Crystal Padilla

From:	Metzner, Jeffrey <JEFFREY.METZNER@CUANSCHUTZ.EDU>
Sent:	Wednesday, March 18, 2026 11:39 AM
To:	NMDml_Judge Browning's Chambers nmd.uscourts.gov
Cc:	kelsea@roblesrael.com; Kelly Waterfall (kelly@rjvlawfirm.com); M Kumar (emailofkumar@gmail.com)
Attachments:	responses.docx; March 2026 final report.docx; Attachment 1 Screening and Assessment studies.docx; Attachment 2 Quality of MH assessments.docx; Attachment 3 Treatment Planning.docx; Attachment 4 Chronic care clinic.docx; Attachment 5 MH input into disc process.jpeg; Attachment 6 Timely medication reviews.docx; Attachment 7 Treatment Plans.docx
Follow Up Flag:	Follow up
Flag Status:	Flagged

4/2/26

CAUTION - EXTERNAL:

Dear Judge Browning:

Attached in my report based on my February 2026 site assessment. My July 2025 email to you re: the July 2025 site assessment included the following:

> I am also attaching an additional document, which is excerpted from the report (pages 4-7) because it highlights my response to a specific objection by Plaintiff Intervenors' regarding the monitoring process. Unless the Court instructs me otherwise, I will continue with the revised monitoring process for the reasons I have summarized in the issue of concern attachment.

Please note that Plaintiff Intervenors continue to voice their objections to my revised monitoring process. I am attaching a document entitled "responses" that I have sent to both parties in an attempt to address their concern.

Pleased contact me if you have any questions.

Sincerely,

Jeffrey L. Metzner, M.D., P.C.
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CAUTION - EXTERNAL EMAIL: This email originated outside the Judiciary. Exercise caution when opening attachments or clicking on links.

I need a working copy.
4/2/26

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March 18, 2026

United States District Court
District of New Mexico
Attn: The Honorable Judge James Browning
United States District Court
Pete V. Domenici United States Courthouse
333 Lomas Blvd. NW, Suite 660
Albuquerque, New México 87102

Re: McClendon, et. al. v. The City of Albuquerque, et. al.
USDC No. CIV 95-0024 MV/ACT

Dear Judge Browning:

I have completed my assessment relevant to the mental health services provided at the Metropolitan Detention Center (MDC) in the context of Judge Parker's September 23, 2014, June 27, 2016, and September 29, 2021 Orders. This report is based on my site visit during February 25, 2026, which involved participation by University of New Mexico Hospital (UNMH) staff, key correctional leadership staff and attorneys for plaintiff-intervenors, UNMH and MDC.

Sources of information in compiling this report included review of the following documents:

1. the PSU Matrix 2025 (January 1 – December 31, 2025),
2. Suicide Prevention committee meeting minutes from July, August, October, November, December 2025,
3. a February 19, 2026, 130-page letter from Kelly Waterfall, Esq. re: *McClendon, et al. v. City of Albuquerque, et al.* – the February 2026 Site Visit, which included responses from UNMH and MDC,
4. the following Quality Improvement studies for Q3 and Q4 2025:
    a. 01 Clinical Seclusion (MH Observation) Audit,
    b. 02 Constant Monitoring of Inmates Presumed to be of Moderate or High Risk of Suicide or Self-Harm,
    c. 03 Final DC Planning of PAC and RHU Audits,
    d. 05 Inmates who Should have been Opened to PSU but Never were,

e. 06 Psych Meds Renewal,
f. 06B Psych Med Renewal GP Audit,
g. 07 Psych Med Adjustment ,
h. 07B Psych Med Adjustment 30-day FU GP Audit,
i. 08 Quality of BH Assessments of Non SMI Patients in GP-Q3,
j. 09 Quality of BH Assessments of SMI Patients in GP,
k. 11 Referrals Open to PSU from GP (Negative MH Screens from Intake),
l. 12 Request for Service (HCR) MH Response Time,
m. 14 Suicide Watch Follow-up Rounding Audit,
n. 15 Treatment and Discharge Planning for Non-SMI Patients in GP- Q4,
o. 16 PAC 1, 3, 4, and HSU 6 Treatment Team Treatment and Discharge Planning,
p. 18 UoF Cleared By Medical and PSU,
q. 19 PSU Chronic Care,
r. 20 Treatment Team Treatment and Discharge Planning RHU,
s. 21 Safety Monitor Suicide Observation Logs. July 2025-December 2025 audits,
t. 21A Constant Suicide Watch Safety Monitor Observation Logs Audit. July 2025-December 2025 audits,
u. 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals,
v. 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2 Referrals,
w. 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3 Referrals,
x. 26 Inmates Placed on Suicide Watch,
y. 27 Inmates Placed on Clinical Seclusion- Qs 3&4 audit,
z. 28 Timeliness of Nursing MH,
aa. 30 Quality of BH Assessments,
bb. 32 Behavioral Assessments of Detainees Displaying SA, SI or Self-harming Behavior,
cc. 15- minute audits,
dd. RHU audits,

5. Psychological autopsies completed during the monitoring period,
6. SPC meeting minutes and sing-in logs,
7. Morbidity reviews completed during the monitoring period,
8. Morbidity and Mortality logs,
9. M&M Action Plan, and
10. Bernalillo County jail diversion efforts.

During the site visit I also met with line staff in a group setting and interviewed detainees in Fox 2, RHU 3, RHU 6 and Delta 3. I inspected safe cells in two of the detox housing units. I also met briefly with many of the available line mental health staff in a group setting.

Population Statistics
UNMH Status Update as of 12/31/25

POPULATION INFORMATION	Jul	Aug	Sep	Oct	Nov	Dec
Total MDC average daily population (ADP) CAP 1950	1723	1735	1735	1,667	1,675	1,627
MDC ALL POPULATION - ALOS (as of last working day of the month)	22.6	23.7	22.7	25.4	23.8	24.4
PSU POPULATION ALOS (as of last working day of the month)						
Absolute # on PSU caseload (on last working day of the month)	856	790	804	768	832	864
% of total Population on PSU Caseload	50%	46%	46%	46%	50%	53%
Absolute # of SMIs in total population (last working day of the month)	166	183	185	170	175	168
% of total Population who are SMI	10%	11%	11%	10%	10%	10%
% of PSU caseload who are SMI	19%	23%	23%	22%	21%	19%

February 2026 Findings: As per status update. The average daily population has somewhat decreased since the July 2025 site visit. The percentage of detainees on the PSU caseload has slightly increased since the last site visit. The percentage of detainees with a SMI has slightly increased.

UNMH Status Update as of 02/06/2026

BACKLOG DATA	June	July	August	Sept	Oct	Nov	Dec
# of 30-day MD SMI follow ups NOT seen (absolute number on the 30th day of the month) - BACKLOG	47	25	20	42	36	23	60
% SMI who haven't been seen within 30 days.(30th day of the month) total caseload	31%	15%	11%	23%	21%	13%	7%
# for 30-day MD NON-SMI follow ups NOT seen (absolute number on the last working day of the month) - BACKLOG	121	204	63	163	191	160	75
% NON SMI who haven't been seen within 90 days. (last day of the month)	15%	24%	8%	20%	25%	19%	9%
# days out for oldest back log appointment for MDs as of the last day of the month.	30	30	37	39	52	26	75

UNMH Status Update as of 02/06/2026

Staffing Table, A:

Study: Staffing Fill Rate Compared to Budget (Average for Auditing Period Q3/Q4)

QMHP	• 18.8 filled / 19 allocated **(99%)** o All counselor positions are filled. The 0.2 variance reflects two employees working at 0.9 FTE.
Psychiatrists	• 4.9 filled / 7 allocated (70%) o Vacancies are currently being backfilled with Psychiatric Nurse Practitioners.
Psychiatric Nurse Practitioners (NPs)	• 1.9 filled / 1 allocated (190%) o The additional NP is supporting coverage for one Psychiatrist vacancy.
Average Psychiatric Provider Coverage Combined (July/Dec)	• 7.3 FTE / 8.0 allocated (91.0%)
Psychiatric Director:	• 1 filled / 1 allocated (100%)
Mental Health Director	• 1 filled / 1 allocated (100%)
Registered Nurses (RNs):	• 4.5 filled / 6.4 allocated (70%) o UNMH RN's are providing floating to support areas with staffing needs.
Licensed Practical Nurses (LPNs):	• 1 filled / 0 allocated (100%) o Position provides additional clinical support beyond the allocated staffing model.

The staffing chart is included below for reference. Due to image size limitations, please refer to the **PSU Monthly Matrix** included in the packet for the full-size, original version.

ACTUAL STAFFING NUMBER PER MONTH

STAFFING	Jul	Aug	Sept	Oct	Nov	Dec
Actual # MHPs functionally filled	19.0	19	19	19	15	18.8
Total # of MHP FTEs allocated	19	19	19	19	19	19
% MHP Filled positions	100%	100%	100%	100%	79%	99%
Actual # nursing (RN) positions functionally filled	5.4	5.4	5.4	5.4	5.4	4.5
Total # RN FTEs allocated	6.4	6.4	6.4	6.4	6.4	6.4
% RN Filled positions	84%	84%	84%	84%	84%	70%
Actual # nursing (LPN) positions functionally filled	1	1	1	1	1	1
Total # LPN FTEs allocated	0	0	0	0	0	0
% LPN Filled positions	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Actual # of Psychiatrists functionally filled	5.4	5.4	5.2	5.3	5.9	4.9
Total # Psychiatrists FTEs allocated	7	7	7	7	7	7
% Psychiatrists Filled positions	77%	77%	74%	84%	84%	70%
Actual # of PSYCH NP functionally filled	1.9	1.9	1.9	1.9	1.9	1.9
Total # PSYCH NP FTE allocated	1	1	1	1	1	1
% Psychiatrists Filled positions	190%	190%	190%	190%	190%	190%
Actual # of PSYCH Director functionally filled	0.9	0.9	0.9	0.9	0.9	0.9
Total # PSYCH Director FTE allocated	1	1	1	1	1	1
% Psychiatric Director Filled positions	90%	90%	90%	90%	90%	90%
Actual # of MH Director filled	1	1	1	1	1	1
Total # MH Director FTE allocated	1	1	1	1	1	1
% MH Director Filled positions	100%	100%	100%	100%	100%	100%

The current custody line staff vacancy rate was 28%.

In the next section of this report, in order to decrease the number of pages and make the status section easier to read, I have cut and pasted portions of many status update sections to various attachments in order to keep the length of this report more manageable.

The following section will summarize my findings regarding the provisions of the Settlement Agreement. Findings from prior site visits may be included when they provide context to the current findings. In the findings sections I have attempted to specify what each provision is requiring, and which audit(s) or instruments should be used to measure compliance with such requirements.

A. Screening and Assessment

1) Whether MDC has developed and implemented policies and procedures for appropriate screening and assessments of inmates with serious mental health needs.

July 2025 Findings: As per status update. This provision will be assessed during future site visits in the context of timely healthcare screening in the RDT by nursing staff.

Compliance will be measured by results of pertinent elements of the following audits:

a. 05 Inmates who Should have been Opened to PSU but Never were,
b. 11 Referrals Open to PSU from GP (Negative MH Screens from Intake),
c. 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals
d. 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2 Referrals
e. 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3 Referrals
f. 28 Timeliness of Nursing MH Audit,

UNMH Status Update as of 02/06/2026:

As outlined in the requirements above, the requested audits focusing on Q3 and Q4 2025 are provided summarized in Attachment.1.

February 2026 Findings: My July 2025 report indicated the following: "This provision will be assessed during future site visits in the context of timely healthcare screening in the RDT by nursing staff." However, I also stated the compliance would be measured by 6 different audits as listed above, which means I did not clearly state how this provision was to be assessed. The assessment includes reviewing audits regarding the timeliness of the nursing screen and quality of the nursing screen.

Timeliness of QMHP and psychiatrists' responses to referrals will be assessed in SA provision A2.

As per Attachment 1. All of the above audits, except for audit 11 demonstrated compliance.

Audit 11 Negative Intake referrals open to PSU from GP:

> Overall compliance demonstrated steady progress, improving from 84% in Q3 to 88% in Q4, with several indicators consistently above the 90% threshold, reflecting strong performance. While some elements showed minor variability, results overall indicate continued adherence to intake PSU exclusion protocols and strengthened documentation standards.

Partial compliance is present.

2) Whether MDC has developed and implemented an appropriate screening instrument that identifies mental health needs and ensures timely access to a mental health professional when inmates present symptoms requiring such care.

July 2025 Findings: This provision is specific to referrals generated from RDT to a qualified mental health professional (QMHP) and requires timely assessments based on their acuity level.

The audits used to assess the level of compliance for this provision are as follows:

a. 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals,
b. 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2 Referrals Audit,
c. 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3 Referrals Audit,

Only the results in these audits specific to the timeliness of assessments by a QMHP should be reported in this provision. The results will not be averaged because the timeframes differ for each P level.

SA provision 11 assesses the quality of these assessments.

UNMH Status Update as of 02/06/2026:

See Attachment 1—audits 22,23,24—questions 2 & 3 in each audit.

February 2026 Findings: As per status update. Issues were present with timeliness of QMHP assessments (for one quarter) although UNMH is coming close to compliance.

Partial compliance is present.

3) Whether MDC screens all inmates with Qualified Medical Staff upon booking at MDC, but no later than four (4) hours after booking, to identify the inmate's risk for suicide or self-injurious behavior.

July 2025 Findings: The outcome measure for this provision is whether the initial healthcare screening includes an adequate suicide or self-injurious behavior screening. The current healthcare screening includes the use of the Columbia-Suicide Severity Rating Scale. The relevant audits are as follows:

a. 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals,
b. 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2 Referrals
c. 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3 Referrals

These audits currently include an assessment whether an appropriate referral is made, which

includes whether the assessed P levels are accurate and whether the Columbia Suicide Severity Rating Scale is appropriately administered and assessed. However, these audits have not reported such findings.

I discussed with staff the above issue and it was agreed that future audits will include the following results in this provision:

a. Was the Columbia Suicide Severity Rating Scale appropriately administered and assessed?
b. Was the appropriate P level assigned consistent with results of the Columbia Suicide Severity Rating Scale assessment?

UNMH Status Update as of 02/06/2026:

2025	22 Timeliness P1	Q3	Q4
4	Was Columbia Suicide Severity Rating Scale appropriately administered and assessed?	100%	100%
5	P-Level Assigned Correctly	100%	100%

2025	23 Timeliness P2	Q3	Q4
4	Was Columbia Suicide Severity Rating Scale appropriately administered and assessed?	90%	100%
5	P-Level Assigned Correctly	87%	100%

2025	24 Timeliness P3	Q3	Q4
4	Was Columbia Suicide Severity Rating Scale appropriately administered and assessed?	100%	100%
5	P-Level Assigned Correctly	100%	100%

Across Q3 to Q4 2025 compliance with suicide risk assessment and P-Level assignment remained strong. Questions 4 and 5 for P1 and P3 were consistently 100%, while P2 showed notable improvement, rising from 90% to 100% for P-Level assignment. The Q3 P2 audit served as a baseline, and targeted education and process adjustments helped address earlier issues, resulting in full compliance by Q4. These results reflect staff dedication, effective training, and ongoing attention to accurate risk assessment and P-Level assignment.

February 2026 Findings: As per status update. Compliance continues.

4) Whether MDC's Qualified Medical Staff conducting intake screening receive adequate training on identifying and assessing suicide risk, are assigned appropriate tasks and guidance, and properly conduct intake screening.

UNMH Status Update as of 02/06/2026:

To ensure accurate and consistent intake screening, UNMH has established a structured training and quality assurance program for Med 3 nursing staff. All new hires complete the UNMH Med 3 Orientation Checklist and are enrolled in Learning Central training modules. Notably, the module OAT 2455INPT Online Annual Competency – Suicide Screening and Precautions in Non-Psychiatric Inpatient Settings 2024 was added to provide foundational instruction on the use of the Columbia Suicide Severity Rating Scale (C-SSRS).

Ongoing education is provided through orientation, one-on-one instruction from the Supervisor and Director, and support from UNMH's Unit-Based Educator (UBE). A dedicated nurse also conducts real-time audits of intake screenings, using results to deliver immediate feedback and targeted training as needed.

This multi-level approach ensures Med 3 staff are well-prepared to accurately assess suicide risk, supporting timely and appropriate mental health evaluations at intake.

February 2026 Findings: As per status update. Compliance is maintained.

5) Whether MDC Qualified Medical Staff, based on the screening, develop, and implement an acuity system or triage scheme (P1, P2, or P3) to ensure that inmates with immediate mental Health needs are prioritized for services.

July 2025 Findings: The outcome measure for this provision is whether the initial healthcare screening results in an appropriate assigned P level. The relevant audits are as follows:

d. 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals,
e. 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2 Referrals Audit,
f. 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3 Referrals Audit.

These audits currently include an assessment whether an appropriate referral is made, which includes whether the assessed P level was accurate. However, these audits have not reported such findings.

I discussed with staff the above issue and it was agreed that future audits will include the following results in this provision: Was the appropriate P level assigned consistent with results of the healthcare screening performed by nursing staff?

UNMH Status Update as of 02/06/2026:

See Attachment 1.

Based on the Q3 and Q4 2025 audits for P1, P2, P3 referrals, MDC Qualified Medical Staff are appropriately assigning P levels consistent with the initial healthcare screenings conducted by nursing staff.

The above results demonstrate that the intake screening process effectively supports the acuity-based triage system, ensuring individuals with immediate mental health needs are appropriately prioritized. While compliance was already high for P1 and P3, the improvements in P2 indicate that identified gaps were addressed, reinforcing the reliability of the P-level assignment process. On average, P1-P3 referrals are completed within approximately 17 hours and 56 minutes. In this study the patients that were beyond 24-hours:

- 29:16
- 26:38
- 29:19
- 38:47 (seen on time, documentation enter later in the shift

Overall, these results demonstrate that MDC provides timely psychiatric services and effectively prioritizes residents with identified metal health needs.

February 2026 Findings: See Attachment 1—audits 22,23,24 (question #5 on each audit).

Compliance is present.

6) Whether MDC provides "sufficient psychiatric services to assure that a psychiatrist will evaluate no later than the business day after a resident's admission, any resident who: 1) reports being on any psychoactive medication when taken into custody, 2) requests any psychoactive medication or other psychiatric service, or 3) has been identified by any mental health or health

professional at the jail as appropriate for a psychiatric assessment." *[Doc. No. 256, IIII (1-3)].*

a. Whether MDC provides adequate and timely psychiatric services to assess any inmate who:
(1) reports being on any psychiatric medication when taken into custody,
(2) requests any psychiatric medication or other psychiatric service, or
(3) has been identified by any mental health or health professional at the jail as appropriate for a psychiatric assessment.

UNMH Status Update as of 02/06/2026:

2025	22 Timeliness P1	Q3	Q4
3	Evaluated by Psychiatry within one Business Day of Referral	80%	87%
2025	23 Timeliness P2	Q3	Q4
3	Evaluated by Psychiatry within one Business Day of Referral	97%	90%
2025	24 Timeliness P3	Q3	Q4
3	Evaluated by Psychiatry within one Business Day of Referral	80%	90%

Based on the Q3 and Q4 2025 audits for P1, P2, and P3 referrals, MDC provides psychiatric evaluations within one business day in the majority of cases, supporting timely access to psychiatric services for residents who are on psychoactive medications, request psychiatric care, or are identified by staff as needing an assessment:

- P1 Referrals: Evaluations improved from 80% in Q3 to 87% in Q4.
- P2 Referrals: Evaluations remained high, slightly decreasing from 97% in Q3 to 90% in Q4.
- P3 Referrals: Evaluations improved from 80% in Q3 to 90% in Q4.

On average, P1-P3 referrals are completed within approximately 17 hours and 56 minutes. In this study the patients that were beyond 24-hours:

- 29:16
- 26:38
- 29:19
- 38:47 (seen on time, documentation enter later in the shift)

Overall, these results demonstrate that MDC provides timely psychiatric services and effectively

prioritizes residents with identified metal health needs.

Overall, these results demonstrate that MDC provides timely psychiatric services and effectively prioritizes residents with identified metal health needs.

February 2026 Findings: As per status update. Partial compliance remains.

7) **Whether MDC implements policies and procedures, commensurate with the level of risk of suicide or self-harm, that ensure that inmates are protected from identifiable risks for suicide or self-injurious behavior.**

UNMH Status Update as of 02/06/2026

Based on the July-December 2025 Safety Monitor Observation Log audits, UNMH demonstrates adherence to policies and procedures designed to protect residents from identifiable risks of suicide or self-harm. Compliance with required observation intervals remained strong especially after retraining in August 2025, however; there is still room for on-going improvement.

2025	21 Safety Monitor Observation Logs	July	Aug	Sept	Oct	Nov	Dec
1	If the watch level is staggered, did the safety monitor stay within the allowed parameters of checks/observations not to exceed 15 minutes on any patient checks/observations?	87%	87%	97%	93%	97%	93%
	Overall Compliance	87%	87%	97%	93%	97%	93%

These results indicate that Safety Monitors are more consistent in maintaining the required frequency of checks, including staggered watch levels, since September 2025. The sustained performance reflects both staff diligence and the effectiveness of prior quality improvement measures, such as refreshed training and improved clarity. Overall, UNMH continues to implement procedures aligned with suicide and self-harm risk, supporting timely and accurate observations while continuing to refine practice toward full compliance.

2025	21A Safety Monitor Constant Observation Logs	July	Aug	Sept	Oct	Nov	Dec
1	If the watch level is constant, did the safety monitor stay within the allowed parameters of checks/observations providing constant 10-minute checks/observations?	83%	100%	100%	100%	100%	100%

Constant Observation Performance July – December

UNMH continues to monitor the effectiveness of constant observation watches to ensure adherence to required safety protocols, specifically that checks/observations occur continuously and are documented at least every 10 minutes.

Compliance improved substantially after July and remained consistently high through December, reflecting increased consistency in staff adherence to constant observation standards. The performance demonstrates the effectiveness of ongoing training, supervisor, and accountability measures for Safety Monitors.

February 2026 Findings: As per status update. The fifteen-minute watches can be performed by either Custody staff or healthcare "sitters." Currently, MDC and UNMH do separate audits relevant to this provision, which has raised several questions regarding results as summarized in the Plaintiffs-Intervenors letter. I discussed with leadership staff implementing just one audit relevant to this provision. If nursing staff provide appropriate supervision to the sitters, review of videotapes would not be a necessary component of such an audit.

Partial compliance.

February 2026 Recommendations: As above.

8) Whether MDC's policies and procedures require that a Qualified Mental Health Professional performs a mental health assessment within the prescribed period of time, based on the inmate's risk.

July 2025 Findings: This provision is specific to the RDT process and requires a policy and procedure that provides relevant time frames for completion of mental health referrals by a QMHP.

Such a policy exists - MDC HCA 12.34. Compliance is present.

This provision does not address the implementation of such a policy. SA provision 2 addresses the implementation of this policy.

UNMH Status Update as of 02/06/2026:

MDC policy HCA 12.34 remains in effect and defines specific time frames for a Qualified Mental Health Professional to complete mental health assessments based on an inmate's level of risk. The policy continues to exist without substantive changes, and its next scheduled annual review is May

2026.

February 2026 Findings: As per status update. Compliance is maintained.

February 2026 Recommendations: Report any changes in this policy in the future.

9) Whether MDC security staff monitors inmates who are presumed to be of moderate or high risk of suicide or self-harm with constant supervision until the inmate is seen by a Qualified Mental Health Professional for assessment, and thereafter on the schedule chosen by the Mental Health Professional.

UNMH Status Update as of 02/06/2026:

We acknowledge that 100% compliance is required for this standard. Recent audit results for Q3 and Q4 2025 were 97% and 93%, respectively. While these scores fall short of full compliance, constant monitoring remains a priority.

2025	02 Constant Monitoring of Patients Presumed to be of Moderate or High Risk of Suicide or Self-Harm	Q3	Q4
1	MDC security staff monitors inmates with constant supervision until the inmate is seen by a QMHP for assessment.	97%	93%

The Q3-Q4 2025 scores were primarily due to documentation issues, not lack of supervision. In these cases, patients were continuously monitored by MDC security staff until a QMHP or our RRT department arrived; however, encounter notes did not always capture this information. Dr. Oliver has recently reinforced that proper documentation including statements such as "Upon arrival, the patient was within line of site of security staff." The RRT department often arrives first on the scene and should provide the QMHP with a complete "warm handoff" to support accurate documentation and achieve full compliance. Any staff assessing the patient must ensure documentation clearly reflects adherence to monitoring protocols.

February 2026 Findings: As per status update. Partial compliance although significant improvement is noted.

10) Whether MDC conducts appropriate mental health assessments within the following periods from the initial screen:
  a. 14 days, or sooner, if medically necessary, for inmates classified as low risk (P3);

b. 8 hours, or sooner, if medically necessary, for inmates classified as moderate risk (P2); and
c. Immediately, but no later than four hours, for inmates classified as high risk (P1).

July 2025 Findings: As per status update. This provision monitors the quality of the mental health assessments generated as result of the RDT screening process. Audits need to be developed and implemented similar to audits 8 & 9 that are used for SA provision 11 (along with the recommended revisions as described in SA provision 11).

UNMH Status Update as of 02/06/2026:

UNMH has implemented an audit of mental health assessments for P-Level referrals from RDT, covering both Non-SMI and SMI individuals. This audit specifically evaluates the assessment factors outlined in SA Provision 11, including current mental health conditions, psychiatric medications, current and past suicidal ideation or attempts, prior mental health treatment, recent significant losses, family history or suicidal behavior, and relevant observation from staff or external sources.

By reviewing these elements, the audit confirms that assessments capture the critical information necessary to evaluate risk and determine the appropriate timing of follow-up based on P-Level classification. This supports the intent in Provision 10, demonstrating that low, moderate, and high-risk individuals received thorough mental health evaluations within the prescribed timeframes.

See Attachment. 2.

February 2026 Findings: As per status update. Future audits should include the twelve (12) elements of Audit 8 and the eight (8) elements of Audit 30. The sample should be inmates referred from the RDT and include all 3 P levels.

Compliance is present.

February 2026 Recommendations: As above.

11) Whether MDC ensures that mental health assessments include the assessment factors described below:

a. Intake screening shall inquire as to the following:
   (1) Current mental health conditions;
   (2) Current psychiatric medications;

(3) Current suicidal ideation, threat, or plan;
(4) Past suicidal ideation and/or attempts;
(5) Prior mental health treatment or hospitalization;
(6) Recent significant loss – such as the death of a family member or close friend;
(7) History of suicidal behavior by family members and close friends;
(8) Any reported observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk.

July 2025 Findings: The assessment for this provision was the quality of the evaluation by the mental health professional in the context of assessments of general population inmates as measured by the following audits:

a. 08 Quality of BH Assessments of Non SMI Patients in GP, and
b. 09 Quality of BH Assessments of SMI Patients in GP.

However, the wording of this provision does not specifically refer to mental health assessments based on housing location. Upon further review of the methodology of these audits, the sample population was caseload inmates currently housed in the general population independent of whether the relevant mental health evaluation was generated by either the RDT screening process or generated by a referral while the inmate was housed in general population.

The audit instruments used did not assess the presence or absence of all of the relevant elements as required by this provision although it included elements that were not required by this specific provision. The audit instruments should be revised to include all of the eight elements required by SA provision 11. Specifically, whether the patient was asked about current psychiatric medications, as required by A(11)(a)(2) or any reported observations of the transporting officer, court, transferring agency, or similar individuals regarding the patient's potential suicidal risk, as required by A(11)(a)(8), are missing from the current two audits.

I interpret SA provision 11 to specify the elements of "appropriate mental health assessments" that is referenced in SA provision 10.

After the audit instrument is revised as recommended above, a single audit using the revised instrument can be used to assess compliance with SA provisions 10 & 11 if the following conditions are met:

a. the sample includes similar numbers of P1, P2 and P3 caseload inmates,
b. the sample population includes an adequate number of caseload inmates currently housed in general population, and

c. the sample population includes adequate numbers of both non-SMI inmates and SMI inmates although the number of SMI inmates can be greater than the number of non-SMI inmates.

UNMH Status Update as of 02/06/2025:

UNMH revised the behavioral health assessment audit instrument to include all eight required assessment elements outlines in SA Provision 11. The updated audit evaluates whether assessment of all eight elements.

The revised audit methodology also incorporates P-level referrals originating from the RDT screening process and referrals generated while individuals are housed in general population. The sample includes P1, P2, and P3 classifications and includes both SMI and non-SMI individuals, consistent with monitoring recommendations. This revision instrument allows UNMH to evaluate the quality and completeness of mental health assessments and supports compliance with SA Provisions 10 and 11.

See Attachment 2

February 2026 Findings: As per status update. Future audits should include the twelve (12) elements of Audit 8 and the eight (8) elements of Audit 30. The sample should be inmates referred from GP. I recognize that the vast majority of such a sample, if not all of the sample, will have P3 classification.

Compliance is present.

February 2026 Recommendations: As above.

12) Whether MDC Qualified Mental Health Professionals complete all assessments, pursuant to generally accepted correctional standards of care.

July 2025 Findings: This provision initially does not appear to be any different than what will be measured by the revised audit instrument described in SA provision 11. The results from the recommended revised audit instrument to be used for SA provision 11 can also be used for this provision.

However, since this provision is rather vague, if it is discovered that assessments are being performed in a manner not "consistent with generally accepted correctional standards of care", such information will be utilized in the compliance assessment. For example, if mental health

assessments were routinely being performed in a nonconfidential manner, even if the audits 10 & 11 results indicated that the relevant information was documented, such an assessment would not be within the correctional standard of care.

UNMH Status Update as of 02/06/2026:

UNMH utilizes the revised behavioral health assessment audit instrument referenced in SA Provision 10 and 11 to evaluate the completeness and quality of mental health assessments performed by Qualified Mental Health Professionals. Audit results demonstrate that required clinical assessment elements are being completed and documented in a manner consistent with generally accepted correctional standards of care.

UNMH continues to monitor assessment practices through ongoing quality review processes to support sustained compliance and identify opportunities for continued improvement.

February 2026 Findings: As per status update. See Attachment 2. Additionally, whether assessments are being performed in a manner not "consistent with generally accepted correctional standards of care" may involve consideration of clinical decision making.

Compliance is present.

13)Whether MDC Qualified Mental Health Professionals perform in-person mental health assessments no later than one working day following notification of any adverse triggering event (*i.e.*, any suicide attempt, any suicide ideation, and any aggression to self-resulting in injury).

July 2025 Findings: Based on the wording of this provision (specifically using "i.e." rather than e.g."), the triggering events are defined to be "any suicide attempt, any suicide ideation and any aggression to self-resulting in injury". The audit instruments to be used and assessing compliance should be the following:

a. 01 Clinical Seclusion (just element 1 of that audit), and
b. an audit to be developed based on the crisis call log that addresses the triggering events listed in this provision.

July 2025 Recommendations: Develop and implement the relevant audits as described above.

UNMH Status Update as of 02/06/2026:

UNMH has implemented audit measures to evaluate whether Qualified Mental Health Professionals complete in-person mental health assessments within one working day following notification of adverse triggering events, including suicide attempts, suicidal ideation, and aggression to self-resulting in injury.

Audit 01 (Clinical Seclusion-MH Observation, Element 1) reflects that patients placed in seclusion are evaluated by nursing, provider, or mental health staff within the required timeframes.

2025	01 Clinical Seclusion (MH Observation)	Q3	Q4
1	Seen by a Nurse, provider, or MHP for initiation of seclusion	100%	100%

In addition, MDC developed and implemented Audit 32, which reviews crisis call and adverse triggering event encounters to monitor whether a behavioral health assessment occurs within one working day of notification.

Baseline results from Audit 32 reflect adherence to the required timeframes for applicable triggering events. Both the Q3 and Q4 audit scored 100% compliance.

2025	32 BH Assessment of Inmates Displaying SA, SI, or Self-Harm	Q3	Q4
1	Patient was assessed no later than one working day following notification of any adverse triggering event (i.e., any suicide attempt, any suicide ideation, and any aggression to self-resulting injury).	100%	100%

MDC will continue to track these measures to support ongoing compliance with assessment timeframes following adverse triggering events.

February 2026 Findings: As per status update. Compliance is maintained.

14) Whether MDC Mental Health Staff conduct in-person assessments of inmates before placing them on suicide watch, clinical seclusion, or segregation and on regular intervals thereafter, as clinically appropriate and defined by MDC policy.

UNMH Status Update as of 02/06/2026

UNMH policy requires Qualified Mental Health Professionals to conduct in-person assessments prior to placement on suicide watch, clinical seclusion, or segregation, with follow-up assessments

conducted at intervals defined by policy and clinical presentation, Q3-Q4 2025 audit findings support that required preplacement assessments and ongoing clinical monitoring are occurring, with noted improvements across monitoring periods.

2025	01 Clinical Seclusion (MH Observation)	Q3	Q4
1	Seen by a Nurse, provider, or MHP for initiation of seclusion	100%	100%
2	Doctor's order obtained per policy (initial and daily renewal).	100%	100%
3	Seen daily by a doctor and encounter documented.	100%	100%
4	Seen daily by an MHP and encounter documented	93%	90%
5	Seen q shift by Nursing and encounter documented	83%	60%
6	Order for release by a doctor per policy was completed	100%	100%
7	All Holds Appropriately Placed in OMS for Clinical Seclusion?	100%	100%
	Overall Compliance	97%	93%

Audit 01 – Clinical Seclusion (MH Observation)
Q3 and Q4 results demonstrate high compliance with initiation assessments, physician oversight, and required daily provider evaluations. The lower Q4 nursing compliance rate reflects scoring of q-shift documentation, although UNMH policy requires daily nursing assessment for clinical seclusion rather than q-shift monitoring. The audit above will be updated to reflect policy.

2025	26 Patients Placed on Suicide Watch	Q3	Q4
1	Pt assessed by a QMHP, a Nurse, or a Psychiatrist prior to placing pt. on suicide watch	100%	100%
2	Pt assessed by a Psychiatrist the same day or the following day (if the pt. is placed on suicide watch after hours).	100%	100%
3	Pt assessed and treated daily by a Psychiatrist	97%	100%
4	Pt assessed daily by a QMHP	73%	87%
5	Pt assessed q shift by a Nurse	87%	97%
6	Pt cleared from suicide watch by a Psychiatrist	100%	100%
	Overall Compliance	93%	97%

Audit 26 – Patients Placed on Suicide Watch
Results demonstrate consistent compliance with required pre-placement assessments and timely psychiatric evaluations. Follow-up QMHP and nursing assessments improved Q3 to Q4, reflecting increased adherence to required monitoring intervals.

2025	27 Patients Placed on Clinical Seclusion	Q3	Q4
1	Pt assessed by a QMHP, a Nurse, or a Psychiatrist prior to placing pt. on clinical seclusion	100%	100%
2	Pt assessed by a Psychiatrist the same day or the following day (if the pt. is placed on suicide watch after hours).	100%	100%
3	Pt assessed and treated daily by a Psychiatrist	93%	97%
4	Pt assessed daily by a QMHP	73%	90%
5	Pt assessed daily (q shift) by a Nurse	63%	93%
6	Pt assessed cleared from clinical seclusion watch by a Psychiatrist	100%	100%
	Overall Compliance	88%	97%

Audit 27 – Patients Placed on Clinical Seclusion
Results show full compliance with pre-placement assessments and improvement in required follow-up psychiatric, QMHP, and nursing evaluations from Q3 to Q4. Similar to Audit 01, Q3 reduced nursing scores reflect q-shift scoring methodology rather than daily clinical seclusion monitoring requirements.

Overall, audit data indicates that MDC mental health staff conduct required in-person assessments prior to placement and complete ongoing assessments consistent with MDC policy requirements, with continued quality improvement monitoring in place.

February 2026 Findings: As per status update. Partial compliance is present.

15) Deleted from check-out audit.
16) Deleted from check-out audit.
17) Deleted from check-out audit.

B. Treatment Plan

1) Whether Defendants provide treatment plans consistent with prevailing professional standards for those inmates requiring a treatment plan.
   a. Whether treatment plans for inmates in specialized mental health units are designed by an appropriate treatment team; and
   b. Whether the plans are reviewed periodically, ordinarily at least every 90 days, and at the request of the resident.

July 2025 Findings: This provision is specific to treatment plans for inmates in specialized mental health units. The relevant elements of this provision is whether the treatment plans are designed

by an appropriate treatment team and whether they are reviewed at least every ninety days, or at the request of the inmate. The following instruments are appropriate to be used for assessing compliance specific to this provision:

a. audit 16 (PAC 1,3,4, RHU 6 and discharge planning),
b. audit 20 (treatment and discharge planning RHU 3), and
c. the PSU tracking log.

UMMH Status Update as of 02/06/2025

Based on the requirements outlined above, UNMH currently monitors compliance with this provision through Audit 16, Audit 20 and the PSU Tracking Log. These audits assess treatment plans through a 10-day initial assessment, then assessments every 30-day and 90-day review based on units, evaluating treatment plan development by an appropriate multidisciplinary team, periodic review requirements, discharge planning, patient involvement, and documentation of treatment team participation.

Current results demonstrate that treatment plans are developed by the treatment team.

See Attachment 3

February 2026 Findings: As per status update. Partial compliance remains primarily due to timeliness issues

2) Whether MDC's policies and procedures ensure that adequate and timely treatment for inmates are continued and further developed for inmates whose assessments reveal serious mental health needs and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate. *[Doc. No. 256, III(I)]*.

July 2025 Findings: As per the status update section, I am in agreement that the following policies are relevant to this provision:

- HCA 12.48 – Basic Mental Health Services (Updated 05/13/2025)
- HCA 12.48-1 – PSU Therapeutic Services (Effective 03/13/2025)
- HCA 12.49 – Suicide Prevention Program (Revised 04/24/2025)
- HCA 12.34 – Mental Health Screening & Evaluation (Updated 05/13/2025)

To the extent that other SA provisions assess the implementation of a specific policy, the status

update section can just reference that provision. If relevant parts of any of the above policies are not assessed in other provisions, any relevant existing audit results should be reported in the status update section or an audit or audits need to be developed to assess implementation of such parts of the policy and reported in the status update section of this provision.

UNMH Status Update as of 02/06/2026:

MDC has adopted and implemented comprehensive policies to support timely and appropriate mental health care for detainees with serious mental health needs and/or suicidal ideation. The following policies are associate with specific audits:

- HCA 12.48 – Basic Mental Health Services (Updated 05/13/2025)
    - 03 Final Discharge Planning of PAC and RHU
    - 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1
    - 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2
    - 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3
- HCA 12.48-1 – PSU Therapeutic Services (Effective 03/13/2025)
    - 06 Psych Med Renewal Audit
    - 06B Psych Med Adjustment
    - 07 Psych Med Adjustment
    - 07B Psych Med Adjustment
    - 15 Treatment and Discharge Planning
    - 19 PSU Chronic Care
- HCA 12.49 – Suicide Prevention Program (Revised 04/24/2025)
    - 13 Suicide Watch Level Ordered and Provided
    - Suicide Watch Follow up and Rounding
    - 26 Inmate Placed on Suicide Watch
    - 21 Safety Monitor Suicide Observation Logs
    - 21A Constant Suicide Watch Safety Monitor Observation
    - 26 Inmates Placed on Suicide Watch
- HCA 12.34 – Mental Health Screening & Evaluation (Updated 05/13/2025)
    - 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1
    - 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2
    - 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3

February 2026 Findings: As per status update. Implementation of relevant components of the above policies are reported in other provisions of the Settlement Agreement.

Compliance is present.

3) Whether MDC's treatment plans adequately address inmates' serious mental health needs and whether the plans contain interventions specifically tailored to the inmates' diagnoses and problems. *[Doc. No. 256, III(I)].*

July 2025 Findings: This provision is specific to treatment plans developed for inmates in general population housing units. The appropriate audit for this provision, if revised as recommended below, is audit 15 (Treatment and Discharge Planning for Non-SMI Patients in GP).

The audit should be revised to include both SMI and non-SMI inmates in GP.

UNMH Status Update as of 02/06/2026:

UNMH has implemented individualized Mental Health Treatment Plans that are specifically designed to address detainees' serious mental health needs. These plans include tailored interventions that align with each patient's diagnoses, clinical history, and presenting concerns. The plans are developed by psychiatric providers in collaboration with PSU counselors and nursing staff to ensure a multidisciplinary approach.

Audit 15 – Treatment and Discharge Planning for Non-SMI Patients in General Population (Q4)
Dr. Hamilton conducted a preliminary audit in October 2025 but discontinued the review after five charts were evaluated. The review identified that while service and treatment planning were being completed, documentation did not consistently address the questions listed in the audit in a clear "plan." Instead a reference was dictated that stated "see plan." Targeted retraining and standardization of documentation practices were implemented following the review.

In response to the July 2025 recommendations, UNMH revised the audit tool to include both SMI and non-SMI patients housed in general population. The Q4 audit results for Treatment and Discharge Planning for SMI and Non-SMI patients in GP demonstrated 99% overall compliance for the individual patients selected.

See Attachment 3-audit 15.

February 2026 Findings: As per status update. Partial compliance is present.

4) Whether MDC makes available appropriate therapy services by a licensed mental health provider where medically necessary for inmates with serious mental health needs as ordered by their attending psychiatrist.

July 2025 Findings: The relevant audits for this provision are audits 12 (requests for services

response time) and audit 19 (PSU chronic care).

UNMH Status Update 02/06/2026

See Attachment 4.

UNMH continues to provide appropriate therapy services, when medically necessary, as ordered by attending psychiatrist for detainees with serious mental health needs. The Behavioral Health Chronic Care Clinic (CCC) process remains active, with licensed mental health providers delivering therapy and tracking patient progress through the EMR.

During this reporting period, ~65 detainees were enrolled in CCC services. Of these, approximately 15 completed treatment, 31 detainees actively engaged in therapy, 30 are assigned to counselors with initial sessions pending, and 26 are pending assignments. UNMH continues to monitor caseload trends and implement workflow adjustments to support timely service initiation.

Q3 and Q4 quality assurance audits demonstrated 100% compliance with all documentation related to the audit indicator listed above. Audit samples included seven detainees in Q3 and nine detainees in Q4, all meeting compliance standards. During this reporting period, the limited sample was due to an IT reporting limitation, which required manual data compilation and significantly increased the time needed to identify eligible records.

These results demonstrate that proper documentation has been maintained. However, the current backlog highlights the need for additional staffing. Based on the staffing analysis, the addition of seven counselors is recommended to reduce the backlog and ensure timely access to therapy services.

February 2026 Findings: As per status update. Problems with the sick call process were identified by audit 4.

Partial compliance is present

5) Whether MDC completes mental health evaluations as part of the disciplinary process and can demonstrate that the hearing officer incorporates those recommendations into the disciplinary process for determining whether an inmate's actions should be excused and, if not, for mitigation of sanctions if the inmate's behaviors were a result of a mental or developmental disability. *[Doc. No. 256, IV(A)(1)].*

UNMH Status Update as of 02/06/2026:

See Attachment 5.

February 2026 Findings: As per status update. It is likely that the small percentage of disciplinary reports involving PSU inmates is related to the large percentage of disciplinary reports that are not adjudicated. Please be prepared to discuss this issue during the next site visit.

Compliance is present.

February 2026 Recommendations: As above.

6) Whether MDC implemented an adequate scheduling system to ensure that mental health professionals assess inmates with mental illness as clinically appropriate, regardless of whether the inmate is prescribed medications. *[Doc. No. 256, III(I)].*

July 2025 Findings: As per status update. Element 1 of audit 19 (PSU Chronic Care) and what appears to be a tracking log (see above table) are the right instrument to assess compliance with this provision.

UNMH Status Update as of 02/06/2026

2025	19 PSU Chronic Care	Q3	Q4
1	Documentation records that patient was seen as scheduled (Monthly, bi-monthly, weekly, etc...)	100%	100%

Dec-25	30	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
Crisis Counseling																																			
Amy Albertus	D4	D4	D4					D4	D4	D4					D4	*D4	D4					D4	D4	D4					D4	D4	D4				
Tonya Oliver*				D3	[illegible]	[illegible]																	[illegible]	[illegible]	[illegible]	[illegible]									
Isaac Vasquez											D4	D4	D4				S1								D4	[illegible]	[illegible]					D4			
Maria Morales	D4	D4	D4					D4	D4	D4					D4	D4	*D4					D4	D4	D4				D4	D4	D4	D4				
Cheyenne Shinear				D4	D4	D4	D4				D4	D4	*D4	D4				D4	D4	D4	D4				D4	D4	D4	D4			S1	D4	D4	D4	
Olivia Bengo			*D4	*D4	*D4	*D4		D4	D4	D4	D4				D4	D4	D4	D4				RTC	RTC	RTC	RTC	RTC	RTC	RTC	RTC	D4	D4	D4			
[illegible] Mendez			S1	S1	S1	F1	S1		S1	S1	S1	S1				S1	S1	S1	S1			D4	S1	S1	RTC	RTC	RTC	RTC	RTC	RTC		S1	S1		D4
Sonia Arbizu		D4			D4							D4	D4	D4					D4	D4	D4					D4	D4	D4					D4	D4	D4
Toccara Hudson	D4	D4		RTC	RTC	RTC	RTC	RTC	RTC		D4	D4	D4	D4				D4	D4	D4	D4											D4	D4	D4	D4
Eiko Gillis*							D4																						[illegible]						
Rachel Thomas																								RTC	RTC	RTC	RTC	RTC	RTC						

February 2026 Findings: As per status update. An adequate scheduling system is present although the actual schedules are hampered by staffing allocations/vacancies.
Compliance is present.

7) Whether MDC inmates have the opportunity to participate meaningfully in the development of a treatment plan. *[Doc. No. 256, III(I)].*

July 2025 Findings: As per status update. See audit 16 (PAC 1, 3, 4, and HSU 6 Treatment Team Treatment and Discharge Planning-Q1). The relevant audits should be revised to include whether or not the inmate was invited to attend at least a portion of the treatment planning team process.

UNMH Status Update as of 02/06/2026

See Attachment 3.

UNMH evaluates detainee participation in treatment planning through Audit 16 (PAC 1, 3,4, and HSU 6. Treatment Team and Discharge Planning 30 and 90-Day Audit). The audit measures detainee involvement through documentation that treatment plans are reviewed with the detainee, including whether the treatment plan is signed by the detainee or includes documentation explaining why a signature was not obtained, and whether the detainee was invited to attend at least a portion of the treatment team planning meeting.

During Q3 2025, audit results demonstrated consistent documentation that detainees were provided with the opportunity to review and acknowledge treatment plans and were invited to participate in the treatment team planning process.

February 2026 Findings: As per status update. Partial compliance is present because the treatment plans are often not timely, which means inmates participation may not be so meaningful.

8) Whether MDC inmates receive appropriate psychotropic medications in a timely manner.

July 2025 Findings: As stated in my January 2025 report, this provision is being monitored in the context of whether medications are administered in a timely manner once they have been ordered. Other provisions are relevant to whether detainees in need of being prescribed psychotropic medications are identified in a timely manner and re-assessed in a timely manner (e.g., see SA provisions A1-2, B9-12).

Audit 06 (psychotropic med renewal) is a relevant audit and should be continued as an audit. I have assessed this issue during site visits in the specialized mental health units by asking inmates in a community like setting whether they have difficulties receiving their medications once they were prescribed. However, I have not been able to adequately assess continuity of medication for general population inmates during my site visit.

Patients in the various mental health housing units' patients reported receiving their prescribed medications in a timely manner.

I discussed with staff the need to develop and implement an audit that reviews medication administration records (MAR's) of general population inmates by targeting a random sample of GP inmates being prescribed psychotropic medications.

Plaintiffs' attorneys raised issues specific to medication continuity for inmates returning from a hospital. Staff reported being aware of issues related to such inmates but indicated that they are being resolved. I recommended that steps be taken to ensure that such issues have been resolved in order to be able to rely on the above recommended audit results.

UNMH Status Update as of 02/06/2026

UNMH monitors timely renewal and continuation of prescribed psychotropic medications through Audit 06 (Psychotropic Medication Renewal) and Audit 06B (Psychotropic Medications Renewal in General Population). These audits evaluate whether mediations are renewed prior to expiration/stop date.

Q3 2025 results demonstrate high compliance with timely medication renewal, with Audit 06 reflecting 97% compliance.

2025	06 Psych Med Renewal	Q3	Q4
1	Medication renewed before the stop date, d/cd by doctor, d/c'd due to IM release, d/c'd due to inmate off site, or d/c'd due to once monthly injection requiring a new order for each injection.	97%	100%

Audit 06B, which evaluates general population detainees, reflecting 95% compliance.

2025	06.B Psych Med Renewal in GP	Q3	Q4
1	Medication renewed before the stop date, d/cd by doctor, d/c'd due to IM release, d/c'd due to inmate off site, or d/c'd due to once monthly injection requiring a new order for each injection.	95%	100%

These findings support that prescribed psychotropic medications are generally renewed and maintained within the required timeframes across both specialized mental health housing units and general population.

February 2026 Findings: As per status update. Based on information obtained from staff, it is very likely GP inmates are receiving their prescribed psychotropic medication in a timely manner. However, in order to find compliance, I need to have proof of practice via an audit specific to medication administration records (MARs) of general population inmates being prescribed psychotropic medications.

In addition, continuity of medications has been identified as problematic for inmates being evaluated outside of MDC and returning a short time later to MDC. They are triaged by nurses at the nursing station in contrast to being triaged in RDT. An audit should be developed and implemented specific to this issue.

Partial compliance is present.

February 2026 Recommendations: Perform the above audits.

9) Whether MDC's use of psychotropic medications is reviewed by a Qualified Mental Health Professional on a regular, timely basis.

July 2025 Findings: As per status update. Backlog data in the PSU matrix is an appropriate measure to use in assessing compliance with this provision. Partial compliance continues.

UNMH Status Update as of 02/06/2026:

BACKLOG DATA	July	August	Sept	Oct	Nov	Dec
# of 30-day MD SMI follow ups NOT seen (absolute number on the 30th day of the month) - BACKLOG	25	20	42	36	23	60
% SMI who haven't been seen within 30 days. (30th day of the month) total caseload	15%	11%	23%	21%	13%	7%
# for 30-day MD NON-SMI follow ups NOT seen (absolute number on the last working day of the month) - BACKLOG	204	63	163	191	160	75
% NON-SMI who haven't been seen within 90 days. (last day of the month)	24%	8%	20%	25%	19%	9%
# days out for oldest back log appointment for MDs as of the last day of the month.	30	37	39	52	28	75

UNMH monitors psychotropic medication management through follow-up tracking in the PSU backlog matrix, which records whether detainees are seen by QMHP within required timeframes. From July to December 2025, timely follow-up improved, for detainees with Serious Mental Illness (SMI), those not seen within 30-days decreased from 15% to 7%. For NON-SMI detainees, those not seen within 90 days decreased from 24% to 9%. While monthly fluctuations occurred, overall follow-up compliance increased.

February 2026 Findings: As per status update. Partial compliance.

10) Whether MDC properly monitors and timely adjusts medications.

July 2025 Findings: The PSU backlog data and audit 7 (psychotropic med adjustment) are not the appropriate instruments to measure compliance with this provision because the outcome measures of the audits are not specific to whether the prescribed medications are timely adjusted when clinically appropriate to do so. Another SA provision measures whether the psychiatric appointments are timely (e.g., see the PSU data re: backlogs). This was discussed with Dr. Hamilton, who will be devising an appropriate audit instrument to measure compliance. I suggested that this audit could be done as a peer review activity.

UNMH Status Update as of 02/06/2026:

2025	07 Psych Med Adjustment PSU 30- & 90-day FU	Q3	Q4
1	Timely Adjusted 1st 30-day FU	75%	90%
2	Timely Adjusted 2nd 30 Day FU	100%	90%
3	Timely Adjusted 3rd 30 Day FU	80%	100%
4	Review agrees with adjustment	100%	100%
	Overall Compliance	89%	94%

2025	07.B Psych Med Adjustment GP 30- & 90-day FU	Q3	Q4
1	Timely Adjusted 1st 30-day FU	100%	57%
2	Timely Adjusted 2nd 30-day FU	67%	100%
3	Timely Adjusted 3rd 30-day FU	100%	50%
4	Review agrees with adjustment	100%	100%
	Overall Compliance	95%	83%

UNMH conducted audits of psychotropic medication adjustment during 30-and 90-day follow-ups. The audits assessed whether medications were adjusted in a timely manner and whether adjustments aligned with clinical review. Q3-Q4 results show an overall compliance of 95% and 83% in Q4, with the majority of adjustments completed within expected timeframes. These audits provide data specific to psychotropic medication management and address prior feedback regarding appropriate measurement tools.

February 2026 Findings: Audit 7 has been revised to include whether medication adjustments are appropriate based on documentation. Timeliness of such adjustments, particularly for general

population inmates, remained a problem. Because this provision specifically includes the words "timely adjusts medications", it will be measured by both timeliness and appropriateness of the medication adjustment, when it is clinically indicated. Untimely medication adjustments, when clinically indicated, are better than no medication adjustments, but still problematic.

Partial compliance is present.

11) Whether MDC has established standards for the frequency of review and associated charting of psychotropic medication.

July 2025 Findings: As per status update. This provision is being monitored in the context of the presence or absence of the relevant policies and procedures. Compliance is present in the context of developing the relevant policy.

Implementation is monitored by SA provisions 9 & 10.

UNMH Status Update as of 02/06/2026

UNMH monitors the frequency of review and associated charting of psychotropic medications through audits of follow-up appointments and medication adjustment (SA provisions 9 & 10). The audits track whether medications are reviewed and adjusted at scheduled intervals and whether charting reflects that review (MAR).

February 2026 Findings: As per status update. Compliance is maintained.

12) Whether a psychiatrist personally assesses every MDC inmate on psychiatric medication at least once every thirty (days. *[Doc. No. 256, III(C)]*.

- With what frequency should a psychiatrist personally assess every MDC inmate on psychiatric medication who is not seriously mentally ill.
- With what frequency should a psychiatrist personally assess every seriously mentally ill inmate.

October 2014 findings: Based on the MDC PSU Quality Management Data Matrix 2014 process, information obtained from inmates and mental health staff, and review of records, it is my opinion that compliance has been achieved for the provisions relevant to psychotropic medication management except for the following provision:

B. 12. Whether a psychiatrist personally assesses every MDC inmate on psychiatric medication at least once every 30 days.

Regarding the above and my recommendations concerning the frequency of assessments by a psychiatrist for inmates receiving psychotropic medications and/or are seriously mentally ill, I am in agreement with the recommendations contained in Policy 12.45.1 (Chronic Psychiatric Disorder Services) includes the following provision:

> G. The frequency of chronic care visits is based on the clinical judgment of the treating clinician and not to exceed the following recommendations:
> a. Any inmate on suicide watch – a minimum of daily assessments
> b. Any inmate in clinical seclusion – a minimum of daily assessments
> c. Any inmate diagnosed with an SMI – a minimum of visits every 30 days
> d. Any inmate on an acute HSU (I & IV) – a minimum of weekly visits
> e. Any inmate assigned to HSU III- a minimum of every 30 days.
> f. Any inmate in a segregation unit with access to out of cell time less than 4 hours per day – a minimum of every 30 days
> g. Any inmate in General Population with a non-SMI designation – a minimum of every 90 days.

June 2015 MDC Update: The definition of SMI and the application of the definition has changed due to the suggestions of the federal and county monitor. Currently any patient with a diagnosis of Bipolar Disorder, Schizophrenia, Schizoaffective Disorder, and Major Depressive Disorder, recurrent type are automatically designated SMI. We also designate patients' SMI if the patient's level of functioning requires PAC placement or a higher level of care, permanently or temporarily. Our current percentage of SMI at MDC is sixteen percent, which is the reported national average.

UNMH Status Update as of 02/06/2026

See Attachment 6.

UNMH monitors psychiatrist assessments of inmates on psychotropic medications through follow-up audits (07 and 07B) that track whether medications are reviewed and adjusted at scheduled intervals. Current polices 12.45.1) set minimum visit frequencies based on clinical status; daily for suicide watch or seclusion, every 30 days for SMI or certain housing assignments, and every 90-day for non-SMI in general population. Audits continue to track adherence to these standards.

February 2026 Findings: As per status update. Also see PSU matrix. Partial compliance.

February 2026 Recommendations: After it is established by the PSU matrix that there is no longer a significant backlog of psychiatric appointments, audits will be required to assess compliance with timeframes as summarized in the October 2014 findings section.

13) Whether MDC's treatment of suicidal inmates involves more than segregation and close supervision (*i.e.*, providing psychiatric therapy, regular counseling sessions, and follow-up care).

UNMH Status Update as of 02/06/2026:

2025	14 Suicide Watch Follow-up Rounding Audit	Q3	Q4
1	24-hour MH Follow-up Intervention Completed as Scheduled?	80%	90%
2	7-day MH follow-up Intervention Completed as Scheduled?	77%	97%
3	28-day MH Follow-up Intervention Completed as Scheduled?	73%	73%
4	Was there an Acute Hold Placed in OMS?	100%	100%
	Overall Compliance	83%	90%

- 24-hour, 7-day, and 28-day mental health follow-ups were completed as scheduled.
- Acute holds were properly documented in OMS.
- Results reflect consistent monitoring and timely interventions for patients on suicide watch.

2025	26 Patients Placed on Suicide Watch	Q3	Q4
1	Pt assessed by a QMHP, a Nurse, or a Psychiatrist prior to placing pt. on suicide watch	100%	100%
2	Pt assessed by a Psychiatrist the same day or the following day (if the pt. is placed on suicide watch after hours).	100%	100%
3	Pt assessed and treated daily by a Psychiatrist	97%	100%
4	Pt assessed daily by a QMHP	73%	87%
5	Pt assessed q shift by a Nurse	87%	97%
6	Pt cleared from suicide watch by a Psychiatrist	100%	100%
	Overall Compliance	93%	97%

- All patients were assessed by a QMHP, nurse, or psychiatrist before placement.
- Daily psychiatric and QMHP care, as well as Q-shift nursing assessments, were provided.
- Psychiatric clearance was documented for patients removed from suicide watch.
- Results demonstrated active treatment and ongoing supervision beyond segregation.

February 2026 Findings: As per status update. Partial compliance continues.

14) Deleted from check-out audit.
15) Deleted from check-out audit.
16) Deleted from check-out audit.

17) Whether Defendants have developed and implemented adequate formal procedures for seeking psychiatric hospitalization or other appropriate residential mental health care for inmates who need and would benefit from such care, and who are eligible for such placement, consistent with the court-imposed conditions of their confinement. *[Doc. No. 256, III(M)].*
    1. Whether MDC has sent an inmate to a psychiatric hospital or other appropriate residential mental health care for inmates who need and would benefit from such care, and who are eligible for such placement, consistent with the court-imposed conditions of their confinement.
    2. Whether MDC has the realistic option of sending an inmate to a psychiatric hospital or other appropriate residential mental health care for inmates who need and would benefit from such care, and who are eligible for such placement, consistent with the court-imposed conditions of their confinement.

UNMH Status Update as of 02/06/2026

INMATES MEETING CRITERIA FOR INPT ADMISSION	July	August	Sept	Oct	Nov	Dec
Total # of all certificates of evaluation issued	9	16	17	25	10	19

UNMH has formal procedures for identifying inmates who would benefit from psychiatric hospitalization or other residential mental health care.

1. Psychiatric Hospital Transfers:
    - Inmates meeting clinical criteria are identified and evaluated. Certificates of Evaluation document eligibility for post-custody inpatient care. Psychiatric providers coordinate with attorneys and the court to facilitate transfers to Psychiatric Emergency Service (PES) or other appropriate settings.
2. Options for Placement:
    - While the court approves transfers, UNMH ensures clinically appropriate referrals, initiates legal advocacy when needed, and follows the MDC Patient Transfers to UNMH Inpatient Psychiatry policy for patient transfers to standardized steps and guide staff.

During this monitoring period, multiple patients were sent to UNMH for ECT as they did require

a treatment that was not available at MDC.
As of June 20, 2025, HB 8 went into effect. This new law allows MDC psychiatric providers to file for involuntary commitment to NMBHI, our state hospital. MDC psychiatric staff work with the DA's office to select patients that qualify and would benefit from longer term care at the state hospital.

These processes reflect structured, ongoing efforts to connect eligible inmates with higher-level psychiatric care.

February 2026 Findings: As per status update. Compliance is maintained.

C. Suicide Precautions

1) Whether MDC's suicide prevention policies, procedures, and practices include provisions for constant direct supervision of actively suicidal inmates, close supervision of special needs inmates with lower levels of risk (e.g., 15-minute checks), and follow-up assessments after the suicide watch is discontinued.

July 2025 Findings: As per status update. The relevant policy contains the required elements of this provision. Other provisions of this Settlement Agreement addresses implementation of this policy.

UNMH Status Update as of 02/06/2026:

UNMH continues to apply Policy HCA 12.49 – Suicide Prevention Program, which includes:

- Constant direct supervisor for inmates identified as actively suicidal.
- Close supervision, including straggled 15-minute checks, for inmates assessed at lower but significant risk.
- Follow-up psychiatric assessments completed before removal from suicide watch to confirm clinical stability.

Targeted Safety monitor trainings occurred in August and September 2025 reinforced observation intervals, documentation, and application of these protocols as outlined in the policy.

February 2026 Findings: As per status update. Compliance is maintained.2) Whether MDC inmates on suicide watch are monitored by security with constant direct supervision until a Qualified Mental Health Professional conducts a suicide risk assessment, determines the degree of risk, and specifies the appropriate degree of supervision.

UNMH Status Update as of 02/06/2026:

2025	02 Constant Monitoring of Patients Presumed to be of Moderate or High Risk of Suicide or Self-Harm	Q3	Q4
1	MDC security staff monitors inmates with constant supervision until the inmate is seen by a QMHP for assessment.	97%	93%

Audit 02 tracked whether security staff maintained constant supervisor of inmates assessed as moderate or high risk until a QMHP conducted a suicide risk assessment. For Q3 and Q4 2025, supervision was maintained in 97% and 93% of cases, respectively.

February 2026 Findings: As per status update. Partial compliance continues.

3) Whether MDC security staff provide the amount of supervision specified by a Qualified Mental Health Professional and accurately document their well-being checks on forms that do not have pre-printed times.

UNMH Status Update as of 02/06/2026

UNMH continues to assign Safety Monitors according to the level of supervisor recommended by a QMHP. Well-being checks are recorded on observation logs without pre-printed times, supporting accurate documentation of monitoring activities.

Audit results as follows:

2025	02 Constant Monitoring of Patients Presumed to be of Moderate or High Risk of Suicide or Self-Harm	Q3	Q4
1	MDC security staff monitors inmates with constant supervision until the inmate is seen by a QMHP for assessment.	97%	93%
	Overall Compliance	97%	93%

Consistent observation provided in Q3 and Q4

As noted earlier: The Q3-Q4 2025 scores were primarily due to documentation issues, not lack of

supervision. In these cases, patients were continuously monitored by MDC security staff until a QMHP or our RRT department arrived; however, encounter notes did not always capture this information. Dr. Oliver has recently reinforced that proper documentation including statements such as "Upon arrival, the patient was within line of site of security staff." The RRT department often arrives first on the scene and should provide the QMHP with a complete "warm handoff" to support accurate documentation and achieve full compliance. Any staff assessing the patient must ensure documentation clearly reflects adherence to monitoring protocols.

2025	21 Safety Monitor Observation Logs	July	Aug	Sept	Oct	Nov	Dec
1	If the watch level is staggered, did the safety monitor stay within the allowed parameters of checks/observations not to exceed 15 minutes on any patient checks/observations?	87%	87%	97%	93%	97%	93%

2025	21A Safety Monitor Constant Observation Logs	July	Aug	Sept	Oct	Nov	Dec
1	If the watch level is constant, did the safety monitor stay within the allowed parameters of checks/observations providing constant 10-minute checks/observations?	83%	100%	100%	100%	100%	100%

Overall, the data reflects consistent adherence to required monitoring standards, with continuous improvements in both staggered and constant observation practices after a retraining was conducted in August. UNMH remains committed to ensuring patient safety through diligent monitoring, responsive staff coordination, and ongoing performance evaluation.

February 2026 Findings: As per status update. Partial compliance remains.

4) Whether MDC follows its policy of having a psychiatrist or psychologist evaluate all inmates placed on suicide precautions before they are removed from suicide watch, and whether MDC assures that its policies are followed.

UNMH Status Update as of 02/06/2026:

A psychiatric provider continues to evaluate all individuals placed on suicide precautions prior to their removal from suicide watch, in accordance with MDC policy. To ensure adherence, MDC provides ongoing training and routinely monitors compliance.

Prior to clearance, the psychiatric provider issues a formal order, completes the MDC-42 Standard Referral Form, and documents the encounter in the EMR using the MDC Behavioral Health Psychiatric Provider Note.

Audit Results:

2025	26 Patients Placed on Suicide Watch	Q3	Q4
6	Pt cleared from suicide watch by a psychiatrist	100%	100%

These results demonstrate consistent compliance with MDC's suicide prevention and clearance procedures.

February 2026 Findings: As per status update. Compliance is maintained.

5) Whether MDC conducts all follow-up assessments on all inmates discharged from suicide watch.

UNMH Status Update as of 02/06/2026:

The following policy is still in effect.

Policy:

- MDC HCA 12.49 Suicide Prevention Program, last reviewed 04/04/2025

Audit Results are as follows:

2025	14 Suicide Watch Follow-up Rounding Audit	Q3	Q4
1	24-hour MH Follow-up Intervention Completed as Scheduled?	80%	90%
2	7-day MH follow-up Intervention Completed as Scheduled?	77%	97%
3	28-day MH Follow-up Intervention Completed as Scheduled?	73%	73%
4	Was there an Acute Hold Placed in OMS?	100%	100%
	Overall Compliance	83%	90%

February 2026 Findings: As per status update. Partial compliance is present.

6) Deleted from check-out audit.

7) Deleted from check-out audit.

8) Whether MDC has developed and implemented appropriate policies for the housing of suicidal inmates.

UNMH Status Update as of 02/06/2026:

MDC HCA 12.49 Suicide Prevention Program (pages 3,5, & 10), last reviewed 04/04/2025

February 2026 Findings: As per status update. Compliance is maintained.

9) Whether MDC assures that its policies and procedures in paragraphs 1-8 are followed.

UNMH Status Update as of 02/06/2026:

- Policy: MDC HCA 12.49 Suicide Prevention Program

February 2026 Findings: See findings re: SA provisions C1-C8. Partial compliance.

D. Suicide Prevention Training Program

1) Deleted from check-out audit.

2) Whether all medical and mental health staff are trained on the suicide screening portion of the mental health intake form and medical intake tool.

UNMH Status Update as of 02/06/2026:

UNMH continues to conduct routine training with the medical and mental health staff on the suicide screening portion of the Mental Health Intake Form and Medical Intake Tool.

February 2026 Findings: As per status update. Compliance is maintained.

3) Whether all MDC staff who work directly with inmates have demonstrated competence in identifying and managing suicidal inmates and have shown comprehension of the training objectives via a performance measure tool such as a pre-and post-test.

UNMH Status Update as of 02/06/2026:

UNMH PSU staff completes the training for new cadets and officers working in HSU that includes topics such as:

- Psychiatric emergencies: Suicidal and Homicidal ideation
- Serious Mental Illness
- Social Determinants of health and diathesis stress model
- Psychiatry Referral Process and Crisis Intervention
- Trauma Informed Care – Creating Safety for Everyone
- Substance Use

CADET TRAINING						
	July	Aug	Sept	Oct	Nov	Dec
#of Cadets	23	0	19	0	44	10

February 2026 Findings: As per status update. Compliance is maintained.

4) Deleted from check-out audit.

5) Deleted from check-out audit.

6) Whether an emergency rescue tool is in close proximity to all housing units.

UNMH Status Update as of 02/06/2026:

All officers working at MDC have an Emergency Rescue tool on their person.

MDC update:

All officers working at MDC have an Emergency Rescue tool on their person.

February 2026 Findings: As per status update. Compliance is maintained

7) Whether all staff coming into regular contact with inmates know the location of the emergency rescue tool and are trained in its use.

UNMH Status Update as of 02/06/2026:

All officers working at MDC have an Emergency Rescue tool on their person.

MDC update:

All officers working at MDC have an Emergency Rescue tool on their person.

February 2026 Findings: As per status update. Compliance is maintained.

E. Use of Clinical Restraints

1) Deleted from check-out audit.

2) Whether the MDC policy requires restrained inmates with mental health needs to be monitored at least every 15 minutes by security staff to assess their physical condition. *[Doc. No. 256, III (N)&(I)].*

UNMH Status Update as of 02/06/2026:

Yes, UNMH's policy requires that restrained inmates with identified mental health needs to be monitored at least every 15 minutes by security staff / safety monitors to assess their physical condition, consistent with [Doc. No. 256, III (N) & (I)].

Please refer to the following policy for detailed guidance:

- MDC HCA 12.60 – Restraint and Seclusion, reviewed and updated on 05/03/2025.

Security staff are trained on these monitoring requirements, and documentation of 15-minute checks is maintained in accordance with policy.

February 2026 Findings: As per status update. Compliance is maintained.

3) Deleted from check-out audit.

4) Whether MDC follows its clinical restraint policies. *[Doc. No. 256, III (N)&(I)].*

UNMH Status Update as of 02/06/2026:

MDC continues to follow its established clinical restraint policies in accordance with [Doc. No. 256, III (N) & (I)].

Please refer to the following policy for details:

*MDC HCA 12.60 – Restraint and Seclusion

During the current monitoring period, no clinical restraints have been used. When clinically indicated, all procedures would follow established policies and involve appropriate oversight and

documentation by Qualified Mental Health Professionals (QMHPs) in coordination with custody staff.

February 2026 Findings: As per status update. Compliance is maintained.

F. Use of Security Four Point Restraints

1) Whether MDC ensures that, in the event an emergency results in a four-point restraint of an individual identified as having a psychiatric, neuropsychological or developmental disorder, a Qualified Mental Health professional is notified immediately and personally assesses the appropriateness of the restraint and designs a plan to safely end the restraint as soon as possible.

UNMH Status Update as of 02/06/2026:
In the event of an emergency that results in a four-point restraint involving an individual with a psychiatric, neuropsychological, or developmental disorder, a Qualified Mental Health Professional (QMHP) is immediately notified via a Crisis Call. The QMHP then:

- Conducts a timely in-person assessment of the individual's mental health status and the appropriateness of the restraint;
- Collaborates with custody staff to develop a clinical plan for safely discontinuing the restraint as soon as possible.

During the current monitoring period, no clinical four-point restraints were used.

This process remains in place and is aligned with generally accepted correctional mental health standards to ensure safety, appropriateness, and the least restrictive interventions possible.

February 2026 Findings: As per status update. Compliance is maintained.

G. Basic Mental Health Training

1) Deleted from check-out audit.

2) Whether MDC provides adequate specialized training for all security staff working on specialized mental health units.

July 2024 Findings: As per status update. Leadership staff stated that security staff, who are newly assigned to the mental health units, will continue to receiver an 8 - hour refresher course.

Compliance continues.

UNMH Status Update as of 02/06/2026:

MDC, in collaboration with UNMH, provides specialized mental health training to security staff assigned to specialized mental health units, including PAC and RHU units. Training is provided during cadet orientation. During this auditing period, the semi-annual refresher session was delayed due to the pod moves throughout the building. The required training will be completed. Attendance is tracked in PSU training logs. Training sessions involve clinical and administrative leadership and include behavioral health symptom recognition, suicide prevention awareness, de-escalation techniques, safety precautions, and response to psychiatric emergencies.

During July through December 2025, specialized mental health training was provided to 96 cadets. Training activity continues to support coordination between custody and clinical staff working in specialized housing units.

MDC Update:

MDC has continued to require training as previously demonstrated compliance.

February 2026 Findings: As per status update. Compliance is maintained.

H. Mental Health Staffing

1) Whether the caseload for psychiatrists treating MDC inmates exceeds 100 residents per FTE. *[Doc. No. 256, III(C)].*

    a. What caseload allows psychiatrists treating MDC inmates to provide adequate access to psychiatric care for inmates in need of such treatment.
    b. Whether the current caseload for psychiatrists treating inmates provides for adequate access to psychiatric care for inmates in need of such treatment.

December 2017 Findings: The psychiatrists' allocations (6.0 FTE positions and 0.5 FTE p.r.n. position), if without vacancies are adequate to meet an average caseload of 100 mental health caseload inmates per 1.0 FTE psychiatrist. However, the patient: psychiatrist ratios will significantly vary depending on the level of the health care being provided. As a result, psychiatrists just treating GP outpatient inmates receiving an outpatient level of mental health care will have more than 100 inmates on their caseloads. Psychiatrists providing an acute mental health level care will have a much smaller ratio.

July 2024 Findings: As per status update and below. Partial compliance is present due to both the psychiatrists' vacancies and the increased PSU census, which is predominantly related to recent city/County practices specific to the homeless population.

July 2024 Recommendations: As per status update. I strongly recommend increasing the psychiatrists' allocations in order to eventually comply with this provision because it has been rare during the duration of the Settlement Agreement that significant psychiatry vacancies have not existed.

July 2025 Findings: As per status update. Partial compliance for the monitoring period.

I discussed with staff issues related to this provision's required ratio. In the future, the denominator will be the average monthly number of mental health caseload inmates during the monitoring period and the numerator will be the average number of FTE psychiatrists during the same period of time.

July 2025 Recommendations: Future status updates should provide the numerator and denominator as above.

UNMH Status Update as of 02/06/2026:

Month	Total patients on Case Load	Provider FTE/HRS per Month	# of PTs per provider	Total Encounters
July	856	6.9	**124**	877
Aug	790	6.4	**123**	885
Sept	804	6.8	**118**	901
Oct	768	7.3	**105**	858
Nov	832	7.3	**115**	848
Dec	864	5.9	**146**	663

Psychiatrists' caseload data for July through December 2025 was reviewed using average monthly mental health caseload and psychiatrist FTE coverage. Monthly caseloads ranged from 768 to 864 patients, with psychiatrist coverage ranging from 5.9 to 7.3 FTEs. The resulting patients-per-provider ratio ranged from 105 to 146 patients per provider. Psychiatric encounter volumes were documented throughout the monitoring period, reflecting continued provider contact with patients receiving mental health services.

PRN psychiatric providers are also utilized to assist with coverage needs. PRN coverage does not have assigned FTE allocation and is used to supplement services during periods requiring additional provider availability.

This data provides the requested numerator and denominator and reflects ongoing review of psychiatrist caseloads and patient access to psychiatric care.

February 2026 Findings: As per status update. Partial compliance continues.

2) Whether MDC's mental health staffing is sufficient to provide all safety precautions (referencing suicide prevention and planned use of force), treatment, and services required by the Court's orders.

UNMH Status Update as of 02/06/2026:
Mental health staffing continues to support safety precautions, treatment, and services related to suicide prevention and planned use of force. Provider recruitment and staffing adjustments have contributed to clinical coverage, including psychiatric support during periods of provider transition (prn's).

Dedicated mental health coordinators are assigned to Fox 2, Delta 3, PAC 4, RHU 3 and RHU6, supporting coordination of clinical services and safety-related interventions. Staffing activity, caseload data, and follow-up monitoring continue to be reviewed in relation to service delivery and safety practices.

Caseload and backlog data are reflected in the PSU matrix, which demonstrates continued service activity and monitoring of patient care needs.

February 2026 Findings: As per status update. Partial compliance remains based on assessments as noted in other provisions of the Settlement Agreement.

3) Whether MDC provides adequate care for inmates' serious mental health needs.

July 2025 Findings: This provision is essentially being monitored in the context of compliance ratings pertinent to other provisions that provide a structure for an adequate correctional mental health system. When such other provisions are found to be in compliance, it is very likely that this provision will also be in compliance.

UNMH Status Update as of 02/06/2026:

UNMH continues to provide mental health services for patients with serious mental health needs through psychiatric care, counseling services, medications management, suicide prevention monitoring, and follow-up care. Staffing recruitment and role adjustments have supported service delivery, and therapy group availability has expanded across PSU housing units. Audit data and clinical service monitoring reflect ongoing provider involvement in treatment and follow-up care.

February 2026 Findings: As per status update. Partial compliance remains based on assessments is noted in other provisions of the Settlement Agreement.

4) Whether MDC's mental health staffing is sufficient to provide adequate care for inmates' serious mental health needs, consistent with generally accepted correctional mental health standards of care.

July 2025 Findings: This provision is very similar to the prior provision except it is specific to the question of whether MDC's mental health staffing is sufficient to come into compliance with SA provision H.3.

As in SA provision H.3, when other relevant provisions of the SA are found to be in compliance, this provision will be in compliance.

UNMH Status Update as of 02/06/2026:

Mental health staffing continues to be monitored in relation to service delivery, clinical encounters, follow-up care, medication management, and suicide prevention services. Recent staffing changes include on-boarding of a psychiatrist and reassignment of counselor roles to task-specific responsibilities to support accountability and service coordination. Therapy group availability has expanded across PSU housing units.

Multidisciplinary team implementation and workflow processes, including RDT/LEA coordination, sick call, and chronic care services, remain under review. Staffing levels and service activity continue to be elevated alongside performance data to monitor access to mental health.

February 2026 Findings: As per status update. Partial compliance remains based on assessments as noted in other provisions of the Settlement Agreement.

5) Whether MDC annually reviews staffing patterns based on data of timeframes in which staff have completed necessary functions such as response to sick call requests, initial assessments, follow up contacts, and other essential clinical processes during the past year.

January 2025 Findings: As per status update and discussion with leadership staff. The analysis demonstrated a need for increased mental health staffing allocations. Compliance is now present.

UNMH Status Update as of 02/06/2026:

UNMH conducts ongoing reviews of staffing patterns using data that measures performance on critical clinical processes, including sick call response times, initial assessments, follow-up contacts, and other essential functions. The staffing analysis is ongoing due to the significate increase in the jail population.
A staffing analysis was conducted for Mental Health that department identified that the department requires seven additional counselors to provide adequate and timely patient care.

The psychiatry department was allocated an additional psychiatrist in 2025 in response to the increase caseload.

February 2026 Findings: As per status update.

Compliance continues.

6) Whether there is evidence that MDC addressed staffing needs whenever new programming is initiated.

UNMH Status Update as of 02/06/2026:

No new programming was initiated during this auditing period.
MDC Update:

No new programming was initiated during the monitoring period.

February 2026 Findings: As per status update. Compliance is maintained.

I. Quality Assurance/Improvement ***[Doc. No. 256, III(K)].***

1) Whether MDC developed and implemented policies and procedures that create an adequate quality management system to review suicide and self-injurious behaviors, morbidity and mortality and implementation of its mental health policies and procedures and implemented appropriate corrective action to prevent or minimize future harm to inmates.

July 2025 Findings: As per status update. M & M reports are now completed within required

timeframes. Compliance is now present.

UNMH Status Update as of 02/06/2026:
UNMH has developed and implemented policies and procedures that support an adequate quality management system to review suicide and self-injurious behaviors, morbidity and mortality, and the implementation of mental health policies and procedures. This includes:

- Policy MDC HCA 12.06 – Continuous Quality Improvement Program, which outlines the formal structure for quality improvement and corrective action planning across medical and mental health services.
- The Morbidity and Mortality (M&M) Committee meets biweekly and conducts structured reviews of adverse mental health events, including cases referred by the Suicide Prevention Committee (SPC). These reviews help identify clinical or operational gaps and generate recommendations to prevent or minimize future harm.
- The SPC and M&M Committees now meet consistently, and case reviews are occurring within expected timeframes, as evidenced by the M&M log. These reviews inform targeted corrective actions and system adjustments as needed.

February 2026 Findings: As per status update. Compliance continues.

2) Whether MDC developed and implemented a Suicide Prevention Committee that reviews individual and system data about triggers and thresholds and determines whether these data indicate trends either for individuals or the adequacy of treatment and suicide prevention overall.

UNMH Status Update as of 02/06/2026:

UNMH/MDC maintains an active Suicide Prevention Committee (SPC) that meets monthly review of incidents of self-harm and suicide attempts. Cases involving serious injuries are referred to by the Morbidity and Mortality (M&M) Committee for further evaluation. These reviews focus on identifying both individual-level and system-wide trends to inform suicide prevention strategies and assess the adequacy of behavioral health interventions.

Recent trends and issues identified include:

Dr. Hamilton created a SPC Trends, Self-Harm and Safety Event Data Dashboard, which captures location, type of event and other relevant trigger and threshold data. Please refer to the included document for additional information.

February 2026 Findings: As per status update. Compliance continues.

3) Whether MDC's Quality Improvement Committee:

a. Includes the Medical Director, the Psychiatric and Behavioral Health Directors, related clinical disciplines, Jail Director or the Assistant Chief of Operations, and the Health Services Administrator;
b. Conducts analyses of the mental health processes and makes recommendations on changes and corrective actions;
c. Provides oversight of the implementation of mental health policies, procedures, guidelines, and support plans;
d. Reviews policies, training, and staffing levels;
e. Monitors implementation of recommendations and corrective actions;
f. Reports its findings and recommendations to appropriate County officials periodically; and
g. Refers appropriate incidents to the Morbidity/Mortality Committee for review, a necessary.

July 2024 Findings: As per status update. During the site assessment I discussed with leadership staff the current implementation status of the various elements of this provision. I disagree with the Plaintiff Intervenors assertion that the correct legal interpretation of "appropriate County officials" is elected County commissioners.

Compliance is present.

UNMH Status Update as of 02/06/2026:

MDC's Quality Improvement (QI) Committee continues to meet all outlined expectations and remains in compliance:

- The QI Committee includes the Medical Director, Psychiatric and Behavioral Health Directors, other clinical disciplines, the Jail Director or Assistant Chief of Operations, and the Health Services Administrator.
- The committee conducts regular analyses of mental health processes and makes recommendations for changes and corrective actions.
- It provides oversight for the implementation of mental health-related policies, procedures, guidelines, and support plans.
- It reviews current policies, staff training, and staffing levels to ensure ongoing quality and safety.
- The committee monitors the implementation of recommendations and corrective actions. For example, safety monitor reviews conducted in September, October, and December

demonstrated improved training outcomes.

- It reports findings and recommendations to appropriate County officials, including leadership at UNMH and MDC (e.g., Natalie Vance and others).
- When appropriate, the committee refers incidents to the Morbidity/Mortality Committee for further review.

These ongoing QI processes contribute to sustained compliance and continuous improvement of mental health services within MDC.

February 2026 Findings: As per status update. Compliance is maintained.

4) Whether MDC's Morbidity/Mortality Committee reviews suicides, serious suicide attempts, all other deaths of people committed to the custody of the MDC, and other sentinel events occurring at MDC in order to improve care on a jail-wide basis.
   a. Whether MDC's Morbidity and Mortality Review Committee conducts an interdisciplinary review, consisting of members of the correctional, medical, and mental health staffs, of all deaths of people housed at MDC, serious suicide attempts and other sentinel events;
   b. Whether MDC's Morbidity and Mortality Review Committee's inquiry includes:
      i. circumstances surrounding the incident;
      ii. facility procedures relevant to the incident;
   c. All relevant training received by involved staff;
   d. Pertinent medical and mental health services/reports involving the victim;
   e. Possible precipitating factors leading to the event;
   f. Recommendations, if any, for changes to policy, training, physical plant, medical or mental health services, and operational procedures; and
   g. Tracking of whether MDC implements recommendations and, if so, when.

July 2024 Findings: During the site assessment I discussed with leadership staff the implementation status of the various elements of this provision. Compliance is present.

UNMH Status Update as of 02/06/2026:

Please reference question one above.

February 2026 Findings: As per status update referring to I(1). Compliance is maintained.

5) Whether the review team, when appropriate, develops a written plan (and timetable) to address areas that require corrective action.

UNMH Status Update as of 02/06/2026:

Corrective Action Plans are developed when appropriate to address areas that require corrective action. ~50 audits have been conducted between July 2025 - December 2025.

Various corrective action plans have been developed; however, some corrective action plans are hindered due to budget as well as operational issues.

February 2026 Findings: As per status update. Compliance is maintained.

6) Whether MDC's Mortality Committee or Suicide Prevention Committee (for review of morbidity only) conducts a preliminary mortality or morbidity review within 30 days of each suicide or serious suicide attempt (e.g., those incidents requiring hospitalization for medical treatment).

July 2024 Findings: Compliance is present regarding meeting the 30-day timeframe for conducting a preliminary mortality review within 30 days of each suicide. Partial compliance was present for conducting a preliminary morbidity review for a serious suicide attempt (e.g., those incidents requiring hospitalization for medical treatment).

I reviewed both the psychological autopsy report and the administrator mortality report regarding the suicide of Ms. MM. I discussed with key clinicians the following issues and/or recommendations:

1. It was my understanding that the use of the term seclusion did not refer to seclusion for mental health purposes but to being placed in a single cell for close observation purposes. Both reports need to be revised to clarify this area of confusion.
2. The psychological autopsy did not include any interviews with mental health staff, correctional staff, family members or other detainees. It appeared that correctional staff were not interviewed due to the investigation conducted by either the Office of Professional Standards (OPS). The result of such an investigation are not made available to the M&M committee until the investigation is completed, which should take about 90 days.
3. The M&M report included relevant recommendations but did not include planned interventions or identify who was responsible for implementing the recommendations.
4. I discussed with relevant staff the need for the suicide prevention committee to clearly document at subsequent meetings the status of the recommendations.
5. The M&M committee also needs to have a standing agenda item from the suicide prevention committee for purposes of reviewing activities of the suicide prevention

committee as well as providing a status update regarding recommendations made by the M&M committee relevant to suicides or serious suicide attempts.

6. The M&M committee needs to incorporate relevant findings from the OPS report within 30 days of receipt of the report.
7. I recommended that UNMH contact the California Department of Corrections and Rehabilitation (CDCR) in order to obtain information regarding CDCR's psychological autopsy process.
8. Consultation should also be obtained the UNMH's department of psychiatry re: writing a psychological autopsy report.

July 2024 Recommendations: As above. Remedy the timeframe issue for M&M reports.

January 2025 Findings: As per status update. During the monitoring period there continued to be compliance issues with meeting timeframes for morbidity reports. Partial compliance continues.

UNMH Status Update as of 02/06/2026:

UNMH conducted the initial reviews within the Suicide Prevention Committee (SPC), with most reviews completed within 30 days. During the monitoring period, it appears that two reviews were missed due to technical reasons. Processes have been updated to prevent future missed cases and to improve timely review moving forward.

February 2026 Findings: As per status update. Partial compliance is present.

7) Whether Mortality Committee or Suicide Prevention Committee's preliminary report of any mortality review is completed within 30 days of each suicide or serious suicide attempt.

UNMH Status Update as of 02/06/2026:

UNMH conducts all initial reviews within 30-days, however; OMI is unable to return their report to us within 30-days, therefore; the Final Mortality reports are not completed within 30-days. We did not have any completed suicides during this audit period.

MENTAL HEALTH MORTALITY	July	August	Sept	Oct	Nov	Dec
# TOTAL Facility-wide deaths at end of month related to Mental Health	1***	0	0	0	0	1

Total Mortality Rate per 100,000	#VALUE!	0.00%	0.00%	0.00%	0.00%	0.06%
# deaths of inmates on the PSU caseload	0	0	0	0	0	0
# of suspected suicides facility-wide	0	0	2	0	0	0
Total Suicide Rate per 100,000	0.00%	0.00%	0.12%	0.00%	0.00%	0.00%
# of initial Mortality reviews documented within 30 days of the event	1***	0	0	0	0	1
% of timely initial Mortality reviews	100%	100%	100%	100%	100%	100%
Final Mortality reports completed within 30 days of receipt of the OMI autopsy, toxicology reports and OPS	0	0	0	1	2	0
% of timely Final Mortality reviews	0%	0%	0%	100%	100%	0%
# deaths of inmates on CCP	0	0	0	0	0	0

There were two deaths on the PSU Caseload during this auditing period.

- Both cases were reviewed within the 30-day timeframe.

February 2026 Findings: As per status update. Compliance is present.

8) Whether MDC completes a final mortality review report within 30 days after the pathological examinations are complete.

UNMH Status Update as of 02/06/2026:

Please refer to the M & M data that is included in this packet.

February 2026 Findings: As per status update. Compliance is present.

February 2026 Recommendations: There were questionable timeliness issues that need to be addressed by UNMH in the context of receiving the OMI report in a more timely fashion.

J. Other Matters

1) Whether any individual who has been identified as having a psychiatric, neuropsychological or developmental disorder who was subjected to a Taser, pepper gas, mace or other chemical

agent is assessed by a mental health professional and the circumstance of the event is included in the resident's mental health file.

UNMH Status Update as of 02/06/2026:

All inmates subject to use of force are brought to medical for post use of force clearance by medical and PSU. The encounter is documented in the medical record.
Audit Results as follows below:

2025	18 UOF Cleared by Medical and PSU	Q3	Q4
1	Cleared by PSU	93%	97%
2	Cleared by Medical	90%	97%
3	Circumstances Documented	93%	100%
	Overall Compliance	92%	98%

February 2026 Findings: As per status update. Compliance is maintained.

2) Whether Defendants have developed an adequate plan to implement an effective jail diversion program for persons with psychiatric or developmental disabilities. *[Doc. No. 319 at 6 ¶ 4]*

December 2023 Findings: Compliance continues.

It is my understanding that the diversion programs focus more on persons with substance use disorders in contrast to persons with a serious mental illness. More diversion programs for persons with a SMI would be very helpful in reducing the number of incarcerated persons with a SMI as would a population reduction program in the jail that focused on persons with a SMI.

UNMH Status Update as of 12/22//2024:

MDC has developed an adequate plan to implement an effective jail diversion program for persons with psychiatric or developmental disabilities.
MDC Update:

Bernalillo County has continued to implement all jail diversion efforts identified in its previous plans. Additionally, through its work with the CJCC, Bernalillo County has adopted a plan to implement the Stepping Up Initiative which requires:

1. Convene or draw on a diverse team of leaders and decision makers from multiple agencies committed to safely reducing the number of people with mental illnesses in jails.

2. Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk, and use that baseline information to guide decision making at the system, program, and case levels.
3. Examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders, and identify state and local policy and funding barriers to minimizing contact 58 with the justice system and providing treatment and supports in the community.

4. Develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity, while considering identified barriers.
5. Implement research-based approaches that advance the plan.
6. Create a process to track progress using data and information systems, and to report on successes.

The original Stepping Initiative and the more recent CJCC presentation on the plan to implement it is enclosed.

Additionally, the County entered into an agreement with UNMH Institute of Social Research to gather data relevant to recidivism and specifically those individuals with SMI. This agreement is enclosed.

July 2025 Findings: As per status update. Compliance continues.

UNMH Status Update as of 02/06/2026:

The County operates multiple fully implemented diversion initiatives—including LEAD, Pre-Prosecution Diversion, Mental Health Court, Community Custody, UNM Jail Diversion Services, the Resource Reentry Center, and the Competency Diversion Pilot Program, each with structured processes, community partnerships, and operational oversight. These programs collectively constitute an *adequate plan* under the Settlement Agreement. Compliance is based on the existence, execution, and oversight of these programs, not on historical or contemporaneous population statistics.

MDC Update:

Bernalillo County has continued to implement all jail diversion efforts identified in its previous plans.

February 2026 Findings: As per status update. Compliance is maintained.

3) Whether Defendants developed, in consultation with the Court's Mental Health Expert, a plan for the provision of specialized mental health treatment for both female and male residents who are segregated. May 22, 2013 "Order Resolving Order to Show Cause," *[Doc. No. 1004]*.

July 2025 Findings:

Summary

During this site visit I again discussed with leadership staff my understanding of the correctional mental health standard of care specific to placement of patients with a mental illness in restricted housing unit settings. Specifically, the standard of care indicates that patients with a serious mental illness should not be placed in prolonged restricted housing unit settings and, if they are, they should receive appropriate out of cell time (both structured therapeutic out of cell time and unstructured out of cell time). Hence, the 10:10 principle (offering 10 hours per week of out of cell structured therapeutic activities and 10 hours per week of out of cell unstructured activities per patient).

I discussed with staff the need to track out of cell unstructured time offered to PSU inmates in a RHU setting and report such data in futured status update sections.

Compliance is present in the context of Defendants having developed, in consultation with the Court's Mental Health Expert, a plan for the provision of specialized mental health treatment for both female and male residents who are segregated. Partial compliance is present for this provision due to implementation issues of the referenced plan.

July 2025 Recommendations: Increase the out of cell time for PSU patients in RHU settings.

UNMH Status Update as of 02/06/2026:

Housing assignments changed in November 2025:

old	new
PAC 1	FOX 2
PAC 3	DELTA 3
PAC 4	PAC 4
RHU 3/6	RHU 3/5
Rhu 6	RHU 6

Psychoedu Group Hours						
Unit	July	Aug	Sept	Oct	Nov	Dec

PAC 1	31:10	45:30	44:30	42:30	40:30	42:25
PAC 3	9:00	21:00	26:45	40:00	46:30	51:30
PAC 4	32:35	20:40	8:30	18:52	17:04	24:59
RHU3	29:50	40:30	22:30	39:15	27:00	36:20
RHU 6	27:00	40:05	40:55	41:43	30:35	3:00

- Table: Activity Hours

Activity Hours						
Unit	July	Aug	Sept	Oct	Nov	Dec
PAC 1	35:00	50:10	3:49	46:45	50:45	48:00
PAC 3	0:0	5:59	3:48	34:00	41:30	40:00
PAC 4	0:0	29:12	4:25	18:00	0:00	17:10
RHU3	13:00	38:00	15:00	23:10	17:30	30:30
RHU 6	4:00	16:55	15:35	6:00	9:15	0:00

February 2026 Findings:

RHU 6

RHU 6 is a residential program for restricted housing PSU male inmates. Inmates on the lower tier are offered out of cell time on a twice per weekday basis for two hours each time (total of four hours per weekday). Out of cell time during weekends is limited due to custody staffing issues.

Lower tier inmates described reasonable access to the mental health counselor and a psychiatrist. Medication continuity issues were not present. Reasonable access to the discharge planner was also reported by the residents. The residents reported being offered 1-2 hours per weekday of structured therapeutic activities that were described as being helpful.

Conditions of confinement for inmates housed on the upper tier were very restricted due to either their gang affiliation or their "red shirt" status. They were offered out of cell time for 30 minutes on a twice per weekday status on a single person basis (i.e., not with other inmates). Their status could be changed to a "copper" level as a transition to the lower tier. These inmates were offered one therapy group per week when the cert team was available.

RHU 3

RHU 3 is a residential program for restricted housing PSU female inmates. The lower tier inmates are offered out of cell time from 8 a.m.-2 p.m. and from 4 p.m. – 8 p.m. on a daily basis. Out of cell time on weekends is more limited due to custody staffing issues. These residents generally receive 2 hours per days of group treatment in addition to other structured activities. The treatment was reported to be helpful. Reasonable access to the mental health counselor and psychiatrist was reported by the residents. Medication continuity issues were not present but one inmates, who was not prescribed any medications, complained about the variability in the timing of the medication administration process.

Inmates on the upper tier were either "red shirts" on a time out alone (TOA) status in addition to section on the upper tier of protective custody inmates. Red shirt inmates and TOA inmate w ere offered out of cell time for 30 minutes on a twice per weekday basis.

Assessment

Residents in the RHU 6 & 3, who were housed in the lower tiers, were receiving adequate mental health treatment. The residents on the upper tiers, excluding the female PC inmates, were not receiving adequate out of cell time or structured therapeutic activities.

Data should be collected regarding the average and median length of stays for the inmates on the upper tiers so that a reasonable treatment program can be developed and implemented.

Partial compliance is present.

February 2026 Recommendations: As above

K. Constitutionally adequate mental health care

1) Whether the mental health care provided by MDC to its inmates' evidence repeated examples of negligent acts.

July 2025 Findings: As per status update. I did not find evidence that the mental health care provided by MDC to its inmates' evidence repeated examples of negligent acts.

UNMH Status Update as of 02/06/2026:

UNMH is not aware of any negligent acts.

February 2026 Findings: As per status update. Compliance is maintained.

2) Whether the conduct of MDC mental health staff effectively denies inmates access to adequate mental health care;

July 2025 Findings: As per status update. The conduct of MDC mental health staff does not deny inmates access to adequate mental health care although the provision of adequate mental health care has been problematic during the monitoring period related to staffing vacancies.

UNMH Status Update as of 02/06/2026:

Due to improved staffing, UNMH has a much-reduced backlog for psychiatric intakes and follow-ups. The study for missed in RDT showed that we have improved results quarter over quarter reflecting a visible decrease in inadequate PSU referrals. This is attributed to continuous training and supervision of intake staff which is reflected in the audits. In addition to training, spot audits are conducted to review referrals from intake to determine if timeframes were met, and patients were referred appropriately.

February 2026 Findings: As per status update. Compliance is maintained.

3) Whether there are systematic deficiencies in staffing, facilities, equipment, or procedures.

July 2025 Findings: As per status update. Current systematic deficiencies in staffing, facilities, equipment, or procedures were not present. Partial compliance is present for the monitoring period due to staffing vacancies earlier in the monitoring period.

UNMH Status Update as of 02/06/2026:

- Please refer to the table below. The annual staffing analysis determined that UNMH requires seven additional counselors to meet the needs of the facility. An increase in mental health counselors will require approval by the county.
- There continue to be a decrease in turnover among mental health counselors due to several of our travels extending their contract or signing on as "CORE" staff/ We remain committed to prioritizing care for individuals with acute needs and those in the SMI population.

As of the most recent update, there are no identified systematic deficiencies in facilities, equipment, or procedures—these continue to remain functional and appropriately maintained.

Study: Staffing Fill Rate Compared to Budget (Average for Auditing Period Q3/Q4)	
QMHP	• 18.8 filled / 19 allocated (99%) ▫ All counselor positions are filled. The 0.2 variance reflects two employees working at 0.9 FTE.

Psychiatrists	• 4.9 filled / 7 allocated (70%) o Vacancies are currently being backfilled with Psychiatric Nurse Practitioners.
Psychiatric Nurse Practitioners (NPs)	• 1.9 filled / 1 allocated (190%) o The additional NP is supporting coverage for one Psychiatrist vacancy.
Average Psychiatric Provider Coverage Combined (July/Dec)	• 7.3 FTE / 8.0 allocated (91.0%)
Psychiatric Director:	• 1 filled / 1 allocated (100%)
Mental Health Director	• 1 filled / 1 allocated (100%)
Registered Nurses (RNs):	• 4.5 filled / 6.4 allocated (70%) o UNMH RN's are providing floating to support areas with staffing needs.
Licensed Practical Nurses (LPNs):	• 1 filled / 0 allocated (100%) o Position provides additional clinical support beyond the allocated staffing model.

February 2026 Findings: As per status update. Current systematic deficiencies in staffing allocations/vacancies, both custody and mental health staff, were not present. Partial compliance is present

4) Whether the inmate population is effectively denied access to adequate mental health care.

UNMH Status Update as of 02/06/2026:

The delays were primarily attributed to the rigorous timeframes. Please see above and relevant CQI studies.

February 2026 Findings: As per status update. Some of the inmate population were effectively denied timely access to adequate mental health care related to staffing vacancies earlier in the monitoring period.

L. Americans with Disabilities Act

1) Whether the Defendants have made the modifications to their policies, procedures and practices that are necessary to provide to sub class members mental health care which is adequate

UNMH Status Update as of 02/06/2026:

UNMH continues to review and update policies at our monthly policy and procedure committee meeting. Previous staffing concerns have been addressed. Please see the above and the relevant CQI studies.

February 2026 Findings: As per status update. Regarding ADA in the context of mental health disabilities, the policies and procedures reviewed are adequate. The practices were problematic during the monitoring period for reasons previously summarized in the context of staffing vacancies.

Partial compliance remains.

2) Whether sufficient communication occurs between MDC administration and treating mental health care professionals regarding an inmate's significant mental health needs that must be considered in classification and housing decisions in order to preserve the health and safety of that inmate, other inmates, or staff.

UNMH Status Update as of 02/06/2026:

Communication between MDC administration and treating mental health care professionals remains consistent and effective. Weekly meetings of the MDC Classification Committee continue to serve as a key platform for collaborative decision-making regarding inmates housed in the Restrictive Housing Unit (RHU) and Psychiatric Acute Care (PAC) Unit. The weekly UNMH / MDC Collaboration meeting focuses on resolving any obstacles in patient care.
An additional weekly meeting with MDC Leadership was created to discuss issues with the movement from PAC to FOX 2 and Delta 3.

These meetings allow PSU staff to present clinical input and advocate for appropriate classification and housing decisions based on detainees' mental health needs. This multidisciplinary exchange ensures that mental health considerations are integrated into decisions aimed at preserving the safety and well-being of the individual, other detainees, and staff.

The ongoing collaboration reflects a shared commitment to informed, coordinated care and to maintaining a safe and therapeutic environment within the facility.

February 2026 Findings: As per status update. Compliance is maintained.

3) Whether MDC security staff is adequately advised of inmates' special mental health needs that may affect housing, work, program assignments, disciplinary measures, and admissions to and transfers from institutions.

UNMH Status Update as of 02/06/2026:

Metropolitan Detention Center (MDC) security staff are appropriately advised of inmates' special mental health needs through established documentation and communication protocols. The Psychiatric Services Unit (PSU) utilizes the MDC-42 Standard Referral Form and the Inmate Discipline Form to inform custody staff of relevant mental health considerations that may impact decisions related to housing, work assignments, program eligibility, disciplinary actions, and institutional transfers or admissions.

These forms are transmitted directly from PSU to Security, detailing the rationale for any recommended placements or restrictions. This process ensures that custody staff have timely and relevant information to support informed decision-making while maintaining the safety and well-being of inmates with special mental health needs.

February 2026 Findings: As per status update. Compliance is maintained.

4) Whether mental health care and security staff communicate sufficiently about inmates with special needs conditions.

UNMH Status Update as of 02/06/2026:

We currently have good communication between PSU and custody. Please see above.

February 2026 Findings: As per status update. Compliance is maintained.

5) Whether MDC follows a proactive program which provides care for special needs patients who require close mental health supervision or multidisciplinary care.

UNMH Status Update as of 02/06/2026:

PAC 3 is now Delta 3: The patients benefit from a dorm style unit. Psycho Education and Activity hours have increased, please refer to the above table.
PAC 4: During this auditing period, Pyscho Education and Activities hours have become more consistent.

RHU 6: During this auditing period, the coordinator has remained consistent. The unit now has a higher number of high-acuity patients than it had previously due to the changes in the PAC structure, which allows for a safer environment for patients who require time out alone.
RHU 3: During this auditing period, the coordinator has remained consistent.

The relocation from PAC to Fox 2 and Delta 3 units has expanded PSU's capacity to house psychiatric patients.

Psychoedu Group Hours						
Unit	July	Aug	Sept	Oct	Nov	Dec
PAC 1/Fox 2	31:10	45:30	44:30	42:30	40:30	42:25
PAC 3/D3	9:00	21:00	26:45	40:00	46:30	51:30
PAC 4	32:35	20:40	8:30	18:52	17:04	24:59
RHU3	29:50	40:30	22:30	39:15	27:00	36:20
RHU 6	27:00	40:05	40:55	41:43	30:35	3:00

Pac treatment teams improve overall consistency, however; on some units, lock-downs and security staffing continue to affect group sessions. Treatment Team meetings have resumed and encourage patient participation. The discharge planners continued to meet with the patients and provide discharge plans.

February 2026 Findings:

Fox 2

This unit is an intermediate care residential treatment unit for men. Many residents on this unit had previously been housed in PAC 1. Mila Mansaram, PSU, MA, LMHC continues to be the mental health coordinator on this unit.

During the morning of February 26, 2026, I received an introduction to the treatment program on Fox 2 by two of the peer support residents and other residents on the unit. I also talked with all the residents on the unit in a community-like setting.

Residents reported being offered out of cell time from 8 AM-8 PM on a seven days per week basis. Most of their out of cell time involved structured therapeutic activities including community meetings. Good access to individual counseling and to the psychiatrist was described by these

residents. Medication continuity issues were not present. Reasonable access to discharge planners was also reported. The correctional officer staff was an important component of the therapeutic milieu established on this unit. Residents were very complementary regarding the treatment program on this unit.

Delta 3

Delta 3 is a residential treatment unit for men, which also serves as a step-down unit for inmates being discharged from Fox 2. I met with residents on this unit, in a community meeting like setting, who reported access to the dayroom from 8 AM-8 PM on a seven-day per week basis. Reasonable access to the mental health counselor was reported and access to a psychiatrist was limited related to staffing vacancies. The residents described structured therapeutic activities occurring on a daily basis, which were reported to be helpful. Medication continuity issues were absent. Access to discharge planners was reasonable.

Assessment: Therapeutic milieus have been maintained on these units, which is a reflection of dedication by both custody and mental health staff and cooperation by the residents on these units.

Compliance is present.

Detox housing Units

I also went into two housing units used for detoxing purposes as well as for seclusion and/or suicide watch. The cells used for the latter purposes did not have beds or chairs. Inmates slept on a thin mattress on the floor.

Assessment: The placement of inmates on seclusion or suicide watch in the detox housing units can be problematic. The lack of beds in the cells is very problematic and should be remedied. Major Alaniz showed me a possible solution, which would remedy this issue.

6) Whether individual mental health treatment plans are developed by a psychiatrist or other qualified clinician at the time the condition is identified and updated when warranted

UNMH Status Update as of 02/06/2026:

Individual mental health treatment plans are developed by a psychiatrist or other qualified clinician at the time the condition is identified and updated when warranted.

February 2026 Findings: As per status update. See prior provisions relevant to the treatment

planning process. This provision will be assessed in the context of timeliness of treatment plans based on Audit 20 element 3, Audit 16 element 4, and Audit 15 element 1. The only difference is that Audit 15, element 1 is also required.

Partial compliance is present.

7) Whether the mental health treatment plan includes, at a minimum:

a. The frequency of follow-up for mental health evaluation and adjustment of treatment modality;
b. The type and frequency of diagnostic testing and therapeutic regimens; and
c. When appropriate, instructions about diet, exercise,

UNMH Status Update as of 02/06/2026:

See Attachment 7.

February 2026 Findings: As per status update. Compliance is present.

SUMMARY

The pre-site information received was very helpful and comprehensive in nature. Specifically, the status update sections and/or pre-site data contained very useful QI studies. As during prior site visits, both the mental health and custody staffs were very helpful throughout the site visit.

As compared to my prior site assessment, custody vacancies remained significant at 28% and the psychiatrists' staffing vacancies remained significant. Of note, a recent staffing analysis demonstrated the need for an additional 7.0 FTE QMHP positions. All these staffing issues have contributed to many of the SA provisions being in partial compliance related to required timeframes,
It is very encouraging that the various PSU residential programs, which have been relocated to different housing units, have been able to re-establish and/or maintain a therapeutic milieu. Such an accomplishment is reflection of a very good working relationship between mental health and custody staffs working on those units.

Detainees in RHU 3 & 6, who are housed in the upper tiers (excluding the female PC detainees) are not receiving the proper amount of out of cell time and/or structured therapeutic activity. Custody and mental health staff should work together to remedy this problem.

I also went into two housing units used for detoxing purposes as well as for seclusion and/or suicide watch. The cells used for the latter purposes did not have beds or chairs. Inmates slept on a thin mattress on the floor. The placement of inmates on seclusion or suicide watch in the detox housing uses can be problematic. The lack of beds in the cells is very problematic and should be remedied. Major Alaniz showed me a possible solution, which would remedy this issue.

The following provisions were found to be in compliance:

A. Screening and Assessment

3) Whether MDC screens all inmates with Qualified Medical Staff upon booking at MDC, but no later than four (4) hours after booking, to identify the inmate's risk for suicide or self-injurious behavior.

4) Whether MDC's Qualified Medical Staff conducting intake screening receive adequate training on identifying and assessing suicide risk, are assigned appropriate tasks and guidance, and properly conduct intake screening.

5) Whether MDC Qualified Medical Staff, based on the screening, develop, and implement an acuity system or triage scheme (P1, P2, or P3) to ensure that inmates with immediate mental Health needs are prioritized for services.

8) Whether MDC's policies and procedures require that a Qualified Mental Health Professional performs a mental health assessment within the prescribed period of time, based on the inmate's risk.

10) Whether MDC conducts appropriate mental health assessments within the following periods from the initial screen:
   a. 14 days, or sooner, if medically necessary, for inmates classified as low risk (P3);
   b. 8 hours, or sooner, if medically necessary, for inmates classified as moderate risk (P2); and
   c. Immediately, but no later than four hours, for inmates classified as high risk (P1).

11) Whether MDC ensures that mental health assessments include the assessment factors described below:
   b. Intake screening shall inquire as to the following:
      (1) Current mental health conditions;
      (2) Current psychiatric medications;

(3) Current suicidal ideation, threat, or plan;
(4) Past suicidal ideation and/or attempts;
(5) Prior mental health treatment or hospitalization;
(6) Recent significant loss – such as the death of a family member or close friend;
(7) History of suicidal behavior by family members and close friends;
(8) Any reported observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk.

12) Whether MDC Qualified Mental Health Professionals complete all assessments, pursuant to generally accepted correctional standards of care.

13) Whether MDC Qualified Mental Health Professionals perform in-person mental health assessments no later than one working day following notification of any adverse triggering event (*i.e.*, any suicide attempt, any suicide ideation, and any aggression to self-resulting in injury).

B. Treatment Plan

2) Whether MDC's policies and procedures ensure that adequate and timely treatment for inmates are continued and further developed for inmates whose assessments reveal serious mental health needs and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate. *[Doc. No. 256, III(I)]*.

5) Whether MDC completes mental health evaluations as part of the disciplinary process and can demonstrate that the hearing officer incorporates those recommendations into the disciplinary process for determining whether an inmate's actions should be excused and, if not, for mitigation of sanctions if the inmate's behaviors were a result of a mental or developmental disability. *[Doc. No. 256, IV(A)(1)]*.

6) Whether MDC implemented an adequate scheduling system to ensure that mental health professionals assess inmates with mental illness as clinically appropriate, regardless of whether the inmate is prescribed medications. *[Doc. No. 256, III(I)]*.

11) Whether MDC has established standards for the frequency of review and associated charting of psychotropic medication.

18) Whether Defendants have developed and implemented adequate formal procedures for seeking psychiatric hospitalization or other appropriate residential mental health care for

inmates who need and would benefit from such care, and who are eligible for such placement, consistent with the court-imposed conditions of their confinement. *[Doc. No. 256, III(M)].*

1. Whether MDC has sent an inmate to a psychiatric hospital or other appropriate residential mental health care for inmates who need and would benefit from such care, and who are eligible for such placement, consistent with the court-imposed conditions of their confinement.
2. Whether MDC has the realistic option of sending an inmate to a psychiatric hospital or other appropriate residential mental health care for inmates who need and would benefit from such care, and who are eligible for such placement, consistent with the court-imposed conditions of their confinement.

C. Suicide Precautions

1) Whether MDC's suicide prevention policies, procedures, and practices include provisions for constant direct supervision of actively suicidal inmates, close supervision of special needs inmates with lower levels of risk (e.g., 15-minute checks), and follow-up assessments after the suicide watch is discontinued.

4) Whether MDC follows its policy of having a psychiatrist or psychologist evaluate all inmates placed on suicide precautions before they are removed from suicide watch, and whether MDC assures that its policies are followed.

D. Suicide Prevention Training Program

2) Whether all medical and mental health staff are trained on the suicide screening portion of the mental health intake form and medical intake tool.

3) Whether all MDC staff who work directly with inmates have demonstrated competence in identifying and managing suicidal inmates and have shown comprehension of the training objectives via a performance measure tool such as a pre-and post-test.

6) Whether an emergency rescue tool is in close proximity to all housing units.

7) Whether an emergency rescue tool is in close proximity to all housing units.

E. Use of Clinical Restraints

2) Whether the MDC policy requires restrained inmates with mental health needs to be monitored at least every 15 minutes by security staff to assess their physical condition. *[Doc. No. 256, III (N)&(I)].*

4) Whether MDC follows its clinical restraint policies. *[Doc. No. 256, III (N)&(I)].*

F. Use of Security Four Point Restraints

1) Whether MDC ensures that, in the event an emergency results in a four-point restraint of an individual identified as having a psychiatric, neuropsychological or developmental disorder, a Qualified Mental Health professional is notified immediately and personally assesses the appropriateness of the restraint and designs a plan to safely end the restraint as soon as possible.

G. Basic Mental Health Training

2) Whether MDC provides adequate specialized training for all security staff working on specialized mental health units

H. Mental Health Staffing

5) Whether MDC annually reviews staffing patterns based on data of timeframes in which staff have completed necessary functions such as response to sick call requests, initial assessments, follow up contacts, and other essential clinical processes during the past year

6) Whether there is evidence that MDC addressed staffing needs whenever new programming is initiated.

I. Quality Assurance/Improvement *[Doc. No. 256, III(K)].*

1) Whether MDC developed and implemented policies and procedures that create an adequate quality management system to review suicide and self-injurious behaviors, morbidity and mortality and implementation of its mental health policies and procedures and implemented appropriate corrective action to prevent or minimize future harm to inmates.

2) Whether MDC developed and implemented a Suicide Prevention Committee that reviews individual and system data about triggers and thresholds and determines whether these data indicate trends either for individuals or the adequacy of treatment and suicide prevention overall.

3) Whether MDC's Quality Improvement Committee:

h. Includes the Medical Director, the Psychiatric and Behavioral Health Directors, related clinical disciplines, Jail Director or the Assistant Chief of Operations, and the Health Services Administrator;
i. Conducts analyses of the mental health processes and makes recommendations on changes and corrective actions;
j. Provides oversight of the implementation of mental health policies, procedures, guidelines, and support plans;
k. Reviews policies, training, and staffing levels;
l. Monitors implementation of recommendations and corrective actions;
m. Reports its findings and recommendations to appropriate County officials periodically; and
n. Refers appropriate incidents to the Morbidity/Mortality Committee for review, a necessary.

4) Whether MDC's Morbidity/Mortality Committee reviews suicides, serious suicide attempts, all other deaths of people committed to the custody of the MDC, and other sentinel events occurring at MDC in order to improve care on a jail-wide basis.
   h. Whether MDC's Morbidity and Mortality Review Committee conducts an interdisciplinary review, consisting of members of the correctional, medical, and mental health staffs, of all deaths of people housed at MDC, serious suicide attempts and other sentinel events;
   i. Whether MDC's Morbidity and Mortality Review Committee's inquiry includes:
      i. circumstances surrounding the incident;
      ii. facility procedures relevant to the incident;
   j. All relevant training received by involved staff;
   k. Pertinent medical and mental health services/reports involving the victim;
   l. Possible precipitating factors leading to the event;
   m. Recommendations, if any, for changes to policy, training, physical plant, medical or mental health services, and operational procedures; and
   n. Tracking of whether MDC implements recommendations and, if so, when.

5) Whether the review team, when appropriate, develops a written plan (and timetable) to address areas that require corrective action.

7) Whether Mortality Committee or Suicide Prevention Committee's preliminary report of any mortality review is completed within 30 days of each suicide or serious suicide attempt.

8) Whether MDC completes a final mortality review report within 30 days after the pathological examinations are complete.

J. Other Matters

1) Whether any individual who has been identified as having a psychiatric, neuropsychological or developmental disorder who was subjected to a Taser, pepper gas, mace or other chemical agent is assessed by a mental health professional and the circumstance of the event is included in the resident's mental health file.

2) Whether Defendants have developed an adequate plan to implement an effective jail diversion program for persons with psychiatric or developmental disabilities. *[Doc. No. 319 at 6 ¶ 4]*

K. Constitutionally adequate mental health care

1) Whether the mental health care provided by MDC to its inmates' evidence repeated examples of negligent acts.

2) Whether the conduct of MDC mental health staff effectively denies inmates access to adequate mental health care;

L. Americans with Disabilities Act

2) Whether sufficient communication occurs between MDC administration and treating mental health care professionals regarding an inmate's significant mental health needs that must be considered in classification and housing decisions in order to preserve the health and safety of that inmate, other inmates, or staff.

3) Whether MDC security staff is adequately advised of inmates' special mental health needs that may affect housing, work, program assignments, disciplinary measures, and admissions to and transfers from institutions.

4) Whether mental health care and security staff communicate sufficiently about inmates with special needs conditions.

5) Whether MDC follows a proactive program which provides care for special needs patients who require close mental health supervision or multidisciplinary care.

7) Whether the mental health treatment plan includes, at a minimum:

d. The frequency of follow-up for mental health evaluation and adjustment of treatment modality;
e. The type and frequency of diagnostic testing and therapeutic regimens; and
f. When appropriate, instructions about diet, exercise,

The following provisions were found to be in partial compliance

A. Screening and Assessment

1) Whether MDC has developed and implemented policies and procedures for appropriate screening and assessments of inmates with serious mental health needs.

2) Whether MDC has developed and implemented an appropriate screening instrument that identifies mental health needs and ensures timely access to a mental health professional when inmates present symptoms requiring such care.

6) Whether MDC provides "sufficient psychiatric services to assure that a psychiatrist will evaluate no later than the business day after a resident's admission, any resident who: 1) reports being on any psychoactive medication when taken into custody, 2) requests any psychoactive medication or other psychiatric service, or 3) has been identified by any mental health or health professional at the jail as appropriate for a psychiatric assessment." *[Doc. No. 256, IIII (1-3)].*

1. Whether MDC provides adequate and timely psychiatric services to assess any inmate who:
    a. reports being on any psychiatric medication when taken into custody,
    b. requests any psychiatric medication or other psychiatric service, or
    c. has been identified by any mental health or health professional at the jail as appropriate for a psychiatric assessment.

7) Whether MDC implements policies and procedures, commensurate with the level of risk of suicide or self-harm, that ensure that inmates are protected from identifiable risks for suicide or self-injurious behavior.

9) Whether MDC security staff monitors inmates who are presumed to be of moderate or high risk of suicide or self-harm with constant supervision until the inmate is seen by a Qualified Mental Health Professional for assessment, and thereafter on the schedule chosen by the Mental Health Professional.

14) Whether MDC Mental Health Staff conduct in-person assessments of inmates before placing them on suicide watch, clinical seclusion, or segregation and on regular intervals thereafter, as clinically appropriate and defined by MDC policy.

B. Treatment Plan

1) Whether Defendants provide treatment plans consistent with prevailing professional standards for those inmates requiring a treatment plan.

a. Whether treatment plans for inmates in specialized mental health units are designed by an appropriate treatment team; and
b. Whether the plans are reviewed periodically, ordinarily at least every 90 days, and at the request of the resident.

3)Whether MDC's treatment plans adequately address inmates' serious mental health needs and whether the plans contain interventions specifically tailored to the inmates' diagnoses and problems. *[Doc. No. 256, III(I*

4) Whether MDC makes available appropriate therapy services by a licensed mental health provider where medically necessary for inmates with serious mental health needs as ordered by their attending psychiatrist.

7) Whether MDC inmates have the opportunity to participate meaningfully in the development of a treatment plan. *[Doc. No. 256, III(I)]*.

8) Whether MDC inmates receive appropriate psychotropic medications in a timely manner.

9) Whether MDC's use of psychotropic medications is reviewed by a Qualified Mental Health Professional on a regular, timely basis.

10) Whether MDC properly monitors and timely adjusts medications.

12) Whether a psychiatrist personally assesses every MDC inmate on psychiatric medication at least once every thirty (days. *[Doc. No. 256, III(C)]*.

- With what frequency should a psychiatrist personally assess every MDC inmate on psychiatric medication who is not seriously mentally ill.
- With what frequency should a psychiatrist personally assess every seriously mentally ill inmate.

13) Whether MDC's treatment of suicidal inmates involves more than segregation and close supervision (*i.e.*, providing psychiatric therapy, regular counseling sessions, and follow-up care).

C. Suicide Precautions

2) Whether MDC inmates on suicide watch are monitored by security with constant direct

supervision until a Qualified Mental Health Professional conducts a suicide risk assessment, determines the degree of risk, and specifies the appropriate degree of supervision.

3) Whether MDC security staff provide the amount of supervision specified by a Qualified Mental Health Professional and accurately document their well-being checks on forms that do not have pre-printed times.

5) Whether MDC conducts all follow-up assessments on all inmates discharged from suicide watch.

8) Whether MDC has developed and implemented appropriate policies for the housing of suicidal inmates.

9) Whether MDC assures that its policies and procedures in paragraphs 1-8 are followed.

H. Mental Health Staffing

1) Whether the caseload for psychiatrists treating MDC inmates exceeds 100 residents per FTE. *[Doc. No. 256, III(C)].*

   c. What caseload allows psychiatrists treating MDC inmates to provide adequate access to psychiatric care for inmates in need of such treatment.
   d. Whether the current caseload for psychiatrists treating inmates provides for adequate access to psychiatric care for inmates in need of such treatment.

2) Whether MDC's mental health staffing is sufficient to provide all safety precautions (referencing suicide prevention and planned use of force), treatment, and services required by the Court's orders.

3) Whether MDC provides adequate care for inmates' serious mental health needs.

4) Whether MDC's mental health staffing is sufficient to provide adequate care for inmates' serious mental health needs, consistent with generally accepted correctional mental health standards of care.

I. Quality Assurance/Improvement *[Doc. No. 256, III(K)].*

6) Whether MDC's Mortality Committee or Suicide Prevention Committee (for review of morbidity only) conducts a preliminary mortality or morbidity review within 30 days of each

suicide or serious suicide attempt (e.g., those incidents requiring hospitalization for medical treatment).

J. Other Matters

3) Whether Defendants developed, in consultation with the Court's Mental Health Expert, a plan for the provision of specialized mental health treatment for both female and male residents who are segregated. May 22, 2013 "Order Resolving Order to Show Cause," *[Doc. No. 1004]*.

K. Constitutionally adequate mental health care

3) Whether there are systematic deficiencies in staffing, facilities, equipment, or procedures.

4) Whether the inmate population is effectively denied access to adequate mental health care.

L. Americans with Disabilities Act

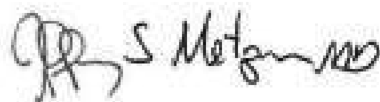
1) Whether the Defendants have made the modifications to their policies, procedures and practices that are necessary to provide to sub class members mental health care which is adequate

6) Whether individual mental health treatment plans are developed by a psychiatrist or other qualified clinician at the time the condition is identified and updated when warranted

I continue to be encouraged by the commitment made by UNMH to provide medical and mental health services for incarcerated persons at MDC. The improvements in the CQI process continue to be impressive.

Unless either party objects, the next site assessment will be September 15, 16, 2026 although I may need to reschedule it based on a potential conflict.

Sincerely,



Jeffrey L. Metzner, M.D.
Clinical Professor Emeritus of Psychiatry
University of Colorado School of Medicine

Attachment 1 - Screening and Assessment Studies

Attachment 2 - Quality of MH Assessments

Attachment 3 – Treatment Planning

Attachment 4 – Chronic Care Clinic

Attachment 5 – Mental Health Input into Discipline Process

Attachment 6 – Timely Medication Reviews

Attachment 7 – Treatment Plans

Attachment 1

Screening and Assessment Studies

UNMH Status Update as of 02/06/2026:

As outlined in the requirements above, the requested audits focusing on Q3 and Q4 2025 are provided below.

Audit 05 Inmates that Should have been Opened to PSU but Never Were:

2025	05 Inmates that Should have been Opened to PSU but Never Were	Q3	Q4
1	Patient has not had an acute PSU hold or PSU med hold in OMS within the past two years or on the last booking if they had not been incarcerated at MDC in the past two years.	90%	100%
2	Patient has not been open to PSU in the past two years as documented in OMS and/or Cerner.	97%	87%
3	Patient has not reported active (within the last six months) psych med use in the community.	100%	100%
4	Patient does not present with MH symptoms/ agitation/ suicidality/ homicidally.	100%	100%
5	Patient is not high profile and/or the alleged crime is not heinous.	100%	100%
6	Patient did not request to be opened to PSU or reports a history of recent Psych diagnosis.	100%	100%
7	Patient was not referred to PSU from Med 3 as P1, P2, or P3 for an initial PSU evaluation	100%	100%
8	If "No" to any of the previous questions (1-7), there was documentation as to why the patient was not opened.	100%	97%
9	Patient did not meet any criteria for referral to PSU at intake and should not have been "opened" to PSU per existing protocol.	100%	97%
	Overall Compliance	98%	98%

Minor declines were noted in documentation of prior PSU history, decreasing from 97% to 87%. Overall compliance remained stable at 98% from Q3 to Q4 2025. Most indicators maintained strong performance, sustaining 100% compliance, including review of psychiatric medication use, demonstrating continued adherence to PSU screening and documentation standards.

Audit 11 Negative Intake referrals open to PSU from GP:

Overall compliance demonstrated steady progress, improving from 84% in Q3 to 88% in Q4, with several indicators consistently above the 90% threshold, reflecting strong performance. While some elements showed minor variability, results overall indicate continued adherence to intake PSU exclusion protocols and strengthened documentation standards.

2025	11 Negative Intake referrals open to PSU from GP	Q3	Q4
1	Patient has not had an acute PSU hold or PSU med hold in OMS within the past two years or on the last booking if they had not been incarcerated at MDC in the past two years.	63%	77%

2	Patient has not been open to PSU in the past two years as documented in Cerner	60%	67%
3	Patient has not reported active (within the last six months) psych med use in the community.	97%	90%
4	Patient does not present with MH symptoms/ agitation/ suicidality/ homicidally.	100%	100%
5	Patient is not high profile and/or the alleged crime is not heinous.	100%	100%
6	Patient did not request to be opened to PSU or reports a history of recent Psych diagnosis.	100%	97%
7	Patient was not referred to PSU from Med 3 as P1, P2, or P3 for an initial PSU evaluation.	100%	90%
8	If "No" to any of the previous questions (1-7), there was documentation as to why the patient was not opened.	28%	83%
9	Patient did not meet any criteria for referral to PSU at intake and should not have been "opened" to PSU per existing protocol.	57%	80%
	Overall Compliance	84%	88%

Audit: 22 Timeliness P1

Overall compliance demonstrated strong performance, improving from 93% in Q3 to 95% in Q4 2025, reflecting continued adherence to P1 timeliness standards. PSU mental health evaluations within four hours of referral improved from 83% to 90%, demonstrating enhanced responsiveness. Psychiatric evaluations within one business day also showed improvement, increasing from 80% to 87%, indicating continued progress toward timeliness goals.

2025	22 Timeliness P1	Q3	Q4
1	Screened by Med 3 within 4 hours of booking?	100%	100%
2	Evaluated by PSU Mental Health within 4 hours of referral by Med 3	83%	90%
3	Evaluated by Psychiatry within one Business Day of Referral	80%	87%
4	Was Columbia Suicide Severity Rating Scale appropriately administered and assessed?	100%	100%
5	P-Level Assigned Correctly	100%	100%
	Overall Compliance	93%	95%

On average, P1 referrals are completed within 17 hours and 56 minutes.

Questions 4 and 5 were newly introduced during this auditing period as requested, with both measures achieving 100% compliance, supporting accurate suicide risk assessment and appropriate P-Level assignment. Overall results reflect sustained compliance and ongoing improvement in critical timeliness and clinical assessment practices.

On average, P1-P3 referrals are completed within approximately 17 hours and 56 minutes. In this study the patients that were beyond 24-hours:

- 29:16
- 26:38

- 29:19
- 38:47 (seen on time, documentation enter later in the shift)

Overall, these results demonstrate that MDC provides timely psychiatric services and effectively prioritizes residents with identified metal health needs.

Audit: 23 Timeliness P2

2025	23 Timeliness P2	Q3	Q4
1	Screened by Med 3 within 4 hours of booking?	100%	100%
2	Evaluated by PSU Mental Health within 8 hours of referral by Med 3	100%	97%
3	Evaluated by Psychiatry within one Business Day of Referral	97%	90%
4	Was Columbia Suicide Severity Rating Scale appropriately administered and assessed?	90%	100%
5	P-Level Assigned Correctly	87%	100%
	Overall Compliance	95%	97%

Overall compliance demonstrated strong performance improving from 95% in Q3 to 97% in Q4 2025, reflecting continued adherence to P2 timeliness standards. Screening by Med 3 within four hours of booking remained consistently high at 100% for both quarters. PSU mental health evaluations within eight hours of referral remained strong at 97%, demonstrating sustained responsiveness. Psychiatric evaluations within one business day showed minor variability but remained at the compliance threshold, slightly decreasing from 97% to 90% reflecting continued attention to timely evaluation.

As noted, Questions 4 and 5 were newly introduced during this auditing period as requested. Question 4 achieved 100% compliance in Q4, supporting accurate suicide risk assessment, while Question 5 improved to 100% in Q4, supporting appropriate P-level assignment. The issues identified in Q3 were addressed. Dr. Hamilton provided the Quality Consultant with a P-Level refresher training, as limited familiarity with P-Level criteria impacted Q3 audit results, not the nurses, who were already familiar with the criteria. The Q3 P2 audit served as a baseline and trial for the additional questions, and the refreshed training provided on P-Level qualifications helped resolve the issues that affected Q3 outcomes. Q3 results. Overall results reflect sustained compliance and ongoing improvement in timeliness and clinical assessment.

Audit: 24 Timeliness P3

2025	24 Timeliness P3	Q3	Q4
1	Screened by Med 3 within 4 hours of booking?	100%	100%
2	Evaluated by PSU Mental Health within 14 days of referral by Med 3	100%	100%
3	Evaluated by Psychiatry within one Business Day of Referral	80%	90%
4	Was Columbia Suicide Severity Rating Scale appropriately administered and assessed?	100%	100%
5	P-Level Assigned Correctly	100%	100%
	Overall Compliance	96%	98%

Overall compliance demonstrated strong performance, improving from 96% in Q3 to 98% in Q4 2025, reflecting continued adherence to P3 timeliness standards. Screening by Med 3 within four hours of booking and PSU Mental Health evaluations within 14 days of referral remained consistently high at 100%. Psychiatric evaluations within one business day improved from 80% to 90%. Demonstrating ongoing attention to timely evaluation.

Questions 4 and 5 were new introduced during this auditing period as requested with both achieving 100% compliance, supporting accurate suicide risk assessment and appropriate P-Level assignment. Overall results reflect sustained compliance and continued improvement in timeliness and clinical assessment practices.

Audit: 28 Timeliness of Nursing Intakes:

2025	28 Timeliness of Nursing Intakes	Q3	Q4
1	Screened by Med 3 within 4 hours of booking?	100%	100%
	Overall Compliance	100%	100%

Overall compliance remained excellent, maintaining 100% in both Q3 and Q4 2025, reflecting consistent adherence to nursing intake timeliness standards. Screening by Med 3 within four hours of booking remained consistently high, demonstrating sustained efficiency and responsiveness in the intake process.

Attachment 2

Quality of Mental Health Assessments

UNMH Status Update as of 02/06/2026 (SA Provision 10):

UNMH has implemented an audit of mental health assessments for P-Level referrals from RDT, covering both Non-SMI and SMI individuals. This audit specifically evaluates the assessment factors outlined in SA Provision 11, including current mental health conditions, psychiatric medications, current and past suicidal ideation or attempts, prior mental health treatment, recent significant losses, family history or suicidal behavior, and relevant observation from staff or external sources.

By reviewing these elements, the audit confirms that assessments capture the critical information necessary to evaluate risk and determine the appropriate timing of follow-up based on P-Level classification. This supports the intent in Provision 10, demonstrating that low, moderate, and high-risk individuals received thorough mental health evaluations within the prescribed timeframes.

2025	30 Quality of BH Assessments of P-Level Referrals from RDT, Non-SMI and SMI from GP	Q3	Q4
1	Current Mental Health Conditions	100%	93%
2	Current Psychiatric Medications	90%	90%
3	Current Suicidal ideation, treat, or plan	97%	100%
4	Past suicidal ideation and / or attempts	93%	100%
5	Prior mental health treatment or hospitalization	83%	100%
6	Recent significant loss-such as the death of a family member or close friend	90%	100%
7	History of suicidal behavior by family members and close friends	96%	84%
8	Any reported observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk	100%	100%
	Overall Compliance	93%	97%

Previous Audits 8 and 9 are include as reference:

	32 BH Assessment of Inmates Displaying SA, SI, or Self-Harm	Q3 25'	Q4' 25

1	Patient was assessed no later than one working day following notification of any adverse triggering event (i.e., any suicide attempt, any suicide ideation, and any aggression to self-resulting in injury).	100%	100%

2025	08 Quality of BH Assessment of Non-SMI Pts in GP	Q3	Q4
1	Personal History adequately documented	100%	
2	Criminal History adequately documented	100%	
3	Medical History adequately documented	83%	
4	Mental Health History adequately documented	100%	
5	Family Psychiatric History adequately documented	87%	
6	Substance Abuse History adequately documented	97%	
7	Suicide Risk appropriately assessed and adequately documented	100%	
8	Trauma History adequately documented	93%	
9	Violence Risk appropriately assessed and adequately documented	100%	
10	Mental Status appropriately assessed and adequately documented	100%	
11	Provisional Diagnosis appropriately assessed and adequately documented	N/A	
12	Disposition and Referral consistent with the history and provisional diagnosis adequately documented	100%	
	Overall Compliance	96%	

2025	9 Quality of BH Assessment of SMI Pts in GP	Q3	Q4
1	Personal History adequately documented	96%	
2	Criminal History adequately documented	96%	
3	Medical History adequately documented	89%	
4	Mental Health History adequately documented	96%	
5	Family Psychiatric History adequately documented	89%	
6	Substance Abuse History adequately documented	96%	
7	Suicide Risk appropriately assessed and adequately documented	96%	
8	Trauma History adequately documented	89%	
9	Violence Risk appropriately assessed and adequately documented	89%	
10	Mental Status appropriately assessed and adequately documented	100%	
11	Provisional Diagnosis appropriately assessed and adequately documented	N/A	

12	Disposition and Referral consistent with the history and provisional diagnosis adequately documented	100%	
	Overall Compliance	94%	

UNMH Status Update as of 02/06/2025 (SA Provision 11):

UNMH revised the behavioral health assessment audit instrument to include all eight required assessment elements outlines in SA Provision 11. The updated audit evaluates whether assessment of all eight elements.

The revised audit methodology also incorporates P-level referrals originating from the RDT screening process and referrals generated while individuals are housed in general population. The sample includes P1, P2, and P3 classifications and includes both SMI and non-SMI individuals, consistent with monitoring recommendations. This revision instrument allows UNMH to evaluate the quality and completeness of mental health assessments and supports compliance with SA Provisions 10 and 11.

2025	30 Quality of BH Assessments of P-Level Referrals from RDT, Non-SMI and SMI from GP	Q3	Q4
1	Current Mental Health Conditions	100%	93%
2	Current Psychiatric Medications	90%	90%
3	Current Suicidal ideation, treat, or plan	97%	100%
4	Past suicidal ideation and / or attempts	93%	100%
5	Prior mental health treatment or hospitalization	83%	100%
6	Recent significant loss-such as the death of a family member or close friend	90%	100%
7	History of suicidal behavior by family members and close friends	96%	84%
8	Any reported observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk	100%	100%
	Overall Compliance	93%	97%

Preliminary Q3 results indicate that assessments consistently addressed the required suicide risk screening components, supporting the appropriateness and quality of evaluations. These findings suggest that staff are generally incorporating the required assessment factors into clinical documentation, with continued opportunities for improvement.

Q4 reflects an overall compliance rate of (97%), demonstrating consistent quality assessments. Dr. Oliver has been working with the Informatics Department to build a user-friendly enhanced electronic Intake Form.

UNMH will continue monitoring performance through ongoing quarterly audits to ensure sustained compliance and continued improvements in assessment quality and documentation standards.

Attachment 3
Treatment Planning

UMMH Status Update as of 02/06/2025
Based on the requirements outlined above, UNMH currently monitors compliance with this provision through Audit 16, Audit 20 and the PSU Tracking Log. These audits assess treatment plans through a 10-day initial assessment, then assessments every 30-day and 90-day review based on units, evaluating treatment plan development by an appropriate multidisciplinary team, periodic review requirements, discharge planning, patient involvement, and documentation of treatment team participation.

Current results demonstrate that treatment plans are developed by the treatment team.

2025	16 PAC 1, 3, 4 RHU 6 TX and DC Planning 90-day audit	Q3	Q4
1	MHP completed the Preliminary Discharge Plan in its entirety and patient needs are outlined	N/A	N/A
2	Initial Treatment Team generated Tx Plan is documented within 7 business days (10 calendar days) of patient's admission to PAC 1,3,4, or HSU 6 (Mental Health Unit: Treatment Plan Review).	73%	83%
3	Treatment Team generated Tx Plan is documented within 30 business calendar days of patient's admission to PAC 1,3, 4, or HSU 6	10%	71%
4	Treatment Team generates Tx Plan is updated every 30 business calendar days for PAC 1&4, every 90 calendar business days for PAC 3&HSU 6.	44%	80%
5	Treatment Team generated Tx Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	100%
6	Treatment Team generated Tx Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	100%	95%
7	All members of the Treatment Team are documented as present	100%	100%
8	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	100%	100%
9	Whether the patient was invited to attend at least a portion of the treatment team planning meeting.	100%	95%
	Overall Compliance	85%	95%

Current results demonstrate treatment plans are developed by the treatment team. Q4 data for Audit 20 has been compiled and is included below

Audit results showed 94% overall compliance, reflecting improvement from Q3. Findings demonstrate that treatment plans were developed for PSU patients on the unit. These results are provided to supplement previously submitted compliance data and support responses to the applicable provisions. In an attempt to submit two quarter-of-data in the short timeframe as requested by Dr. Metzner.

2025	20 TX and DC Planning RHU 3	Q3	Q4
1	Preliminary Discharge Plan is completed in its entirety and patient needs are outlined	N/A	N/A
2	Initial Treatment Team generated TX Plan is documented within 7 business days (10 calendar days) of patient's admission to RHU 3 (Mental Health Unit: Treatment Plan Review).	33%	25%
3	Treatment Team generated TX Plan is updated every 30 business days for PAC 1, 4, RHU 3 and every 90 business days for PAC 3 and HSU 6.	97%	97%
4	Treatment Team generated TX Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	100%
5	Treatment Team generated TX Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	70%	100%
6	All members of the Treatment Team are documented as present	100%	100%
7	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	95%	100%
8	Whether the patient was invited to attend at least a portion of the treatment team planning meeting		100%
	Overall Compliance	88%	94%

Based on the question and the timeframe indicated in SA 1 above, the audits described above were adjusted to specifically review treatment plan periodically, ordinarily at least every 90-days, and at the request of the resident rather than strictly using the 30-day and 90-day intervals outlined in original audits

- Whether the plans are reviewed periodically, ***ordinarily at least every 90 days***, and at the request of the resident.

The result below reflect improvement with the revised, more flexible timeframe.

		Original	New
2025	16 PAC 1, 3, 4 RHU 6 TX and DC Planning 30 and 90-day	Q3A	Q3B
1	MHP completed the Preliminary Discharge Plan in its entirety and patient needs are outlined	N/A	N/A
2	Initial Treatment Team generated Tx Plan is documented within 7 business days (10 calendar days) of patient admission to PAC 1,3,4, or HSU 6 (Mental Health Unit: Treatment Plan Review).	73%	N/A

3	Treatment Team generated Tx Plan is documented within 30 business calendar days of patient's admission to PAC 1,3, 4, or HSU 6	10%	93%
4	Treatment Team generates Tx Plan is updated every 30 business calendar days for PAC 1&4, every 90 calendar business days for PAC 3&HSU 6.	44%	89%
5	Treatment Team generated Tx Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	100%
6	Treatment Team generated Tx Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	100%	100%
7	All members of the Treatment Team are documented as present	100%	100%
8	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	100%	100%
9	Whether the patient was invited to attend at least a portion of the treatment team planning meeting.	100%	100%
	Overall Compliance	85%	94%

2025	20 TX and DC Planning RHU 5	Original Q3A	New Q3B
1	Preliminary Discharge Plan is completed in its entirety and patient needs are outlined	N/A	N/A
2	Initial Treatment Team generated TX Plan is documented within 7 business days (10 calendar days) of patient admission to RHU 3 (Mental Health Unit: Treatment Plan Review).	33%	N/A
3	Treatment Team generated TX Plan is updated every 30 business days for PAC 1, 4, RHU 3 and every 90 business days for PAC 3 and HSU 6.	97%	97%
4	Treatment Team generated TX Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	100%
5	Treatment Team generated TX Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	70%	70%
6	All members of the Treatment Team are documented as present	100%	100%
7	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	95%	95%
	Overall Compliance	88%	93%

Audit 15

UNMH Status Update as of 02/06/2026:
UNMH has implemented individualized Mental Health Treatment Plans that are specifically designed to address detainees' serious mental health needs. These plans include tailored interventions that align with each patient's diagnoses, clinical history, and presenting concerns. The plans are developed by psychiatric providers in collaboration with PSU counselors and nursing staff to ensure a multidisciplinary approach.

Audits Pending:

2025	15 TX and DC Planning for SMI and Non-SMI Patients in GP	Q3	Q4
1	Did initial psychiatric evaluation take place within 14 business days after the referral or if returned to custody after 90 days of prior intervention w/in 14 days	Audit Terminated for Documentation Training Related to specific Audit Questions.	96%
2	Preliminary Discharge is completed by MHP's in its entirety and patient needs are outlined		N/A
3	Treatment Plan appropriately addresses the symptoms of the diagnosis		100%
4	Interventions are tailored to the Treatment Plan		100%
5	Discharge Plan documented that addresses patient needs and includes community follow-up		100%
6	Discharge Plan recommends Substance Use Disorder Treatment if a Substance Use Disorder is part of the diagnosis (N/A if no diagnosis)		100%
7	Whether the patient was an active participant in the Treatment Planning conversation.		100%
	Overall Compliance		99%

Audit 15 – Treatment and Discharge Planning for Non-SMI Patients in General Population (Q4)

Dr. Hamilton conducted a preliminary audit in October 2025 but discontinued the review after five charts were evaluated. The review identified that while service and treatment planning were being completed, documentation did not consistently address the questions listed in the audit in a clear "plan." Instead a reference was dictated that stated "see plan." Targeted retraining and standardization of documentation practices were implemented following the review.

In response to the July 2025 recommendations, UNMH revised the audit tool to include both SMI and non-SMI patients housed in general population. The Q4 audit results for Treatment and Discharge Planning for SMI and Non-SMI patients in GP demonstrated 99% overall compliance for the individual patients selected.

Attachment 4

Chronic Care Clinic

2025	12 Requests for Service Response Time	Q3	Q4
1	HCR screened and signed by nursing staff within 24 hours	87%	90%
2	Request has a triage level of Emergent, Urgent, or Routine.	100%	100%
3	If triage level was Emergent, patient was seen within 1 hour of the HCR receipt.	100%	N/A
4	If triage level was Urgent, patient was seen within 8 hours of the HCR receipt.	100%	100%
5	If triage level was routine, patient was seen or HCR resolved within 48 hours if submitted to PSU on Sunday through Thursday.	39%	68%
6	If triage level was routine, patient was seen or HCR resolved within 72 hours if submitted to PSU on Friday or Saturday.	17%	50%
7	HCR scanned and contains documented plan or indicates how/if it was resolved after completion.	100%	100%
8	EMR contains documentation of PSU Intervention in response to HCR	100%	100%
	Overall Compliance	84%	90%

2025	19 PSU Chronic Care	Q3	Q4
1	Documentation records that patient was seen as scheduled (Monthly, bi-monthly, weekly, etc...)	100%	100%
2	Most recent documented intervention includes reference to treatment plan progress	100%	100%
3	Most recent documented intervention includes follow-up plan.	100%	100%

4	If applicable, reason for program termination is documented in the last CC intervention note. (NA if still enrolled)	100%	100%
	Overall Compliance	100%	100%

UNMH continues to provide appropriate therapy services, when medically necessary, as ordered by attending psychiatrist for detainees with serious mental health needs. The Behavioral Health Chronic Care Clinic (CCC) process remains active, with licensed mental health providers delivering therapy and tracking patient progress through the EMR.

During this reporting period, ~65 detainees were enrolled in CCC services. Of these, approximately 15 completed treatment, 31 detainees actively engaged in therapy, 30 are assigned to counselors with initial sessions pending, and 26 are pending assignments. UNMH continues to monitor caseload trends and implement workflow adjustments to support timely service initiation.

Q3 and Q4 quality assurance audits demonstrated 100% compliance with all documentation related to the audit indicator listed above. Audit samples included seven detainees in Q3 and nine detainees in Q4, all meeting compliance standards. During this reporting period, the limited sample was due to an IT reporting limitation, which required manual data compilation and significantly increased the time needed to identify eligible records.

These results demonstrate that proper documentation has been maintained. However, the current backlog highlights the need for additional staffing. Based on the staffing analysis, the addition of seven counselors is recommended to reduce the backlog and ensure timely access to therapy services.

://app.smartsheet.com/sh...
MDC Team Site | Workday | (372) RingCentral -... | ITRF | IT HelpDesk Tickets | Smartsheet | MDC Scorec
Forms Connections Dynamic View

MDC Inmate Disciplinary Stats_2.24.26

Metric	AUG	SEPT	OCT	NOV	DEC	Total
Total number of disciplinary reports before adjudication	967	965	778	659	688	4057
Total number of PSU disciplinary reports before adjudication	584	609	468	391	409	2461
Number of PSU disciplinary reports adjudicated [NUM] (excludes Technical Dismissals)	200	172	171	158	144	845
Monthly Statistic Request [NUM/DEN] (p. 51, July 2025 Findings)	*57%*	*57%*	*61%*	*59%*	*55%*	
Number of mental health assessments received related to the disciplinary process	31	29	34	25	34	153
Number of assessments resulting in a mitigation recommendation	3		3	4	5	15
Number of recommendations that were accepted by the disciplinary hearing officer	3		3	4	5	15

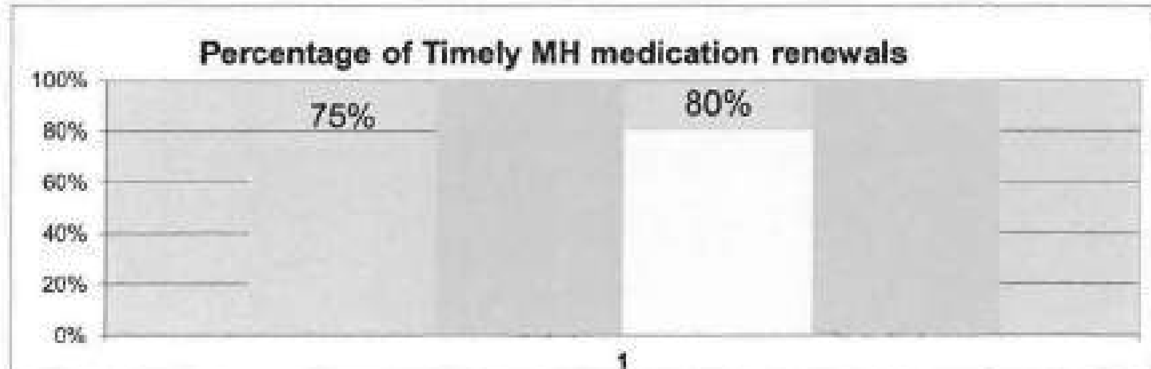
Attachment 6

Timely medication reviews

Audit7 results

Q3 PAC Units

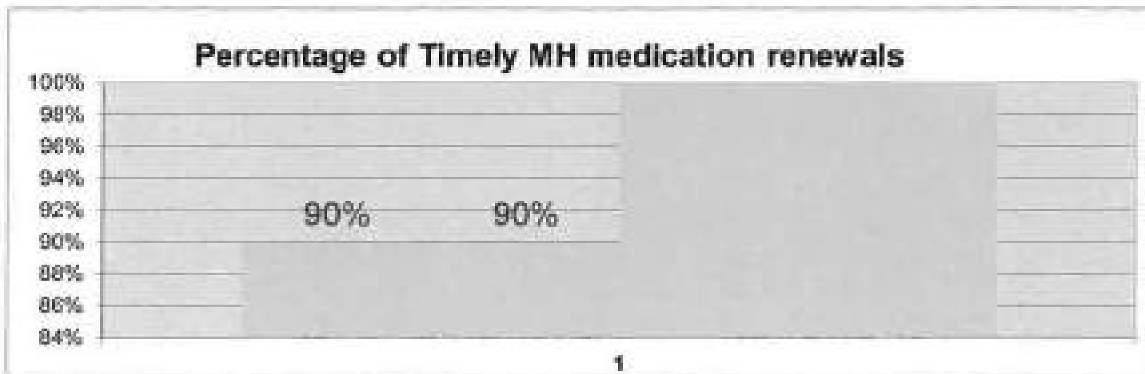
EVALUATIONThreshold for each indicator is 90 % (unless otherwise noted)



	CRITERIA		Results		
	06B Psych Med Renewal GP	Yes	No	NA	%
1	Timely/Appropriately Adjusted First 30-days	6	2	2	75%
2	Timely/Appropriately Adjusted 2nd 30-days	5	0	5	100%
3	Timely/Appropriately Adjusted 3rd 30-days	4	1	5	80%
4	Review agrees with adjustment	10	0	0	100%
	Overall Compliance 89%	25	3	12	89%

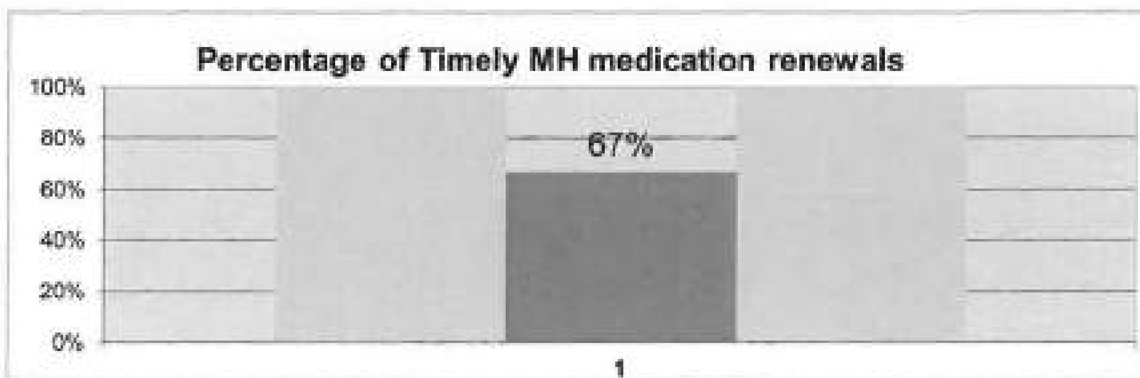
Q4 PAC Units

EVALUATIONThreshold for each indicator is 90 % (unless otherwise noted)



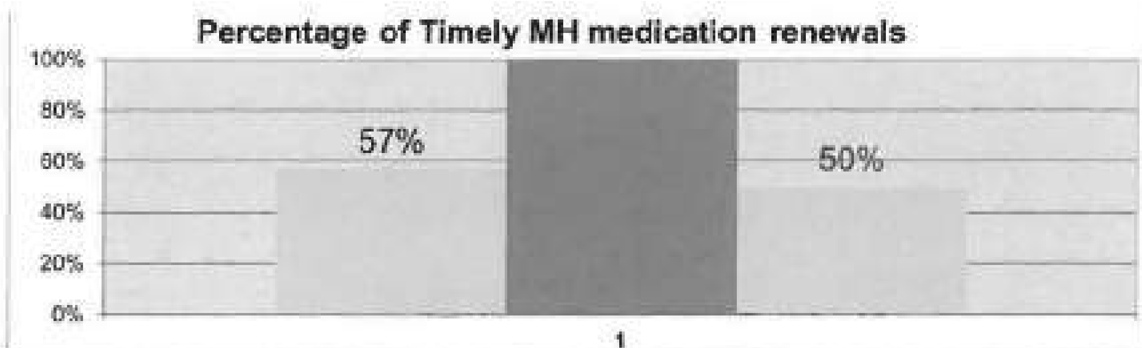
CRITERIA		Results			
	06B Psych Med Renewal GP	Yes	No	NA	%
1	Timely/Appropriately Adjusted First 30-days	9	1	0	90%
2	Timely/Appropriately Adjusted 2nd 30-days	9	1	0	90%
3	Timely/Appropriately Adjusted 3rd 30-days	5	0	5	100%
4	Review agrees with adjustment	10	0	0	100%
	Overall Compliance 94%	33	2	5	94%

Q3 GP units



CRITERIA		Results			
	06B Psych Med Renewal GP	Yes	No	NA	%
1	Timely/Appropriately Adjusted First 30-days	6	0	4	100%
2	Timely/Appropriately Adjusted 2nd 30-days	2	1	7	67%
3	Timely/Appropriately Adjusted 3rd 30-days	2	0	8	100%
4	Review agrees with adjustment	10	0	0	100%
	Overall Compliance 95%	20	1	19	95%

Q4 GP units



	CRITERIA		Results			
	06B Psych Med Renewal GP		Yes	No	NA	%
1	Timely/Appropriately Adjusted First 30-days		4	3	3	57%
2	Timely/Appropriately Adjusted 2nd 30-days		5	0	5	100%
3	Timely/Appropriately Adjusted 3rd 30-days		1	1	8	50%
4	Review agrees with adjustment		10	0	0	100%
	Overall Compliance	83%	20	4	16	83%

Attachment 7
Treatment Plans

UNMH Status Update as of 02/06/2026:

2025	03 Final DC Planning of PAC and RHU	Q3	Q4
1	Final Discharge Plan Completed or documented reason why Final Discharge Plan was not completed	87%	100%
2	Housing Needs and Referral adequately documented	83%	100%
3	Transportation needs and referral adequately documented	20%	64%
4	Mental Health needs and referral adequately documented	53%	100%
5	Substance Use Disorder needs and referral adequately documented	63%	91%
6	Benefits Packets/Income/ Resources/Treatment Guardian needs and referral adequately documented	10%	71%
7	MSE adequately documented	N/A	N/A
8	Patient signed Discharge Plan or documented reason why patient refused or was unable to sign	20%	100%
	Overall Compliance	48%	90%

Overall compliance improved from 48% in Q3 to 90% in Q4, reflecting efforts to ensure all elements of the discharge planning process were properly documented. By Q4, most categories achieved full compliance.

Two categories, transportation and benefits packets, including income, resources, treatment guardian needs and referrals, showed lower performance in Q3 (20% and 10%, respectively). This was due to a change in the DC Electronic Form in August, during which the questions for these areas were accidentally omitted. The form is currently being updated to ensure these elements are consistently captured. A meeting was held to review the Q3 results, during which the DC Planners were informed of the omission and instructed to include this information in the narrative section of the MDC BH Discharge Form. By Q4, documentation in these areas improved significantly (64% and 71%, respectively) as a result of this temporary workaround.

These results demonstrate clear improvement in overall discharge planning compliance and highlight the importance of ensuring electronic forms accurately reflect all required fields.

2025	16 PAC 1, 3, 4 RHU 6 TX and DC Planning 90-day audit	Q3	Q4
1	MHP completed the Preliminary Discharge Plan in its entirety and patient needs are outlined	N/A	N/A

2	Initial Treatment Team generated Tx Plan is documented within 7 business days (10 calendar days) of patient's admission to PAC 1,3,4, or HSU 6 (Mental Health Unit: Treatment Plan Review).	73%	83%
3	Treatment Team generated Tx Plan is documented within 30 business calendar days of patient's admission to PAC 1,3, 4, or HSU 6	10%	71%
4	Treatment Team generates Tx Plan is updated every 30 business calendar days for PAC 1&4, every 90 calendar business days for PAC 3&HSU 6.	44%	80%
5	Treatment Team generated Tx Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	100%
6	Treatment Team generated Tx Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	100%	95%
7	All members of the Treatment Team are documented as present	100%	100%
8	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	100%	100%
9	Whether the patient was invited to attend at least a portion of the treatment team planning meeting.	100%	95%
	Overall Compliance	85%	95%

2025	20 TX and DC Planning RHU 5	Q3	Q4
1	Preliminary Discharge Plan is completed in its entirety and patient needs are outlined	N/A	N/A
2	Initial Treatment Team generated TX Plan is documented within 7 business days (10 calendar days) of patient's admission to RHU 3 (Mental Health Unit: Treatment Plan Review).	33%	25%
3	Treatment Team generated TX Plan is updated every 30 business days for PAC 1, 4, RHU 3 and every 90 business days for PAC 3 and HSU 6.	97%	97%
4	Treatment Team generated TX Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	100%
5	Treatment Team generated TX Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	70%	100%
6	All members of the Treatment Team are documented as present	100%	100%

7	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	95%	100%
8	Whether the patient was invited to attend at least a portion of the treatment team planning meeting		100%
	Overall Compliance	88%	94%

As both parties are aware, during the past two site assessments, I have attempted to significantly reduce the number of provisions that include similar outcome measures. I have done that although there are still some provisions that contain at least one similar outcome measure (generally a timeliness measure) because, in my opinion, timeliness for those specific provisions cannot be removed from the assessment.

For instance, Provision B.10, which evaluates whether MDC appropriately monitors and adjusts medications in a timely manner, necessitates the inclusion of timeliness as a core component. This aspect is not directly measured in other provisions, despite the presence of timeliness metrics in medication review audits. This is in contrast to Provision A.2 (whether MDC has developed and implemented an appropriate screening instrument that identifies mental health needs and ensures timely access to a mental health professional when inmates present symptoms requiring such care),

My July 2025 findings included the following: This provision (A.2) is specific to referrals generated from RDT to a qualified mental health professional (QMHP) and requires timely assessments based on their acuity level.

The audits used to assess the level of compliance for this provision are as follows:

a. 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals,
b. 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2 Referrals Audit,
c. 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3 Referrals Audit,

Only the results in these audits specific to the timeliness of assessments by a QMHP should be reported in this provision [emphasis added]. The results will not be averaged because the timeframes differ for each P level.

SA provision 11 assesses the quality of these assessments.

Provision A.11 asks the following:

> Whether MDC ensures that mental health assessments include the assessment factors described below:
>
> a. Intake screening shall inquire as to the following:
> (1) Current mental health conditions;
> (2) Current psychiatric medications;
> (3) Current suicidal ideation, threat, or plan;
> (4) Past suicidal ideation and/or attempts;
> (5) Prior mental health treatment or hospitalization;
> (6) Recent significant loss – such as the death of a family member or close friend;
> (7) History of suicidal behavior by family members and close friends;
> (8) Any reported observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk.

Since timeliness of such assessments is assessed in Provision A.2, I am only assessing the quality of such assessment in A.11.

I am aware of the following:

1. By attempting to decrease the number of provisions that have similar or exact outcome measures, the overall percentage of provisions found to be in compliance will be increased. For example, if I used the same timeliness outcome audit for provisions A.2 and A.11 and the timeliness audit was not in compliance, both provisions would not be in compliance. When I only use the timeliness outcome measure for A.2 and just the quality outcome measure for A.11, assuming the timeliness audit remains not in compliance but the quality audit for A.11 is in compliance, the compliance rate would be 50%.

   The main reasons for adopting the July 2025 methodology include the following:

   a. It simplifies and isolates components of each provision that needs to be measured, and decreases the use of similar audit elements in multiple provisions without eliminating any element of audit provisions that have been used in the past.
   b. It clarifies some of the provisions of the Settlement Agreement and/or checkout audit that were unclear or vague.

2. I am aware that many of my assessments and changes in methodology involve making clinical determinations, which can be reasonably disputed. I assume that is the reason the parties chose a clinician as the monitor and have a dispute process in place via the Settlement Agreement.

   Another example of a change in my methodology is the result of the continued improvement in UNMH's QI process. Many of the audits have increased the number of elements in the audit in order to be responsive to various Settlement Agreement provisions. These changes have resulted from comments from Plaintiffs Intervenors, myself and from UNMH staff as part of the ongoing QI process. Although a specific audit may be used for multiple provisions, in general, different elements of the audit will be used for different provisions.

   Five elements of an audit may be used for a specific provision. To be found in compliance under such circumstances will depend on the nature of each element---meaning it might not require 90% compliance with each element; rather, it will depend on the clinical significance of each component, as determined by the monitor.