and Mental Health Staff are encouraged to provide real time incident reporting to enhance the timeliness of communications with CCDOC; creation of the " Staff Safety Incident Report", as a supplement to the EMERS report (June 2016).

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 the identified 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 75 calls/referrals. Of those referrals, (71%) had already been identified, evaluated, placed on the MH caseload and were receiving treatment. (21%) of the referrals yielded new additions to the MH caseload or yielded information that Cermak providers did not yet have access to, and the remaining (8%) 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.

November 2016 Metzner assessment:

Attachment E provides statistics relevant to admissions, discharges and average length of stay within the second floor mental health units.

Programming hours on the second floor mental health units were as follows:

INPATIENT MENTAL HEALTH PROGRAMMING HOURS

On the inpatient side, programming hours have climbed steadily over the course of 2016. On 2 North, where programming hours are calculated on a daily rather than weekly basis owing to the brief stays patients have there, hours have increased from 4.9 per day in January to 7.3 hours in October. The other inpatient units calculate programming in weekly hours. On 2 South, the average has climbed from 18.9 hours per week in January to 29.7 hours per week in October. On 2 East, programming has increased from 15.3 to 25.3 hours per week. On 2 West, programming hours have climbed from 25.4 to 41.7 over the same period. Because of staffing shortages over the course of this year, 2 East has been designated as the unit where staff can be pulled to other higher priority service areas in Cermak when needed. Out-of-cell hours per day on 2 North have increased from 5.9 per day on average for January to 8.5 in October.

INPATIENT WEEKLY PROGRAMMING HOURS BY UNIT 2016 *2N CALCULATED BY DAY, OTHERS BY WEEK													
LOC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVE
2N*	4.9*	5.1*	4.4*	4.9*	6.7*	7.8*	6.8*	5.0*	6.3*	7.3*			5.9*
2S	18.9	20.1	19.6	21.6	27.6	32.2	28.6	19.6	26.8	29.7			24.1
2E	15.3	18.2	17.4	23.8	24.6	23.2	21.1	14.8	24.5	25.3			20.8
2W	25.2	22.5	23.6	33.5	41.6	38.2	39.8	40.9	44.7	41.7			35.2

The out of cell programming offered to inmates within the inpatient mental health units continues to improve. Significant improvement has occurred on the 2S/SE units related to both the implementation of the IMU and using a door to separate the unit into two units that has allowed for increased out of cell time for inmates in both units. Television sets have also been installed in the 2SE hallways. 2W inmates' access to the dayrooms during the afternoon continues to be problematic related to the presence of "walk-alone" designated inmates. It is my understanding that a remedy for this issue into West will be implemented similar to the remedy that was implemented on the 2S/SE units.

A very reasonable process has been implemented relevant to the administration of involuntary psychotropic medications on a nonemergency basis that is largely the reflection of administrative skill and work demonstrated by David Kelner, MD.

The staffing allocations to the inpatient unit includes 3.9 FTE psychiatrists since August 2016. As a result, psychiatric staffing has been adequate. This will be problematic during staff absences due to lack of a built in relief factor.

During the site visit, I observed programming and out of cell time on all the units, which was consistent with the data previously summarized. I also talked with inmates in group settings, who generally had very positive comments regarding the treatment program. Information obtained from these inmates was consistent with the information summarized in the status update section.

It is a significant achievement that the elements of this provision are now in compliance, which is directly related to the adequate psychiatrists' staffing, diligent work by the mental health specialists and nursing staff and the good working relationship between healthcare and custody staffs. It is particularly encouraging that the custody staff have facilitated increased out of cell time for the inmates.

Recommendations:

I am in agreement with the key areas identified for improvement, which are summarized in the update section as follows:

1. Monitor dayroom closures more closely and develop interagency procedures to minimize

dayroom closures.

2. Increase small group room programming by scheduling one small group per clinician per week.

3. Continue to encourage full multidisciplinary participation at clinical staffings.

4. Continue to monitor compliance with treatment plan policy

Maintaining adequate staffing allocations it is also recommended.

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. (included in this appendix for formatting purposes only)

Assessment: Substantial compliance (since June 2012)

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). (included in this appendix for formatting purposes only)

Factual Findings:

November 2016 Cermak Status Update

Disciplinary Unit continues to adhere to the following framework: 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. Combined huddle meeting for Special Management Units 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. Please see PDF Appendix for Mitigation Report.

CCDOC - TOTAL INMATE DISCIPLINARY REPORTS WRITTEN
JUNE 1, 2016 TO SEPT 30,2016

DIVISION 1	**375**
DIVISION 2	**678**
DIVISION 3	**9**
DIVISION 3 ANNEX	**131**
DIVISION 4	**98**
DIVISION 6	**657**
DIVISION 8 CERMAK	**230**
DIVISION 8 RTU	**318**
DIVISION 9	**1,880**
DIVISION 10	**708**
DIVISION 11	**504**
TOTAL REPORTS	**5,588**

In April 2016, the DOC piloted a revised procedure for restrictive housing in Division 9 to allow detainees in restrictive housing to have 1.5 hours out of cell each day. In May 2016, the DOC transferred all general population restrictive housing units to Division 9 and initiated our Special Management Unit (SMU) housing. SMU Tiers replaced disciplinary segregation and allowed detainees to receive at least 3 hours out of cell. All detainees are secured using a waist restraint system or security cuffs and are monitored by an increased number of Officers who engage with the detainees on the tier. General population SMU tiers are staffed with at least 3 Officers and mental health SMU tiers are staffed with at least 2 Officers because the census is lower. All tiers, with the exception of Division 9-1F, allow for at least 2 detainees to interact in the dayroom at a time. Division 9 Tier 1F houses detainees that are deemed the most violent based on their recent incidents. The census remains low to allow for increased engagement between correctional staff and detainees, which has a positive impact on the detainee's behavior. Detainees housed in 9-1F are housed alone and come out of their cell alone. They are allowed 1.5-3 hours out of cell depending on their behavior and receive direct behavioral modeling from the DOC staff that remain on the unit with them during hours out of cell. The tier is managed by the DOC's Emergency Response Team, with shift reports distributed to the DOC Executive Staff detailing detainee behavior and overall compliance with the rules. Some of the most problematic detainees have successfully matriculated through the general population SMU and been allowed the opportunity to participate in divisional programs.

When a seriously mentally ill detainee receives a disciplinary infraction, he/she is consequence with no more than 14 days in the SMU for each incident from the Inmate Hearing Board. When a

detainee with serious mental illness has multiple disciplinary infractions, ongoing collaboration occurs between DOC and Cermak to develop behavioral management plans.

If a detainee is identified as P4, he/she is not placed in restricted housing until they are deemed stable for transfer to a lower level of care.

November 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:

November 2016 Cermak Status Update

CCDOC Administration brought in the State of IL statutory compliance their disciplinary SMU process and, presently, detainees' stay in disciplinary SMU cannot exceed 29 days, whereupon, they are removed from SMU 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 SMU screening for this cohort of detainees reentering restrictive settings. Mental health

staff continues to conduct rounds on restrictive housing units at minimum weekly (in addition to the rounds conducted by Nursing/PCS). New updated universal SMU placement notification sheet has been created and implemented. 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. Please refer back to Div. IX updtaes for discussion. Please see PDF Appendix for SMU Screening Compliance data.

To centralize the notification to Cermak mental health and nursing staff of detainees placed in Special Management Units, both agencies agreed upon a revised process that mimics the successful bed control notification process. Cermak leadership will be creating an SMU Notification email address that will be used by the DOC Classification unit to provide daily notifications.

November 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:

November 2016 Cermak Status Update

A restraint audit completed by the Cermak nurse manager, Madonna Mikaitis, R.N. can be found in the PDF Appendix.

Notifications to Facility Director/Chief of Psychiatry are issued via a new process whereby nursing staff scans and emails those notification forms. Chief of Psychiatry continues to review the charts once either a restraint or therapeutic seclusion has been employed during one 24 hour period pursuant to the IL Mental Health and Developmental Disabilities Code.
Cermak Policy I-01 Restraint and Seclusion was reviewed and updated in September 2016 to reflect that: When issuing restraining orders for special populations (i.e. pregnant females, morbidly obsess with BMI> 40, BMI.35 with comorbidity, complex individual behavioral management treatment plans), patients will be evaluated and treated on a case by case basis.

November 2016 Metzner Assessment: QI orders demonstrated continued compliance.

Recommendations: Continue to monitor the 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.

November 2016 Cermak Status Update

There have been minimal changes in the response to or compliance with timeliness in responding to HSRF since the last site visit, as the data has remained relatively unchanged. The primary reason for delayed response to HSRF are largely attributable to staff allocations (more than 50%). However, this trend is actually encouraging given that we have experienced a decrease in staff allocation since the last visit. This means staff have placed increased focus on the completion of this task and maintaining access to care for our patients. This has unfortunately come at the detriment of other clinical activities, such as clinical groups and community meetings. Please see Excel and PDF Appendix.

November 2016 Metzner Assessment: As per status update section.

Recommendations: Complete the previously referenced staffing needs assessment.

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:

November 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. As demonstrated by the chart, the frequency of medication monitoring has reached levels well above 90%.

Periodic monitoring of metabolic indices is essential for the safe administration of second generation antipsychotics. Chief of Psychiatry proposed that an alert be created to ensure timely monitoring of blood glucose levels and lipids against the backdrop of the administration of second generation antipsychotics. The whole CCHHS Health System adopted this new initiative in October 2016. The new alert is now operational. The new rule will automatically fire with the tests for Non-fasting Lipids, Hb A1C, and weight measurement, if the said tests have not been performed over the past 6 months.

Critical Medications Missing Alert is being built in Cerner. It would capture weekly instances of patients missing critical medications (including Clozapine and Decanoate formulations). This report is going to trigger a review by nursing and further notifications of Providers.

	# of Med Order(person)	# of Lab Order	Ratio
10_27_2016			

Lithium	24	24	100.00%
Divalproex Sodium/ Valproic Acid	182	175	96.15%
Risperidone/ Ziprasddone/ Olanzapine	564	251	44.50%

November 2016 Metzner Assessment: As per current status update section

Recommendations: Repeat the audit after training the psychiatrists relevant to the new alert system.

E. SUICIDE PREVENTION MEASURES

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 Metzner assessment: Substantial compliance continues

November 2016 Cermak Status Update

See PDF Appendix for Suicide Detection and Prevention QI Report Qtr. 1-3 2016

November 2016 Metzner assessment: Results of the above referenced QI report were consistent with continued 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 2016 Cermak Status Update

Please refer to QI reports referenced in provision #62.

November 2016 Metzner assessment: Review of the relevant QI results were consistent with the presence of continued 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:

November 2016 Cermak Status Update

Several additional QI projects have been undertaken since the last site visit, referenced throughout this report and/or found in the PDF Appendix.

Mental Health Disposition at Intake
Psychiatric Diagnoses, Self-Injury, and Disciplinary Status of "High Disruption" Detainees
Disciplinary Beds in Segregation & Self-Injury
Cermak Dayroom Hours
HSRF Reason for Delay/Not Seen

November 2016 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. Substantial compliance continues.

Appendix V

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 November 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.

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.

Attachment A

Attachment A

Dorm 1

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	15
Chess	4.5	12
Narcotics Anonymous	1	13
Sheriff's Anti-Violence Effort (S.A.V.E.)	45	Currently 25; Up to 48 – C House

Dorm 2

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	15
Meditation	2	20
Yoga	1.75	40

Dorm 3

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	15
Art	2.5	15
Houses of Healing	1.5	10

Dorm 4 (Workers' Tier)

Program	Number of Hours/Week	Number of Participants
None	None	None

DIVISION 3 AX

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	40
Kennel	31.5	15
Urban Farming Garden	29.25	15

DIVISION 4

Inmate Services Programming – General Population/Floor 2

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	65
Narcotics Anonymous	1	65
Art Therapy (Murals)	2.5	6
Book Club	1	12
Knitting	3	25
Meditation	1.5	20
Piven Theatre Group	2	18
Psychoeducation	4 h/w for Tier I2; 3 h/w for tier P2; 1 h/w for tiers J2, Q2, L2	I2 = 4 hrs. X 15; P2 = 3 hrs. X 15: Q2 1hr X 15; J2 1 hr X 15 and L2 1 hr X 15
Still Point Theater Collective	1.5	20
Storybook Project	3 hrs/wk, once a month	12 monthly

DWJS Programming – Floor 1

Program	Number of Hours/Week	Number of Participants
Adoption Center of IL at Family Resource	1.5	20
Access Community Health Network	4	35
Art Therapy – Sister Angele	4	3

Yoga for Recovery	1	12
Education		
CPS	Approx. 25	23
PACE GED	12	50

DIVISION 6

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	45
Larry's Barber College	18	15
Houses of Healing	1	45
Male Leadership	1	40
Meditation (Claire Seryak)	3	40 – TIER 2H
Meditation (Scott Chambers)	2	20
Narcotics Anonymous	1	120 – TIERS 2A,B,&C, 2Q, 2R
Storybook	3 hrs, once a month	12 monthly
Spanish-Speaking Alcoholics Anonymous	1.25	10
Transgender Group	2	30
Yoga	1	20

DIVISION 8 RTU

Program	Number of Hours/Week	Number of Participants
Art Therapy	2	12 – Tiers 5C & 5D
Book Club	1	15
Houses of Healing	1.5	10 – Tier 5E
Organic Mentoring	1	30
Successful Women Think Differently	1	20 – Tiers 5G & 5H
Yoga	2	15 – 5th floor

DIVISION 9

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	45
Literacy Empowerment	1.75	45 – Tier 1D
Man Up	1	45 – Tier 1D
Men's Wellness Group	50	90 – Tiers 1C & 1D
Narcotics Anonymous	1	90 – Tiers 1C & 1D
Storybook – Law Library	2.5 hrs, once a month	12, monthly
Transgender Group	1.25	5
Yoga/Mindfulness/Meditation	1	45 – Tier 1C

DIVISION 10

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	40
Ethics Class	1.5	15
Meditation	1	20
Storybook	2.5, once every TWO mo.	Varies based on request

DIVISION 11

Program	Number of Hours/Week	Number of Participants
Alcoholics Anonymous	1	40
Anger Management	2	20
Chess	4	16
Drums	4	10
Guitar Lessons	1.5	15
Cermak Administered Health Education	9	15
Health and Wellness (Yoga)	1.5	10

CCDOC Enrichment Programs

Division 2

- 13 hours weekly of enrichment programs
  - involving a total average of 117 participants
  - who attended 11 group sessions
    - 44% 12-Step
    - 33% Personal Transformation
    - 22% Creative Expression

Division 3-Annex

- 51 hours of weekly enrichment programs
  - involving a total average of 70 participants
  - who attended 11 group sessions
    - 95% Vocational
    - 5% 12-Step

Division 4

- 74 hours of weekly enrichment programs
  - involving a total average of 810 participants
  - who attended 54 sessions.
    - 52% Personal Transformation
    - 26% Creative Expression
    - 19% 12 Step
    - 4% Vocational

Division 6

- 33 hours of weekly enrichment programs per week
  - involving a total average of 443 participants
  - who attended 16 sessions.
    - 55% Personal Transformation
    - 27% 12 Step
    - 9% Creative Expression
    - 9% Vocational

Division 8-RTU

- 11.5 hours of weekly enrichment programs
  - involving a total average of 102 participants
  - who attended 9 sessions.
    - 67% Personal Transformation
    - 33% Creative Expression

Division 9

- 29 hours of weekly enrichment programs
  - involving a total average of 368 participants
  - who attended 13 sessions.
    - 56% Personal Transformation
    - 33% 12 Step

Division 11

- 46.5 hours of weekly enrichment programs
  - involving a total average of 306 participants
  - who attended 22 sessions.
    - 50% Personal Transformation
    - 29% Creative Expression
    - 14% 12 Step
    - 7% Vocational

CCDOC Totals as of 10/11/2016

- **262.5 total average number of hours of weekly enrichment programming**
- **2291 average participants**
- **140 sessions**

Notes:

- Group sizes vary – current emphasis being placed on conducting on-living unit programming as frequently as is feasible. Divs 4, 6 and RTU are most impacted by this.
- Data reflected above may include participants who are active in multiple programs.
- Personal Transformation programming encompasses Psycho-Education, Health Education, Vocational, Yoga, Meditation, Mindfulness, Emotional Intelligence, Literacy, Anger Management, Conflict Resolution, and Impulse Control. Some of the key curricula currently being emphasized by CCDOC Enrichment Program staff and Interns includes:
    - ***House of Healing*** – used in Jails and Prisons throughout the Country and focused on Emotional Literacy
    - ***Discovering Ethics: A Path to Virtue*** based upon HH the Dalai Lama's book "Ethics for the New Millennium" – Study Guide adapted by The Prison Mindfulness Institute – a values based curriculum
    - ***Thinking for a Change*** an integrated cognitive behavioral change program used in Prisons and Jails throughout the Country. Used in MHTC.
    - ***Path of Freedom*** a mindfulness-based emotional intelligence curriculum designed by The Prison Mindfulness Institute
- Creative Expression programming encompasses Music, Art, and Theatre.

Attachment B

Cermak Health Services **Functional FTE's** **11/1/2016**

11/1/2016 FTE Psychiatrists and Psychiatric PA

Chair (1)	1.0	(Kelner)
Attending Psychiatrists McNeal, Haq, Miller)	9.8	(Advani, Howard, Marri 0.8, Menezes, Paschos, Ward, Bednarz,
Psychiatric PA (2)	1.1	(Balawender, Locums -Bastidas 0.1)
Psychiatrists Overtime	0.2	(Howard, Moreno)
Psychiatrists (133 acct)	1.5	(Lassen, Chinweze, Ramic, Chavlayohan, Kartan)
Consulting Psychiatrist	0.3	(Binius)
Psychiatrist Locums	1.0	(Garb, Pandit)
Total Functional FTE	***14.9***	

11/1/2016 FTE Psychologists

Chief Psychologist (1)	1.0	(K. Key)
Psychologists (10)	6.0	(Briney, Kaniuk, Waxler, Sillitti, Nunez, Augustine) -
Total Functional FTE	***7.0***	

11/1/ 2016 FTE Mental Health

Mental Health Director	1.0 FTE Gomez
Admin. Asst.	1.0 FTE Burnett
Medical Social Workers	7.0 FTE Musa, Hinds, Tomlin, Mojica, Hooks, Posten, Escamilla
MH Specialists	60.0 FTE (53 licensed***, 7 unlicensed****)
Art Therapists	3.0 FTE
Total Functional FTE	***72.0***

Department of Mental Health ***93.9***

- Consulting Psychiatrist (PT Psychiatry) – Cherian is in credentialing
- Kartan (FT Psychiatry)-presently part time; was given a job offer FT; pending acceptance
- Jonsson (FT Psychiatry); anticipated start January 2016- she is already credentialed as she was employed by JSH until April 2016
- Greiner (FT Physician Assistant); presently in credentialing
- Bastidas (Locums Physician Assistant); being let go in December for performance related issues
- Martinez (Psychology FT) is done with credentialing; had anticipated start November 2016; withdrew from consideration
- Quant (Psychology FT) submitted DTH
- MHS: out of 60 filled PID's:
  -1 (Radici) (credentials/security clearance pulled 10/15/2015, extended administrative paid leave since November 2015)
  -1 (Thomas) (modified leave of absence)
- Summary of Vacancy Rates:

Psychiatry Full Time

Filled	Vacant/Vacancy Rate	Total
10	5 (33.3%)	15

Psychiatry Part Time

Filled	Vacant/Vacancy Rate	Total
6	2(25%)	8 (5PT and 3 Consulting)

Psychology Full Time

Filled	Vacant/Vacancy Rate	Total
6	4(40%)	10

Physician Assistant

Filled	Vacant/Vacancy Rate	Total
1	1(50%)	2

Mental Health Specialists

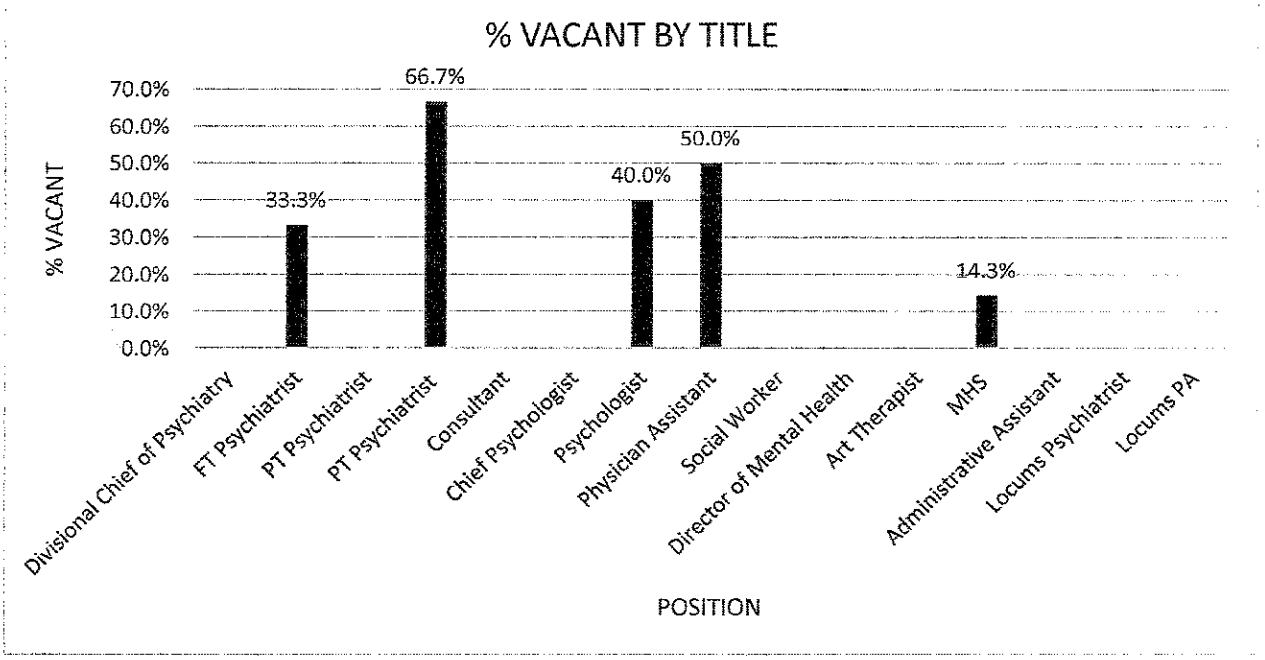
Filled	Vacant/Vacancy Rate	Total
60	10(14.2%)	70

Total Vacancy Rate 18%

Attachment C

Attachment C

POSITION TITLE	ACCOUNT #	VACANT	FILLED	SUM	% VACANT
Divisional Chief of Psychiatry	110	0	1	1	0.0%
FT Psychiatrist	110	5	10	15	33.3%
PT Psychiatrist	133	0	5	5	0.0%
PT Psychiatrist Consultant	155	2	1	3	66.7%
Chief Psychologist	110	0	1	1	0.0%
Psychologist	110	4	6	10	40.0%
Physician Assistant	110	1	1	2	50.0%
Social Worker	110	0	7	7	0.0%
Mental Health Director	110	0	1	1	0.0%
Art Therapist	110	0	3	3	0.0%
MHS	110	10	60	70	14.3%
Administrative Assistant	110	0	1	1	0.0%
Locums Psychiatrist			2	2	0.0%
Locums PA			1	1	0.0%
TOTAL		22	100	122	18.0%



The main task remains attracting full time Correctional Psychiatrists through assertive national search and advertisement campaigns.

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 and 20 direct service hours.
There is one filled position of a Consulting Psychiatrist. The rate of compensation for this position has been made sufficiently attractive.

The rate of compensation for Physician Assistants remains below what is average in the Chicago market.

Recruitment in process:
+2 Psychiatrist candidates selected and in process (Kartan and Jonsson)
+.25 1 Consulting Psychiatrist candidate selected and in process (Cherian)
+ 1 Physician Assistant candidate selected and in process (Greiner)

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 October 2016 the creation of this position has not been cleared.

Cermak has contracts with 3 (three) staffing agencies to provide Locum Tenens Psychiatrists: Medical Doctor Associates (MDA), Maxim Physicians Resources and Columbus Organization. The fourth (Re-Group Inc.) is being added. All Vendors' contracts have Amendments for Telepsychiatry. Dr. Garb, furnished by Columbus, is deployed on site at Cermak in Division X. Dr. Pundit (Maxim) started providing direct service hours in Division X as a Telepsychiatrist in September 20916. The contracts for the three locum tenens agencies have been extended into 2017. Based on present clinical needs and recruitment yield, Cermak Mental Health Department projects that we will continue to need staffing assistance. Some of the Locums Psychiatrists who are currently in the credentialing process did not complete it. One Locums Provider decided not to pursue this position after the first two weeks of Orientation.

Ongoing current advertisement efforts by CCHHS involved postings in industry publications, including the AAPL quarterly letter, communication with the local feeder schools, and participation in local Psychiatry Fairs (October 2016).

On the CCHHS Job Site there has seen a significant increase in visiting candidates for this reporting period (June– Sept 2016) compared to the previous reporting period (Mar – May 2016). The specific metrics were for the Physician, Psychologist, Mental Health & Services and PA postings. There has been a credible increase in all candidate categories and, specifically, in the categories critical for Cermak. There was an averaged 44% increase in candidate views for this reporting period (June– Sept 2016) compared to the previous reporting period (Mar – May 2016) across all job categories.

For psychiatrists, Salary increases for K10, from $216,661 to $231,084, in addition to the same $15,000 Cermak differential, were made in April 2016.

Additional staff hired in the CCHHS's Credentialing office will provide for increased support to engage applicants and expedite processing.

New "Advanced Clinical Process (ACP)" started as a pilot at Cermak in November 2015. The Advanced Clinical Process was created to assist Cermak in filling hard to fill credentialed positions. The ACP process has helped enhance the recruitment process by allowing for the participation of departments to solicit candidates to submit resumes / CVOs to a centralized mailbox, which allows for the expedited review and determination of candidates meeting minimum requirements. Due to success of this pilot, the ACP process is now implemented CCHHS wide.

In May 2016 Chief of Psychiatry submitted a program addendum to cooperative educational master agreement for rotation of Forensic Fellows from Forensic Fellowship Program at Northwestern University at Cermak. The identified need is to provide evaluations, prepare Petitions, and testify during trials for the Administration of Involuntary Medications (non-emergency basis).

Cermak Mental Health continues to support student and Psychiatry residents' rotations/training on site from nearby medical schools (Rush+ UIC's Master Educational Agreement is being renewed presently).

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 40% (4 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.

Recruitment in Process until end of October, when both candidates withdrew:
+0 2 Psychologist candidates withdrew (Martinez had pending start date/Quant in credentialing)

For FY 2017, Cermak has submitted a request to fund 2 post-doctoral Psychology Fellows to work under the supervision of the Chief of Psychology, to provide diagnostic assessment, crisis intervention, intake evaluations, group and individual therapy, consultation with multidisciplinary treatment team, projective and objective psychological testing, security and civilian staff training, and supervision of practicum students.

There is a total of 70 MHS Specialist Positions with a current vacancy rate of 14.2 %. 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).The ones who have matriculated Master's Programs and obtained licensure are being promoted into MHS III Positions. If these employees do not achieve licensure by their specified dates, their position will be eliminated. The first rounds of separations took place in July 2016. Presently, licensed staff (as they meet their educational and licensure requirements) is being promoted to fill positions vacated by the unlicensed staff. Some of the resignations, attrition, and internal transfers coincided with the first round of separations and caused a temporary increase in vacancy rates during the months of July-October of 2016. A staffing proposal calling for additional MHS III (licensed positions) was developed and submitted to Cermak Leadership for sponsorship. Cermak had submitted a FY 2017 Budgetary Request for a large number of positions for Cermak.

Cermak has received support for a number of positions, some of which were for the Mental Health Department. Approval by the Cook County Board of Commissioners is necessary and should be considered pending approval until that time. The start of the fiscal year is December 1st. Cermak received support for 14 new Mental Health Specialist III positions and 1 Activity Therapist.

There is a total of 7 Medical Social Workers Positions. All the positions have been filled.

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.

Attachment D

Attachment D

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	3	4	4	2	7	6	1	4	5			39
2015	3	7	2	2	3	10	0	3	2	4	6	3	45
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	10	13	11	5	39
2015	12	15	5	13	32
2014	12	13	11	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 Judges at the Leighton Center (26th and California), thus reducing Cermak's travel and time expenditures. 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).

Cermak Mental Health has put forth a new initiative in order to facilitate and streamline petitions for the administrations of involuntary medications for pretrial detainees at Cook County Jail. A two-member review committee. This committee includes representatives of the Mental Health Department Administration: Director of the Mental Health Department (Chief of Psychiatry) and Chief Psychologist. The Committee performs the following functions:

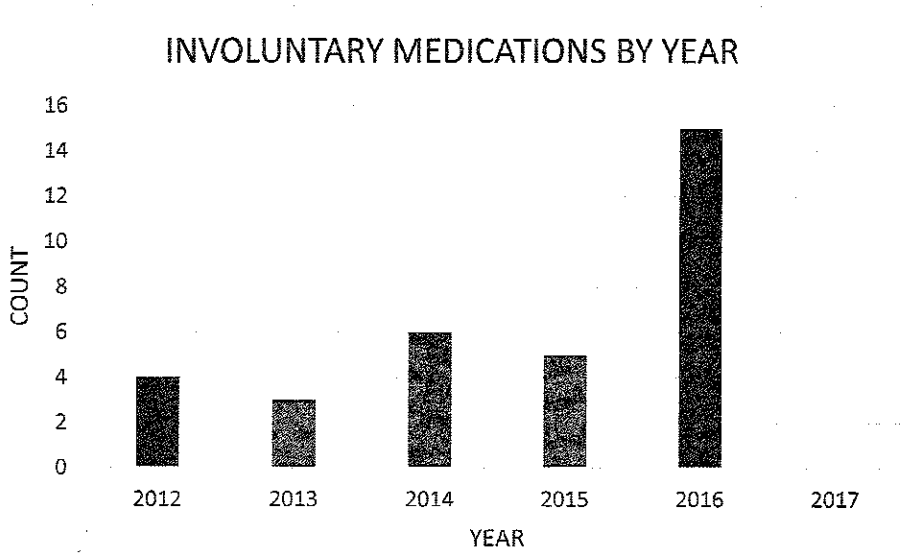
1. The Committee assist psychiatric Providers in the process of selection of patients meeting criteria for the involuntary administration of psychotropic medications. The committee's finding and recommendations have advisory power and the Committee will work closely with Providers in order to efficiently identify and select Patients who are in need of treatments.

2. The Committee works with Providers assisting in filing the motions for the "modification" of petitions granted in Cook County so that they be applicable at the DMH facilities located in different counties of the state of Illinois. Conversely, assistance will be provided in having orders "domesticated "to Cook County for detainees returning from DMH facilities in outlying counties.

Judge S. Sullivan and Assistant General Counsel, Cook County Health & Hospitals System J. Dimoff guided Cermak in the exploring various alternative arrangements to replace/supplement MH Court hearings at the Dailey Center. As the result of their efforts, some of the Petition hearings have been conducted at the Leighton Center and, more importantly, an attempt was made to start conducting those hearings from Cermak Basement using the already existing Polycom teleconferencing equipment.

New Rule governing the use of videoconferencing equipment in hearings under the MH and Developmental Disabilities Code was approved by the Circuit Court of Cook County in September 2016. It was designed to facilitate fair, just, and clinically appropriate hearings for persons in need of psychotropic medications by court order and reduce clinically inappropriate and burdensome transportation of persons with SMI from mental health facilities and jail to courtrooms. Cermak was able to identify a physical location/lighting and security arrangements for the respondent and his counsel and other participants. Videoconferencing equipment at Cermak was compatible with the court's system. However, the results of the pilot teleconferencing hearings were not satisfactory in that the existing conferencing capabilities do not measure up to the standards necessary to assure the integrity of court hearings should the respondent and his counsel as well as ASA are present at Cermak altogether. An ad hoc possibility remains that Providers (witnesses) are allowed to testify in these proceedings from Cermak while the Judge, respondent, counsels, and witnesses are located in a courtroom elsewhere. The room and equipment previously identified will only work when there is one witness (Provider) testifying from the hospital. This can only happen when the respondent has elected not to be present, the attorneys agree and the court so orders.
There is a CODEC Video-conferencing machine in Markham Courthouse that may be of assistance at Cermak. Office of general Counsel, CCHHS is actively assisting in exploring the possibility of transporting this equipment to Cermak to facilitate videoconferencing hearings. The said equipment is able to pan, tilt, or zoom, which is necessary to adequately conduct the hearings in compliance with the newly adopted Circuit Court Rules governing such proceedings.

Between exploring new venues for Petition hearings, receiving active support from the Office of General Counsel, CCHHS and Judge Sullivan, and capitalizing on new staffing allocations, Cermak has filed 15 petitions for Involuntary Medications in 2016 thus far. As a reference point, in 2012 there were 4 petitions filed altogether. This surge in Petitions represents almost 300% increase.


INVOLUNTARY MEDICATIONS BY YEAR
COUNT
16
14
12
10
8
6
4
2
0
2012
2013
2014
2015
2016
2017
YEAR

Attachment E

NURSING DEPARTMENT -CENSUS REPORT
FY 2016

2ND FLOOR - PSYCHIATRY -

MONTH	CENSUS	AVG	ADMISSIONS	TRANSFERS	DISCHARGES	TOTAL PAT, DAYS	AVG LENGTH OF STAY
JUNE	2218	73.93	186	83	187	2218	11.86
JULY	2381	76.81	169	64	177	2381	13.45
AUG	2379	76.74	199	70	176	2379	13.52
SEPT	2516	83.87	191	133	148	2516	17.00
OCT	2458	79.29	187	57	172	2458	14.29

2 NORTH -

MONTH	CENSUS	AVG	ADMISSIONS	TRANSFERS	DISCHARGES	TOTAL PAT, DAYS	AVG LENGTH OF STAY
JUNE	756	25.20	148	45	104	756	7.27
JULY	724	23.35	130	33	105	724	6.90
AUG	769	24.81	145	41	99	769	7.77
SEPT	865	28.83	149	88	60	865	14.42
OCT	877	28.29	145	39	114	877	7.69

2 WEST - FEMALE

MONTH	CENSUS	AVG	ADMISSIONS	TRANSFERS	DISCHARGES	TOTAL PAT, DAYS	AVG LENGTH OF STAY
JUNE	326	10.87	38		40	326	8.15
JULY	411	13.26	39		45	411	9.13
AUG	452	14.58	54		46	452	9.83
SEPT	470	15.67	42		46	470	10.22
OCT	450	14.52	42		37	450	12.16

NURSING DEPARTMENT -CENSUS REPORT
FY 2016

2 SOUTH

MONTH	CENSUS	AVG	ADMISSIONS	RECEIVED BY TRANSFER	DISCHARGES	TOTAL PAT, DAYS	AVG LENGTH OF STAY
JUNE	535	17.83		28	32	535	16.72
JULY	616	19.87		19	17	616	36.24
AUG	552	17.81		19	20	552	27.60
SEPT	575	19.17		31	29	575	19.83
OCT	497	16.03		13	16	497	31.06

2 SE

MONTH	CENSUS	AVG	ADMISSIONS	RECEIVED BY TRANSFER	DISCHARGES	TOTAL PAT, DAYS	AVG LENGTH OF STAY
JUNE	268	8.93		5	6	268	44.67
JULY	275	8.87		4	4	275	68.75
AUG	269	8.68		6	6	269	44.83
SEPT	268	8.93		11	10	268	26.80
OCT	277	8.94		2	2	277	138.50

2 EAST

MONTH	CENSUS	AVG	ADMISSIONS	RECEIVED BY TRANSFER	DISCHARGES	TOTAL PAT, DAYS	AVG LENGTH OF STAY
JUNE	333	11.10		5	5	333	66.60
JULY	355	11.45		8	6	355	59.17
AUG	337	10.87		4	5	337	67.40
SEPT	338	11.27		3	3	338	112.67
OCT	357	11.52		3	3	357	119.00