

JAIL & JUSTICE SYSTEM ASSESSMENT

Montgomery County
Adult Correctional System Review

December 7, 2021

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Needs Assessment Consulting Team:

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Executive Summary

This review of the Montgomery County (County) jail and justice system provides analysis of current and projected justice system needs as they relate to the current jail facility. The analysis highlights trends that contributed to current system issues, as well as current justice system programs that have been developed in response to these issues. It should be noted our analysis and review took place prior to the COVID-19 epidemic hitting our Country and Montgomery County. Key findings of this report include:

- The current physical plant of the Montgomery County Jail inhibits the ability of County staff to provide current best practices in the areas of care and supervision of detainees. Major areas of concern are lack of space for social workers and program providers, inadequate medical facilities, and inappropriate housing for persons with mental health needs.
- The average length of stay for a detainee in the jail is low, approximately 50 percent below the national average. The incarceration rate for the county is in the mid-range of the ten largest counties in Ohio.
- The medical services areas are cramped and undersized. Housing for detainees in need of medical care is deficient in both area and capacity. There are no medical program areas in the housing units, which necessitates most service delivery be limited to the clinic, which lacks adequate space and has limited functionality.
- The lack of available space for program services places severe limits on providing rehabilitative programming in the facility. While jail management coordinates a variety of volunteer programs for the detainee population, the facility lacks space to provide evidence-based programs to detainees in need of these critical services.
- Existing community programs provide a robust set of alternative sanctions and diversion from the jail. While the effectiveness of some services could be improved with additional resources to address service needs, the overall system of programs is consistent with best practices. One area of unmet need is a community mental health crisis stabilization center.
- In recent years there has been an increased use of citation and release by law enforcement agencies, diversion of low risk offenders from incarceration, and the expedited processing of cases. These policies have been used to manage the jail population within the constraints of the current facility.
- Demographic and crime trends indicate a relatively stable jail population over the next thirty years. Our projection model indicates the average daily general population at the jail will grow to 903 detainees by 2050, an increase of 11.9 percent over 30 years, or an annual increase of 0.4 percent.
- In order to assure enough beds to accommodate fluctuations in population levels and manage different classifications or types of detainees, this population level will require a

capacity of 1,038 general population beds by 2050. The need for dedicated beds for mental health treatment, medical housing, and segregation adds 150 – 200 additional beds to required facility capacity needs, for a total of 1,134 beds.

Section I. Project Background

In September 2019, Montgomery County contracted with HDR, Inc. to review the County's long-term jail facility needs. The first phase of the project reviewed current issues with the jail and its role in the local criminal justice system, as well as long-term jail capacity requirements for the County. The review included an assessment of existing alternatives to incarceration, an analysis of current jail operations, and an assessment of medical care and mental health service delivery.

Key elements of this Phase 1 review include:

- *Analysis of justice system characteristics and conditions*
- *Profile of the offender population*
- *Review of current jail operational staffing*
- *Assessment of in-custody and community programs*
- *Analysis of current and future capacity needs*

Methodology

The project team used a comprehensive information-gathering and data review process that utilized four primary approaches: data analysis, stakeholder and staff surveys, stakeholder and staff interviews, and facility reviews.

Data analysis: We reviewed historical and current data describing the jail population, programs, staffing, and service delivery. We also reviewed a wide range of data describing program alternatives to jail and the utilization of these programs.

Stakeholder and staff surveys: In order to gain background and context for the review, we surveyed with key justice system stakeholders and program administrators. These surveys requested perspectives on the key issues facing the local justice system, the jail, and opportunities for system improvements. We collected surveys from judges, police chiefs, Sheriff's Office staff, the public defender, the prosecutor's office, probation, and medical service providers.

Stakeholder and staff interviews: We supplemented the written documentation and data provided by the County with information gained from extensive interviews with key justice system stakeholders and program administrators. These interviews centered on internal perspectives of the key issues facing the County justice system, strengths of the current programs, and opportunities for improved performance. Montgomery County jail staff provided information on the physical layout of the jail facility, organizational structure, classification method, detainee demographics, and infrastructure challenges,

Facility review: The project team also participated in multiple tours of the jail to gain firsthand exposure to the layout of the facility and management's approach to operations and the delivery of programs and services. The project team also reviewed existing floor plans and had numerous discussions with staff and stakeholders to obtain a more thorough understanding of the facility's history, including the 1964 original jail, 1992 addition, and renovations. The project

team also reviewed ancillary functions for the jail that directly support the detention function to determine the adequacy of services in those areas. These tours and discussions provided first-hand exposure to the conditions of these facilities and the County's approach to operations and the delivery of program services.

Section II. Jail Overview

Key Findings:

- *The current jail facility houses more than twice the number of detainees its capacity should support according to the Ohio Department of Rehabilitation and Correction. Jail population demands have sometimes forced double occupancy of every general population housing cell in the facility as well as the conversion of recreation and program space to dormitory housing.*
- *Jail bookings have dropped by 26 percent over the last ten years due to diversion of misdemeanor offenders away from the jail.*
- *Although the jail's average daily population has been relatively stable over the last ten years, the proportion of female offenders in the jail has grown by 15 percent.*
- *With the increasing proportion of felony bookings into the jail, the average length of stay has increased by 37 percent over the last ten years to 12.68 days. This level is approximately 50 percent below the national average length of stay in county and municipal jails.*
- *Montgomery County's use of jail incarceration compared to benchmark counties in Ohio is near the average for the group. Montgomery County also is near the average in the rate at which it utilizes the state prison system.*

The mission of the Montgomery County Jail is to protect and serve the citizens of Montgomery County by providing care, custody and control of legally incarcerated pre-trial and sentenced detainees in a safe and secure environment. It is the intent of the jail to deliver basic human services fairly and equally in the most cost-effective manner possible.

The Montgomery County Jail is a multi-story structure located in downtown Dayton, OH. The original portion of the jail, built in 1964, is a four-story structure with linear style housing. A second phase of the building, built in 1992, adding four additional direct supervision housing pods and support spaces. The most recent renovation, completed in 2004, double-bunked the cells in the four direct supervision style housing pods, bringing the jail up to its current capacity of 910.

The first floor of the 1964 section of the jail houses the medical services component and two minimum security dormitories which are used for swing housing for either male or female detainees depending upon the need and for overflow housing. The larger of the two dormitories with a capacity of 58 is direct supervision. That post is also responsible for intermittently supervising the second dormitory located nearby. The medical services component include exam and treatment rooms, office space for medical staff, and several infirmary beds. The jail's Treatment Coordinator also has an office in this area.

Detainee housing on the second, third, and fourth floors of the older portion of the jail is predominantly linear style multiple occupancy housing units or dormitories. The second-floor

houses primarily female detainees. The housing on this floor does include two minimum security dormitories designated as swing housing for either male or female detainees depending upon the need. The third floor of the older section houses general population male detainees in what is classified as medium-maximum security housing. Third floor housing is a combination of single occupancy housing units, multiple occupancy housing units, and dormitories. The fourth-floor houses male detainees in administrative segregation and disciplinary detention. Detainees are housed in units with single occupancy cells or in smaller dormitory style units. Currently one Correctional Officer is assigned to supervise detainees on each of these floors.

The pod housing was added in later construction in 1992. This section of the building includes four direct supervision housing pods stacked on two levels. Each pod was designed originally with 48 single occupancy cells that have been since double bunked. In addition a recreation/program room in each pod has been converted to 8-bed dormitories bringing the total capacity of each pod to 104. The pods are designed as typical direct supervision housing unit with a staff workstation inside the dayroom area. Exercise areas are located adjacent to and accessible from each pod.

An assessment of space utilization and existing conditions in the existing facility by functional component can be summarized as follows:

Public Entry Area

Provides general public access and circulation for the facility. The reception lobby on the first floor provides space to receive, stage, and direct visitors to visitation areas.

Facility Administration

A building across the street from the jail houses the majority of the jail administration. Offices for supervisory staff in the jail are provided in various location in the facility where space is available.

Staff Services

Staff lockers for male, female uniformed staff and a small staff break/dining room are provided on the ground (lower) level of the facility. Staff amenities in the facility are extremely limited.

Central Control

Located in the center of the main level, in proximity of the detainee and release area, the Central Control Room controls staff/other access to the secure parts of the facility.

Intake/Transfer/Release

The intake/transfer/release component is located on the first floor, adjacent to the vehicular sallyport. It was designed for both central booking and intake/ transfer/ release functions. The property room stores property for detainees in the facility. This is an extremely busy areas with intake, release, records, classification, property, court transfer, and utility/escort staff all working within or staged out of this area.

Food Service

The food service area is located on the ground floor (lower level) and was designed as a full-service cook-serve facility. Currently, this area is operated by a contract vendor. In this facility

the food is portioned onto insulated serving trays for movement to each respective housing area. Detainees take their meals in dayroom areas or cells depending upon where they are assigned.

Laundry

The laundry area is located on the ground floor (lower level) as well. This area handles all laundry from the facility. Laundry services are also provided by detainee workers supervised by a Laundry Officer on second watch (day shift).

Loading Dock/Central Storage

The dock for receiving deliveries and central storage areas are located on the ground level. The west end opens onto a two-bay loading dock.

Program Services

This component deals with the provision of counseling, recreation, and related services to detainees during incarceration. There is one classroom available for programs. Space available for detainee programs is woefully inadequate and inconsistent with the desired operational philosophy of the Sheriff's office to provide opportunities for detainee self-improvement. Space originally designed for potential program use on the direct supervision pods has been repurposed as additional housing. An indoor gym that is utilized by detainees in the linear housing is located on the fourth floor. The pods have ample space in the dayrooms for indoor recreation and have outdoor recreation areas located adjacent to each pod. Secure outdoor recreation areas have been designed for access by every housing unit.

Library

There is a central library area on the fourth floor adjacent to the gym that provides legal materials and general reading materials for prisoners. Detainees, depending upon classification, may visit the library during gym time or books may be brought to detainees via book cart. The location of the library is difficult to monitor.

Visiting

Visiting is primarily non-contact and is decentralized. Visitors access non-contact visitation areas on each floor of the linear housing. Non-contact visiting space is provided on the mezzanine level of each direct supervision pod. Professional visiting/interview rooms are located on the first floor adjacent to the Intake area.

Health Services

Centralized clinic and infirmary space is provided in the older section of the first floor. This includes medical exam/treatment rooms, pharmacy, dentist space, and related facilities for detainees that need to be seen by a doctor or dentist. Sick calls are typically handled in housing unit before an appointment is made for the central clinic visit – which can handle a limited number of prisoners at a given time. A total of four inpatient medical rooms are provided as part of the infirmary area. Space for medical services is extremely limited and not well designed for efficient delivery of medical services. Health services are provided by a contract vendor.

Commissary

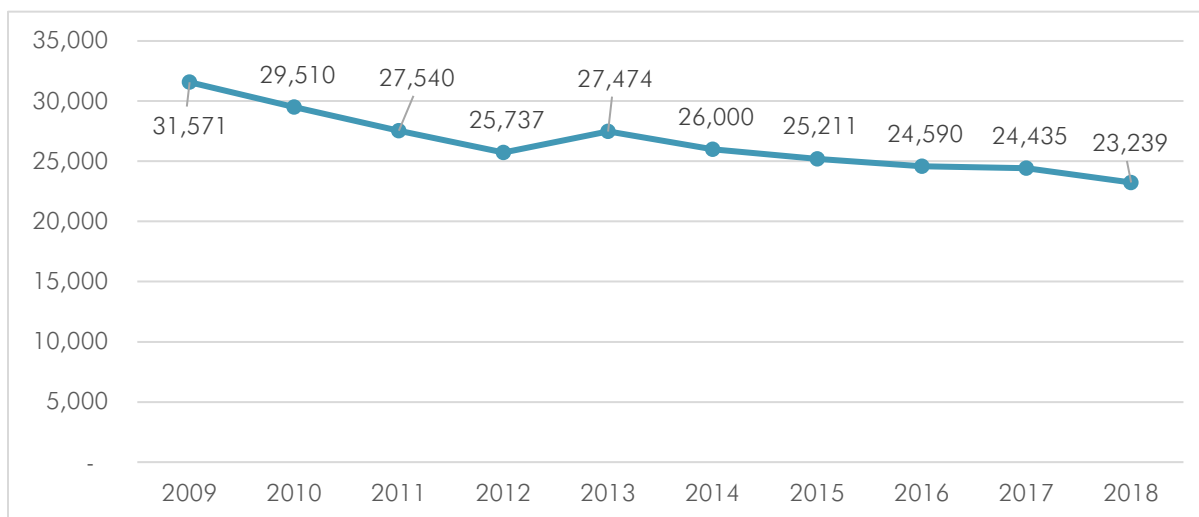
There is a central commissary, staging area on the ground floor (lower level) near the loading dock that provides commissary items to detainees on a regularly scheduled basis. Once orders are filled, they are delivered to each housing unit.

Though the facility has been operating at 910 beds, the Ohio Department of Rehabilitation and Correction, Bureau of Adult Detention's recommended capacity for the facility is 443 beds. In effect, jail administrators have maximized the housing capacity of the facility by double-bunking available single cells and converting common areas to dormitory housing to support population levels far beyond the level the facility was designed to sustain.

Jail Bookings and Population Trends

Figure 1 shows the trend in admissions into the County jail system. In 2018, there were a total of 23,239 bookings into the jail. This represents a drop of 8,832 bookings over the last ten years, or a reduction of 26.4 percent. The reduction was most pronounced from 2009-2012, followed by a sharp increase in booking in 2013 and subsequent moderate annual declines. Jail bookings through August 2019 are down by 1 percent from the same period for 2018. The jail is averaging 1,981 bookings per month in 2019.

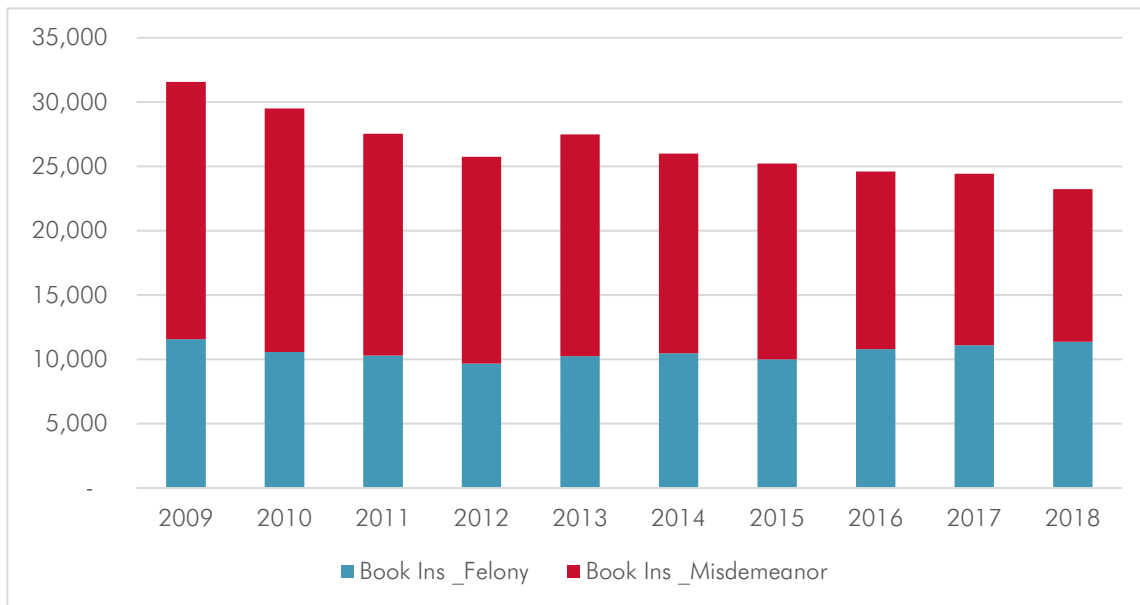
Figure 1: Montgomery County Jail Bookings, 2009 – 2018



Source: Montgomery County Sheriff's Office

The profile of offenders booked into the jail has changed substantially even as the overall number of bookings has declined. Felony bookings over the last ten years have remained stable, with 2018 felony bookings only 1.6 percent below 2009 levels. Total misdemeanor bookings fell by 41 percent during the same period. While misdemeanor offenders made up nearly 64 percent of total bookings in 2009, by 2018 the number of misdemeanants booked into the jail had fallen to approximately 52 percent of total bookings. It should be noted, the decline in misdemeanor bookings is indicative of a successful effort to divert low-level offenders away from the jail.

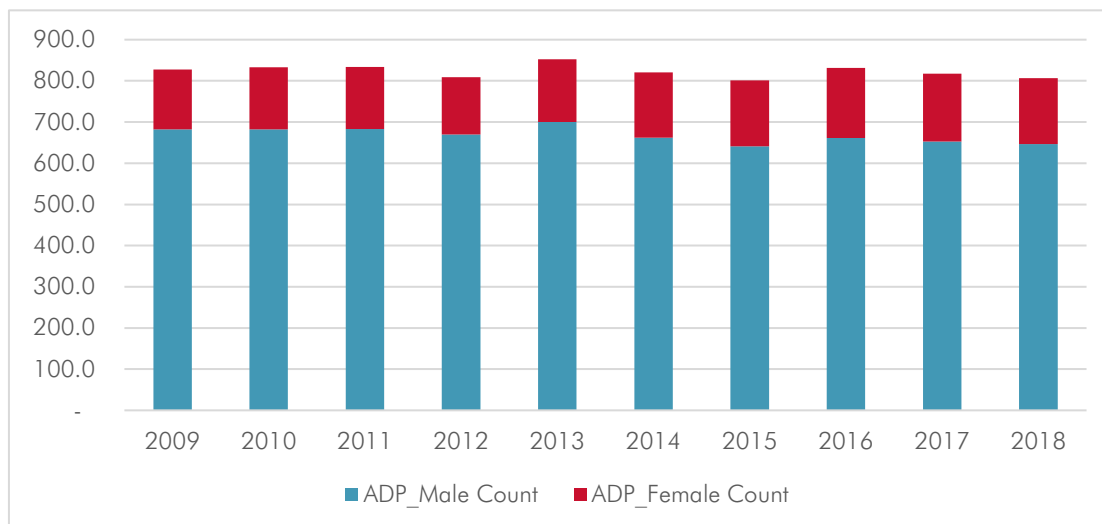
Figure 2: Misdemeanor & Felony Jail Bookings, 2009 - 2018



Source: Montgomery County Sheriff's Office

Despite this drop in bookings, the average daily population at the jail over the last ten years has been stable, generally ranging from 800 – 830 detainees. The average number of female offenders in the jail averaged 160 in 2018, an increase of 15 over the last ten years. Female offenders now make up 19 percent of the average daily jail population. The average number of male detainees decreased from 682 to 646 from 2009 to 2018.

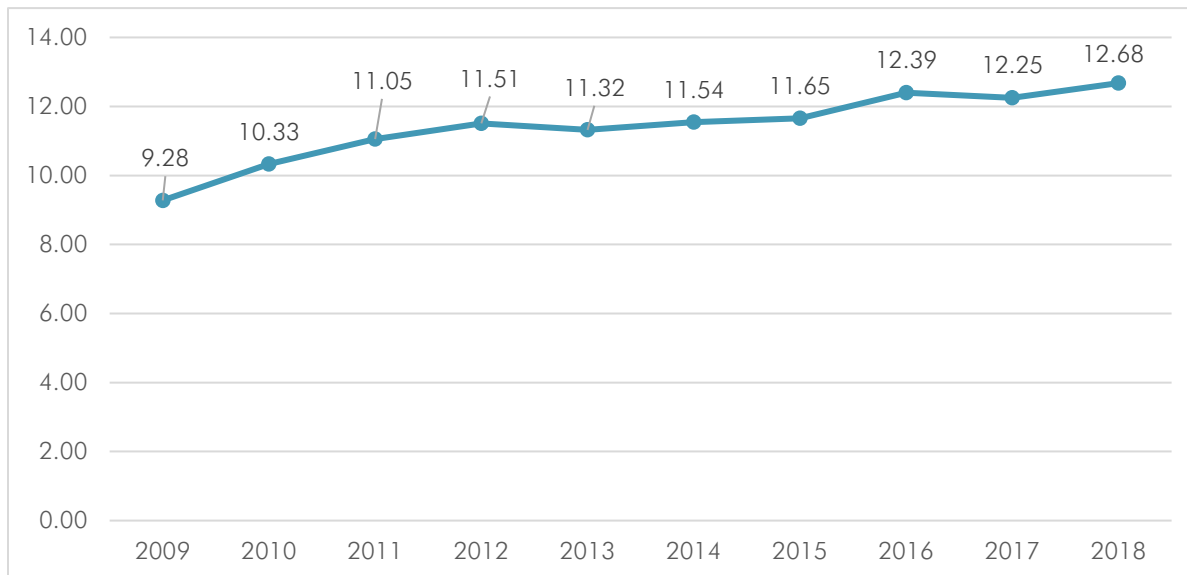
Figure 3: Montgomery County Jail Average Daily Population by Gender, 2009 - 2018



Source: Montgomery County Sheriff's Office

Part of the reason for the stable ADP is that even as bookings have dropped, the average length of stay in the jail has increased over the last ten years, growing from 9.28 days in 2009 to 12.68 in 2018, an increase of 37 percent.

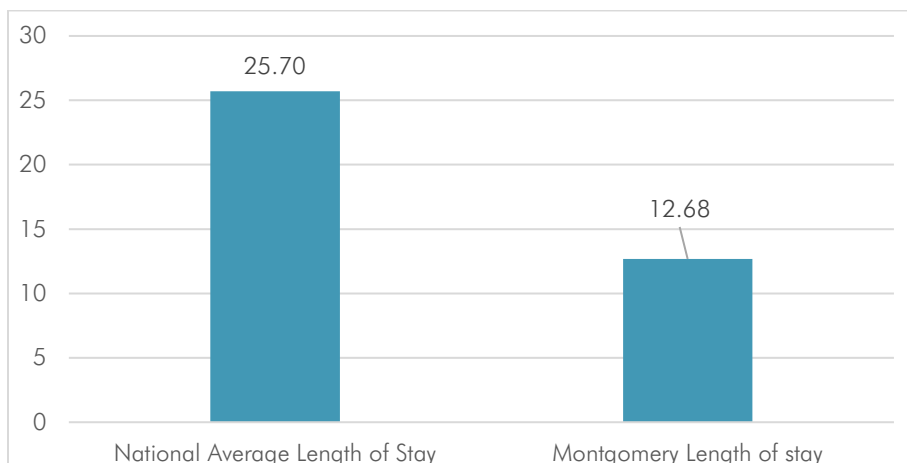
Figure 4: Montgomery County Jail Average Length of Stay, 2009 - 2018



Source: Montgomery County Sheriff's Office

Even with this increase, the length of stay in the Montgomery County Jail is nearly 50% below the national average for jail length of stay as reported by the Bureau of Justice Statistics. This suggests that County programs to expedite the return of offenders to the community has been effective.

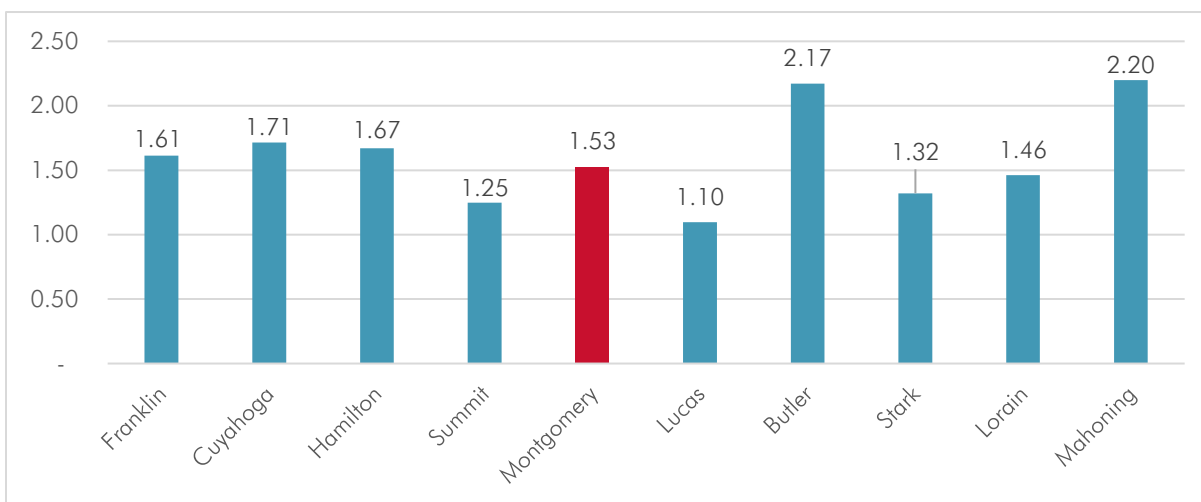
Figure 5: Jail Length of Stay, United States Average & Montgomery County



Source: Montgomery County Sheriff's Office; US Department of Justice, Bureau of Justice Statistics

Based on comparisons with the ten largest counties in Ohio, Montgomery County appears in the mid-range in its jail use, as indicated by the incarceration rate (the number people incarcerated in the jail per 1,000 county residents) and the number of offenders sent to prison from the county (Ohio Department of Rehabilitation and Correction detainee population from the county per 1,000 county residents.) The average jail incarceration rate for the ten largest Ohio counties is 1.60 compared to a jail incarceration rate of 1.53 for Montgomery County.

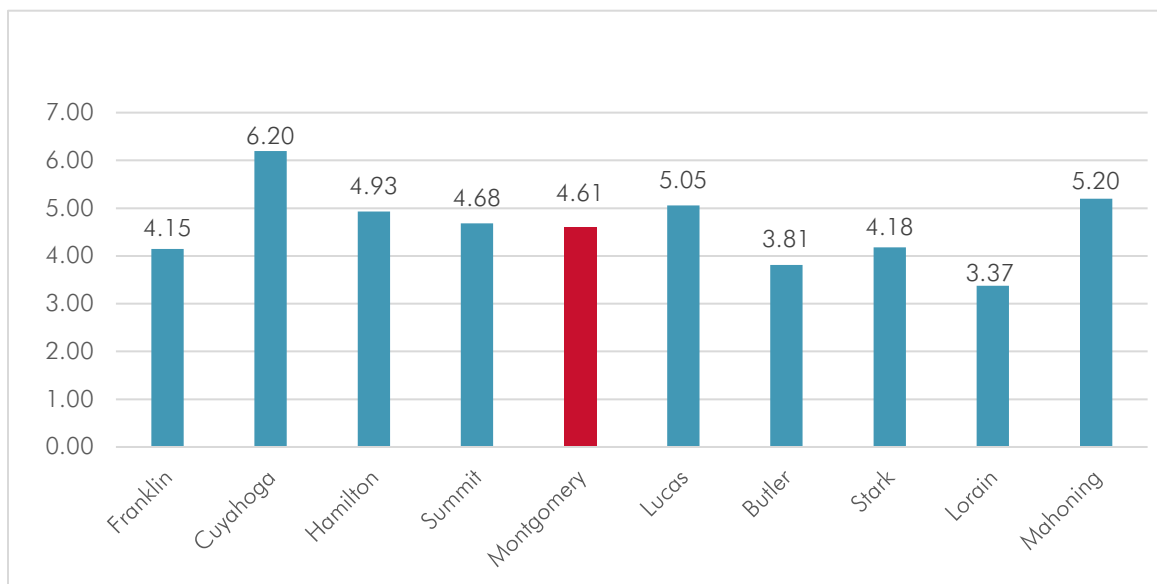
Figure 6: Ohio County Jail Incarceration Rate



Source: US Census, Ohio Department of Rehabilitation & Correction

Similarly, the state prison incarceration rate for Montgomery County is 4.61 compared to the ten-county average of 4.62. The data suggests that Montgomery County does not make excessive use of incarceration as a response to crime.

Figure 7: Ohio County State Prison Incarceration Rate



Source: US Census, Ohio Department & Rehabilitation & Correction

Section III. Detainee Characteristics

Key Findings:

- *82% of persons in jail are held on a felony charge*
- *17% of persons in jail are women*
- *Montgomery County has been hit hard by the opioid crisis and drug possession is the most common crime charged in the County*
- *Most of the persons in jail (77%) are residents of Montgomery County*

Booking and release data of Montgomery County detainee population from June 19, 2019 through January 30, 2020 was analyzed to determine the characteristics of the persons held in the jail. Data on 10,859 detainees was analyzed.

Detainee profile data is important as it describes the risks and needs of the detainees in the jail. This information is used to inform housing classifications and bed distributions as well as detainee programming needs. The data analyzed was collected from the Montgomery County Sheriff's Office. Where relevant, Montgomery County data was compared to national data trends for comparison purposes.

Felonies and Misdemeanors

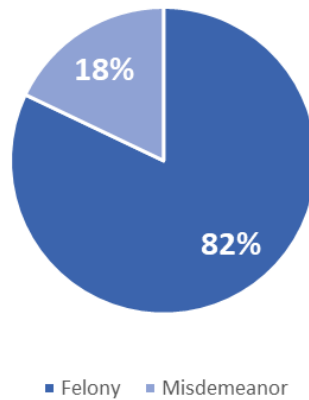
In Ohio, a crime that is more serious and can be punished by a year of incarceration in state prison is a felony. There are five classifications of felonies. A first-degree felony (F1) is the most serious classification of crime and a fifth-degree felony (F5) is least serious. Felonies generally include robbery and burglary, but they also include violent and assaultive type crimes.

Misdemeanors are less serious crimes that can be punished by a sentence of less than a year of incarceration in a county jail. There are various levels of misdemeanors ranging from first degree misdemeanors (M1) being most serious to fifth degree misdemeanors (M5). The least serious classification is minor misdemeanor (MM). Examples of misdemeanor crimes include passing bad checks, disorderly conduct, and petty theft (theft of goods or services less than \$500 in value). The percentage of misdemeanor crimes that are violent or include assaultive behaviors is relatively low.

In the data sample studied, 55% of those admitted to the jail were charged with a misdemeanor while 45% were charged with a felony. Those charged with a felony however occupied the vast majority of beds -- 82% for felonies and 18% for misdemeanors. This means that those charged with a misdemeanor are diverted from the jail for the most part through diversion programs, release on recognizance, and affordable bail.

The ratio of felony to misdemeanor charges in the jail vary from community to community. What the high ratio of felony charges means for Montgomery County is that the criminal justice system tends to only hold those with the most serious charges in the jail.

Figure 8: Felonies versus Misdemeanors by ADP



Source: Montgomery County Sheriff's Office

Opioids and Montgomery County

Opioids have had a devastating impact on the State of Ohio and especially Montgomery County. It's important to highlight this issue because it's a significant driver of the jail population and cause for arrests within the County. Ohio had the second highest number of opioid deaths per 100,000 population in the country in 2017 at 37 deaths per 100,000 only behind West Virginia at 50 deaths per 100,000¹.

Montgomery County had the second highest rate of opioid overdose deaths in the state at 88 deaths per 100,000.² This is nearly 2.4 times the state rate. And, the number of opioid deaths in Montgomery County, 470, is second only to Cuyahoga County at 524 deaths.³ And, it should be noted that Cuyahoga has more than twice the population of Montgomery County.

¹ Centers for Disease Control and Prevention (CDC), 2017

² Fayette County with a population of 28,655 (2017) had the highest opioid overdose death rate at 108/100,000 population according to 2017 CDC data.

³ Centers for Disease Control and Prevention (CDC), 2017

Crimes Committed and Use of Jail Beds

Of the men and women in jail, the most common charge is violating the condition of their probation. During the time period of the study, probation violators accounted for 114 ADP and made up 16% of those persons in jail on any given day. Those charged with drug possession (also coded as possession of drugs) represented 11% of the population on any given day.

Figure 9: Top 10 Charges by Average Daily Population (ADP)

Top 10 Charges by ADP					
Charge	Count	ALOS	ADP	% of ADP	
1 PROBATION VIOLATION CCS	939	27.5	114.1	16%	
2 DRUG POSSESSION	865	17.4	66.5	9%	
3 FELONIOUS ASSAULT	198	51.0	44.7	6%	
4 DOMESTIC VIOLENCE/INJRY	754	10.6	35.5	5%	
5 AGGRAVATED ROBBERY	98	81.7	35.4	5%	
6 MURDER	36	190.6	30.4	4%	
7 RAPE	52	106.7	24.6	3%	
8 HAVING WEAPONS WHILE UNDER DIS	155	34.5	23.7	3%	
9 AGGRAVATED BURGLARY	64	69.4	19.7	3%	
10 POSSESSION OF DRUGS	343	10.9	16.6	2%	

Source: Montgomery County Sheriff's Office

Frequent Users of the Jail

All criminal justice systems see people who are arrested over and over again. Many of these people are often homeless, and/or have substance abuse issues, or have mental health issues. In some jurisdictions it is not unusual to see upwards of the 30% of the jail population return to the jail three or more times in a single year.

In the seven months of data analyzed, very few persons returned to the Montgomery County Jail during that time period. 1.1% of those persons in the data base were incarcerated two times and only three persons (0.03%) were incarcerated three or more times.

Residency

The figure below indicates the residency of the detainees in the jail. Most (approximately 77%) of the detainees in the jail are residents of Montgomery County. Given a high percentage of detainees being local residents, many could benefit from wraparound services (mental health, substance abuse services, vocational services, and educational services) that begin in jail (i.e. detainee programming) and continue after release into the community.

Figure 10: Jail Population by Residency

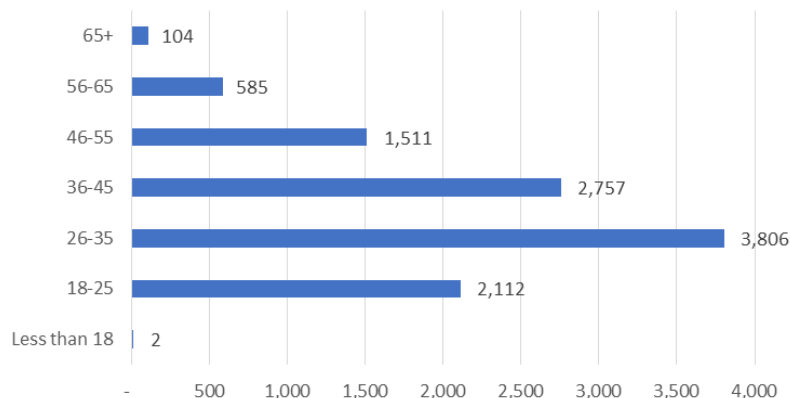
Residency		
	City	Count
1	DAYTON	6,220
2	TROTWOOD	369
3	HUBER HEIGHTS	367
4	MIAMISBURG	324
5	KETTERING	311
6	MORAIN	158
7	RIVERSIDE	149
8	WEST CARROLLTON	131
9	Vandalia	102
10	Englewood	97
11	Centerville	91
Total		8,319

Source: Montgomery County Sheriff's Office

Age of Detainees

54% of the jail population is 35 years-old or younger and 19.4% are 25 years-old or less. Younger populations can benefit from detainee programs focused on vocational training and cognitive-based treatment programs. Those over the age of 55 represent just 6.3% of the population. This population typically requires more medical attention and care.

Figure 11: Age Distribution of the Jail Population

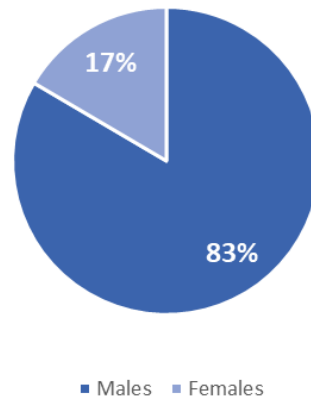


Source: Montgomery County Sheriff's Office

Gender

Nationwide, females make up the fastest growing cohort in jails and recent data indicates that females make up 15.3% of a typical jail's population.⁴ In the Montgomery County data studied, women made up 29% of admissions to the jail and they occupied 17% of the beds in the jail. According to the data, women in the Montgomery County Jail were charged with less serious crimes than men – 36.2% felonies versus 41.6% felonies for men. And their average length of stay was less than men – 13.9 days versus 24.5 days for men.

Figure 12: ADP by Gender



Source: Montgomery County Sheriff's Office

Female Detainee Characteristics

Nationwide there has been a dramatic rise in the number of women being held in local jails. Since 1970, the number of women in jail nation-wide increased 14-fold from under 8,000 to nearly 110,000.⁵ According to the latest data from the US Bureau of Justice Statistics, there are 113,700 women in jail, and they represent 15.3% of all persons held in local jails.⁶

Across the country the vast majority (82%) of women in jail are being held for lower-level, non-violent offenses. These include property offenses (32%), drug offenses (29%) and public order offenses (21%).⁷ And, women tend to have less extensive criminal histories compared to their male counterparts.⁸

⁴ Zhen Zeng, Ph.D. Jail Inmates in 2017. US Bureau of Justice Statistics, April 2019.

⁵ Vera Institute of Justice. Overlooked: Women and Jails in the Era of Reform. August 2016.
<https://www.vera.org/downloads/publications/overlooked-women-and-jails-fact-sheet.pdf>

⁶ Zhen Zeng, Ph.D. Jail Inmates in 2017. US Bureau of Justice Statistics, April 2019.

⁷ Vera Institute of Justice. Overlooked: Women and Jails in the Era of Reform. August 2016.
<https://www.vera.org/downloads/publications/overlooked-women-and-jails-fact-sheet.pdf>

⁸ Ibid ****[Throughout this Report, Ibid will indicate that the reference is from the same source as the previous citation]****

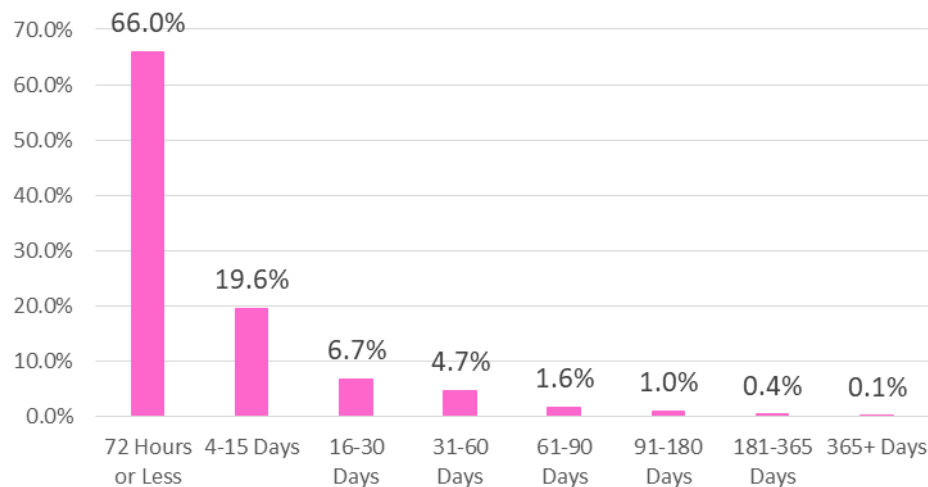
In Ohio, the percentage of women in jail is high compared to national statistics and there is likely a link between the number of women in jail and the prevalence of opioid use. As stated previously, Montgomery County has been hit hard by opioid use.

It is important to note that the majority of women across the county who enter jails have medical and behavioral health issues including medical problems (53%), serious mental illness (32%), and drug or alcohol abuse/dependence (82%).⁹ As a consequence, their care and housing become jail operational and physical plant issues.

From a system and community point of view, it is also important to note that women in jails are often primary caregivers to their young children – nearly 80% of the women in jails across the country are mothers, and most are single parents.¹⁰

As noted previously, 29% of the admissions to the jail during the course of the study were women. On average, each admission resulted in a stay 13.9 days with 66% of the women released within 72 hours of arrival. See Figure 13: Female Length of Stay Distribution.

Figure 13: Female Length of Stay Distribution



Source: Montgomery County Sheriff's Office

According to data, most of the women admitted to the jail were charged with a misdemeanor with 42.4% charged with a M1. See Figure 14. The most common charges for women were drug possession, probation violation, and theft of less than \$1,000.

⁹ Vera Institute of Justice. Overlooked: Women and Jails in the Era of Reform. August 2016.
<https://www.vera.org/downloads/publications/overlooked-women-and-jails-fact-sheet.pdf>

¹⁰ Ibid

Figure 14: Female Jail Data by Charge

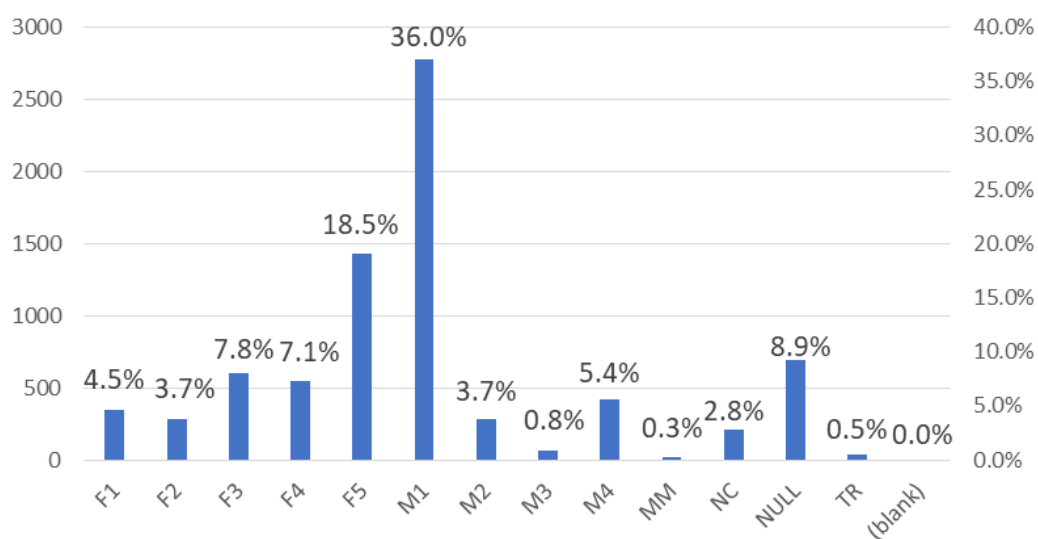
Female Data by Charge						
Charge	Number	Percent Number	ALOS	Detention Days	ADP	Percent ADP
F1	34	1.1%	70.1	2,382	10.6	8.1%
F2	82	2.6%	34.8	2,851	12.7	9.7%
F3	157	5.0%	20.6	3,232	14.4	11.0%
F4	152	4.8%	12.2	1,858	8.3	6.3%
F5	717	22.7%	14.8	10,602	47.1	36.0%
M1	1338	42.4%	4.2	5,598	24.9	19.0%
M2	133	4.2%	5.8	766	3.4	2.6%
M3	29	0.9%	10.0	290	1.3	1.0%
M4	194	6.1%	2.3	452	2.0	1.5%
MM	14	0.4%	3.4	48	0.2	0.2%
NC	79	2.5%	1.5	117	0.5	0.4%
NULL	208	6.6%	5.6	1,172	5.2	4.0%
TR	18	0.6%	0.9	17	0.1	0.1%
(blank)		0.0%	8.6	43	0.2	0.1%
Total	3,155	100%		29,428	130.8	100.0%
Average			13.9			

Source: Montgomery County Sheriff's Office

Male Detainee Characteristics

According to study data, 42% of the men admitted to the Montgomery County Jail were charged with a felony. In addition, the most common charge for men was a M1 charge at 36.0%. See Figure 15: Distribution of Charges – Men showing the top five crimes committed by men.

Figure 15: Distribution of Charges - Men



Source: Montgomery County Sheriff's Office

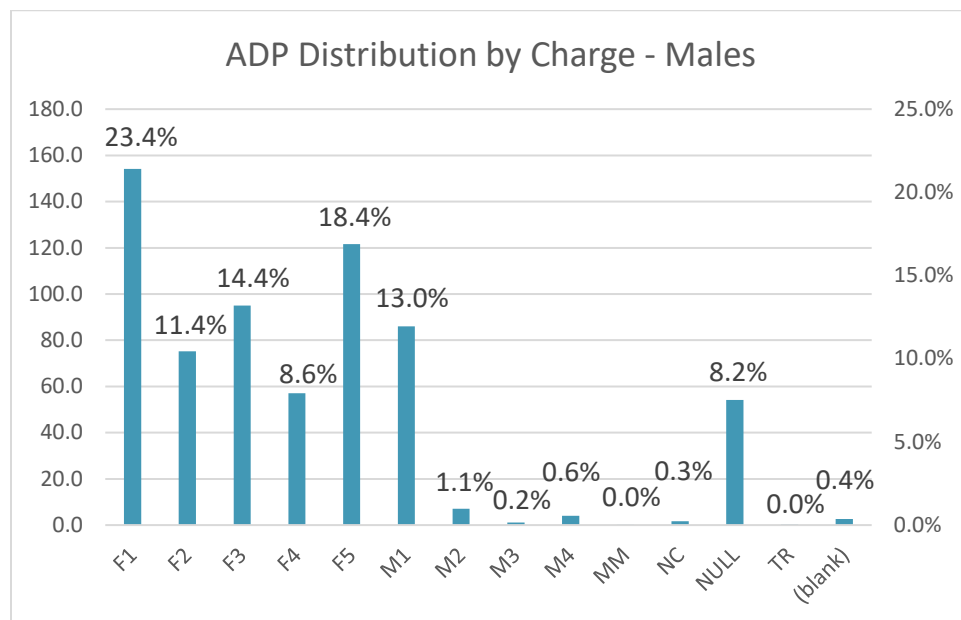
Figure 16: Top 5 Crimes Charged - Men

Top 5 Crimes Charged - Men		
Rank	Crime	N
1	Drug Possession	827
2	Probation Violation	625
3	Domestic Viol. w/Injury	552
4	Felonious Assault	344
5	Theft <\$1,000	219

Source: Montgomery County Sheriff's Office

As noted previously, 71% of the admissions to the jail during the course of the study were men. On average, each admission resulted in a stay 24.5 days. The longer stays compared to the length of stays for women are attributable to the severity of the crimes committed by men. Moreover, few men with misdemeanors are held in the jail. Of the men in jail during the study, 76.2% were charged with a felony.

Figure 17: ADP Distribution by Charge - Male



Source: Montgomery County Sheriff's Office

Section IV. Staffing

Key Findings:

- *Growth in the detainee population has led to persistent overcrowding and staffing levels have not kept pace with detainee population growth.*
- *There are insufficient staff to maintain routine custody operations, detainee services, and programs.*
- *Staff presence in detainee housing units should be increased to facilitate more active supervision of detainee behavior.*
- *The jail has had difficulty in recruiting and hiring to get staffing up to the full authorized strength due to tight job markets and less than ideal working conditions.*
- *Staff retention has been a problem. Turnover was 28% in 2017. Often staff leave to pursue law enforcement careers at other local jurisdictions and agencies who offer higher pay.*
- *Overtime use should be used for “healthy” purposes and not relied upon to cover staffing shortfalls in a long-term basis. Too much overtime contributes to burnout and increased leave usage, and likely contributes to turnover.*

Staffing Analysis Definition and Purpose

A staffing analysis is a study conducted of a jail to determine the number and type of staff required to operate safely and efficiently. The analysis is accomplished through a systematic evaluation of what work has to be done, where, and by how many persons at a given time; what schedule is most suitable for the work; and how many hours and days an average staff person is available to work per year.

The purpose of the study is to understand the existing staffing needs and provide a baseline for staffing in any renovation/expansion or new facility consideration. The study will also include recommendations for immediate opportunities to achieve staffing efficiencies.

Mission and Philosophy

A jail's mission describes the business purpose of the organization -- why it exists, who it serves, and how services will be provided. A jail's philosophy generally reflect the values and beliefs of the organization. They not only provide a basis for establishing goals, but also set ethical boundaries for how those goals are to be achieved in carrying out the mission.

The jail's mission defines, in part, how detainees will be housed and how they will be managed. The characteristics of the jail population can have a significant impact on staffing depending upon such factors as the number of detainees, age, sex, security level, special needs, and length of stay. Detainees with special needs and the specialized tasks associated with meeting special needs require specialized staffing. This may affect both the type of staff required and their qualifications.

The jail's philosophy also influences staffing. For example, a jail that leans toward rehabilitation or reintegration may provide additional staff for education, treatment, and work programs. They may also allow additional opportunities for visitation, telephone, or other services to help reduce idleness.

Physical Plant

The physical plant influences staffing needs in a number of ways:

- **Style of facility** - campus vs. single structure; level of security
- **Number of floors** - Staffing is required for each floor of detainee housing.
- **Location, size & style of housing units** - Style of housing unit (indirect vs. direct), cell type (single cell vs. multi-occupancy cell or dormitory), and housing configuration and proximity all influence staffing needs
- **Housing separations** - How detainees are separated impacts staff. More housing units generally require more staff.
- **Circulation** - Decentralization, or bringing services to the detainees, can reduce the need for staff to escort detainees to centralized services. The location of control posts with direct views down movement corridors can also allow detainees to move to services unescorted.
- **Sight lines and observation** - Direct sight lines into living areas can reduce staff needs. Linear designs or areas with blind spots require more staff to circulate through the facility.
- **Compartmentalization** - Allows detainees to some areas, but not others. This reduces the need for staff to escort detainees.
- **Role and effectiveness of security technology** - all points of entry to the secure area should be electronically controlled. In this way the perimeter can be monitored and controlled remotely. A weak perimeter requires more staff to control.

A determination of staffing requirements must take into account physical plant characteristics such as those described above.

Organizational Structure and Activity Levels

Shift patterns, rank structure, scope of responsibilities for services, and use of contractors are all factors relating to organizational structure that influence staffing. Frequency of functions and activities also affect staffing levels. For example, the frequency and duration of exercise periods, visits, commissary, sick call, and similar activities can affect staffing needs, particularly if they require detainee movement. In some cases jail officials can alter the activity to accommodate staffing while, in others, jail officials simply must provide staffing to cover the activity. Trends in admissions and fluxes in population levels impact activity levels which, in turn, impacts staffing needs.

Standards

Standards rarely specify staffing levels, but they do detail what needs to be done to have a sound and legally defensible operation. As such, standards define many of the essential tasks and performance levels the jail should strive to meet. The implication for staffing is to determine what staff are needed to see that the tasks essential to standards-compliance get done.

Several different sets of standards must be taken into consideration in determining staffing needs including the Ohio Bureau of Adult Detention Standards, the standards established pursuant to the Prison Rape Elimination Act (PREA), the National Commission on Correctional Health Care Standards, and the American Correctional Association (ACA) Adult Local Detention Facility Standards.

Methodology

Mark Martin, of MJ Martin Inc. led the staffing study on behalf of HDR. Major Jeremy Roy was the primary contact. The study consisted of four stages. First, Mark Martin conducted a review of selected documents off-site provided by the Montgomery County Sheriff's Office. Second, Mark Martin conducted an on-site visit at the Montgomery County Jail on October 29-30, 2019 to continue with the analysis. The third stage was the development of a draft written report to document the preliminary findings of the analysis and recommendations for improvement with a submittal of the draft to the MCSO for review. The fourth and final stage was the production and submittal of this final report electronically and in hard copy.

The methodology used for completion of the staffing study included completion of the following tasks:

1. Development of a profile of the Montgomery County Jail to provide a clear picture of the current state of the facility and the relevant factors which may influence staffing requirements.
2. Review of operations and activity schedules to assess the capacity of existing posts to handle current activity levels effectively and, if applicable, recommend schedule modifications to improve staffing efficiency.
3. Review of operational Policy and Procedures, Post Orders, and related documentation to get understanding of day-to-day operations, tasks, duties and responsibilities of correctional staff.
4. An analysis of statistical data including historical average daily population and booking and release trends, types of offenders being housed to assess impact on workload.
5. Development of a shift relief factor, including analysis of net annual work hours, for correctional officers and sergeants to ascertain the actual availability of staff to work.
6. Assessment of posts and positions to determine if each post and job assignment in the facility is properly staffed with the correct number of personnel to accomplish the job and are staffed with the correct job classification.
7. Development of a post coverage plan to determine the total number of staff needed to operate each post or position, by classification in the facility.
8. Development of a final report and presentation to document staffing needs and recommendations for improvement.

Definitions

Below are definitions of some key terms used in the staffing analysis process:

- Post - A staff assignment which can either be a specific place (i.e. Master Control) or can relate to a specific function (i.e. Rover). Posts are generally staffed by qualified individuals of a particular job classification and must be staffed during specified hours.
- Position - A job not filled by any other staff member when the person holding the position is not on duty (e.g., secretary, classification officer, assistant jail administrator). A position has tasks that can usually be deferred until the staff member is available. Continuous coverage usually distinguishes a post from a position; a post has tasks that cannot usually be deferred.
- Staffing Plan - The relationship of posts over time. It identifies the shift(s) when each post is staffed.
- Schedule - The actual days and times when staff are expected to work.
- Net annual work hours (NAWH) - A calculation of the number of hours employees are available to work, based on the contracted number of hours per year minus the number of hours off per staff person per year.
- Coverage Plan - The description of the *minimum* numbers and types of staff needed to operate the facility at each hour of each day in the week.
- Full-time equivalent (FTE) - A term used to translate staffing needs into the number of full-time staff members needed to fill the required hours. FTE calculations consider the net amount of time a full-time staff member is available (*net annual work hours*) after time away from the job (e.g., vacation, sick leave, holidays, training time) is subtracted.

Jail Profile

Mission and Philosophy

The following is the stated mission of the Montgomery County Jail as established in Policy 1.1.1 dated 4/6/2013:

“The mission of the Montgomery County Jail is to protect and serve the citizens of Montgomery County by providing for the care, custody, and control of legally incarcerated pretrial detainees in a safe and secure environment. The jail recognizes the importance of delivering basic human services and thrives to provide those detained with an opportunity for positive growth and change. It is the intent of the jail to accomplish these goals fairly and equally in the most cost-effective manner possible. Furthermore, the jail believes that professional, trained staff holds the key to an effective detention operation and ensures the development of a progressive organization.”

The language of the mission statement suggests achieving the following goals are important to the facility and Sheriff's office:

- Maintaining a safe and secure environment for detainees, staff, and the community
- Complying with the legal and professional standards of the field
- Maintaining a well-trained, competent workforce
- Providing programs and services to meet the basic needs of detainees
- Providing detainees opportunities to maintain community and family ties
- Maintaining cost effective operations

A mission and philosophy of this type impacts staffing in several ways:

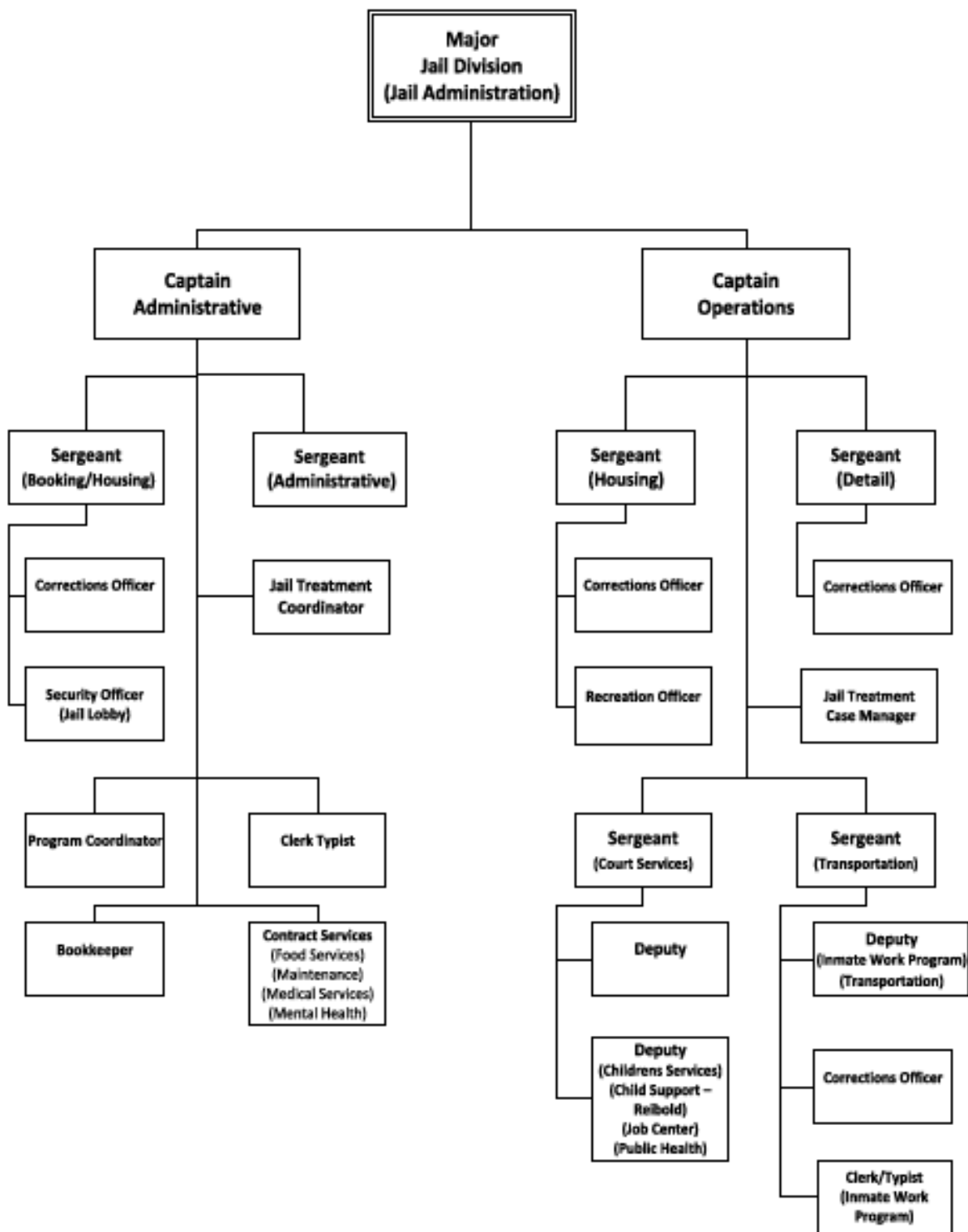
- There needs to be a sufficient number of staff, deployed properly, to provide active supervision of detainees to manage their behavior and maintain a safe environment.
- Sufficient relief must be allocated for staff to attend training to achieve the desired level of professional competency. Qualified staff are also needed to provide the necessary training.
- Both correctional and non-correctional personnel (such as contractors, community agency staff, volunteers, etc.) are needed to provide the range of programs and services necessary to meet the basic needs of detainees.
- To be cost effective, staff availability must be maximized (by managing leave use, scheduling, etc.).

Organizational Structure and Current Staffing

The Montgomery County Jail is administered by the Montgomery County Sheriff's Office under the leadership of Sheriff Rob Streck. Major Jeremy Roy serves as Jail Administrator. The Jail Division is organized into two sections – an Administrative section and an Operations section. The Captain of the Administrative section is responsible for intake and release, jail programs, treatment coordination, contract services, bookkeeping and clerical support, and lobby security.

The Captain of the Operations section is responsible for custody operations, court services, and transportation.

A chart illustrating the organizational structure of the Jail Division is presented below:



Current Staffing Levels

The table below provides a comparison of authorized staffing with actual staffing levels. Full authorized staffing for the jail is 139 FTEs as of October 2019. There were ten Correctional Officer vacancies as of that date. One Correctional Officer was listed as being on Injury leave and one CO on Military leave.

Figure 18: Current Authorized Staffing - Jail

Current Authorized Staffing - Jail		
Job Classification	Auth. Positions	Auth. Positions
Major	1	
Captain	2	
Sergeant	11	
Corrections Officer	121	10
Recreation Officer	2	
Program Coordinator	1	
Jail Bookkeeper	1	
Total	139	10

In addition to the jail, authorized staffing for Court Services as of October 2019 included two Sergeants (one vacant) and forty-one Deputies (four vacant). Authorized staffing for Transportation included one Sergeant and ten Deputies, plus one Deputy listed as temporary.

Sixteen of the Jail Correctional Officers and two Jail Sergeants were listed as Probationary.

Physical Plant

The Montgomery County Jail is a multi-story structure located in downtown Dayton, OH. The original portion of the jail, completed in 1964, is a four-story structure with linear style housing. A second phase of the building, completed in 1992, adding additional housing and support spaces. The most recent renovation, completed in 2004, included was designed with four direct supervision style housing pods, bringing the jail up to its current capacity of 910.

The first floor of the older section of the jail houses the medical services component and two minimum security dormitories which are used for swing housing for either male or female detainees depending upon the need and for overflow housing. The larger of the two dormitories with a capacity of 58 is direct supervision. That post is also responsible for intermittently supervising the second dormitory located nearby. The medical services component include exam and treatment rooms, office space for medical staff, and several infirmary beds. The jail's Treatment Coordinator also has an office in this area.

Detainee housing on the second, third, and fourth floors of the older portion of the jail is predominantly linear style multiple occupancy housing units or dormitories. The second-floor houses primarily female detainees. The housing on this floor does include two minimum security dormitories designated as swing housing for either male or female detainees depending upon the need. The third floor of the older section houses general population male detainees in what is classified as medium-maximum security housing. Third floor housing is a combination of single occupancy housing units, multiple occupancy housing units, and dormitories. The fourth-

floor houses male detainees in administrative segregation and disciplinary detention. Detainees are housed in units with single occupancy cells or in smaller dormitory style units. Currently one Correctional Officer is assigned to supervise detainees on each of these floors.

The pod housing was added in later construction. This section of the building includes four direct supervision housing pods stacked on two levels. Each pod was designed originally with 48 single occupancy cells that have been since double bunked. In addition a recreation/program room in each pod has been converted to 8-bed dormitories bringing the total capacity of each pod to 104. The pods are designed as typical direct supervision housing unit with a staff workstation inside the dayroom area. Exercise areas are located adjacent to and accessible from each pod.

An assessment of space utilization and existing conditions in the existing facility by functional component can be summarized as follows:

Public Entry Area

Provides general public access and circulation for the facility. The reception lobby on the first floor provides space to receive, stage, and direct visitors to visitation areas.

Facility Administration

A building across the street from the jail houses the majority of the jail administration. Offices for supervisory staff in the jail are provided in various location in the facility where space is available.

Staff Services

Staff lockers for male, female uniformed staff and a small staff break/dining room are provided on the ground (lower) level of the facility. Staff amenities in the facility are extremely limited.

Central Control

Located in the center of the main level, in proximity of the detainee and release area, the Central Control Room controls staff/other access to the secure parts of the facility.

Intake/Transfer/Release

The intake/transfer/release component is located on the first floor, adjacent to the vehicular sallyport. It was designed for both central booking and intake/ transfer/ release functions. The property room stores property for detainees in the facility. This is an extremely busy areas with intake, release, records, classification, property, court transfer, and utility/escort staff all working within or staged out of this area.

Food Service

The food service area is located on the ground floor (lower level) and was designed as a full-service cook-serve facility. Currently, this area is operated by a contract vendor. In this facility the food is portioned onto insulated serving trays for movement to each respective housing area. Detainees take their meals in dayroom areas or cells depending upon where they are assigned.

Laundry

The laundry area is located on the ground floor (lower level) as well. This area handles all laundry from the facility. Laundry services are also provided by detainee workers supervised by a Laundry Officer on second watch (day shift).

Loading Dock/Central Storage

The dock for receiving deliveries and central storage areas are located on the ground level. The west end opens onto a two-bay loading dock.

Program Service

This component deals with the provision of counseling, recreation, and related services to detainees during incarceration. There is one classroom available for programs. Space available for detainee programs is woefully inadequate and inconsistent with the desired operational philosophy of the Sheriff's office to provide opportunities for detainee self-improvement. Space originally designed for potential program use on the direct supervision pods has been repurposed as additional housing. An indoor gym that is utilized by detainees in the linear housing is located on the fourth floor. The pods have ample space in the dayrooms for indoor recreation and have outdoor recreation areas located adjacent to each pod. Secure outdoor recreation areas have been designed for access by every housing unit.

Library

There is a central library area on the fourth floor adjacent to the gym that provides legal materials and general reading materials for prisoners. Detainees, depending upon classification, may visit the library during gym time or books may be brought to detainees via book cart. The location of the library is difficult to monitor.

Visiting

Visiting is primarily non-contact and is decentralized. Visitors access non-contact visitation areas on each floor of the linear housing. Non-contact visiting space is provided on the mezzanine level of each direct supervision pod. Professional visiting/interview rooms are located on the first floor adjacent to the Intake area.

Health Services

Centralized clinic and infirmary space is provided in the older section of the first floor. This includes medical exam/treatment rooms, pharmacy, dentist space, and related facilities for detainees that need to be seen by a doctor or dentist. Sick calls are typically handled in housing unit before an appointment is made for the central clinic visit – which can handle a limited number of prisoners at a given time. A total of four inpatient medical rooms are provided as part of the infirmary area. Space for medical services is extremely limited and not well designed for efficient delivery of medical services. Health services are provided by a contract vendor.

Commissary

There is a central commissary, staging area on the ground floor (lower level) near the loading dock that provides commissary items to detainees on a regularly scheduled basis. Once orders are filled, they are delivered to each housing unit.

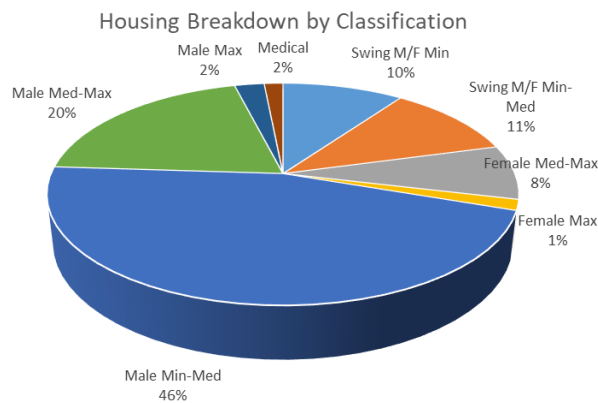
Figure 19 provides a breakdown of the housing units by classification, use, and capacities. Note: Additional bunks have been added to some housing areas to handle the current bed space need.

Figure 19: Housing Unit Breakdown

Housing Unit Breakdown				
Unit Designation	Housing Classification	Cell Type	# of Cells	# of Beds
Med-1	Medical	Multiple	1	2
Med-2	Medical	Multiple	1	4
MED-3	Medical	Multiple	1	4
MED-4	Medical	Double	1	2
S-1-1	Overflow M/F Minimum	Dormitory	1	12
W-1-1	Swing M/F Minimum	Dormitory	1	58
N-2-1	Swing M/F Minimum-Medium	Dormitory	1	61
E-2-1	Female Medium-Maximum	Dormitory	1	10
E-2-2	Female Maximum Admin. Seg.	Double	3	6
E-2-3	Female Maximum Admin. Seg.	Double	4	8
E-2-4	Female Medium-Maximum	Multiple	1	8
E-2-5	Female Medium-Maximum	Multiple	1	8
E-2-6	Female Medium-Maximum	Dormitory	1	4
S-2-1	Female Medium-Maximum	Double	1	2
S-2-2	Female Medium-Maximum	Double	1	2
S-2-3	Female Medium-Maximum	Double	1	2
S-2-4	Female Medium-Maximum	Multiple	1	12
S-2-5	Female Medium-Maximum	Multiple	1	12
S-2-6	Female Medium-Maximum	Double	2	2
S-2-7	Female Medium-Maximum	Double	2	2
S-2-8	Female Medium-Maximum	Dormitory	1	6
W-2-1	Overflow Swing M/F Minimum-Medium	Dormitory	1	38
E-3-N	Male Medium-Maximum	Single	11	11
E-3-S	Male Medium-Maximum	Single	11	11
S-3-1	Male Medium-Maximum	Double	1	2
S-3-2	Male Medium-Maximum	Double	1	2
S-3-3	Male Medium-Maximum	Double	1	3
S-3-4	Male Medium-Maximum	Multiple	1	12
S-3-5	Male Medium-Maximum	Multiple	1	12
S-3-6	Male Medium-Maximum	Double	1	2
S-3-7	Male Medium-Maximum	Double	1	2
S-3-8	Male Medium-Maximum	Double	1	2
W-3-1	Male Medium-Maximum	Dormitory	1	10
W-3-2	Male Medium-Maximum	Dormitory	1	8
W-3-3	Male Medium-Maximum	Dormitory	1	12
W-3-4	Male Medium-Maximum	Dormitory	1	12
W-3-5	Male Medium-Maximum	Dormitory	1	8
E-4-N	Male Maximum Admin. Seg.	Single	11	11
E-4-S	Male Maximum Admin. Seg.	Single	11	11
S-4-1	Male Medium-Maximum	Dormitory	1	8
S-4-2	Male Medium-Maximum	Dormitory	1	21
W-4-1	Male Medium-Maximum	Dormitory	1	8
W-4-2	Male Medium-Maximum	Dormitory	1	12
W-4-3	Male Medium-Maximum	Dormitory	1	12
W-4-4	Male Medium-Maximum	Dormitory	1	8
Pod A	Male Minimum - Medium	Double/Dormitory	49	104
Pod B	Male Sentenced Misd. - Detainee Worker	Double/Dormitory	49	104
Pod C	Male Minimum - Medium	Double/Dormitory	49	104
Pod D	Male Minimum - Medium	Double/Dormitory	49	104
N-5-1	Overflow Swing/Weekenders Minimum	Dormitory	1	10
N-3-1	Overflow Swing/Weekenders Minimum	Dormitory	1	10
Total Capacity				910

The following chart shows the breakdown of housing by classification:

Figure 20: Housing Breakdown by Classification



Implications for Staffing

Staffing requirements for the Montgomery County are significantly influenced by the physical plant in terms of its location, size, housing design and philosophy, and location of support services elements in the building. The following features, in particular, influence staffing needs in the jail:

Location

Location of the jail on the downtown site required a vertical solution when the original facility and later phases were constructed. Multilevel facilities often require additional staffing to accommodate movement between floors and support for custody staff assigned to housing or other functions on each floor.

Size

With the phased construction, the facility's capacity has increased substantially. The increased detainee population impacts the jail in many areas including meals, laundry, visits, sick call, programs, etc. Escorted movement is particularly impacted, with both the higher frequency of activity and the travel distances involved.

Design Philosophy

The facility, constructed in phases over time, is an example of the generational shift in jail design from linear style on the older areas and direct supervision style in the newer. Current concepts and principles associated with effective detainee management are difficult to follow in the old-style linear design. Correctional Officers are not in a position to see and hear what is happening within the housing areas. They are, at best, able to intermittently conduct rounds to check on the well-being of detainees and respond to events when they occur. They are not able to actively manage detainee behavior and be in a position to proactively prevent problems before they escalate into major incidents. Current staffing with one officer assigned to each floor of linear housing is particularly of concern as staff are not able to safely enter housing units to interact with detainees and respond to emergencies until a second officer can be summoned from another area of the jail.

The double bunking of the newer direct supervision pods is also troublesome as it results in significant in-cell time for detainees as they are released into the dayroom on a scheduled basis

in smaller numbers. This approach, while intended to promote officer safety, is contrary to the principles and concepts of direct supervision. Direct supervision is an operational philosophy as well as a design. With the current population levels (104 detainees in pods designed for 52), these housing pods are not being operated in a manner consistent with direct supervision concepts.

Location of Programs and Services

There are a number of inefficiencies in the layout of the facility which influence the amount of escorted movement required. These include centralized exercise and program areas for detainees on the linear side of the facility and centralized delivery of medical services. The facility lacks medical triage rooms strategically located in each housing zone; space for haircuts, counseling, and other program activities located within each housing zone; etc. The capability to allow unescorted movement to services due to the design is limited.

The direct supervision units are more efficiently designed, however space originally designed for programs has been repurposed for additional capacity. Space is available in the direct supervision dayrooms for programs (and some are offered there), however the time-phased release of detainees limits opportunities for their participation in a range of programs and activities that could keep them productively occupied.

Use of Technology

The facility employs some level of technology that is intended to aid in detainee supervision and care. Newly admitted detainees are provided armbands that assist with identification, however, the technology is not in place to track movement of detainees within the facility or to verify their location with scanning devices as they move from one location to another. Kiosks have been recently installed with the intent of providing detainees with more options to managing their own needs. The kiosks provide detainees the ability to order commissary, file grievances, make detainee requests, and request sick call. An unintended consequence has been an additional burden on sergeants to review and respond to an increasing number of requests and grievances filed via the kiosks – many of which should have been able to be handled at the housing unit level by the housing officer. Mark Martin noted that historical practice and policy of deferring to the sergeants to make decisions relating to detainee issues and concerns contributes to these consequences. The role of technology and supervision practices should be carefully reviewed in conjunction with assessment of staffing needs. Additional staffing will not overcome poor design or management policies and practices which are not consistent with effective detainee management – regardless of design.

Conditions

Mark Martin agrees with the findings and recommendations of the *Report of the Justice Committee* on the Jail Facility regarding conditions. Building systems within the structure are worn out, obsolete, and in serious need of repair or replacement. During two visits of Mark Martin to the facility, there were major plumbing issues which resulted in flooding and significant disruption of operations. Mark Martin also found sanitation and general environmental conditions to be lacking, impacting quality of life for detainees and poor working conditions for staff. Age and condition of the facility are significant factors contributing to these conditions, along with lack of staffing needed to maintain proper sanitation and perform essential maintenance functions. While this study did not assess maintenance and support staffing needs, Mark Martin agrees with the Jail Administrator's assertion of the need for "a fulltime

plumber and around the clock maintenance staff, as well as custodial staff to supplement detainee workers” as detailed in the Justice Committee’s report.

Detainee Classification System

During the booking process, a classification officer evaluates each detainee based upon their behavior and attitudes, the detainees’ needs, current and past charges, level of security risk, and prior institutional behaviors. This evaluation is completed as a paper and file review, but does not include a face-to-face interview with the detainees. Based upon this evaluation, the Classification Officer assigns the detainee to housing.

Changes in housing assignment, including placement in administrative segregation, are made by the Classification Officer. The Classification Officer reviews detainees’ requests for reclassification and, by policy is to conduct a classification review after 30 days of confinement and every six months thereafter. Again, it is not clear that the Classification Officer ever conducts face-to-face interviews for purposes of reclassification.

Implications for Staffing

An effective classification system is one of the building blocks of effective detainee supervision. The lack of classification based upon a face-to-face interview as part of the classification process and current classification staffing levels for the classification function are areas of concern.

Operations and Activities

The types and frequency of facility operations and activities influence the workload, schedule, and the number and type of staff required for coverage of shifts to manage the workload. Operations and activities include:

- **Routine custody operations** such as head counts, security checks, maintenance, sanitation, searches, admissions and releases, escorts, transports, shift changes and briefings, surveillance and monitoring, etc.
- **Detainee services** such as meals, laundry, sick call, medication rounds, visitation, mail, commissary, haircuts, library, etc.; and
- **Programs** such as religious services, education, Alcoholics Anonymous (AA), substance abuse services, volunteers, etc.

The nature and scope of activities are defined largely by the mission of the facility, size and characteristics of the detainee population, standards and case law, facility capabilities, and sound security practice. The scheduling, sequence, and interactions of these activities must be coordinated with the location and coverage of posts and positions in order to avoid unnecessary "peaks" and "valleys" in the workload. A general assessment of facility operations and activities indicates the following:

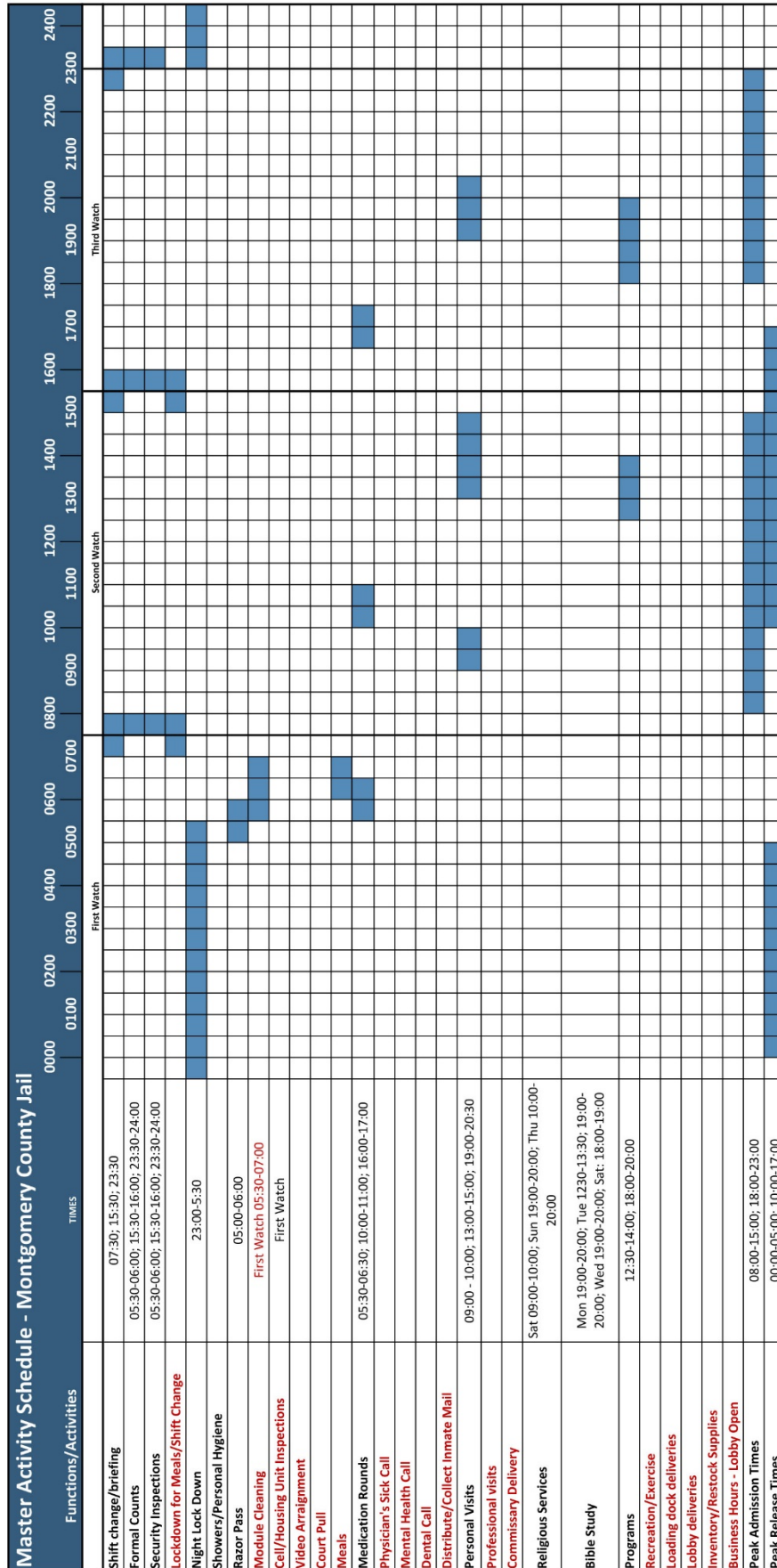
- A substantial amount of activity occurs during the day and evening shifts, creating some potential bottlenecks and schedule conflicts;
- While there may be some opportunities to adjust the schedule to more evenly distribute the workload, a number of staff intensive activities over which the jail has little control

over schedules (e.g. admissions and releases, court runs, video arraignment) occur in the middle of the day;

- Activities must be scheduled over longer periods of time to accommodate the increased population from the expansion.
- Contract services for medical, food services, and commissary are being effectively used to significantly reduce non-custody staffing needs of the facility.

A Master Activity Schedule is a good aid to optimizing operations and managing workload given the staffing and facility resources that are available. The table on the following page is the start of a Master Activity Schedule for the Montgomery County Jail. Many of the functions and activities that occur over the course of the day or week are listed in the left-hand column. The times during which each function is to occur are to be highlighted in the appropriate columns to the right. When all of the scheduled activities are highlighted, the table can provide a visual depiction of the overall workload—when the jail is busiest and least busy over the course of the day. It can highlight potential conflicts between scheduled activities and times when staff may be expected to be attending to two or more functions at the same time. The MCSO is encouraged to complete the Master Activity Schedule in more detail and use it as a resource in assessing and adjusting workload.

Figure 21: Master Activity Schedule



Other Agency Staffing-related Factors/Issues

Overtime

Overtime usage in county detention settings varies by type and amount, depending on local policy, physical plant setting, staffing issues, and financial limitations. Usually, three different types of overtime are found in local criminal justice agencies.

Partial overtime, or “spillage”, is a common type of overtime and usually occurs when a correctional officer must stay at work for part of an hour or for several hours beyond the scheduled eight-hour shift (or other work schedule) to finish an assignment. In this sense, it is work that “spills over” beyond the expected time on duty. If partial overtime occurs frequently, or is found in large quantities, it is a clue that some staffing problems exist. Otherwise, the use of partial overtime, when properly managed, is a normal and efficient method of delivering services.

Non-replacement overtime typically occurs when the agency requests that a correctional officer work an extra full shift (eight hours) because additional staffing is necessary, either because of special events or because **not enough funded positions are available to complete the expected workload**. Other correctional officers who were scheduled to work have also reported for duty, but due to the amount of the workload, more correctional officers are needed. Non-replacement overtime is a wise and efficient use of staff when it is used in limited quantities and for short periods of time, and **not on a continuing basis**.

Replacement overtime typically occurs when the agency has an **established minimum staffing policy** for each work period and each day of the week, and the **minimum number of correctional officers are not present as planned or scheduled**. To correct the situation, the agency requests that some correctional officers work an additional shift (eight hours) as replacement for the lost correctional officer or correctional officers. **Usually, the scheduled staffing does not report to work because of vacation time, sick time or other normal losses**. In a replacement scenario, the agency is paying one correctional officer straight time pay for being absent, and paying another correctional officer overtime pay for replacing the lost correctional officer. The use of replacement overtime is healthy only when used in limited quantities. When the use of replacement overtime occurs often, it is possible that over a long period of time, the total cash cost could exceed the cost of hiring a new correctional officer at straight-time costs. Detailed financial and scheduling records must be kept to make this determination. To avoid excessive costs for replacement overtime, agencies typically apply a relief factor in calculating their overall staffing needs. The relief factor takes into account the time staff are not available to work for the reasons described above. See Section III for a further discussion on relief factors.

In an organization that is properly staffed to the setting by time of day and day of week, the use of overtime is limited. Examples of healthy uses of overtime in these settings include:

- The occasional and temporary replacement of correctional officer because of high simultaneous unplanned losses (sick, injury, etc.);
- Occasional training on scheduled workdays;
- Occasional short-term special assignment;

- Finishing assigned work that extends beyond the scheduled work period;
- Holiday pay;
- Court time on day off or during non-duty hours; and
- Shift differential pay.

In a correctional setting that is **properly staffed, spillage or partial overtime is usually the most frequent type of overtime** used, and replacement and non-replacement overtime are rarely used. In the Montgomery County jail setting, the reverse appears to be the case. The use of overtime in 2017 - 2019 (through early October) was found to be frequent, and replacement and non-replacement overtime appears to occur on a relatively large scale. The table below provides a breakdown of overtime hours by job class. The highlighted leave types are due, in large part, to insufficient number of personnel to cover posts when these types of leave are taken.

Figure 22: Overtime Hours by Job Class

Overtime Hours by Job Class (2018)					
Leave Type	CO	DEP	SGT	Other	Total
Court	60.0	12.5	30.0	-	102.5
Funeral		33.0		-	33.0
Garcia	55.0	11.8	75.5	0.3	142.5
Invest -Crim		8.0	1.0	-	9.0
Invest- Spec			3.0	-	3.0
Comp	1,220.8	25.8	34.8	46.0	1,327.3
PA Da or Vac	2,040.5	58.0	325.0	97.5	2,521.0
Military	505.0			23.0	528.0
Sick	4,579.6	6.3	107.5	110.3	4,803.6
Training	1,927.2	11.5	163.8	72.5	2,174.9
Vacant	12,878.6	17.0	335.5	360.5	13,591.6
Spec Assign	44.0		18.5	-	62.5
Late Call	27.8	11.5	60.3	4.0	103.6
Meeting	1.5		21.0	-	22.5
Other	181.7	47.5	116.3	57.2	402.6
Reg Train	103.0		8.0	-	111.0
Transport		219.0	1.3	-	220.3
	23,624.6	461.8	1,301.3	771.2	26,158.8

Again, **replacement overtime** is used when officers use annual leave, sick leave, and other leave and then are replaced by other officers **because the minimum staffing levels were not met**. These types of losses are planned and known in advance and **any relief/availability factor used to calculate previous staffing needs should have taken these losses into account**. Either the corrections workload increased significantly beyond present capacity of staff, and/or **the previous staffing calculations underestimated the corrections workload**.

The most frequent use of **non-replacement overtime** was the filling of **vacant funded or non-funded positions** deemed necessary for the safe, secure and constitutional operation and management of the jail facilities.

Implications for Staffing Needs

The overtime data clearly suggests that sufficient funded positions were not available to meet the minimal 24/7 – 365 staffing needs for the jail operations. The table below shows the overtime hours and costs for Correctional Officers and Sergeants over the past three years. Using the “**Net Annual Work Hours calculation** (1,681) for the Correctional Officer job class presented in the following Section, the total of 31,714 overtime hours accrued in 2017 would convert to **18.8 Correctional Officers**. The 28,673 overtime hours in 2019 would convert to 17.07 officers.

Figure 23: Montgomery County Jail Overtime Hours and Costs

Montgomery County Jail Overtime Hours and Costs For Correctional Officers and Sergeants 2017-2019						
	2017		2018		2019*	
Job Class	OT Hours	Cost	OT Hours	Cost	OT Hours	Cost
Correctional Officer	31714	\$ 960,316.08	23264	\$ 760,306.15	28673	\$ 951,955.23
Sergeant	771	\$ 34,792.37	1301	\$ 74,715.57	2749	\$ 163,356.60
Total	32485	\$ 995,108.45	24565	\$ 835,021.72	31422	\$ 1,115,311.83

Realistically, some overtime will always be necessary in the jail setting. Therefore, no more than 70-75% of the funds currently used for overtime dollars should be used to fund additional full-time positions if a decision were made to do so.

The overtime situation for Montgomery County detention facilities has developed over a period of time and cannot be corrected instantly. The next step in the evolution of such problems is that correctional officers tire of working overtime and want to spend more time at home with families. Fewer correctional officers are then available, on a volunteer basis, to come to work and the agency is forced to utilize mandatory overtime to the point that turnover goes up. Availability of officers then drops to less than projected, producing increased stress levels on the fewer officers who are working in the facility. The constant shortage of officers to complete the existing or new workload produces a situation that only deteriorates.

Staff Survey Results

A cross-section of staff working in the various functional areas responded to a written survey seeking their input on staffing issues. Their responses are summarized below.

1. What are the primary duties and areas of responsibility of your assigned post?

Classification	Run every person that is brought into the jail in L.E.A.D.S.; Check Old Tiburon for past behavior; Place hazards as needed; House them; If a detainee that is already housed has a problem, then move them. Place keep separates, if needed; Check medical screens.
Prints/Photos	Live ID every detainee that comes into facility; Take photos of all detainees in custody; Print most detainees on MI charges for most county agencies.
Release	Review and release of all detainees leaving facility.

Linear Housing	Care, custody, control.
Intake/Utility	Maintain care, custody, and control of all detainees assigned to the floor, as well as search all incoming prisoners.
Booking	Book in detainees when they come in thru receiving; put armbands on them. Put court dates in the computer. Write down their property.
Records	Maintain detainee records; update court paperwork, write up releases.
Pod Housing Unit Officer	Linear and pods
Pod Housing (B-Pod)	Supervise detainees, maintain safety, care, meals, medication rounds, hiring and removing workers, searching detainees and cells
Intake/Utility	Pat down and scan new arrests into the jail and dress in detainees; feed, cleaning, care, and control of detainees

2. How many officers are typically assigned to this post on each shift?

Classification	One officer per shift; Midnight usually pulls the classification officer if short staffed (happens all the time)
Prints/Photos	One.
Release	One.
Linear Housing	One.
Intake/Utility	Four.
Booking	One.
Records	Three records officers (2nd/3rd watch)
Pod Housing Unit Officer	One.
Pod Housing (B-Pod)	One per shift.
Intake/Utility	Four.

3. Is this a 7 day, 24- hour post? If not, when is it typically staffed?

Classification	Yes; But midnights doesn't cover it all the time, due to short staffing.
Prints/Photos	24/7
Release	Supposed to be 24/7, however evening watch on weekends is not filled, but ran by 2nd Records.
Linear Housing	Yes.
Intake/Utility	Yes.
Booking	Seven days a week. One officer every watch.
Records	Two of the three positions are 7 days/week 24 hours/day
Pod Housing Unit Officer	Staffing after roll call till EOW
Pod Housing (B-Pod)	24/7
Intake/Utility	Yes.

4. Are you actively completing tasks during the entire time you are on duty?

Classification	Yes; All shift
Prints/Photos	Most days, yes.
Release	Majority of days, yes. On rare occasions or weekends, not often.
Linear Housing	Yes.
Intake/Utility	Yes.
Booking	Yes. If I am caught up, I help out with escorts and dress-in list.
Records	Yes
Pod Housing Unit Officer	Yes, requesting help [dirty?] [could not read word] on floors
Pod Housing (B-Pod)	Yes.
Intake/Utility	Yes.

5. When are you most busy, and why? What are you doing at those peaks?

Classification	24-7 (all the time except holidays)
Prints/Photos	9-3 on Tuesdays/Thursdays. Fingerprint/photo court orders as well as detainees brought in.
Release	Court days (Mon-Fri) 7:30-10:30 and 11:30-3:30 pm; Morning releases, other agency, ride outs, CRC ride outs, sentence releases, detection releases, court releases.
Linear Housing	Weekdays: Monday-Friday; Personal/Prof. visits; Laundry; Medical; Maintenance; Commissary; Walks. Courts. One officer. Multiple tasks involving numerous detainees.
Intake/Utility	After 11:00 am on weekdays, a lot of incoming prisoners.
Booking	Between 9:00 am and 3:30 pm; Arrests and courts. I book them in.
Records	7:30am - 3:30 pm; constant flow of paperwork
Pod Housing Unit Officer	Lunch time; attorney visits mainly at these times and always to do lunch.
Pod Housing (B-Pod)	11:00 am-1:00 pm. Workers are returning. Other workers being sent to work. Hiring new workers.
Intake/Utility	All day, 8 hours.

6. When are the least busy times? What are you doing during those times?

Classification	I haven't seen it yet. Holidays are usually slower.
Prints/Photos	It varies; all depends on detainees/people who were arrested.
Release	Weekends mainly. If I have downtime, I act as an additional escort officer.
Linear Housing	Weekends: Saturday/Sunday; Cleaning, Care, Custody, Control, Walks
Intake/Utility	Weekends; cleaning the floor, helping out co-workers in housing.
Booking	Between 8:00 am-9:00 am. Catching up on bookings.
Records	Not applicable. Always busy.

Pod Housing Unit Officer	Just before lunch; go to bathroom because only chance.
Pod Housing (B-Pod)	8:15 am-8:30 am. After count, checking work clearances and cleaning supplies.
Intake/Utility	Early morning, cleaning and supplies to detainees.

7. What, if any, critical tasks are not being consistently completed that impact staff or detainee safety or facility security (welfare checks, inspections, searches, addressing misbehavior, etc.)

Classification	Probably a lot since floor officers have to watch detainees with professionals; Can't walk through catwalks to check detainees; We are spread thin!
Prints/Photos	No answer.
Release	None. Critical tasks come before release, results in loads up of releases slowing down process for rest of day.
Linear Housing	Cause and Effect. If tasks are missed, it piles up on the next officer making you behind the remainder of the shift.
Intake/Utility	Communication between shifts during shift change.
Booking	Booking detainees in so they can be taken upstairs.
Records	At times feel as if we are being rushed to process the paperwork which could result in overlooked (e.g. bad release)
Pod Housing Unit Officer	Floors are usually too busy for one person. Pods are usually alright.
Pod Housing (B-Pod)	Pods being locked down early on third watch for no reason. Staff watching technology instead of supervising detainees.
Intake/Utility	Wellness checks and log entries.

8. Are the tasks not being completed due to lack of time/staff?

Classification	Yes, all the time.
Prints/Photos	On the busy days, yes there are prints and photos not getting done and court orders/outside print jobs not getting done
Release	Yes. Average officer can release 45 detainees in 8 hours. Court days can have up to 70 releases in total for day shift only.
Linear Housing	Absolutely.
Intake/Utility	No.
Booking	Both.
Records	No answer.
Pod Housing Unit Officer	Lack of time and staff (mainly floors)
Pod Housing (B-Pod)	Not usually.
Intake/Utility	Yes.

9. How many detainees, on average, do you watch and manage during your shift?

Classification	Hard to say; I have to house post-book and females on first floor. Sometimes there are 10 detainees, sometimes 50 plus.
Prints/Photos	One or two at a time.
Release	On average, 40-50 and as much as 65-70 detainees.
Linear Housing	114
Intake/Utility	30-40 detainees.
Booking	Around 30 detainees. Depends how many are in pre and post book.
Records	Not applicable.
Pod Housing Unit Officer	100
Pod Housing (B-Pod)	75
Intake/Utility	50-100.

10. Are there times when there are no detainees to supervise at this location? Why or why not?
Where are they? What do you do with your time under those circumstances?

Classification	Never
Prints/Photos	Yes, no detainees were arrested so no one needs photographed or printed.
Release	On weekends, there can be no detainees at certain periods of time to release. I act as an escort at those times.
Linear Housing	No.
Intake/Utility	When intake gets busy, there are times walks cannot be completed in medical cells and 5-11.
Booking	No. We always have detainees on the first floor due to 31 hazards or no housing to place detainees in.
Records	Always on a look out and have open ears.
Pod Housing Unit Officer	No, always around detainees.
Pod Housing (B-Pod)	No, there are always detainees in the unit.
Intake/Utility	Detainees 24/7.

11. Do you feel safe in this location? If not, what would make you feel safer?

Classification	Yes, but we do deal with detainees that are intoxicated and they are assaultive.
Prints/Photos	Prints, yes. Other locations, no. More officers 60-1, 110-1 (housing issues).
Release	Safe as one can be in a facility like this; More officers, Better D.T. training.
Linear Housing	No. Violent detainees. One officer. Little to no help. Need two officers. Security flaws.
Intake/Utility	Yes.
Booking	Yes.
Records	Yes.
Pod Housing Unit Officer	Yes, I feel safe.
Pod Housing (B-Pod)	Fairly safe. Safety in number of officers available.
Intake/Utility	80% more staff.

12. Are you relieved from duty for meals or breaks? If so, how?

Classification	Yes, dorm officers, 2-3 dorms.
Prints/Photos	No, we eat when we have time, if we have time.
Release	No. Eat when able or don't eat at all.
Linear Housing	No. Working lunch. Depending on how busy the shift is.
Intake/Utility	No.
Booking	No.
Records	Can leave if need to, but phone may go unanswered (only restroom breaks)
Pod Housing Unit Officer	No, not enough staff. Have to lock pods down to go to bathroom. Left empty if go to lunch. (I do not eat at work)
Pod Housing (B-Pod)	No, I lock the pod down for breaks, if no professional visits.
Intake/Utility	No, too busy.

13. Are there any changes in staffing levels, deployment, or assignment that you feel would improve overall safety, security, and efficient operation?

Classification	Yes, we need two officers in all pods and floors. We need about 40 more officers.
Prints/Photos	We need more officers, especially on Tuesdays and Thursdays, to assist in the quantity of prints/photos that are done. Allowing C0's to carry Tasers and O.C. pepper spray would help.
Release	Two officers assigned to release on weekdays; Two officers to all housing units.
Linear Housing	Staff two officers/ensure consistency across the board/FTO training needs to hit linear housing more often. Need more training or consistent staffing in rollover/linear housing. Needs to have a standard to operate through all three shifts.
Intake/Utility	Yes, on weekdays add a dress-in escort officer, whose responsibility would be to dress in all incoming prisoners so intake/utility officers can continue searching.
Booking	We need one more booker.
Records	Just have adequate staffing; do not do the minimum "just to get by"
Pod Housing Unit Officer	(1) Medical escort for floors to take medical around. No procedures make medical rounds next to impossible.
Pod Housing (B-Pod)	Two officers would ensure that all things can be completed as expected.
Intake/Utility	(1) We always need more bodies, especially on second, third, and fourth floor; (2) due to the amount of movement and more dangerous detainees, more staffing. More staffing and more staffing.

The officer surveys highlight concerns about safety, the quality work, getting all tasks done consistently and completely, and the overall need for more help. The lack of opportunity to take breaks for meals or even bathroom breaks was mentioned by most responders. Several noted the low ratio of staff to detainees they were responsible for (1:100; 1:114).

Relief Factor

Definition

A relief factor is the ratio between the total number of hours of coverage needed for a post and the average number of hours an employee is actually available to work. The relief factor takes into account regular days off, vacation, sick time, mandatory training, breaks, and other types of leave. The number of hours an employee is actually available to work on average after the leave use is subtracted from the total hours of coverage needed for the post is known as the Net Annual Work Hours (NAWH). It is important to calculate and apply an accurate relief factor to determine the total number of FTE's (full-time equivalent) necessary to provide the amount of coverage required. Failure to apply a relief factor or understating it may result in increased overtime costs to cover staff shortages.

Different classifications may have different relief factors because of the amount of vacation time or training time that is allotted and used. For example more veteran staff may be working in supervisory positions where they may earn more vacation and sick time. Also, it is important to note that relief factors may apply to more than just fixed posts. It applies to all posts and positions that have duties which must be carried out if the person assigned to it on a given shift is not available to work.

Influencing Factors

There are a variety of factors which influence the relief factor; the most common are county and agency policies which influence the accrual and use of leave as well as factors which influence employee use of leave. Factors which are most influential are:

1. The schedule worked,
2. County policy regarding accrual and use of any type of leave,
3. Training requirements,
4. The amount of time required to fill vacancies,
5. Contractual requirements, and
6. Organizational factors, such as morale, stress, etc., which influence staff use of leave.

Leave use by Job Classification

Mark Martin worked with MCSO staff to collect information on leave use for 2018. The table on the following page shows the NAWH calculation for the Correctional Officer job class.

Figure 24: Net Annual Work Hours

<i>Net Annual Work Hours</i>		<i>Job Classifications</i>	
		CO	SGT
1	Total hours contracted per employee per year	2,086	
2	Average number of vacation hrs. off per employee per year	97.58	
3	Average number of compensatory hrs. off per employee per year	0	
4	Average number of sick leave hrs. off per employee per year	92.93	
5	Average number of training hrs. off per employee per year	47.33	
6	Average number of personal hrs. off per employee per year	0.066	
7	Average number of military hrs. off per employee per year		
8	Average number of break hrs. off per employee per year	0	
9	Average number of hrs. required to fill a vacancy	0	
10	Other (Personal, military, comp, FMLA-Vac, transitional day, etc.)	143.42	
11	Unpaid days off per employee per year (FMLA, active military, AWOP, BWC, other)	22.88	
12	Other		
13	Total hrs. off per employee per year (lines 2-12)	404	
14	Net Annual Work Hours (subtract line 13 from line 1)	1,681	

The NAWH calculation indicate that, for every Correctional Officer post created on a single 8-hour shift that must be staffed 7 days a week, it will take a total of 1.74 FTE's to provide that level of coverage. If coverage is required for all three shifts, it will require 5.21 FTE's to provide 24-hour coverage of the post.

The shift relief factor would actually be higher if vacancies and pre-service training were factored in. It typically takes 3-6 months to fill a vacant Correctional Office position and provide the training to prepare the new employee to assume the post independently. The turnover rate, the time it takes to recruit, screen, and select a new hire, and the time it takes to complete the academy and pre-service training all go into the time it takes to fill a vacancy. During this time essential posts must be staffed, usually with existing personnel working overtime. As a result, the shift relief factor used in this staffing study is conservative.

Post Reviews

Post Review Process

Mark Martin reviewed security posts and job assignments to determine why and where posts are located, the duties of each post, and schedule and frequency with which those duties are performed. The specific purpose of this task was to determine if each post and job assignment in the facility is properly staffed with the correct number of personnel to accomplish the job and staffed with the correct job classification.

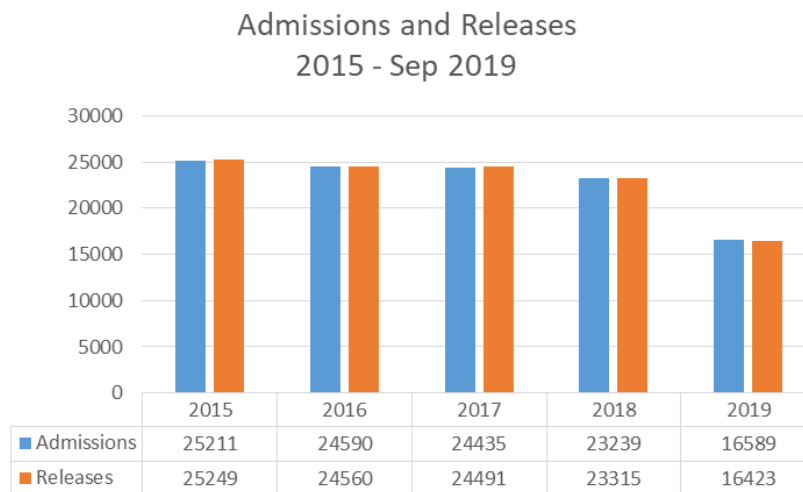
Post Review Summary

Staffing related issues which were identified in the course of the post evaluation, along with recommended adjustments in staffing, are summarized below:

Intake and Release

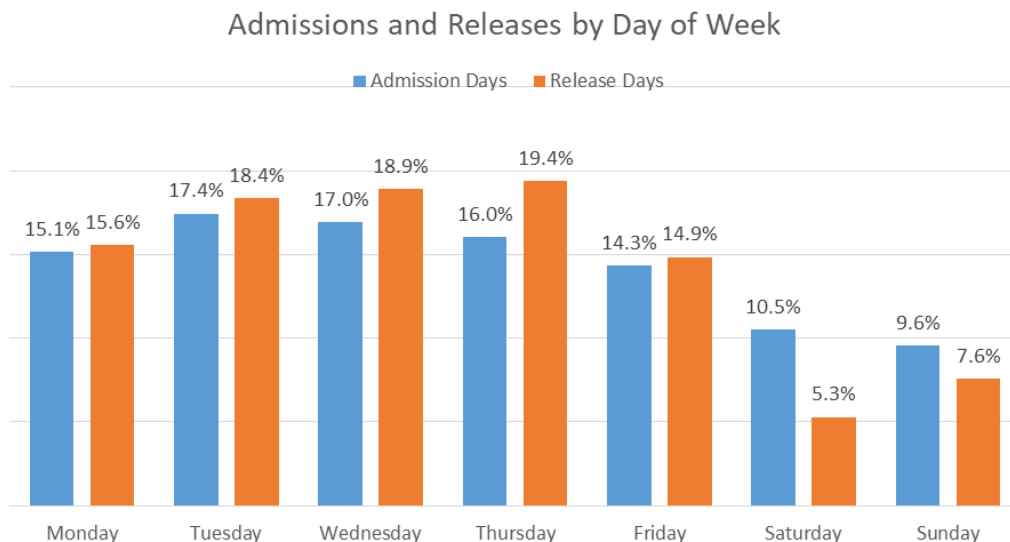
The intake and release functions of a jail are staff intensive operations that are ongoing 24-hours a day, 7 days per week. The chart below shows the number of admissions and releases processed each year over the past three year and nine months. The jail averaged over 24,000 bookings and releases over the time period.

Figure 25: Admission and Releases



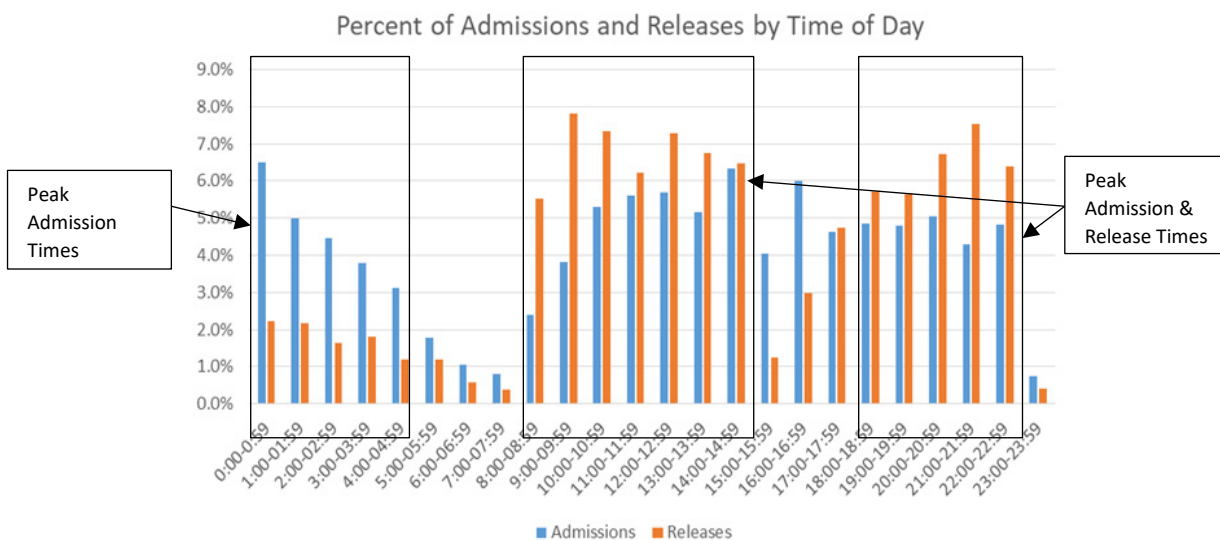
A survey of bookings and releases between June and October 2019 show that the highest volume of bookings and releases occur midweek from Tuesday through Thursday. On the second week of October 2019, the number of bookings per day ranged from a low of 40 on Saturday to a high of 72 on Wednesday of that week.

Figure 26: Admission and Releases by Day of Week



Over this same period, the survey showed that over 70% of admissions occurred between 9:00 AM and 11:00 PM. Peak times for releases were between 8:00 AM-3:00 PM and 5:00 PM-11:00 PM when over 82% of releases occurred.

Figure 27: Percent of Admissions and Releases by Time of Day



The function is currently managed by a Booking Sergeant working each shift. The Intake function is staffed with a number of Correctional Officers carrying out a host of functions including screening, searches, identification, booking, showering and dressing-out, property inventory and storage, classification, and monitoring behavior. The process is somewhat reversed in the processing of detainees for release. In addition to intake and release, staging of detainees for transport to/from court and to other locations also occurs in this area.

With current staffing shortages and a lack of a Shift Supervisor, the Booking Sergeant often becomes responsible for other duties as well, leaving the Intake area unsupervised for periods of time. The Intake staff expressed concerns about getting work done in a safety, secure, and timely manner.

- The following are recommended to improve staffing of the intake and release function:
 - Provide a shift supervisor and additional supervisory support in other aspects of operations to allow the Booking Sergeant to remain focused on his or her primary duties.
 - Add **one additional Booking Officer on second watch.**
 - **Reestablish the Admissions Officer post on second and third watches.**
 - Add **one additional Photo and Print Officer post on second and third watches.**
 - Ensure **Classification staffing is sufficient to provide 24/7 coverage.** Review the classification process to give consideration of requiring face-to-face interviews with newly admitted detainees and in classification reviews. This may require additional classification staffing and space for conducting interviews.

Housing - Linear and Pod Housing Officer Posts

The number of correctional officers currently available are insufficient to provide the coverage needed to enhance the safety and security of both staff and detainees at to manage the workload. The workload of available staff is compounded by the chronic overcrowding in almost all areas of the facility. The combined staff shortages and overcrowding impact operations in the following ways:

- Some work on shift is left undone or done inconsistently;
- The level of staff to detainee contact and interaction is limited, leaving detainees much to their own devices in housing units for significant periods of the day;
- Staff have limited ability to actively manage detainee behavior;
- Staff are limited in their opportunities to conduct regular inspections of housing areas to assess sanitation levels, presence of contraband, tampering of security devices, equipment and furnishings in need of repair, etc.;
- Detainee basic needs may go unmet or are delayed;
- Access to medical services and programs may be impacted as staff are unavailable to escort detainees internally to these services in a timely fashion;
- There is increased use of administrative segregation, disciplinary confinement, and protective custody as a response to detainee misconduct and/or self-destructive behavior.

The effectiveness of detainee supervision is also hampered by the linear layout and design of the housing units in the older section of the jail. Staff observation into housing areas is intermittent at best with officers conducting rounds where they observe dayroom areas through glazing or bars in the housing unit walls. Staff are required, by policy, to enter each dayroom area to conduct well-being checks at least hourly, with secondary checks conducted in between by observation from the corridor.

- In the short term, it is essential that **vacant correctional officer positions be filled to bring staffing up to currently authorized and funded levels** and steps be taken to **reduce population levels of housing units back to original design capacity**. This should serve to reduce overtime, reduce the need to activate non-correctional officer positions to cover posts, and provide coverage of posts according to the current post plan.
- In addition to the posts identified in the current post plan, the following additional posts are recommended to address the operational issues described above:
 - Second Floor housing - **one additional 24/7 post** is needed
 - Third floor housing - **one additional 24/7 housing officer post** is needed
 - Fourth floor housing - **one additional 24/7 housing officer post** is needed
 - Pods A and B - **one additional Rover post to assist the Pod Officers** is needed on the second and third watches when detainees are out of their cells
 - Pods C and D - **one additional Rover post to assist the Pod Officers** is needed on the second and third watches when detainees are out of their cells
- Sufficient staff need to be available to provide breaks for persons working housing and master control posts. The application of a realistic shift relief factor to the staff coverage plan and the additional escort posts should provide additional flexibility to cover meals and breaks.

Escort

The Escort positions are job assignments with a primary duty of supporting the housing units and other essential functions of the facility by supervising detainee movement within the facility, providing back-up and meal relief to staff in housing units and other fixed posts, responding to emergencies and codes, escorting vendors and other visitors in the facility, receive deliveries to the facility, conduct fire and health inspections, investigate incidents, assist with critical cell and dayroom inspections, and so on.

- In addition to the existing escort posts, the following additional escort posts are recommended:
 - Add **an additional escort post on all watches** to the current escorts assigned to the third and fourth floors (bringing a total number of escorts to three on second and third watches and one on first watch to cover all linear floors.).

- Add a **medical escort post to third watch** to provide for timely escort of detainees to/from the medical clinic and to supervise detainees while in the clinic during the evening hours.

Support Services Security

Due to staffing shortages, the security post for the Ground Floor where food services, laundry, warehouse and loading dock, and related support services are located was eliminated.

Currently the only security staff on this floor is the Dock Officer working second watch and the Laundry Officer working third watch. Detainee workers assigned to kitchen, laundry, or warehouse duties are working on the Ground floor throughout the day and evening.

- A **Ground Floor correctional officer post should be added to the first and second watches**. The Laundry Officer, working the third watch should be sufficient to provide security coverage on that shift.

Control Center

The Control Center is the secure, fixed post staffed 24-hours a day that serves as the hub for monitoring and coordination of communications, life safety, and security systems. Closed circuit television monitors, intercoms, telephone lines, fire/smoke alarms, door alarms, and door controls are located in the control center. The Control Center is designed to operate with two staff. Due to staffing shortages current staffing limits assignment of two officers on second watch only.

- In addition to the current staffing, **one additional post should be added to Central Control on Third Watch** when activity levels and movement in the building remain high. The Control Center could remain staffed with one officer on First Watch when activity levels are lower.

Housing Sergeants

Currently, supervisory support for housing officers is limited due both to staffing limitations but also to current policy and practice. It should be the responsibility of supervisors to set performance expectations for correctional officers under their supervision, coach and guide as needed, provide resources, and to monitor and evaluate performance. They are currently dealing with administrative work, leaving little time for providing active supervision and support of officers. By policy and practice, they are often called in to resolve conflicts within the housing areas, unintendedly but effectively undermining the officers' authority over the detainees for which they are responsible. Additional supervisory staffing is needed, along with adjustments to the roles of housing officers and supervisors to more effectively manage detainee behavior.¹¹

- The jail should be staffed such that two Housing Sergeants are on duty at all times of second and third watches. This would require **the addition of a second Housing Sergeant 24/7 on all three watches** with the current Operations Sergeants serving as

¹¹ The MCSO should explore opportunities to implement the concepts and principles of Direct Supervision and the elements of effective inmate behavior management through training and resources which may be available through the National Institute of Corrections.

the second Housing Sergeant on second and third watch and the Detail Sergeant filling this role on the first shift.

Shift Supervisor

The Shift Supervisor has overall responsibility for jail operations on an assigned shift. These responsibilities fall largely to Sergeants, contributing to their current challenges of providing adequate support to housing and intake officers. Given the level of crowding in the facility, challenges of operating a facility of obsolete design and deteriorating building systems, and dealing with a population with higher risks and needs, it is essential that there be shift command presence.

- The **Shift Supervisor post should be established and staff on an ongoing basis on at least the second and third watches**. An on-duty Sergeant should then be assigned to function as the Lead Supervisory Officer on first watch when a Shift Supervisor is not assigned to work.

Staff Coverage Plan

This section identifies a staffing plan for the Montgomery County Jail which identifies coverage needs of **all essential custody posts and positions**. Administrative, support, and program positions are included in the staffing plan, but are not the primary focus of this study. Contract services including medical, food service, and commissary are not included in this study. The staffing plan **includes a relief factor** necessary to provide the number of FTE's necessary to provide the coverage indicated.

Figure 29 shows Mark Martin's complete recommended coverage plan based on the staffing study. Recommended new posts and positions are highlighted in red. Mark Martin's recommended staff coverage plan uses the relief factors for the correctional officer job class developed in the course of the staffing study (See Section III).

The number of authorized, actual current staffing levels, and recommended FTE levels by job classification or rank are summarized in the table below.

Figure 28: Current Authorized Staffing – Jail Division

Current Authorized Staffing - Jail Division			
Job Classification	Auth. Positions	Current Staffing	Recommended
Major	1	1	1
Captain	2	2	2
Shift Supervisor	0	0	3.5
Sergeant	11	11	15.9
Corrections Officer	121	111	177.7
Recreation Officer	2	2	2
Program Coordinator	1	1	1
T-Cap Treatment	2	2	2
Civilian	3	3	3
Total	143	133	208.1

The recommended staffing requires a total of **208 FTE** to provide the recommended level of coverage. The table below shows the actual number of staff on duty on each watch by job class if fully staffed.

Figure 29: Recommended Staffing by Shift

Recommended Staffing by Shift			
Job Classification	First Watch	Second Watch	Third Watch
Major	0	1	0
Captain	0	2	0
Shift Supervisor	1	1	1
Sergeant	3	4	3
Corrections Officer	26	40.5	38.5
Recreation Officer	0	1	1
Program Coordinator	0	1	0
T-Cap Treatment	0	2	0
Civilian	0	3	0
Total	30	55.5	43.5

Summary of Findings and Recommendations

Summary of Findings

Detainee Population Growth and Changes in the Characteristics of the Detainee Population

- Growth in the detainee population has led to persistent overcrowding.
- Staffing levels have not kept pace with detainee population growth.
- Recent trends include more female detainees, more detainees with significant medical and/or mental health needs; more detainees with higher risk profiles.

Factors influencing staff needs:

- Style of facility – Detainees housed in a **multi-story facility that has been expanded overtime resulting in a building without a coherent design philosophy.**
- Number of floors – Detainees housed on **four floors in the older section of linear design and on two levels with mezzanine housing in the newer section of podular design.**
- Location, size & style of housing units – Housing units are a combination of linear, podular direct, and dormitory housing of varying configurations and capacities.
- Housing separations – **Forty-seven (47)** separate housing units of varying size and design, in addition to medical housing.
- Circulation – **Key functions including programs, exercise, and medical/mental health services are predominantly centralized,** particularly in the linear section of the jail, requiring a substantial amount of escorted detainee movement.
- Sight lines and observation – Layout of linear housing permits only **intermittent observation** by staff patrolling adjacent security corridors. Housing unit locking systems require two staff for entry into housing units for checks, inspections, and other interaction with detainees.
- Intake and Release – Facilities were not sized or designed to manage the current number of and of detainees processed into and out of the facility.

Insufficient Staffing for Operations and Activities

- There are insufficient staff to maintain routine custody operations, detainee services, and programs.
- Current staffing levels present challenges in carrying out routine custody operations such as security checks, maintenance, sanitation, searches, admissions and releases, escorts, transports, surveillance and monitoring, etc.

- Staffing short falls and crowding present challenges in delivering essential detainee services such as meals, laundry, sick call, medication rounds, visitation, mail, commissary, haircuts, library, etc. in a timely and consistent manner.
- Programs such as religious services, education, AA, substance abuse services, volunteers, etc. are limited due to staffing shortfalls, crowding, and lack of sufficient program space.

Inadequate Shift Relief Factor

- Staffing shortfalls are due, part, to an inadequate shift relief factor.

Difficulty in Filling Vacancies and Retaining Staff

- The Montgomery County Jail has had difficulty in recruiting and hiring to get staffing up to full authorized strength due to tight job markets and less than ideal working conditions.
- Staff retention has been a problem. Turnover was 28% in 2017. While job dissatisfaction and working conditions may have been contributing factors, the MCSO (like many Sheriff's Offices) has a historic practice of recruiting from civilian jail staff to hire into court deputy, transport deputy, and ultimately road deputy positions. When these positions become vacant, civilian jail officers apply and, if hired, fill those positions. Each time this occurs, it is the jail that stands the vacancy.

Overreliance on Overtime to Cover Shifts

- Increases costs, contributes to burnout and increased leave usage, and likely contributes to turnover.
- Overtime is being used to ensure the safety and security of the facility.

Physical Plant Conditions and Maintenance

- The building systems (HVAC, electrical, plumbing, etc.) in the older section are original to the building. As such they are, in many respects, obsolete and worn out. They require a high level of maintenance by technicians familiar with the systems and trained in their repair and maintenance.
- The breakdowns and failures of these systems present ongoing hazards to the safety and well-being of staff, detainees, contractors, and other visitors to the facility.
- The age and heavy use of the building impact the level of sanitation. Poor sanitation, along with graffiti on walls, and other signs of neglect send a strong message to detainees regarding their expected behavior. Expectations of positive behavior by detainees must be supported both directly through rules and guidelines but also indirectly through the environmental cues such as maintaining a clean and healthful living environment.

Recommendations

The following summarizes the recommendations made in the staffing study and addresses issues for future consideration.

Overcrowding

Recommendations:

1. The County, local justice system, and the MCSO should reach consensus on the maximum capacity of the jail (by housing area) and agree on relief measures to prevent the jail from exceeding the agreed-upon capacity. The overall goal should be to limit the maximum number housed at no more than the original design capacity and to maintain an average daily population of no more than 80-85% of design capacity to allow for proper classification and housing of detainees.
2. Housing units should not hold detainees in excess of their original design capacity.

Operations and Activities

Recommendations:

1. Program areas in the direct supervision housing pods should be restored to their original use to allow detainees meaningful access to exercise and opportunities to participate in programming and other productive activities.
2. Staff presence in detainee housing units should be increased to facilitate more active supervision of detainee behavior.
3. Improving sanitation and living conditions should continue to be a high priority.
4. The Master Activity Schedule should be completed with as many intermittent functions and activities as possible included on the schedule. When functions and activities are not scheduled, jail routines become less predictable and stable for detainees and it becomes easier to let things slide, particularly when staffing levels are at issue. The scheduling of functions and activities should be adjusted to make optimum use of available staff to level out the workload across the day.

Net Annual Work Hours (NAWH) Calculation

Recommendations:

1. The NAWH computation should be applied to the staffing plan to accurately reflect number of FTE's required to meet coverage requirements.
2. NAWH computations should be updated regularly, both to keep the shift relief factor current and valid for use in estimating staffing needs and to spot emerging trends.

Overtime Usage

Recommendations:

1. Overtime use should be used for "healthy" purposes and not relied upon to cover staffing shortfalls in a long-term basis.
2. Ways of reducing overtime use include:

- Filling vacancies quickly.
- Efficient scheduling of vacation time by shift.
- Efficient scheduling of training time by shift.
- Stricter controls on the use of unpaid leave.
- Keeping the number of authorized and funded positions consistent with the coverage needs.
- Updating the NAWH each year.
- Filling all positions identified in this study.

Staff Coverage Plan

Recommendation:

1. The MCSO should use this staffing report to establish of a baseline authorized staffing for the jail and identify the exact posts to be authorized. Any new posts or positions in the plan would then need to be authorized for additional funding before the slot is filled on a permanent basis. See Staff Coverage Plan in Figure 29.

Vacancies and Turnover

Recommendations:

1. The MCSO should continue to make it a priority to fill vacancies as quickly as possible.
2. The MCSO should support an initiative to recruit, hire, and train a sufficient number of custody staff as **expeditiously as possible** to provide sufficient staffing levels to cover key custody posts and get staffing up to currently authorized levels as a first step. The MCSO should then use the staff coverage plan presented in the staffing study completed pursuant to this initiative to establish of a baseline of staffing for the jail. New posts or positions identified in the staffing plan should be filled as they are authorized and funding is provided, but as soon as practical.

Physical Plant Conditions and Maintenance

Recommendation:

1. Assign a sufficient number of trained and qualified maintenance staff to the facility to be available to make prompt repairs when plumbing, electrical, HVAC or other building system issues arise and to perform essential preventive maintenance.

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Section V. Medical Services

Key Findings:

- *Only serious medical issues are transported off-site to local hospitals. Any active overdose is refused. There is no infirmery-level care available at the jail.*
- *The jail was not designed for persons with mobility issues. However, accommodations are made when needed. In some instances, other detainees are used to assist detainees that are non-ambulatory or that have other mobility issues.*
- *The medical services area is constrained and not designed well for its function. The screening area is cramped and undersized. The only suicide resistant cells are in Intake.*
- *Medical housing is undersized in both area and numbers and currently houses patients with Dementia, Parkinson's Disease, End Stage Cancer, and Stage 4 Liver Cancer. The space is often used for other housing purposes, lacks flexibility, and has limited capability for infectious isolation.*
- *There are no medical spaces in the housing units, however medical treatment can be provided in those spaces including medicine pass.*
- *The clinic area is cramped and undersized, with limited functionality. Anything over a basic level of care is taken offsite. There are no gender-specific treatment areas.*

The Montgomery County Jail is certified by the National Commission on Correctional Health Care (NCCCHC). Certification by NCCCHC recognizes that the jail is committed to patient treatment, staff training, disease prevention, and health records. The jail has been accredited since 1980 and has annual on-site audits every three years.

Other than very limited information from the American Correctional Association (ACA), there are no space standards for correctional health spaces. In addition, state health codes very rarely dictate programs and spaces in correctional facilities. In determining facility needs for health care service delivery, best practices use a combination of the ACA space standards and the benchmarks established by Facilities Guidelines Institute (FGI). The FGI publishes guidelines for the design and construction of Hospitals, Outpatient Facilities, and Residential Health Care and Support Facilities.

Because there are no mandated space requirements, best practices require an analysis of the detainee health conditions the facility currently prefers to provide “in-house”, and which conditions they would like to provide in the future, and then determine space needs based on the acuity of the patient and any concerns surrounding security and supervision. If in the future, Federal dollars do become available for detainee healthcare, the Centers for Medicare and Medicaid Services (CMS) rules may change the space requirements.

The specific scope of this review of jail medical services focused on the following areas:

- Intake and receiving
- Medical screening/ assessment tools and other associated documentation forms
- Classification
- Male/female housing units
- Crisis intervention
- Suicide prevention practices
- Restrictive housing
- Medical and mental health programs and processes
- Alcohol intoxication and detox process
- Re-entry/Discharge planning processes
- Medical and mental health administration
- Medical and mental health staffing
- Jail policy and procedures for medical care
- Medication administration

NaphCare, Inc. is currently contracted by Montgomery County to provide healthcare and mental health services to the Detainee population of the Montgomery County Jail. NaphCare took over medical treatment by contract in 2012. That contract was amended in 2018 to included Mental Health services that was to begin starting January 1st, 2019. The current Healthcare service contract is in its third year, with the possibility of renewing for the next 2 years for a total of 5 years. The mental health contract is in its first year.

System Policies and Process

Contract

NaphCare medical staff professionals determine which detainees are treated in the Jail facility and which detainees are transported to local hospitals.

Transports to local hospitals are by two different methods. Though all detainees are transported by the Sheriff's office, some detainees are secured by Sheriff's office and some are secured by Merchant Security, who is a subcontractor to Montgomery County. Most detainee-patients who are admitted to local health facilities are secured by Merchant Security. It was noted that in a medical emergency, NaphCare health professionals would stabilize the detainee-patient on site (at the point of emergency) and then the EMS team would transport the detainee-patient to the local hospital.

NaphCare also provides an electronic medical record system (TechCare) and a health record monitoring system (StatCare). This system monitors the detainee-patient medical record to help determine medical priority and provide oversight to reduce medical errors. This system is monitored from the NaphCare home office in Alabama.

Hospitals

Montgomery County has partnered with two major hospital networks for their offsite healthcare, Premier Health Network (Miami Valley Hospital) and Kettering Health Network (with Grandview being the closest location to the jail for emergency services). The Kettering Health Network does have other hospitals (i.e. Sycamore, Southview, Kettering's Main Hospital), but Grandview is their hospital closest to the Jail and is most often used.

Intake

The following intake processes was reviewed during the facility tour and subsequent staff interviews. It was noted that detainees cannot be housed until the screenings are completed. The County tries to keep this process under four hours:

- Step 1: The arresting Officer fills out a Questionnaire prior to the jail accepting the arrestee. If the arrestee is showing signs of Medical or Mental Health concerns, they are referred to the Medic for a brief screening. If the arrestee has an open wound, or admits to swallowing pills, they automatically refused admittance and turned back to the arresting agency to seek further treatment transferred to one of the local partner hospitals. Anyone who is in active overdose is refused. The Arresting Officer determines where the arrestee is taken if they are refused intake to the jail. All admitted detainees are offered drug screening. It was noted that most of those do comply.
- Step 2: After the initial questionnaire, all arrestees are dressed out immediately, then sent to fingerprinting, etc.
- Step 3: A Full Receiving Screening is then completed. An Emergency Medical Technician completes a multi-screen intake assessment of the arrestee. If the EMT is called out, the screening is completed by an LPN or RN. During this screening, the following items are completed:
 - Physical health history/assessment, including vital signs
 - Mental health screening
 - Tuberculosis questionnaire
 - Consent for treatment form is completed
 - Medication verification
 - Urine drug screening for identifying detoxing patient
 - Urine screening for pregnancy

- Step 4: If an arrestee is flagged with a Mental Health concern, Mental Health Clinical Staff is called down for another screen by QMHP. During the screening process, patients are not automatically scheduled to see a physician. If they have a chronic care illness or comorbidities, they are scheduled for chronic care visit and follow ups. Otherwise, Physician consultations are on an as requested or as needed basis. If the detainee refuses consent to treatment, MH staff helps them understand the implications. However, that detainee would still get housed after that refusal.

Though the Intake process is linear, there are a few instances where the process can be adjusted. Because of a medical issue, a detainee can go directly from Intake to the Clinic. In addition, for any detainee who may be in cardiac arrest, EMT's would be called and the detainee would be taken to one of the local hospitals.

Classification

Offender classification is based primarily on the detainee's charges and secondarily on their medical or mental health diagnosis and the offender's behavioral history in the jail. However, it was noted that the systems must work together, since there is no step-down units to house the mentally ill.

Sick Call

A detainee can make a sick call request in three different ways:

- They can make a request using the Kiosk in the housing units.
- They can make a request thru the on unit Correctional Officer.
- They are also provided a communication button in their cell, where they can make a sick call request. (It was noted that the use of the button system is not routinely abused). The NaphCare health professionals then triage the request and schedule appointments as required. The NaphCare staff noted that they try to complete the sick call list within 18 hours.

Medications

NaphCare staff are able to distribute medications. Medication carts are brought to the housing units for medication passes. Pill call is provided for chronic care management, in the day room on the individual housing units.

Medical Housing

Montgomery County Jail does not currently provide an infirmary level of care. No active treatment is provided in the Medical Housing Cells. NaphCare medical professionals are able to enter the Medical Housing Cells to provide medical care. Any enhanced treatment for the detainees housed in the medical cells would be provided in the Clinic Area. NaphCare has contracts with local nursing homes to provide skilled nursing care for any detainee that may require it. However, it was noted that those nursing homes do not always have capacity for those Montgomery County detainees needing that level of care. Because of that issue (and also sometimes because of a detainee's charges), The jail is currently housing detainees with Dementia, Parkinson's Disease, End Stage Cancer, and Level 4 Liver Cancer. In some

instances, other detainees may be used to provide assistance for detainees that are non-ambulatory, or that have other mobility issues.

Dietary

There are provisions for detainees that require medically restricted diets. The food services provider (Aramark) does provide medically restricted diets on an “as-needed” basis. However, it was noted that some detainees will “work around” those diets by their commissary purchases.

Clinic Area-Medical

Medical services provided in the clinic are primarily for Chronic Care management and Blood Draw. Any conditions over a basic level of care are taken to the off-site partner hospitals.

Clinic Area-Dental

The provision of dental care focuses on reduction of pain and restoration of function. The primary service provided is extractions. Any oral surgery is taken off-site.

Transports

Any medical concern that is above a basic care need is sent out to the local partner hospitals. Any major injury or trauma would be stabilized on site and transported to the local partner hospitals. Any advanced imaging (CT, MRI, Nuclear Medicine) would be sent off-site. Any invasive or non-invasive procedures would also be sent off-site. Any pregnant female detainee would be sent to local partner hospitals for OB/GYN consultations and some prenatal care. All Ultrasounds are completed off-site. Active labor would also be taken to the local partner hospitals.

Patient Volume

On the weekend previous to the assessment team visit, the jail population was 863, including 170 females, 286 offenders with mental health concerns and 60 offenders in detox procedures. It was noted that over the last five years, the jail housed 92,450 detainees with medical concerns and 7,800 detainees that needed a Dental intervention. The jail is also currently housing detainees with Parkinson’s disease, Dementia, End Stage Cancer, and Stage 4 Liver Cancer.

Staffing

Figure 30 summarizes the revised jail health care staffing plan that took effect this month. The plan supports 24/7 coverage for RN’s, LPN’s, and EMT (booking). The Dentist is on-site ½ day, one day per week and a Physician is on call.

Figure 30: Medical Services Staffing

Montgomery County Jail									
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Hours	FTE
Position Title	Day Shift								
Health Service Administrator (RN)	8.000	8.000	8.000	8.000	8.000			40	1.000
Director of Nursing	8.000	8.000	8.000	8.000	8.000			40	1.000
Mental Health Nurse (RN)						8.000	8.000	16	0.400
Medical Director		7.000		7.000				14	0.350
NP/PA	8.000	8.000	8.000	8.000	8.000			40	1.000
Dentist					6.000			6	0.150
Dental Assistant					6.000			6	0.150
Psychiatrist						9.000	9.000	18	0.450
Psych NP/PA	8.000	8.000	8.000	8.000	8.000			40	1.000
Mental Health Director	8.000	8.000	8.000	8.000	8.000			40	1.000
Mental Health Professional	16.000	16.000	16.000	16.000	16.000	12.000	12.000	104	2.600
Discharge Planner (MHP)	24.000	24.000	24.000	24.000	24.000			120	3.000
Administrative Assistant	8.000	8.000	8.000	8.000	8.000			40	1.000
Registered Nurse	8.000	8.000	8.000	8.000	8.000			40	1.000
Registered Nurse	12.000	12.000	12.000	12.000	12.000	12.000	12.000	84	2.100
Licensed Practical Nurse	36.000	36.000	36.000	36.000	36.000	36.000	36.000	252	6.300
Licensed Practical Nurse	8.000	8.000	8.000	8.000	8.000			40	1.000
Emergency Medical Technician (Booking)	12.000	12.000	12.000	12.000	12.000	12.000	12.000	84	2.100
	Night Shift								
Registered Nurse	12.000	12.000	12.000	12.000	12.000	12.000	12.000	84	2.100
Licensed Practical Nurse	36.000	36.000	36.000	36.000	36.000	36.000	36.000	252	6.300
Emergency Medical Technician (Booking)	12.000	12.000	12.000	12.000	12.000	12.000	12.000	84	2.100
Mental Health Professional/Psychiatric RN	8.000	8.000	8.000	8.000	8.000			40	1.000
Mental Health Professional/Psychiatric RN	12.000	12.000	12.000	12.000	12.000	12.000	12.000	84	2.100

Total FTEs 39.200

Facility Analysis

Intake

There are currently two suicide resistant cells for males and two suicide resistant cells for females in the Intake area. They are the only suicide resistant cells in the facility. There is only one Screening Room and its layout is not conducive to both interviews and physical examinations. There is also not adequate space for Mental Health evaluation. However, there is a Mental Health office within the Intake area. It was also noted that due to the lack of female housing, that many times, females are kept in Intake for a couple of days.

Housing

Overall, the units are older and not designed with current standards of accessibility. Historically, most jails were designed for the young, healthy, male population. They were not designed to house aging detainees with mobility issues, gender specific needs, or those with mental health concerns.

Pods A, B, C, D

These are mezzanine housing pods with 48 cells, double bunked. There are an additional 8 beds located in space that was previously used for detainee programming. Those 8 beds are

primarily used for detainees without behavioral health issues and are violent. Detainees can request a sick call intervention either through the kiosk in the day room, or by asking the Corrections Officer. There is not currently any Medical Exam space in the Housing Pods. We also note that the JMS system used by the Corrections Officers does not link to the TechCare system used by NaphCare.

Open Dorms

This area can house up to 60 detainees. At the time of the tour, they were housing 55 detainees. Detainees can request a sick call intervention either thru the kiosk in the day room, or by asking the Corrections Officer. There is not currently any Medical Exam space in the Dorm.

“Roll Overs”

This area can house up to 10 detainees in 1 room. It is in the old part of the jail and consists of barred cells that include bunks, showers, and recreation areas. Detainees recreate in the basketball court 1 time per week. This area will house detainees who were recently released from suicide watch, if they will be returning to Administrative Segregation. The assessment team was not able to observe the interior components of the “Roll Over” areas.

Administrative Segregation

This area houses 11 detainees on each side. Most detainees are housed in this area for protective custody, though it was also stated that many detainees housed here have Mental Health issues. These detainees will be allowed out of their cells for one hour each day for recreation. It was also noted that they do not house recent suicide watch detainees in this area. Mental Health or Medical Staff will work with the Corrections Officer to determine if the detainee should be moved out of this housing area. Nurses routinely complete spot checks of detainees in this area as part of Medication Passes. In addition, Medical Staff will round in this area at least once per week, and Mental Health Staff will round in this area at least twice per week. There is a kiosk in this area to request a Medical intervention.

Medical Housing

This area consists of 4 cells, each with a capacity of 4 beds. One of the 4 cells is an Infectious Isolation Room with an Anteroom. However, that room is often used to house juveniles. These cells often times also serve as additional overflow beds. As noted earlier, these cells are not used for treatment. They are used for detainees who require frequent medical consultations or need to be separated from the general population for medical reasons. These could include chronic conditions, injuries, and significant lengths of stay. As noted earlier, any infirmity level of care or above is transported to the local partner hospitals. Due to these issues, there is limited capability to provide for infectious isolation, as well as providing an infirmity level of care.

Clinic

The Clinic area consists of 3 Exam Rooms and administrative and support space. Overall, the clinic is tightly packed and many spaces are undersized. Because of the space limitations, the Exam Rooms are multi-used with disparate functions. There is very limited waiting area for the

detainees and there is not an “off-stage” area where the Medical Staff can move freely away from the detainee-patient traffic. The three Exam Rooms are used for the following functions:

- Dental procedures, Blood Draw, and Portable X-Ray
- Chronic conditions Treatment
- Exam Room and Office

Portable X-Ray is brought in once a week and it is completed in the Dental Exam Room. All ultrasounds are completed off-site.

Because of the multi-use functionality of the Exam Rooms, as well as their smaller size, it is difficult to be flexible in the types of procedures that can be performed. Due to this, it was noted that they do not currently do pelvic exams.

Though there is no Sterilization Room, they do have an Autoclave in the Dental Exam Room.

Opportunities for Improvement

Level of Acuity

In order to determine the proper amount of health services to be provided in the Jail, Montgomery County will need to determine what level of medical acuity will be treated in the Jail versus being sent out to local hospitals. Knowing that transportation and security of a detainee outside of the jail is an inherent safety risk, any conditions that can reasonably be treated within the Jail should be evaluated. This will then help determine the scope of the medical treatment areas within the Jail.

Intake

The jail currently has one screening room. This has shown to be inadequate for their needs. The room is also poorly designed from both a medical and security standpoint. During the interviews, staff had stated that 3 screening rooms would be more appropriate for their needs. It would also help their functionality to have those rooms be HIPPA compliant. Ideally, these rooms would be set up as contiguous bays to allow ease of staff flow between detainees, as well as observation and supervisions by the Corrections Officers. This space should also allow for a staff access in the back of the room so that staff cannot be barricaded in the room. In addition, there should be a Patient Toilet with a specimen pass thru to a Soiled Utility Room. This would allow for a more efficient process for collecting and completing drug testing.

Clinic

The current Clinic is undersized and inefficient from a space standpoint. The size of the treatment areas limits the types of procedures that can be completed, and the layout of those spaces challenges the efficiency of the staff working there.

Ideally, the Clinic would have 4 Exam Rooms sized at 120SF. This Exam Room size would allow the Medical Staff to manage any chronic condition that a detainee may have. It would also allow for the Exam Table to be equipped to provide pelvic exams, while maintaining patient privacy. In addition, there should be a Treatment/Procedure Room for completing more

complicated procedures such as suturing. This room should be a minimum of 150SF, with the ideal being 180SF. This would be the proper room to house the portable X-ray unit.

The Dental Exam should also be located in its own room. Ideally, there would be a separate Sterilization Room for the Dental instruments. During the interviews, it was also noted that staff would like additional hours from the Dentist.

In addition to Exam Space, there are a number of other treatment and support spaces that should be considered:

- A dedicated Patient Toilet adjacent to a Soiled Utility Room. This would allow for a urine specimen pass-thru from the Toilet to the Soiled Utility Room. This would allow for a more efficient process of specimen testing.
- A three bay Infusion area for detainees needing IV medications. This would eliminate the need of occupying the Exam Rooms with longer infusion treatments.
- The Pharmacy should also be increased in size and made into a private space. Right now, the Pharmacy area is part of the main admin/office area for the Clinic. The Pharmacy should be a secured area, with space that can be converted into a compounding area in the future. It should also be sized to allow for future use of an automated system.
- Additional ancillary support spaces should also be added for efficiency, infection control, and future flexibility purposes. These spaces should include:
 - Medical Equipment Storage
 - Soiled Utility
 - Clean Utility
 - Staff Breakroom
 - Staff Toilet

In regard to detainee-patient transfers to the local partner hospitals, there are a number of medical conditions that can be considered to keep in house. Though this would increase the amount of medical staffing needed in the jail, it would limit the number of transfers needed to local hospitals.

An analysis was completed of 2018 data that listed the number of detainees who were sent to local Emergency Departments and what conditions they were treated for. After review of that data, it was determined that up to 33% of those detainees could have stayed at the Jail if the Jail was equipped with an Urgent Care level of care. For an additional 14% of those detainees, more information would be needed regarding their medical disposition to determine if they could have stayed at the Jail for treatment if the Jail was equipped with an Urgent Care level of care. Based on the number of detainees that could remain in the Jail, we would recommend adding an Urgent Care clinic.

Figure 31 lists the number of cases that were sent to local Emergency Departments based on the 2018 data. They are listed by chief complaint.

Figure 31: Emergency Room Cases

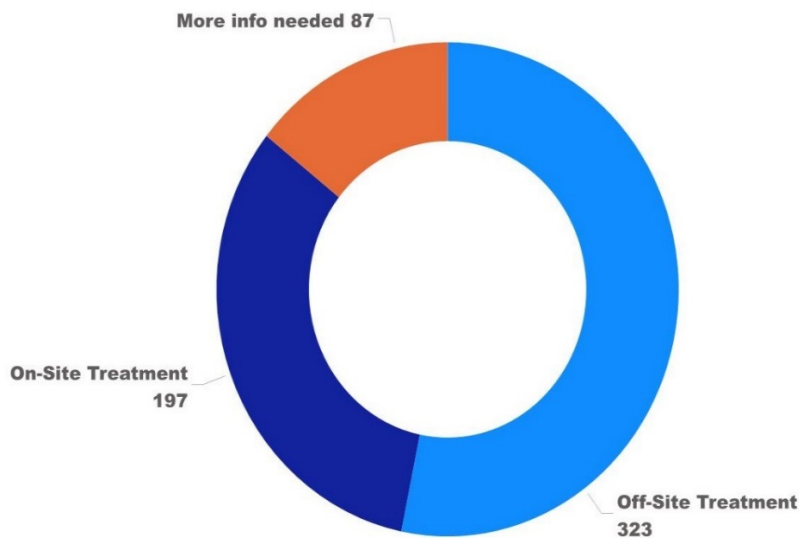
Off-Site ER Visits

Selected Reasons	Count of Selected Reasons
Trauma/Injury	1
Hepatic/Cirrhosis	5
Kidney Disease/ESRD	5
AMS	8
Pain	10
Diabetes/Hyper-Hypo-glycemia	12
Asthma/Other Respiratory	14
Suicide Attempt	14
Stroke/Other Neurological	17
Fever/Infection	19
Hypertension/Cardiovascular	19
Laceration	19
Chest Pain	22
Seizure	22
Bleeding/Hemorrhage	27
OB/GYN	27
Orthopedic Injury	28
Suspect Overdose	29
Abdominal Pain	76
Trauma/Injury	95
Other	138
Total	607

Figure 32 shows an analysis of which detainees may have been able to stay in the Jail if the Jail was equipped with an Urgent Care. In this analysis, the Dark Blue color indicates detainees who could have been treated in an Urgent Care, Light Blue indicates detainees who would have still needed to be taken to a local Emergency Room, and Orange indicates detainees whose condition we would need more information to determine.

Figure 32: Emergency Room Cases that Could Have Been Treated in Urgent Care

On-Site Urgent Care Treatments



Medical Housing

During the tour and interviews, staff expressed interest in increasing the Medical Housing to 12–16 rooms that can house 30-32 patients. They also expressed the need for 2 Infectious Isolation Rooms. Those 2 rooms could share an Anteroom for greater space efficiency. In addition to the numbers of rooms, the rooms should also be designed with accessibility in mind. They should accommodate hospital beds, patient lifts, and accessible showers and toilets. They should not use any beds that are bunked. These rooms should also be sized to be converted to private rooms to allow for active treatment for those patients that need 24-hour infirmary level of care. Though the jail does not provide an infirmary level of care today, the data did show that the jail currently houses some detainees who could benefit from that level of care. Designing for flexibility to provide that level of care would be advantageous.

Housing

The current housing units do not allow for any medical treatment on the unit. They also do not have any suicide resistant cells. The units would benefit from a small Exam Room where blood could be drawn, and where some examinations could take place. This would limit the number of detainees who would have to be brought to the clinic. This Exam Room could also be used for the pill call, thereby taking that activity out of the dayroom.

Besides the Exam Room, the housing units could also benefit from suicide resistant cells. As noted above, the only suicide resistant cells in the facility are in the Intake area. By adding 4 -5 suicide resistant cells throughout the housing units, it would limit the number of detainees who have to stay in the Intake area.

Additionally, any new expansion or renovation of the Jail should be designed to accommodate accessibility for those who may be mobility impaired as well as being sensitive to the needs of an aging population. It should also be designed for needs that are gender specific. Meaning that spaces housing young, healthy men, should be different than those housing women or the elderly.

Section VI. Mental Health Services

Key Findings:

- *Out of 23,296 total jail bookings in 2018, four thousand eight hundred sixty-seven (4,867) had contact with a community provider within 60 days of their booking, totaling 20.89% of the population.*
- *34% of MCSO detainees are on psychotropic medications on any given day in September 2019. Approximately 35% of detainees received opioid withdrawal monitoring and 10% received alcohol withdrawal monitoring in September 2019.*
- *The contracted mental health provider, NaphCare, provides mental health services 24 hours a day, seven days a week. Comparing NaphCare's level of staffing to the jail's ADP, the staffing levels are consistent and appropriate for a jail population of this size.*
- *Mentally ill detainees who are not suitable for general population and are not considered a risk for suicide or homicide are generally placed in Administrative Segregation due to a lack of specialized mental health housing.*
- *The MCSO would benefit from housing to segment populations and maximize staffing resources for mentally ill and substance-withdrawing detainees.*
- *Having built-in appropriate programming space for support and therapeutic services, it is recommended.*

NaphCare serves as the medical provider and initiated its mental health services in January of 2019. NaphCare mental health services are described as centering on crisis intervention and stabilization of detainees. NaphCare employs nine mental health clinicians, including one Mental Health Director, three qualified mental health professionals, three discharge planners, a psychiatrist, and a nurse practitioner.¹² The Discharge Planners work in tandem with the county-employed Jail Treatment Case Manager and Jail Treatment Coordinator. The Jail Treatment Coordinator also facilitates communication between the jail, courts, and community providers. Discharge Planners create individualized discharge packets for soon-to-be released detainees, which may include community referrals and appointments arranged by the Discharge Planners.

Montgomery's mental health services are not accredited through the National Commission on Correctional Health Care, although they report having initiated the application process, thus demonstrating Montgomery's commitment to best practice delivery of care. Medical services have achieved NCCHC accreditation. Though rarely used, telepsych is available for medical services.¹³

The Montgomery County Sheriff's Office (MCSO) offers a range of programs to male and female detainees and coordinates on-the-unit religious services. These programs are volunteered. The Program Coordinator/Chaplain leads the decision-making in terms of

¹² NaphCare Amendment to Service Agreement

¹³ October 16, 2019 Jail Tour.

acceptance/removal of detainees into/from these programs. Detainees identified as Veterans will be seen by Veterans Outreach while in custody.¹⁴

Montgomery County's Alcohol Drug Addiction and Mental Health Services (ADAMHS) is a statutory agency that plans, funds, and evaluates the full continuum of behavioral health services in the community. Funds given to the MCSO were used to retain NaphCare to provide mental health services in 2019. Service codes have been created which allow community behavioral health agencies to bill ADAMHS when following up with clients who are open for service but incarcerated in the jail. This is reported as an under-utilized service by Jail Administration. How much or how often ADAMHS is billed for continuity of care services for detainees at the jail was not identified. The Training Division offers criminal justice trainings including Mental Health First Aid at the Officer Academy and Crisis Intervention Training and trauma-informed care for all law enforcement, including corrections officers in the county. ADAMHS is also capable of offering support, debriefing, and resiliency services to first responders following critical events. The rate of which MCSO staff use these support services is unknown.

Montgomery County Sheriff's Office (MCSO) mental health operations was evaluated by a correctional behavioral health subject matter expert, from Falcon, Inc. This expert's study concentrated on the daily mental health operations, programs, housing areas, process flows, and interagency relationships between mental health, security and medical staff.

Objectives and Methods

Assessment and Methodology

The Consultant from Falcon Inc. arrived at the Montgomery County Jail on Wednesday, October 16, 2019 to begin a mental health needs assessment. The study began with a tour of the facility led by administrative and security staff (Jail Captain). Later that day, the following professionals were interviewed:

- Montgomery County Sheriff's Office Major
- Montgomery Jail Treatment Coordinator
- NaphCare Mental Health Director
- NaphCare Health Services Administrator
- Montgomery Program Coordinator/Chaplain
- Montgomery Jail Treatment Case Manager
- Montgomery Classification representatives

¹⁴ibid.

On Thursday, October 17, 2019, the Consultant from Falcon Inc. arrived at the ADAMHS office to interview the Associate Director.

On Thursday, October 24, 2019, phone interviews were held with a NaphCare Qualified Mental Health Professional and Discharge Planner. The Jail Treatment Coordinator and MCSO Major were also present for the follow-up phone interviews.

Telephonic and electronic communications continued with the MCSO through March 2020 in order to clarify data and study findings, further demonstrating the county's active engagement and continued cooperation with Falcon.

Areas of Inquiry

Information-gathering was completed through a facility tour, on-site and remote data collection, as well as in-person and telephonic interviews. The review and assessment of mental health services provided at the facility was based on the following areas of inquiry: Intake; Triage/Classification/Housing; Referral System; Mental Health Services: Evaluations (Mental Health Professionals, Psychiatric), Medication Services, Treatment Services (i.e. Individual, 1:1 support or therapy, Group therapy); Treatment Planning; Crisis Intervention or Management; Suicide Prevention; Close Observation; Segregation or Restrictive Housing; Discharge Planning, Re-entry Services; Staff Training (Mental Health and Security); Policies and Procedures.

Summary of Interview Content

During the assessment period, discussions were held with jail administration, security officers, programming staff, community partners, mental health and medical providers. Interview subjects were highly cooperative and knowledgeable in their respective disciplines. Interviewed staff also demonstrated an organizational culture of professionalism and collaboration. Falcon's follow-up documentation and interview requests were readily accommodated by MCSO and NaphCare staff.

Montgomery County representatives provided information on detainee demographics, the physical layout of the facility, housing areas, classification structure, intake process flows, current programming, and infrastructure challenges. NaphCare representatives provided insight into mental health staff's daily activities and schedules, suicide prevention and crisis intervention process flow, referral and triage processes, documentation practices, segregation pre-placement assessments and segregation rounds, quality control processes, MAT coordination, discharge packets, and interdisciplinary team communication.

NaphCare's mental health representatives are able to provide quantifiable data regarding the mental health population housed in the jail to include daily screenings/assessments/contacts performed by mental health staff through both the daily Jail Commander and monthly health services reports. NaphCare's Health Services Administrator did caution that some data may not be reflected accurately given misunderstandings regarding data input. The HSA stressed that as mental health staff become more familiar with expectations regarding data input and communication is strengthened between the two departments, they will achieve more reliable data. NaphCare is unable to give quantifiable data regarding the Incompetent to Stand Trial population housed within the jail, due to lack of access to court management systems to directly identify who is in the evaluation process or has been deemed Incompetent to Stand Trial. Jail Administration identified that jail records is notified of cases involved on the felony level, as they manage transport to the state hospital for restoration services for those detainees. However,

local municipal courts manage their own transports and do not always share the court order until they present with a request for the detainees' release to transport. Without court management systems that talk to the jail management system and NaphCare's TechCare, or copies of orders uploaded into a public records database, this information is unable to be obtained by both corrections and NaphCare staff.¹⁵ Finally, the ADAMHS representative explained its relationship with the county jail, funding sources and community resources for persons with mental health and substance use disorders.

List of Collateral Data Gathered

Jail administrations, NaphCare, and ADAMHS provided the following documentation:

- HDR Jail and Justice System Assessment – Sheriff/Jail Administrator Survey
- HDR Jail and Justice System Assessment – Medical Services Provider
- Suicide Prevention Plan Mental Health Team – Montgomery County Jail – NaphCare – 2019
- NaphCare Guide to Drug and Alcohol Withdrawal Management
- Montgomery County Jail Detainee Intake & SOTER RS Pre-Screening Form
- Montgomery County Forensic Data
- Programs and Church Services for Male and Female Detainees
- TechCare Monthly Report
- Montgomery County ADAMHS Funding
- ADAMHS Criminal Justice Initiatives Across the Sequential Intercepts
- Substance Abuse Residential Bed Capacity for Montgomery County, Ohio
- Planning for Sequential Intercept Mapping – Jail Bookings
- ADAMHS' Total # of Clients booked in CY2018 who received service in past 60 days of their booking
- NaphCare Amendment to Service Agreement
- NaphCare Mental Health Staffing and Medical Grid
- NaphCare New Nursing Staffing Grid

¹⁵ November 2019 Telephonic Discussion with Jail Administration.

- NaphCare Receiving Screening
- NaphCare Mental Health Screening
- NaphCare Authorization for Release of Health Information Pursuant to HIPPA
- NaphCare Informed Consent – Intake
- NaphCare Health Care Policy and Procedure Manual

Mental Health Data Analysis

The analysis of the mental health data is grounded on nationwide standards and best practices in jail medical and mental health services as established by the National Commission on Correctional Healthcare (NCCHC). The NCCHC has been an essential resource to the corrections industry in improving the health of detainees in facilities, increasing efficiencies of care, strengthening delivery of services, and reducing risk of adverse legal judgments. In conjunction with these standards, Falcon bases its analysis and subsequent recommendations in contemporary advancements in evidenced-based interventions, programs and therapies, as well as Falcon's knowledge of achievable and sustainable correctional practices.

Jail Mental Health Jail Population and Caseload Composition

Determining MCSO's jail mental health population was complicated by the lack of reliable tracking methods regarding: 1) the number of mental health detainees in the MCSO held at any given day, 2) the caseload that NaphCare actively treats, provides services to, or manages while in custody, and 3) the percentage of acute and non-acute mental health detainees within the MCSO's total detainee population. In NaphCare's electronic medical record (known as TechCare) and the MCSO's jail management system, flags can be set for detainees on suicide precautions; however, there are no other flags to attach to other high-risk populations. Tracking was reported to have been possible for detainees prescribed psychotropic medications, however that is not tracked on a regular basis.¹⁶ Fortunately, NaphCare and MCSO have expressed goals of improving data collection.

Data was presented by ADAMHS which assisted in the inference of MCSO's mental health population. Through JusticeWeb¹⁷, ADAMHS gets a daily booking spreadsheet that is cross-referenced with persons receiving Medicaid or ADAMHS-paid behavioral health treatment in the last sixty days of their booking date. Out of 23,296 total jail bookings in 2018, four thousand eight hundred sixty-seven (4,867) had contact with a community provider within 60 days of their booking, totaling 20.89% of the population. Figure 33 summarizes the ten most frequently utilized community providers by Montgomery County detainees within 60 days of their booking. For instance, about 23% of MCSO detainees received some type of treatment at Samaritan Behavioral Health within the two-month window prior to their admission into the jail.

¹⁶ *Planning for Sequential Intercept Mapping – Jail Bookings*, data pulled from January 1, 2018 – December 31, 2018.

¹⁷ Digital platform tracking arrest and booking information for Montgomery, Ohio.

Figure 33: Breakdown of Community Providers and Percentage of Detainees Who Received Behavioral Health Services Within 60 Days of Their 2018 Booking¹⁸

Community Behavioral Health Provider	2018 Percentage
Samaritan Behavioral Health, Inc.	23.84%
Nova Behavioral Health, Inc.	15.16%
Eastway Corporation	10.08%
Recovery Works Healing Center, LLC	7.90%
South Community Inc.	7.10%
Addiction Services	5.25%
Access Ohio, LLC	3.59%
Cornerstone (dba Mansfield UMADAOP Inc.)	3.20%
Project C.U.R.E., Inc.	2.35%
TCN Behavioral Health Services, LLC	2.17%

¹⁸ ADAMHS' Total # of Clients Booked in CY2018 Who Received a Service in the Past 60 Days document.

Mental Health Acuity (Mild, Moderate and Severely Mentally Ill Detainees). According to the Bureau of Justice Statistics, the total mental health population at any given jail should run about 25-40%. However, no data was received to reliably determine the total mental health caseload within the facility's total average daily population (ADP). The MCSO does not track acuity or assign acuity levels to detainees in the jail.¹⁹ Figure 34, 35, and 36 reflect national averages of mental health acuity and conditions in the nation's jails. Similar percentages are expected within the MCSO's total population.²⁰

**Figure 34: Comparative Data Acute and Non-Acute Jail Mental Health Populations
(% of MH Population)**

Mental Health Population	National Trend	In MCSO
Seriously and Persistently and Mentally Ill (Acute)	16-20%	Unknown
Mild to Moderate (Non-Acute)	40-60%	Unknown

As Figure 35 indicates, according to the Bureau of Justice Statistics, when substance abuse issues are considered, jails have as much as 60-80% of detainees with mental health conditions within the total jail population. Without consideration of substance abuse disorders however, jails could average 30-40% of detainees with mental health conditions within the total jail population.²¹ While the MCSO jail management system does not automatically receive information from NaphCare's TechCare system that identifies and separates detainees by diagnosis, the MCSO does obtain information, through the daily jail commander report, that identifies the portion of the detainee population that receives psychotropic medications.²² MCSO reports that, from this report, they can determine the percentage of detainees with mental health needs through detainee self-reports or NaphCare's contacts with detainees through staff or detainee referrals.²³ It is expected that national trends in mental health disorders (as shown in Figure 35 and 36) would be similarly reflected in the MCSO mental health population.

¹⁹ *Planning for Sequential Intercept Mapping – Jail Bookings*, data pulled from January 1, 2018 – December 31, 2018.

²⁰ Although the BOJ Statistics study on prevalence of mental illness in jails and prisons is from 2006, this study remains relevant and continues to be cited by the Substance Abuse and Mental Health Services Administration (SAMSHA).

²¹ Bureau of Justice Statistics Special Report – Mental Health Problems of Prison and Jail Inmates. September 2006.

²² Information provided by MCSO Administration via electronic communication, March 2020.

²³ Ibid.

Figure 35: National Data on Jail Mental Health Conditions (% of MH Population)

Mental Health Disorders	National Trends
Co-Occurring Disorders	60-80%
*Anxiety Disorders	30-50% (combined depression, bipolar, anxiety)
*Depression and Bipolar Disorder	30-50% (combined depression, bipolar, anxiety)
Schizophrenia and Other Psychotic D/O	15-20%

Figure 36: National Data Jail on Mental Health Conditions (% of Total Population)

Mental Health Disorders	National Trends
Trauma- Male (242)	20%
Trauma- Female (78)	60%
Behavioral-Related Disorders	20-30%

As Figure 35 and Figure 36 suggests, the following general levels of acuity in any given jail are indicated by the Bureau of Justice Statistics, 2006:

- Acute/ Sub-Acute (or SMI) Levels: Psychosis 15-20% of the mental health population; Major Depression/ Severe Bipolar Issues 20-25% of the mental health population;
- Non-Acute (Mild to Moderate) Levels: Adjustment D/O (w/ Depression and Anxiety), Mild to Moderate Depression and Bipolar 30-50% of the mental health population;
- Behavior Management 20-30% of the mental health population;
- Substance Abuse Disorders 60-80% (or more) of total population.

Regional Data Comparison

Nearby Franklin County Sheriff's Office, Ohio, reported an ADP of 2,000 detainees in the year 2018. Of that total, 800 were identified as having mental health disorders which represented 40% of its population.²⁴ Franklin County's mental health population reflects a higher prevalence of conditions, but still aligns with national averages. Given its proximity to Montgomery, it is probable that the MCSO would contain similar mental health population trends as the Franklin County Jail.

²⁴ Stephens, D. Falcon's Franklin County Design Assist Mental Health Deliverable, 2018.

Medical's Tracking of Mental Health Data

Medical supplied the *TechCare Monthly Report January to September 2019*. In review of the September 2019 medical statistics, the following mental health-related data was supplied:

Figure 37: Mental Health Data from NapChare TechCare Monthly Report

TechCare Mental Health Data	September 2019
ADP	832
Receiving Screenings Performed	1,727
Mental Health Evaluations Performed	202
Patients Receiving CIWA Monitoring	86
Patients Receiving COWA Monitoring	293
Patients on Suicide Watch	35
Patients on Mental Health Medication	536
Patients on MH Medication Daily Average	286
Mental Health Chart Review	142
Mental Health Discharge Planner	147
Mental Health Professional	634
Mental Health Provider	5
Mental Health Psychiatrist	94

Using the data from the month of September, it appears that 11% of the jail population was flagged for mental health issues at intake resulting in subsequent Mental Health Evaluation. While it is difficult to confidently infer mental health caseloads from this data, particularly given NaphCare's disclosure that data input expectations are unclear or inconsistent across mental health staff,²⁵ it is likely that the MCSO is under-identifying, thereby underserving, detainees with mental illness. More consistent with national averages, 34% of MCSO detainees are on psychotropic medications on any given day in September 2019. Approximately 35% of detainees received opioid withdrawal monitoring and 10% received alcohol withdrawal monitoring in September. Overlap between these totals is unknown.

²⁵ October 16, 2019 interview with NaphCare HSA; HSA stressed that efforts continue to target improvement in the consistency and quality of data tracking.

Reported Services

Currently, M.A.-level, licensed mental health professional (MHP) services primarily consist of risk lethality assessments and mental health evaluations. B.A.-level Discharge Planners provide case management services for aftercare purposes, court orders, housing placements, employment, Medicaid applications, psychiatric and substance use services, and Medication Assisted Treatment (MAT) connections. A fulltime Nurse Practitioner, fulltime Psych Registered Nurse, and 18-hour a week Psychiatrist also compose the NaphCare mental health team.

NaphCare representative stated it is contracted only as a “crisis forensic team,” therefore only offers crisis and stability services; no groups or formal treatment plans.²⁶ While this statement was pronounced in NaphCare and MCSO staff interviews, NaphCare’s contract and *Health Care Policy and Procedure Manual*, described more comprehensive services, better resembling an industry best practice behavioral health program. Specifically, the Manual lists treatment goals as the stabilization/resolution of mental illness, prevention of decompensation, development of an understanding of mental illness, development of self-improvement, and development of coping skills.²⁷ Given the lack of dedicated programming space in the jail, jail administration has allowed the current mental health staff to function solely as a crisis team given logistical barriers.²⁸ With NaphCare’s identified treatment goals and the jail’s commitment to best practices (evidencing congruent missions) Falcon is confident that with the allocation of more programming spaces, a more comprehensive mental health program can be successfully implemented and executed by staff.

NaphCare Mental Health Staffing

The NCCHC Standards for Health Services in Jails, 2014, states that staffing ratios must provide detainees with adequate and timely evaluation along with treatment consistent with industry best practices. Determining staffing levels always poses a challenge for county jails. Determining if NaphCare’s levels of staffing meets the mental health needs of the MCSO was particularly difficult since the number of mental health detainees treated and managed was not reliably tracked by them. Healthcare staff explained that they are consistently able to contact referred detainees in a timely manner²⁹ and reported feeling comfortable completing all of their daily duties without stress of backlogs or delays to detainees accessing care.³⁰ Discharge Planners, however, acknowledge that while priority detainees are generally provided linkage before release, they are unable to meet with all referred detainees prior to their release from custody.³¹ Acquiring a deeper understanding of the mental health caseload would better inform expectations on service delivery.

²⁶ October 16, 2019 interview with NaphCare Mental Health Director.

²⁷ NaphCare *Health Care Policy and Procedure Manual*, J-F-03 Mental Health Services, pg. 212.

²⁸ Information provided by MSCO Administration via electronic communication, March 2020.

²⁹ October 16, 2019 interviews with NaphCare Mental Health Director and HSA.

³⁰ October 24, 2019 interviews with NaphCare Mental Health Professional and Discharge Planner.

³¹ October 24, 2019 interview with NaphCare Discharge Planner.

At the MCSO, NaphCare provides mental health services 24 hours a day, seven days a week.³² At the time of this assessment, NaphCare stated it was fully staffed,³³ with first and second shift overlapping to allow for some coordination between staff. Comparing NaphCare's level of staffing to the jail's ADP, their staffing levels appear consistent and appropriate for a jail population of this size. In consideration of regional trends of acuity level increases, a ratio of 300 detainees or less to every one mental health professional should be considered.

Falcon's rigorous analysis of MHP caseloads and job functions from over 150 jail facilities nationwide, dictate that for a full-time mental health professional with a standard set of job functions or duties, an MHP should be able to comfortably see, per an eight-hour shift, 10-12 detainees.

This reflects a daily total of 10 detainees per day (10 detainees x 1 day=10), 50 detainees per week (10 x 5 days per week), and 1,000 per month (50 detainees x 20 business days/ month). The MCSO has three core mental health professionals. Collectively, these three core MHPs should be averaging between 2,000 - 3,000 detainee contacts a month. TABLE 5. data however, shows that NaphCare (including MHPs working weekends) only saw 634 detainees in the month of September 2019. This likely indicates: 1) inadequate caseload requirements, 2) a TechCare system glitch, 3) inaccurate data reporting,³⁴ 4) flawed or nonexistent mental health tracking systems for daily contacts.

Nowadays, great focus is placed on re-entry services across the country. In line with this philosophical shift in the industry, Discharge Planners are often assigned to work Sunday through Saturday, with more manpower placed on first shift and tiered on second shift according to the needs and operations of facilities. As a rule of thumb, one FTE Discharge Planner (if a caseload management approach is used) can manage no more than fifty detainees.³⁵ Specific tailoring of staffing recommendations, however, is dependent on the philosophical strategy of the facility and the acuity of the mental health caseload since persons with more severe mental health conditions generally require more social service support in the community. For instance, a facility with limited resources may focus their individualized discharge services to the moderate to severe mental health caseload. Releases with mild mental health conditions or general population detainees that require discharge planning services may be offered a standardized brochure with local organizations' contact information.

NaphCare Mental Health Policies and Procedures

NaphCare does have established policies and procedures for their mental health care delivery in the Montgomery County Jail. These policies were reviewed, and they appeared to be based on NCCHC standards. Site-specific program components, however, are marginally mentioned in the current HealthCare Policy and Procedure Manual.

³² NaphCare *Amendment to Service Agreement* document.

³³ October 16, 2019 interview with NaphCare Mental Health Director.

³⁴ Inconsistent data inputting was reported by the NaphCare HSA during the October 16, 2019 interview.

³⁵ Caseload may decrease as the intensity of discharge/re-entry services increases.

Mental Health Findings

The following section summarizes this consultant's, from Falcon Inc. key findings, which include the MCSO's strengths, challenges, and bridgeable gaps between current processes and industry best practices. Given this consultant's study of the MCSO and experiences with its employees and stakeholders, great confidence exists in the MCSO's ability to build upon its existing strengths and achieve even higher standards of detainee care.

Mental Health Intake, Classification, and Population Management

Intake

An arrestee's contact with the MCSO begins with a medical and mental health pre-screen completed by an officer. *The Montgomery County Jail Detainee Intake & SOTER RS Pre-Screening Form* does not include a Disposition section. Including space to document an officer's disposition is important. From there, all MCSO detainees will be offered a receiving screening and mental health screening administered by the medic, as well as a drug screen. MCSO reports that most agree to participate in the drug screens.³⁶

The *NaphCare Mental Health Screening* contains some elements of a best practice screening; however, the form lacks overall organization and space for narrative responses. Typically, intake forms are structured into the following inquiry areas: A) patient identifying information B) mental health history C) substance history D) suicide risk potential E) patient's current state of mind/mental status F) disposition. Best practice screenings also include space for narrative responses, as opposed to strictly Yes/No responses. Under Disposition, it is best to tailor this section to the facility, with one column for Housing Recommendations (i.e. Suicide Watch, General Population, Mental Health/Special Population Housing, etc.) and one column for Referrals to services available within the facility (aligning with facility's triage system). With a more organized, thorough, and facility-specific screening, MCSO intake staff will be better positioned to formulate the patient's mental health condition and needs, and document subsequent referral(s) to some type of special housing and treatment.

Substance use noted in the medic screening phase will not automatically flag for mental health follow-up.³⁷ Intake staff referrals to mental health are accomplished over the phone, over the radio, through emails, through sick calls, or in-person requests. There are no reviews of intake screenings by MHPs unless one chooses to engage in a chart review prior to detainee contact.³⁸ Screenings may be reviewed later during one's incarceration if mental health services are requested. Although all intake screenings are not reviewed by MHPs, the Mental Health Director does reportedly review all mental health screens that are flagged through STATCare. Additionally, all medical and mental health intake screens are reviewed by corporate STATCare staff (RNs or LPNs) daily, allowing for the expedition of medication reconciliation and detainee referrals to the sick call list for immediate, comprehensive assessments.³⁹ Aligning with best

³⁶ October 16, 2019 Jail Tour.

³⁷ October 16, 2019 interview with NaphCare Mental Health Director.

³⁸ October 24, 2019 interview with NaphCare Mental Health Professional.

³⁹ Information provided by MSCO Administration via electronic communication, March 2020.

practices, all non-emergency referrals are seen within 48-72 hours and detainees identified as being in crisis are seen immediately - exceeding best practice timeframes.⁴⁰

Classification

MCSO Classification is determined by charges, history, and current medical and mental health needs. The mental health population is not segmented from the general population through security and mental health staff expressed a desire to designate specific units for special populations.⁴¹ Mentally-ill detainees who are not suitable for general population and are not considered a risk for suicide or homicide are generally placed in Administrative Segregation.⁴² After release from suicide watch, steps are taken to ensure that detainees are housed with a roommate. The collaboration between Classification and NaphCare regarding suicidal detainees appears strong.

Housing

Four cells located in Intake are used for suicide precautions, two for males and two for females. The female intake area is separate from the male area. Finding housing solutions for female populations is a common difficulty not only for MCSO but also a trend across our nation's jails as well.

When the number of suicide placements exceeds available cells, suicidal detainees will be bunked together in a cell.⁴³ Outside of suicide watch precautions, any detainee that displays signs of psychiatric abnormalities may be housed anywhere in the facility in the absence of designated mental health housing areas for mentally-ill detainees. At times, Classification will try to house mentally ill detainees in the newer side of the jail,⁴⁴ but there is no formalized practice of this type of housing placement.

Similarly, there are no designated detoxification dorms. There are four 4-person cells in the centralized Medical area. One cell is used for juveniles or detainees with infectious diseases; however, behavioral detainees reportedly are not housed in this area.⁴⁵ Two exam rooms, one dental room, and admin offices are also located in Medical.

"Rollovers" (10-person, barred units on the older side of the jail) are often used for detainees released from suicide watch before moving to general population. Pods A, B, C, and D in the jail are for general population detainees and are located on the newer side of the jail. Detainees identified as having a significant violence potential are housed in administrative segregation consisting of two housing units containing 11 barred-cells in the "old jail."

⁴⁰ Ibid.

⁴¹ October 16, 2019 Jail Tour & Interview with NaphCare Mental Health Director.

⁴² *Planning for Sequential Intercept Mapping – Jail Bookings*, data pulled from January 1, 2018 – December 31, 2018.

⁴³ October 16, 2019 Jail Tour.

⁴⁴ October 16, 2019 interview with Classification.

⁴⁵ October 16, 2019 Jail Tour.

Triaging and Mental Health Service Requests

Kiosks are available on each pod, allowing detainees to request necessary services. Detainee requests, or “kites,” are triaged by the Floor Officer, Medical, or Mental Health. Officers will also create log entries in the JMS to document phone call referrals they made to mental health staff. NaphCare’s TechCare and MCSO’s JMS are not linked.

NaphCare utilizes a two-step triage system,⁴⁶ emergent and non-emergent. Emergent cases are seen during the shift on which a case was referred. Non-emergent cases are seen within 24 hours of referral. Sick Calls can also be scheduled through TechCare if they are not deemed Urgent/Emergent and will be seen within 24-hours.

There is no reported backlog for the psychiatrist and the nurse practitioner is reported to clear her Sick Calls on a daily basis.⁴⁷ MHPs will refer detainees to the psychiatrist, as needed, after they complete an assessment. If a detainee has already been seen by mental health and requests a medication adjustment after his/her initial psychiatrist visit, Medical will send the request straight to the psychiatrist without activating an MHP referral.⁴⁸

Aligning with best practices, Segregation Rounds are completed by MHPs at least twice weekly. Medical Cell Rounds and Juvenile Rounds are completed at least once weekly. Detox Well Checks for detainees actively receiving or refusing Detox Protocols are provided within 48 hours of placement and/or as needed. Mental Health acquires the list of detoxing detainees through TechCare. ISTs who become known to Mental Health will receive a Well Check and Mental Health Evaluation.

Programming

The MCSO Program Coordinator/Chaplain manages custodial programming, all of which are volunteer-led groups. A nice mixture of spiritual, substance use, parenting, and self-help programming is offered. At times, the Program Coordinator will call an MHP to discuss severely mentally ill detainees requesting admission to ensure detainees’ symptoms are stabilized enough for safe and meaningful group engagement.

Interview Spaces

A limited number of interview rooms are available, but they are shared. All interview rooms are available for Mental Health services.

Detainee Programming Spaces

Two centralized classrooms are used for MCSO programming (such as AA, Conflict Resolution, Celebrate Recovery, etc.). What initially served as decentralized programming/recreation spaces on A, B, C, and D pods, the “Dayrooms” now house detainees. A decentralized basketball court is shared among all units on the old side.

⁴⁶ October 16, 2019 interview with NaphCare Mental Health Director.

⁴⁷ October 16, 2019 interview with NaphCare HSA and Mental Health Director.

⁴⁸ October 16, 2019 interview with NaphCare HSA.

Delivery of Evidenced-Based Treatments

Throughout the study period, staff from multiple departments described NaphCare mental health services as crisis-only. Individual or Group therapies are not offered at this time.

Restrictive Housing

Security engages MHPs to assess detainees for contraindications to segregation before their placement in such housing which is an important safeguard in the housing/classification process. MHPs will conduct chart reviews and face-to-face contacts in order to assess for contraindications to placement. As mentioned earlier, Segregation Rounds are completed by MHPs at least twice weekly.

A detainee will be removed from MCSO program groups when he/she is placed on suicide watch or in segregation.⁴⁹ Once a detainee successfully returns to general population, he/she can re-apply for group participation.⁵⁰

Re-Entry/Discharge Planning

Multiple staff positions are involved in the re-entry process, illustrating the County's commitment to safe and successful handoffs into the Montgomery community. On the county side, the Jail Treatment Coordinator and Jail Treatment Case Manager manage requests and information-sharing between the courts, parole, probation, attorneys, diversion entities, and NaphCare staff. They are also responsible for streamlining competency cases. Of the six state hospitals, Summit Hospital is most often used for jail pink slips (emergency civil commitments), Not Guilty by Reason of Insanity, and IST persons. As recipients of the county's information-gathering, NaphCare Discharge Planners are responsible for the scheduling of and linkage to a continuum of community services. One Discharge Planner is currently responsible for specialized case management and linkage services surrounding Medication Assisted Treatment (MAT) services.

Referrals to Discharge Planners surface through the kiosk system, staff Sick Calls, or during mental health "huddle" meetings occurring every Monday, Wednesday, and Friday.⁵¹

Conveniently, NaphCare Mental Health, NaphCare Discharge Planners, and the Jail Treatment Case Manager share an office in Intake resulting in easy communication among staff.

While no feelings of being overwhelmed were communicated, Discharge Planners are unable to meet with all of the detainees requesting/needing discharge services before their release.⁵² With the rise of mentally-ill persons incarcerated in our nation's jails, it is not uncommon for re-entry professionals to struggle to meet the dynamic needs of persons preparing for release.

⁴⁹ October 16, 2019 interview with MCSO Program Coordinator/Chaplain.

⁵⁰ Ibid.

⁵¹ October 16, 2019 interview with NaphCare Mental Health Director.

⁵² October 24, 2019 interview with NaphCare Discharge Planner.

Suicide Prevention System

All interviewed staff conveyed a dedication to their roles and responsibilities, particularly in regard to suicide prevention activities within the jail. In the event of a completed suicide, the MCSO ensures that a written psychological and medical review occurs within 24 hours, and, in the event of a serious attempt, a full mortality review occurs within ten days.⁵³ Committed to elevating its suicide prevention activities, the MCSO enlisted nationally renowned Lindsey Hayes to conduct a weeklong site survey⁵⁴ in 2019 and worked diligently thereafter to implement survey recommendations.

The MCSO uses one level of suicide watch. Persons deemed at risk for suicide are housed in Intake and given a safety gown and blanket. At times, MHPs will recommend a safety mattress. Mental Health adheres to an “all or nothing” approach towards suicide precautions, meaning no property adjustments or interim housing are implemented.⁵⁵ This appears to foster consistency among suicide intervention practices across departments. There is no formal step-down from suicide watch, but MHPs will recommend that recently released suicide watches are housed with a roommate. Mental Health suicide watch assessments are typically completed cell side. As stated previously, detainees may be double-bunked in a suicide cell given the lack of suicide watch cells. Placement on suicide precautions does not automatically activate a referral the psychiatry. The JMS will flag any detainee that has been placed on suicide precautions during any of his/her previous incarcerations.

Treatment Planning

NaphCare and the MCSO have established a communication forum,

referred to as “mental health huddles,” that occur every Monday, Wednesday, and Friday. These multidisciplinary team meetings involve healthcare and security personnel. Huddles are used to discuss high-risk detainees, particularly those on suicide precautions. Themes/recommendations resulting from the meetings are logged in the Shift Book. Individualized treatment plans are not created as a result of these meetings. Outside of NaphCare SOAP notes, thorough treatment plans are not created for detainees.⁵⁶

At the point of entrance into the MCSO, a potential for strong collaboration between custody, healthcare, and community behavioral health providers exists. If maximized, this collaborative potential could strengthen NaphCare’s ability to swiftly identify detainee needs and employ appropriate treatment interventions. As stated earlier, ADAMHS receives daily booking information, cross-references that with their list of clients, and alerts community treatment providers that a client has been booked into the jail.

⁵³ Information provided by MSCO Administration via electronic communication, March 2020.

⁵⁴ Ibid.

⁵⁵ October 16, 2019 interview with NaphCare Mental Health Director.

⁵⁶ October 16, 2019 interview with NaphCare Mental Health Director.

In ideal circumstances, each agency would designate an individual for security clearance and an alerted treatment provider would call the jail to send diagnostic information and attempt to coordinate contact with the client inside the jail. ADAMHS-contracted agencies have been supplied service codes, allowing them to bill ADAMHS after they meet with an incarcerated client at the jail; however, jail administration reports that this process rarely occurs.⁵⁷

Training

Fairly new to the MCSO, NaphCare mental health recently provided a four-hour suicide prevention training to staff. ADAMHS County Board was also brought in to this training.⁵⁸⁵⁹ NaphCare also provided a two-day mental health training during the required officer “block training.”⁶⁰ Included in these reported trainings are concepts trauma-informed care, de-escalation, emergent vs. non-emergent referrals, NaphCare mental health’s role in the facility⁶¹ and symptom recognition.⁶² The NaphCare training is described as site-specific and part of the annual corrections training.

⁵⁷ October 17, 2019 interview with ADAMHS Associate Director.

⁵⁸ October 16, 2019 interview with NaphCare Mental Health Director.

⁵⁹ According to MSCO Administration, ADAMHS does not assist, fund or support the current corrections training for suicide prevention; clarification provided via electronic communication, March 2020.

⁶⁰ October 16, 2019 interview with NaphCare Mental Health Director.

⁶¹ Ibid.

⁶² Information provided by MSCO Administration via electronic communication, March 2020.

Chief Highlights of Best Practice Mental Health Program Components

Mental health policy, procedure, care delivery, and unit design rooted in best practice philosophies will strengthen program success and resource efficiency in any given jail. Key components of national best practices are outlined below to provide the general landscape of evolving best practices in the correctional industry. MCSO-specific areas of attention will be provided in the Recommendations section later.

Mental Health Intake Best Practices

Correctional industry standards now dictate more stringent requirements at intake for mental health.⁶³ The following summarizes these requirements:

- Mental health clearance at booking that ensures referral and immediate care for individuals who are mentally unstable, suicidal, or otherwise urgently in need of clinical attention;
- If on-site or available, mental health staff conduct mental health receiving screenings and assessments;
- When mental health professionals are not on-site or available, mental health trained correctional or nursing staff perform the receiving screenings, which is reviewed by mental health staff on the next shift they are present;
- Mental health needs are identified and addressed. Mental health screenings must place for all detainees as soon as possible, as timeliness of referrals mitigate negative mental health consequences.
- All mental health screening and appraisal forms are developed, reviewed and approved by a Mental Health Authority, either the Director of Mental Health or the lead Psychiatrist. They should document answers, non-verbal observations (i.e. appearance, behavior, orientation, movement, etc.), and include the following line of inquiry:
 - Existing and past mental health conditions or illnesses;
 - History of hospitalizations and outpatient treatment;
 - History of Psychotropic Medications;
 - Suicidal Ideations (past and current);
 - Details of suicidal behavior prior to incarceration;
 - History of current and past substance or illegal drug use;
 - Other relevant mental health problems as directed by the Mental Health Authority;
- The form must take document detainee disposition such as, “referred to mental health or medical services,” “suicide precautions,” “general population,” etc.; Triage criteria for acuity needs are also established and documented;
- Forms should be signed and dated immediately by mental health or nursing staff after the interview;
- Prescribed medications are reviewed and bridged according to prescriptions prior to incarceration or alternate treatment is initiated promptly and documented by a psychiatrist;

⁶³ Idib.

- All aspects of the intake process are addressed by written policy and defined procedures which are regularly monitored to determine the safety and effectiveness of the process.

Response to acuity needs should be grounded on Standards for Jail Mental Health Care as outlined by the following:

- Detainees exhibiting suicidal behavior, acute psychosis, emotional distress, or any behaviors indicative of acute mental illness are considered urgent and are seen ASAP or within 4 hours of referral.
- **Priority:** Detainees exhibiting unusual behavior but relatively stable, reporting a mental health history, or have requested to address specific concerns are considered a priority and are seen within 24-48 hours of referral.
- **Routine:** All other non-emergency referrals (including detainees with developmental disabilities who are otherwise stable) are considered routine and are seen within 48-72 hours.

Classification, Housing and Population Management Best Practices

*Innovative program and design solutions for acute and non-acute mental health detainee-patient populations are placed within the Recommendations section to maximize organization of related themes and convenience for the MCSO.

Suicide Prevention Best Practices

During the initial intake screening, a detainee should be referred or seen immediately by a Qualified Mental Health Professional (MHP) for intervention if any of the following are present:

- severe agitation, signs and symptoms suggestive of self-harm or potential harm to others
- symptoms of psychosis
- suicidal thoughts or behaviors
- severe mood instability

All mental health, healthcare and security staff should work collaboratively when a detainee is deemed suicidal and placed on suicide watch, making certain that all treatment needs are addressed and outside transfer to a facility is considered especially for severely unstable or severely mentally ill detainees. Contact and monitoring procedures should be strictly followed by mental health and medical staff.

Suicide Watch Levels

The following suicide risk categories and their corresponding contact and observation levels are dictated by NCCHC standards:

- Level I/Constant or Direct Observation - 24/7 supervision by security; daily contact by mental health and medical staff.
- Level II/Close Observation – Observation every 15 minutes (staggered) by security; every 24-48 hours contact by mental health staff.

NCCHC designates two levels of observation for suicide watch. Close Observation for a Level II potentially suicidal detainee and Direct Observation for a Level I acutely suicidal detainee:

Close Observation:

- Is reserved for detainees who are potentially suicidal, not actively or acutely suicidal. Potentially suicidal detainees express suicidal ideation and may have a recent prior history of suicidal behavior. They may also have passive, ruminative thoughts of suicide but do not have a plan.
- Is reserved for detainees who deny suicidal ideations or who do not threaten suicide, but demonstrate other concerning behaviors through their actions, current circumstances, or recent history, indicating potential for self-harm.
- Require supervision at staggered intervals not to exceed every 10-15 minutes.
- Require mental health staff to assess the detainee every 48 to 72 hours and provide follow-up assessments

Constant or Direct Observation:

- Is reserved for a detainee who is actively or acutely suicidal. For example, a detainee is threatening or engaging in the act.
- Requires continuous, uninterrupted, direct supervision.
- Can be supplemented by Monitors or TVs but it can never be substituted with these items.
- Requires mental health staff to assess the detainee daily, provide follow-up assessments and treatment planning services.

The following are additional safeguards that should be followed for Suicide Precautions:

- Suicidal detainees should be placed in an observation area where they can be more readily observed by security and healthcare staff. They are placed in an individual cell where they can be separated from other detainees. Security should take all precautions to “suicide proof” all such cells.

- All garments and belongings (including eyeglasses, inhalers, etc.) are removed from the detainee and he/she is given a “suicide gown” to wear throughout the duration of the watch.
- Throughout the duration of the watch, all items from the cell should be removed including sheets, blankets, mattresses or any loose items which can be utilized as a suicide weapon. Mattresses and blankets are only acceptable if “suicide blankets” and “suicide mattresses” are available.
 - Pencils, pens, books, magazines, toothbrush, and other such loose objects which may be utilized as weapons are restricted for use during the duration of a detainee’s suicide watch. Styrofoam trays and cups are acceptable for eating purposes. If hygiene is an issue, the detainee may use a toothbrush, comb, and razor only when supervised. These items are returned to the officer immediately after use.
 - The detainee should be placed on watch for at least 24-48 hours and is evaluated by a mental health professional within 24 hours, and within 48 hours thereafter.
 - Upon a detainee’s admission, if information is received from an outside party or agency indicating that the detainee has recently engaged in suicidal behavior or behavior which would deem the detainee “at risk”, booking staff should take precaution and place the detainee on suicide watch for at least 24-48 hours. Protocol for evaluation by mental health is then followed.
 - When an individual is placed on a suicide watch, A Crisis Watch Monitoring Sheet should be positioned by the door of his cell, to document security, medical and, mental health checks. The Monitoring sheet should indicate which professional has contacted the detainee, when the contact occurred, at what level of risk the detainee poses, and the disposition determined by the professional at the time of visit.
 - Detainees should be reassessed periodically with the frequency determined by the detainee’s level of risk and as dictated by standards. Every contact by a healthcare staff should be documented in the detainee chart utilizing all approved clinical documentation formats. Every contact by security should also be documented using all approved documentation formats.
 - When an individual is released from suicide watch, it is best practice to release the detainee into a “step down” unit or “transitional” unit (if possible) prior to returning the detainee to the General Population, and to monitor the detainee for a period. Upon release from watch, the detainee should continue to be closely monitored in a step down or transitional unit. Some important highlights for Suicide Intervention Programs.

- All security, healthcare and mental health staff should receive yearly suicide and self-injury prevention training. Training of staff should include the recognition and reporting of warning signs for those detainees exhibiting self-injurious behavior and suicidal ideations.
- Only mental health (or in their absence, qualified medical staff) determine risk of self-injurious behavior, assign/discontinue suicide observation status, and make other decisions that significantly impact healthcare delivery, such as when to admit/discharge from a given level of care.
- Detainee declared emergencies and emergent staff referrals should be responded to within an hour. Emergency evaluations should contain enough clinical justification for the final disposition.
- Suicide Watch Rooms are certified as safe housing for detainees who are at risk for self-harm by authorized mental health personnel.

A facility's suicide prevention program should also include provisions for intervention, notification, reporting, review, and critical incident debriefing (for detainees and staff). All suicide prevention programs should incorporate the cooperative efforts of security, mental health, and executing the following elements of their plan: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, and a mortality review. All security, mental health and health services staff should be oriented to the suicide prevention policy, trained and guided throughout implementation. Copies of the policy should be available to all staff.

Recommendations

Strengthen Mental Health Intake

When detainees enter the facility, the first task is to separate those out who may be at risk for significant mental health problems. There should be comprehensive screenings, standardized assessment tools, and established triaging criteria which prioritize intervention, address critical needs, and reduce risk to the jail.⁶⁴

It is strongly recommended that:

- NaphCare and MSCO work to implement stronger, more reliable means of screening individuals as they enter the facility and consider utilizing MHPs (when available) to complete Mental Health Screenings at intake.
- Utilizing the highest Mental Health Authority, update current Pre-Screening and Mental Health Screening forms to not only meet accreditation standards but also better align with best practices.
- NaphCare needs to clearly define identifying and classifying criteria for the mental health population and align intake practices to meet industry standards. These standards should be part of the facility policy and procedures for intake screening. NaphCare, using its highest Mental Health Authority, create a document for non-Mental Health staff (i.e. Security, Medical) to use when activating a referral to mental health services. This document would be used to communicate staff's observations/concerns regarding a detainee. Since MCSO's JMS and NaphCare's TechCare's systems are not linked, a Staff Referral document will strengthen the referral and triaging of non-emergent mental health needs. Once created, NaphCare will train all staff on this paper form and ensure that all staff have access to these forms. See Appendix A for an example of a Request or Referral for Mental Health Services Form.

Strengthen Classification, Housing and Population Management

An enhanced management process of mental health groupings and appropriate segmentation of detainee categories would greatly benefit the MCSO. Lack of special population management can lead to under-identification or over identification of mental illness through a generally disorganized system. An organized jail facility with smooth, reliable and sustainable operations in place at all major critical points of the jail (i.e. intake, referral and triage, classification, housing, medical and mental health service areas) will have greater ability to streamline and proactively manage their mental health or special populations. Disorganized jail systems can quickly lead to rapid detainee and staff decompensation, increased incidences (i.e. assaults, self-harm), and increased grievances.

⁶⁴ NCCHC Standards for Mental Health Services in Correctional Facilities, 2015.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2367319/>

<http://www.cssrs.columbia.eduhttps://nicic.gov/free-brief-and-validated-standardized-instruments-low-resource-mental-health-settings-2016>.

Similarly, a greater focus is now placed on needs-based classification for special populations. Industry best-practices also provide guidance for triaging, streamlining, and housing mentally-ill and developmentally-disabled detainees.⁶⁵

It is recommended that:

- Mental Health and Medical would participate to determine the average mental health caseload and acuity levels of mentally ill and special populations;⁶⁶
- These departments would collaborate with Security to identify pod restructuring to segment populations and maximize staffing resources in these restructured pods for mentally ill and substance-withdrawing detainees.

The best practice stabilization and step-down unit guidelines described below are longer-term solutions for Montgomery County and would need to be integrated in future design considerations for the new facility or renovations to the current facility.

Acute Mental Health Housing

Detainees with a significant history of mental health treatment, currently presenting with urgent signs and symptoms such as Psychosis, Major Depression or Severe Bipolar or detainees who are severely mentally-ill; actively psychotic; a danger to self or others due to a severe mental illness; having displayed self-injurious behavior which have sustained for the last 90 days; and active suicide ideations which have sustained for the last 60 days are considered appropriate for placement in an Acute Mental Health Unit. Regarding severely suicidal detainees, it is important to note that their stabilization process begins on suicide watch. If their acute crisis has been resolved but staff continue to believe the detainee's baseline is such that suicide issues persist or will become unpredictable, the detainee is appropriate for long-term stay in the Acute Mental Health Unit. Once a detainee is admitted, a Psychiatrist should complete a psychiatric review, history, and mental status exam on all new admissions within 24 hours.

Mental Health units should, in general, be kept in small, manageable groups for therapeutic community and programming purposes. The Acute Mental Health Unit should specifically be designed with a structure that promotes easier patient accessibility and manageability. Unstable Severely Mentally Ill Detainees (SMI's) are best housed in individual cells within the unit where they are less threatened, triggered and can feel safer. It is recommended that the MCSO consider the following steps in establishing an Acute Mental Health Unit:

- Develop a clear definition of the unit and unit criteria. For "Acute Mental Health" definition and programming requirements, utilizing the 2015 NCCHC Standards for Mental Health Services for Correctional Settings.

⁶⁵ NCCHC Standards for Mental Health Services in Correctional Facilities, 2015.

⁶⁶ Acuity designation, an important strategy in optimizing resources, shall be defined by the jail in collaboration with NaphCare, and taking into account the jail's level of care capacity; suggested features of Acute vs. Non-Acute inmate-patients found in Best Practice Stabilization Unit descriptions.

- Establish the unit, execute all criteria, objectives and mission in unison with a multidisciplinary team.
- Seek strong guidance from competent mental health staff.
- Require that admission and exit from the unit be signed off by the highest-level mental health authority (Psychiatrist).
- Management should always be in a multidisciplinary treatment team approach with documented treatment plans.

The MCSO for Discharge Criteria from the Acute Mental Health Unit

Evaluations for discharge for each detainee should be done every two weeks. The severity of a detainee's condition and the persistence of his/her mental illness should be factored into a detainee's length of stay. All detainees will be regularly assessed for thresholds required for discharge to the Non-Acute Placement Unit. The goal should be to stabilize symptoms of mental illness and to improve functionality so the detainee is able to adjust to a less restrictive placement. Most SMI detainees may not fall within this discharge criteria. Consideration for discharge must fall within the following criteria:

- Stabilization started in the infirmary, was medicated, showed improvement and now able to function in a less acute area.
- Not acutely psychotic, not acutely suicidal, or assaultive, not hostile or aggressive.
- Able to function in a higher-level group therapy.

Those detainees determined to meet the above criteria should be placed in the Non-Acute Mental Health Unit of the jail. Those detainees requiring ongoing monitoring due to being lower functioning and having a baseline of "being chronic," cannot perform activity and daily living (ADL) routines without prompting, and requires frequent staff redirection, should remain in Acute Mental Health Housing.

Acute Mental Health Unit Programming and Therapeutic Services

It is recommended to the MCSO that the Acute Mental Health Unit have as much as possible a therapeutic milieu environment with direct treatment components, including therapeutic behavioral interventions and behavioral management plans developed by Mental Health Staff. Chronically impaired detainees will inevitably remain in these units for an extended period of time, however if stabilized and managed appropriately, can be effectively programmed.

For some jail facilities, the level of programming in Acute Mental Health Housing can be intense. Having built-in programming space for support and therapeutic services, it is recommended to the MCSO that programming for this unit involve a combination of the following services:

- Orienting the detainee to unit objectives and goals
- Intensive monitoring and management of medications
- Evidence-based group or Individual therapy or 1:1 Supportive contact

- Detainee behavior management
- Substance abuse treatment
- Individual treatment plans
- Mental health record and case reviews
- Discharge and aftercare planning
- Intervention for medication non-compliance
- Structured out-of-cell activities

Non-Acute Mental Health Housing

Detainees who have an active mental health disorder but are stable on medications, with or without participation of any other form of treatment; or, has an active referral with Psychiatry and requires ongoing psychiatric monitoring whether or not on medications; are not acutely psychotic; are not acutely a danger to self or others; and his/her diagnosis or mental disability precludes functioning in general population, are appropriate for placement in the Non-Acute Mental Health Unit. Non-Acute Mental Health Units should be medium to small size units that promote normalization, socialization, and the ability for open observation. Non-acute detainees may also respond positively to sub-groupings within the unit as it promotes opportunities for relationships within a smaller sub-group setting as well as the overall unit. It is also appropriate for the MCSO to utilize this unit as a “Transitional” Unit or a “Step-Down” Unit for detainees released from suicide watch. Once a detainee is admitted to this unit, a Mental Health Professional should complete a mental health review, history, and mental status exam on all new admissions within 24 hours.

Discharge Criteria to the General Population

Evaluation for discharge for each detainee should be done every two weeks. Consideration for discharge must fall within the following criteria:

- Meets treatment plan goals
- Stabilized on medications and mental status exam is stable
- No outward signs of hostility and aggression
- Good performance in the unit for a consistent period of time as shown by displaying good judgment and impulse control
- No self-harming and suicidality
- Good interactions with others
- Able to follow security rules
- Able to function in a GP environment as indicative by unit behavior

- Must be able to meet hygiene and basic ADL needs

*Detainees meeting the above criteria can be considered for discharge into the general population.

Non-Acute Mental Health Unit Programming and Therapeutic Services

It is recommended to the MCSO that the Acute Mental Health Unit have as much as possible a therapeutic milieu environment with direct treatment components, including therapeutic behavioral interventions and behavioral management plans developed by Mental Health Staff. All detainees in this unit should be stable and should be programmed. Having built-in appropriate programming space for support and therapeutic services, it is recommended to the MCSO that programming for this unit involve a combination of the following services:

- Orienting the detainee to unit objectives and goals
- Intensive monitoring and management of medications
- Evidence-based group or Individual therapy or 1:1 supportive contact
- Detainee behavior management
- Substance abuse treatment
- Individual treatment plans
- Mental health record and case reviews
- Discharge and aftercare planning
- Intervention for medication non-compliance
- Structured out of cell activities

Therapeutic Activity Requirements for Acute and Non-Acute Units

Being specialized mental health units, it is recommended that each detainee is provided with a minimum number of therapeutic activities as established by the treatment team and in adherence to NCCHC guidelines. For example, each detainee should engage and maintain treatment services including individual therapy, 1:1 supportive follow-ups, evidence-based group therapies, vocational therapies, and recreational therapies. Structured evidence-based groups should be provided on a recurring basis that cover topics related to: substance abuse issues, relapse prevention, responding to peer pressure, challenging pro-drug belief systems, trauma and conflict, learning better affect regulation, challenging criminal thinking, violence and delinquency, grief, loss and life challenges. Mental Health should support and coordinate with court programs and communicate with probation officers regarding progress and compliance with treatment. MCSO may even want to invite outside community groups and probations to attend weekly or bi-weekly treatment team meetings.

It is recommended to the MCSO that whatever treatment program is chosen, that the program curriculum is outcome-driven and an evidence-based therapy. For example, the following programs are appropriate and encouraged: Alcoholics Anonymous (AA), Narcotics Anonymous

(NA) Alcohol and other Drugs Program (AOD), Anger Management, Commitment to Change, Job Readiness, Parenting, Seeking Safety, and Life Skills.

Gender-Responsiveness and Gender Appropriate Design

The national increase of female detainees has raised important concerns regarding the impact on jail operations, the adequacy of the physical plant, medical and mental health services, privacy, and crowding of female units. An important aspect of this study is to ensure that the MCSO considers the importance of gender-responsiveness in program design and addresses the need for effective gender-responsive programming for women. In order to accomplish this, the MCSO should consider the demographics and history of the female offender population, as well as the factors that contribute to a female's pattern of offending. Women often enter the criminal justice system in different pathways that respond to supervision and custody in ways different than men. Women exhibit differences in substance use, trauma, mental illness, parenting responsibilities, employment histories, and they typically represent a different level of risk in the institution as well as the community. The following is important to consider (Covington and Bloom, 2006):

- Women offenders are mostly poor, come from impoverished urban environments, were raised by single mothers or come from foster care, undereducated, unskilled and are disproportionately women of color.
- Women offenders are likely to have committed a crime to obtain money or purchase drugs (engagement in prostitution and property crime is common).
- Crimes are also commonly relationship driven.
- Women offenders are typically within their early to middle 30's and are survivors of physical and/or sexual abuse as children or adults.
- Women offenders typically have significant substance abuse problems, multiple physical and mental health problems.
- Women offenders typically are unmarried mothers of minor children who may have high school degrees but have sporadic work histories and little to no vocational training.

It is recommended that the MCSO incorporate gender-responsiveness into:

- Environmental decisions to ensure female living spaces are more "home-like" and with smaller subdivided socialization spaces to promote connections to the dorm/unit community.
- Policies and program designs that address a women's psychological growth through familial/significant partner relationships, addiction, trauma and victimization, mental health issues, and vocational education and training.

Enhance Management and Treatment of the Mentally Ill

NaphCare Services

Our study demonstrates that compared to industry trends, NaphCare mental health staffing levels are adequate for the current ADP of approximately 830. However, based on an analysis of their program, it is highly recommended that, with the assistance of a Correctional Mental Health Specialist, NaphCare's mental health program model is restructured to align more closely with correctional standards and best practices for jails nationwide.⁶⁷ Program realignment with industry best practices and its own *Health Care Policy and Procedure Manual*, corresponding mental health policies, procedures, and job functions will result in a more robust mental health system of delivery producing:

- Increased strength and reliability in population identification, placement, triage, crisis observation and housing; enhance treatment for detainees that are the most severe and high risk (i.e. suicide risk), diagnosed with various levels of psychiatric disorders, having special needs, and substance addictions;
- Increased manageability, reduce suicides, safety issues, stress and strain on staff;
- Expanded MCSO population eligibility for reentry services.

NaphCare Mental Health Policies and Procedures

Lack of clarity or structure of critical program components impedes in the effectiveness of service delivery. As such, there is a need to more clearly develop and operationalize certain program areas that are considered standard of care or best practice for mental health care in jails.⁶⁸

It is recommended, with the assistance of a Correctional Mental Health Specialist,⁶⁹ NaphCare should develop MCSO site-specific mental health policies and procedures vs. generic corporate policies and procedures which integrate with mental health and security operations that include best practice policies for:

Access to Care, the Responsible Mental Health Authority; Clinical Autonomy; Administrative Meetings and Reports; Policies and Procedures; Continuous Quality Improvement Program; Emergency Response Plan; Communication on Patients' Mental Health Needs; Federal Sexual Abuse Regulations; Mental Health Staff Credentials; Training For Mental Health Staff; Mental Health Training for Correctional Officers; Medication Administration Training; Detainee Workers; Mental Health Pharmaceutical Operations; Medication Services; Inpatient Psychiatric Care; Information on Mental Health Services; Receiving Screening for Mental Health Needs; Transfer Screening; Mental Health Assessment and Evaluation; Nonemergency Mental Health Care Requests and Services; Emergency Services; Segregated Detainees; Continuity and Coordination of Mental Health Care During Incarceration; Discharge Planning; Basic Mental

⁶⁷ NCCHC Standards for Mental Health Services in Correctional Facilities, 2015.

⁶⁸ Ibid.

⁶⁹ Correctional Mental Health Specialist may be an external consultant or from NaphCare's corporate leadership.

Health Services; Mental Health Programs and Residential Units; Treatment Plans; Suicide Prevention Program; Patients with Alcohol and Other Drug Problems; Counseling and Care of Pregnant Detainee; Clinical Record Format and Contents; Confidentiality of Clinical Records and Information; Restraint and Seclusion; and Emergency Psychotropic Medication.⁷⁰

Data Management

When substance abuse issues are considered, national statistics indicate that some jails could hold as much as 60-70 percent of detainees with mental health problems, and without consideration of substance abuse disorders, jails could hold 25-30 percent on the low side.⁷¹ Litigation filings regarding the failure to provide necessary follow-up services to detainees on the mental health caseload are trending in the correctional industry.

To execute effective mental health programming and make informed decisions regarding spatial reconfigurations requires a clear understanding of MCSO's total mental health population, mental health acuity levels, and NaphCare's active caseload composition. While jails may utilize different methods for designating the mental health caseload, the most accurate way to determine the caseload is after detainees have been evaluated by an MHP or psychiatrist. Only after a detainee is clinically evaluated will it be known if the detainee requires follow-up or has been put on psychotropic medication and similarly requires psychiatric follow-up. The need for follow-up best reflects a mental health caseload. Determining the caseload at the Classification phase may reflect only situational conditions that did not require mental health follow-up.

It is strongly recommended that TechCare IT experts evaluate solutions on how to capture mental health data more accurately, and develop a more effective system of data management that will reliably capture the following data points:

- The number of mental health detainees in the MCSO held at any given day;
- The caseload that NaphCare actively treats, provides services to, or manages while in custody;
- The percentage of acute and non-acute mental health detainees (as defined by the within the MCSO's total detainee population;
- The number of Incompetent to Stand Trial detainees held at any given day.

Additionally, Mental Health Professional job requirements should be re-evaluated and ensure caseload requirements are reinforced. There should be close examination of current mental health systems to ensure a process (potentially similar to the Sick Call/Referral process) for mental health follow-ups exists. If none exists, create another process for mental health follow-ups.

Treatment Planning

Successful stabilization, management, and re-entry services must address the individual needs of the participating detainees.

⁷⁰ NCCHC Standards for Mental Health Services in Correctional Facilities, 2015.

⁷¹ Bureau of Justice Statistics, 2006.

Detainee needs while in custody are regularly identified and discussed between the MCSO and NaphCare, particularly during “huddle” meetings. While this multi-disciplinary collaboration appears strong, outside of MHP SOAP notes, NaphCare is not creating formalized treatment plans. It is recommended that NaphCare align its treatment plan processes with best practices as summarized below.

According to NCCHC standards,⁷² the treatment plan should include a written statement, which specifies the course of therapy and the roles of medical, mental health, non-medical personnel in carrying out the therapy. It should be individualized and based on an assessment of the person’s needs and short and long-term goals and the methods by which the goals will be pursued. It should provide a specific course of therapy, treatment, and re-evaluation of the progress of the detainee, an update of the problem list, and the effectiveness of the documented treatment plan. The treatment plan should be developed and updated regularly at the medical detainee review and treatment team meeting. The detainee’s cooperation, motivation, progress, current mental status, and the detainee’s ability to socialize are all considered in the development and renewal of the treatment objectives.

The treatment plan should provide the detainee with access to a range of supportive and rehabilitative services (e.g. individual or group counseling and/or self-help groups) that the team deems appropriate. The clinical portion of the plan should be under the authority and direction of the Psychiatrist. Mental Health Professional and Psychiatric patient follow-ups should be conducted according to follow-up timeframes as set forth by the Mental Health Authority. Best practice dictates that more frequent, consistent follow-ups occur for acute or unstable patients, and more stable patients are at the discretion of the attending clinician (MHP or Psychiatrist).

Segregation Detainees

Detainees should be housed in the least restrictive setting necessary to ensure the safe operation of the facility.⁷³ It is important to note that living and confinement conditions define a segregated detainee, not the reason that detainee was placed in segregation (i.e. administrative segregation, disciplinary segregation, protective custody, detainees considered to have severe behavior issues with a component of mental-illness). Detainees in segregated environments become vulnerable to mental-illness and often experience irritability, anxiety, depression and even suicidality. When severely mentally ill detainees are alleged to have committed a disciplinary infraction, it should be the assumption that the behavior was the result of an unmet treatment need while in the facility, therefore, placement in restrictive housing should be re-evaluated and reviewed by the multi-disciplinary treatment team with Security, Medical, Mental Health, and other adjunctive treatment providers as apply. When placing any detainee into restrictive housing, this placement should be used only as a last resort, in response to the most serious and threatening behavior, and for as short of a time as possible with the least restrictive conditions possible.⁷⁴

⁷² NCCHC’s Standards for Mental Health Services in Correctional Facilities, 2015, MH-G-03 essential standard.

⁷³ U.S. Department of Justice Report and Recommendations Concerning the Use of Restrictive Housing – Executive Summary. January 2016.

⁷⁴ Vera Institute of Justice, Rethinking Restrictive Housing, May 2018.

NaphCare does assess for contraindications to segregation placements, however, the prevalence of mentally-ill detainees residing in segregation is unknown by NaphCare and jail staff, and conflicting estimations were given as to whether mentally-ill detainees represented the minority or majority of segregated detainees.⁷⁵ Administrative Segregation is used for mentally-ill detainees deemed inappropriate for general population⁷⁶. Segregation rounds are reported to occur regularly, however, ongoing treatment services are not offered to these potentially vulnerable, segregated persons. Segregation cells are barred cells, resulting in easier opportunity for self-harm and suicidal behavior due to the number of tie-off points.

It is recommended that:

- Effective behavioral management strategies, counseling, behavior modification groups (when applicable), and ongoing staff trainings on the detrimental psychological and physical effects of isolation be offered.
- The MCSO draw in the appropriate amount of natural light to segregation units and individual cells.
- Visibility and line of sight for the security staff is increased.
- MCSO place equipment (such as cameras) in cells which pose the most visibility issues.
- The MCSO consider alternate housing options for severely mentally ill persons requiring single cells to aid in placement of this high-risk population in barred cells.

Management of Behavioral Detainees with a Mental-Illness

For those detainees who have become serious management problems due to their mental illness it is recommended that the detainee receive a thorough evaluation and recommendation for housing management by the highest mental health authority in the facility. Once the evaluation is completed and if the detainee conduct is classified as “behavioral” in nature, security and mental health staff should work together to: a) as much as possible, provide counseling and behavioral modification groups such as *Moral Reconation Therapy* or other treatment approaches that are known in the mental health industry to be effective in changing problematic behaviors b) stabilize the detainee to allow the detainee to return to a less restrictive setting c) train staff on behavioral management issues. Security and mental health staff should collaborate on housing assignments, program assignments, disciplinary measures and detainee transfers to other facilities. These detainees should have a treatment plan that monitors medications, lab findings, documents opportunities for treatment or participation in treatment, and documents detainee progress.

Use of Evidence-Based Treatments and Programs

The strict fidelity checks of results-based treatments produce higher rates of real abstinence, permanent behavioral change, and program completion rates. Within a correctional setting, evidence-based treatments are valuable in: managing/reducing psychiatric symptoms, reducing

⁷⁵ October 16 and 24, 2019 interviews with security and NaphCare.

⁷⁶ *Planning for Sequential Intercept Mapping – Jail Bookings*, data pulled from January 1, 2018 – December 31, 2018.

incident rates, treating severe mental-illness, reducing substance abuse, increasing detainee treatment compliance, and managing disruptive behavioral problems.⁷⁷ For instance, Moral Reconnection Therapy (MRT) is a systematic, cognitive restructuring rehabilitation system for treatment-resistant clients, particularly those who use substances and/or are involved in the criminal justice system. A report done by the Washington State Department of Corrections found that successfully completing MRT was shown to be correlated with lower drug usage, a higher employment rate, more stable living conditions, lower violation and in-custody rates, and fewer rearrests.⁷⁸ Given the wealth of knowledge between the MCSO, NaphCare, and ADAMHS professionals, selection and implementation of empirically-supported, corrections-appropriate treatment interventions is highly achievable at the MCSO.

It is recommended that:

- NaphCare use individual and group sessions to proactively target and reduce detainee symptomology.
- NaphCare and the MCSO identify and establish several evidence-based treatments and behavioral modification groups that best fit the facility's mental health population and use these treatments in individual and group therapies.

Staff Training

The MCSO has the benefit of NaphCare's and ADAMHS' knowledge pools in terms of the rolling out staff training initiatives. It is recommended that NaphCare strengthen its collaborative relationship with ADAMHS to update MCSO's suicide prevention and mental health training processes and curriculum. Comprehensive training of all team members is integral to the success of MCSO's behavioral health program.

The following themes, some already included in MCSO's training, are strongly encouraged to be incorporated into the updated, correctional trainings:

- Warning signs of impending suicidal behavior
- Responding to suicidal and depressed detainees
- Signs and symptoms of mental illness, violent behavior, and acute substance intoxication/withdrawal
- Effective and litigation-resistant communication between correctional and healthcare personnel
- Referral and triage procedures

⁷⁷ Robinson, K. *Overcoming the Challenges of Ineffective Inmate Behavioral Healthcare: How to Establish a Strong Jail System of Mental Health Care Delivery Using Evidence-Based Models Proven to Work*, Washington D.C., 10 February 2018

⁷⁸ Grandberry, G. *Moral Reconnection Therapy Evaluation: Final Report*. 1998.

- Mental health acuity, classification, and associated housing
- Crisis recognition and intervention
- Latest techniques on suicide intervention
- Behavior management and modification with segregated detainees
- Therapeutic seclusion, therapeutic restraints, and involuntary medications.
- Detoxification, medication assisted withdrawal, medicated assisted treatment
- Procedures for patient transfers to appropriate medical facilities or health care providers
- Procedures in the event of detainee self-inflicted death
- Custody as active members of a treatment team
- Recognizing signs of burnout in staff and enacting wellness precautions
- Self-care for correctional professionals
- Understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors

Suicide Prevention

Suicide prevention programs are critical in the operation of an effective detainee mental healthcare program. Industry standards dictate that the highest level of suicide prevention programming must be employed as much as possible. NCCHC Standards, as well as, State established policies and procedures should be utilized when developing a suicide prevention program. Suicides are a major cause of detainee deaths in jail facilities. To date, the MCSO did not experience a completed suicide in 2019.⁷⁹ Even still, one lost life warrants not only a retrospective review of the system, but a progressive analysis aimed at corrective actions and future prevention of suicidal behavior. Unidentified deficiencies within a suicide prevention system can result in unmanaged, high-risk detainees, ultimately depleting facility resources (i.e. available crisis beds and staff attention) and increasing the likelihood of legal exposure. In years 2017 and 2018, and under the previous jail mental health care provider, MCSO did experience multiple custodial suicides.⁸⁰ While the county incorporates some components of best practices set forth by NCCHC, they should ensure processes for all NCCHC components are in place, executed, and enforced.

⁷⁹ October 16, 2019 interview with NaphCare Mental Health Director.

⁸⁰ Dr. Daphne Glindmeyer 2018 Report.

The following is highly recommended that the MCSO:

- Strengthen the intake process by having MHPs (when present) administer a screening and suicide risk assessment for all detainees. If they are not present, allow them to review intake screenings conducted by the officers daily.
- Restructuring of Housing and Management Practices - Develop a committee designed to rethink the additional suicide watch cell locations and strengthen suicide watch practices. Restructure housing and management procedures for suicidal detainees and other special populations with the goal of aligning with industry best practices as much as possible.
- For detainees being released from watch, examine options for a transition or step-down pod or unit and integrate this process into the site-specific suicide prevention policies.
- Formalize treatment planning and ensure that all detainees discharged from suicide precautions receive a treatment plan developed by a Qualified Mental Health Professional.
- Continue to ensure the maintenance of its strong mortality review process to reinforce learning opportunities and active remedial planning from serious attempts or suicides, and continue to utilize suicide cases as opportunities for training, staff proactivity, and preventative measures.

Strengthen Coordination, Collaboration, and Alignment between the Jail and Community Partnerships

Providing a “best practice” model for linkage services is vitally important to the overall success of any jail mental health program. At the time of this assessment, collaborative efforts between NaphCare, community behavioral health providers, and Security in establishing discharge planning and a reentry process was minimal. If a collective and collaborative hand-off process and community follow-ups do exist, then more efforts to establish a reliable process is needed.

NaphCare Discharge/Re-Entry Services

Discharge planning should begin at intake and facilitated through in-reach and out-reach activities during treatment plan meetings. All severely mentally ill detainees and other qualified detainees should be assigned to a Qualified Mental Health Professional. Upon initial meeting with the detainee, this MHP should identify psychosocial, medical, behavioral health needs, and gather collateral information. The MHP should administer a Discharge Planning Assessment tool, as selected and implemented by the Facility’s Director of Behavioral Health or highest mental health authority. All information gathered should be utilized in creating an Individualized Discharge Plan, which should follow the detainee until the end of their custody, detailing how basic needs will be met upon a detainee’s release such as, housing, medical, mental health, substance abuse, medication management, vocational and employment, etc.

While the individual is in custody, the MHP should be closely involved with the detainee, monitoring his or her compliance with medication, individual or group therapy. About 30-45 days prior to a detainee’s release, the MHP should finalize a Release Planning Assessment that should serve as a hand-off tool to community agency representatives. The Release Planning

Assessment should include: identifying specific community referrals or community providers for continued off-site services, identifying a resource to continue services (if applicable), ensuring a supply of release medications and prescriptions are included with the detainee's discharge packet, identifying resources for financial assistance, identifying resources for housing assistance, and other relevant resources. During this process, the prime focus of the MHP should be to transfer information to community agencies who can be active in handling and continuing services for the detainee.

Consider the Following Recommendations:

Maximize potential work productivity for all dedicated re-entry positions by establishing a structured, comprehensive re-entry and hand-off program. Establish a multidisciplinary committee to collectively develop a site-specific plan for discharge planning, aftercare, and a hand-off process from the jail to the community. This plan begins with increased collaboration between NaphCare, Security, and ADAMHS and ADAMHS-contracted behavioral health providers to focus on:

- Identifying and establishing a process by which all detainee treatment and reentry planning is initiated upon admission to the facility as opposed to immediately prior to release.
- Identifying and establishing a process that is reliable and effective; that leverages known resources or networks, while building or establishing new community relationships; and geared towards a detainee's recovery and successful transition into the community.
- Ensure all screenings/forms/tools used by NaphCare Discharge Planners are created by the highest Mental Health Authority.

Quality Control Processes

Per industry standards, three major components comprise Quality Control: 1) Peer Reviews of employee performance occurring on a regular basis; 2) Quality Initiative and Quality Assurance processes on the site level and at the vendor, corporate level (which are generally led by the Chief Medical Officer with support from the Chief Behavioral Health Officer); 3) Administrative Reviews (i.e. mortality reviews). Objective examinations of the healthiness of the behavioral health system, through rigorous reviews of adverse events and statistical monitoring, etc. are crucial activities for correctional behavioral health programs.

At the MCSO, Multidisciplinary Team Meetings occur monthly with the Health Services Administrator, Mental Health Director, Captains, Major, and Jail Treatment Coordinator to discuss systemic issues. These administrative meeting minutes are recorded and sent through email.⁸¹ NaphCare did not describe participation in formal quality control studies. Although there is no NCCHC accreditation for mental health at this time, quality control remains an expectation of the county and such themes are reportedly discussed with frequency and included in its contract with NaphCare.⁸²

⁸¹ October 16, 2019 interview with NaphCare Mental Health Director.

⁸² Information provided by MSCO Administration via electronic communication, March 2020.

Multidisciplinary “huddle” meetings, occurring three times weekly, are documented by the Jail Treatment Case Manager and minutes are forwarded to the MCSO accreditation manager. Case conceptualizations and collaborative, proactive problem-solving strategies are reviewed with the aim of preventing similar issues in the future.⁸³ The combination of their weekly and monthly meetings evidence jail professionals’ concerted efforts towards the delivery of the highest quality of detainee care.

As an example, improving the flagging of suicide watches was identified by leadership as an ongoing quality improvement initiative. This strengthening of the electronic alerts for persons on suicide watch is a prudent measure undertaken by Montgomery leadership. The MCSO could accelerate its commendable remediation efforts even further by refining its Quality Control processes and ensuring all staff engaged in the alert system are adequately informed of the mission.

It is recommended that the MCSO:

- NaphCare implements a more rigorous Mental Health Quality Control process, aligning with NCCHC standards.
- NaphCare in conjunction with MCSO, shall continue to ensure systemic issues and active remedial plans are communicated from leadership to frontline staff (as appropriate).
- Vendor accountability should continue to be enforced by MCSO by a) ensuring NaphCare implements remedial plans with target objectives that are measurable and quantifiable; and b) NaphCare relays and shares data in a transparent manner.

⁸³ Ibid.

Section VII. In-Custody Programs

Key Findings:

- *The lack of available space in the jail places severe limits on the amount and type of program services that can be provided to the detainee population.*
- *The jail does offer a variety of religious and self-help programs to the detainee population, largely provided by volunteers.*
- *The jail existing programs are both evidenced based and non-evidence-based. The jail does not use a formal, validated screening instrument to assess offender program needs and criminogenic risks. However this is completed by pre-trial services but the not shared with the jail.*

As a result of very limited program space designed into the facility and the conversion of most program and recreation space to housing, the jail has relatively little physical space to provide program services for the detainee population. The facility has limited areas for congregate program services and virtually no space for individual counseling. Given the lack of dedicated program space, the current facility has virtually no physical ability to expand program offerings beyond current levels.

Within these constraints, the jail does offer a variety of programs to the detainee population provided by volunteers. The programs are coordinated by a full time Program Director/Chaplain. Jail staff should be commended for the recruitment of a large volunteer network. Programs provided by these volunteers include:

- Alcoholics Anonymous: Provided separately for males and females
- Narcotics Anonymous: Provided separately for males and females
- Men's Issues: Men's issues from a biblical standpoint
- Men's Reflections: Program for men to voice what they are facing
- Spiritual Solutions: Provided separately for males and females Substance recovery related program
- Domestic Violence/Anger Management: provided for male detainees
- Celebrate Recovery from the Inside: Provided separately for males and females. Merges 12 step program into 8 biblical-related steps
- Job Readiness: Provided separately for males and females. Designed to prepare detainees for employment
- Y.E.S. Program: Program for females with history in the sex industry provided by Oasis House
- Circles of Recovery: Restorative justice program for females

- Sacred Stories: For female detainees: Applies biblical teachings to practical life lessons
- Hope 29:11: For female detainees. Biblical based program to address addictions
- Women's Issues: Cognitive behavioral therapy for female detainees
- Conflict Resolution: For female detainees
- Yoga: Exercise class for female detainees
- Abigail's Journey: Assists women and low-income families reach independence through self-sufficiency
- Montgomery County Ex-Offender Re-Entry: provides re-entry support to detainees

Additionally, a volunteer GED tutoring program is provided by the University of Dayton and offered from August through May of each year. The tutoring program provides GED instruction and testing and varies in number of participants from 3 to 20 detainees.

The jail has limited resources to support reentry services. Staff work with the courts and probation to facilitate referrals of released detainees to the Day Reporting Center as well as community programs such as Monday or STOP. Staff also provide discharge planning for detainees receiving outpatient services at Recovery Works and Cornerstone, and work with probation to make referrals for housing, AOD treatment, mental health treatment, and general community resources such as getting IDs or birth certificates, childcare, and insurance.

Best practices call for initial detainee screening to determine specific detainee service program needs with a validated assessment instrument, such as the Level of Service Inventory-Revised (LSI-R) that identifies offenders' risks of reoffending and establishes specific treatment needs that can reduce these risks. Eligibility and suitability for the programs needs to be based on validated, objective criteria to provide a reasonable assurance of successful program outcomes. Once their needs are identified, detainees should be referred to an appropriate evidence-based program, with services coordinated by full-time case managers.

The specific program services to be provided in a best practice approach to in-custody programming needs to be informed by evidence-based research. The Washington State Institute for Public Policy (WSIPP) has conducted a meta-analysis of current research on what correctional rehabilitative programs work and what does not work and calculated the return on investment provided by different program strategies. According to WSIPP research the following jail-based programs are evidence-based and as such offer the best opportunity for reducing future criminality⁸⁴:

- Cognitive Behavioral Therapy
- Employment Counseling and job training (transitional reentry from incarceration into the community)

⁸⁴ Washington State Institute for Public Policy, Inventory of Evidence-Based, Research-Based, and Promising Programs for Adult Corrections, 2018.

- Inpatient drug treatment
- Outpatient drug treatment
- Parenting
- Offender Reentry Community Safety Program (for individuals with serious mental illness)
- Work Release

An additional component is evaluation. Effective programs build in formal evaluative processes to examine program outcomes after program completion, such as recidivism, employment, housing, or ongoing treatment in the community once the offender is released from the program. Without this type of data, it is impossible to determine if in fact the program services provided are having any impact and are providing a reasonable return on the resources allocated.

The assessment and service delivery strategy assumed in this model requires a significant investment of staff resources and dedicated program space. The jail at this time does have the space or the resources to support a best practices approach to program services.

Section VIII. Community Resources & Alternative Programs

Key Findings:

- *Montgomery County has a robust set of community programs that provide alternative sanctions and diversion from the jail. While the effectiveness of some services could be improved with additional resources to address service needs, the overall system of programs is consistent with best practices.*
- *One area of unmet need is a community mental health crisis stabilization center. Individuals in need of the services of such a facility often end up in the jail.*
- *The justice system should invest in evaluation of current programs to determine their impact on recidivism and use that research to guide investment of program resources.*

Offender programming has changed significantly over the past 20 years. Today, a wide-range of in-custody, probation, pretrial service, re-entry, and other programs are used by counties across the country to help change offender behavior, control their jail populations, and reduce recidivism. In the past decade, there has been an emphasis on implementing evidence-based and re-entry programming. In this section of the report, we will summarize the many types of programming used in Montgomery County.

Probation

The Probation Service Department within the Court of Common Pleas provides community supervision for a total caseload of 3,249 offenders as of August 2019. There are also additional probation departments within the community that are not represented in this report. Probation's objective is to manage the offender in the community with a focus on preventing the probationer from committing another crime while on supervision. The Department has 62 probation officers that manage both general and specialized caseloads. The caseload per Probation officer are at a level that should address supervision requirements for each type of offender.

Figure 38: Probation Department Caseloads

Program	# of Probation Officers	Average Caseload
Community Supervision	12	108
Sex Offenders	2	40
Domestic Violence	2	78
Specialty Courts	7	37
Intensive Supervision	12	63
STOP Aftercare	4	43
Residential	6	13
Interstate	1	269

The average length of stay on probation is 18 months. Most probationers visit their officer at least once per month. Day reporting and drug testing are typically mandated as terms of probation and approximately 75% are compliant. The overall probation caseload is comprised of over 93 percent felons, with the majority being Felony 5-level offenders. Probation has access to a robust array of programs to meet offender needs and facilitate positive outcomes. A description of these programs follows.

STOP

The Secure Offender Transitional Program (STOP) provides secure residential drug intervention services to offenders sentenced to probation. Probationers who are granted community-based supervision as an Adult Community Residential Service. The program was developed in 2002 with 48 beds for sentenced male offenders and was expanded by 48 beds for female offenders in 2015.

Offenders with any felony other than a sex offense or an order of protection are eligible after spending seven to ten days in jail to assure detoxification. Probation staff provide programming focused on assisting offenders transition to a drug-free lifestyle, combined with a significant community service component. Facility security is provided by private contractors. The program is accredited by both the ACA and Ohio Department of Rehabilitation and Correction.

Program participants are sentenced to probation in lieu of a 180-day jail sentence. The average length of stay in the program is 42 days. For 2019, through August the program had 690 referrals from the courts and had approved 341 for entry into the program, an acceptance rate of 49 percent. Participants have contributed 76,639 hours of community service during this period.

Approximately 90 percent of males and 86 percent of female offenders graduate from the program. The overall success rate, defined as the absence of a new offense or probation violation for three months following probation graduation is 89 percent for female offenders and 94 percent for males. Data on longer-term success rates is not available.

Offenders with any significant health issues are not eligible for placement at the facility. This disqualifies a number of offenders at the jail with significant medical and mental health issues that could otherwise participate in the program. To the extent that this criterion makes filling program beds difficult, the County should consider establishing a minimal level of nursing service at the facility to broaden the pool of acceptable program participants.

Specialty Courts

The County's Common Pleas courts maintain several specialized dockets to provide service and case management customized to meet offender needs and avoid incarceration. The Mental Health Court, established in 2018, offers services for offenders diagnosed with a serious mental illness and determined to be amenable to treatment. The program is limited to 20 offenders and facilitates access to community treatment services.

The Veteran's Court facilitates placement into community and Dayton VA Medical Center services for eligible offenders on probation or in lieu of conviction. Through August the Veteran's Court had received 189 referrals, with 79 percent of program participants successfully completing the program.

The Drug Court coordinates substance abuse treatment services for offenders at medium to

high risk of reoffending based on Ohio Risk Assessment System (ORAS) score. The program is highly structured, with weekly court appearances, intensive supervision, drug testing, and treatment. The program commenced in 1996 and had received 3,901 referrals through August 2019, with a success rate of 75 percent.

The Women's Therapeutic Court coordinates substance abuse treatment services customized for female offenders at medium to high risk of reoffending based on Ohio Risk Assessment System (ORAS) score. The program is highly structured, with weekly court appearances, intensive supervision, drug testing, and treatment. The program commenced in 2014 and had received 771 referrals through August 2019, with a success rate of 73 percent.

Day Reporting

The Day Reporting Center provides evidence-based, on-site cognitive restructuring programs, public health services, life skills, drug treatment, legal aid, behavioral health services, education, and job training for offenders under community supervision and in STOP. In 2019 The Day Reporting Center through August had managed over 14,500 service encounters with probationers.

Stop the Violence

This program provides anger management, education, and accountability for male domestic violence offenders. Offenders participate in a 16-week program. The program has received 62 referrals in 2019, and 46 offenders have successfully completed the program.

Alternatives to Violence

This is an anger management program that makes offenders aware of the circumstances and situations that can cause violence and how to better manage personal decisions to avoid violence. The program has had 33 referrals in 2019.

Theft Clinic

The program provides an alternative for offenders convicted of shoplifting or petty theft. The program educates offenders on the social, legal, and financial consequences of theft. The program has had 62 referrals in 2018.

Victims Impact Panels

This is a restorative justice program that offer panels for Drug, DUI and violent offenders to understand the impact of their actions on victims and provide victims an opportunity to communicate the impact the offender has had on their lives. In 2019 there have been 59 referrals to the DUI Panel, and 131 referrals to the Drug Impact Panel, and 28 referrals to the Victim of Violent Crime Panel.

SEASONS

This 13-week parenting and life skills program is targeted to offenders at risk of developing substance abuse issues or criminal lifestyles, but that are not in need of substance abuse treatment at this point. The program provides offenders with skills to better manage their personal lives and families. The program has had 3 referrals in 2019.

Pretrial Services

The primary front-end diversion from the jail is provided by the Pretrial Services program. Program staff screen felony arrestees charged under the Common Pleas Courts and violent misdemeanor offenders charged booked into the jail to determine their risk of failure to appear and their risk to reoffend. Staff conduct interviews with arrestees, conduct background checks, criminal history reviews, and administer the ORAS risk assessment instrument to provide the basis for a recommendation on supervision strategy. Levels of supervision electronic home detention, phone contact, regular office visits, urinalysis, social service referrals when necessary, and telephone calls to advise defendants of changes in court appearance dates.

Currently Pretrial Services reviews approximately 50 percent of the approximately 23,000 annual bookings into the jail. The program's goal is to screen all arrestees, not just those charged under both the Common Pleas and the Municipal Courts. Since April 2019, Pretrial Services has been screening and providing bond recommendation reports for all misdemeanor offenses for Dayton Municipal Court and is in discussion with the Kettering Municipal Court to begin screening of misdemeanor offenders charged in their jurisdiction. The program intends to transition to the Arnold Ventures Public Safety Assessment risk assessment tool with implementation of a new probation as part of a move away from bail and use of a common, validated risk assessment instrument and pretrial case management system in 2020 that will facilitate referral of arrestees to treatment programs.

Despite the program's major role in managing the jail population and daily involvement, lack of space in the current facility makes support of the program difficult. Because of a lack of available office space, all interviews are currently conducted by video.

Community Corrections

The Monday program is a community corrections program that provides an alternative for offenders who would otherwise be sent to state prison. The program is funded by the State and has been in operation since 1978. The facility has 120 staff and budget of \$7.5 million. The facility is an ACA-accredited, secure diversion for prison-bound offenders and accepts referrals from county common pleas courts in six counties in southwest Ohio. The facility contracts for 675 annual diversions from prison, of which 340 were from Montgomery County last year.

In terms of screening potential placements into the facility, mental health and medical issues are the primary factors preventing eligible offenders from entering the program. The facility has limited nursing staff on days and limited ability to manage offenders with chronic health care issues.

Monday offers an evidence-based treatment program to residents, with a heavy emphasis on cognitive services. Programs offered at the facility include Cognitive Behavioral Therapy, Thinking for a Change, Anger Management, Employment Readiness, Parenting, Adult Basic Education, Vocational Training, Sex Offender, Medication Assisted Treatment, and Residential Drug Treatment.

Approximately 70%-80% of program participants successfully complete the program and exit to probation. The most recent three-year recidivism rate for the program from 2015 was 38 percent. Upon program completion residents transition to alternative or family-based housing.

Analysis

The County has a robust set of community programs that provide alternatives to incarceration for offenders in the justice system. Despite this infrastructure however, the capacity of these programs is not sufficient in some cases to meet justice system needs. Current mental health treatment, substance abuse treatment, and transitional housing assistance all require expansion to provide an effective level of services. The system also lacks a non-forensic facility for persons who anticipate or are experiencing a mental health crisis and require stabilization. This facility would provide emergency crisis stabilization services for individuals experiencing severe mental health issues. Crisis respite centers serve people who anticipate or are experiencing a mental health crisis and provide a temporary residential stay in a safe and supportive environment. Currently, such individuals often end up in a hospital emergency room or jail as a result of acting out behaviors. Such a facility would allow for stabilization that is currently happening in the jail. Services provided at such a facility could include linkage to medical and psychiatric providers, medication management, support groups, individual counseling, and psycho-education.

Another area of need is program evaluation. Montgomery County ADAMAS maintains little meaningful outcome data for current programs. Few of the programs or systems reviewed in are being evaluated to determine their long-term impact on offender behavior and recidivism. There is no central repository of planning or research data available to criminal justice system stakeholders seeking basic information on the operational performance of the system or its characteristics.

As a result, policymakers have very limited means to assess whether, in fact, programs are working and affecting offender behavior as designed. As a result, key policy decisions must be made on either anecdotal information or very limited data analysis. The lack of a basic understanding of program outcomes further makes it difficult to perform any type of meaningful cost/benefit analysis on programs to determine whether the impact of a program is worth the investment of resources required.

The County needs to be able to identify basic metrics of program activity and the effects of these activities. Activity data should be maintained on admissions, attendance, phase completions, program completions, and terminations for all programs. In addition, outcome data that tracks offender behavior in terms of violations of supervision, re-arrests, convictions, and other indicators of recidivism should be collected. This data should then provide the basis for analysis of cause-effect relationships that result in desired program and operational outcomes.

In addition to collecting appropriate data, criminal justice system policymakers need regular reports that summarize trends, activities, and outcomes for key system components. Many counties use a monthly dashboard report that provides key system metrics in a clear, concise format.

The collection of data by itself is important, but not sufficient. In order to effectively use data to make decisions on program investments and assess system needs, the County needs to develop a robust evaluation system for programs currently in place and those to be developed. The best means to this end is to contract with a local university to design a research model to

study these programs. University criminal justice and sociology programs make good partners in developing rigorous evaluations of criminal justice system performance.

Section IX. Capacity and Facility Projections

Key Findings:

- *Demographic and crime trends indicate a relatively stable jail population over the next thirty years. The population most at risk for criminal behavior in Montgomery County is projected to decrease by 3.1 percent from 2018 to 2050. Annual reported crimes in the county have decreased by 29.1 percent over the past eleven years and appear to be stabilizing, following national trends. The increasing length of stay in the jail will continue to drive small increases in the jail population.*
- *Changing justice system policies impact jail capacity needs. In recent years there has been an increased use of citation and release by law enforcement agencies, diversion of low risk offenders from incarceration, and the expedited processing of cases. These are examples of policies that are being used to manage the jail population. Our projections assume that these policies and practices will continue.*
- *The projection model indicates the average daily general population at the jail will grow to 903 detainees by 2050, an increase of 11.9 percent over 30 years, or an annual increase of 0.4 percent.*
- *In order to assure enough beds to accommodate fluctuations in population levels and manage different classifications or types of detainees, requires adding a factor to the projected general population level to forecast facility capacity needs. Based on actual jail data and our experience with jail systems nationally, our projection indicates a multiplier of 14.9 percent should be applied to the projected population to produce an estimate of required general population capacity. This assumption results in a need for 1,038 general population beds by 2050.*
- *The need for dedicated beds for mental health treatment, medical housing, and segregation adds 150 – 200 additional beds to required facility capacity needs, for a total of 1,200 beds.*
- *Preliminary construction cost estimates indicate that providing these 1,200 beds in a new facility would cost from \$206.7 million - \$252.7 million. Providing these beds in a planned renovation of 250 existing jail beds and 950 new beds would cost \$194.8 - \$238.1 million.*

One aspect of a criminal justice assessment is a forecast of jail bed space need for the county. We examined the factors that impact the day-to-day operations of its jail and future jail bed space needs. Jails have little or no control over factors that impact the size of the jail population. In reality, the practices of other components of the County's criminal justice system have the largest effect on the jail's population. This includes law enforcement citation and booking practices, the speed of criminal case processing, and the availability of alternatives to incarceration as well as county population trends and local crime rates.

Accordingly, an assessment of practices within the entire County's criminal justice system was required to clearly project future needs and to develop a sound, rational proposal for key system stakeholders.

The jail needs assessment used data provided by the Montgomery County Common Pleas Court, Dayton Police Department, Montgomery County Sheriff's Office, the Ohio Department of Public Safety, Ohio Office of Research, JusticeWeb, and the US Census Bureau. Projections for average daily population and bed space needs were calculated to the year 2050 for the purposes of effective and efficient jail planning.

Database for Projections

A database was developed to support the analysis, profiling, and forecasting activities. This database will include information on both the detainee population and existing diversion programs, as well as other components of the criminal justice system that can impact on the jail population levels. The database will support the multiple models considered for the jail average daily population (ADP) projections and subsequent bed space need projection.

Historic and Projected Total County General Population

Historic county population data for the study is from the US Census Bureau. Population projections are from the Ohio Development Services, Office of Research. County population data is a key variable in jail population projections.

Figure 39 presents the county population trends from 2008 to 2018. The Montgomery County population has decreased by 19,655 residents since 2008, a decrease of 3.7 percent. The annual growth rate in Montgomery County from 2008 to 2018 was -0.4 percent. The population by gender shows that the male population decreased by 9,005 and the female population decreased by 10,600. The female population decreased slightly more than the male population in Montgomery County by percentage change, -3.8 percent for the female and -3.4 percent for the males. The "at-risk" population aged 20-44 decreased by 7.7 percent from 2008 to 2018. The "at risk" population makes up most of the jail population traditionally.

Figure 39: Historic County Population (2008-2018)

Year	County Population	Male Population	Female Population	At Risk Population
2008	537,711	257,157	280,554	173,754
2009	535,183	256,006	279,177	171,187
2010	535,153	256,961	278,192	168,689
2011	532,996	255,863	277,134	167,609
2012	530,840	254,765	276,075	166,529
2013	528,683	253,666	275,017	165,450
2014	526,527	252,568	273,958	164,370
2015	524,370	251,470	272,900	163,290
2016	522,262	250,364	271,898	162,328
2017	520,154	249,258	270,896	161,366
2018	518,046	248,152	269,894	160,404
# Change	-19,665	-9,005	-10,660	-13,350
% Change	-3.7%	-3.5%	-3.8%	-7.7%
Annual % Change	-0.4%	-0.4%	-0.4%	-0.8%

Source: US Census Bureau, September 2019.

The population in Montgomery County is projected to decrease from 2018 to 2050. According to the Ohio Development Services, Office of Research, the resident population in Montgomery County is projected to decrease to 488,040 by the year 2050, a decrease of 5.8 percent overall, or an average annual decrease of 0.2 percent. The projected population by gender shows both the male and female populations decreasing by more than 5.5 percent to the year 2050. Female residents are projected to decrease by 5.6 percent, while that males are projected to decrease by 5.9 percent during the same time.

The “At Risk” population is projected to decrease by 3.1 percent to the year 2050, decreasing from 160,404 to 155,440. Figure 40 shows the projected populations in Montgomery County in five-year increments to 2050.

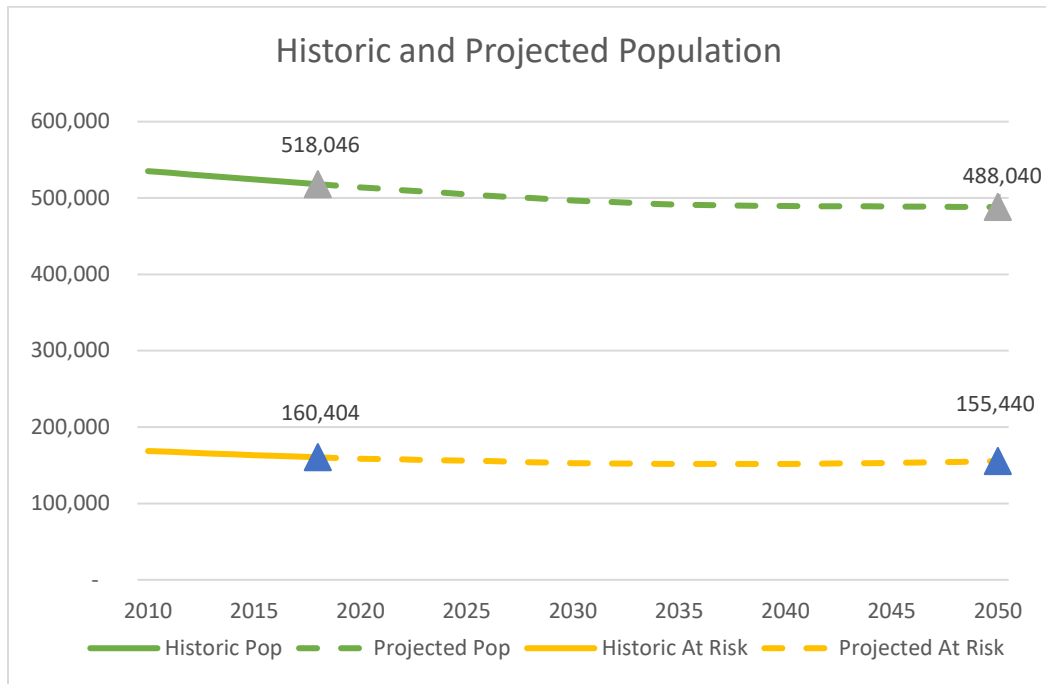
Figure 40: Projected County Population (2018-2050)

Year	County Population	Male Population	Female Population	At Risk Population
2018	518,046	248,152	269,894	160,404
2020	513,830	245,940	267,890	158,480
2025	504,770	241,150	263,620	156,190
2030	496,650	236,900	259,750	152,690
2035	491,080	234,200	256,880	151,750
2040	489,400	233,690	255,710	151,750
2045	488,890	233,580	255,310	153,120
2050	488,040	233,390	254,650	155,440
# Change	-30,006	-14,762	-15,244	-4,964
% Change	-5.8%	-5.9%	-5.6%	-3.1%
Annual % Change	-0.2%	-0.2%	-0.2%	-0.1%

Source: Ohio Development Services, Office of Research, April 2018.

Figure 41 illustrates the historic and projected overall and “at risk” populations in Montgomery County. Montgomery County population decreased 3.7 percent from 2008 -2018, an annual decrease of 0.4 percent. The projected Montgomery County Population in 2050 is 488,040, a decrease of 5.8 percent which slows the annual decrease to -0.2 percent. The “At Risk” population decreased 7.7 percent from 2008 to 2018 and is projected to decrease 3.1 percent to 2050.

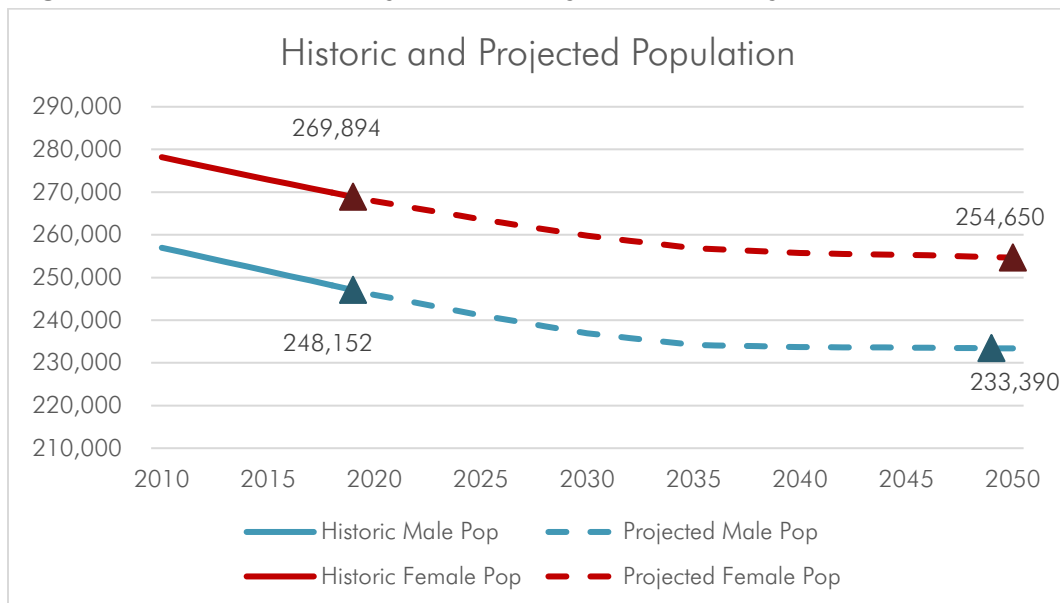
Figure 41: Historic and Projected Overall and “At Risk” County Populations (2010-2050)



Source: Ohio Development Services, Office of Research, April 2018

Figure 42 shows the historic and projected population by gender in Montgomery County. The male population in Montgomery County decreased 3.5 percent from 2008 to 2018 and is projected to decrease another 5.9 percent by 2050. The female population decreased 3.8 percent from 2008 to 2018 and is projected to decrease another 5.6 percent by 2050.

Figure 42: Historic and Projected County Population by Gender (2010-2050)



Source: Ohio Development Services, Office of Research, April 2018

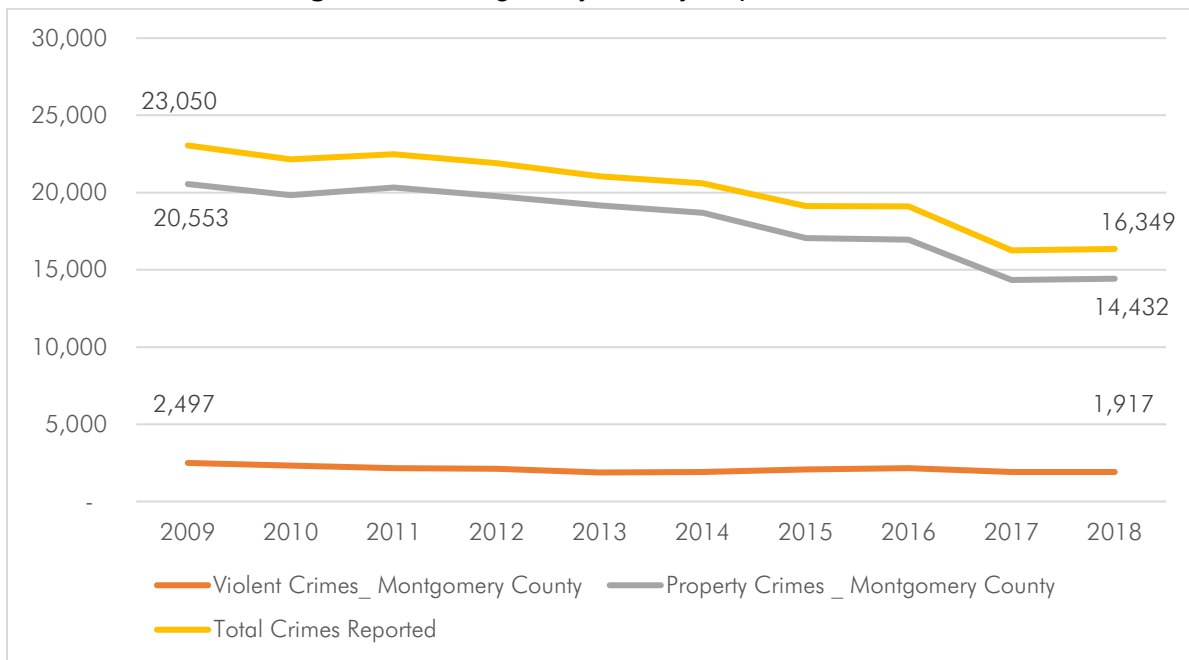
Reported Crimes

Historic annual reported crimes are used in population projection modeling, tying the number of reported crimes to the average daily population (ADP) and the jail book-ins (ADM) when the variables are correlated. Most often, annual reported crimes will correlate more directly with ADM, while the ADP of most jails often do not correlate with the number of annual arrests. ADP is more dependent on the number of book-ins (not all arrests will result in an admission to the jail; some are cited and released or ordered to appear in court without being taken to jail).

The reported crime trends are from the Ohio Department of Public Safety. Annual reported county crimes overall have decreased from 23,050 in 2009 to 16,349 in 2018, a decrease of 29.1 percent. The number of reported property crimes decreased from 20,533 to 14,432, a decrease of 29.8 percent. This decrease follows the national trend in the past decade.

The number of reported violent crimes in Montgomery County decreased from 2,497 to 1,917, a decrease of 23.2 percent. The annual number of reported crimes in Montgomery County from 2009 to 2018 is shown in Figure 43.

Figure 43: Montgomery County Reported Crimes



Source: Ohio Department of Public Safety, Office of Criminal Justice Services, September 2019

The reported crime trends from the City of Dayton were analyzed as well. The data from the City of Dayton Police Department is broken into Part 1 and Part 2 crimes, with Part 1 crimes being the more serious crimes. Part 1 violent crimes in the City of Dayton decreased 24.0 percent and Part 2 violent crimes decreased 14.0 percent from 2009 to 2018. Figure 44 graphs the historic violent crimes in the City of Dayton.

Figure 44: City of Dayton Reported Violent Crimes

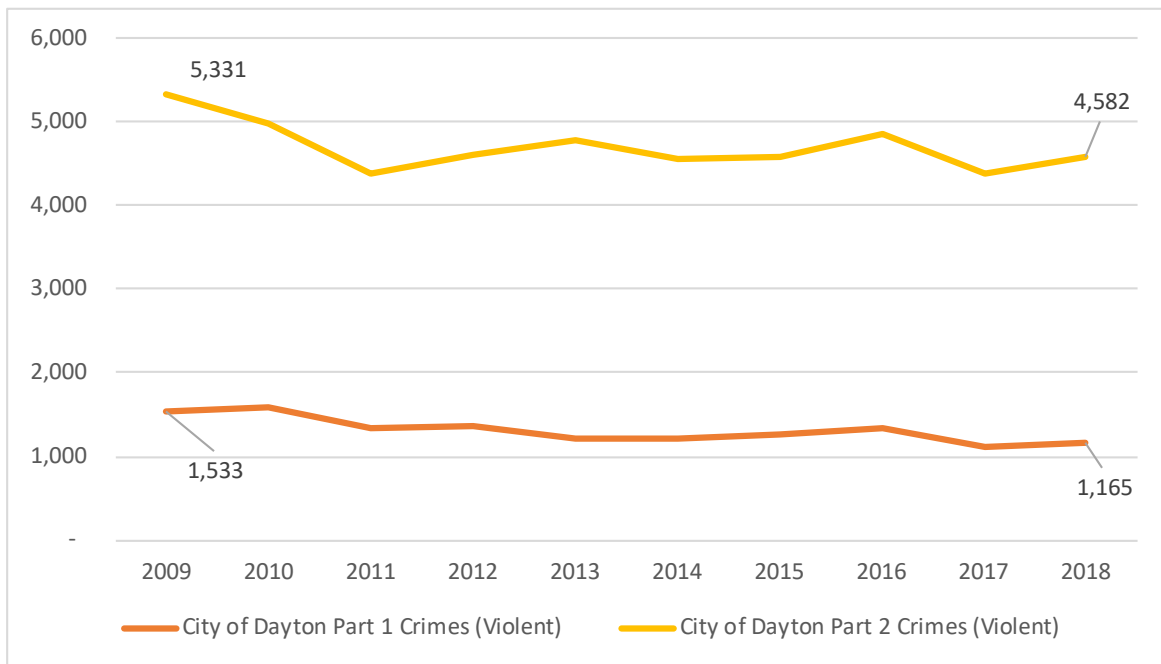
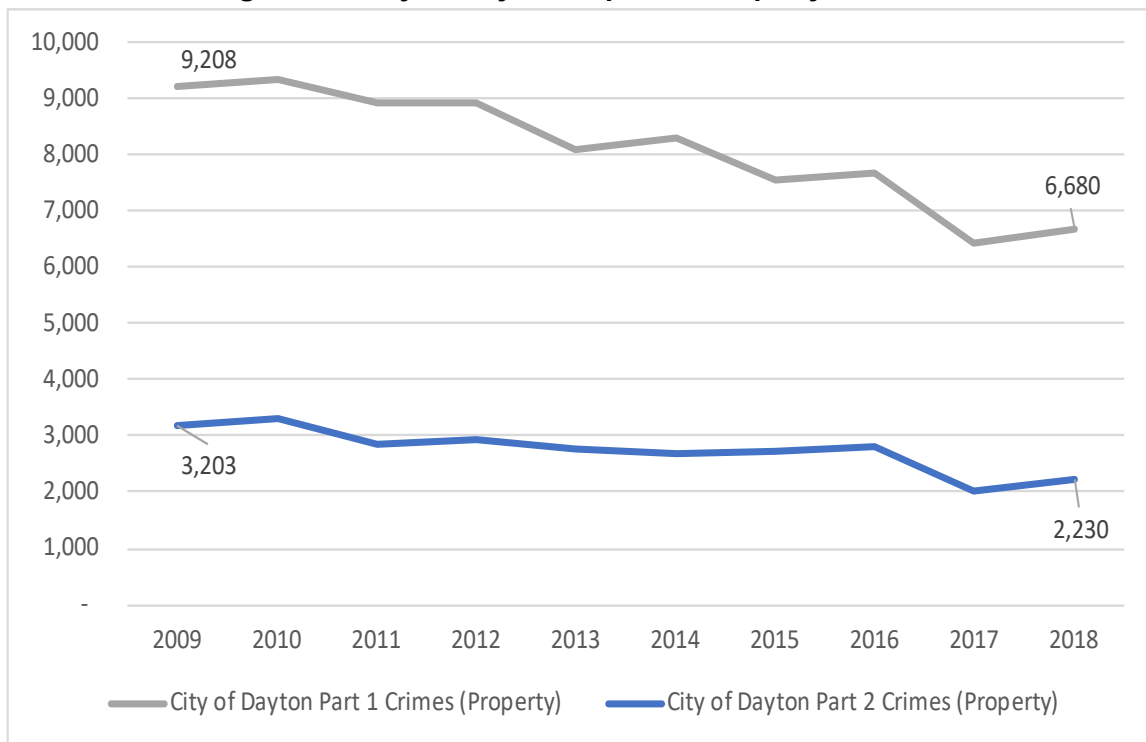


Figure 45 graphs the historic property crimes in the City of Dayton. Part 1 property crimes in the City of Dayton decreased from 9,208 to 6,608 from 2009 to 2018, a decrease of 27.5 percent. Part 2 property crimes decreased 30.4 percent from 2009 to 2018, from 3,203 to 2,230.

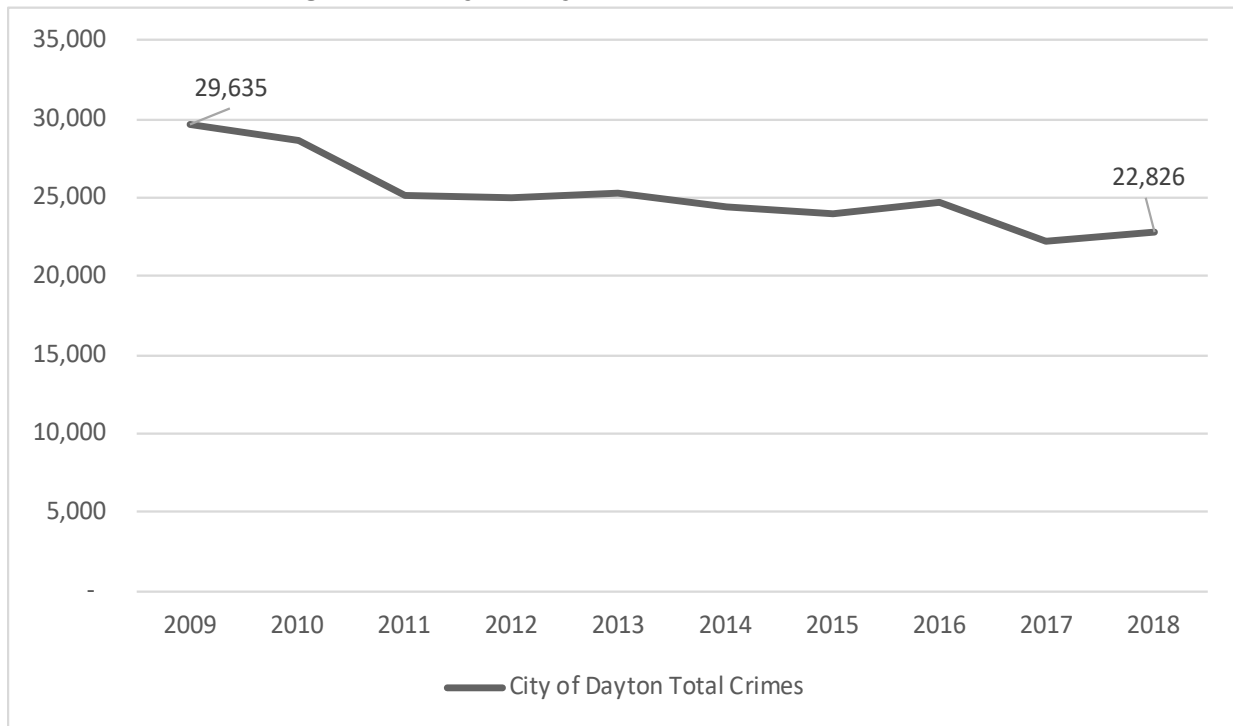
Figure 45: City of Dayton Reported Property Crimes



Source: Ohio Department of Public Safety, Office of Criminal Justice Services, September 2019

The total number of reported crimes in the City of Dayton is graphed in Figure 46. Total crime decreased from 29,635 to 22,826, a decrease of 23.0 percent.

Figure 46: City of Dayton Reported Total Crimes



Source: Ohio Department of Public Safety, Office of Criminal Justice Services, September 2019

The total number of reported crimes in the City of Dayton includes violent, property, disorder, drug/narcotics, and other crimes. From 2009 to 2018, the number of Disorder Crimes decreased by 19.3 percent, the number of Drug/Narcotic Crimes decreased by 10.5 percent and Other Crimes decreased by 39.7 percent. All categories of reported crimes in the City of Dayton decreased from 2009 to 2018.

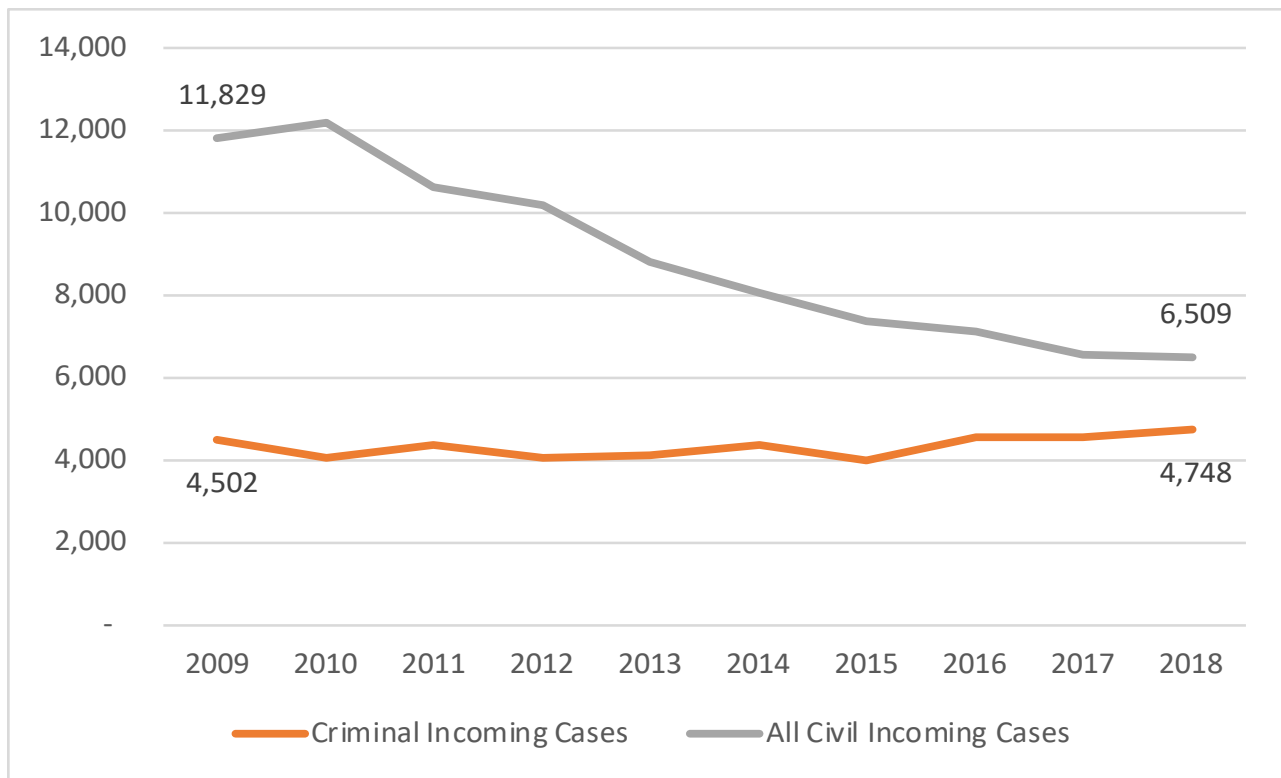
The total offenses known to law enforcement in Montgomery County and the City of Dayton are both used in the jail population projections. Both metrics are set against the corresponding ADP by year, and that rate is applied to projected offenses in the future.

Criminal Caseload Filings

One of the largest indicators of jail bed needs is the number of criminal court filings. Increased time to disposition often increases the average length of stay in the jail, resulting in more jail beds needed.

The Montgomery County criminal caseload data comes from the State of Ohio Courts of Common Pleas monthly reports. The number of incoming criminal and civil court cases in Montgomery County is illustrated in Figure 47. The number of incoming criminal cases increased from 2009 to 2018, from 4,502 to 4,748. This is an increase of 5.5 percent. All civil incoming cases dropped significantly from 2009 to 2018, dropping from 11,829 to 6,509, a decrease of 45.0 percent.

Figure 47: Incoming Case Filings



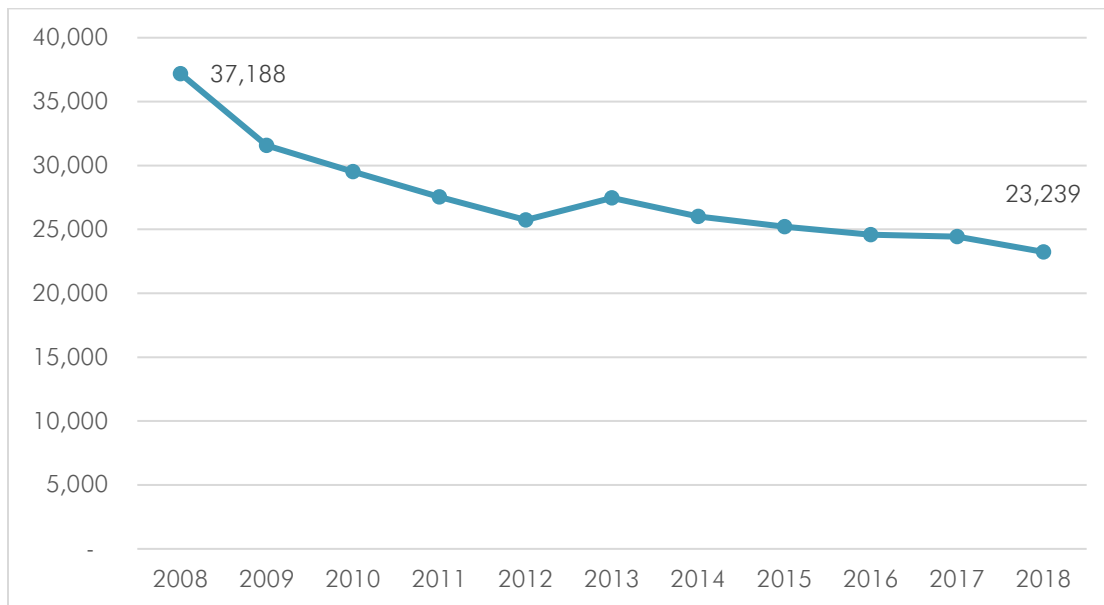
Source: State of Ohio Courts of Common Pleas

For the projection model, the number of incoming criminal cases were examined in relation to the ADP in the Montgomery County Jail.

Jail Book-ins

Historic jail book-ins (ADM) annual data is from the Montgomery County Sheriff's Office. The annual ADM has decreased from 37,188 in 2008 to 23,239, a decrease of 37.5 percent. The peak annual ADM occurred in 2008 and then immediately started to decrease. Figure 48 shows the annual jail book-ins in Montgomery County.

Figure 48: Annual Jail Book-ins (2008-2018)



Source: Montgomery County Sheriff's Office

Jail book-ins, along with the average length of stay of the detainees, is used in the projection models of average daily population and jail bed space needs. Increasing jail book-ins, with average length of stay held constant, would increase the number of jail bed spaces needed in the criminal justice system.

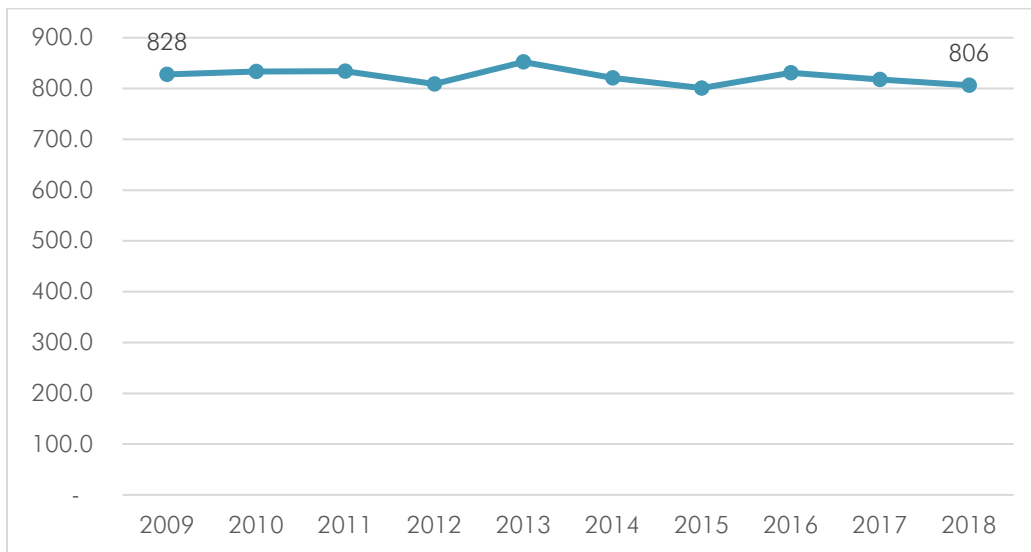
The Jail book-ins data is from Justice Web and was provided by the Montgomery County Sheriff's Office.

Jail Average Daily Population

The Average Daily Population (ADP) in the jail is the primary variable for projections, as it determines future bed space need. The historic annual ADP from 2008 to 2018 is the average monthly number of detainees held in Montgomery County jail and other detention facilities contracted by Montgomery County. This is identified as the total ADP.

The total ADP has remained essentially stable from 2009 – 2018, as shown in Figure 49. This is notable given the significant reduction in bookings into the jail and the more general decline in area crime rates over the same period. The explanation is that the decline in bookings is largely attributed to low-level misdemeanor offenders. Misdemeanor bookings into the jail actually fell by 41 percent from 2009 – 2018 while admissions for felony offenses remained stable, as shown in Figure 50. The reduction in the number of low-level offenders booked into the jail has a relatively minor impact on average jail population levels, as these offenders typically have a very short length of stay. Consistency in the number criminal cases filed and the number of offenders booked into the jail for serious, felony crimes drives the very stable jail population levels experienced in Montgomery County.

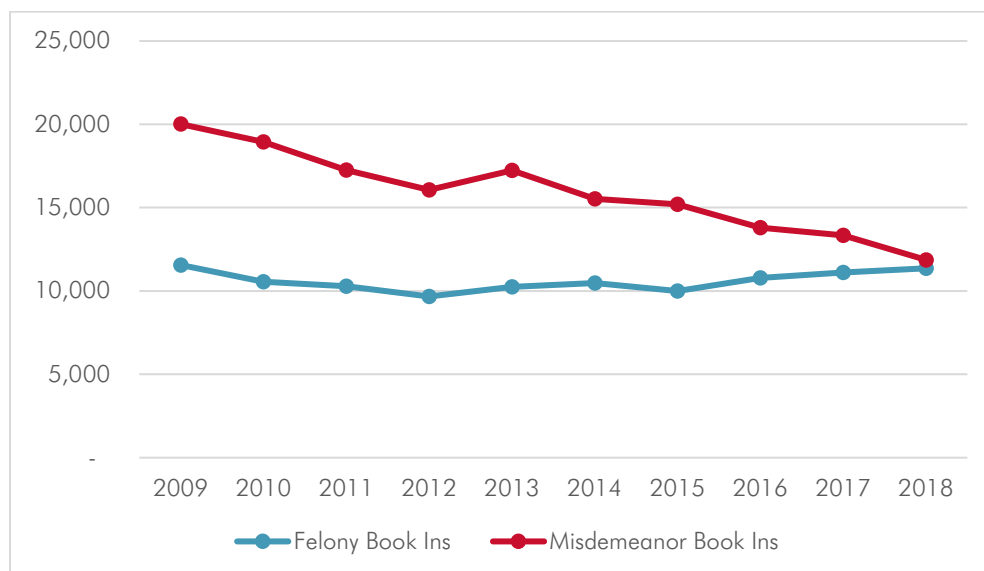
Figure 49: Total ADP (2009-2018)



Source: Montgomery County Sheriff's Office

The changing nature of jail population to a more serious, felony offender can also be seen in the changing length of stay data. The average length of stay for jail detainees in Montgomery County has increased by 37 percent over the past ten years. This does not appear to be driven by changes in sentencing or court processing practices but is instead attributable to a more serious offender population housed in the jail. The impact of length of stay on the population projections is discussed in more detail later in this report.

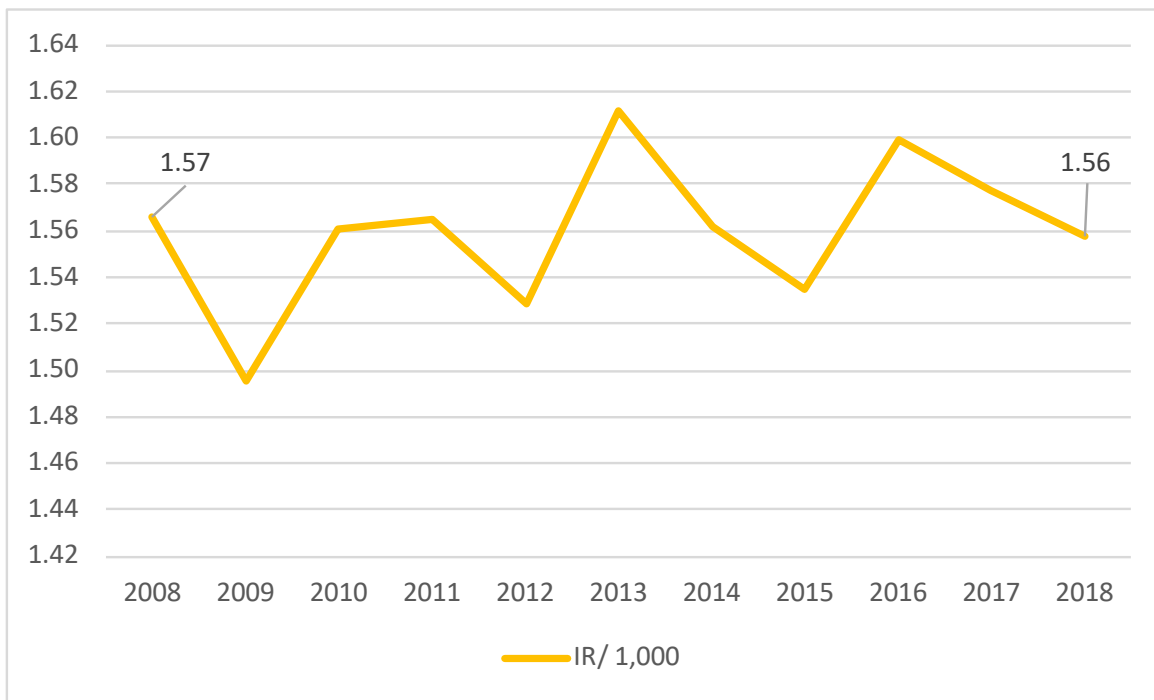
Figure 50: Misdemeanor and Felony Bookings (2008-2018)



Source: Montgomery County Sheriff's Office

The incarceration rate (IR) measures the ADP in relation to the resident population. The IR in Montgomery County has decreased 0.5 percent from 2008 to 2018. The IR ranges from 1.50 in 2009 to 1.61 in 2013, as shown in Figure 51.

Figure 51: Annual Incarceration Rate per 1,000 Residents

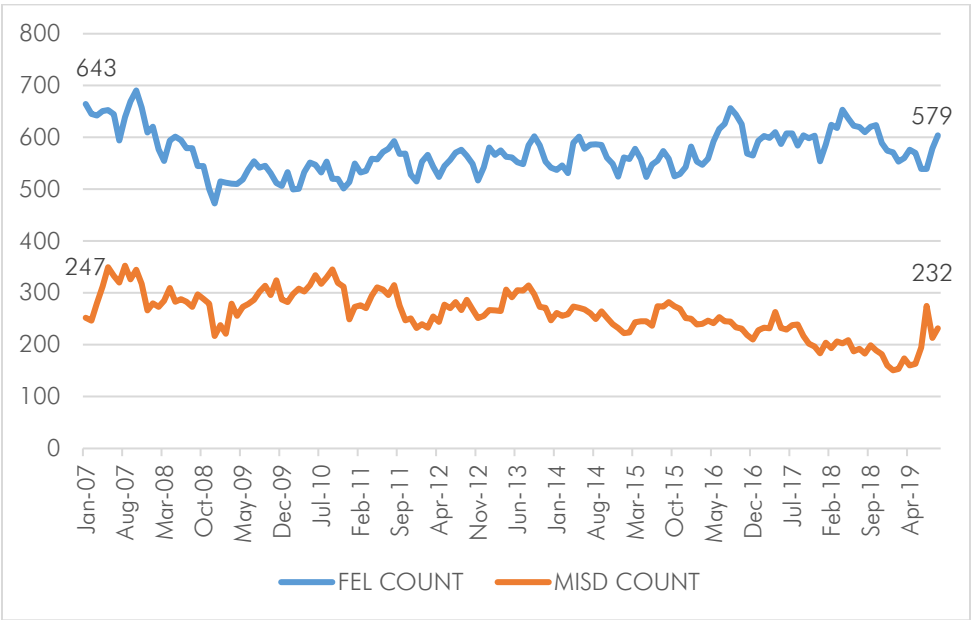


Source: Montgomery County Sheriff's Office

Figure 52 shows the breakdown of the offenders in the Montgomery County system by charge. The data is from monthly Sheriff's Office reports from January 2007 to September 2019. This monthly data is the basis for the classification percentage for the bed space projections.

The monthly average from January 2007 to September 2019 for detainees with felony charges is 536, while the average for detainees with misdemeanor charges is 286. The detainees with felony charges decreased from 643 in January 2007 to 579 in September 2019. The detainees with misdemeanor charges decreased from 247 to 232 during the same time frame.

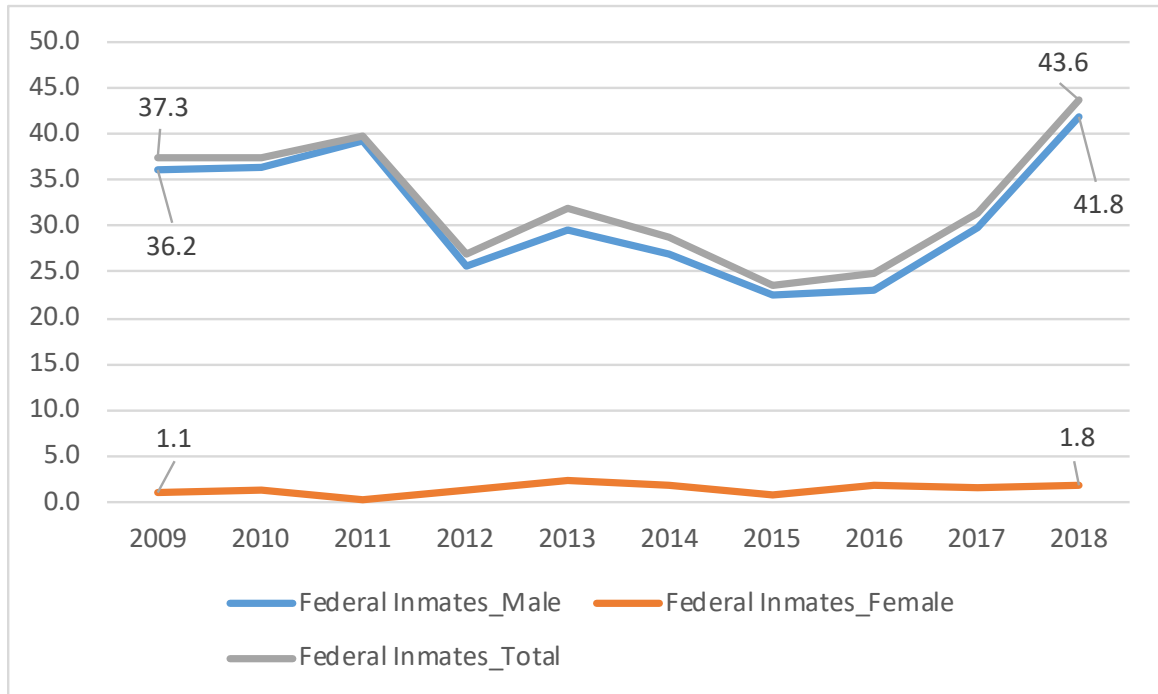
Figure 52: Jail Population Profile: by Charge



Source: Montgomery County Sheriff's Office

Figure 53 shows the annual ADP of federal detainees held in the Montgomery County jail by gender. The male and female federal detainees have both increased from 2009 to 2018. The female federal detainees have increased 66.2 percent from 1.1 to 1.8 while the male federal detainees have increased from 36.2 to 41.8, an increase of 15.6 percent.

Figure 53: Jail Population Profile: Federal Detainees



Source: Montgomery County Sheriff's Office

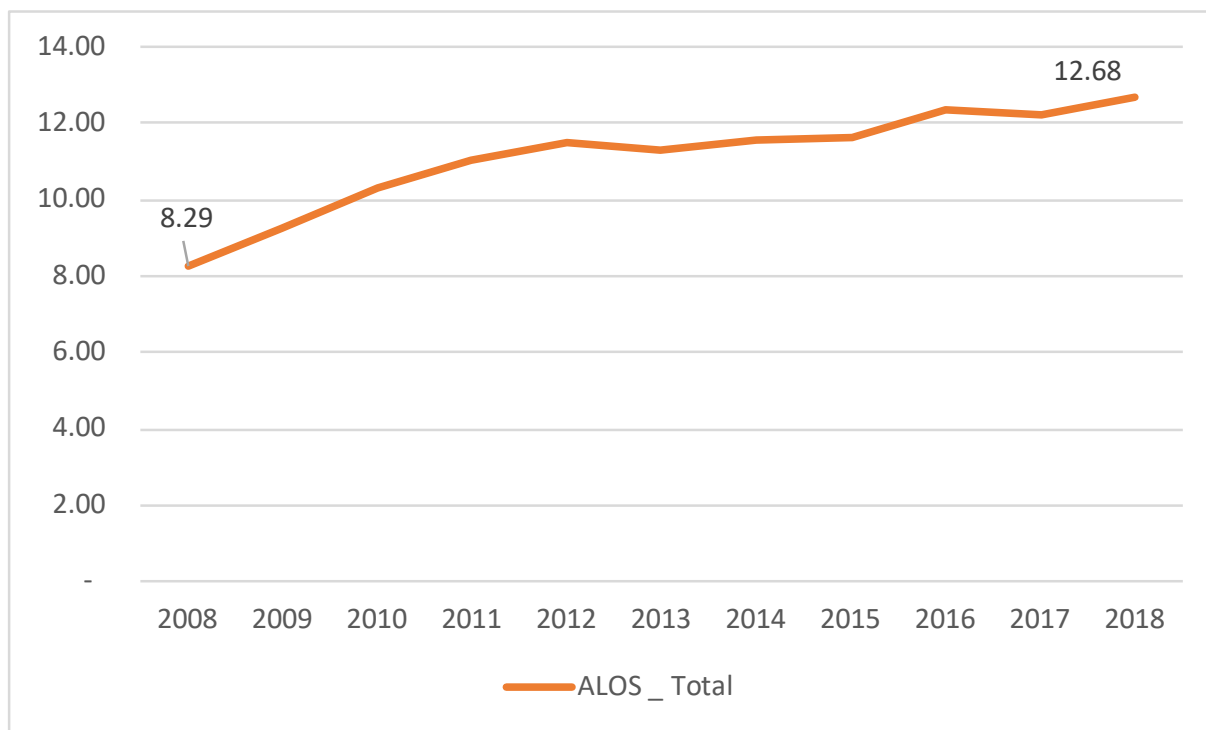
Overall, the federal detainee ADP in the Montgomery County jail has increased 17.0 percent from 2009 to 2018.

Average length of stay (ALOS) in Jail

The annual average length of stay (ALOS) of detainees in the system was provided by the Montgomery County Sheriff's Office. ALOS data is reported on an annual basis by the County from 2008 to 2018. Figure 54 shows the steadily increasing ALOS in the Montgomery County jail from 2008 to 2018. ALOS has a significant effect on jail populations, with higher ALOS often resulting in higher ADP and bed space need.

The overall ALOS averaged 11.12 days from 2008 to 2018. Figure 54 is the total detainee ALOS. The ALOS has increased from 8.29 days in 2008 to 12.68 days in 2018, an increase of 53.0 percent.

Figure 54: ALOS All Detainees

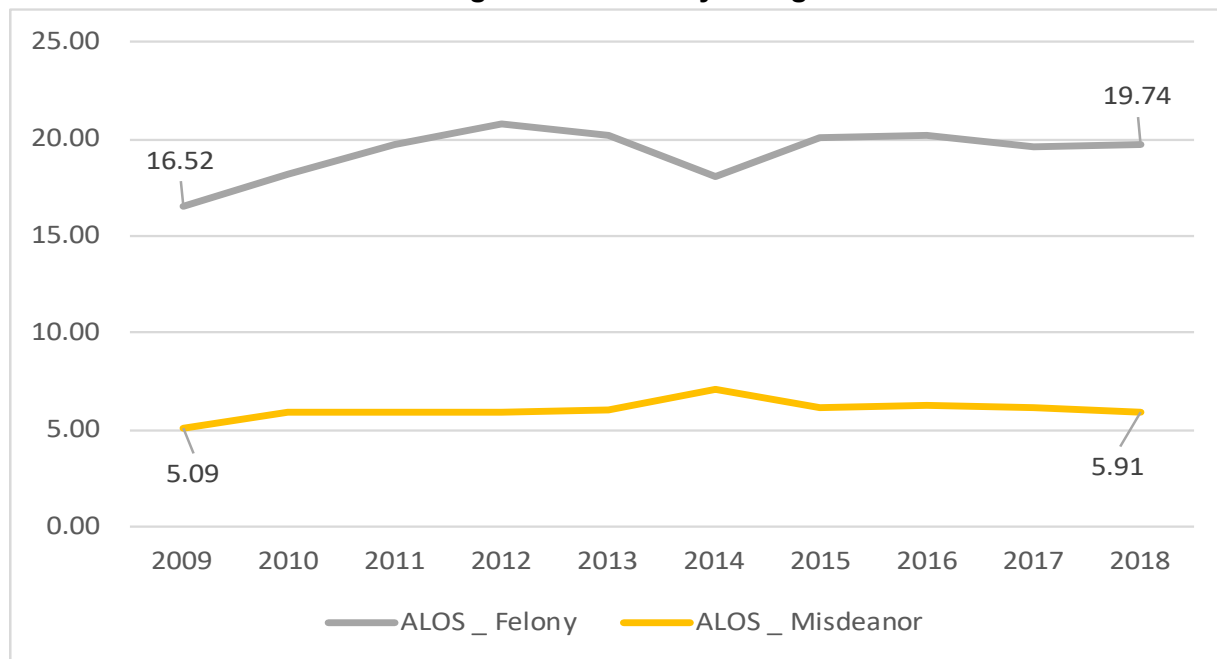


Source: Montgomery County Sheriff's Office

Figure 55 breaks down the ALOS by charge provided by the Montgomery County Sheriff's Office. The chart shows that the ALOS for detainees with felony charges is consistently higher than the ALOS for detainees with misdemeanor charges, which is expected. The ALOS for both populations have increased from 2009 to 2018.

The ALOS for detainees with felony charges increased from 16.52 days in 2009 to 19.74 days in 2018, an increase of 19.5 percent. The ALOS for detainees with misdemeanor charges increased from 5.09 days in 2009 to 5.91 days in 2018, an increase of 16.0 percent.

Figure 55: ALOS by Charge

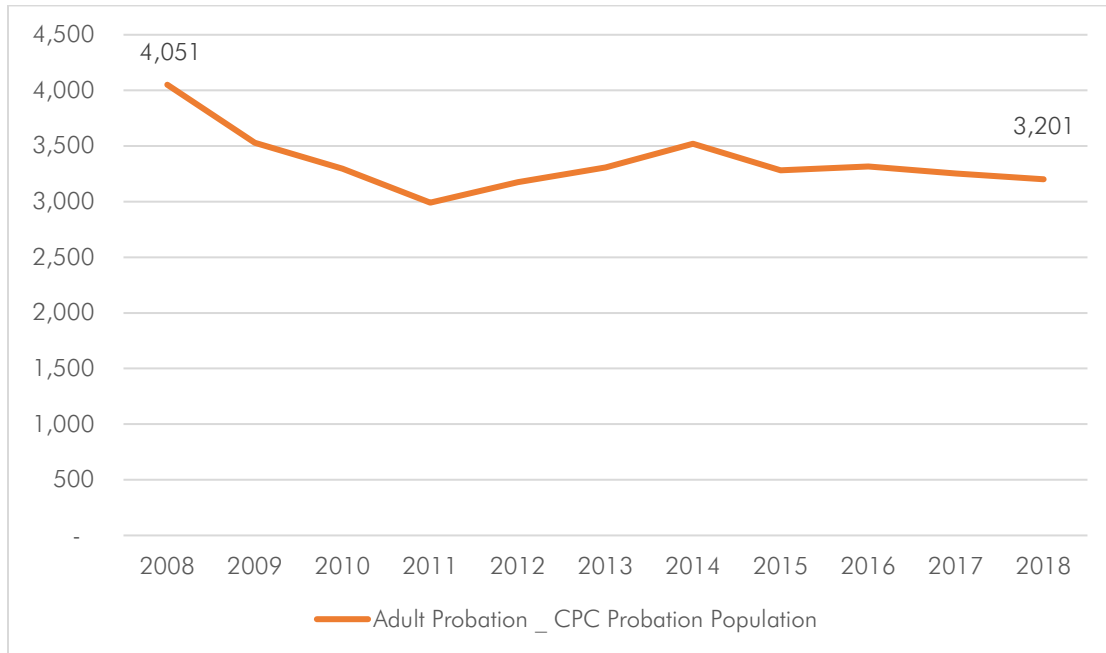


Source: Montgomery County Sheriff's Office

Probation Caseload

Adult probation data is from the Montgomery County Common Pleas Court. Figure 56 shows the annual adult probation population from 2008 to 2018.

Figure 56: Historic Probation Population

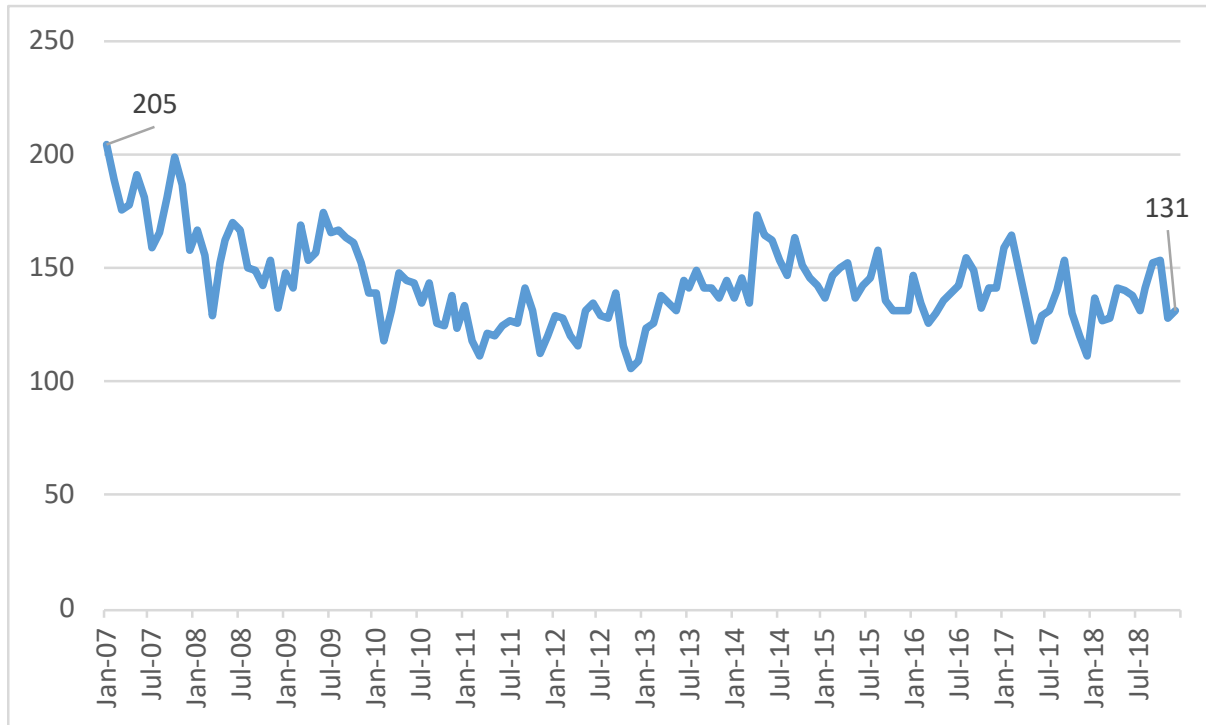


Source: Montgomery County Common Pleas Court

The probation population has decreased from 4,051 in 2008 to 3,201 in 2018, a decrease of 21.0 percent. The annual probation population peaked in 2008. The lowest annual probation population was in 2011 at 2,991.

Figure 57 shows the monthly ADP of detainees at the Montgomery County Jail that are on probation with other charges. The average ADP of detainees at the Montgomery County Jail that are on probation with other charges from January 2007 to September 2019 was 138. From January 2007 to September 2019, the ADP of detainees at the Montgomery County Jail that are on probation with other charges decreased 18.9 percent, from 205 to 131.

Figure 57: Jail Population: Probation with Other Charges



Source: Montgomery County Common Pleas Court

Forecast Correctional System Needs. The development of the needs assessment projection model centered around fifteen forecast models to the year 2050. The primary factors used for the models were the ADP, ADM, ALOS, reported crime, criminal caseload and population projections for Montgomery County and the State of Ohio.

The models are grouped into three major categories: systems based statistical models, demographic based models, and time series models. The fifteen projection models used different independent variables and statistical methods to analyze and project historic data. The 2018 annual average daily population served as the base year.

The following is a description of each model, broken into the three modeling categories.

System Based Statistical Models

Model 1 – Historic Trend Percentage Change calculates the total percentage change from the beginning point to the end point of the historic data series. The annual percentage increase rate used in the model was applied to the base year 2018 and subsequent years to calculate future daily counts.

Model 2 – Historic Compound Annual Growth Rate (CAGR) uses the historic annual growth rates to determine a percentage of growth. Often used in financial forecasting, the CAGR is applied to the projection end date of 2050.

Model 3 – Mean Deviation compares the peak year population to the average from the historic data. The model is standardized by dividing the number of years observed. The mean deviation model shows the high points in most models as it is projected forward.

Demographic Based Models

Model 4 – Ratio of ADP to County Population uses the total ADP and compares it to the county population. The projected figure applies the average ratio of total ADP to the projected county population to the year 2050.

Model 5 – Ratio of ADP to At Risk County Population uses the total ADP and compares it to the county at risk population. The projected figure applies the average ratio total ADP to the projected county at risk resident population to the year 2050.

Model 6 – Reported Crime/Average Daily Population uses historic reported crime rate in the county to project average daily population to the year 2050. The existing, average, high and low average arrest rates are calculated using historic data.

Model 7 – Incarceration Rate to Montgomery County Population determines the incarceration rate per County population. The existing, average, high and low population incarceration rates are applied to the projected Montgomery County population projections to the year 2050.

Model 8 – Incarceration Rate to Montgomery County at Risk Population determines the incarceration rate per County at risk population. The existing, average, high and low population incarceration rates are applied to the projected Montgomery County at risk population projections to the year 2050.

Model 9 – Book-ins/Average Length of Stay uses historic book-ins to project book-ins to the year 2050. The existing, average, high and low average length of stay in days is calculated using historic data and applied to the projected book-ins to determine a projected ADP.

Model 10 – Probation Population/Average Daily Population uses historic probation population in the county to project average daily population to the year 2050. The existing, average, high and low probation population rates to jail ADP are calculated using historic data.

Model 11 – Criminal Caseload/Average Daily Population uses historic criminal caseload in the county court system to project average daily population to the year 2050. The existing, average, high and low average criminal court caseload rates compared to jail ADP are calculated and applied to projected caseload.

Time Series Modeling

Model 12 – Linear Regression determines a best fit line considering the historic total detainee ADP over time. This best fit line is extended to the year 2050.

Model 13 – Multiple Regressions determines a best fit line considering the historic total ADP over time, book-ins and county population. This best fit line is extended to the year 2050.

Model 14 – Box-Jenkins ARIMA uses an Autoregressive Integrated Moving Average technique from a computerized formula. This model is used typically for accurate short-term projections of data that shows predictable repetitive cycles and patterns. The Box Jenkins model uses historic annual data from 2008 to 2018.

Model 15 – Exponential Smoothing ARIMA identifies levels and trends by smoothing the latest data points to decrease irregularity and adds a seasonality factor. The seasonal indexes are obtained by smoothing seasonal patterns in the historic data. Exponential Smoothing is an alternate ARIMA model. The exponential smoothing model gives older data progressively-less weight while new data is weighted more. The Exponential Smoothing model uses historic annual data from 2008 to 2018.

Models determined to have appropriate statistical reliability and significance were weighted equally to determine forecast figures. For the ARIMA models, the r-squared values below 0.8 were not used in the final average. R-squared shows the amount of explained variance in the statistical model. There are no concrete levels for acceptable r-squared.

All statistically significant models, with at least one from each of the three subsections, were selected and averaged. Each model presents a differing snapshot to the future that is beneficial to the final projection. While one must recognize that all have limitations and precautions in the forecasting model, the averaging of multiple models dampens the extremes and finds some model agreement necessary for long-range projections.

Key Assumptions

Model 1 – Status Quo Projections

The status quo projections extend the trends in demographics and ADP counts forward 32 years without factoring in changes in attitude in crime, legislation, policy changes or any other factor that could potentially impact the number of detainees in the system. The key assumption in the Status Quo projection is that existing conditions will extend into the forecast horizon. The middle series of the status quo model is the recommended model.

Model 2 – Upper and Lower Bound Projections

The lower bound and upper bound projection use the same models used in the status quo projections; however, they use the corresponding lower and upper ratios for the incarceration rate model and the book-ins/length of stay models for example. The lower and upper bound series also use the 95 percent bounds for the regression and ARIMA models.

Average Daily Population Projections

The ADP projections employ eleven models of the fifteen considered. The only models excluded from the projection model were Probation Population to ADP, Reported Crime to ADP, ARIMA Exponential Smoothing and the Linear Regression models.

The eleven models used were given equal weight. Projections are presented in five-year increments to the year 2050.

The recommended model has the ADP projected to increase to 903, an increase of 11.9 percent over 30 years.

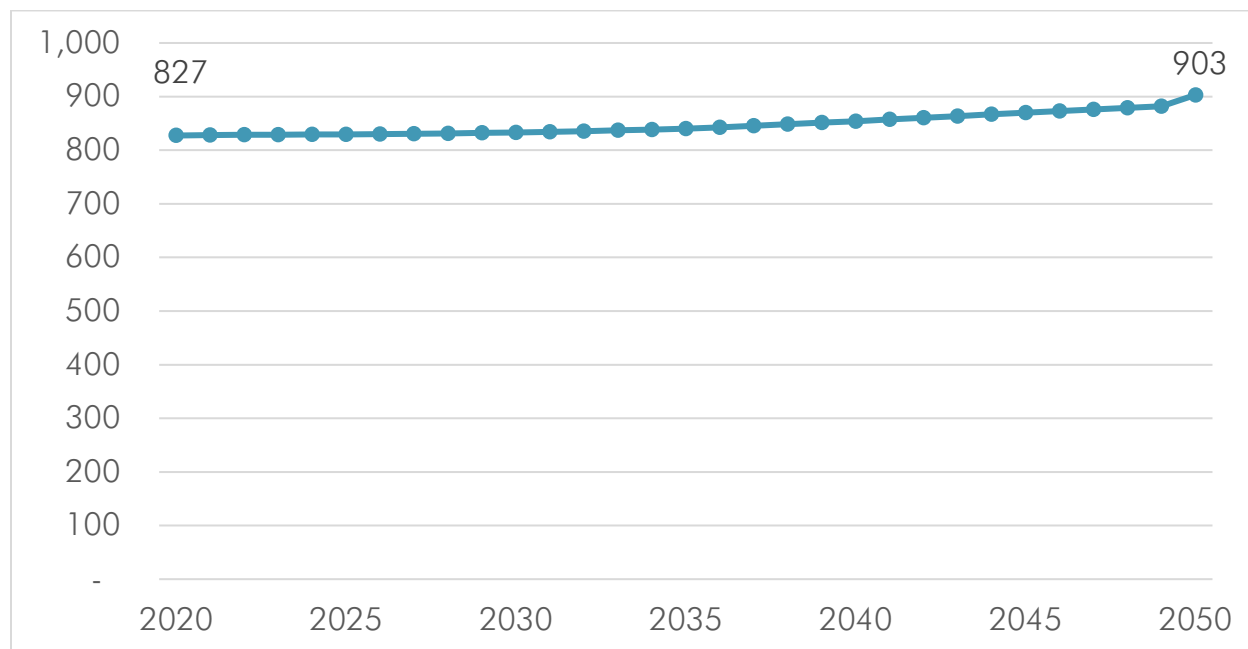
Figure 58: Projected ADP

	2020	2025	2030	2035	2040	2045	2050	% Total Change	% Annual Change
Projected ADP	827	829	833	840	854	870	903	11.9%	0.4%

Source: CGL

The historic and projected recommended total ADP is plotted on Figure 61.

Figure 59: Historic and Projected ADP – Recommended Model



Source: CGL

Jail Bed Space Need Projections – Recommended Model

Criminal justice facilities cannot be planned for the ADP solely; peaks in population must be accommodated, along with beds for differing detainee classification. A peaking factor accounts for seasonal variations in the detainee population. There needs to be enough beds to accommodate seasonal increases without overcrowding. The peaking value of the Montgomery County jail is calculated using monthly data from January 2008 to December 2018. The percentage difference from the highest month was compared to the annual ADP for each year to determine the peaking factor of 8.9 percent for Montgomery County.

A classification factor accounts for a fluctuation in the type of detainees held at any given time. There may be times where there are more maximum-security detainees than the average number, conversely there may be times when there are more minimum-security detainees than the average. There needs to be enough flexibility in the type of beds at any given time to provide appropriate separations between the classification levels of detainees. It is very difficult or impossible to ascertain a historic percentage for a classification factor, as systems do not retain classification data in an aggregate manner historically. As such, CGL applies 6 percent for a classification factor based on experience working with similar sized jails.

The peaking and classification factors are added together and then added to the projections to calculate the number of beds needed. Taking these factors into account, the projected jail bed space need for Montgomery County is 957 in 2030, 981 in 2040 and grows to 1,038 beds in 2050.

Figure 60: Projected Capacity Needs

	2020	2025	2030	2035	2040	2045	2050	% Total Change	% Annual Change
Projected Bed Needs	951	953	957	965	981	1,000	1,038	11.9%	0.4%

Source: CGL

The recommended ADP and jail bed space projections are based on status quo conditions moving forward in time.

Projected Jail Beds by Gender

Disaggregate projections by gender are based on the annual ADP and from 2009. The overall ADP projection models were used with gender-specific population to determine ADP projections by gender.

The projected jail bed space need for females in Montgomery County grows from 180 in 2018 to 207 in 2050, an increase of 15.2 percent. The number of male bed space needed in Montgomery County increases from 729 in 2018 to 795 in 2050, an increase of 8.9 percent, see Figure 61.

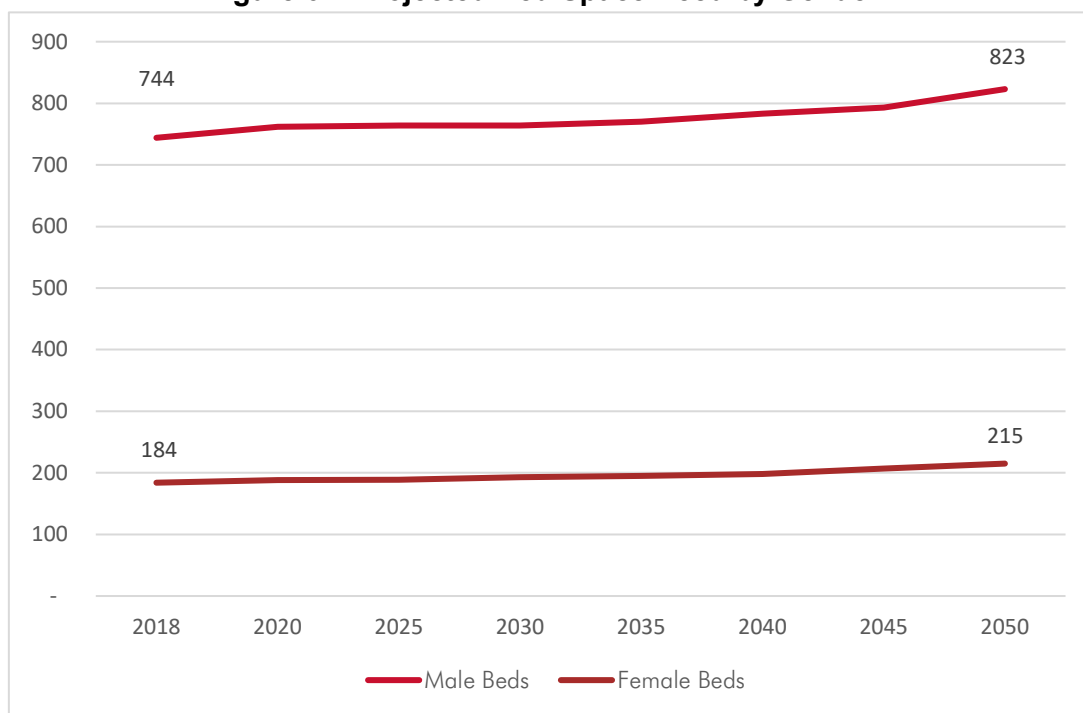
Figure 61: Projected Bed Space Need by Gender

	2020	2025	2030	2035	2040	2045	2050	% Total Change	% Annual Change
Male	762	764	764	770	783	793	823	10.6%	0.3%
Female	188	189	193	195	198	207	215	16.8%	0.5%
Total Beds	951	953	957	965	981	1,000	1,038	11.9%	0.4%

Source: CGL

Figure 62 plots the projected bed space need in Montgomery County to 2050 by gender.

Figure 62: Projected Bed Space Need by Gender



Source: CGL

The female jail population increased by 10.0 percent from 2009 to 2018 while the male jail population decreased by 5.3 percent during the same time period. While the female jail population has been 18.7 percent of the overall jail population on average, it has been increasing in the past 5 years. This increase is reflected in the female bed projections.

Projected Jail Beds by Classification

Disaggregate projections by classification are based on the monthly population breakdown provided by Montgomery County. The percentage of felony detainee and misdemeanor detainee populations was translated to bed space need and extended to 2050.

Figure 63 shows the greatest demand for beds is felony detainee beds, growing by 11.3 percent from 2018 to 2050. The felony detainee bed space need is 771 in 2050. The misdemeanor detainee bed demand grows at a slower pace than the felon bed space need. The misdemeanor detainee bed space need in 2050 is 230, an increase of 6.4 percent from 2018.

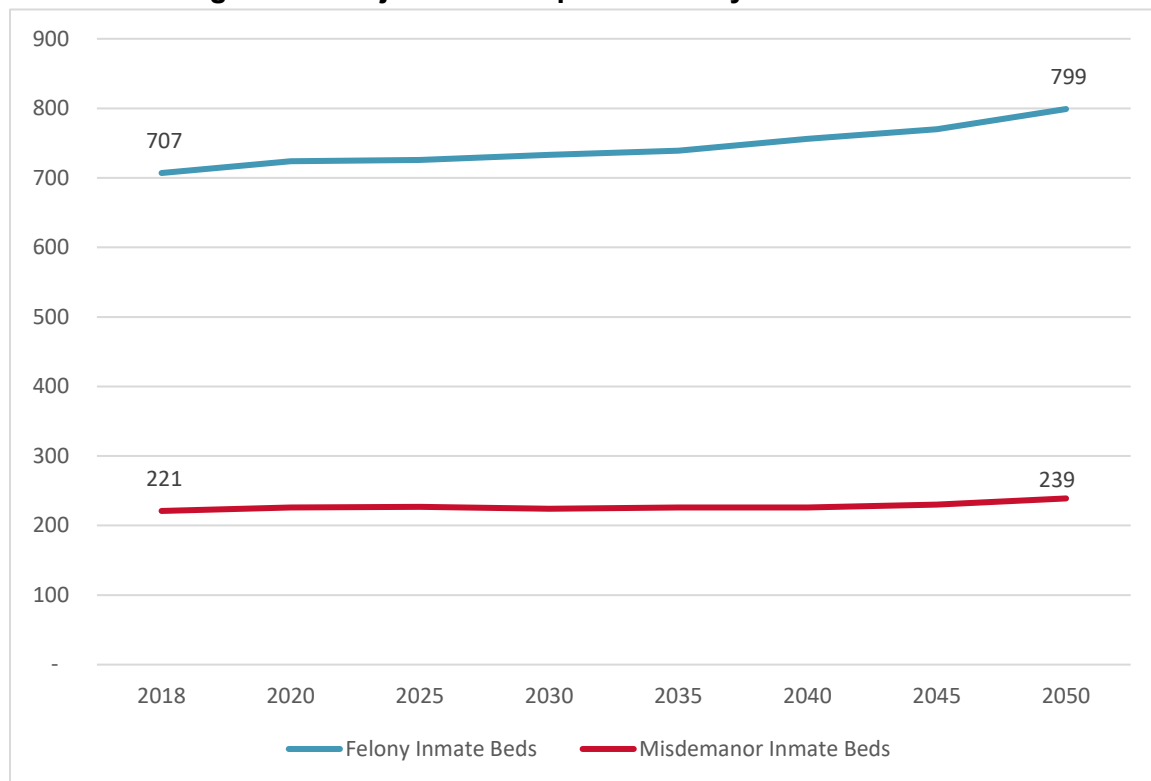
Figure 63: Projected Bed Space Need by Classification

	2020	2025	2030	2035	2040	2045	2050	% Total Change	% Annual Change
Felony	724	726	733	739	756	770	799	13.0%	0.4%
Misdemeanor	226	227	224	226	226	230	239	8.1%	0.2%
Total Beds	951	953	957	965	981	1,000	1,038	11.9%	0.4%

Source: CGL

Figure 64 plots the historic and projected bed space need for felony and misdemeanor detainees to the year 2050.

Figure 64: Projected Bed Space Need by Classification



Source: CGL

The increasing bed space need for the typically more serious offenders with felony charges is consistent with the current local trends with lower book-ins but higher ALOS.

Conclusion

Many of the criminal justice variables in Montgomery County have been decreasing in the past decade, including total ADP, book-ins, resident population, at risk population, reported crimes, probation population and criminal caseload. The driving factor for the small growth in jail bed need to 2050 is the growing length of stay of detainees and the number of higher security felons held in the jail.

It is critical to stress that these projections are for general population jail beds. As noted in our analysis of the jail's medical and mental health services programs, the jail also has a substantial need for dedicated capacity for detainees with medical needs and mental health treatment. Disciplinary segregation beds and beds for juvenile offenders who must be kept separate from adults are also not included in this projection. Our analysis indicates an ongoing need for approximately 150-200 beds to meet this need. This suggests the County should plan for a facility that will support approximately 1,134 beds to manage both general population and special needs detainees.

There are two primary paths toward development of a facility with this capacity: construction of a new 1,134 bed facility, or; renovation of a 250-bed pod in the existing facility combined with construction of a new, 950-bed addition to the jail.

It should be noted that these projections assume the status quo in terms of current state and local criminal justice system policies. At the state level, Ohio is considering a number of "justice reinvestment" initiatives that will have wide-ranging impacts on local justice systems. Although it is premature to plan for the implementation of these initiatives, the experience of other states suggests that these measures have the potential to increase county jail populations and program service requirements.

Appendix A. Request/Referral for Mental Health Services



Falcon Correctional and Community Services, Inc.
155 N. Wacker Dr., Suite 4250, Chicago IL 60606

MHF #001
Telephone (312-803-5666)

REQUEST OR REFFERAL FOR MENTAL HEALTH SERVICES

Note: This form must be filled out for all requested mental health services or for all inmates referred for services.

ORIGIN:			
Inmate Name: _____ DOB: _____ Date: _____ Time: _____			
Jail ID #: _____ Housing Area : _____ Unit: _____			
Staff Making Request or Referral : _____ Title: _____ Dept: _____			
REASON FOR REFERRAL:			
<input type="checkbox"/> Unusual Behavior <input type="checkbox"/> Inappropriate Behavior <input type="checkbox"/> Refusing Medications <input type="checkbox"/> Other			
Describe: _____			
OBSERVATIONS:			
BEHAVIOR	PERCEPTION/ COGNITION	MOOD	PERSONAL HYGIENE
<input type="checkbox"/> Sleeping problems <input type="checkbox"/> Eating problems <input type="checkbox"/> Unable to Sit Still <input type="checkbox"/> Sits alone all the time <input type="checkbox"/> Talks very rapidly <input type="checkbox"/> Talks very slowly <input type="checkbox"/> Paces all the time <input type="checkbox"/> Wanders aimlessly <input type="checkbox"/> Does not speak at all <input type="checkbox"/> Talks loud all the time <input type="checkbox"/> Whispers <input type="checkbox"/> Trembles, shakes <input type="checkbox"/> Wrings hands <input type="checkbox"/> Unusual gait <input type="checkbox"/> Steals from others <input type="checkbox"/> Stares into space <input type="checkbox"/> Other _____	<input type="checkbox"/> Visual hallucinations <input type="checkbox"/> Auditory hallucinations <input type="checkbox"/> Excessive religiosity <input type="checkbox"/> Excessive preoccupation <input type="checkbox"/> Extremely paranoid <input type="checkbox"/> Suspicious <input type="checkbox"/> Assaultive <input type="checkbox"/> Suicidal <input type="checkbox"/> Unable to concentrate <input type="checkbox"/> Confused <input type="checkbox"/> Doesn't know what he's doing <input type="checkbox"/> Doesn't know where he is <input type="checkbox"/> Doesn't know who he is <input type="checkbox"/> Other _____	<input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Happy <input type="checkbox"/> Laughs all the time <input type="checkbox"/> Euphoric <input type="checkbox"/> Anxious <input type="checkbox"/> Irritable <input type="checkbox"/> Changing moods (labile) <input type="checkbox"/> Other _____	<input type="checkbox"/> Clean and Neat <input type="checkbox"/> Unclean <input type="checkbox"/> Disheveled <input type="checkbox"/> Untidy <input type="checkbox"/> Exudes body odor <input type="checkbox"/> Does not take showers <input type="checkbox"/> Careless <input type="checkbox"/> Very poor grooming <input type="checkbox"/> Other _____
MENTAL HEALTH DEPARTMENT USE ONLY			
DISPOSITION:			
Received by: _____ Date: _____ Time: _____			
Response (Action Taken): _____			