James Browning

From: Metzner, Jeffrey <JEFFREY.METZNER@CUANSCHUTZ.EDU>
Sent: Thursday, July 31, 2025 8:37 AM
To: NMDml_Judge Browning's Chambers nmd.uscourts.gov
Subject: MDC report
Attachments: MDC July 2025 report.docx; Issue of concern.docx

CAUTION - EXTERNAL:

Dear Judge Browning

Attached is my July 2025 report re: mental health services in the context of the *McClendon* Settlement Agreement.

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.

If you want to discuss further or just meet me for the first time, I am available via my cell phone (303 638-0005) or via Zoom or Teams.

Jeffrey L. Metzner, M.D., P.C.
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Give me a
work copy.
8/10/25

File in CM/ECF
8/10/25

8/10/25

During prior site visits, I had discussed with leadership staff and attorneys representing Defendants and Plaintiffs issues with the Settlement Agreement (SA) in the context of various provisions overlapping each other that resulted in some confusion from a monitoring perspective. After reading the Settlement Agreement (SA) on multiple occasions prior to this site visit, I have attempted to modify the monitoring process so that all of the elements of a specific audit used for compliance assessment purposes would, with some exceptions, not be used for multiple SA provisions. Many audits currently in use have multiple elements within the audit. From my perspective, it is not problematic that certain elements of a specific audit may be used for multiple SA provisions as long as the same element of a specific audit is not used for multiple SA provisions except under exceptional circumstances. For example, audit 22 (Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals) outcome measures were as follows:

1 Screened by Med 3 within 4 hours of booking?
2 Evaluated by PSU Mental Health within 4 hours of referral by Med 3?
3 Evaluated by Psychiatry within one Business Day of resident's admission?

Results of element 1 may be used for provision X, results of element 2 may be used for provision Y, and results of element 3 may be used for provision Z. But under usual circumstances, all three elements should not be used for provisions X, Y, and Z.

A specific example is the following two provisions:

A. Screening and Assessment
1) 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.

One of the Plaintiff Intervenors' stated objections to my finding re: A.1) was as follows:

Your draft report also proposes narrowing the review of this provision, stating: "The outcome measure for this provision is whether the initial healthcare screening results in an appropriate assigned P level." Draft Report at p. 11. Respectfully, Plaintiff Intervenors' reading of this provision is that implementation of the acuity system also includes appropriate and timely follow up based upon the triaging.

However, the following provision does address the appropriate and timely follow-up based upon the triaging.

A. Screening and Assessment

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.

There are similar examples of similar issues among the various provisions.

Plaintiff Intervenors raise the issue of the timeliness of this change in monitoring various provisions – i.e., why change now? This change is related to a number of factors that include the following:

1. In the past, audits have been modified based on comments from the Plaintiff Intervenors that various audits were too narrow and not capturing the substance of a specific provision. See SA A. 11) Whether MDC ensures that mental health assessments include the assessment factors described below…

The assessment for this provision was subsequently defined by me as "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."

Neither party objected to such an interpretation.

There are other examples of audits being changed related to either my comments or the comments from the Plaintiff Intervenors. I am attempting to more precisely define the scope of each provision so that it will be clearer re: the nature of the audits needed for assisting in the compliance assessment process.

2. The SA includes the following:

The Court-appointed experts in each area, in conjunction with Defendants, will develop self-monitoring protocols.

My restructuring of the monitoring process is intended to facilitate implementation of the above requirement.

3. All aspects of the SA relevant to the mental health system will continued to be monitored in the context of this revised monitoring process but, with a few exceptions, a specific element of the SA will not be monitored within multiple provisions (see the screening and assessment example previously summarized).

During the site visit I discussed such issues with leadership staff and provided specific examples of my proposed modifications in the monitoring process.

I have deferred compliance assessments for eight (8) SA provisions for reasons explained in the findings sections of those provisions. Plaintiff Intervenors have requested that a compliance rating be not deferred and generally request a partial compliance rating be used if such an assessment was reported during the previous monitoring period. My use of "deferred" is not intended to mean I will retrospectively make a compliance rating that includes the monitoring period in question. I view a partial compliance rating to be a more favorable assessment as compared to a deferred compliance rating (which is made due to lack of pertinent data).

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July 29, 2025

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 July 9,10, 2025, 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 – May 31, 2025),
2. Suicide Prevention committee meeting minutes from December 2024-April 2025,
3. a July 1, 2025, letter from Kelly Waterfall, Esq. re: McClendon, et al. v. City of Albuquerque, et al. – the July 2025 Site Visit,
4. the following Quality Improvement studies:
    a. 01 Clinical Seclusion (MH Observation) Audit- Q1,
    b. 02 Constant Monitoring of Inmates Presumed to be of Moderate or High Risk of Suicide or Self-Harm-Qs 1&2,
    c. 05 Inmates who Should have been Opened to PSU but Never were-Q1,
    d. 07 Psych Med Adjustment-Qs 1 & 2,

e. 08 Quality of BH Assessments of Non SMI Patients in GP-Q1,
f. 09 Quality of BH Assessments of SMI Patients in GP-Q1,
g. 10 RDT Management (Follow-up to PSU referrals-Q4)
h. 11 Referrals Open to PSU from GP (Negative MH Screens from Intake)-Q1,
i. 12 Request For Service (HCR) MH Response Time – March 2025,
j. 13 Suicide Watch Level Order and Provided (January 2025-April 2025),
k. 14 Suicide Watch Follow-up Rounding Audit Q1 2025,
l. 15 Treatment and Discharge Planning for Non-SMI Patients in GP- Q1,
m. 16 PAC 1, 3, 4, and HSU 6 Treatment Team Treatment and Discharge Planning-Q1,
n. 18 UOF Cleared By Medical and PSU- Q1 Audit,
o. 19 PSU Chronic Care-Q1,
p. 20 Treatment Team Treatment and Discharge Planning RHU 3- Q1,
q. 21 Safety Monitor Suicide Observation Logs. December 2024-May 2025 audits,
r. 22 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P1 Referrals Q1,2
s. 23 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P2 Referrals Q1,2 Audit,
t. 24 Timeliness of Nursing, PSU RDT, and Psychiatric Evaluations of P3 Referrals Q1,2 Audit,
u. 26 Inmates Placed on Suicide Watch- Q1 Audits,
v. 27 Inmates Placed on Clinical Seclusion- Q1 Audit,
w. 28 Timeliness of Nursing MH- Q1 Audit,

5. morbidity reviews completed during the monitoring period, and
6. UNMH MDC M&M Log through May 2025
7. RHU audits re: out of cell time,

During the site visit I also met with line staff in a group setting and interviewed detainees in PAC 1, PAC 4, RHU 5, and RHU 6. I also met briefly with many ofthe available line mental health staff in a group setting.

Population Statistics

UNMH Status Update as of 06/10/2025

POPULATION INFORMATION	Jan	Feb	Mar	Apr	May
Total MDC average daily population (ADP) CAP 1950	1721	1799	1816	1852	1839

MDC ALL POPULATION - ALOS (as of last working day of the month)	41.3	82.1	78	23	23.4
Absolute # on PSU caseload (on last working day of the month)	757	740	724	767	888
% of total Population on PSU Caseload	**44%**	**41%**	**40%**	**41%**	**48%**
Absolute # of SMIs in total population (last working day of the month)	150	169	146	143	142
% of total Population who are SMI	**9%**	**9%**	**8%**	**8%**	**8%**
% of PSU caseload who are SMI	**20%**	**23%**	**20%**	**19%**	**16%**

July 2025 Findings: As per status update. The average daily population does not appear to have significantly since the January 2025 site assessment. The percentage of detainees on the PSU caseload has slightly decreased since the last site visit. The percentage of detainees with a SMI has not significantly changed.

Staffing Statistics

UNMH Status Update as of 06/10/2025

1. Study: Staffing Fill Rate Compared to Budget:
   - Mental Health Professionals: 19.8 filled / 15 allocated (132%)
     - All counselor positions are filled.
   - Psychiatrists: 100% (6 filled / 6 allocated, backfilling w/Psychiatric NP until August 2025)
   - Psychiatric Nurse Practitioners (NPs): 100% (1 filled / 1 allocated)
   - Psychiatric Director: 1 filled / 1 allocated (100%)
   - Mental Health Director: 1 filled / 1 allocated (100%)
   - Registered Nurses (RNs): 7.2 filled / 8.4 allocated (86%)
     - UNMH RN's are floating to backfill any areas that are in need of assistance.
   - Licensed Practical Nurses (LPNs): 1 filled / 0 allocated (100%)

STAFFING	May
Actual # MHPs functionally filled	19.8
Total # of MHP FTEs allocated	15
% MHP Filled positions	**132%**
Actual # nursing (RN) positions functionally filled	7.2
Total # RN FTEs allocated	8.4

% RN Filled positions	**86%**
Actual # nursing (LPN) positions functionally filled	1
Total # LPN FTEs allocated	0
% LPN Filled positions	**+100%**
Actual # of Psychiatrists functionally filled	5
Total # Psychiatrists FTEs allocated	6.2
% Psychiatrists Filled positions	**81%**
Actual # of PSYCH NP functionally filled	2
Total # PSYCH NP FTE allocated	1
% Psychiatrists Filled positions	**200%**
Actual # of PSYCH Director functionally filled	1
Total # PSYCH Director FTE allocated	1
% Psychiatric Director Filled positions	**100%**
Actual # of MH Director filled	1
Total # MH Director FTE allocated	1
% MH Director Filled positions	**100%**

July 2025 Findings: As per UNMH response. Significant and impressive improvement in decreasing mental health staffing vacancies, especially the psychiatrists' positions, as compared to the prior site visit.

The current custody line staff vacancy rate was 28%. This vacancy rate has decreased slightly since the prior site assessment.

During prior site visits, I had discussed with leadership staff and attorneys representing Defendants and Plaintiffs issues with the Settlement Agreement (SA) in the context of various provisions overlapping each other that resulted in some confusion from a monitoring perspective. After reading the Settlement Agreement (SA) on multiple occasions prior to this site visit, I have attempted to modify the monitoring process so that all of the elements of a specific audit used for compliance assessment purposes would, with some exceptions, not be used for multiple SA provisions. Many audits currently in use have multiple elements within the audit. From my perspective, it is not problematic that certain elements of a specific audit may be used for multiple SA provisions as long as the same element of a specific audit is not used for multiple SA provisions except under exceptional circumstances. For example, audit 22 (Timeliness of

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A specific example is the following two provisions:

A. Screening and Assessment

1) 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.

One of the Plaintiff Intervenors' stated objections to my finding re: A.1) was as follows:

> Your draft report also proposes narrowing the review of this provision, stating: "The outcome measure for this provision is whether the initial healthcare screening results in an appropriate assigned P level." Draft Report at p. 11. Respectfully, Plaintiff Intervenors' reading of this provision is that implementation of the acuity system also includes appropriate and timely follow up based upon the triaging.

However, the following provision does address the appropriate and timely follow-up based upon the triaging.

A. Screening and Assessment

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.

There are similar examples of similar issues among the various provisions.

Plaintiff Intervenors raise the issue of the timeliness of this change in monitoring various provisions – i.e., why change now? This change is related to a number of factors that include the following:

1. In the past, audits have been modified based on comments from the Plaintiff Intervenors that various audits were too narrow and not capturing the substance of a specific provision. See SA A. 11) Whether MDC ensures that mental health assessments include the assessment factors described below…

The assessment for this provision was subsequently defined by me as "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."

Neither party objected to such an interpretation.

There are other examples of audits being changed related to either my comments or the comments from the Plaintiff Intervenors. I am attempting to more precisely define the scope of each provision so that it will be clearer re: the nature of the audits needed for assisting in the compliance assessment process.

2. The SA includes the following:

The Court-appointed experts in each area, in conjunction with Defendants, will develop self-monitoring protocols.

My restructuring of the monitoring process is intended to facilitate implementation of the above requirement.

3. All aspects of the SA relevant to the mental health system will continued to be monitored in the context of this revised monitoring process but, with a few exceptions, a specific element of the SA will not be monitored within multiple provisions (see the screening

and assessment example previously summarized).

During the site visit I discussed such issues with leadership staff and provided specific examples of my proposed modifications in the monitoring process.

I have deferred compliance assessments for eight (8) SA provisions for reasons explained in the findings sections of those provisions. Plaintiff Intervenors have requested that a compliance rating be not deferred and generally request a partial compliance rating be used if such an assessment was reported during the previous monitoring period. My use of "deferred" is not intended to mean I will retrospectively make a compliance rating that includes the monitoring period in question. I view a partial compliance rating to be a more favorable assessment as compared to a deferred compliance rating (which is made due to lack of pertinent data).

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 deleted portions of various status update sections if the provided narrative, summary and /or audits were not specific to the SA provision. I have also deleted some relevant copies of forms or workflows in order to keep the length of this report more manageable. As a result the length of this report decreased from 110 pages to 91 pages. A copy of the report without the deleted information is available upon request.

The following section will summarize my findings re: the provisions of the Settlement Agreement. Findings from prior site visits may be included when they provide a 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

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

UNMH Status Update as of 06/20/2025:

The following policies were reviewed, updated or newly developed, finalized and implemented:

- MDC HCA 12.48.1 PSU Therapeutic Services - Updated 03/15/2025
- MDC Patients Transfer to a UNMH Inpatient Psychiatry – Finalized and implemented on 03/13/2025 (formerly titled MDC Patients Transfer to a Higher Level of Care/Transfer to Inpatient Psychiatry)

The Nursing Intake timeliness performance continues to set the standard for excellence. In Q1 2025, we returned to 100% compliance, maintaining the high performance seen in Q1 and Q3 of the previous year. This marks a full recovery from the slight dip in Q2 and Q4, demonstrating both consistency and a strong commitment to meeting intake timelines. Our ability to sustain perfect compliance in this critical first step of care reflects the effectiveness of our processes and the dedication of our nursing and intake teams.

See Audit 11 (Referrals Open to PSU from GP (Negative MH Screens from Intake).

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 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,

Audit results from 22, 23 & 24 for this provision will be restricted to timeliness of screening by nursing staff. Results from audits 22, 23, & 24 will be averaged by quarter. Quarter results will not be averaged.

SA provision 2 will be used to assess the timeliness of the assessments by mental health professionals (excluding the psychiatrists) and SA provision 8 will be used to assess the quality of such assessments.

SA provision 6 will assess the timeliness of the psychiatrists' assessments.

Partial compliance is present for the monitoring period related to audit 11's (Referrals Open to PSU from GP (Negative MH Screens from Intake)) findings, which indicated a significant number of problematic initial healthcare screens by nursing staff.

July 2025 Recommendations: Continue to audit as above.

3) 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.

UNMH Status Update as of 06/20/2025:

An RDT Intake process and a corresponding Mental Health Intake Form have been developed and successfully implemented.

Policy Updates:

- MDC-HCA 12.31 Receiving Screenings was approved on August 31, 2024.
- MDC-HCA 12.49 Suicide Prevention Program was reviewed and updated on April 24, 2025.

Continuous Quality Improvement

	22 Timeliness P1	Q4	Q1	Q2
	Overall Compliance	85%	93%	95%
	23 Timeliness P2	Q4	Q1	Q2
	Overall Compliance	89%	94%	97%
	24 Timeliness P3	Q4	Q1	Q2
	Overall Compliance	87%	93%	98%

P1 Timeliness (Audit 22):

In Q1, we met the 90% compliance requirement with an overall score of 93% and maintain compliance in Q2 (95%), a significant improvement from 85% in Q4. The increase reflects our strategic staffing adjustments and enhanced responsiveness to high-priority cases.

P2 Timeliness (Audit 23):

In Q1, we successfully met the 90% compliance requirement, reaching 94% overall and maintained compliance in Q2 (97%). This builds on a solid Q4 performance of 89%, where we were just shy of the benchmark. The continued upward trend reflects effective interventions and steady improvement.

P3 Timeliness (Audit 24):

We achieved 93% overall compliance in Q1, surpassing the 90% threshold and maintained compliance in Q2 (98%). This marks a strong recovery from 87% in Q4, demonstrating significant gains in timeliness and consistency across increasing volumes.

	08 Quality of BH Assessment of Non-SMI Pts in GP	Q3	Q4	Q1
	Overall Compliance	90%	88%	92%

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..

As per status update. Very impressive improvement. Compliance is present re: timeliness of assessments by mental health professionals.

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's should be reported in this provision. The results will not be average because the timeframes differ for each P level.

SA provision 11 assesses the quality of these assessments.

July 2025 Recommendations: Continue to audit as stated above.

4) 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.

UNMH Status Update as of 06/20/2025:

The Columbia Suicide Severity Rating Scale (C-SSRS) continues to be a vital part of the intake screening process, helping staff identify and triage individuals based on their mental health and suicide risk levels. The tool remains in active use, with staff trained to utilize it during orientation and through ongoing one-on-one training sessions.

UNMH's IT department designed the screening form to be self-guided, ensuring consistency and ease of use.

Audit 28 evaluates the timeliness of nursing intakes for all inmates, specifically ensuring that evaluation by the Med 3 Nurse occurs within 4 hours of arrival at MDC. The audit confirms that the Columbia Suicide Severity Rating Scale (C-SSRS) continues to be effectively utilized by our screening clinicians as part of the intake process.

These results demonstrate sustained excellence in early mental health screening and timely nursing intake evaluations.

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 Audit,
c. 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 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?

As per status update. Compliance continues.

July 2025 Recommendations: Continue to audit with the report being revised as stated above.

5) 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 06/20/2025:
To support consistent and accurate intake screenings, UNMH has implemented a comprehensive training and quality assurance framework. All Med 3 nursing staff complete a UNMH Med 3 Orientation Checklist and are enrolled in Learning Central modules upon hire. Notably, the module OAT 2455INPT ONLINE ANNUAL COMP – Suicide Screening and Precautions in Non-Psychiatric Inpatient Settings 2024 was added to their required training. This module provides foundational instruction on the use of the Columbia Suicide Severity Rating Scale (C-SSRS) tool.

Ongoing education is provided through a combination of orientation, one-on-one instruction by the Supervisor and Director, and continuous support from UNMH's Unit-Based Educator (UBE). To ensure fidelity to the screening process, UNMH has also assigned a nurse to conduct real-time audits of intake screenings, using immediate results to deliver just-in-time training and support to staff as needed.

This multi-tiered approach ensures that Qualified Medical Staff are well-prepared to accurately identify and assess suicide risk, reinforcing UNMH's commitment to appropriate, timely mental health evaluations at intake.

July 2025 Findings: As per status update. Compliance is maintained.

July 2025 Recommendations: Continue to audit.

6) 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.

UNMH Status Update as of 06/20/2025:
UNMH continues to utilize an acuity-based triage system (P1, P2, P3) to ensure that inmates with the most urgent mental health needs are prioritized for timely evaluation and care. This structured approach enables clinical teams to allocate resources effectively and respond based on the level of risk.

In alignment with this triage system, intake screenings are routinely audited to verify that referrals to mental health services are appropriate and timely. Audit results are tracked and trended quarterly to drive continuous process improvement and accountability.

The effectiveness of this implementation is reflected in the most recent audit outcomes for Q1 2025, where all three priority levels met the 90% compliance benchmark for overall timeliness:

- P1: Improved from 85% in Q4 to 93% in Q1.
- P2: Rose from 89% in Q4 to 94% in Q1.
- P3: Increased from 87% in Q4 to 93% in Q1.

These gains demonstrate the successful operationalization of the acuity model and the positive impact of targeted training, enhanced staffing, and monitoring on intake performance and mental health service delivery.

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 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?

A compliance rating is not being made for this monitoring period due to lack of written documentation regarding the relevant audit results.

7) 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 06/20/2025:
Since the December 2024 update, UNMH has made strategic staffing advancements to strengthen psychiatric coverage at MDC. Dr. Hazelwood joined in November 2024, followed by Dr. Whinnery at the end of February 2025, and Dr. Husain at the beginning of April 2025. An additional Nurse Practitioner was hired bring NP's from one to two. These additions, combined with sustained PRN coverage by Dr. Egwuonwu and Coty, NP, have helped stabilize provider capacity and improve timely access to psychiatric evaluations.

Our new providers have directly contributed to significant improvements in Question 3 of Audits 22, 23, and 24, which assess whether psychiatric evaluations are completed within one business day of PSU Mental Health referral. From Q4 2024 to Q2 2025, compliance rates improved as follows:

	22 Timeliness P1	Q1	Q2	Q3	Q4	Q1	Q2
3	Evaluated by Psychiatry within one Business Day of Referral	69%	83%	70%	72%	90%	93%
	23 Timeliness P2	Q1	Q2	Q3	Q4	Q1	Q2
3	Evaluated by Psychiatry within one Business Day of Referral	50%	87%	70%	73%	89%	97%
	24 Timeliness P3	Q1	Q2	Q3	Q4	Q1	Q2
3	Evaluated by Psychiatry within one Business Day of Referral	83%	80%	77%	67%	80%	93%

- P1 patients (Audit 22): From 72% at the end of 2024 to 93% in 2025.
- P2 patients (Audit 23): From 73% at the end of 2024 to 97% in 2025.
- P3 patients (Audit 24): From 67% at the end of 2024 to 93% in 2025.

These gains reflect the early impact of our expanded team and operational efforts to address a 47% evaluation backlog caused by the previous 50% provider vacancy in Fall 2024. While progress is evident, continued monitoring and support are in place to ensure sustained performance and full compliance.

The PSU Quality Consultant, active since March 1, 2024, continues to drive quality assurance through regular audits and feedback loops.

July 2025 Findings: As per status update. Significant improvement is noted. Partial compliance although compliance has almost been achieved.

July 2025 Recommendations: Continue to audit.

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 06/20/2025:

UNMH Safety Monitor Performance Update: November 2024 – May 2025

Many of our Safety Monitors have remained with the organization for over a year, demonstrating consistent service and experience. However, between December and March 2025, performance on Safety Monitor Observation Logs fell below the 90% compliance threshold, prompting corrective action.

To address these findings, UNMH implemented the following steps in April 2025:

- Refreshed and redistributed training materials for all Safety Monitors.
- Revised the Safety Monitor Log for improved clarity and accuracy.
- Instructed Monitors to calculate and document their own time intervals between checks.
- Conducted a secondary audit of previous audit cycles to identify and provide feedback to staff who repeatedly submitted noncompliant logs.

These interventions led to a successful rebound in April and May 2025, with results returning to full compliance at 90%, reflecting both staff responsiveness and system-level support for quality improvement.

	21 Safety Monitor Observation Logs	Nov	Dec	Jan	Feb	March	April	May
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?	90%	87%	83%	83%	87%	90%	90%

Constant Observation Performance Update: November 2024 – April 2025

UNMH continued 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.

Results for Audit 21A remained strong, with slight variability:

	21A Safety Monitor Constant Observation Logs	Nov	Dec	Jan	Feb	Mar	April
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?	100%	100%	100%	93%	100%	97%

Despite a temporary dip to 93% in February, performance quickly rebounded and remained near-perfect overall, reflecting consistent staff compliance with constant observation standards. The high level of performance across most months demonstrates the effectiveness of ongoing training, supervision, and accountability measures in place for our Safety Monitors.

MDC Update: MDC has included updated audits. MDC acknowledges compliance has not remained at or above 90% for the monitoring period.

July 2025 Findings: As per status update. Partial compliance continues.

July 2025 Recommendations: Continue to audit.

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.

UNMH Status Update as of 06/20/2025:
Policy Update – MDC HCA 12.34: Mental Health Screening and Evaluation

As of May 13, 2025, MDC HCA 12.34 has been updated to reinforce and clarify screening and evaluation protocols for all three mental health priority levels. This policy revision ensures that intake procedures align with established acuity criteria and that timely evaluations are conducted according to patient risk:

- P1: Highest priority—must be evaluated by PSU within 4 hours of referral.
- P2: Moderate priority—must be evaluated by PSU within 8 hours of referral.
- P3: Lowest priority—must be evaluated by PSU within 14 days of referral.

These standards are reflected in Audits 22, 23, and 24, specifically Question 2, which assesses PSU's compliance in meeting these required timeframes.

Key Highlights:

- P1 (Evaluated within 4 hours): Compliance improved from 93% in Q4 2024 to 100% in Q2 2025, reflecting a sustained upward trend.
- P2 (Evaluated within 8 hours): Maintained 100% compliance in both Q1 and Q2 2025, continuing the high standard achieved in Q4 2024.
- P3 (Evaluated within 14 days): Sustained perfect compliance (100%) for the fifth consecutive quarter.

This data demonstrates strong adherence to acuity-based mental health response protocols, further validating the effectiveness of policy implementation and PSU team performance.

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.

July 2025 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 06/20/2025:
Response to Audit 02 – Constant Monitoring of Patients Presumed to be at Moderate or High Risk of Suicide or Self-Harm (Crisis Calls)

We acknowledge that 100% compliance is required for this standard. While recent results (Q3: 90%, Q4: 93%, Q1 2025: 83%) fall short of that mark, we continue to emphasize the importance of constant monitoring.

It's important to note that only 30 charts are audited per quarter, which may not fully represent overall performance. The PSU Quality Consultant is reviewing charts closely and providing targeted feedback and training to ensure continued improvement toward full compliance.

	02 Constant Monitoring of Patients Presumed to be of Moderate or High Risk of Suicide or Self-Harm	Q1	Q2	Q3	Q4	Q1 '25	Q2' 25
1	MDC security staff monitors inmates with constant supervision until the inmate is seen by a QMHP for assessment.	30%	90%	90%	93%	83%	93%

The above audit scored 83% due to documentation issues, not because the patient was left unmonitored until the MHP arrived. Training was conducted in January and February instructing MHPs to clearly state, upon arrival, that the patient was being monitored by [staff name] or was within line of sight. In this instance, the encounter note provided specifics about the situation but failed to use the required sentence structure.

July 2025 Findings: As per status update. Partial compliance is present.

July 2025 Recommendations: Continue to audit.

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).

UNMH Status Update as of 06/20/2025:

Note: This status section was intentionally deleted since the information did not address the appropriateness of the mental health assessments.

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).

A compliance rating will not be provided for this monitoring period due to the lack of such audits.

July 2025 Recommendations: Develop and implement the recommended audits.

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.

UNMH Status Update as of 06/20/2025:

Mental Health Assessment Documentation

MDC is actively working to ensure that mental health assessments comprehensively address factors 1–8 as outlined in policy. A training guide titled the "DC Mental Health Intake Form" has been implemented to clarify which forms and sections staff are required to complete. This tool is designed to enhance accuracy and consistency in the documentation process, supporting overall improvements in EMR quality.

Audit 08 – Quality of Behavioral Health Assessment: Non-SMI Patients (General Population) Audit results for Q4 2024 and Q1 2025 show steady or improved documentation in most areas, including notable gains in Trauma History (from 59% to 90%) and Suicide Risk Assessment (from 96% to 100%).

	08 Quality of BH Assessment of Non-SMI Pts in GP	Q4	Q1
1	Personal History adequately documented	93%	93%
2	Criminal History adequately documented	97%	97%
3	Medical History adequately documented	97%	97%
4	Mental Health History adequately documented	93%	100%
5	Family Psychiatric History adequately documented	72%	72%
6	Substance Abuse History adequately documented	90%	90%
7	Suicide Risk appropriately assessed and adequately documented	96%	100%
8	Trauma History adequately documented	59%	90%

9	Violence Risk appropriately assessed and adequately documented	69%	73%
10	Mental Status appropriately assessed and adequately documented	100%	97%
11	Provisional Diagnosis appropriately assessed and adequately documented	N/A	N/A
12	Disposition and Referral consistent with the history and provisional diagnosis adequately documented	100%	97%
	Overall Compliance	88%	92%

Audit 09 – Quality of Behavioral Health Assessment: SMI Patients (General Population)
In contrast to Audit 08, results for SMI patients in Audit 09 show a decline in several key areas from Q4 2024 to Q1 2025. Areas of concern include Medical History (from 100% to 83%), Violence Risk Assessment (from 87% to 66%), and Trauma History (from 73% to 66%). These declines highlight the need for focused refresher training and continued chart reviews to ensure full adherence to documentation standards.

	9 Quality of BH Assessment of SMI Pts in GP	Q4	Q1
1	Personal History adequately documented	93%	90%
2	Criminal History adequately documented	100%	93%
3	Medical History adequately documented	100%	83%
4	Mental Health History adequately documented	93%	90%
5	Family Psychiatric History adequately documented	76%	69%
6	Substance Abuse History adequately documented	100%	90%
7	Suicide Risk appropriately assessed and adequately documented	100%	93%
8	Trauma History adequately documented	73%	66%
9	Violence Risk appropriately assessed and adequately documented	87%	66%
10	Mental Status appropriately assessed and adequately documented	100%	90%
11	Provisional Diagnosis appropriately assessed and adequately documented	N/A	N/A
12	Disposition and Referral consistent with the history and provisional diagnosis adequately documented	100%	93%

	Overall Compliance	93%	84%

- Overall Compliance:
  - Q4: 93%
  - Q1: 84%

MDC will use these results to guide targeted interventions, such as case-based review sessions and ongoing documentation audits, to ensure SMI patient assessments meet all required standards.

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:

c. 08 Quality of BH Assessments of Non SMI Patients in GP, and
d. 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.

As per status update. Partial compliance although improvement is noted.

July 2025 Recommendations: Revise the audit instrument and methodology as recommended above.

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

January 2025 Findings: As per status update. Partial compliance.

UNMH Status Update as of 06/20/2025:

Q4 2024 – Q1 2025 Update:
MDC Qualified Mental Health Professionals (QMHPs) have received training on the completion of all behavioral health assessments pursuant to generally accepted correctional standards of care. Updated training materials have been developed, and revised policies have been implemented facility-wide to ensure consistency and quality in mental health documentation and clinical practices.

Audit Results – Quality of Behavioral Health Assessments for Non-SMI Patients in General Population:
Audit findings from Q3 2024 through Q1 2025 show measurable improvement and sustained high compliance in several key assessment areas. Notable progress was observed in the documentation of Medical History (from 73% in Q3 to 97% in Q4 and Q1) and Trauma History (from 59% in Q4 to 90% in Q1), following focused training efforts.

	08 Quality of BH Assessment of Non-SMI Pts in GP	Q3	Q4	Q1
1	Personal History adequately documented	97%	93%	93%
2	Criminal History adequately documented	97%	97%	97%
3	Medical History adequately documented	73%	97%	97%
4	Mental Health History adequately documented	100%	93%	100%
5	Family Psychiatric History adequately documented	87%	72%	72%
6	Substance Abuse History adequately documented	83%	90%	90%
7	Suicide Risk appropriately assessed and adequately documented	97%	96%	100%

8	Trauma History adequately documented	83%	59%	90%
9	Violence Risk appropriately assessed and adequately documented	73%	69%	73%
10	Mental Status appropriately assessed and adequately documented	100%	100%	97%
11	Provisional Diagnosis appropriately assessed and adequately documented	N/A	N/A	N/A
12	Disposition and Referral consistent with the history and provisional diagnosis adequately documented	97%	100%	97%
	Overall Compliance	90%	88%	92%

Overall Compliance:

- Q3: 90%
- Q4: 88%
- Q1: 92%

These results reflect ongoing improvements in assessment quality, particularly in areas that received targeted staff training and policy revision. Continued focus will be placed on enhancing documentation of Family Psychiatric History and Violence Risk Assessment, which remain below target thresholds.

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.

Patrial 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).

UNMH Status Update as of 06/10/2025:
Qualified Mental Health Professionals (QMHPs) continue to conduct in-person mental health assessments no later than one working day following notification of any adverse or triggering event, in alignment with established correctional behavioral health standards of care.

01. Clinical Seclusion (Mental Health Observation)
Overall Compliance:
- Q4 2024: 91%
- Q1 2025: 95%

Audit 01 Clinical Seclusion has shown improvements across all seven metrics. Question 4, Seen daily by MHP and encounter documented and Question 5, Seen each shift by Nursing and encounter documented fell below the 90% compliance benchmark due to challenges with a manual documentation process. As of May 2025, this process transitioned to an electronic system that now generates an order in our EMR, streamlining documentation and reducing errors.

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 ot be developed based on the crisis call log that addresses the triggering events listed in this provision.

A compliance rating is deferred for this monitoring period due to lack of all relevant audits.

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

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 06/20/2025:
UNMH continues to follow established procedures aligned with MDC policy to ensure that in-person assessments are conducted by Mental Health Staff *prior to placement* on suicide watch, clinical seclusion, or segregation, and that follow-up assessments are completed *at clinically appropriate intervals* thereafter.

This process is governed by:

- Policy HCA 12.49 – Suicide Prevention Program (Updated 04/24/2025)

- Policy HCA 12.48 – Basic Mental Health Services (Updated 05/13/2025)
- Policy HCA 12.34 – Mental Health Screening & Evaluation (Updated 05/13/2025)

	01 Clinical Seclusion (MH Observation)	Q1	Q2	Q3	Q4	Q1 25'
1	Seen by a Nurse, provider, or MHP for initiation of seclusion	100%	97%	100%	100%	100%
2	Doctor's order obtained per policy (initial and daily renewal).	100%	100%	100%	100%	100%
3	Seen daily by a doctor and encounter documented.	90%	93%	93%	100%	100%
4	Seen daily by an MHP and encounter documented	100%	72%	73%	80%	87%
5	Seen q shift by Nursing and encounter documented	90%	83%	77%	59%	80%
6	Order for release by a doctor per policy was completed	100%	100%	100%	100%	100%
7	All Holds Appropriately Placed in OMS for Clinical Seclusion?	100%	100%	90%	100%	100%

	26 Patients Placed on Suicide Watch	Q4	Q1 25'
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	100%	100%
4	Pt assessed daily by a QMHP	93%	100%
5	Pt assessed q shift by a Nurse	77%	90%
6	Pt cleared from suicide watch by a Psychiatrist	100%	100%
	Overall Compliance	95%	98%

	27 Patients Placed on Clinical Seclusion	Q4	Q1 25'
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	90%	97%
4	Pt assessed daily by a QMHP	83%	83%
5	Pt assessed q shift by a Nurse	83%	87%
6	Pt assessed cleared from suicide watch by a Psychiatrist	100%	97%
	Overall Compliance	93%	94%

These outcomes show consistent adherence to policy requirements and clinical standards, ensuring the safety and mental health of detainees. UNMH continues to focus on maintaining these high standards and addressing any performance gaps, especially through additional staff onboarding and expanded mental health training initiatives.

July 2025 Findings: As per status update. Partial compliance.

July 2025 Recommendations:

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.

UNMH Status Update as of 06/20/2025:
Vacancies in psychiatry have delayed the treatment team meetings from October to Mach 2025.

The PSU's tracking log which includes 30-day and 90-day follow-up dates.

	16 PAC 1, 3, 4 RHU 6 TX and DC Planning	Q3	Q4	Q1

1	MHP completed the Preliminary Discharge Plan in its entirety and patient needs are outlined	N/A	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).	40%	3%	0%
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	62%	0%	0%
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.	52%	0%	71%
5	Treatment Team generated Tx Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	62%	10%	27%
6	Treatment Team generated Tx Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	79%	100%	97%
7	All members of the Treatment Team are documented as present	61%	10%	27%
8	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	69%	13%	27%
	Overall Compliance	61%	23%	32%

Due to a shortage of psychiatric providers, metrics decreased quarter over quarter, with overall compliance dropping from 61% in Q3 to 23% in Q4.

	20 TX and DC Planning RHU 3	Q3	Q1
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).	81%	47%
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.	44%	40%
4	Treatment Team generated TX Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	93%
5	Treatment Team generated TX Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	100%	93%
6	All members of the Treatment Team are documented as present	100%	93%
7	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	100%	93%
	Overall Compliance	91%	78%

Questions 2 and 3, related to timeframes for treatment plan completion and updates, fell below target due to psychiatric provider shortages. However, counselors continued to meet one-on-one with patients to address their goals and provide ongoing support. Overall compliance decreased from 91% in Q3 to 78% in Q1.

Across audits 16 (PAC 1, 3, 4 / RHU 6), and 20 (RHU 3), compliance was impacted by a temporary discontinuation of treatment team meetings due to provider shortages which have been corrected. Despite these challenges, individual one-on-one sessions continued, ensuring that patient needs and goals were addressed.

Initial treatment plans were generally completed within 14.8 days, and 30-day updates within 37 days. Meetings have since resumed, corrective actions are in progress to restore compliance, and focused efforts are underway to address the backlog, ensure timely updates, and reinforce both documentation standards and patient involvement.

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.

As per status update. Partial compliance.

July 2025 Recommendations: Continue to audit using the above instruments.

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)]*.

UNMH Status Update as of 06/20/2025:
MDC has adopted and implemented comprehensive policies to ensure that detainees with serious mental health needs and/or suicidal ideation receive timely, appropriate, and ongoing treatment. These include:

- 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)

These policies establish clearly defined protocols for timely screening, triage, referral, and ongoing psychiatric care. They also guide how mental health concerns are escalated and managed, including suicide prevention and clinical seclusion procedures.

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.

I am deferring a compliance assessment during this monitoring period.

July 2025 Recommendations: As above.

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)].*

November 2018 findings: This provision is being assessed in the context of the quality of the treatment plans for mental health caseload inmates in the general population in contrast to treatment plans for mental health caseload inmates in the PAC units, which were addressed in a separate provision.

UNMH Status Update as of 06/20/2025:
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.

July 2025 Findings: See Nov. 2018 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. I am deferring a compliance assessment due to lack of relevant data to review.

July 2025 Recommendations: Audit the quality of GP caseload inmates' treatment plans as recommended above.

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.

UNMH Status Update as of 06/20/2025:
MDC makes appropriate therapy services available, when medically necessary, as ordered by an

attending psychiatrist, for detainees with serious mental health needs.

The Chronic Care process outlined in UNMH's June 2024 response remains active and ongoing. Therapy services are provided by licensed mental health providers, and patient progress is tracked systematically. An Excel-based tracking tool is used to monitor treatment status. Patients currently receiving Chronic Care services are listed on an active caseload tab. Upon completion of treatment, the patient's name is moved to a "Completed" tab within the same spreadsheet to ensure accurate documentation and continuity of care.

As of this report, 100 detainees have been enrolled in Chronic Care therapy services. Of these, 40 are currently in active treatment, and 60 have completed treatment and are listed on the "Completed" tab.

	12 Requests for Service Response Time	Q3	Q4	Q1
1	HCR screened and signed by nursing staff within 24 hours	40%	80%	60%
2	Request has a triage level of Emergent, Urgent, or Routine.	10%	100%	N/a
3	If triage level was Emergent, patient was seen within 1 hour of the HCR receipt.	N/A	0%	N/a
4	If triage level was Urgent, patient was seen within 8 hours of the HCR receipt.	100%	N/A	N/a
5	If triage level was routine, patient was seen or HCR resolved within 48 hours if submitted to PSU on Sunday through Thursday.	25%	0%	0%
6	If triage level was routine, patient was seen or HCR resolved within 72 hours if submitted to PSU on Friday or Saturday.	50%	0%	0%
7	HCR scanned and contains documented plan or indicates how/if it was resolved after completion.	100%	89%	100%
8	EMR contains documentation of PSU Intervention in response to HCR	100%	90%	100%
	Overall Compliance	81%	70%	65%

	19 PSU Chronic Care	Q3	Q1
1	Documentation records that patient was seen as scheduled (Monthly, bi-monthly, weekly, etc....)	33%	10%
2	Most recent documented intervention includes reference to treatment plan progress	88%	70%
3	Most recent documented intervention includes follow-up plan.	78%	80%
4	If applicable, reason for program termination is documented in the last CC intervention note. (NA if still enrolled)	50%	50%

	Overall Compliance	63%	53%

July 2025 Findings: As per the status update section, the relevant audits for this provision or audits 12 (requests for services response time) and audit 19 (PSU chronic care).

As per status update. Partial compliance.

July 2025 Recommendations: Continue to audit.

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)]*.

July 2024 Findings: As per status update. It was my understanding from talking with leadership staff that the current MDC practice is for the hearing officer to always follow any mitigation recommendations resulting from the mental health assessment.

The PSU disciplinary data was not specific enough to confirm the following information obtained from staff:

1. The total number of PSU detainees receiving disciplinary reports during the monitoring period.
2. The percentage of such detainees who received a mental health assessment specific to the disciplinary process.
3. The percentage of such mental health assessments that resulted in a mitigation recommendation.
4. The percentage of medication recommendations that were accepted by the disciplinary hearing officer.

Partial compliance is present due to the lack of adequate proof of practice.

January 2025 Findings: As per status update. I discussed with leadership staff apparent discrepancies in the relevant data between the information provided by MDC as compared to information provided by UNMH.

As set forth in the Plaintiff Intervenors' January 8, 2025 letter, the audits and data are unclear as to how many evaluations were done, how it was determined that the vast majority of incidents

involving individuals with a SMI did not require an evaluation, and whether individuals with a mental or developmental disability who are not designated as having a SMI received evaluations prior to discipline.

A workflow chart should be provided as part of the next pre-site package and the reports by MDC and UNMH should be consistent with each other.

Partial compliance remains.

UNMH Status Update as of 06/20/2025:
MDC continues to conduct mental health evaluations as part of the disciplinary process. Both MDC and UNMH staff participate in the weekly Classification Committee meetings to collaborate on disciplinary actions. Additionally, the UNMH PSU Behavioral Health Director completes the MDC Form FIRD 004 — *Mental Health Input into Inmate Discipline Form* — as needed. This form is tracked separately from the *Bernalillo County Metropolitan Detention Center PSU – SMI/DD Disciplinary Analysis Report* generated by MDC. During this reporting period, Dr. Oliver completed the following reviews using the FIRD 004 form:

1. The total number of PSU detainees receiving disciplinary reports during the monitoring period.

Disciplinary Form						
Month	January	February	March	April	May	June 17th
# of Non-SMI Evaluations	3	10	5	8	8	5
# of SMI Evaluations	2	5	0	4	13	12
Total Number of FIRD 004 evaluation requests per month	5	15	5	12	21	16

MDC UPDATE: MDC will provide additional audits regarding input into discipline.

July 2025 Findings: The number of PSU inmates receiving disciplinary reports, as reported in the status update section, appears to be very low. I am requesting for the next site visit that monthly totals be provided regarding the total number of inmates receiving one or more disciplinary reports during each month of the monitoring period that are actually adjudicated in contrast to being written but dismissed for a variety of different reasons. The number of PSU inmates on a monthly basis having disciplinary reports that are adjudicated should also be

reported. The latter should be a numerator and the former should be a denominator as a monthly statistic. In addition, a report should be generated that includes the following:

1. The total number of PSU detainees receiving disciplinary reports that are adjudicated during the monitoring period.
2. The percentage of such detainees who received a mental health assessment specific to the disciplinary process.
3. The percentage of such mental health assessments that resulted in a mitigation recommendation.
4. The percentage of mitigation recommendations that were accepted by the disciplinary hearing officer.

It is my understanding that Margo Frasier monitors this issue. If that is correct, the status update section could include excerpts from her assessment.

I am also requesting the relevant policy and procedure be sent to me again.

Based on the history of this case, it is likely that compliance is present. However, I am going to defer a compliance assessment during this monitoring period due to lack of the type of data that I need to review as referenced 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)]*.

UNMH Status Update as of 06/20/2025:

	19 PSU Chronic Care	Q3	Q1
1	Documentation records that patient was seen as scheduled (Monthly, bi-monthly, weekly, etc....)	33%	10%
2	Most recent documented intervention includes reference to treatment plan progress	88%	70%
3	Most recent documented intervention includes follow-up plan.	78%	80%
4	If applicable, reason for program termination is documented in the last CC intervention note. (NA if still enrolled)	50%	50%
	Overall Compliance	63%	53%

MDC has implemented an adequate scheduling system to ensure that mental health professionals assess detainees with mental illness as clinically appropriate, regardless of whether they are prescribed medications. PSU counselors are available 24 hours a day, 7 days a week, allowing for continuous access to mental health services.

Detainees may submit a Health Service Request (HSR) at any time to request mental health services. Each HSR is triaged by medical staff and categorized as routine, urgent, or emergent, which ensures timely and clinically appropriate responses based on the detainee's needs.

Chronic Care services are accessible throughout a detainee's stay at MDC and may be initiated at several points of contact, including referrals, PSU sick call requests, or interactions with medical or behavioral health providers. When either a provider or detainee identifies a need for ongoing mental health care, the provider initiates the process by placing a Chronic Care Power Order. This ensures that individuals receive appropriate follow-up and continued clinical oversight.

Dr. Oliver has an assignment tracking system and is currently working on add order sets in Cerner. We are working with our new IT Architect to automate the ordering process.

During this auditing period 383 orders have been submitted and 307 orders have been completed. Currently 79 patients are pending an initial evaluation. On average patients are seen within 42 days of initial request.

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.

Partial compliance continues.

July 2025 Recommendations: Continue to audit as above.

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

UNMH Status Update as of 06/20/2025:
Treatment plans are collaboratively developed by the counselor, incorporating the patient's goals as discussed during individual sessions, as well as input from the Psychiatrist. Due to psychiatric provider vacancies between October 2024 and March 2025, regular multidisciplinary treatment team meetings were held on a limited basis. Although full team meetings were infrequent during this time, counselors and discharge planners continued to meet with patients individually to

review and update treatment goals.

As stated above: Treatment plans are formally reviewed every 30 and 90 days. Detainees at MDC are encouraged to actively participate in the creation and ongoing development of their individualized plans. However, due to provider shortages, some units experienced a temporary suspension of treatment team meetings, resulting in delays in the completion of certain treatment plans. These meetings have since resumed, proper documentation practices have been reinstated, and efforts are actively underway to address the backlog and ensure timely updates moving forward.

	16 PAC 1, 3, 4 RHU 6 TX and DC Planning	Q3	Q4	Q1
1	MHP completed the Preliminary Discharge Plan in its entirety and patient needs are outlined	N/A	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).	40%	3%	0%
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	62%	0%	0%
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.	52%	0%	71%
5	Treatment Team generated Tx Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	62%	10%	27%
6	Treatment Team generated Tx Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	79%	100%	97%
7	All members of the Treatment Team are documented as present	61%	10%	27%
8	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	69%	13%	27%
	Overall Compliance	61%	23%	32%

	15 TX and DC Planning for Non-SMI in GP	Q3	Q1
1	Initial Evaluation conducted by Psychiatry if first time incarceration or if returned to custody after 90 days of prior intervention w/in 14 days (N/A if patient returned within 90 days of prior incarceration.)	89%	95%

2	Preliminary Discharge is completed by MHP's in its entirety and patient needs are outlined	83%	97%
3	Treatment Plan appropriately addresses the symptoms of the diagnosis	83%	97%
4	Interventions are tailored to the Treatment Plan	83%	97%
5	Discharge Plan documented that addresses patient needs and includes community follow-up	83%	97%
6	Discharge Plan recommends Substance Use Disorder Treatment if a Substance Use Disorder is part of the diagnosis (N/A if no diagnosis)	83%	97%
	Overall Compliance	84%	96%

	20 TX and DC Planning RHU 3	Q3	Q1
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).	81%	47%
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.	44%	40%
4	Treatment Team generated TX Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	93%
5	Treatment Team generated TX Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	100%	93%
6	All members of the Treatment Team are documented as present	100%	93%
7	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	100%	93%
	Overall Compliance	91%	78%

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.

Partial compliance continues.

July 2025 Recommendations: Revise the relevant audits as above.

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

UNMH Status Update as of 06/20/2025:
MDC has implemented an effective and reliable system to ensure that detainees receive appropriate psychotropic medications in a timely manner. Once prescribed, medications are automatically renewed monthly through our pharmacy system, maintaining consistent treatment unless modified or discontinued by the psychiatric provider. Our pharmacy team plays an essential role in promptly processing renewals and adjustments, ensuring continuity of care aligned with individual treatment needs.

	06 Psych Med Renewal	Q3	Q4	Q1 '25
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.	100%	90%	93%

We are also working to identify and address any gaps in care at intake and during housing transitions. As part of our quality improvement efforts, an audit was conducted (Audit 5), to evaluate PSU follow-up for detainees in general population housing units who were not initially identified at intake. The audit findings demonstrate significant improvements over time in ensuring appropriate PSU engagement and medication continuity for patients with psychiatric needs.

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.

I am deferring a compliance assessment due to the need for the recommended audit.

July 2025 Recommendations: As above.

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

UNMH Status Update as of 06/20/2025:
UNMH has implemented a streamlined process to ensure the timely and appropriate review of psychotropic medications by psychiatric providers. Treatment schedules—including 7-day and 30-day follow-ups—are coordinated based on individual psychiatric care plans and tracked through a master list

Psychotropic medication monitoring is a priority function of the Psychiatric Services Unit, with oversight provided by psychiatrists and supported by behavioral health nurses. Medication compliance, refusals, and clinical follow-ups are tracked daily. The pharmacy department also supports continuity of care by flagging medication issues in real time.

Progress in reducing appointment backlogs has been substantial over the past four months, as detailed below:

BACKLOG DATA	Jan	Feb	Mar	Apr	May

# of 30 day MD SMI follow ups NOT seen (absolute number on the 30th day of the month) - BACKLOG	51	71	33	9	18
% SMI who haven't been seen within 30 days.(30th day of the month) total caseload	**34%**	**42%**	**23%**	**6%**	**13%**
# for 30 day MD NON SMI follow ups NOT seen (absolute number on the last working day of the month) - BACKLOG	184	127	37	11	18
% NON SMI who haven't been seen within 90 days. (last day of the month)	**24%**	**17%**	**5%**	**1%**	**2%**
# days out for oldest back log appointment for MDs as of the last day of the month.	35	43	15	19	15

These improvements reflect the impact of enhanced staffing, increased appointment capacity, and operational changes, including the implementation of a new tracking system in Cerner EMR. As backlog numbers continue to decline, compliance with timely psychotropic medication reviews is expected to reach and maintain target levels.

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.

July 2025 Recommendations: Continue to monitor.

10) Whether MDC properly monitors and timely adjusts medications.

UNMH Status Update as of 06/20/2025:
UNMH continues to prioritize the timely monitoring and adjustment of psychotropic medications. While timely follow-up rates for 30- and 90-day medication reviews have historically been below optimal levels, recent improvements in staffing and operational workflows are producing measurable improvements.

	07 Psych Med Adjustment 30- & 90-day FU	Q3	Q4	Q1 '25	Q2
1	Timely Adjusted 30 & 90 FU	25%	10%	30%	78%

UNMH has hired three new psychiatrists and one new psychiatric nurse practitioner, significantly increasing provider capacity. This expanded team is expected to continue reducing delays and improving future audit results.

- 07 Psych Med Adjustment 30 & 90 Day FU Q2 2025:
  Q4 and Q1 2025 results showed low compliance at 10% and 30% respectively,

largely due to staffing shortages. With psychiatric provider positions now 100% filled, we are actively working down the backlog. While Q2 2025 (audit period April 1 – June 18) reflected significant improvement at 78%, we did not hit our 90% compliance goal. If is important to note that audit sample consisted of only 20 patients, compared to over 800 patients on the unit. Providers are working efficiently, often seeing patients ahead of their 30- and 90-day follow-up schedules, particularly when patients are present on the unit and scheduled within the next few days.

- On average 30-day FU's are completed within 28 days, and 90-day FU's within 88 days
  - These averages are shorter than the standard follow-up timeframe because providers are focused on catching up the backlog. which requires some appointments to be moved up.

The PSU team has made considerable progress in addressing the backlog, as shown below:

BACKLOG DATA	Jan	Feb	Mar	Apr	May
# of 30 day MD SMI follow ups NOT seen (absolute number on the 30th day of the month) - BACKLOG	51	71	33	9	18
% SMI who haven't been seen within 30 days.(30th day of the month) total caseload	34%	42%	23%	6%	13%
# for 30 day MD NON SMI follow ups NOT seen (absolute number on the last working day of the month) - BACKLOG	184	127	37	11	18
% NON SMI who haven't been seen within 90 days. (last day of the month)	24%	17%	5%	1%	2%
# days out for oldest back log appointment for MDs as of the last day of the month.	35	43	15	19	15

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.

A compliance rating is deferred for this monitoring period due to lack of relevant data to review.

July 2025 Recommendations: As above.

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

of psychotropic medication.

UNMH Status Update as of 06/20/2025:
MDC has established clear standards for the frequency of review and charting of psychotropic medications. During Mental Health Intake, PSU counselors perform comprehensive chart reviews that include assessment of current medications. They also inquire about any medications prescribed by community providers to ensure accuracy and continuity of care.

Policy:
MDC HCA 12.48.1 PSU Therapeutic Services (page 7) outlines that psychotropic medications are reviewed and documented by a psychiatric provider on a regular, timely basis:

- Seriously Mentally Ill (SMI) patients receive medication reviews at least every 30 days
- Non-SMI patients are reviewed up to every 90 days

These standards ensure ongoing monitoring and timely updates to medication regimens, consistent with best practices. Training has been rolled out.

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.

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

a. With what frequency should a psychiatrist personally assess every MDC inmate on psychiatric medication who is not seriously mentally ill.
b. 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 06/10/2025

While 30- and 90-day follow-up psychiatric assessments are not yet consistently completed on the exact due dates, significant progress has been made, particularly with the recent addition of psychiatric providers. These changes are expected to further improve compliance in upcoming quarters.

Currently, approximately 30% of 30- and 90-day follow-up appointments are completed on time, with thorough psychiatric medication reviews conducted during these visits. These assessments are essential for ensuring appropriate medication management and patient safety.

Medication Oversight & Continuity of Care:

- The Pharmacy Department actively monitors psychiatric medications.
- Behavioral Health nurses track and report daily medication refusals.

- Daily updates are provided to Dr. Hamilton, who oversees continuity of care and ensures clinical follow-up.

	07 Psych Med Adjustment 30 & 90 day FU	Q3	Q4	Q1 '25	Q2
1	Timely Adjusted 30 & 90 FU	25%	10%	30%	78%

This metric is expected to improve due to recent staffing increases and greater scheduling capacity.

- 07 Psych Med Adjustment 30 & 90 Day FU:
  - Q4 and Q1 2025 results showed low compliance at 10% and 30% respectively, largely due to staffing shortages.
  - With psychiatric provider positions now 100% filled, we are actively working down the backlog.
  - While Q2 2025 (audit period April 1 – June 18) reflected significant improvement at 78%, we did not hit our compliance goal.
    - Please refer to response above for additional information
  - We anticipate continued progress and stronger results over the next two months as the backlog is resolved.

Several factors can contribute to delays in psychiatric follow-ups. These include patient refusals, providers discovering—after thorough chart reviews—that patients are no longer in custody, or logistical barriers such as court appearances, work assignments, or other obligations that limit availability. Additional challenges include limited correctional officer (CO) availability for patients housed in REDS, as well as individuals expressing reluctance to engage in PSU services.

Despite these obstacles, we remain committed to improving timeliness and decrease barriers to care. To support this effort, we have implemented a new tracking system within the EMR (Cerner), which enhances our ability to monitor appointments and follow-up needs in real time.

July 2025 Findings: As per status update. Partial compliance.

July 2025 Recommendations: Continue to monitor.

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 06/20/2025:
MDC has demonstrated clear and consistent improvement in ensuring that the treatment of inmates on suicide precautions goes well beyond segregation and close supervision. Suicidal

inmates receive comprehensive clinical intervention, including psychiatric assessments, daily counseling, and structured follow-up care.

Enhanced Therapeutic Interventions:

- Daily check-ins with PSU counselors are conducted for all patients on suicide watch.
- Psychiatric evaluations occur the same day or the next (if after hours), ensuring rapid engagement.
- Upon removal from suicide precautions, a structured follow-up schedule is implemented at 24 hours, 7 days, and 28 days, supporting ongoing recovery and risk monitoring.

	26 Patients Placed on Suicide Watch	Q4	Q1 25'
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	100%	100%
4	Pt assessed daily by a QMHP	93%	100%
5	Pt assessed q shift by a Nurse	77%	90%
6	Pt cleared from suicide watch by a Psychiatrist	100%	100%
	Overall Compliance	95%	98%

	14 Suicide Watch Follow-up Rounding Audit	Q4	Q1 25'
1	24-hour MH Follow-up Intervention Completed as Scheduled?	86%	87%
2	7-day MH follow-up Intervention Completed as Scheduled?	70%	73%
3	28-day MH Follow-up Intervention Completed as Scheduled?	77%	90%
4	Was there an Acute Hold Placed in OMS?	90%	100%
	Overall Compliance	81%	84%

- Psychiatric and QMHP involvement is timely and consistent, meeting or exceeding 100% in most categories.
- Nursing compliance has improved significantly (+13%).
- 28-day follow-up care rose by 13%, demonstrating sustained engagement.
- Acute hold documentation is now consistently completed at 100%.

- Over the last three months UNMH has begun to use Power Orders in the EMR to follow suicide watch.
- Of the individuals marked incorrect, four patients were seen on average 2 days after their required 24-hour follow-up (i.e., follow-up occurred at approximately 2 days instead of 24 hours).
- Of the individuals marked incorrect, eight patients were seen on average 2 days after their required 7-day follow-up (i.e., follow-up occurred at approximately 9 days instead of 7 days).
- Of the individuals marked incorrect, two patients were seen on average 1.5 days after their required 28-day follow-up (i.e., follow-up occurred at approximately 29.5 days instead of 28 days).

These results reflect a consistent, multidisciplinary approach to suicide prevention and recovery, showing that treatment for suicidal detainees is active, therapeutic, and focused on promoting better health outcomes and supporting patients in reaching their goals.

July 2025 Findings: As per status update. Significant improvement is noted. Partial compliance continues.

July 2025 Recommendations: Perform relevant audits covering the entirety of the next monitoring period.

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 06/20/2025:
UNMH has developed and implemented formal procedures for seeking psychiatric hospitalization or appropriate residential mental health care for inmates who are both eligible and would clinically benefit from such placement, consistent with court-imposed conditions of confinement.

1. Psychiatric Hospital Transfers:

UNMH continues to identify individuals who meet criteria for a higher level of psychiatric care. In collaboration with legal stakeholders, including public defenders and judges, efforts are made to facilitate their transfer to the Psychiatric Emergency Services (PES) or other appropriate settings upon release from custody.

INMATES MEETING CRITERIA FOR INPT ADMISSION	Jan	Feb	March	April	May
Total # of all certificates of evaluation issued	3	5	9	14	32

Certificates of Evaluation are issued when a patient meets clinical criteria for inpatient psychiatric care post-custody. In many cases, MDC psychiatric providers proactively engage with the patient's attorney and the court to advocate for legal release, enabling the patient to be transferred to UNMH PES for further evaluation and treatment. These collaborative efforts have become more structured and routine over the past year.

2. Realistic Options for Placement:

While UNMH does not have the direct authority to commit or transfer inmates to psychiatric hospitals while in custody, the process in place ensures that:

- Clinically appropriate referrals are made.
- Legal advocacy is initiated when a patient's condition necessitates higher-level care.
- The court retains the final authority to approve such releases.

Policy:
- MDC Patient Transfers to UNMH Inpatient Psychiatry went into effect 03/13/2025.

The updated procedures and policy aim to standardize clinical advocacy and guide providers and administrators in navigating the legal and medical steps necessary to secure care for inmates requiring psychiatric hospitalization. UNMH remains committed to working within legal

constraints to ensure access to clinically appropriate care.

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

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.

UNMH Status Update as of 06/20/2025:
UNMH continues to implement and enforce Policy HCA 12.49 – Suicide Prevention Program, which outlines:

- Constant direct supervision for inmates identified as actively suicidal.
- Close supervision (e.g., staggered 15-minute checks) for inmates assessed to be at lower—but still significant—risk.
- Follow-up psychiatric assessments are completed before individuals are removed from suicide watch to confirm clinical stability.

To support consistent application of these protocols, targeted Safety Monitor trainings were conducted in January and April 2025. These trainings emphasized the importance of accurate observation intervals and documentation, especially under staggered watch protocols.

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.

Compliance continues

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 06/20/2025:
Audit Results are as follows:

	02 Constant Monitoring of Patients Presumed to be of Moderate or High Risk of Suicide or Self-Harm	Q1	Q2	Q3	Q4	Q1 '25	Q2' 25
1	MDC security staff monitors inmates with constant supervision until the inmate is seen by a QMHP for assessment.	30%	90%	90%	93%	83%	93%

July 2025 Findings: As per status update. Significant improvement is noted. Partial compliance continues.

July 2025 Recommendations: Continue to audit.

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 06/20/2025:
UNMH continues to assign Safety Monitors based on the level of supervision determined by a Qualified Mental Health Professional (QMHP). Well-being checks are accurately documented using observation logs that do not include pre-printed times, supporting authenticity and accountability of monitoring practices.

Audit Results as follows:

	02 Constant Monitoring of Patients Presumed to be of Moderate or High Risk of Suicide or Self-Harm	Q1	Q2	Q3	Q4	Q1 '25	Q2' 25
1	MDC security staff monitors inmates with constant supervision until the inmate is seen by a QMHP for assessment.	30%	90%	90%	93%	83%	93%

This reflects a notable improvement in the timely deployment of safety monitors and coordination with mental health staff.

	21 Safety Monitor Observation Logs	Nov	Dec	Jan	Feb	March	April	May
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?	90%	87%	83%	83%	87%	90%	90%

	21A Safety Monitor Constant Observation Logs	Dec	Jan	Feb	Mar	April
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?	100%	100%	93%	100%	97%

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

July 2025 Findings: As per status update. Partial compliance due to the constant monitoring audit results.

July 2025 Recommendations: Continue to audit.

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 06/20/2025:
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:

	26 Patients Placed on Suicide Watch	Q1	Q2	Q3	Q4	Q1 25'
6	Pt cleared from suicide watch by a Psychiatrist	100%	100%	100%	100%	100%

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

July 2025 Findings: As per status update. Compliance continues.
5) Whether MDC conducts all follow-up assessments on all inmates discharged from suicide

watch.

UNMH Status Update as of 06/20/2025:
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:

	14 Suicide Watch Follow-up Rounding Audit	Q1	Q2	Q3	Q4	Q1 25'
1	24-hour MH Follow-up Intervention Completed as Scheduled?	87%	93%	87%	86%	87%
2	7-day MH follow-up Intervention Completed as Scheduled?	83%	83%	90%	70%	73%
3	28-day MH Follow-up Intervention Completed as Scheduled?	90%	87%	90%	77%	90%

July 2025 Findings: As per status update. Partial compliance.

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 06/20/2025:
MDC HCA 12.49 Suicide Prevention Program (pages 3,5, & 10), last reviewed 04/04/2025

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

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

UNMH Status Update as of 06/20/2025:

- Policy: MDC HCA 12.49 Suicide Prevention Program

July 2025 Findings: See findings re: SA provisions C1-C8. Partial compliance.

July 2025 Recommendations: Continue to audit.

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.

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

UNMH Status Update as of 06/20/2025:
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.

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

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.

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

UNMH Status Update as of 06/20/2025:
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						
	Dec	Jan	Feb	Mar	Apr	May
# of Cadets	25	11	0	20	20	28

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

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 06/20/2025:
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.

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

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

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

UNMH Status Update as of 06/20/2025:
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.

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

July 2025 Recommendations:

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)].*

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

UNMH Status Update as of 06/20/2025:
Yes, UNMH's policy requires that restrained inmates with identified mental health needs 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.

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

3) Deleted from check-out audit.

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

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

UNMH Status Update as of 06/20/2025:
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 policy and involve appropriate oversight and documentation by Qualified Mental Health Professionals (QMHPs) in coordination with custody staff.

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

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 06/20/2025:
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.

July 2025 Findings: Staff reported that four-point restraints are not used by security staff. Compliance continues.

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.

December 2023 Findings: An 8- hour refresher course was recently provided to officers assigned to work in the HSU. Compliance continues.

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 06/20/2025:
MDC, in collaboration with UNMH, provides specialized mental health training to all security staff assigned to specialized mental health units, including PAC and RHU units.

- New cadets receive training during Orientation, which includes behavioral health and suicide prevention content specific to working in mental health housing units.

- Annual refresher trainings are provided to existing security staff, and attendance is tracked in the PSU training logs.
- Training sessions are jointly led by UNMH trainers, the Mental Health Director, and the Psychiatric Director, ensuring content is clinically appropriate and operationally relevant.
- Training topics cover behavioral health symptom recognition, de-escalation techniques, safety precautions, and how to appropriately respond to psychiatric emergencies and suicide risk indicators.

These training efforts aim to improve collaboration between custody and clinical teams and support a safer, more therapeutic environment on specialized units.

MDC Update:
MDC has continued to require training as previously demonstrated compliance.

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

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.

January 2025 Findings: As per status update. Partial compliance continues.

UNMH Status Update as of 06/20/2025:
While the 1:100 psychiatrist-to-patient ratio is often referenced as a national benchmark in correctional healthcare, UNMH recognizes that every facility has unique population dynamics, acuity levels, and operational demands. At MDC, the behavioral health needs are intensified by a complex population with high rates of serious mental health illness, substance use and some legal complications.

UNMH's Psychiatric Services Unit (PSU) supports a current caseload of 888 detainees, though this number is fluid. The detainee population frequently fluctuates due to complicated external factors.

Dr. Hamilton has made great strides in staffing the psychiatric team. The current provider roster includes:

- Psychiatrists: (100% Filled):
  - Eide MD (1.0 FTE)
  - Hazlewood MD (1.0 FTE)
  - Hardy MD (1.0 FTE)
  - Whinnery MD (1.0 FTE)
  - Husain (1.0 FTE)
  - Ngodo NP (1.0 FTE; temporarily covering psychiatrist position until August 2025)
- Psych Nurse Practitioners:
  - McDougal NP (1.0 FTE)
  - PRN coverage available for weekends

UNMH has made substantial progress in achieving 100% staffing for its psychiatric positions.

POPULATION INFORMATION	Jan	Feb	Mar	Apr	May
Total MDC average daily population (ADP) CAP 1950	1721	1799	1816	1852	1839
MDC ALL POPULATION - ALOS (as of last working day of the month)	41.3	82.1	78	23	23.4

PSU POPULATION ALOS (as of last working day of the month)					
Absolute # on PSU caseload (on last working day of the month)	757	740	724	767	888
% of total Population on PSU Caseload	44%	41%	40%	41%	48%
Absolute # of SMIs in total population (last working day of the month)	150	169	146	143	142
% of total Population who are SMI	9%	9%	8%	8%	8%
% of PSU caseload who are SMI	20%	23%	20%	19%	16%

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.

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's mental health staffing has improved overall. In response, UNMH has filled critical provider vacancies and allocated a Nurse Practitioner to backfill remaining psychiatric position until August 2025. UNMH has assigned dedicated mental health coordinators to PAC 1, PAC 3, PAC 4, RHU 3, and RHU 6. These assignments have strengthened the facility's ability to implement safety precautions, particularly related to suicide prevention and planned use of force, while also supporting consistent treatment and service delivery as required by the Court's orders. During this monitoring period, we did have a temporary vacancy in the PAC 3 Coordinator position, which has since been filled.

For staffing specifics, please refer to Staffing Table A. Updated caseload and backlog data can be found in the PSU matrix, which reflects improved follow-up rates and reduced backlogs.

July 2025 Findings: As per status update. Significant improvement is noted. Partial compliance remains based on assessments is noted in other provisions of the Settlement Agreement.

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

UNMH Status Update as of 06/20/2025:
UNMH has made significant strides in providing adequate care for inmates with serious mental health needs. Additional staff have been hired to address critical gaps, including psychiatrists and mental health providers, as reflected in the staffing table.

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.

Partial compliance is present.

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.

UNMH Status Update as of 06/20/2025:
Three psychiatrists have been successfully onboarded, along with an additional psychiatric nurse practitioner, addressing critical gaps in psychiatric coverage. Intake processes have been improved through the implementation of multidisciplinary care teams, ensuring that mental health needs are identified early. Treatment team meetings are now held weekly.

To improve clinical workflow, the Mental Health Director has plans to assign counselors from broad unit coverage to focused task-specific roles. This change is aimed at increasing accountability and reducing delays in essential processes like response to sick call requests, initial assessments, and follow-ups. Although compliance with timeframes for these activities remains a work in progress, performance audits are routinely conducted, and workflow adjustments are made based on data and operational feedback.

Additionally, daily group therapy programming is monitored by a dedicated mental health coordinator, and supplemental self-guided materials have been distributed to expand structured out-of-cell therapeutic time, even in the absence of live facilitation.

While challenges persist, MDC is aligning its staffing utilization strategies with correctional mental health standards of care and continues to refine internal systems to deliver adequate services within existing constraints.

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.

Partial compliance is present.

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.

UNMH Status Update as of 12/22/2024:

UNMH regularly reviews staffing patterns based on data that tracks the timeframes in which staff complete essential functions, such as responding to sick call requests, conducting initial assessments, following up with patients, and performing other critical clinical processes throughout the past year.

Table A below presents the PSU Staffing Analysis for 2025-2027, while Table 2 STAFFING MODEL for the same period. Following a brief staffing analysis, it has been determined that additional staff are required to meet various timeframes effectively.

Table A: Mental Health Staffing Summary as of November 30, 2024

Name	Budgeted	Filled	Future Goal 2025-2027	Vacancy Rate to Budget	% change from current budget to future goal
Director Psych Providers	1	1	1	0%	0%
Admin Assist MH	1	0	3	-100%	67%
Coordinator Telehealth	1	1	1	0%	0%
Consultant Quality	1	1	1	0%	0%
Community Support Worker - Discharge Planners	5	5	6	0%	17%
Manager Clinical Therapy	0	1	2	100%	100%
Counselor Social Worker Clinician	18	16.7	18	-7%	0%
Aide Patient Sitter	6	15.5	12	158%	50%
LPN Inpt	0	1	1	100%	100%
RN Psych Inpt	8.4	8.4	12	0%	30%

Supv Rn Inpt	4.2	0.9	4.2	-79%	0%
APP Psychiatry	3	2.4	4	-20%	25%
Director of Psychiatry	1	1	1	0%	0%
Psychiatrist	6	2.9	7	-52%	14%
UNMH Total:	**55.6**	**57.8**	**73.2**	**4%**	**24%**

The amount of staffing in August was not appropriate to maintain the level of UNMH Sick and Mental Health referrals. Since June we have had an increase in staffing and established a new assignment process. This has resulted in a decrease in backlog that is manageable by the current staff numbers. Refinement of the current system is occurring to maintain the time frames.

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 06/20/2025:
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. Please refer to the PSU Staffing Summary and UNMH's Annual Budget.

July 2025 Findings: As per status update. This provision requires an annual review of staffing patterns, which was completed during the prior monitoring period. Compliance continues.

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

UNMH Status Update as of 06/20/2025:
No new programming was initiated this auditing period.

MDC Update:
No new programming was initiated during the monitoring period.

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

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.

January 2025 Findings: As per status update. The infrastructure for an adequate QI system is present although during the monitoring period there have been implementation issues regarding relevant timeframes in the context of M&M reports. Partial compliance continues.

UNMH Status Update as of 06/20/2025:
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.

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

Plaintiff Intervenors disagree with this compliance rating for reasons summarized below:

> While you previously found that there is an adequate QI system present, you also found, as you have stated, that there were "implementation issues regarding relevant timeframes in the context of M&M reports." Thus your assumption appears to be that the timeliness of M&M reports is the sole remaining factor in contention, and that timely M&M reports now support sufficient efforts to support a finding of compliance. This is not accurate.

Plaintiff Intervenors also summarize problems with corrective action plans during prior monitoring periods, with a focus on documentation issues

Plaintiff Intervenors mistakenly assume that the "timeliness of M&M reports is the sole remaining factor in contention", which is an incorrect assumption. The timeliness issue is just one of multiple requirements of this Settlement Agreement provision. The other factors are covered under my prior assessment that "the infrastructure for an adequate QI system is present."

The focus of this site assessment was on the current monitoring period. During the site visit information was obtained from mental health clinicians and/or administrators specific to this issue as partially summarized in the Plaintiff Intervenors' July 20, 2025 letter. Specifically, documentation relevant to corrective action plans, including tracking of such plans will be revised to make it much more findable in the pre-site data package. Dr. Hamilton was able to demonstrate that documentation did occur relevant to corrective action plans during the monitoring period.

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 06/20/2025:
UNMH/MDC maintains an active Suicide Prevention Committee (SPC) that meets monthly to review incidents of self-harm and suicide attempts. Cases involving serious injuries are referred to 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:

- A recurring pattern in which individuals deny behavioral health histories or medication use at intake, particularly during the detox period, only to later submit service requests for medications addressing anxiety, sleep disturbance, and other post-detox symptoms once detox protocols have ended.
    - Action: PSU will not close patient who refuse PSU services while on detox. They will be rescheduled for later in the week.
- The SPC has also noted a pattern where certain individuals intentionally engage in "suicidal gestures" to manipulate their housing assignment (e.g., attempting to be moved off a specific pod), to be seen by a provider sooner, or to gain access to perceived benefits.
    - Action: This trend was discussed in the suicide prevention committee and it was noted that each patient individual complex issues related to treatment and their

classification.

- Continued incidents of self-harm during detox have highlighted the complexity of managing withdrawal symptoms, especially among individuals with intellectual or personality disorders, who may exhibit heightened psychiatric distress. These individuals are often transferred to PAC for enhanced monitoring.

The Suicide Prevention Committee continues to guide improvements in clinical and operational practices related to suicide risk and mental health care, balancing compassionate response with the need for systemic integrity.

July 2025 Findings: As per status update. Although plaintiffs' attorneys did not object to a continuing funding of compliance, they expressed "clarification as to how trends and recommendations that the SPC reports internally in the SPC minutes, are tracked and addressed in a methodical way." This issue was discussed with leadership staff, who reported that the tracking documentation used by the SPC will be revised in a manner that will provide such clarification.

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 06/20/2025:

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.

July 2025 Findings: As per status update. Plaintiff's' attorneys raised similar issues regarding tracking of recommendations as referenced in the prior provision.

Compliance continues.

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.

January 2025 Findings: As per status update. Refer to provision I1. Partial compliance due to timeliness issues.

UNMH Status Update as of 06/20/2025:
Please reference question one above.

July 2025 Findings: As per status update. Plaintiff's' attorneys raised similar issues regarding tracking of recommendations as referenced in the two prior provisions.
Compliance is now present.

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 06/20/2025:
Corrective Action Plans are developed when appropriate to address areas that require corrective action. ~50 audits have been conducted between December 2024 to May 2025.

July 2025 Findings: As per status update. Plaintiff's' attorneys raised similar issues regarding tracking of recommendations as referenced in the three prior provisions.

Compliance continues.

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 06/20/2025:
UNMH conducted all initial reviews within the Suicide Prevention Committee within 30-days.

July 2025 Findings: As per status update. Compliance is now present.

In the Plaintiff Intervenors' July 28, 2025 letter to me they request clarification of what is reportedly inconsistent findings in SA I. 6) specific to the timeliness of the preliminary mortality review regarding Ms. MM. Specifically, they state that my February 6, 2025 report found "that the preliminary mortality review was not timely." This letter specifically states that such a finding was on page 62 of my report, which does not correspond to the pagination of the report that I have in my possession. I am assuming that the relevant provision is I.6) since the Plaintiff Intervenors' comment is under that provision.

My February 2025 findings relevant to that provision was as follows:

> **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.

Note that I am referring to timeliness of morbidity reports in contrast to mortality reports. My assessment remains unchanged.

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 06/20/2025:

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	Jan	Feb	Mar	Apr	May
# TOTAL Facility-wide deaths at end of month related to Mental Health	0	0	0	0	0
Total Mortality Rate per 100,000	0.00%	0.00%	0.00%	0.00%	0.00%
# deaths of inmates on the PSU caseload	1	0	0	1	0
# of suspected suicides facility-wide	0	0	0	0	0
Total Suicide Rate per 100,000	0.00%	0.00%	0.00%	0.00%	0.00%
# of initial Mortality reviews documented within 30 days of the event	1	0	0	1	0
% of timely initial Mortality reviews	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	0
% of timely Final Mortality reviews	0%	0%	0%	0%	0%
# deaths of inmates on CCP	0	0	0	0	0

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

- Both cases were reviewed with/in the 30-day timeframe.
- These two cases were on the PSU caseload but were not suicide or self-harming.

July 2025 Findings: As per status update. Compliance is now present.

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

UNMH Status Update as of 06/20/2025:

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

- Both cases were reviewed with/in the 30-day timeframe.
- These two cases were on the PSU caseload but were not suicide or self-harming.
- OMS reports were received and reviewed within 30-days.

July 2025 Findings: As per status update. There were no suicides during the monitoring period. A compliance rating is not applicable during this monitoring period.

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 06/20/2025:

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:

	18 UOF Cleared by Medical and PSU	Q1	Q2	Q3	Q4	Q1
1	Cleared by PSU	96%	100%	100%	90%	93%

2	Cleared by Medical	93%	100%	100%	93%	100%
3	Circumstances Documented	93%	83%	100%	93%	96%
	Overall Compliance	94%	94%	100%	92%	96%

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

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.

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

UNMH Status Update as of 06/20/2025:
Please refer to the MDC update below.

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

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

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]*.

UNMH Status Update as of 12/22/2024:

MH Director monitors completion of daily groups on the units with a dedicated coordinator. The Counselor also do milieu therapy with inmates as inmates engage with each other in community building activities. In addition, dedicated self-guided materials have been made and printed so additional out of cell time can be structured even when a coordinator if not present.

Dr. Hazelwood started in November and is working to restore RHU 6.

MDC Response: As the County has previously voiced, the provision, as written, does not require a certain amount of out of cell time for inmates in RHU. Instead, it requires specialized treatment for both males and females. The focus on out of cell time was based upon a concern that females in segregation often received far less out of cell time than males. While this concern was a valid concern, it shifted monitoring of this provision away from the stated language. The evidence shows there continues to be specialized mental health programming for both male and female inmates in segregation. MDC did not revise the format for out of cell time reporting, but expects to have a revised report by your visit.

UNMH Status Update as of 06/20/2025:

Psychoedu Group Hours						
Unit	Jan-25	Feb-25	Mar-25	April-25	May-25	June-25

PAC 1	33	30.50	33.0	30.50	36	
PAC 3	22.65	20.90	15.15	5.5	10.3	
PAC 4	22	0	3.45	13.54	4.15	
RHU3	19.45	18.95	24.50	21.1	21.8	
RHU 6	21.64	24.14	22.55	18.1	24.95	

- Table: Activity Hours

Activity Hours						
Unit	Jan-25	Feb-25	Mar-25	April-25	May-25	June-25
PAC 1	0	40.4	0	0	0	
PAC 3	50.95	31.6	0	0	0	
PAC 4	0	0	17.1	.30	2.15	
RHU3	1.45	2.75	.3	0	0	
RHU 6	0	0	0	0	0	

UNMH has formal plan for specialized mental health treatment for segregated male and female detainees has been developed. During January, partial compliance was noted due to challenges in consistent implementation—primarily related to staffing shortages and operational barriers in RHU settings.

Since then, as of the June 10, 2025 update, notable steps have been taken to improve and sustain implementation of the plan:

RHU 3 is now RHU 5 (Female Residents)

- Psychoeducational Group Hours have remained consistent and robust, with RHU 5 providing between 18.95 and 24.5 hours per month from January through April 2025.
- Activity Hours, while limited, were highest in February at 2.75 hours and tapered in subsequent months.
- The therapeutic environment remains collaborative and well-integrated with custody support.

RHU 6 (Male Residents)

- Group programming has also remained steady, ranging from 18.1 to 24.14 psychoeducational group hours per month between January and April.
- However, Activity Hours in RHU 6 have consistently remained at zero, which remains an area for improvement in meeting the standard 10:10 principle (10 hours of structured and 10 hours of unstructured out-of-cell time per week).
- Despite this, the presence of a dedicated mental health coordinator since December 2024 has helped restore group therapy consistency.

Implementation Enhancements (Since January 2025)

- Treatment team meetings now occur weekly with the exception of PAC 3 due to a recent retirement of a long-term employee; however, the new Coordinator started in June and treatment teams will resume.
- The Mental Health Director directly monitors daily group activity completion, ensuring accountability and consistent delivery of services.
- Milieu therapy is facilitated by counselors, with a focus on community-building and patient engagement.
- UNMH's goal in the psychiatric units is psychiatric stability and decreasing recidivism once the patient is released.
- Self-guided therapeutic materials have been developed and printed, offering detainees structured activity options even when facilitators are not present.

Summary of Progress

The data reflects sustained group therapy activity and incremental improvements in structured care delivery.

July 2025 Findings: During the morning of July 10, 2025, I interviewed inmates in a community meeting - like setting in housing units RHU 5 and RHU 6.

RHU 5

Women on a PC status or disciplinary status reside in this restrictive housing unit, which provides enhanced mental health programming to female patients on the PSU caseload. I interviewed about 14 women in two group settings. This information was confirmed by custody staff. These patients reported generally receiving four to five hours per day of out of cell time, which included access to one group per weekday. The group treatments were described as being helpful. Very good access to the psychiatrist and to the mental health counselor was described. Meetings with their treatment team occurred on a monthly basis. It was not uncommon to be

locked down due to custody issues (especially shortages), particularly on weekends.. Continuity of medications was not an issue. Discharge planning occurred on this unit.

Assessment: The treatment program and the therapeutic milieu on this unit has been maintained, which is a reflection of a good working relationship between mental health and custody staffs..

RHU 6

This housing unit provides enhanced mental health treatment to male patients in a restrictive housing setting. I interviewed 14 inmates in a community -like setting. Access to a psychiatrist has significantly improved since the psychiatric vacancy has been filled. Inmates reported being out of their cell for 2-4 hours per day although lockdowns were not uncommon related to custody issues (often due to shortages).one group is offered on a daily basis, which last 1-1.5 hours, which was described as generally being helpful. Medication continuity issues were not present. Discharge planning was provided to these inmates.

Reasonable access to the psychiatrist and mental health counselor was reported.

Assessment: The therapeutic milieu has improved since the prior site assessment, which is a reflection of the unit having a fulltime psychiatrist and mental health coordinator.

Summary

As per status update. 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.

K. Constitutionally adequate mental health care

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

UNMH Status Update as of 06/20/2025:
UNMH is not aware of any 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.

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

UNMH Status Update as of 06/20/2025:
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 improve 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 conduct to review referrals from intake to determine if timeframes were met, and patients were referred appropriately.

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.

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

UNMH Status Update as of 06/20/2025
The previously noted staffing deficiencies, particularly in psychiatry, have been addressed since the last audit period.

- Psychiatric staffing is now fully restored. Three new psychiatrists and one additional psychiatric nurse practitioner have been successfully hired, filling all allocated positions. While mental health counselor staffing remains strong, there continues to be some turnover, including a recent retirement; however, the position has been filled.

- Mental Health Professionals: 15 filled / 15 allocated (100%)
  - All counselor positions are filled.
- Psychiatrists: 100% (6 filled / 6 allocated, backfilling w/Psychiatric NP until August 2025)
- Psychiatric Nurse Practitioners (NPs): 100% (1 filled / 1 allocated)
- Psychiatric Director: 1 filled / 1 allocated (100%)
- Mental Health Director: 1 filled / 1 allocated (100%)
- Registered Nurses (RNs): 6.3 filled / 8.4 allocated (75%)
  - UNMH RN's are floating to backfill any areas that are in need of assistance.
- Licensed Practical Nurses (LPNs): 1 filled / 0 allocated (100%)

There has recently been 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.

In summary, while partial compliance was previously reported due to psychiatrist vacancies, current data reflects full psychiatric staffing and no systemic issues in 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.

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

UNMH Status Update as of 06/20/2025:
The delays were primarily attributed to staffing vacancies and limited mental health counselor allocations, has been addressed. Please see above and relevant CQI studies.

July 2025 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 06/20/2025:
UNMH continues to review and update policies at our monthly policy and procedure committee meeting. Previous staffing concerns have been addressed, please see above and the relevant CQI studies.

July 2025 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 06/20/2025:
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.

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.

July 2025 Findings: As per status update. Mental health staff reported good communication and working relationships with custody staff.

Compliance continues.

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 06/20/2025:
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.

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

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

UNMH Status Update as of 06/20/2025:
We currently have good communication between PSU and custody. Please see above.

July 2025 Findings: As per status update. See the findings sections for the previous two provisions. Compliance continues.

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 06/20/2025:
PAC 1: has had no changes during this audit period.
PAC 3: had the coordinator retire and the position was filled.
PAC 4: had a new coordinator since December 2024.
RHU 6: had a new coordinator since December 2024.

RHU 3 had a new coordinator since December 2024.
Pac treatment teams were not consistently occurring due to previous psychiatry staffing vacancies that have since been resolved. Treatment Team meetings have resumed and the backlog is being address. The discharge planners continued to meet with the patients and provide discharge plans.

We continue to have a good working relationship with custody staff on the HSU/PAC.
The PAC/HSU officer training is completed prior to the new officer rotation. This continues to aid in PSU and custody staff working as a team. Our PAC units continue to have dedicated PSU nurses who address PAC acute needs and sick calls.

July 2025 Findings: During July 10, 2025 I interviewed inmates in a community meeting - like setting in housing units in PAC 1, PAC 3 and PAC 4. Relevant findings were as follows:

PAC 1

Patients were very complementary of the therapeutic milieu within this housing unit, which provides an acute psychiatric level of care for male patients. The patients reported being offered 10 hours per day of out of cell time. Patients reported being offered one group therapy per weekday (1-3 hours/group), which were reported to be very helpful. They described very good access to individual counseling on a PRN basis and good access to the psychiatrist.. Discharge planning services were also available to them. They met with their treatment team on a monthly basis.

Medication continuity issues were not present.

Assessment: This unit continues to maintain a therapeutic milieu and was providing an appropriate level of acute psychiatric treatment to these patients. It was clear that the mental health staff and correctional officers on this unit have a very good working relationship and have been instrumental in establishing the therapeutic milieu.

PAC 3

This unit provides a residential level of mental health care for male patients. The unit was overcrowded as evidenced by more than several patients sleeping on the floor.

The patients described daily access to group therapies (1-2 hours per group), which were reported to be helpful. Good access to individual counseling on an as-needed basis was

described. Reasonable access to a psychiatrist was reported. Discharge planning services were available.

Medication continuity issues were not present.

Several patients were very disruptive during meeting and required intervention from the staff.

Assessment: The therapeutic milieu on this unit has not been maintained at the same level observed during prior site visits, which is likely due to the retirement of the mental health coordinator, overcrowding and apparent frequent turnover of residents.

PAC 4

This housing unit provides both and acute level of psychiatric care and a residential level of psychiatric care to female patients. Patients reported being offered 10 hours per day of out of cell time.A therapeutic milieu was present. Most of these patients lived in a dormitory setting, which resulted in not being locked down. Patients reported access to one group therapy (30 minutes per group) per weekday, which was described as helpful. Discharge planning was offered to these patients.

Medication continuity issues were absent.

Assessment: A therapeutic milieu has generally been maintained on this unit.

MDC does attempt to follow a proactive program, which provides care for special needs patients who require close mental health supervision or multidisciplinary care.

Compliance is present although significant improvement is needed regarding PAC 3.

July 2025 Recommendations: Improve the treatment program on PAC 3.

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 06/20/2025:

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.

July 2025 Findings: As per status update. See prior provisions relevant to the treatment planning process. See audit results in the next provision's status update. This provision will be assessed in the context of timeliness of treatment plans. 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 06/20/2025:

Audits results are as follows:

	03 Final DC Planning of PAC and RHU	Q2	Q4	Q1 '25
1	Final Discharge Plan Completed or documented reason why Final Discharge Plan was not completed	76%	77%	87%
2	Housing Needs and Referral adequately documented	81%	77%	87%
3	Transportation needs and referral adequately documented	30%	53%	83%
4	Mental Health needs and referral adequately documented	75%	62%	87%
5	Substance Use Disorder needs and referral adequately documented	80%	45%	87%
6	Benefits Packets/Income/ Resources/Treatment Guardian needs and referral adequately documented	75%	52%	83%
7	MSE adequately documented	81%	81%	N/A
8	Patient signed Discharge Plan or documented reason why patient refused or was unable to sign	80%	70%	83%
	Overall Compliance	72%	65%	85%

The Q1 2025 audit of Final Discharge Planning for PAC and RHU shows a marked improvement in overall compliance, increasing to 85% from 65% in Q4. Significant gains were seen across all core areas, particularly in documenting transportation needs, substance use referrals, and benefits/resources planning. This reflects strengthened discharge coordination and improved documentation practices across the multidisciplinary team.

	16 PAC 1, 3, 4 RHU 6 TX and DC Planning	Q3	Q4	Q1
1	MHP completed the Preliminary Discharge Plan in its entirety and patient needs are outlined	N/A	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).	40%	3%	0%
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	62%	0%	0%
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.	52%	0%	71%
5	Treatment Team generated Tx Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	62%	10%	27%
6	Treatment Team generated Tx Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	79%	100%	97%
7	All members of the Treatment Team are documented as present	61%	10%	27%
8	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	69%	13%	27%
	Overall Compliance	61%	23%	32%

In Q1 2025, results were impacted by a 50% psychiatric provider vacancy during November and December 2024. While this initially delayed Treatment Team meetings, staffing steadily improved with the hiring of Dr. Hazelwood in late November, Dr. Whinnery in February, Dr. Husain in April, and a Nurse Practitioner to fill the final vacancy. As providers onboarded, Treatment Team meetings gradually resumed.

Despite these challenges, counselors consistently met with patients individually, providing support, addressing treatment goals, and reinforcing therapeutic techniques. Their dedication helped sustain patient progress during a period of limited team availability.

	20 TX and DC Planning RHU 3	Q3	Q1
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).	81%	47%
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.	44%	40%
4	Treatment Team generated TX Plan appropriately addresses the symptoms of the diagnosis and subsequent meetings follow the initial plan.	100%	93%
5	Treatment Team generated TX Plan includes a Discharge Plan that addresses patient needs and includes community follow-up	100%	93%
6	All members of the Treatment Team are documented as present	100%	93%
7	Treatment Plan is signed by the patient, or if not, a reason is documented as to why not	100%	93%
	Overall Compliance	91%	78%

Q1 2025 results for RHU 3 reflect a decrease in compliance, primarily due to delays in holding Treatment Team meetings, which impacted timely completion of 10-day and 30-day follow-ups. On average, 10-day follow-ups were completed in 14.8 days, and 30-day follow-ups in 37 days. Despite these scheduling challenges, the quality of the treatment plans remained strong, with 93% compliance across clinical content, discharge planning, documentation, and patient engagement.

July 2025 Findings: As per status update. Partial compliance is present.

SUMMARY

The pre-site information received was very helpful and generally 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, there were somewhat less custody vacancies and significantly less mental health staffing vacancies (including psychiatric providers). However, the

custody line staff vacancies remained significant and negatively impacted the delivery of mental health services at MDC as evidenced by lockdowns not being uncommon due to custody staff vacancies. The significant use of mental counselor "travelers" has positively impacted the county hired mental health counselors but creates an ongoing training issues due to the inherent frequent turnover of the travelers.

Discharge planning and cooperative efforts with community mental health resources and other programs has been maintained.

The following provisions were found to be newly in compliance:

A. Screening and Assessment

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.

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.

B. Treatment Plan

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

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.

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.

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).

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.

L. Americans with Disabilities Act

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

The following provisions were found to be maintaining 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.

B. Treatment Plan

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)].

a. 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.
b. 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.

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

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

E. Use of Clinical Restraints

2) Whether the MDC policy requires restrained inmates with mental health needs are 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 time frames 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 was initiated.

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

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:

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, as necessary.

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

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]

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.

The following provisions were 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.

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 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.

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.

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

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.

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.

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)]*.

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

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

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

a. With what frequency should a psychiatrist personally assess every MDC inmate on

psychiatric medication who is not seriously mentally ill.

b. 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.

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)]*.

a. What caseload allows psychiatrists treating MDC inmates to provide for 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.

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.

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," *[. No. 1004]*

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.

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,

Compliance rating was deferred for the following provisions:

A. Screening and Assessment

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.

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).

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)].*

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)].*

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)].*

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

10) Whether MDC properly monitors and timely adjusts medications.

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.

My next site assessment will occur from February 25,26, 2026.

Sincerely,

Jeffrey L. Metzner, M.D.

Clinical Professor Emeritus of Psychiatry
University of Colorado School of Medicine