MENTAL HEALTH REMEDIAL PLAN
CONTRA COSTA COUNTY
TABLE OF CONTENTS

I. Definitions

A. Qualified Mental Health Professional ("QMHP"): Includes psychiatrists, psychologists, physicians, mental health clinical specialists ("MHCSs"), registered nurses, nurse practitioners, and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for the mental health needs of patients.

B. Clinical Health Staff: Includes health staff who provide direct and indirect care to patients including QMHPs and other allied health professionals.

II. General Provisions

A. The County shall provide mental health treatment that conforms to community standards of care, through a system of treatment to include comprehensive assessments and structured treatment, including face-to-face clinical contacts, group therapy, individualized courses of therapy, and emergency offsite services when clinically indicated and unavailable within the facility. Assessments and treatment can be provided per a telemedicine policy and procedure when available and as clinically indicated.

B. Patients with mental health needs will be assessed and placed in one of four treatment tracks ("tracks") per the mental health basic treatment policies.

1. Track 1 is a high level of care for patients deemed acutely and severely decompensated.

2. Track 2 is an intermediate level of care for patients with active psychosis which interferes with their ability to participate in detention activities.

3. Track 3 is an outpatient level of care for patients able to tolerate and participate in detention activities with minimal support.

4. Track 4 is an outpatient level of care for those deemed able to participate independently in detention activities.

C. Regardless of classification or where the patient is housed within the County's detention facilities, mental health patients will receive the services described herein as clinically indicated.

D. Behavioral Health Unit(s) for Track 1 and Track 2 Patients

1. Contra Costa County shall have one or more housing areas designated as behavioral health units for the management of track 1 and track 2 patients.

2. Except as clinically indicated or where there are individualized and documented safety and security concerns, the County will house track 1 and track 2 patients on these units, which will offer the least restrictive settings appropriate for the clinical and safety and security needs of the patients.

3. Programming and structured activities appropriate for the acuity of the mental health needs and capabilities of the patients will be provided as set forth in this remedial plan.

    a. Track 1 patients' out-of-cell time will be determined in their plans of care.

    b. Services for individuals in track 2, regardless of housing location, will include a minimum of 10 hours per week unstructured out-of-cell time and 7 hours per week of scheduled structured out-of-cell therapeutic activities, unless a higher number is specified in a patient's plan of care or unless deemed detrimental by a QMHP.

    c. The County shall not discriminate with respect to track 1 and 2 patients' out-of-cell time based on gender. This provision does not limit the County's ability to schedule or provide gender-specific programming.

    d. Track 2 patients in behavioral health units shall not generally be provided less out-of-cell time than they would receive if housed consistent with their classification level in a non-behavioral health unit in the same jail. Because behavioral health units mix different security levels, however, it may not always be possible to offer equivalent out-of-cell time for all patients. The benchmark for compliance with this provision shall be if each behavioral health patient receives, on average, at least 80% of the out-of-cell time offered to non-behavioral health people at the same jail in the same classification level.

4. The Unit(s) will have private individual interviewing space, private smaller group settings, and dayroom space for programming.

5. Unit management shall operate through collaborative efforts of custody staff, classification staff, and clinical health staff, with weekly meetings among custody and clinical health staff to ensure a collaborative approach to patient care and behavior management. These meetings should be co-chaired by a QMHP and the facility commander or designee.

6. Except in exigent circumstances, custody staff will not transfer a track 1 or track 2 patient from one housing unit to another unless a QMHP has been consulted to determine whether the transfer is therapeutically appropriate and would not be detrimental to the mental health of the patient. Any conflicting recommendations may be resolved through consultation between a QMHP and the facility commander or his/her designee. If this consultation fails to resolve the conflict, the facility commander or his/her designee shall have the sole discretion to approve the transfer.

E. As part of the provision of these services, the County will develop the following policies and procedures in consultation with the Chief Nursing Officer, Chief Quality Officer, or Chief Medical Officer (or their designees) as appropriate:

1. Operational definitions for the four track levels for patients with mental health needs;

2. Criteria for determining appropriate track for care for patients with mental health needs and criteria for determining movement between track levels;

3. General description of out of cell programming and structured activities for patients in the four track levels;

5. Time frames to complete and respond to initial assessments, suicide risk assessments, health services requests, referrals from staff, initial and follow-up suicide prevention and other emergency care reviews, and individual treatment planning;

6. Quality improvement plan that includes compliance indicators and expectations;

7. Involvement of psychiatrists in developing referral criteria and the services provided to patients in tracks 1 and 2;

8. Qualifications and training for custody staff working with patients in track 1 and track 2; and

9. Suicide or self-harm observation procedures.

III. Plans of Care

A. Plans of care will be used for all patients on the mental health caseload (track levels 1-4) and will be documented in the electronic health record. Plans of care will be patient-specific and problem-based.

B. Track 1 and Track 2 Patients

1. Track 1 and track 2 patients will receive individual plans of care with scheduled reviews by the treating mental health team.

2. The plans of care for track 1 patients must contain at least the following:

   a. Date of the review
   b. List of the multidisciplinary clinicians participating in the review
   c. A follow up review date at least weekly
   d. Patient's diagnoses
   e. Plans for crisis stabilization and stepping down to a lower level of care.
   f. The frequency of the services to be provided
   g. The date by which the goal is expected to be met

3. The plans of care for track 2 patients must contain at least the following:

   a. Date of the review
   b. List of the multidisciplinary clinicians participating in the review
   c. A follow-up review date at a minimum of every 60 days
   d. Patient's diagnoses
   e. Identification of problems to be addressed with a specific measurable intervention/goal

f. Notation of who is responsible to complete the intervention
g. Plans for stepping down to a lower level of care
h. The frequency of the services to be provided
i. The date by which the goal is expected to be met
j. Address basic discharge planning needs

C. Track 3 and Track 4 Patients

1. Plans of care for track 3 and track 4 patients will be documented in the psychiatric provider's progress note. However, if a patient on track 3 or track 4 is not on medication, a QMHP will document the plan of care in the progress note.

2. All track 3 and track 4 patients' plans of care shall address basic discharge planning needs.

IV. Mental Health Care Staffing

A. Staffing Requirements

1. All Mental Health Staff will provide community standard of care in their respective roles in detention.

2. Psychiatrists must meet the Medical Staff Membership and Privileges requirements at the Contra Costa Regional Medical Center.

B. Staffing Analysis

1. The County shall gather the data necessary for a staffing analysis for all mental health positions, including psychiatrists, MHCSs, supervising nurses, psychiatric nurses, RNs, LVNs, health information management staff, and administrative support.

2. The County will also gather data necessary to determine the custodial support needed, including custody staff trained as treatment team members for the specialized mental health placements as well as escorts and security for appointments and transportation in all housing units.

3. The data shall include analyses of actual current time frames for key mental health functions to ensure that the review does not rely on anecdotal material, including but not limited to the following:

   a. triaging health service requests;

   b. seeing patients face to face in response to health service requests, as clinically indicated;

   c. time of referral to time seen by the psychiatrist;

   d. comprehensive mental health assessments;

   e. developing Plans of Care.

4. The County shall consult with the Mental Health Expert regarding the data to be gathered and the analysis of the data.

5. The staffing analysis shall be completed within two months from the date the Consent Decree is signed by the Court.

C. Staffing Plan

1. General Requirements

   a. The County will use the staffing analysis to develop a staffing plan.

   b. The County will consult with the Mental Health Expert regarding the development of the staffing plan.

   c. The staffing plan shall be completed and provided to the Mental Health Expert and Plaintiffs' counsel within two months from the date the Consent Decree is signed by the Court. Any disputes regarding the staffing plan are subject to the Dispute Resolution procedure in Section G of the Consent Decree.

2. Staffing Levels

   a. The staffing plan shall include measures to be taken in the event of long-term significant vacancies.

b. The County shall employ adequate numbers of custody staff to assist with medication administration and the movement of patients to receive health care services.

c. The County will provide a budget for detention health care services sufficient to finance adequate health care and custody staff to comply with this Remedial Plan.

3. Psychiatrists

a. The staffing plan will address whether additional psychiatric time is needed, considering the additional involvement of psychiatrists as set forth below.

b. The staffing plan will take into account the need for psychiatrists to be involved in the following:

i. developing policies and procedures regarding definitions of tracks for patients with mental health needs, services associated with each track, and criteria for movement between tracks;

ii. the expansion of the role of the psychiatrists to include active participation in multidisciplinary treatment planning as appropriate and described in policies and procedures.

4. Reassessment of Staffing Plan

a. The County's plan will allow for ongoing tracking of staffing.

b. The County shall annually reassess its mental health care staffing to ensure that it employs sufficient staff necessary to provide adequate mental health care and supervision.

c. The annual assessments shall review all categories of mental health care staff, including but not limited to psychiatrists, MHCSs, supervising nurses, psychiatric nurses, RNs, LVNs, health information management staff, and administrative support.

d. Escort and transportation deputies shall be included in the assessments.

V. Intake

A. Health Screening and Initial Mental Health Assessment

1. Intake health screening shall continue to be performed by RNs.

2. Intake health screening shall include an initial mental health screening that shall include questions related to identifying level of risk of self-harm from the Columbia tool or an equivalent.

3. Intake nurses will conduct a reasonable review of available electronic medical records at the time of intake for evidence of past suicide attempts and self-harming behavior.

4. Nurses who perform the intake health screening function shall receive additional training by a QMHP on how to complete and document the initial mental health screening and look for signs and symptoms of suicide risk. These trainings will have a developed curriculum and sign in sheets as proof of training. Training records will be retained by the County.

5. Nurses referring for mental health services from intake health screening shall triage the referrals as emergent, urgent, or routine.

6. The County shall revise the Pre-Intake Form used by arresting officers to include a question regarding whether odd thought patterns or behavior were observed.

7. Referral criteria for psychiatry shall conform to community standards and shall be documented as a protocol for consistency among the QMHPs.

B. Privacy

1. All intake health and initial mental health screenings shall be performed in areas that provide reasonable auditory privacy and confidentiality, unless there is an individualized security or safety risk, which shall be documented.

C. Psychotropic Medications

1. The County shall continue to make every reasonable effort to verify psychotropic medications claimed by incoming patients, including contacting pharmacies and non-jail providers for prescription information with a signed release of information from the patient.

2. When current psychotropic medication prescriptions are verified, bridging medications shall be ordered within 24 hours of verification for a minimum of seven days or until seen by a psychiatrist, unless otherwise directed by a provider. This will help decrease the possibility of a lapse in medications due to any delay in obtaining a psychiatrist appointment.

3. Patients claiming to be on psychotropic medication that is not verified during intake shall have their prior health care records reviewed by a psychiatrist or psychiatric nurse practitioner within 5 calendar days to allow prescription of psychotropic medications and follow-up appointment as clinically indicated. If prior records are unavailable or inadequate, the patient shall be seen face-to-face by a psychiatrist within 10 business days.

VI. Access to Health Care

A. Health Service Requests

1. The County has a telephone access line for non-emergency health care requests and services at both the West County Detention Facility (WCDF) and the Martinez Detention Facility (MDF). The telephone access line for non-emergency mental health care requests and services is currently only at WCDF. The county may cancel the telephone access line at any time, but while it is in use it will include the following:

    a. Health Care Telephone Access Line

        i. A RN will serve as the Triage (Advice) Nurse.

        ii. The Health Care Phone Triage times will be seven days a week as follows: MDF: 0730 to 1000, or until completed; and WCDF: 0800 to 0930 and 1900 to 2100, or until completed.

b. Mental Health Care Telephone Access Line

i. A QMHP will serve as the Mental Health Phone Triage staff, during the times listed in A.1.a.ii, above.

2. The County shall refine its system to review inmate requests for health services, including requests made over the telephone access lines, as follows:

a. RNs shall review the submitted inmate requests for medical and/or mental health services once per day.

b. The review process shall include an assessment of the level of urgency of the request, whether the patient needs to be seen and, if so, the disposition and time frames for the triaging and subsequent appointments, and a tracking system.

c. The following timelines apply for triaging inmate requests for medical and/or mental health services for patients who need to be seen.

i. Patients whose requests are deemed to be emergent will be seen by Clinical Health Staff immediately or as soon as possible.
ii. Patients whose requests are deemed urgent will be seen by Clinical Health Staff within eight hours.
iii. Patients whose requests are deemed routine will be seen by Clinical Health Staff within three to five calendar days.

3. Patients requesting to see a psychiatrist shall receive a mental health assessment by a QMHP to determine whether they have a clinical need to see a psychiatrist.

4. Health Services staff will provide patients with a response to a request for health services within 72 hours, for requests handled by means other than a face-to-face visit. Responses will be documented in the patient's electronic health record.

5. When custody staff observes a psychiatric emergency, they will contact a QMHP as soon as possible. Custody staff will ensure, by policy, that the inmate remains within line of sight of an officer or

health provider until a QMHP arrives, or is placed in a safety or observation cell with safety checks made pursuant to policy. A QMHP will contact the patient as soon as possible thereafter to conduct an assessment. The QMHP contact may be in person, via the telephone or via video-conference.

6. When custody staff observes an inmate who appears to be decompensating, they will contact a QMHP as soon as possible and no later than one-hour, absent exigent circumstances. The QMHP will contact the patient within a timeframe determined by clinical necessity (urgent vs. emergent). The QMHP contact may be in person, via the telephone or via video-conference.

7. When patients with limited reading and writing skills make a verbal request for health care services, staff shall ensure that the appropriate health care services are initiated, whether by request slips or alternative means.

8. Health service staff shall handle patient requests for health care services in a confidential manner.

9. Confidentiality

    a. Patients may submit requests for health care services via telephone, if available, in writing, or electronically once kiosks are available.

    b. Blank health service request forms shall be readily available on all housing units, program areas, and libraries and shall be offered regularly to patients in administrative segregation housing.

    c. When health care staff provides confidential medical information to patients by mail, they will do so by using a sealed envelope with the patient's name, number and location on the front and an indication on the front of the envelope that the envelope contains confidential medical information.

    d. Custody staff will open the envelopes in the presence of the inmate and will visually inspect for contraband due to safety and security concerns but will not read the document.

    e. Confidential Locked Boxes or Equivalent Electronic System

i. Confidential locked boxes shall be available on every housing unit for routine health service requests and for complaints and/or grievances relating to the provision of health care services.

ii. These boxes shall be readily accessible to patients on free time.

iii. Health services staff will retrieve and review the contents of the boxes at least once a day.

iv. Patients who do not have daily access to a locked box shall be provided the opportunity to give health service requests to health care staff on a daily basis.

B. Treatment

1. Mental Health Evaluations for all patients on the mental health caseload (track levels 1-4) will include current symptoms, history of the present mental illness, past history, psychosocial information, diagnostic formulation, and confirmation or re-assignment of track designation.

2. The County shall make every reasonable effort to provide continuity of care with psychiatrists for patients in tracks 1 and 2. These efforts are limited to patients during a continuous period of incarceration and within a single facility.

3. Absent agreement by the patient, non-emergency clinical contacts with mental health patients shall occur in a room with auditory privacy from custody staff and inmates unless the QMHP determines that a face to face contact would be a threat to safety and security, based on documented individualized reasons. In cases where the QMHP determines that a face to face contact would be a threat to safety and security, based on documented individualized reasons, the contact shall take place behind glass in a non-contact room with auditory privacy from custody staff and other inmates, unless the patient refuses to leave his/her cell. In the latter situation cell front contact may be the only means to assess the patient and this should be documented in the medical record as a variance from standard practice.

C. Higher Level of Care

1. The County will provide prompt access to inpatient level of psychiatric care for patients requiring this level of service, either at the Contra Costa Regional Medical Center, onsite in detention, or at another appropriate facility.

2. For patients returning to the jail from higher levels of community mental health care, including emergency services and state and county hospitals, the County shall establish policy guidelines for an intake appointment with a QMHP to review the community care documentation. The QMHP will exercise clinical judgment about whether the patient requires an expedited appointment with a psychiatric provider or if they can be seen routinely within 10 calendar days.

VII. Medication Administration

A. The County will provide pill call at least twice a day in each housing unit and at regular times that are consistent from day to day unless no patient on that unit requires medication. For any patient who requires administration of medications at times outside the regular pill call, the physician will document this information in the electronic medical record and the patient will be provided that medication at the times determined by the physician with exceptions described in Section B below.

B. Patients will be provided medications at therapeutically appropriate times when out to court, in transit to or from any outside appointment, or being transferred between facilities, to the extent feasible. If administration time occurs when a patient is in court, in transit or at an outside appointment, medication will be administered as close as possible to the regular administration time.

C. When a medication has previously been identified as keep on his/her person for a particular patient, the medication will be given to the patient for self-administration at the appropriate time, subject to safety and security concerns.

D. Medications will be reviewed for efficacy and side effects by the appropriate clinicians at appropriate intervals.

E. Policy Development: The County shall develop or maintain policies and procedures for A through D.

VIII. Suicide Prevention

A. The County shall develop a comprehensive suicide prevention plan, including policies and procedures.

B. The County shall develop and implement a suicide assessment tool utilizing validated screening questions.

C. As part of the suicide prevention plan, the County shall modify the training curriculum to reflect correctional risk factors.

D. The County shall contract with Lindsay Hayes to review its suicide prevention plan and to assist the County in determining the number of suicide-resistant cells needed.

E. The County shall implement the following recommendations from Lindsay Hayes:

1. Training
    a. Revise suicide prevention policies to include a more robust description of the requirements for both pre-service and annual suicide prevention training, to include the duration of each workshop and an overview of the required topics, including a requirement for an 8-hour pre-service suicide prevention workshop for new employees working in detention, as well as a commitment to a 2-hour annual suicide prevention workshop for all employees working in detention.

    b. Develop an 8-hour workshop on suicide prevention for all new detention deputies and Clinical Health Staff, as well as a 2-hour workshop for all current detention deputies and Clinical Health Staff. All detention deputies and Clinical Health Staff will thereafter receive 2-hours of annual training.

2. Retrofit the desktops in the suicide-resistant cells on F-Module to better prevent ligatures being attached. One option is to attach triangular extensions to both sides of the desktops.

3. Policies and procedures will be revised as follows:

    a. Suicidal inmates are to have priority for the suicide-resistant cells.
    b. Limit suicidal inmates to no more than six (6) hours in a safety cell at a time except in exigent circumstances when the inmate is an immediate, continuing risk to self and others.
    c. Safety cells should not be the first option available for housed suicidal inmates. They should only be utilized in exigent circumstances when the inmate is an immediate, continuing risk to self and others.
    d. Allow inmates on suicide precautions all routine privileges (e.g., family visits, telephone calls, recreation, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction or in exigent circumstances when the inmate is an immediate, continuing risk to self and others.
    e. Allow inmates on suicide precautions to attend court hearings unless exigent circumstances exist in which the inmate is an immediate, continuing risk to self and others.
    f. Allow inmates on suicide precautions out-of-cell access commensurate with their security level and the clinical judgment of MHCSs.

4. Revise policies and procedures to include levels of observation that specify descriptions of behavior warranting each level of observation. Examples:

    a. ***Constant Observation***
        i. Is reserved for the inmate who is actively suicidal, either by threatening (with a plan) or engaging in self-injury and considered a high risk for suicide.
        ii. This inmate should be observed by an assigned staff member on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals.

    b. ***Close Observation***
        i. Is reserved for the inmate who is not actively suicidal, but expresses suicidal

ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. It is also for an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury.

ii. This inmate should be observed by staff at staggered intervals not to exceed every 10-15 minutes and should be documented as it occurs.

c. ***Mental Health Observation***

i. Is reserved for the inmate who is not suicidal but assessed to need closer observation based upon behavior and/or serious mental illness. This observation level often includes inmates displaying concerning, non-suicidal behavior, or inmates adjusting to the initiation of, or change in, psychotropic medication. There should be no mention of current suicidal ideation (e.g., "fleeting thoughts of suicide"). It can also be utilized as a step-down from suicide precautions.

ii. This inmate should be observed by staff at staggered intervals not to exceed every 30 minutes and should be documented as it occurs.

iii. Inmates placed on this level of observation shall be issued regular clothing and have full access to other possessions and privileges, unless serving a disciplinary sanction.

5. Suicide risk assessments should take place in a private and confidential setting. If an inmate refuses a private interview, or there are individualized safety and security reasons preventing it, the reason(s) must be documented in ccLink.

6. The "Detention Mental Health Suicide Assessment" form should be revised to include inquiry regarding the following risk factors, as well as absence/presence of any protective factors: hopelessness/helplessness, agitation/anxiety, recent

loss/change of psychosocial circumstances, family history of suicide, and substance abuse, as well as a listing (or absence) of protective factors.

7. Specific and individualized "patient safety plans" should be developed for housed inmates discharged from suicide precautions. The plans should describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur.

8. Housed inmates discharged from suicide precautions should remain on the mental health caseload and receive regularly scheduled follow-up assessments by clinicians until released from custody. As such, unless an inmate's individual circumstances directs otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), the follow-up schedule will be simplified and revised as follows: follow-up within 24 hours, again within 72 hours, again within 1 week, and then periodically as determined by the inmate's mental health track level.

IX. Safety Cells

A. General Provisions

1. The overall goal is to use safety cells as infrequently as possible and for as short a period as possible for each patient.

2. The County shall identify patients with frequent safety cell placements. The determination of what constitutes "frequent" shall be at the discretion of a QMHP but shall apply at a minimum to patients with three stays in a six-month period. Patients identified in this manner will be subject to a brief mental health assessment by a QMHP within a week of identification. If clinically indicated, a QMHP will develop a behavioral management plan for the patient in consultation with custody staff.

3. Safety cells and restraint chairs shall be cleaned and sanitized after every use.

4. Patients in safety cells shall be offered meals three times a day. Patients shall be offered water at least every two hours, when awake. Patients shall be offered food or water more frequently, if clinically indicated. These contacts shall be recorded in the log.

5. Patients will be offered all prescribed medications at the appropriate times, unless unforeseen circumstances arise and then medications will be offered once the circumstance has been resolved. The provision of medications will be recorded in the electronic medical record.

6. Patients in safety cells shall be offered use of the toilet facilities at least every four hours and showers every 48 hours while awake. These contacts shall be recorded in the log. Any exceptions for patients who are physically aggressive or highly agitated must be made by a QMHP, in consultation with custody, on a case by case basis.

7. Confidentiality: Patients housed in a safety cell shall be seen in a space with auditory privacy from other staff and patients, unless there are individualized safety and security concerns.

8. Use of eye bolts in the safety cell shall be prohibited.

B. Property Restrictions

1. Following placement in a safety cell, any property restrictions with respect to clothing and other items (e.g., books, slippers/sandals, eyeglasses) shall be made by QMHPs on a case-by-case basis through consultation with custody and recorded in the medical record. Custody staff can make such restrictions in exigent circumstances.

2. A suicide resistant mattress, blanket, and safety clothing will be provided unless there are documented individualized reasons for not providing these items. That determination shall be made after consultation between clinical and custody staff.

C. Supervision

1. Custody supervisors shall periodically question patients in the safety cells to assess the welfare of the patients and check the accuracy of the logs. The findings will be recorded in the observation logs.

2. Custody supervisors will regularly inspect the cells and logs when safety cells are occupied.

3. A lieutenant will inspect the logs at least weekly.

X. Restraints and Seclusion

A. The overall goal is to use restraint chairs as infrequently as possible and for as short a period as possible for each patient.

B. Patients requiring use of the restraint chair shall not be housed in a public passageway.

C. Clinical restraints and/or seclusion may only be used for the management of violent, highly disorganized or self-destructive behavior due to mental health needs or behavioral health crisis.

D. The County shall identify patients with frequent clinical or custodial restraint or seclusion placements. The determination of what constitutes "frequent" shall be at the discretion of a QMHP but shall apply at a minimum to patients with three such placements in a six-month period. Patients identified in this manner will be subject to a brief mental health assessment by a QMHP within a week of identification. If clinically indicated, a QMHP will develop a behavioral management plan for the patient in consultation with custody staff.

E. Policies and Procedures

1. A physician order will be obtained for all patients placed in clinical restraints or seclusion, within one hour from the time of placement. For people in custodial restraints, clinical health staff will be consulted on placement and retention within one hour from the time of placement.

2. A QMHP will conduct a face to face assessment within one hour of restraints or seclusion.

3. Policies will describe the nature and frequency of professional contacts.

4. The County will use restraints and seclusion only when less restrictive alternative methods are not sufficient to protect the patient or others from injury. Restraint and seclusion shall not be used as punishment, in place of treatment, or for the convenience of staff.

5. There shall be no "as needed" or "standing" orders for clinical restraint or seclusion.

6. Policies will identify what types of restraints may be placed for medical/mental health purposes.

7. When restraints or seclusion are used, clinical health staff (for clinical restraints) and custody staff (for custodial restraints) will document the reason for their application and the times of application and removal of restraints.

8. Individuals in restraints or seclusion will be directly observed every 15 minutes. All checks will be documented.

9. Fluids shall be offered at least every four hours and at mealtimes.

10. Patients in restraints shall be checked within one hour of placement and every two hours thereafter by clinical health staff for vital signs, neurovascular assessment, and limb range, and offered an opportunity for toileting.

11. Clinical restraints and seclusion may not be used for medical/mental health purposes beyond four hours without an evaluation by a QMHP and a physician order.

12. If the facility manager, or designee, in consultation with responsible health care staff, determines that an inmate cannot be safely removed from custodial restraints after eight hours, the inmate shall be taken to a medical facility for further evaluation.

XI. Custodial Matters

A. Out of Cell Time

1. Under ordinary circumstances, out of cell time will be scheduled during the hours of 8 a.m. through 10 p.m., six days a week, with the first inmate or group of inmates scheduled to receive out of cell time

no later than 8:00 a.m. On clean-up day, i.e., the seventh day, scheduled out of cell time will begin once the clean-up has been completed. Any cancellation of scheduled out of cell time for the entire module or large group within the module shall last only so long as needed to ensure safety and security, as determined by the appropriate supervisor. Nothing in this section prevents scheduling additional out of cell time outside these hours.

2. In order to maximize out-of-cell time, the County shall have a process to allow inmates to be released together as much as possible. Mental health and custody leadership shall collaborate to maximize the opportunities for inmates to spend time out of their cells safely and productively.

3. Inmates shall be offered outdoor recreation time, weather permitting, a minimum of 3 hours a week, except as set forth in patients' plans of care or if there are unusual occurrences, e.g. a group disturbance or institutional emergency, that requires temporary suspension of recreation access. Any unusual suspension of outdoor recreation time shall last only so long as needed to ensure safety and security, as determined by the appropriate supervisor.

B. Mental Health Issues

1. Custody staff shall refer patients who self-isolate to mental health staff. The County shall provide training to custody staff to identify such patients.

2. Information orienting patients to the mental health services available in the County's detention facilities shall be provided to inmates at booking and via the kiosks when available.

C. Clinical Input into the Disciplinary Process for Track 1 and Track 2 Patients

1. Prior to conducting any discipline-related hearing, custodial staff shall determine whether the individual subject to potential discipline is on track 1 or 2 and, for any such individual, obtain clinical input from a QMHP respecting:

    a. Whether the behavior at issue was a consequence of the individual's mental health or might have been influenced by individual's mental health; and

b. Whether, in the opinion of the QMHP, disciplinary sanctions should be mitigated due to the patient's mental health.

2. Custody staff shall consider such input in determining whether to find the individual guilty of a rule violation and, if so, the disciplinary sanction, the determinations of which are within the sole discretion of custody staff. Custody staff shall indicate whether the findings of any violation of applicable rules and/or disciplinary sanctions were mitigated based on the input by the QMHP.

3. The County shall develop and implement an evaluation process as part of the Quality Improvement program to periodically track this procedure and determine what percent of the time the clinical input results in mitigating findings or disciplinary sanctions.

D. Administrative Segregation

1. Except where clinically indicated or necessary due to exigent circumstances, track 1 and track 2 patients shall not be housed in dedicated administrative segregation housing.

2. Any track 1 or track 2 patient placed on D Module will have a plan of care that includes criteria for moving off of D Module and the date by which the movement is expected to occur.

3. Inmates shall be classified according to the Sheriff's Department's classification policy. The County shall not classify inmates as high security or administrative segregation based solely on a mental illness or other disability, but may classify them as high security or administrative segregation due to behavior resulting from a mental illness or other disability.

4. Track 1 and track 2 patients who are placed in administrative segregation shall be seen by a QMHP at least once a day, unless otherwise clinically indicated.

5. Inmates classified, at time of booking or at any later re-classification, to be placed in administrative segregation will be screened by a QMHP within 72 hours of placement. Classification placement in administrative segregation under this paragraph will be re-evaluated every 30 days. The QMHP will determine whether there is:

a. an exacerbation of the patient's mental illness, if any, and, if so, whether placement in administrative segregation is appropriate in light of the exacerbation;

b. evidence of a need for hospital level of care;

c. an inability to tolerate that level of confinement; and

d. any other mitigating circumstance to warrant a different placement.

If the QMHP determines any of the factors exist, the QMHP will confer with custody staff (facility commander or his/her designee) to determine if alterations to the patient's placement are warranted. If they cannot come to an agreement on the appropriate placement, the question shall be referred to the facility commander and the mental health program manager. Custody staff shall retain final authority as to where to place the inmate.

6. Any patient in segregation who is receiving prescription medications will receive those medications from medical staff at the cell in lieu of dayroom pill call.

XII. Pre-Release Discharge Planning

A. For patients being released to the community, the County shall provide discharge planning for mental health patients, when a release date is known 3 days in advance, providing information and referring them to community health care providers, community social services, community-based housing providers, and/or appropriate services according to the patient's need.

1. Documentation of the health-related pre-release planning efforts made on behalf of track 1 and track 2 patients will be maintained by clinical health staff in the electronic health record.

2. The County shall track the elements of discharge planning for the track 1 and track 2 patients, including:

a. The total number of track 1 and track 2 patients with a projected release date receiving discharge planning per month;

b. How many of that subset received referrals for outpatient appointments, discharge medications, and 5150 referrals.

B. Discharge Medications

1. The County shall implement a system that allows patients who are prescribed psychiatric medications in the jail to discharge from custody with at least a 14-day supply of medications or a prescription, when clinically indicated. Providing medications is the preference when Health Services is provided at least four business days' notice of the release, but the reality of detention is that there is often no advance notice of a patient's release. Patients leaving the facility will be provided with one of the following for their psychiatric medications, in the order of preference, subject to sufficient notice:

a. A 14-day supply of medications;

b. A prescription for the medication; or

c. A prescription sent to the patient's preferred pharmacy, or, if none, a pharmacy close to the patient's last known address.

XIII. Quality Improvement

A. General

1. The County shall conform its quality improvement plan to the community standard.

2. The County shall develop a Quality Improvement Annual Plan with at least two quality improvement studies per year.

3. The quality improvement committee shall meet at least quarterly.

B. Data Collection/Tracking

1. The County will collect data to ascertain the mental health needs of the jail population.

2. The county shall, at a minimum, track the following measures: starting times for out-of-cell time on clean-up days, any cancellation of out-of-cell time for an entire module or large group within a module, compliance with sick call triage, medication refusals, delays in prescription renewals, compliance with medication administration policy, and wait times to see nurses and clinicians, use of suicide precaution, restraint and clinical seclusion.

C. Adverse Event Review

1. The County shall have a policy creating a final documented adverse event review, including interventions and root cause analysis, when indicated, for use within the detention facilities for all in-house deaths and serious morbidities as defined by policy.

2. The County shall develop any necessary corrective action plans based on the reviews looking for systems issues that were identified and correct physical or procedural issues uncovered by the adverse event review process.

3. The County shall track the outcome of applied interventions.

D. Core Elements of QI Plan

1. Intake. Periodic quality improvement reviews of the intake process shall be done to ensure that this most critical function is done with accuracy and that the appropriate referrals are initiated. This includes review of the intake referrals to mental health.

2. Safety Cell Placement. The County shall have a plan to track, review and discuss safety cell placements as part of quality control as well as collaboration between custody and clinical staff.

3. Clinical Restraints and Seclusion. The County shall have a plan to track, review and discuss clinical restraints and seclusion placements as part of quality control as well as collaboration between custody and clinical staff.

4. Triaging Health Requests. Compliance reviews to accurately monitor the efficacy of the process.

5. Tracking of Non-Formulary Requests. Shall be included in the quality improvement practices of the facilities to ensure that appropriate agents are utilized when clinically justified.

6. Morbidities and mortalities

7. Annual staffing analysis

8. Suicide prevention

9. Medication monitoring

10. Adequacy of discharge planning for track 1 and 2 patients

11. Off-site emergency referrals

XIV. Electronic Health Record

A. By March 1, 2019, mental health staff shall review all of the Detention Mental Health specific content currently in the electronic health record and make recommendations for modifications to customize content to the needs of Detention Health setting, if any needed.

B. Electronic health records shall always indicate the date/time of an interaction with a patient, as well as the date/time the interaction is documented, since there may be lapses in the two events.

XV. Implementation of Plan

A. The Health Services Department will revise its detention policies and procedures as necessary to reflect all of the remedial measures described in this Remedial Plan, and the County shall deliver health care pursuant to these revised policies and procedures.

B. In collaboration with the Health Services Department, the Sheriff's Department shall develop and implement such new policies and procedures as are needed to comply with the provisions of this Remedial Plan, including but not limited to the implementation of proper policies,

procedures, and corrective action plans to address problems uncovered during the course of quality assurance review activities.

C. On a rolling basis but no longer than six months from the date the Consent Decree is signed by the Court, the County shall provide a draft of the policies and procedures added or revised as a result of this remedial plan to plaintiffs' counsel for review. If there is a conflict, the parties will provide the policies and procedures to the expert for review. The County's policies and procedures will include the recommendations of the Mental Health Expert's Report of May 17, 2017. Any disputes regarding policies and procedures are subject to the Dispute Resolution procedure in Section G of the Consent Decree as well as terms contained in Section B, paragraph 10.]

D. The County shall formulate and conduct appropriate training with all staff regarding the requirements of this Remedial Plan, as well as changes to policies and procedures.

E. Unless otherwise indicated herein, the policies and procedures shall be implemented as soon as practical once the Consent Decree is signed by the Court, except as to those that remain the subject of the Dispute Resolution procedure in Section G of the Consent Decree.