

EXHIBIT A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Ollie Carruthers, et al., v Scott Israel, et al.
Case No. 76-6068-CIV-MIDDLEBROOKS

INITIAL REPORT OF JOINT MENTAL HEALTH EXPERT
KATHRYN A BURNS MD, MPH

I was appointed to serve as the joint mental health expert in accordance with a Settlement Agreement (“Agreement”) in the above captioned case. I was charged with assessing operations and conditions at the Broward County Jails and to render an opinion regarding whether there are current and ongoing violations of federal rights as pertaining to inadequate mental health care and facilities. If I believe there are current and ongoing violations of federal rights, I was charged with providing the specific basis for each finding and draft an Implementation Plan designed to remedy the violation(s).

I originally drafted a report and implementation plan and distributed them to the parties. I received their responses to the report and carefully considered their feedback and suggestions. I incorporated their information and edited the main body of report as I deemed appropriate. In the course of this review and editing process, the parties began to discuss and negotiate the terms of the implementation plan using the initial draft and subsequent iterations to negotiate an agreement. Subsequently, I have removed the portion of this report that dealt with an implementation plan and supported the efforts and ultimately the adoption of a jointly agreed upon implementation plan. Consequently, this document represents the Initial Mental Health Report which provides supporting rationale

for the terms of the Implementation Plan. It represents the state of the jail and mental health services at the time of the development of the Implementation Plan and the baseline conditions upon which the agreed upon actions and improvements will be measured.

In order to assess operations and conditions at the jails, I organized my inquiry around the six criteria for constitutionally adequate psychiatric care that were originally articulated in *Ruiz v Estelle* (1980)¹ because they form a useful framework for the discussion. The criteria are:

- Systematic screening and evaluation
- Treatment that is more than mere seclusion or close supervision
- Participation by trained mental health professionals (in appropriate numbers)
- Safeguards against psychotropic medications that are prescribed in dangerous amounts, without adequate supervision or otherwise inappropriately administered
- Accurate, complete and confidential records
- Suicide prevention program

It is worth noting that while these six items are described separately for purposes of review and discussion, the separation is somewhat artificial in that they are not only related but actually entwined with one another. For example, systematic screening and evaluation is not possible without participation by an adequate number of trained mental health professionals and the records must be accurate and complete in order to provide treatment interventions and measure progress. Separating the components is simply a

¹ *Ruiz v Estelle*, 503 F.Supp.1265 (S.D.Tex 1980)
Carruthers v Israel
Mental Health Report
08-08-18

way to organize the review and discussion and I will address each of them in the sections of the report that follow.

The Broward County Sheriff's Office (BSO) operates four jail facilities housing inmates: Main Jail (MJ), North Broward Bureau (NBB), Joseph V. Conte Facility (Conte or JVCF) and Paul Rein Detention Facility (PRF). The facilities differ somewhat in their missions and the types of inmates housed in them. For purposes of this report, I will focus on the jails and missions most relevant to the delivery of mental health care to inmates with serious mental illness though I recognize that each of the facilities serves other equally important and critical functions for the BSO and Broward County. The MJ serves as the booking/intake facility for the rest of the jails and thus serves a key function in screening and assessment, crisis intervention, suicide prevention, and detoxification from alcohol and drugs. MJ operates a large infirmary and also houses maximum security inmates, administrative segregation inmates and youthful offenders among its many missions. NBB is identified as the facility to provide housing and residential mental health care to inmates in need of such care due to their condition and/or functional impairment which prevents their placement in general population housing units at other facilities. Conte and PRF house general population inmates some of whom receive programming from BSO staff and "outpatient" psychotropic medication management from Armor Correctional Health Services (Armor) staff. (Armor also provides mental health assessments and crisis intervention as necessary at the "outpatient" jails but has the ability to request transfer of inmates to NBB for housing and additional treatment if necessary.)

The jails have been accredited by the National Commission on Correctional Health Care (NCCHC) since 1998 and received reaccreditation in 2015. They are scheduled for re-accreditation in 2018, in accordance with the regular NCCHC three-year reaccreditation cycle. The NCCHC accreditation is for all health services, including, but not specific to mental health services. The jails have also been accredited by the American Correctional Association (ACA) since 1996 and underwent a re-accreditation audit in November 2016, receiving reaccreditation in January 2017. The jails have also been accredited by the Florida Corrections Association Commission (FCAC) since 1998, receiving reaccreditation in October 2015. Having been a physician surveyor for the NCCHC and involvement with ACA accreditation in my own facilities, I understand these to be important and helpful in terms of providing a judgment on the effectiveness and efficiency of correctional operations and healthcare by comparing a facility or facilities processes to a set of standards developed by the accrediting body and professional organizations. However, the accrediting organizations themselves are also clear that while such accreditation is helpful and may protect against adverse events and reduce liability, they also explicitly recognize that accreditation does not guarantee or represent constitutional adequacy of a facility or system.

Medical and mental health care provided to inmates with serious mental illness and other mental health diagnoses confined in the Broward County Jails is provided through a contract between the BSO and Armor. Armor mental health staff consist of psychiatrists, advanced registered nurse practitioners (ARNP), physician assistants (PAs) and counselors (master's prepared mental health providers.) The BSO also has a number of mental health

professionals at some of the jails (BSO Program Staff) that provide psychosocial interventions, group and counseling and substance abuse programming (SAP) to the inmate population. BSO Program staff may also provide some individual counseling but their primary interventions are programs provided to groups of inmates. There is some overlap in that both Armor mental health staff and BSO Program Staff may serve the same inmate or group of inmates, but Armor is primarily responsible for screening, evaluation, psychotropic medication management, crisis intervention/suicide watch assessments and discharge planning. The Armor patient population consists of inmates with serious mental illness (SMI) and other mental health diagnoses, the overwhelming majority of whom are prescribed or require psychotropic medication for their condition(s). The persons served by BSO Program Staff may or may not be prescribed or require medication and may or may not have a mental health diagnosis. It is important to note that BSO Program Staff cannot serve inmates that are so functionally impaired by symptoms of serious mental illness that they are unable to participate in programs due to the acuity of their illness. The BSO Program Staff are consequently able to serve only a portion of the inmates with SMI – both in outpatient facilities as well as in the residential Mental Health Unit (MHU) at NBB as a result of inmate illness acuity as well as staffing levels, both of which are discussed more fully in the sections that follow.

Deputies supervising inmates in intake, segregation units, the residential mental health units at NBB and other program areas receive a 40-hour Crisis Intervention Team (CIT) training and participate in annual refresher courses as well. The CIT program for correctional facilities better trains officers to identify mental health-based problems

promoting early referral to mental health staff. CIT training also enhances communication skills for dealing with persons with mental illness and used by officers during psychiatric emergencies to minimize or avoid the use of force which reduces injuries to inmates and staff, avoids adverse incidents and improves inmate mental health outcomes.

Qualifications

I am a Medical Doctor licensed in the state of Ohio. I am Board Certified in the practice of General Psychiatry and Forensic Psychiatry. I also have a Master's Degree in Public Health. I am a Distinguished Fellow of the American Psychiatric Association. I am Board Certified by the American Board of Psychiatry and Neurology (ABPN) in General Psychiatry and Forensic Psychiatry. I have served both as a Board Examiner for the ABPN general adult psychiatry oral examination and on the forensic psychiatry committee writing examination questions and preparing the forensic psychiatry board examinations.

Since July 2013, I have served as the Chief Psychiatrist for the Ohio Department of Rehabilitation and Correction, a position I also held from May 1995 to August 1999. I have provided psychiatric care to inmates in jails and prisons in addition to holding administrative posts. I have been a physician surveyor of health services for the National Commission on Correctional Health Care in the past and am a Certified Correctional Health Professional. I have written correctional mental health policies and procedures and developed staffing plans for correctional mental health services. I have written and been published in journals and peer reviewed textbooks on topics pertaining to correctional mental health care.

I have served as both a consulting and testifying expert witness in legal cases involving correctional mental health care. I have conducted assessments of the adequacy of mental health care in individual correctional facilities as well as state systems including Massachusetts, Pennsylvania, Indiana, Illinois, Ohio and Alabama. I have also been a monitoring expert in correctional litigation cases including *Coleman v Brown* (California), *Disability Rights Network of Pennsylvania v Wetzel* (Pennsylvania), *Disability Law Center v Massachusetts Department of Correction* (Massachusetts), *Graves v Arpaio* (Maricopa County, Arizona) and *Carty v Mapp* (US Virgin Islands).

A copy of my current curriculum vitae, which includes a list of all publications authored and a list of all cases in which I have testified at trial or deposition during the past four years is attached to this report.

In forming my opinions, I have relied on my training and experience in general psychiatry, forensic psychiatry and correctional psychiatry: I have provided psychiatric care to inmates in jails and prisons and supervised the care provided by other mental health professionals; I have experience in administration and oversight of correctional mental health care and I have visited dozens of correctional facilities and interviewed staff, administrators and hundreds of prisoners and detainees. I am familiar with the standards for the delivery of mental health care promulgated by the National Commission on Correctional Health Care (NCCHC) as well as position statements and guidelines promulgated by other professional organizations including the American Psychiatric Association.

Sources of information

In conducting the assessment and forming my opinions, I considered information gathered and observations made during a series of site visits to the jail facilities. Site visits consisted of facility tours, meetings with BSO staff (including Program Staff) and Armor mental health staff, observation of mental health housing and program areas, infirmaries at MJ and NBB, reviews of medical records, interviews with individual inmates, reviews of various documents including jail housing plans, organizational charts and staffing rosters, BSO program schedules, caseload rosters and logs maintained in the course of business including hospital transfers and returns, crisis/suicide watches, restraint logs and mental health appointment schedules.

I visited each of the jail facilities on the indicated dates:

- Main Jail (MJ) – August 22, 2016; February 9, 2017; and May 15, 2017
- North Broward Bureau (NBB) – August 23, 2016; February 6,7 and 8, 2017
- Paul Rein Facility (PRF) – May 17, 2017
- Joseph V Conte Facility (JVCF) – May 16, 2017

Case summaries of inmate medical records reviewed, dates of reviews and/or interviews (where applicable) are appended to this report. (The Appendix also includes reviews of medical records requested of inmates that committed suicide in the jail and jail deaths of inmates on the mental health caseload.) While a few inmate case examples are cited in various sections of this report, the Appendix contains more complete summaries of all inmate information reviewed in the course of my review. Each summary is followed by

my assessment/conclusions in italics. The cases cited in the various sections of the report are simply illustrative of a certain point but not the only instance in which certain observations and/or deficiencies existed.

In addition to facility visits and review of documents on site, I also reviewed a number of additional documents that included:

- *Carruthers v Israel* Settlement Agreement
- Armor Correctional Health Services, Inc. Policies & Procedures
 - A- Governance and Administration
 - B- Managing a Safe and Healthy Environment
 - C- Personnel and Training
 - D- Health Care Services and Support
 - E- Inmate Care and Treatment
 - F- Health Promotion and Disease Prevention
 - G- Special Needs and Services
 - H- Health Records
 - I- Medical/Legal Issues
- BSO Standard Operating Procedures:
 - 5.16 Use of Restraints
 - 5.21 Emergency Rescue Tool (revised 6-9-15)
 - 7.13 Inmate Programs
 - 7.30 Administrative Segregation
 - 7.31 Disciplinary Segregation (revised 11-30-15)
 - 8.3 General Policies – Health Care (revised 11-30-15)
 - 8.4 Inmate Health Care Consent (revised 6-28-06)
 - 8.5 Health Care Personnel (revised)
 - 8.6 Health Care Services (revised 9-19-07)
 - 8.7 Inmate Health Records (revised 11-30-15)

8.8 Levels of Care

8.9 Management of Chemical Dependency

8.24 Health Screenings and Examinations (revised 11-30-15)

8.27 Inmate Mental Illness & Developmentally Disabled Policy

8.30 Suicide Prevention and Intervention – Health Care (revised 3-3-16)

- Agreement Broward Sheriff's Office and Armor Correctional Health Services (February 1, 2014-January 31, 2017); amendment for implementation of electronic medical records system (January 21, 2015); second amendment extending terms of agreement for another year (February 9, 2017)
- Hospital Services Agreement between Armor Correctional Health Services and North Broward Hospital District
- An expert report of Jeffrey L Metzner, MD dated March 5, 2006 related to the delivery of mental health care at the jails much earlier in this litigation.
- Commission on Accreditation for Corrections Standards Compliance Reaccreditation Audits conducted in the fall of 2013 of each of the jail facilities (MJ, NBB, JVCF and PRF)
- Armor Correctional Health Services Quality Assurance/Quality Improvement reports and/or audits for the past two years ²
- Special Needs Management Meeting Minutes

² This did not include some expected information such as several of the items outlined in the Armor Continuous Quality Improvement policy including incident reports, several Morbidity/Mortality reports and psychological autopsies, suicide prevention committee meeting minutes and process and outcome studies. I was told that there were no process or outcome studies specific to mental health conducted during the twelve-month period for review which explains their absence from the materials produced. I was provided assurance that all other available information requested was produced and proceeded on this assurance.

Main Jail (MJ)

Site visits: August 22, 2016; February 9, 2017; May 15, 2017

The Main Jail (MJ) serves as the central point of intake for the jails and booking, intake, health and mental health screening and assessment are major missions of the institution. In addition, there is an infirmary, drug and alcohol detoxification observation beds as well as general population housing for adult men of all security classifications, protective custody, and disciplinary and administrative segregation. The facility houses male inmates though there are two very small holding units on the intake floor for females until they are assigned to another facility.

There are 1542 beds in the MJ. The population count at the time of the February site visit was 1111 with 385 inmates (34% of the population) identified as being on the mental health caseload.

As previously noted, the jail serves as the booking and intake facility for the jails. The jail has experienced a decline of approximately 2000-3000 bookings annually over the last five years. In 2012, there were 50,930 bookings and the number in 2017 was 34,596; this is certainly a welcome reduction but even 34,596 bookings last year demonstrate that the MJ intake and booking process remains a very busy service area. Emergency Medical Technicians (EMTs) are on site at the jail and provide medical clearance for admission to the jail for detainees even before they physically enter the booking area to be certain that detainees do not need diversion to emergency medical care prior to entering the jail. The

intake screening is then completed inside the booking area and consists of more detailed questions about health and mental health history in addition to observations of detainee condition and behaviors. Inmates placed on watch or needing watch are expedited through the booking process and sent to the infirmary or over to NBB for suicide watch or psychiatric observation. (Additional information about the intake and assessment process is found in the Intake Screening and Assessment section of this report.)

The infirmary at the MJ contains 30 beds: 4 cells are ADA accessible and 4 cells contain closed circuit cameras to monitor inmates on watch status. Inmates undergoing detoxification (detox) from drugs and/or alcohol are in plastic beds (like a boat or sled) on the floor outside of the cells. Armor mental health staff conduct rounds in the infirmary and evaluate inmates on mental health watch status daily. The 4th floor of the MJ also contains detox observation beds for inmates that are less acute in terms of their withdrawal symptoms. They are monitored and continued on a detoxification protocol that includes symptomatic monitoring and medication(s). The decisions on whether to admit a patient to the infirmary or to the detox observation unit are made on a case-by-case basis by medical staff. Inmates initially placed in the infirmary for detoxification are also generally stepped down to the detox observation unit as their condition improves for some additional monitoring prior to being sent to general population housing. Mental health staff must also clear all detox inmates prior to release to general population. There is a full time Armor psychologist assigned to doing these mental health detox evaluations. He also does some brief, individual counseling.

Juvenile offenders are housed on the 5th floor of the MJ which includes general population and lock-down housing pods for juvenile inmates. There are 3 suicide watch cells located there for this population in need of watch placement as well. There are administrative segregation cells for adult male inmates in some of the 7th floor housing units and in all of the 8th floor housing units. There are 3 additional suicide watch cells on the 8th floor. Prior to placement in administrative segregation, there is a medical staff record review of the proposed placement to identify any contraindications or accommodation required.³ Mental health staff conduct weekly rounds in the administrative segregation units as the conditions there are considered “extreme isolation” according to the Armor policy. (Lesser forms of isolation require less frequent mental health rounds per policy.) Contacts during rounds occur at the cell front. Rounds are not considered treatment interventions but rather a form of monitoring to assess condition and determine whether any additional mental health intervention is necessary. The psychiatrist sees inmates being prescribed psychotropic medication at least monthly. The inmates are seen by the psychiatrist in the nursing office or at the cell front.

Armor mental health staffing at the MJ:

- Psychiatrist works 4 weekdays per week; 0.8 FTE

³ While I saw some of these review forms in many of the records reviewed, I saw no instance in which the review resulted in the inmate’s exclusion from placement in administrative segregation – even when the inmate was diagnosed and being treated for a serious mental illness. Examples are provided later in this report. This process and whether it resulted in diversion would be an excellent item to monitor through a quality improvement process in light of the known deleterious effect of long term segregation on inmates with serious mental illness.

- ARNP works 1 day per week; 0.2 FTE
- ARNP works weekends to do rounds of patients on crisis/watch status; fractional FTE
- Psychologist – assigned to detox evaluations and some counseling; 1.0 FTE
- Licensed Mental Health Counselor – assigned to do initial psych evaluations and some counseling; 0.8 FTE

BSO Program staff at MJ:

- Part-time (0.6 FTE) program specialist – assigned to provide Substance Abuse and Life Skills programming for Juvenile and protective custody inmates, not specific to inmates on the mental health caseload or SMI inmates

Mental health staffing is discussed further in a subsequent section of the report.

However, the mental health staffing levels for the MJ are woefully inadequate for the number of bookings annually and the number and volume of diverse missions of the facility - medical infirmary, detoxification, suicide watches in at least 3 areas of the jail (not including intake), juvenile housing, protective custody, disciplinary and administrative segregation. Other than the intake and assessment forms and psychiatric (or nurse practitioner) evaluations, medication checks and medication administration records (MARs) indicating that ordered medications were offered/provided to the inmate, there was no documentation in any of the records reviewed of any other form of mental health treatment intervention at MJ which was not surprising given the mental health staffing levels.

North Broward Bureau (NBB)

Site visits – 8/23/16, 2/6-8/17

The North Broward Bureau (NBB) contains 1206 beds in housing units 11 and 12. Housing unit 12 contains the residential mental health housing units for the entire jail as well as an infirmary. The mental housing units are located in lettered housing wings E, F, G and H and each of these contain five smaller pods numbered 1 through 5 that radiate off of a central correctional officer office/command center for that particular lettered housing area. Each of the lettered housing units also have both numbered housing pods on the first floor of the building and corresponding numbered pods located on the second story of the building.

The NBB infirmary houses medical patients in need of infirmary care but also has some safe cells for inmate patients requiring suicide watch or observation. Unlike the other housing units, it is located only on the first floor.

The mental health housing pods vary in size from 3-4 beds to a maximum of 21 beds and the construction varies from single cells to larger multi-inmate “rooms” that remain open to the central area of the pod. Celled pods are known as “closed mental health” units and are used to house inmates who have been determined to be too ill to house in the “open mental health” pods, (i.e., pods that contain multi-inmate rooms) those serving a disciplinary sanction (disciplinary segregation) or those inmates in administrative segregation status. Inmates in closed mental health (CMH) are housed alone in cells. Some

of the individual housing unit pods in housing unit 12 have missions unrelated to mental health: two pods in housing unit F serve as step-down for inmates with medical issues, a unit on E pod housed child offenders. The remaining housing units are described below.

Housing wing E contains protective custody (1E1), closed mental health (1E2, 2E1, 2E2, 2E3), open mental health (1E4, 1E5, 2E4), a 7-bed housing unit for suicide watch (1E3) and a 3-bed housing unit for suicide watch overflow (1E2). E houses male inmates. Note that the number preceding the letter indicates whether first or second floor, the number following the letter indicates which of the 5 pods is indicated.

Housing wing F contains closed mental health pods (1F1, 1F2, 1F3, 2F3), disciplinary segregation for mental health inmates (2F1, 2F2) and two open mental health units (2F4, 2F5). Note that 2F5 is considered the Intensive Program Unit (IPU) in which BSO program staff conduct daily (weekday) treatment programs, including addiction education groups for inmates with mental health and substance use disorders so long as they are clinically stable and able to participate. These programs are very good but can only serve a fraction of the population housed in MHU due to program staffing levels but also because a large number of inmates in the MHU are simply unable to participate due to their level of clinical instability or problematic symptomatology. Male inmates are housed on F.

Female inmates are housed in the G units. There is a six-bed unit for women on suicide watch (1G1); closed mental health units (1G2, 1G3, 2G1, 2G2, 2G3), and open

mental health units (1G4, 1G5, 2G5). 2G5 is the female program unit served by BSO program staff. 1G4 is an open mental health unit but it also serves as female intake into NBB mental health.

Housing wing H contains male inmates in both closed mental health (1H1, 1H2, 1H3, 2H1, 2H2, 2H3) and open mental health units (1H4, 1H5, 2H4 and 2H5). Housing pod 1H4 is open but also serves as the intake unit for men entering NBB mental health. BSO Program staff provide treatment programs in housing pod 2H3 – a 7-bed transitional program unit providing treatment services 4 days per week to assist in transitioning stable inmates from closed to open mental health units. BSO Program staff and programs are very good but able to serve only a small number of inmates on the mental health caseload and a fraction of inmates with serious mental illness due to staffing levels, program space and the severity of symptoms, functional impairment experienced by many inmates with SMI that precludes their ability to participate in the types of activities offered.

Inmates housed in the closed mental health units receive recreation once per week. Armor mental health counselors monitor inmates on the closed mental health units weekly at the cell front (as opposed to an individual, confidential interaction.) These contacts are conducted at the cell front “for safety reasons.” Armor mental health staff also seeks input from security and nursing staff about the inmates in closed mental health as part of this monitoring. A “mental health contact” form is completed and filed in the medical record. (Such cell front “monitoring” visits are known as “rounds” – another kind of screening and/or triage function in which the state of the inmate is briefly assessed at the cell front.

Rounds are not mental health treatment. The purpose of rounding is to determine whether someone is doing alright or has decompensated and in need of further assessment and treatment.)

The open mental health units receive recreation twice per week. Open mental health units also receive at least 1 group treatment offered weekly. BSO program staff provide these groups and some individual counseling sessions. Armor mental health staff do not provide any group treatment. Armor reported that their role is primarily “identification and stabilization.” Armor mental health counselors may do some individual counseling sessions with some inmates which is supportive in nature and done on an “as needed” as opposed to a regular basis or to provide an actual course of treatment, which is also true of the individual counseling sessions provided by BSO program staff. Counseling and other appointments (for assessments) are conducted at a table in the hallway, not in confidential treatment space. The only other mental health intervention provided by Armor at NBB is psychotropic medication management. In these instances, a given inmate may see one of several different prescribers, rather than having a standing treatment relationship with any one particular person. (This impairs the formation of a trusting treatment relationship and also leads to frequent assessment, reassessment at every appointment with persons having different prescribing practices. It is not ideal can delay access to effective treatment; psychotropic medications take 6-8 weeks at a therapeutic dose to assess effectiveness, frequent changes of medications do not permit adequate time to assess effectiveness and the net effect can be to delay effective treatment.) Medication management appointments occur at intervals of 30 days generally. A few more frequent

contacts are required after a watch is discontinued, but it quickly reverts to the monthly frequency as opposed to being driven by clinical need. Medication management appointments also occur in the hallway or at cell front and not in confidential treatment space.

BSO program staff conduct daily program groups during the week on 2F5 and 2G5. Each of these contain 21 beds. The programs are psychoeducational in contrast to psychotherapeutic. Inmates must be psychiatrically stable in order to participate and these programs are not available to anyone in closed mental health. The programs are well done but simply not an option available to the majority of inmates with serious mental illness in the mental health treatment facility at NBB.

There are no regular treatment team meetings to discuss each patient on the mental health caseload housed at NBB. There is a treatment team meeting to discuss some patients (2-3 patients discussed in a given week) that are selected either by BSO program staff or Armor mental health staff because they present a particular issue or issues (readiness for admission to the program unit, discharge from NBB, release planning, etc.) The meeting is attended by Armor mental health staff and BSO staff and is conducted in the middle of the hallway just outside the officers' station. It is not private or confidential from anyone else who may be on the unit. The inmate and the primary staff person working with the inmate sit at a table while the others present stand in a semi-circle around them. The discussions I observed provided useful information but were not typical mental health treatment team meetings. A progress note is written, signed by the persons attending the

meeting and placed in the inmate's file. The actual treatment plan itself is not updated to reflect any decision or planned increase in intensity, frequency or types of contacts for the inmate discussed.

As previously noted, suicide watches may be conducted in some of the cells located in the infirmary or on housing units 1E3 (males) and 1G3 (females.) Suicide prevention is discussed more fully later in this report.

Armor mental health staffing at NBB:

- Psychiatrist – 1 FTE and 1 part-time psychiatrist
- ARNP – 2 FTE (1 full time and 2 part-time practitioners)
- Physician Assistant – 1 FTE (primarily administrative)
- MH counselors – 2 FTE (licensed mental health clinicians)
- Discharge planners – 2 FTE

BSO Program staff at NBB⁴:

- Licensed psychologist – 2 FTE
- MH counselors – 3 FTE (master's level clinicians)

⁴ The BSO Program also supports mental health professional training. There are 2 FTE doctoral interns and 2 part-time doctoral practicum students (each for 12 hours per week). The jail is an accredited by the American Psychological Association as an Internship Training site.

Staffing is discussed in a subsequent section of this report. However, it is clear that NBB Armor mental health and BSO program staffing levels (including trainees who require supervision), do not reflect the numbers or varied types of staff necessary to provide a residential treatment level of care. Nothing other than medication management is provided for the vast majority of inmates, and even that is relatively infrequent, not based on clinical assessment of need and may be provided by someone different at every visit. While inmates do not have a “right” to see the same provider at every clinical visit, failing to do so leads to fragmentation in the provision of care, being subjected to differing prescribing practices and frequent medication changes; compromises the development of a consistent treatment relationship such that every visit is a “new” assessment rather than furtherance of a course of treatment. Such fragmentation impacts care provided and prolongs the time it takes for symptoms to respond to treatment. Delays in the provision of care have been shown to negatively impact both the time it takes to respond to treatment as well as the degree of the response; it takes symptoms longer to respond and the response is not as robust as that which occurs when treatment is provided timely.

Frankly, although this is the facility containing the mental health units to which other jails transfer inmates in need of a higher level of mental health care, there really is no different than the outpatient services provided at all of the other facilities. It does not represent a higher or more intensive level of care for inmates in need of such care, and inmates may remain there for many months or even years while awaiting further legal proceedings. Conditions on the closed mental health units and in the infirmary for weeks and months on end actually mimic solitary confinement/segregation in terms of very

limited (if any) out-of-cell time, limited opportunity for social interaction, limited property and cell front interactions, rather than the provision of actual mental health treatment.

Joseph V Conte Facility (Conte or JVCF)

Site visit - 05/16/17

Conte is a male facility housing minimum and medium security male inmates. The capacity of the jail is 1328 but the average daily population (ADP) has been 1000-1050 for the past year. On the day of the site visit, there were 1008 male inmates at JVCF; 319 of them were on the MH caseload (32% of the population.)

JVCF has no infirmary and does not have the capacity to conduct suicide watches. Inmates identified as needing that level of care are transferred out to NBB. The physical plant is structured such that there are two "towers" of housing – A & B tower. Each tower contains 8 housing units. All of the housing units are two-story, and the majority of cells are 2-man cells though there are 4-man and 6-man cells also.

Three of the units house inmates participating in specific programs: a Spiritual Learning program run by religious chaplains is located on housing unit B5, a Substance Abuse Program (SAP on housing unit A6) and a Life Skills Program (A5) are offered by BSO Program staff. The SAP and Life Skills Program consist of group interventions and both are 4 weeks in duration. There is no documentation of group notes contained in the medical records, but inmates get a certificate of completion if they participate for the 4 weeks. Most inmates participating in SAP are court-ordered but some request to participate. The JVCF also provides Narcotics Anonymous and Alcoholics Anonymous meetings on a voluntary

and court-ordered basis as well as GED training. This facility has ample program and outpatient treatment space.

Mental health services consist primarily of medication management appointments scheduled at monthly intervals. When inmates are transferred from MJ, medication orders remain in effect for the duration ordered by the psychiatrist at the MJ so that continuity is maintained. Medical nurses provide two medication administration times daily: 9-10 AM and 4-6 PM. Other mental health services may include new assessments based upon referral (staff referral or inmate self-referral) though the vast majority of inmates on the mental health caseload were identified by virtue of the intake process at the Main Jail.

The Medication Administration Records (MARs) were reviewed on site during the visit. There was very little polypharmacy (inappropriate use of multiple medications), which is a positive finding. Some medications were prescribed at very low doses (lower than the recommended lowest effective dose such as Risperdal 0.25 mg and Zoloft 50 mg long term). It's not clear that such low doses would have any therapeutic benefit, but neither is it harmful except to the extent that it further spreads already thin staff resources for medication management appointments. This is not just a difference in prescriptive opinion; requirements to see inmates on medication, even if it is prescribed in inappropriately low and ineffective doses, take time away from seeing inmates who are seriously mentally ill and preclude time to hold treatment team meetings on inmates on the mental health caseload, which puts them at risk of decompensation and impedes access to care. As an aside, there were a number of people that had MARs who did not appear on the

caseload roster. Any number of reasons explain this: a recent transfer/admission to the facility not yet added to the roster or the intervals at which the roster list is updated/refreshed weekly and the inmate arrived just after the last update and before the next one. There are probably other valid and understandable reasons for the discrepancy as well but in the worst-case scenario, inmates will be missed for follow-up appointments because they are not listed on the roster which is used for scheduling. In any event, I suggested on site that developing a mechanism to ensure the roster list was reconciled more regularly with the MARs/inmates physically present at the facility to promote better tracking/efficiency and follow-up could be worthwhile Continuous Quality Improvement (CQI) project.

BSO Program Staff at JVCF:

7.5 FTE: 1.0 FTE Supervisor (Jones), 4.5 FTE SAP staff; 2 FTE in Life Skills (1 FTE is vacant)

Armor mental health staffing at JVCF:

- Psychiatrist works 3 days per week; 0.6 FTE
- ARNP works 1 day per week; 0.2 FTE (also works at NBB)
- Licensed Mental Health Counselor works 1 day per week; 0.2 FTE (He also works at Main Jail 0.8)

BSO Program staff do not provide mental health treatment per se, they provide programs. There are significant differences. To name just a few: BSO program staff do not write progress notes in the medical record and the specific programs are not reflected as

an intervention specific to a particular mental health problem on the mental health treatment plan. Inmate progress toward goal attainment is not measured or reviewed by members of the treatment team or discussed in treatment team meetings. This is not intended as a criticism of the BSO programs, which are quite good; they are simply not provided as mental health treatment interventions specific to inmates with mental illness, they are programs. Armor mental health staffing levels permit nothing in terms of mental health treatment except very brief medication management appointments at monthly intervals given the size of the jail and the numbers of inmates on the mental health caseload prescribed psychotropic medication.

Paul Rein Detention Facility (PRF)

Site visit – 5/17/17

PRF houses minimum and medium security male and female inmates. The capacity of the jail is 1068 but the census on the day of the site visit was 728, which has been fairly typical for some time. There were 242 inmates at the facility on psychotropic medication (33% of the facility population though proportionately more women than men were on medications. The Director of Nursing explained that while women constituted only about ¼ of the population, they represented about ½ of the number of inmates on medications. This is not atypical with female inmates throughout the country.)

The physical plant floor plan at PRF is essentially the same as that of Conte with the exception that a wall divides adjacent units (rather than simply open space between the two as at Conte.) There are two towers (C and D) containing 8-9 housing units. Women are housed on C tower; Men on D tower. Supervision is direct – a correctional officer is right on the unit in direct contact with the inmates. In some of the housing units (for the minimum inmates), the “cells” are multi-person and really just cubicles with partial walls that do not reach the ceiling with no doors. These are on the third floor of the facility and called “open” units. The 1st floor housing units are “closed” – contain actual multi-person cells.

There is a medical exam room on each housing unit. It is used for mental health appointments as well as nursing sick call. There is sufficient classroom/group treatment space in the hallway just outside but connected to the housing unit. This eliminates the

need for security escorts to programs as the inmates simply enter the central corridor where the programming space is located directly from the housing unit rather than having to be escorted to some other location.

C Tower, housing female inmates, contains units for disciplinary and administrative segregation. (Housing unit C4 contains 28 beds for disciplinary segregation and C5 is administrative segregation and has 20 beds.) At the time of the site visit, there were 8 women on disciplinary segregation, 3 were prescribed psychotropic medication (37.5%). There were 14 women on administrative segregation, 12 (86%) of whom were on psychotropic medication. This degree of difference between the prevalence of women on the mental health caseload in population and disciplinary segregation versus the very high prevalence of women on the mental health caseload in administrative segregation is remarkable and is ripe for a quality improvement study to determine the cause(s) – particularly in light of the evidence that inmates with serious mental illness do not do well in long-term segregation settings. Health care staff conduct a file review prior to placement in administrative segregation to determine whether there are any contraindications for placement or need for accommodation. The charts of inmates in administrative segregation contained the pre-placement documentation but none of them found contraindications to placement or recommended any accommodations. Inmate MD's confinement clearance form indicated she was on psychotropic medication, had a prior history of self-harm, was diagnosed with major mental illness and had been on behavioral health monitoring status within the preceding 90 days, but she was sent to segregation in spite of multiple risk factors and there was no documentation that facility mental health

staff were notified of the placement. (MD's case is summarized in the Appendix on page 53. Additional examples of inmates cleared for placement include inmates SM, DC and SD summarized on pages 54-55.)

Inmates in administrative segregation are reviewed weekly for 8 weeks by a multidisciplinary staff that includes the Director of Nursing; thereafter, the team reviews them monthly. A referral for mental health assessment is routine after 8 weeks of confinement. Inmates in segregation can be seen by mental health staff privately in a medical room located off the dayroom or at tables on the dayroom floor (which is not confidential.) Staff reported that inmates in segregation are permitted out of cell 1 hour per day, 7 days per week. Deputies supervising inmates in segregation units or other program units take 40-hour Crisis Intervention Team (CIT) training and have an annual refresher course as well.

There was a restraint chair in the hallway between segregation units. I asked about its use the Director of Nursing reported that it hadn't been used in at least the last 5 years. She further reported recalling only 1 instance of the need for a cell extraction during the 12 years that she has been at PRF.

Also, similar to programming at Conte, BSO Program staff at PRF provide SAP, Life skills Program and a Lifestyles program. There is also a GED program at PRF. BSO Program staff do not provide mental health treatment.

Armor mental health staff primarily provide psychotropic medication management. There is a Psychiatric Physician's Assistant at PRF four days per week, 0.8 FTE. A licensed mental health counselor is at PRF on Sundays. Inmates requiring crisis care or watch placement are transferred to NBB. Staff reported transfers are timely though I did not see any logs to quantify the timeliness of the transfers. There is a safe space in the intake area of the facility – a large cell that permits direct visibility into all areas from the officer's station immediately across from it (a "fish tank" cell.) This is used to temporarily house suicidal inmates until they are moved to NBB.

Systematic Screening and Evaluation

The Main Jail serves as the centralized intake and booking facility for the jail system. An initial screening is conducted by trained emergency medical technicians at the front door of the jail on every inmate entering the system. The initial screening process is intended to ensure that inmates are sufficiently medically stable to be admitted to the jail and to identify other critical needs such as drug withdrawal, the need for suicide watch and other conditions that require medical attention such as diabetes and hypertension. There are additional levels of medical and mental health screening following the booking procedure. Appropriately trained and credentialed Armor staff complete these assessments. Inmates who screen with a positive mental health screen are referred on for a more comprehensive evaluation.

Based on my review of many records, the measured prevalence rate of inmates with mental illness in the system and Armor's own quality assurance auditing, the processes appear adequate procedurally. However, there are some components of the process requiring focused improvement to facilitate access to the appropriate and necessary level of care at the earliest possible time, improve timeliness of identification and sustain adequacy.

The initial screening should contain a mechanism to divert not only inappropriate, critical medical conditions from the jail, but also divert cases of complicated drug withdrawal that require hospital management and expedite the referral of persons in need

of psychiatric hospitalization to that level of care. Several examples were found in record reviews.

Inmate LB was “agitated, bizarre” at the time of intake to the jail 7/28/16 to the extent that the mental health screening could not be completed, but he was accepted into the jail where he has steadily deteriorated. At the time of my site visit to NBB, he was locked in a closed mental health unit and appeared regressed to the point where he expressed no meaningful communication. (A full summary of his case is found in the Appendix on pages 24-25.) This is an example of a person that should have been immediately referred to a psychiatric hospital after being processed rather than being maintained at the jail. (Florida state law requires persons arrested for a felony be processed through a jail before going to a psychiatric hospital, although acceptance into the hospital is not guaranteed. Nevertheless, the jail has to refer these cases immediately after processing rather than maintaining them in the jail for weeks or months before contemplating attempts to psychiatrically hospitalize.)

Inmate CB had a history of substance abuse and treatment for depression. This information was known at the time of his booking into the jail, but his mental health referral was “routine” although he was placed into a detox unit. Therefore, he was not evaluated by mental health prior to his death by suicide the following day. Substance abuse and treatment for depression are significant risk factors for suicide and should have triggered an immediate mental health referral for a suicide risk assessment. The suicide death was reviewed but processes to triage and prioritize mental health referrals for

suicide risk assessment of individuals with psychiatric history and drug withdrawal have not changed and do not include an immediate referral when these factors are present.

(The full summary of CB is found on pages 64-65 of the Appendix.)

Attempting to psychiatrically hospitalize inmates in need of a higher level of care than can be provided in a jail at the earliest possible time is particularly important for several reasons. One reason is to be able to ensure that care is provided timely so that the response to treatment is timely and the response to treatment is better the sooner that treatment is started. Another reason is that as inmates continue to deteriorate and become increasingly ill, civil hospitals are less likely to agree to take them which makes timely access to inpatient care essentially non-existent. The clinical need for psychiatric hospitalization takes a back seat to containment – civil hospitals will not accept “violent” jail detainees and even the Baker Act⁵ pre-screeners who come to the jail to determine whether or not to approve inmates for admission to the hospital seem to believe that holding people in segregation, or a closed mental health unit or a in a crisis cell, without treatment is the equivalent of psychiatric inpatient care and don’t approve the transfer to a hospital level of care. (This will be discussed more fully in the treatment section of the report relating to hospitalization.) After the inmate is denied access to a hospital level of care by way of the Baker Act, the only effective means of accessing care requires a legal finding of incompetence to stand trial, but that generally doesn’t happen until after months

⁵ The Baker Act is the Florida law regarding involuntary psychiatric hospitalization and pre-screeners come to the jail to determine eligibility for hospital admission when Armor mental health staff file an application for hospital admission.

of a jail stay, severely delaying access to care. Delayed access to hospital level of care leads to worsening of symptoms increasing the risk of harm to self and others, a delayed response to treatment and a less robust treatment outcome.

Multiple instances of persons being considered too psychiatrically ill, uncooperative or unsafe to complete the medical intake process were discovered in record reviews. In these instances, medical assessment forms were simply marked as “refused” or “unable to complete.” There was no documentation that the intake evaluation was completed at a later point in the inmate’s jail stay, regardless of the length of stay. Persons with serious mental illness can also have serious medical problems that must be assessed and treated. Failing to do so can have disastrous consequences.

Inmate RP was unable to be screened at the time of intake because he “sits there and talks to himself, won’t answer questions.” The health assessment form has a line drawn across the page diagonally with the word “Refused” hand-written on the paper as well. RP was accepted into the jail and housed in NBB mental health units. He displayed signs of serious medical problems that included significant weight loss, blood in his urine and swollen feet with “wounds” according to the mental health PA. Eventually, RP was sent out to a medical hospital where he was admitted to the intensive care unit. When he returned to the jail after his hospital stay, he was initially admitted to the NBB infirmary, but then sent to closed mental health. He remained there until he was discovered unconscious and subsequently, he died. (RP’s summary is on pages 68-69 of the Appendix.) RP was in the

jail in 2012, but current record reviews demonstrate that these types of problems continue to exist.

Inmate SO was physically ill when booked into the jail 3/22/16, having been hospitalized medically just prior to his booking. He had cirrhosis of the liver, ascites, varices and hepatosplenomegaly. Nevertheless, he was admitted to a detox floor and remained there for the duration of his time in the jail. His physical condition continued to deteriorate. On 3/25/16, he was found face down on the floor with labored respirations and unable to get up without the assistance of two other people. He was kept at the jail on the detox unit another 10 days until an emergency transfer out to the hospital. He did not return to the jail. (SO's case is summarized on page 74 of the Appendix.)⁶

The above cases are relevant to mental health care because they exemplify the problems with access to appropriate medical care when housed in mental health or detox units which is why the medical assessment at intake is so important – and cannot be left undone or incomplete.

ED, an inmate with serious mental illness in jail since 7/18/16, never had a medical assessment completed. Initially, he refused it and then the medical health assessment form contains “behavior inappropriate” written across the second page dated 8/1/16. As of the

⁶ BSO reported that this case is in litigation and the facts are subject to dispute.
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time of his file review in November, the assessment remained undone. (Inmate ED's summary is on pages 12-13 of the Appendix.)

The Armor quality assurance audits of the mental health intake process are quantitative in nature and contain no measure or assessment of quality. The audits consist of questions that address completion of forms, whether referrals are seen, and compliance with time frames articulated in policy that require only a "yes" or "no" finding. Additional multi-step items such as whether medications requiring laboratory testing have those multiple labs ordered, drawn, reported and reviewed, contain only one simple "yes" or "no" response which doesn't permit an analysis of whether there are problems at any step in the process or with a particular medication or lab study. Inmates may be on multiple medications that require multiple types of laboratory studies. The presence or absence of other forms, such as the treatment plan, provides no indication of whether the plan is complete, individualized, meaningful or relevant.

Staffing levels and task assignment impact the quality of psychiatric assessments completed at the Main Jail. The assessments are cursory due to insufficient staffing and the delegation of this task to the psychiatrist and ARNP at the Main Jail, rather than including other licensed mental health staff that are permitted to assess and diagnose mental illness by virtue of training and state law. (The part-time licensed mental health counselor does do some initial psychiatric assessments, but diagnosis and treatment plans are left to the prescribing professionals. The full-time psychologist does detox evaluations and some counseling.) In addition, there is potentially an issue with regard to whether the Main Jail

psychiatrist has a tendency to minimize inmate psychiatric complaints and/or attribute their reports of symptoms to malingering for secondary gain. There were many examples of this tendency. One case, inmate CS entered jail 4/27/17. He was tearful at the time and facing charges of murder. ARNP Keane did the initial mental health evaluation 4/28/17. The psychiatrist saw the inmate 5/1/17 and diagnosed "adjustment disorder with depressed mood" though both antidepressant (Celexa) and antipsychotic (Risperdal) medications were ordered for him, which would seem to indicate something more severe than an adjustment disorder. Eventually, the diagnosis was updated to Major Depressive Disorder with psychotic features, but the case exemplifies my concern regarding the tendency to minimize symptomatology, diagnoses and draw conclusions about secondary gain – and particularly the psychiatrist at MJ – the front door to services. (The CS case is summarized on page 39 in the Appendix.) Other examples include HB (page 2 in the Appendix), CW and LT (page 34), W (pages 36-37) and RA (page 41). This issue should be monitored and addressed with a meaningful peer review process, and although there are other mechanisms for referral and assessment later in an inmate's jail stay, identification at the front door is absolutely critical to ensure timely access to care. Delays in accessing care increases the risk of worsening symptoms and increased suffering and the risk of harm to self and others. Sufficient staffing levels to permit a more time to conduct these evaluations would also be helpful as would permitting rotation of psychiatric staff to perform this task at intake to prevent burn out.

It was often difficult to determine whether or not outside treatment records were requested, much less received and reviewed in many of the charts I reviewed. Armor staff

reported that many times even when records are requested, outside treatment facilities do not send them. This seems to have had the effect of discouraging the process of requesting such records (in spite of a policy requirement to request them) rather than stimulating a discussion with outpatient treatment providers to send the records. Review and incorporation of information contained in outside treatment records permits a more well-rounded assessment of diagnosis and functional capacity than can be completed with a 15-20-minute examination in a jail where the only information is self-report and it improves continuity of care, particularly with regard to psychotropic medication management. It is particularly important to verify outside medication prescriptions and there appears to be no reliable process to do this in every case of an inmate booked into the jail. Medication continuity is important for patient care to maintain stability or improve condition with a medication known to have worked in the past rather than starting the process from scratch over and over with different medications, risking a re-emergence of symptoms, needless suffering and increased risk of harm to self or others as a result of decompensation.

Additional examples of problems with failing to get or consider information from outside treatment records include inmate II who was transferred directly into the jail from the South Florida Evaluation and Treatment Center, where he had been hospitalized for 3 ½ months. Upon reception at the jail, II refused his initial health assessment including a test for tuberculosis. For this reason, he was housed in an infirmary isolation cell from 7/29/16 “until further notice.” II was still in that infirmary isolation cell at NBB at the end of August when I visited the jail. When I learned he had come directly from the state hospital, I asked to see the records and in fact, II had a tuberculin skin test at the hospital –

which was negative. He did not need another one at the jail and he did not need to be kept in isolation in the infirmary. The records from the hospital were actually at the jail but had not been reviewed which led to housing II in infirmary isolation unnecessarily. After my site visit, II was relocated to general population housing. (II's case is summarized on pages 13-14 of the appendix.)

Inmate MW had a long-standing diagnosis of schizophrenia and received outpatient care, including psychotropic medication, at the Veterans Administration (VA). He refused to take psychotropic medication in the jail until the VA records came to the jail to verify the medication regularly prescribed to him. He signed a release of information to get the records. MW explained this to me in August 2016 and again in February 2017 and it is also documented in the progress notes of his chart; he was waiting for verification of his medication from the VA and said he would take that medication, but not other substitutes. When I inquired whether the VA records had arrived, Armor PA Shootes checked and found a stack of records from the VA that was about 2" tall. It was not clear when they arrived, but it was clear that they hadn't been reviewed. MW was prescribed a small daily dose of Seroquel from the VA. PA Shootes told me that it was not on formulary and she would not make a non-formulary request. MW remained psychotic in the jail, outside treatment records were not reviewed when they arrived and in spite of verification of a valid prescription, Armor refused to prescribe the medication for him. (MW's case is summarized in the appendix on page 17. His case also illustrates issues around psychotropic medication which are more fully described in a later section of this report.)

Inmate P was housed in administrative segregation when I saw him 2/9/17. He had been returned from the state hospital after a 3 ½ month stay and underwent intake to the jail 1/4/17. The only information that accompanied him from the state hospital was a medication list. Medications were ordered at the jail as the “inmate is well known to jail from prior stays.” There was no indication that any additional information about his hospital stay was requested. When I spoke with him, he was clearly psychotic and provided irrelevant and mostly incoherent responses to questions. Continued confinement in administrative segregation, which makes symptoms worse, was contraindicated. Review of hospital records describing the inmate’s condition there, progress in treatment and interactions with others is useful information in determining housing placement at the jail. If Armor mental health staff gave any consideration to his placement in segregation being contraindicated based upon his being a state hospital return and current psychotic mental state, it was not documented in the record. (Inmate P’s case is summarized in the appendix on pages 37- 38.)

Failure to request and review outside treatment records can result in delayed access to care or even denial of effective treatment; it prolongs jail stays and leads to needless suffering and mental decompensation increasing the risk of harm to self and others. Requests for outside treatment records should be made at the time of intake/reception into the jail which is why these case examples are provided in this section of the report although much of the same information is also relevant to the later section on Records. Actually reviewing outside treatment records and considering the information contained in

them are equally important with requesting the records in developing a timely and clinically appropriate treatment plans for inmates in the jail.

TREATMENT

Treatment is more than mere seclusion or close supervision. Jail inmates with serious mental illness must have access to the continuum of mental health care, including timely access to an inpatient level of care. Inmates in the Broward County Jails are not given access to adequate mental health care. Access to inpatient care is nearly non-existent except when court ordered for restoration of competence to stand trial.

Deficiencies related to the provision of mental health treatment have been grouped under separate headings and sub-categories though there are items that may cut across several areas.

Outpatient mental health care

This level of care is analogous to outpatient care in the community. Patients are clinically stable, and their behavior and functioning are not impaired or only mildly impaired. Patients function well in a community setting and have periodic appointments with a mental health professional that may include a mental health counselor and a psychiatrist (or other person licensed to prescribe medication.) The frequency of appointments is based upon the clinical stability of the patient as well as the type of treatment interventions being provided and may range from weekly group treatment or counseling appointments to monthly support sessions and quarterly medication management appointments. In the community, mental health staffing levels are sufficient to be able to respond quickly to crises and increase therapeutic contacts until the crisis is resolved. Unfortunately, this is not the manner in which outpatient services are provided

in the jails. Although the majority of inmates with serious mental illness are housed in general population and receive outpatient care, there are insufficient numbers of Armor staff to provide an adequate level of treatment service to inmates with serious mental illness residing in general population; there are no mental health groups offered and individual counseling is not available to the vast majority of inmates on the mental health caseload.

Outpatient care at the Broward County Jails consists almost exclusively of psychotropic medication if the inmate consents to take it. There is virtually no other mental health treatment as a consequence of insufficient staffing, both in terms of the types of mental health staff providing services as well as the numbers of staff to provide care to the majority of inmates. Inmates are seen at intervals of three months for medication management and have a brief monthly contact with a mental health counselor, although sometimes these two types of visits are combined into one contact to ensure that everyone on the caseload gets seen. There is not enough psychiatric⁷ time to provide adequate assessment and follow-up in response to clinical need. Mental health clinician positions are also severely deficient. Conte and Paul Rein Facilities each have a mental health counselor available only one day per week for a combined population of approximately 1700 inmates, more than 550 of whom are on the mental health caseload. Outpatient treatment plans are meaningless; purport to offer services that simply don't exist; contain no measurable

⁷ In this section, the term psychiatrist is intended to include psychiatric physicians as well as mid-level providers (ARNPs and PAs).

objectives; and are never updated to reflect any change in the inmate's condition (suicide watch placements, transfers to NBB, etc.) no matter how long the jail stay.

Inmate AR is housed at Conte and receives outpatient services. He is seen monthly by the mental health counselor who completes a Mental Health Rounds/Contact Form and is prescribed antipsychotic medication. The medication was increased 5/8/17 because he reported a worsening of symptoms. However, there was no plan for more frequent contact by either the counselor or psychiatrist to determine whether the dose increase was effective or to provide any other mental health intervention in response to the inmate's break-through symptoms. (AR's case is on pages 45-46 of the Appendix.)

DI was housed in disciplinary segregation at the time of the PRF site visit. Her initial mental health evaluation was dated 2/17/17 and she was diagnosed with an anxiety disorder. She was prescribed Atarax for anxiety. In March, the medication was discontinued, and she was prescribed a different medication, Buspar. The dosage of Buspar was increased at subsequent psychiatry appointments 4/12/17 and 5/10/17 because the inmate reported continued symptoms of anxiety. No other treatment interventions were provided; no counseling, no group or individual therapy. The frequency of contacts was not increased in response to continued symptoms. The treatment plan, dated 2/16/17 (the day before the mental health evaluation was dated), was not updated or changed in any way. (A more complete summary of DI is found in the Appendix, pages 52-53.)

Inmate HA was sent from the Main Jail to NBB 4/8/17; from NBB to PRF 4/13/17; from PRF back to NBB saying she didn't want to live anymore; and returned from NBB to

PRF 4/26/17. She was housed in administrative segregation at the time of the site visit. HA was not seen for follow-up from having been on suicide watch until 4/30/17, four days after returning from NBB. She was not seen by psychiatry until 5/11/17. HA has been bounced back and forth between facilities, but her treatment plan is not changed, she has no treatment except medication and is currently housed in administrative segregation. (HA case is summarized on page 55 of the Appendix.) HA also reported that she stopped taking her medications because she felt she no longer needs them. HA presents multiple risk factors for suicide – history of psychiatric hospitalization, prior suicide watch placements, non-compliance with medication, placement in administrative segregation to name a few. Yet, there is no change in the frequency of intensity or types of contacts, support or closer mental health monitoring of her condition.

Maintenance care and access to care at an early stage of a problem or at the earliest sign of symptom recurrence can prevent the progression to a full-blown crisis, suicide watch, transfer and admission to NBB or need for inpatient level of care. Infrequent contacts and Armor staffing levels do not permit the provision of this level of care – patients not identified early and even if identified, do not receive additional outpatient interventions, more frequent contacts or mental health support and monitoring. Clinical studies have demonstrated that the effects of psychotropic medication are enhanced when combined with other forms of mental health treatment. Outpatient services are inadequate and this places inmates with mental illness at risk of harm to self or others and to experience needless suffering.

Outpatient mental health clinicians should play a role with security staff in attempting to de-escalate crises in instances when a planned use of force is contemplated. This can help in avoiding the planned use of force, which can result in injuries to inmates and staff. (Obviously, this is not applicable in a spontaneous or reactive use of force situation.) This function is not articulated in BSO or mental health policy and I found no documentation that this function occurred in the clinical records reviewed.

Mental health clinicians should also play a consultative role in the disciplinary process for inmates on the mental health caseload or for any other inmate for whom there is a concern about his or her understanding of the process, behavior or mental condition. Such consultation may lead to temporary or permanent diversion of the inmate into residential mental health treatment or hospitalization if the behavior is believed to be a manifestation of serious mental illness. In other instances, an alternative sanction to confinement in segregation may be proposed. I did not find this function articulated in BSO procedures or Armor policy. I understand a similar type of informal consultation may occur some of the time in some situations, but it needs to be formal, routine and occur in all relevant situations. This can lead to early identification of symptom recurrence, diversion into treatment and risk reduction through treatment interventions aimed at addressing the problematic behaviors rather than placement into segregation which is harmful to inmates with serious mental illness and simultaneously makes access to them more difficult due to the required security precautions in effect in those areas.

Mental health services in segregation units

There is growing recognition within the corrections profession of the harmful effects of segregation, particularly on inmates with serious mental illness though others also experience harmful psychological effects. Inmates entering segregation should be screened for contraindications to segregation placement. In general, inmates with serious mental illness should not be placed in segregation for prolonged periods of time. (The 2012 Position Statement of the American Psychiatric Association defines a prolonged period of time as 3-4 weeks.) In response to the growing recognition of the harmful effects of segregation on inmates with serious mental illness, some correctional systems have developed high security living units with intensive mental health care into which inmates can be diverted for placement when necessary for the safety of others or as a consequence of a rule infraction rather than being sent to segregation. In systems or facilities without this option, there is recognition that if inmates with serious mental illness are put into segregation even for a short period of time, mental health treatment must continue in accordance with the services on the treatment plan or be enhanced based upon the clinical state of the inmate and the conditions of confinement. Mental health staffing levels have to be sufficient to conduct regular rounds in segregation and clinical interventions when necessary for other inmates housed there.

Current staffing levels in the jails are not sufficient to provide adequate mental health care to inmates in segregation. Firstly, although there is a medical screening conducted in the jails prior to segregation placement, it appeared rote and did not lead to

diversion of inmates with serious mental health risk factors from being placed in segregation. In fact, it didn't appear to result in notification of mental health staff of the placement of the inmate into segregation which is critical in terms of continuing mental health care during placement in segregation. My sample was small but the process seemed to be done to comply with policy requirements rather than with an understanding of the importance or purpose of doing the task.

The "Use of Confinement/Restraint Clearance" form in the chart of inmate FJ indicated she has a major mental illness but it did not preclude her placement into segregation or ensure any additional mental health contact or monitoring when she was there. In fact, it did not indicate that mental health staff had been notified of her placement in order to assure the provision of regularly scheduled on-going care. (FJ summary is on page 53 of the Appendix.)

Inmate DC was placed into segregation 5/4/17. Pre-placement screening indicates "Yes" in responses related to being on psychotropic medication, having major mental illness and being on special accommodation (detox protocol). However, she was still "cleared" for confinement and mental health was not notified. (DC summary is on page 54 in the Appendix.)

Inmate SD was on suicide watch at NBB 4/6/17 - 4/17/17 for having placed a plastic bag over her head in an attempted suicide. The watch was reduced to psych observation until 4/20/17. She was transferred to PRF 5/11/17 and was placed into

segregation. Pre-placement clearance indicates “Yes” responses to history of self-harm (plastic bag over head) and behavioral health monitoring status in the last 90 days. She was not excluded from placement in segregation, nor was mental health staff notified of the placement. (SD’s case is summarized on page 55.)

If not diverted altogether, it is imperative that mental health staff are at least notified of the placement of caseload inmates in segregation – an area where proportionately more suicides are completed in correctional facilities of all types. As it stands, mental health staffing levels at the jails permit only brief, cell front contacts (rounds in segregation), but minimally, mental health staff should be aware that their patients are in segregation and at risk.

Mental Health Unit (MHU) Residential care – NBB

The mental health units at NBB purport to be treatment units, but deficient staffing levels, inadequate confidential treatment space and overall failure to appreciate the mission of residential treatment per se, make these open mental health units simply an extension of any other general population outpatient housing. The conditions of confinement in the closed mental health units actually appear to mimic the conditions in segregation along many parameters (limited out of cell time, cell front contacts, limited socialization) rather than intensive treatment settings.

Treatment modalities in correctional facility residential mental health housing units generally include psychoeducational groups, psychotherapeutic groups, psychosocial and

activity groups, individual counseling and medication management. At NBB, there is virtually no treatment except medication for the majority of inmates sent there for mental health treatment. A very few inmates received occasional supportive counseling sessions, but even these are not conducted in a confidential setting. Individual appointments are conducted at a table in the common area of the housing unit, in the hallway outside of the housing unit or at the cell front.⁸ Confidentiality is a necessary requirement for all of health care, but particularly mental health care. BSO program staff provide psychoeducational programming in two of the open mental health units though this is limited to inmates that are stable and considered “programming” rather than “treatment” according to staff.

There are no clear admission or discharge criteria from the NBB mental health units. There are no regularly occurring treatment team meetings. Individual inmate condition, progress toward goal attainment and adjustment of interventions to achieve desired outcomes should be reviewed by a multidisciplinary treatment team at regular intervals and anytime there is a change in the inmate’s condition. Every inmate should have an updated treatment plan when admitted to the mental health units. As with outpatient services, the treatment plans in the mental health units are meaningless. They do not reflect services actually provided or available contain no objective criteria by which to measure progress and are not updated to reflect a change in the inmate’s condition, placement or diagnosis. There are no treatment program guidelines with respect to the

⁸ This practice appears unchanged since at least 2006 when Dr. Metzner recommended it be addressed.

types and frequency of treatment interventions to be provided in the open and closed mental health units. There has been a long-standing recommendation that inmates in residential treatment be offered at least 10 hours of unstructured out-of-cell time and 10 hours of out-of-cell structured therapeutic activity per week. The BSO staff programming units exceed these guidelines and the other open mental health units provide more than the requisite 10 hours of unstructured out of cell time. The closed mental health units provide neither.⁹ There are no practice guidelines for transitioning inmates out of the mental health units back into population. (Preparation of the inmate for the discharge, frequency of contacts in the new jail, etc.) The lack of transitioning can have severe consequences.

Inmate JV entered jail 2/15/13 as a state hospital return with diagnoses of “malingering, adjustment disorder with mixed anxiety and depressed mood.” While in booking, he was found trying to hang himself. He was placed on suicide watch and admitted to the infirmary in the Main Jail. He was transferred to NBB on suicide watch.

JV remained at NBB for a little over a year and was “transferred per classification request to MJ” on March 3, 2014 though the transfer acceptance form was not completed at the Main Jail until March 7, 2014. (He appears to have been released to population at NBB for a matter of hours prior to being sent to population in the Main Jail.) JV committed

⁹ This also appears unchanged since Dr. Metzner’s criticism of it and recommendations made in 2006.
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suicide by hanging at the Main Jail on March 8, 2014. (JV's case summary is on pages 67-68 of the Appendix.)

The NBB mental health units fail to provide mental health treatment interventions other than psychotropic medication for the majority of inmates sent there for treatment. BSO program staff provide daily program groups on two of the open mental health units as described earlier in the NBB section of this report, each of which houses 21 inmates. However, programming in the closed mental health units is especially problematic. Coincidentally, inmates in the closed mental health units are also by and large, the most seriously ill and symptomatic. There is little structured programming offered in the closed units and inmates can remain there for months and months and months, suffering and without treatment of their serious mental illnesses. Some of these inmates refuse medication and the jail cannot override their refusal. Consequently, they are too ill to participate in what little structured treatment is offered (an "open" mental health group) and sometimes too ill and/or dangerous to be let out of their cells for any opportunity for other psychosocial interactions or individual assessment or counseling. Some of the inmates in closed mental health were in need of psychiatric hospitalization.

Inmate LB was mentioned in the Screening and Assessment section of this report, but his case is also relevant here and as an example of an inmate in desperate need of psychiatric inpatient care. When seen in his closed mental health unit cell, LB was making guttural sounds and wearing something that looked like a diaper or swaddling shorts. He appeared very regressed and didn't verbalize anything that was comprehensible as speech.

The inmate had been locked in what amounts to segregation for almost a year with no treatment interventions. There was no documentation that psychiatric hospitalization was being considered. Mental health staff stood outside his door periodically to round on him. LB was too regressed for meaningful interaction or communication. (A more complete summary on pages 24-25 of Appendix.) There is no way that this man would be able to appear in court in this condition, nor could there be any sort of release planning if his charges were dropped. (Note that the Defendants reported that LB was transferred to the state forensic hospital on 5/26/17. I believe this was for restoration of his competency to stand trial rather than as a result of a Baker Act commitment given his condition and pending felony charges which would allow civil hospitals to refuse him admission under Florida law.)

In summary, there are a number of serious issues in the MHU. Non-compliant and acutely severely mentally ill inmates who refuse medication and are denied access to inpatient care must wait until they are sent to a state hospital for restoration of competency to stand trial before they receive treatment is the most serious of the issues. It is a constitutional violation. While the BSO and its contractor cannot control whether or not civil hospitals agree to accept seriously mentally ill inmates, there are other options that are not routinely exercised that would address and if not eliminate this issue, would certainly ameliorate the suffering. A partial list of these options includes, enacting an internal involuntary medication process (discussed more fully in the Medication section *infra*), initiating guardianship proceedings to seek guardian permission to medicate over the ward's objection, increased out-of-cell structured treatment programming,

individualized treatment planning and treatment team meetings for every inmate to increase intensity, frequency and types of interventions in order to engage the inmate in treatment participation. Other options are also possible as well. As currently operationalized, as inmates with serious mental illness refuse medications and deteriorate, treatment interventions are reduced rather than intensified; the inmate is held in closed mental health housing units and staff see him only at the cell front.

Access to inpatient care

Access to inpatient level of care for patients who desperately need it is profoundly lacking and appears to be a long-standing problem as it was also a focus of concern at the time of Dr. Metzner's report in 2006. The jail doesn't provide the types of services available in a hospital and BSO and Armor staff acknowledge that use of Florida's civil commitment process (the Baker Act) is not a reliable path to hospitalization. Inmates charged with violent felonies are not eligible for hospitalization via the Baker Act. These inmates must wait months to access a hospital level of care until being found incompetent to proceed with their criminal court case. During my visits to the MHU and infirmary, there were many inmates in need of hospital level of care. Generally, BSO and Armor mental health staff agreed that these inmates were in need of hospitalization. In some instances, they had initiated Baker Act proceedings, but the receiving facility assessors refused hospital admission. In other instances, staff knew that even attempting to use the Baker Act was futile and were simply waiting for the criminal court to find the inmate incompetent and order hospitalization for restoration of competency.

The route to civil commitment via the Baker Act is nearly unavailable to inmates in the jail: receiving institutions can refuse admissions based upon their assessment that the patient cannot be managed safely in their facility and the North Broward Hospital District will not admit inmates with pending felony charges. There also appears to be some strange equivalency between being held in segregation-like status at the jail with no treatment and inpatient psychiatric care in the minds of many of the Baker Act receiving facility “assessors” which is absolutely ridiculous and defies the obvious difference between jails and hospitals. While it may be tempting to simply say that some of these factors, such as the Baker Act itself and the receiving facilities’ refusal to accept inmates, are wholly outside the BSO’s control and therefore, the BSO should not be held responsible or accountable for failing to provide timely access to inpatient care, their responsibility is not so easily dismissed. Armor’s contract with the local hospital system covers many medical specialties but is silent with respect to psychiatric inpatient care. Inmates needing a hospital level of care are held in the jail and receive less, rather than more intensive treatment or attempts at treatment than other, less ill inmates as has previously been discussed; contacts are at the cell front, frequency and types of contact are not increased, the treatment plan is not reviewed/updated. Nominally, increasing the frequency and intensity of treatment modalities and contacts is required while awaiting inmate transfer to a more appropriate level of care.

Inmate DW came into the jail from the state hospital 4/15/15; was on watch multiple times and for extended periods of time. When not on watch, he was housed in closed mental health and seen only for weekly rounds at the cell front. Notes indicate he

“didn’t engage” and that is the extent of treatment summary. He attacked staff, or tried to attack staff, but was given no medications. He was considered too violent to take out of his cell for any sort of mental health assessment or treatment. He was considered too unpredictable and violent to go to the clinic but was let out to the visiting room to see the outside psychologist sent to do a competency evaluation – and he tried to attack that person. This is an example of a case that makes little logical sense. The jail received this man from a state hospital. He refused treatment at the jail and clearly decompensated. He was housed in isolation, both in closed mental health and in the infirmary and staff (BSO and Armor) were essentially powerless in terms of getting him treatment. They could not or did not involuntarily medicate; DW was considered too violent and unpredictable to civilly commit via Baker Act and so he continued psychotic, suffering and highly symptomatic to the point where medical and mental health staff could only attempt to interview him from outside the cell due to the deputies’ concerns for staff safety. He presented such a high risk of harm to others that he was not permitted out of cell to attend medical or mental health appointments. Finally, and only by virtue of his severe decompensation, DW was transferred to an outside treatment facility 9/22/16, but it took more than a year of needless suffering, untreated mental illness and dangerousness towards others to get to treatment. Jail inmates must have access to a hospital level of care. (A more complete summary of DW is on page 60 of the Appendix.)

In the case of TD, Armor staff did attempt to have him evaluated for a hospital admission pursuant to the Baker Act. Inmate TD underwent intake into the Main Jail 9/8/16 and was housed in the infirmary and then the detox unit for several days. TD was

on suicide watch 9/16/16-9/25/16; 10/3/16-10/24/16; 11/21/16-11/23/16; 11/25/16-12/3/16; 12/8/16-12/19/16 and again 12/27/16. He was moved into the NBB infirmary on suicide watch 2/1/17 because he was not speaking or eating. The inmate's body weight and other vital signs were not routinely collected either by virtue of the inmate's refusal or the deputies' not permitting nursing staff to enter the inmate's cell to examine him. Armor staff did attempt to send him to a civil hospital in February, but the Baker Act pre-screener wrote: "The client is currently in a highly monitored and secured institution that would afford a greater degree of safety than any community inpatient facility. As such, the assessing clinician determined the client does not currently meet the full and necessary criteria for an involuntary psychiatric assessment at a community inpatient psychiatric facility while remaining in a highly secured and monitored setting as that of the BSO Detention Facilities. This assessment should not in and of itself be interpreted to justify the client's release or continued placement on any suicide watch process." (Of note, the pre-screener did not interview the inmate because he refused to come out of the infirmary cell for an interview.) The pre-screener's conclusion that an inmate who has been on multiple suicide watches for extended periods of time, who is refusing treatment, food and to communicate doesn't meet the "full and necessary criteria for involuntary psychiatric assessment" is preposterous. BSO and Armor staff reported that hospitalization had been denied by the pre-screener for similar types of conclusions on many other occasions as well. Ultimately, denying hospitalization for these types of reasons has a chilling effect on the willingness of BSO and contract staff to even attempt to use the Baker Act; there is no point in doing so if the hospitalization is going to be denied. Waiting for the criminal court to act on trial competency is a much surer path to hospitalization even though it can take

months to accomplish. TD is suffering needlessly and at risk of serious illness or death. (TD's case summary is on page 29 of the appendix.)

Lack of access to hospital level of care is a long-standing problem. I reviewed records of inmate WH who died in 2012 after a hunger strike that lasted more than 40 days. He was originally admitted to the jail 10/26/12 though he was there previously and treated with antipsychotic and antidepressant medication. He was identified as having a psychotic disorder not otherwise specified and bipolar disorder "by history." He said he was fasting as part of some "spiritual belief" and placed on suicide watch. He continued to fast and was medically hospitalized for 5 days in November due to electrolyte abnormalities and compromised kidney function (consequences of prolonged fasting.) WH was returned to the jail 11/13/12 and housed in the infirmary. No lab studies were drawn at the jail and no medications were ordered for him. The medical center's psychiatrist planned to petition for a civil commitment via the Baker Act but WH was returned to the jail where the discharge planner asked the criminal court to move up the date of a court appearance in hopes that the judge would send WH to a hospital for competency restoration. The hearing date was moved up to 11/16/12 but WH collapsed in police custody that day. He was transferred as an emergency to the hospital where he was admitted medically. WH never regained consciousness and died 12/23/12 due to complications of electrolyte imbalance due to prolonged fasting. (WH's case is summarized on page 73 in the appendix.)

Inmates with serious mental illness are suffering needlessly. The risks of untreated serious mental illness are increased and include self-injury, suicide, assault and injury to other inmates and staff. Furthermore, when treatment is delayed, it takes longer for symptoms to improve and the improvement is not as robust as it would otherwise have been if treatment had been provided more timely. It's absolutely inhumane. Short of a change of the state civil commitment procedures, I don't see a solution other than the jail contracting directly with an inpatient provider to permit admissions of jail transfers or opening their own inpatient unit, which is not feasible.

Integrated Care

Chart reviews demonstrated that there are problems with integrating/coordinating medical care for inmates with serious mental illness. At the time of intake, if the inmate was highly symptomatic or uncooperative with medical staff, the medical assessment was not completed. It did not appear to have re-attempted at a later date and the inmate never received the medical assessment in some instances. Case examples were provided in the screening and evaluation section of the report.

There were issues with access to medical care for inmates with serious mental illness confined in the closed mental health units at NBB. This was noted in one particular case summarized, but also recognized to be an access problem by the medical doctor. SB had serious mental illness at the time of his booking into the jail in mid-February 2016. He was initially admitted to the detox unit but transferred to NBB and placed into a closed mental health. He experienced some mental changes (delusions and delirium) that were

attributed to his mental illness, but he also complained of abdominal pain and had tenderness, low blood pressure, elevated heart rate, vomiting, diarrhea and became incontinent of urine and stool. He was eventually admitted to the infirmary but should have been sent out for emergency medical care. He died of peritonitis due to a bowel perforation. In this case, neither his psychiatric condition nor his physical condition was appropriately assessed or treated promptly. In reviewing the case, the medical services physician at the jail concluded "diuretics should be avoided in close mental health where labs are not regularly and often monitored specially if on multiple BP meds." Oddly, rather than address the very serious issue of access to permit regular monitoring and laboratory studies, the proposed solution was to limit blood pressure treatment options though this is fairly indicative of the way other cases of patients with both psychiatric and medical issues have been managed. (SB's summary is on pages 65-67 of the Appendix.) The case of RP was also mentioned in the Screening and Assessment section of the report. He was the inmate with severe weight loss and blood in his urine that was sent to the intensive care unit but put back into closed mental health back at the jail where his access to medical care was impeded. (RP's case summary is on pages 68-69 of the Appendix.)

Finally, there were cases in which acute changes in mental state were incorrectly attributed to psychiatric illness. In some instances, this occurred during substance use withdrawal but in others, there were serious metabolic problems.

AF was booked into the jail and placed on a withdrawal protocol. She had a history of having had a withdrawal seizure in the past. Notes from the nurse indicate she was

“very jaundiced” 5/18/16 at 1800; she was incontinent of urine and feces 5/18/16 at 0300, and disoriented and “inappropriate” so no labs were drawn. AF was unresponsive around midnight with no vital signs 5/18/16 and transported out by EMS after midnight on 5/19/16. AF’s case review raises concerns about the way in which acute changes in mental status are managed at the jail. (AF’s summary is on pages 73-74 of the Appendix.)

TB was booked into the jail 5/27/16. He had a history of schizoaffective disorder and had previously been a patient at the South Florida Evaluation and Treatment Center (SFETC). He was placed on psych observation 5/28/16 and sent from the Main Jail to NBB. On 6/8/16, there was a determination that the inmate had bilateral pneumonia. He was transferred out to the hospital’s emergency department but refused care. He was returned to the jail the same day and placed in the NBB infirmary. On the same day, a Baker Act certificate was completed indicating the inmate was “medically cleared” for psychiatric admission, though this does not appear to be the case since he had pneumonia and refused treatment. At 1605, the Baker Act team and EMS took the inmate to BGH. It does not appear from the record that he ever returned to the jail. (TB case summary is on pages 63-64 of the Appendix.)

Finally, in the case of MV, summarized on pages 61-62 of the Appendix, the medical physician was advocating for an immediate transfer to a psychiatric hospital. However, the inmate in question had very serious medical problems and had recently been medically hospitalized. He should have been sent out for medical stabilization. As it was, he died after a second emergency medical hospitalization when found “unresponsive and gasping”

at the jail - - - not a consequence of mental illness but rather, a serious medical condition. He was housed in closed mental health and was not eating, but his metabolic issues were not addressed. The proposed solution was transfer to a psychiatric hospital.

Regular multidisciplinary treatment team meetings that include participation of medical and mental health providers for every inmate with co-existing serious medical and mental health needs are necessary to reduce the risk of worsening physical condition and death.

Continuous Quality Improvement

A Continuous Quality Improvement (CQI) program is the process utilized in health care organizations to assess a number of parameters including timeliness of treatment, appropriateness of treatment interventions, cost efficiency and patient response to treatment, among other parameters to identify trends and patterns to determine whether a corrective action is required to improve care. It includes comprehensive reviews of critical incidents and deaths, process and outcome studies, professional peer review and patient satisfaction.

At the time of Dr. Metzner's 2006 report, the program was relatively new at the jail and he had a number of suggestions of quality improvement studies that included:

- Timeliness of new admissions receiving prescribed psychotropic medication
- Participation rate of inmates participating in structured therapeutic activities in the closed mental health units with focus on how rate could be increased

- Increasing structured therapeutic out-of-cell time and unstructured out-of-cell time offered on a daily basis to inmates on the closed mental health units
- Treatment interventions related to inmates refusing psychotropic medications
- Clinical course of inmates returning to jail from psychiatric hospitalization

Clearly, given the current state of mental health care provided at the jail, some of the suggestions made in 2006 cannot be completed: measuring participation rates for structured and unstructured out-of-cell time is not relevant when there is so little structured intervention on the closed mental health units, staffing levels do not permit any sort of intervention for inmates refusing medication or increasing structured therapeutic out-of-cell time on the closed mental health units. The clinical course of inmates returning to jail is not studied in quality improvement studies. Unfortunately, what may have started as an ambitious CQI program appears to have stagnated into a much earlier type of “quality assurance” program of chart audits, at least as far as mental health is concerned.¹⁰

The information provided to me related to the QI program pertaining to mental health consisted primarily of chart audits to measure the presence or absence of various elements relative to specific policies and procedures. (Examples were provided regarding intake in which audit questions simply check whether or not various forms were completed requiring a “yes” or “no” response and compliance with timelines stated in policy.) The

¹⁰ Defendants provided studies of participation rates in the closed mental health units conducted in response to Dr. Metzner’s suggestions conducted in 2006, 2007 and 2009, none more recent.

chart audits are repeated at regular intervals and have not changed substantially in several years. There were no process or outcome studies for mental health services during the past twelve months.

A robust quality improvement program consists of much more than chart audits and allows systems to identify problems, take corrective action(s) and re-assess the issue to determine whether or not the corrective action was successful in reducing or eliminating the problem.

Staffing

Armor staffing levels are inadequate to provide any treatment services other than brief psychotropic medication management appointments and rare supportive individual counseling sessions to very few inmates. This is true in the jail facilities that provide “outpatient” mental health care as well as NBB that contains the mental health units. Rounds and cell front contacts do not constitute treatment. There must be sufficient numbers and types of staff to provide actual treatment, including individual and group counseling as well as psychosocial programming, most especially in the mental health housing units.

Armor mental health staff appear to be appropriately trained and credentialed to provide mental health care – there simply aren’t enough of them. Mental health staffing levels must be sufficient to provide screening and evaluation, crisis care, routine outpatient care including rounds and treatment interventions to inmates with serious mental illness housed in segregation status and a residential treatment level of care.¹¹ Current staffing levels simply does not permit Armor to provide the full continuum of treatment and as a result, inmates with mental illness are not receiving adequate care.

¹¹ In discussions with Armor staff, it was not clear that they shared the same philosophy with respect to their involvement in providing a continuum of services. I was told that they viewed their role as “identification and stabilization.”

The American Psychiatric Association's brief monograph "Psychiatric Services in Correctional Facilities, Third Edition" recommends that for a jail general population there be "one FTE psychiatrist for every 75-100 patients receiving psychotropic medication" and one FTE psychiatrist for every 50 patients in residential treatment units.¹² These recommendations do not take into account the role of psychiatrists in the diagnostic assessment process and daily assessments of all inmates on suicide watch status which results in a greater need than a simple ratio of one FTE to 75-100 general outpatients. In other words, Main Jail requires additional staffing based on a very busy reception process, frequent and extended suicide watches conducted in the infirmary as well as on the 8th floor, detoxification units and general outpatients. Applying the ratio to the 385 inmates reported on the mental health caseload at the Main Jail at the time of the site visit, the recommended staffing level would range from 3.8 to 5.2 FTE. The Main Jail has only 1 FTE psychiatrist (0.8 FTE psychiatrist and 0.2 FTE ARNP). Having this degree of deficit translates into brief, cursory evaluations including risk assessments of suicidal inmates, non-confidential cell front contacts at minimally required intervals rather than permitting the flexibility to schedule appointments according to clinical need. JVCF and Paul Rein Facility had a combined mental health caseload of 561 at the time of the site visits. This would require at least 5 FTE psychiatrists using the APA ratios but they have a combined total of only 1.8 FTE. In order to actually provide a residential treatment level of care, NBB requires a ratio of one FTE psychiatrist for 50 beds and there are psychiatrists (1 full time,

¹² The APA guidelines do not provide staffing levels for any other type of mental health professional and do not explicitly address the role of midlevel providers such as ARNPs and PAs used in the Broward County jails. For purposes of this discussion, the ratios expressed shall be relevant to use of either a psychiatric physician or midlevel practitioner.

1 part-time), ARNPs (3 full time and 1 part-time) and at least one FTE PA. (The other PA is primarily administrative.) This facility is much closer to the recommended numbers in terms of the medication management need but the primary issue at NBB is the lack of additional mental health treatment other than psychotropic medication management, for patients that consent to taking medication. There are only two FTE licensed mental health clinicians, which is insufficient to do anything other than rounds and cell front contacts. There must be many more mental health clinicians in order to engage patients in meaningful therapeutic out-of-cell activity on all of the housing units --- not just the programming run by BSO program staff on two open mental health units. Other mental health professionals such as psychology staff positions, activity technicians and attendants are also required to provide residential treatment.

The need for mental health counselors at the other jails is equally dire. At Main Jail, the lone Armor psychologist is assigned to detox evaluations and does some counseling. The mental health counselor is full time but 20% of his time is spent as the sole counselor at Conte one day per week for a caseload of 319 inmates. At the Main Jail, he is assigned to do initial mental health evaluations and some counseling if there is any time left in his 32 hours. Paul Rein Facility also has mental health coverage only one day per week for 242 inmates on the mental health caseload. The jails offering outpatient mental health care are very, very short staffed in terms of mental health counselors. The APA Guidelines do not address mental health counselor staffing levels. However, I recommend there be one mental health counselor for a range of 50-100 inmates on the outpatient caseload, the exact placement in that range being determined by the number of other tasks required at that

facility such as initial assessments, segregation rounds, typical number of mental health crises at a particular jail (treatment of inmates on suicide watch) as well as the security level of the facility. (It is easier to access lower security level inmates because they are permitted much broader and unescorted movement to appointments. Many more of them can be seen than when providing care to higher security inmates who have to be searched, cuffed and escorted to and from appointments with one or two custody staff who also have competing responsibilities.)

The jail mental health staffing levels are insufficient to provide adequate mental health treatment at any level of care: intake, outpatient and residential treatment.

Medications

This provision was originally articulated to promote appropriate use and monitoring of psychotropic medication. The use of psychotropic medication in institutional settings has a checkered history that involved use of some of these medications administered as a means of chemical restraint rather than being prescribed for a psychiatric symptom indication. Armor maintains a policy specific to the use of psychotropic medication (J-D-02.5), which requires referral to an appropriately licensed and credentialed provider with prescriptive authority for all psychotropic medication orders. These include psychiatrists, advanced registered nurse practitioners (ARNPs) and physician assistants (PAs.) Psychotropic medications are not administered without an order from a prescriber.

Inmates are provided informed consent for medications and have a right to refuse them, except in very limited emergency situations. In fact, inmate refusals absent a time limited emergency can be over-ridden only if they are transferred to a hospital where additional proceedings may permit administration over refusal. However helpful and clinically appropriate these types of orders may be, they are relevant only during the inmate's hospital stay and not upon return to the jail – where it is most likely inmates will again stop taking prescribed medications.

There is another, infrequently used option for treatment over objection though it also often impractical and is not timely. This option requires a judicial finding of

incompetence and the appointment of a guardian to make the ward's treatment decisions. As mentioned, this option is not always practical in that it involves an extensive clinical examination, a finding that the inmate lacks decision-making capacity and the availability of a suitable guardian to consent to medical treatment and manage all of the ward's other affairs. There is also no assurance that the guardian would provide consent to the medication recommended or consent to forcible administration if the ward refused oral medication. This option is possible but not always practical.

For all intents and purposes, the current limitations to treatment over objection present serious barriers to treatment at the jail. Inmates with serious mental illness refusing medication must get to a hospital for treatment over objection but they are denied admission. They cannot be treated over objection at the jail and so remain untreated and eventually, isolated and housed under conditions that resemble the conditions of segregation – conditions which further exacerbate their serious mental illness, which makes them less likely to be approved for hospitalization, and the cycle spirals ever downward.

Other correctional systems and facilities have adopted a procedure similar to one initially developed in the Washington state. In 1990, the US Supreme Court upheld the Washington policy that permitted correctional facilities to override medication refusals under limited circumstances.¹³ The Washington policy made provisions for an internal

¹³ *Washington v Harper* 494 US 210 (1990)
Carruthers v Israel
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hearing process involving mental health/medical professionals with no current treatment relationship with the inmate who were charged with making the decision about whether the inmate could be involuntarily treated. The inmate also had a number rights at the hearing including the right to be evaluated, the right to notice of the procedural hearing, the right to be present at the hearing, present evidence and cross examine witnesses and the right to appeal the decision of the hearing panel. Additionally, if the hearing panel approved treatment over objection, the administration of medication under these circumstances was time limited and required periodic re-hearings with all of the attendant rights for continuation of medication. Consideration of a similar sort of internal process for treatment over objection proceedings could be very useful in the jails under limited circumstances such as when inmates pose a serious risk of danger to self or others – the type of circumstances that preclude Baker Act acceptance for treatment in civil hospitals.

Turning attention to the voluntary use of medication, the Armor psychotropic medication policy contains some serious deficiencies with regard to implementation and appropriate use of psychotropic medication in the jail.

The medication formulary (list of medications approved for use) is limited which in and of itself is not uncommon, particularly since there is a mechanism to request approval for psychotropic medications not on the list. The problem lies in the failure to actually make use of this “Drug Exception Request” to preserve continuity of care in essentially every situation with the exception of state hospital returns. Such practice leads to unnecessary delays in the provision of treatment and causes needless suffering. Delays in

treatment, even if the medication selected by Armor is effective, will lead to a slower response to treatment and a less robust response and, there is no guarantee that the chosen medication is going to provide the intended improvement in response at all. It is inexplicable why one would opt not to use a medication of demonstrated efficacy. Even if the medication is more expensive, the indirect costs of delaying treatment can far outweigh the expense of the medication. Inmates with untreated or under treated serious mental illness use more costly services: transfer to NBB; placement on watch status; housing in a single cell rather than a multiple person cell; longer jail stays due to a finding of incompetence to proceed or inability to find a community placement; potential staff and/or inmate injury due to psychotic symptoms, etc.

Issues regarding medication continuity are not limited to the jail admission process. There are multiple prescribing clinicians at NBB and an inmate may be seen by any one of several people, all with differing prescribing practices and treatment philosophies. Medication changes are not infrequent – again, in and of itself not unusual, but it could be remedied with the adoption of prescribing guidelines and assignment of cases to specific prescribers rather than the “prescriber du jour” process currently in place. This is problematic from any number of perspectives, not the least of which is frequent changes in medication but also from the perspective of the failure to establish a therapeutic relationship between the medication prescriber and the patient. Every visit is essentially a new, introductory, assessment visit when a patient is seeing a new prescriber. Documentation of the previous medication management appointment is not always helpful: areas of forms that are to describe the inmate’s condition at the time of the appointment

are fairly cursory, if they are filled out at all; there is no indication of the response to current treatment or a documented mental status examination. Every medication management visit is thus a “first” appointment. Remedies for this problem also include staffing levels that permit and promote continuity of prescriber and additional mental health staff that are able to provide medication education and counseling with a graduated response of interventions to address instances of medication non-compliance before mental decompensation followed by the downward spiral described earlier.

Inmates are seen regularly at monthly or three-month intervals for medication management appointments. There is little to no room in the schedule to permit more frequent contact in response to changes in clinical condition, assess response to new medications or dose adjustments and it is not clear that medication compliance is regularly reviewed with the inmate in that it is not routinely documented in the prescriber’s note (though it is available upon review of the medication administration record.)

Review of multiple records also revealed some positive findings. For example, there was very little polypharmacy - the practice of prescribing multiple medications with no clinical rationale to support the practice. Medications were prescribed for legitimate psychiatric indications and in doses consistent with generally accepted standards of care when prescribed for a clear psychiatric indication.

RECORDS

The fifth criterion is accurate, complete and confidential records. The concerns with regard to the medical/mental health records are related primarily to the use of paper, rather than an electronic health records at the current time. Some psychiatric notes are barely legible which is highly problematic given that multiple prescribers may see the same inmate patient. (The “new” prescriber may or may not be able to decipher the note of the previous one to understand the condition of the inmate, the medications and doses prescribed, etc.) In other instances, forms are incompletely filled out and clinicians provide very little narrative making it difficult to ascertain patient condition, type and severity of symptoms experienced and plan for follow-up. In general, the filing was up to date and papers were filed in the appropriate place of the record.

Problems can and should be addressed through chart auditing and ultimately with the adoption and implementation of an electronic health record. Illegible handwritten notes are eliminated; forms can be developed such that the note cannot be “closed” unless all required fields are completed.

More substantive concerns relate to the failure to request/review and use the information from outside sources and contained in the record. For example, inmates returning from the state hospital are sent with very little information about the course of their treatment while hospitalized. If an admission and discharge summary is not provided, it is not clear that Armor staff consistently request it. If and when the records are

provided, it is not clear that Armor staff review them and that the information is utilized in the current treatment of the inmate. This is true of prior hospital information as well as community outpatient records.

Two examples that illustrate the effects on care due to the failure to use records were described earlier on pages 35-36 in the section on Screening and Evaluation. (Inmate II who had refused a tuberculin skin test and housed in isolation in the infirmary. His outside records were at the jail but not reviewed; he'd had a recent negative test and wouldn't have required infirmary isolation. Inmate MW refused medication because he wanted to take the medication prescribed for him at the VA Medical Center. His records had also been received, but not reviewed. Then, when the records were reviewed, the PA refused to order the VA medication because it wasn't on the formulary. As a consequence of receiving no psychotropic medication, MW's thought processing was disjointed and circumstantial. His serious mental illness was untreated; mental health treatment was severely delayed, his jail stay extended and legal proceedings delayed by questions regarding his competency to stand trial.)

Accurate, complete and confidential records are vitally important and using them appropriately has a profound impact on the delivery of care.

Suicide prevention

The National Commission on Correction Healthcare, which accredits the jail's medical/mental health services, identifies eleven essential components of a correctional suicide prevention program: training, identification, referral, evaluation, treatment, housing and monitoring, communication, intervention, notification, review and debriefing. Armor policy J-G-05 lists these key components and in subsequent paragraphs describes the related procedures for the component in some detail – except the treatment component. The policy is silent on this component. This silence also reflected in implementation. Inmates on watch receive assessments and daily reassessments, but few receive treatment other than medication if it is ordered and the inmate agrees to take it. This is a critical deficiency. Treatment must be provided to address the suicidal thoughts and behaviors. Treatment is more than a brief daily assessment which is conducted in private sometimes but more often at the cell front (MJ 8th floor, NBB infirmary) or in a hallway (NBB).

The assessments that are completed do not contain a uniform, standardized risk assessment instrument of which there are several to choose from which would permit the development of a safety plan and treatment interventions that are individualized and aimed at reducing risk. The assessments reviewed in the records were highly idiosyncratic to the prescriber conducting the assessment. I saw no cases in which a treatment plan had been modified to address an inmate patient having been placed on watch, maintained on watch (sometimes for months and months) or those having multiple watch placements.

Upon release from watch status, a follow-up appointment is scheduled to occur within 7 days of release, but subsequent follow-ups revert back to the usual minimum contact schedule dictated by policy (brief monthly medication management appointment which may or may not be with a provider previously seen), rather than dictated by the inmate's clinical need. Examples of lengthy watch placement include inmates ES (Appendix page 8) and TD (Appendix, page 29). TD was also identified as a person with multiple watch placements.

Use of a standardized assessment instrument would also eliminate the need for automatic placement on suicide watch status if entering the jail following a transfer from a hospital or recent hospitalization. At the time of intake, 2/6/17, inmate PT was put on watch based upon recent history rather than current risk assessment. She was sent from the Main Jail to NBB and although the watch was relatively brief, it was completely unnecessary. (PT's case in on page 31 in the Appendix.)

Additionally, the conditions experienced by the inmate placed on watch are at times, unnecessarily punitive: there is no privacy in some jail areas used for watches which is especially problematic when stripped of undergarments and jail issue clothing and given an ill-fitting suicide smock. Inmates are not given shoes or shower slippers, not permitted to shower regularly, and provided paper eating utensils. While some fairly drastic restrictions are necessary to prevent or ameliorate an imminent and immediate risk of suicide, the conditions themselves are not therapeutic and care has to be exercised that the restrictions be done for the minimum amount of time necessary and that the placement

and restrictions are not used as a type of punishment. Conditions should not be so punitive so as to discourage persons from reporting depressed feelings and suicidal thoughts in fear of being placed and held under these conditions.

The Armor suicide prevention policy describes three levels of suicide watch: continuous observation, close observation and closely monitored while the corresponding BSO standard operating procedure uses somewhat different terminology: close supervision, direct observation and closely monitored. These various levels of observation/supervision also contain some variations in expectations/conditions as well. It is very important that these concepts are reconciled so there is a clear understanding between Armor and BSO staff about the levels of watch and degree of monitoring required, particularly for such a critical, potentially life-saving process.

I was provided only a very small sample of post-suicide reviews. It was not clear whether this was due to no review having been conducted, no documentation of the review that was conducted or whether the reviews were simply not provided. (Although there was some initial delay in receipt of some requested materials based upon Armor's quality assurance confidentiality concerns, we were able to work through this and I do not believe existing records were intentionally withheld.) The individual records that I received and reviewed are located in the Appendix. I am able to say here that as a general observation, the review process would be significantly improved with better correlation between custody, medical and mental health factors found during the investigations conducted separately by all three of these professions. Custody reviews contain an assessment of

whether monitoring was completed as required by custody policy and custody's response upon discovery of the inmate. Medical reviews look almost exclusively at the medical response to the event. Mental health does a psychological review. The findings from these various and different reviews can have profound impact on conclusions and potential action steps to improve the process. For example, if custody has to leave the site of a hanging inmate to get a cut-down tool, medical should be aware of this factor in their review of the incident because a delay of mere minutes is important in rescue and can make the difference between life and death. The point of these reviews is to identify these sorts of potential problems/issues, even if determined that they had no particular relevance to the case at hand, they could impact future rescue responses. In this case, ensuring that cut-down tools are more immediately available certainly has potential ramifications in future instances. (Some facilities have officers assigned to certain locations carry a form of cut-down tool on their belts.)¹⁴ Mental health reviews considered alone won't necessarily uncover an instance in which an inmate came back from a court appearance where he or she received "bad news" though custody staff are aware of it. Integrating this information could have changed a specific outcome or policy regarding notice to mental health so that inmates returning from court hearings are referred to mental health staff for a brief assessment and treatment intervention if necessary. (Inmate NW reportedly was overheard telling her mother that she was going to kill herself if she received bad news in her upcoming court hearing. Information was not relayed to mental

¹⁴ Inmate CB summarized in Appendix pages 64-65; autopsy report indicates deputy left the inmate to retrieve cut down tool; also a question of whether proper periodic checks were done on the unit.

health staff. She went to court 9/2/14 and died by suicide 9/6/14. This is also another case where the deputy had to leave the scene to retrieve a cut down tool. The NW suicide was two years after the CB case; the issue regarding the cut-down tool persisted. NW case is summarized on page 70.) As a second general observation, the reviews would be better if the assessments were more self-critical so that improvements could be made. There were some records in which access to medical care was limited or severely limited for inmates with serious mental illness housed at NBB. In one case, the medical review recommendation was not to use certain types of medication in closed mental health because of the degree of monitoring required as opposed to actually improving ease of access to inmates in closed mental health units. I understand that reviewers are often reluctant to document critical findings out of fear of discovery in the event that the incident leads to litigation. However, if that happens, a plaintiff's expert is likely to draw the same negative conclusions anyway and as a system, it is far better to self-identify and thereafter take steps to address or correct the problem than to wait for legal proceedings to make you do it. Frankly, it demonstrates a far higher degree of commitment to continuous quality improvement than incomplete and cursory self-assessment.

Record reviews of these cases are found among those cases summarized in the Appendix on pages 60-74.

CONCLUSIONS

As stated at the outset of this report, I was charged with assessing operations and conditions at the Broward County Jails and to render an opinion regarding whether there are current and ongoing violations of federal rights. I organized my inquiry around six criteria and have concluded that there are current and ongoing violations of federal rights as they pertain to inadequate mental health care and facilities, most particularly as related to the lack of treatment except psychotropic medication, lack of timely and adequate access to inpatient psychiatric care resulting in prolonged stays in the closed mental health units and infirmary at NBB under conditions that are as isolating as those found in segregation and make symptoms worse and access to treatment more difficult. However, inasmuch as all six of the criteria reviewed are interconnected, each of them contributes to the current and ongoing violations, some to a greater and some to a lesser degree. I have organized my conclusions to articulate the areas needing improvement to correct the deficiencies. This organization also served as the basis for development of the Implementation Plan.

Systematic Screening and Evaluation

Generally appropriate to identify persons with mental health needs for further assessment and placement on the mental health caseload.

Areas for improvement:

- Diversion of serious drug withdrawal to hospitals for complicated medical detoxification and referral of inmates with obvious and severe psychiatric illness to a hospital setting as soon as possible consistent with Florida statute rather than

housing them in the jail for weeks or months, with no ability to treat them to await criminal court action.

- Document that outside treatment records have been requested, reviewed and considered in the treatment of the inmate at the jail.
- Preserve continuity of care with respect to psychotropic medications when prescriptions are verified and response has been favorable.
- When medical assessments cannot be completed at intake due to the condition or refusal of the inmate with serious mental illness, further attempts must be made so that the medical assessment is eventually completed, documented and filed in the chart in the area reserved for physical examinations/medical assessments. A medical progress note should also document the reason the initial intake assessment was postponed, and subsequent medical progress notes should document attempts to complete the assessment.
- Postpone development of a mental health treatment plan so that it is an accurate reflection of the inmate's condition and describes the interventions that will be provided, by whom and in what time frame as opposed to having a non-specific plan drawn up on the basis of a single psychiatric assessment.

Treatment that is more than mere seclusion or close supervision

There is very little mental health treatment provided other than psychotropic medication for inmates that consent to take it.

Areas for improvement:

- The overwhelming majority of inmates with serious mental illness may be appropriately treated as outpatients in general population settings. However, outpatient mental health treatment must include opportunities for counseling, individual and/or group treatment interventions as clinically indicated and crisis intervention in addition to periodic medication management appointments.
- Residential care must include more structured out-of-cell therapeutic activities as well as unstructured out-of-cell time, particularly in the closed mental health units. This is true for all inmates transferred and maintained at NBB for treatment of mental illness, not just those housed on some of the housing units.
- Mental health treatment must be conducted in space that affords sound privacy; not at the cell front, in the hallway or in non-private areas of the housing unit.
- Admission, discharge and mental health treatment programs must be developed for the mental health units at NBB.
- Inmates requiring a higher level of care than can be provided at NBB must be timely transferred to inpatient care. Inpatient care must be readily available and accessible. Access to care cannot wait until a court determines a transfer is necessary for purposes of competency to stand trial restoration, or until the inmate is released from jail.
- Confinement in a closed mental health unit or infirmary for seriously mentally ill inmates is the equivalent of segregation in terms of social isolation, amount of time confined in cell and cell front contacts with staff – not mental health residential care. This must change immediately.

- Mental health and medical care must be better integrated to provide appropriate services to inmates with both conditions. Access to medical services should not be impeded due to the presence of a serious mental illness or being housed in a mental health unit.
- Ensure treatment continues whenever an inmate is confined in segregation.
- Incorporate mental health clinicians into crisis de-escalation when possible to avoid a situation in which the use of force is planned.
- Formalize the role of mental health in the inmate disciplinary process.
- Resume development of a comprehensive CQI program.

Staffing

Vendor staff are trained mental health professionals and appropriately licensed and credentialed for the tasks they are assigned within the facilities. In fact, masters prepared and licensed mental health counselors could expand their role in the provision of diagnostic assessments and group treatment interventions. The primary issue with regard to staffing is simply related to deficient staff numbers, which profoundly limits the amount and type of care that can be provided.

Areas for improvement:

- Increase staffing levels of mental health clinicians and prescribers to permit the delivery of appropriate levels of outpatient, crisis and residential care.
- Ensure that there are sufficient custody staff to provide escort and supervision when mental health treatment is provided.

Safeguards regarding prescription of psychotropic medication

Generally, psychotropic medications are prescribed in appropriate doses for recognized indications.

Areas for improvement:

- Better documentation of patient's condition and response to prescribed medication; better documentation of the rationale for medications prescribed or changed.
- Improve continuity of care with outside providers as well as among various Armor prescribers.
- Inmates should be seen more frequently if clinically indicated than the minimum intervals dictated by policy. Staffing levels must be sufficient to permit this.
- Monitoring and intervention for cases medication non-compliance to include medication education and counseling by nursing staff in addition to notification and referral back to the prescribing clinician.

Accurate, complete and confidential records

For a paper record system, the records were available and filing was up to date. Problems included illegible handwritten notes and incomplete documentation by individual clinicians – but these can have a profound impact on care.

Areas for improvement:

- Move to adoption of an electronic health care record.

Suicide prevention program

Suicide watches can be initiated at any time and in any jail in the Broward County Jail system. However, more emphasis must be placed on the provision of treatment during watches, transfer to a higher level of care if the inmate's condition does not improve rather than continued watch placement because the conditions are unduly restrictive and may contribute to the failure of the inmate to improve.

- BSO and Armor suicide prevention policies/procedure should track one another in terms of monitoring intervals and staff duties such that there are not contradictions or confusion between the two.
- Treatment interventions must be provided during periods of suicide watch to include out of cell contacts by mental health clinicians – not just daily assessments by the prescriber.
- Adopt a standardized risk assessment instrument to assess risk and serve as the basis for developing safety plans when appropriate. (Use of a standardized risk measurement would also prevent the need to “automatically” place inmates returning from the hospital on a restrictive watch.)
- Update individual treatment plans and interventions whenever an inmate is placed on suicide watch.
- Review the use of suicide watch as a response or type of punishment for “manipulative” behavior and consider development of behavior plans to address these types of issues.
- Individuals who remain suicidal in jail should be assessed for the possibility of inpatient hospitalization at appropriate intervals.

- Suicide watch must respect individual dignity and privacy while ensuring risk reduction to prevent self-harm. Conditions while on watch should not be punitive.
- Mental health follow-up after watches are discontinued should be based on individual clinical assessment and need and be particularly mindful of the inmate during the transition off watch and back into population.

As indicated in the opening paragraphs of this report, the original draft of this report shared with the parties included a draft implementation plan. The parties used the draft plan and subsequent iterations of it as the basis for on-going discussion and negotiation of the terms for an Implementation Plan. I have therefore not included such a plan in this report but provided the data and basis for my conclusions about current and on-going constitutional violations and my recommendations for inclusion in the Implementation Plan negotiated by the parties.

Submitted by:

/s/
Kathryn A Burns MD, MPH
8 August 2018