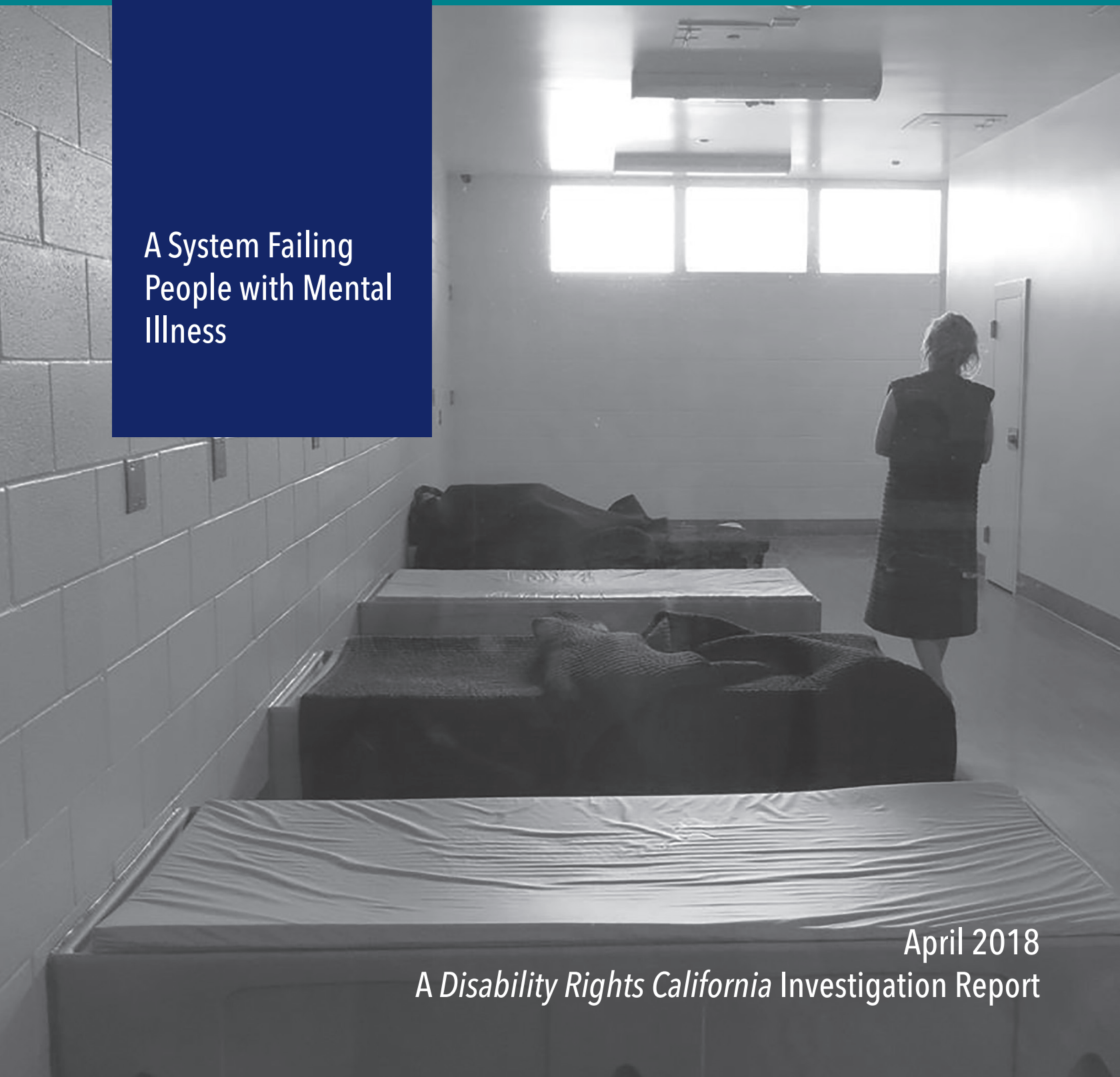


SUICIDES IN SAN DIEGO COUNTY JAIL

A System Failing
People with Mental
Illness



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A Disability Rights California Investigation Report

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An accessible electronic version of this report is available at:
<http://www.disabilityrightsca.org/JailsReports/SDsuicideReportAccessible.pdf>

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<http://www.disabilityrightsca.org/JailsReports/SDsuicideReport.pdf>

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*Cover Photo: Mental Health Enhanced Observation Housing (EOH) Unit at the
Las Colinas Detention and Reentry Facility*

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-Karen Higgins, M.D., Robert Canning, Ph.D., CCHP	

I. EXECUTIVE SUMMARY

San Diego County faces a crisis in its jail system. It has the highest reported number of suicides in a California jail system over several years – more than 30 suicide deaths since 2010. The inmate suicide rate has been many times higher than the rate in similarly sized county jails in California, the State prison system, and jails nationally. This is a crisis demanding meaningful action.

While the County reported just one inmate suicide in 2017, which is a welcome decrease compared to previous years, the system remains deeply challenged. The incidence of inmate suicide attempts and serious self-harm remains extremely high - a rate of approximately two (2) per week. The frequency of suicide attempts indicates that the County must improve its treatment of people with mental health needs.

Recognition that San Diego County has a problem with suicides and other deaths at the jail is not new. There has been a steady drumbeat of calls to action, from the County's grand juries, the media, and people who have been incarcerated at the jail and their loved ones.

As the designated protection and advocacy system charged with protecting the rights of people with disabilities in California, Disability Rights California (DRC) opened an investigation into conditions at the San Diego County jails in 2015. We conducted tours of the County's jail facilities, and completed extensive interviews with Sheriff's Department leadership, jail staff, and jail inmates. We have reviewed thousands of pages of relevant policies and procedures, Sheriff's Department records, and individual inmate records.

Our investigation focuses on four interconnected aspects of San Diego's County jail and mental health systems. We provide specific Recommendations regarding each.

Over-Incarceration of People with Mental Health Needs. First, we found that there is an extremely high number of jail inmates with significant mental health treatment needs. The County's mental health care system, both inside and outside of the jail, has long operated in a way that leads to the dangerous, costly, and counter-productive over-incarceration of people with mental health-related disabilities. This includes a historical failure to provide sufficient community-based mental health services and supports that help individuals with mental health needs to thrive and avoid entanglement with the criminal justice system and incarceration. There is an urgent need for a better approach. We found that the County's recently developed Mental Health Services Act Plan and related initiatives – including increased community based-services and diversion/reentry efforts – provide a reason for optimism. Of course, the County's efforts will be judged on outcomes in the months and years ahead.

Deficiencies in Suicide Prevention. Second, our two subject matter experts, who reviewed inmate suicide cases as well as relevant policies, identified significant deficiencies in the County's suicide prevention practices. These experts, Karen Higgins, M.D., and Robert Canning, Ph.D., CCHP, have considerable expertise in suicide prevention and mental health treatment in detention facilities. They have completed a detailed written report (Appendix A), which identifies twenty-four (24) Key Deficiencies in the County's system and provides forty-six (46) Recommendations to address those deficiencies. While we are convinced that the Sheriff's Department has begun to take the issue of suicide prevention seriously, there remain many aspects of the system's treatment of people at risk of suicide that require urgent action.

Failure to Provide Adequate Mental Health Treatment. Third, we found that the County's jail system subjects inmates with mental health needs to a grave risk of psychological and other harms by failing to provide adequate mental health treatment. Making matters worse, the County subjects inmates to dangerous solitary confinement conditions that take an enormous toll on individuals' mental health and well-being. A substantial number of the suicides in San Diego County's jails have occurred in designated segregation units and other units with solitary confinement conditions. Even with committed jail leadership and staff efforts to reduce solitary confinement and improve conditions, insufficient staffing and lack of other critical resources have caused these problems to persist.

Lack of Meaningful, Independent Oversight. Fourth, we found that the existing systems of jail oversight have failed. The time has come for the County to create an independent and professional oversight entity to monitor jail conditions, suicide prevention and mental health treatment practices, and other jail operations. A truly effective independent oversight entity, building on the models developed in Los Angeles County, Santa Clara County, Sonoma County, and other jurisdictions across the country, would enhance the County's efforts to address its historical challenges in its jails, help to achieve and solidify system improvements, and strengthen the trust of the community through greater transparency.

We have found that the County's jails have the great advantage of committed mental health staff and a number of strong leaders within the Sheriff's Department. They will need sustained investment and support from the County – along with true transparency and accountability – to achieve a durable solution to the inmate suicide crisis, the deficiencies in mental health treatment inside the jail, and the over-incarceration of people with mental health needs.

II. A TROUBLED HISTORY OF SUICIDES IN THE COUNTY JAILS

A. Inmate Suicides: A Crisis by Any Measure

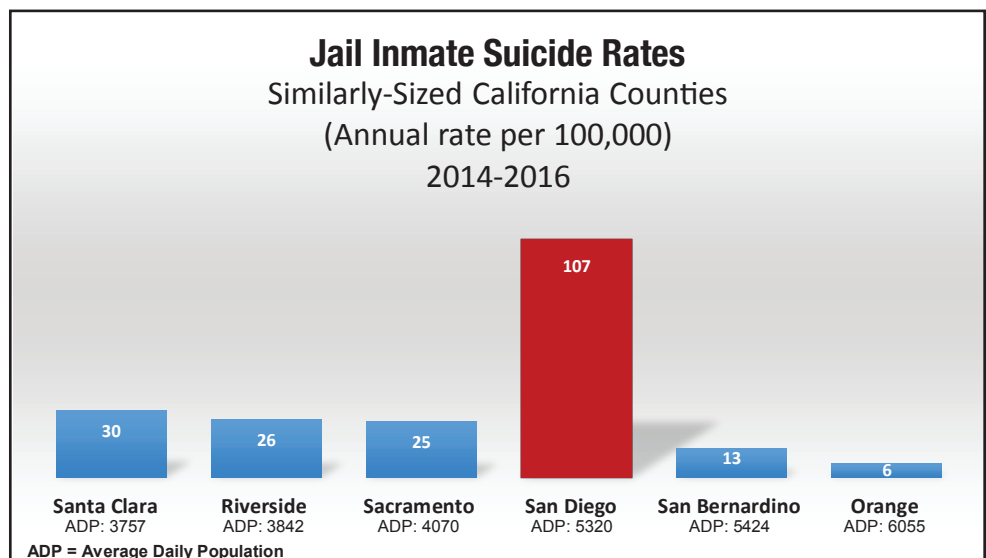
San Diego County Jail has had one of the highest incidences of suicides in a California county jail system over several years – more than 30 suicide deaths since 2010.¹ By any measure, the number of suicide deaths in San Diego County's jails over a period of many years indicates a crisis demanding meaningful action.

DRC investigated inmate suicides during the three-year period from 2014 to 2016. Seventeen (17) people died by suicide in a San Diego County Jail facility during this time period. Among those deaths:

- Fourteen (14) people (82.3%) had a clear history and indication of mental health needs. Several had attempted suicide in the past, sometimes while in the community and often during earlier periods of incarceration.
- Nine (9) people (52.9%) were in jail on non-violent charges, including several cases involving only drug-related offenses.
- Fifteen (15) people (88.2%) were in jail awaiting trial. (One other was in jail for a brief "flash incarceration" related to a probation violation.) These individuals were not in jail because of a criminal conviction at the time of their death. They maintained the presumption of innocence embedded in our laws.
- At least six (6) people (35.3%) were housed in designated solitary confinement housing at the time of their suicide. Several more were in units that we observed to have solitary confinement conditions.
- At least four (4) people (23.5%) had one or more serious medical conditions at the time of their suicide death.

San Diego County's inmate suicide rate has been staggeringly high compared with national, statewide, and local data. In 2016, the County's jail inmate suicide rate was approximately 93.8 per 100,000, similar to the rates for 2015 and 2014 (120.3 and 106.2 per 100,000, respectively).² The average annual inmate suicide rate for San Diego County during this three-year period (107 per 100,000) is more than double the jail inmate suicide rate nationally for 2014 (50 per 100,000), the last year for which complete data is available.³

From 2014 to 2016, the seventeen (17) inmate suicide deaths in San Diego County far outpaced other large California county jail systems. For example,



the Orange County Jail system had one suicide and the Riverside and Sacramento County Jail systems each had three (3) suicides during this three-year period.⁴

Even the Los Angeles County Jail system, which has an inmate population more than three (3) times larger than the San Diego County Jail population and a history of significant problems related to inadequate suicide prevention and treatment of people with mental health needs, had eight (8) suicide deaths during this three-year period, less than half as many as San Diego County.⁵

San Diego County's jail inmate suicide rate has also vastly exceeded (by a factor of 5) the annual inmate suicide rate in California's State prison system (21.8 per 100,000 from 2013 to 2016).⁶ While local jails generally have higher inmate suicide rates than state prisons, we note that California's prison system has itself been under federal court supervision based in part on the prevalence of inmate suicides.

*San Diego County
Jail inmates are*

8X

*more likely to die
by suicide than the
average San Diego
County resident.*

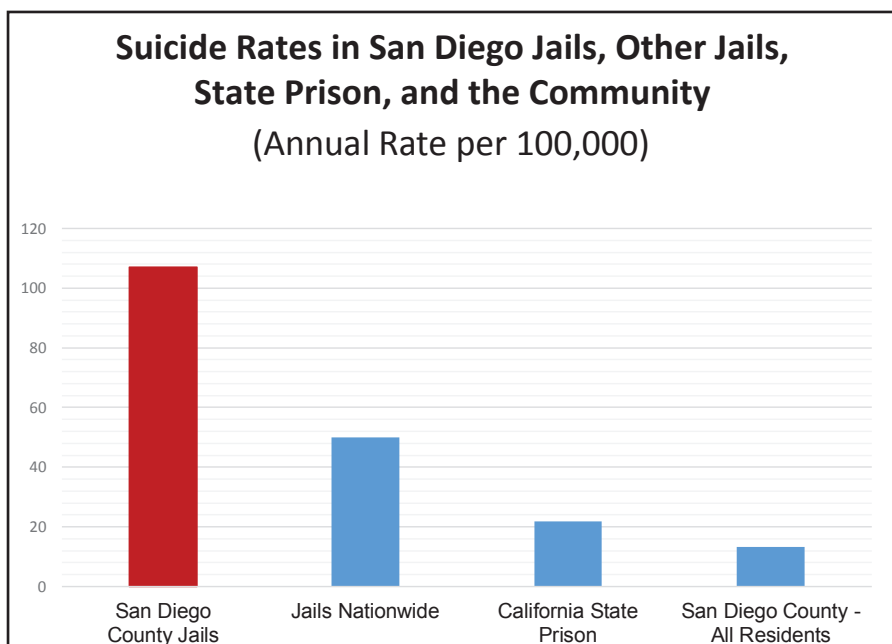
Detention in San Diego County Jail facilities appears to increase the risk of suicide significantly for San Diego County residents. The jail system's inmate suicide rate has been nearly eight (8) times higher than the overall suicide rate for San Diego County (13.1 out of 100,000).⁷

As of this writing, San Diego County has reported one jail inmate suicide during 2017. Another inmate suicide reportedly occurred in March 2018. While this is a decrease in the number of suicide deaths compared to previous years, it does not establish that the County has achieved an enduring solution. Suicide rates are most meaningful when viewed over a sustained period of time. Although the number of inmate suicides in a given year is no doubt an important indicator as to the adequacy of a

system's policies and practices, it is not the sole barometer by which a system's adequacy should be measured.

There are additional reasons for caution with respect to the reported decrease in inmate suicides. First, the County has had other periods with few or no suicides, only to see a return to previous levels. For example, a seven-and-one-half month period without a San Diego jail inmate suicide death (January 2015 - August 2015) was followed by a spate of suicide deaths in late 2015 and into 2016.

Second, our investigation



revealed that there continue to be a significant number of inmate suicide attempts and serious acts of self-harm. We reviewed 73 San Diego County Sheriff's Department incident reports that document distinct "Suicide Attempts" which occurred between the beginning of January 2017 and September 11, 2017. Many of these incidents were very serious and required emergency medical care. They include dozens of attempted hangings and self-strangulations, many jumps off the top tiers of jail housing units, and attempted overdoses. Such incidents occurred at a rate of approximately two (2) per week, which is consistent with the rate of "suicide attempts" reported for previous years – 107 in 2016, and 82 in 2015.

The County has stated to DRC that it began utilizing new definitions for "Suicide Attempt" and "Non-Suicidal Self Injury" in 2017. Under these definitions, the County determined that just 10 of the 73 incidents reported as "Suicide Attempts" were in fact suicide attempts under the new definition.

However such incidents are categorized, the continued frequency of inmate suicide attempts and serious acts of self-harm indicates that the treatment of people with mental health needs requires significant improvement.

Suicide Rate Calculations

In examining suicide rates, DRC follows the methodology for calculating annual mortality rates, per 100,000 inmates, which is used by the United States Department of Justice. Experts in the field have found that this methodology is useful and "enhances our understanding of the jail suicide problem."⁸

The County has suggested an alternative method of calculating inmate suicide rate, which considers the estimated "racial distribution" of the inmate population in San Diego County's jails and in other county jail systems. The basis for this methodology is that San Diego County has an uncommonly high percentage of white inmates, who are statistically at higher risk of suicide compared to African American and Latino inmates.

The fact that San Diego County may have a higher-than-average number of inmates at elevated risk of suicide only *adds* urgency to the need for action. As Raymond F. Patterson, M.D., a national expert in forensic psychiatry and correctional suicide prevention, has written:

If [a detention system] do[es] in fact house groups of persons who tend to have higher rates of suicide, [the system] is therefore on notice of this elevated suicide risk factor and has a duty to address that risk in its suicide prevention efforts. Awareness of a higher propensity to suicide among certain groups requires greater vigilance on the part of [the system], not a reason for acquiescence.⁹

Whatever the methodology for evaluating suicide rates, the number of suicides in San Diego County's jails in recent years is a cause for extreme concern.

B. Repeated Calls for Action

Local advocates and media have called attention to the dangerous conditions and large number of suicides and other deaths in San Diego County Jail facilities. There is an extensive public record documenting the tragic loss of lives, systemic failures, and inadequacy of oversight.¹⁰ Families of those who have died have filed lawsuits alleging that the County and jail staff acted with deliberate indifference to inmates' serious mental health, medical, and related needs.¹¹

Under the leadership of Dr. Alfred Joshua, the chief medical officer, the Sheriff's Department implemented a new Inmate Safety Program in 2015. This program included a number of changes to policy and training, and created new "Enhanced Observation Housing" (EOH) units for individuals meeting criteria indicating possible suicide risk. In spite of these efforts, the number of suicides remained high through 2016. (As discussed in Section IV.C.4, we have serious concerns regarding the harsh conditions and lack of mental health treatment in the EOH units.)

In Spring 2017, a San Diego Grand Jury issued a report regarding the alarmingly high inmate suicide rate. The Grand Jury found that "46 people have committed suicide in San Diego County jails in the past 12 years," noting that the County's inmate suicide rate is "the highest in all of California's large county jail systems."¹²

The Grand Jury recognized a number of steps the Sheriff's Department has taken in response to the inmate suicide crisis, including the addition of EOH units, Safety Cells (which, as we discuss later, are essentially small, empty padded rooms), and medical isolation cells, with related updates to policies and procedures.¹³

At the same time, the Grand Jury found that the Sheriff's Department continues to have inadequate suicide prevention training for jail staff, problematic gaps in personnel, and deficiencies in oversight. The Grand Jury concluded that "increased efforts in suicide prevention are required."¹⁴

On June 29, 2017, Sheriff Gore filed a Response to the Grand Jury's report. He promised a comprehensive suicide prevention policy, additional suicide prevention training, and formation of a Suicide Prevention Response & Improvement Team (SPRIT) to update policies and oversee staff training.¹⁵

Through our investigation, we are convinced that the Sheriff's Department has begun to take the issue of suicide prevention seriously. However, there remain many aspects of the system's treatment of people who have mental health needs, or who are at risk of suicide, that require urgent action. Individuals with mental health needs continue to suffer in San Diego County's jails, and remain at extraordinary risk of harm.

III. SCOPE OF DRC INVESTIGATION AND EXPERTS

A. DRC Investigation Process

Disability Rights California (DRC) is the state's designated protection and advocacy system, charged with protecting the rights of people with disabilities in California.¹⁶ DRC has the legal authority to inspect and monitor conditions in any facility that holds people with disabilities.¹⁷

Pursuant to this authority, DRC opened its investigation into San Diego County Jail based on reports from advocacy groups and community members, individuals with disabilities who have been incarcerated in the County's jails, as well as public and media reports regarding conditions in the County's jail system.

DRC toured four San Diego County Jail facilities that contain units designated for inmates with mental illness: (1) Central Jail, (2) George F. Bailey Detention Facility, (3) Vista Detention Facility, and (4) Las Colinas Detention and Reentry Facility. We toured facilities on May 5 and 6, 2015 and returned for follow-up inspections on November 2 and 3, 2016. We viewed areas accessible to inmates, including the booking/intake area, holding cells, sobering cells, safety cells, health care treatment areas, recreational and program areas, visitation areas, and housing units. During the tour, staff provided information and answered questions about the facilities and programs. We spoke with scores of inmates in the housing units, either at cell-front or face-to-face in common areas. We also conducted confidential interviews with numerous inmates throughout our investigation.

DRC reviewed publicly available documents and obtained records from the Sheriff's Department through California Public Records Act requests, DRC's access authority¹⁸, and signed releases from inmates. We reviewed thousands of pages of relevant policies and procedures, Sheriff's Department records, and individual inmate records.

Based on our initial inspection of the facilities, and pursuant to our protection and advocacy system authority, we found probable cause to conclude that prisoners with disabilities are subjected to abuse and/or neglect in the San Diego County Jail.¹⁹ We continued our investigation, leading to this report.

B. Expert Analysis on San Diego Jails' Suicide Crisis

While the recent investigation efforts of the Grand Jury and other entities have been admirable and provide important recommendations, we determined that the County's inmate suicide crisis and related issues with inadequate mental health treatment warranted an independent, in-depth expert assessment.

DRC retained two subject matter experts to review inmate suicide cases

going back to 2014 as well as relevant policies and procedures. These experts, Karen Higgins, M.D., and Robert Canning, Ph.D., CCHP ("DRC Experts"), have considerable experience and expertise in mental health treatment and suicide prevention in detention facilities.

Dr. Higgins served as the lead psychiatrist for the Denver City and County Jail system. She has also served as the statewide Chief Psychiatrist for the California Department of Corrections and Rehabilitation (CDCR). She has played leading roles in the development of policies related to correctional mental health care and suicide prevention.

Dr. Canning served as CDCR's statewide Suicide Prevention Coordinator for more than a decade, chairing the statewide suicide prevention committee, designing mental health and suicide prevention trainings, leading suicide prevention policy reforms, and building CDCR's quality improvement systems.

Dr. Higgins and Dr. Canning offer an important and independent perspective on San Diego County Jail's system. Their report (Appendix A) identifies twenty-four (24) Key Deficiencies and provides forty-six (46) Recommendations to address those deficiencies. See Section IV.B, below.

Dr. Higgins and Dr. Canning also completed two detailed reports on recent individual inmate suicides. These two reports, provided confidentially to the County, offer a model structure for the County to use to strengthen its own internal critical incident and suicide review processes for the future.

IV. DRC FINDINGS AND RECOMMENDATIONS

A. San Diego County Should End Its Over-Incarceration of People with Mental Illness and Improve Its System of Community-Based Mental Health Services.

As is the case in many counties, the jail facilities in San Diego County were not designed to provide adequate treatment to inmates with mental health needs.²⁰

Yet, San Diego County incarcerates an enormous number of people with mental illness. The Sheriff's Department has reported that approximately 40% of the jail population has a mental illness.²¹ That means there are some 2,000 people with mental illness in the County's jails at any one time, many of whom have very significant treatment needs.

The disproportionately high number of inmates with mental health needs is a problem that begins outside the jail system. Far too many people with serious mental health needs are ending up in San Diego County's jails. The County's recent planning and funding priorities for mental health services appear to take this challenge head-on, after years of lack of attention and investment. Of course, the County's efforts will be judged on outcomes.

By providing appropriate mental health services and taking proactive steps to keep people with mental health needs out of jail, communities can lower incarceration and recidivism rates and improve people's lives. When effective, such efforts are good for families, constitute smart utilization of public monies, and in fact enhance public safety.

In 2017, the County created a jail-based mental competency restoration program at the Central Jail, to provide restoration of competency services to inmates with pending criminal charges who are found "Incompetent to Stand Trial" (IST). The new program is a response to the lack of

DRC emphasizes three strategies for counties to end the dangerous, costly, and counter-productive over-incarceration of individuals with mental health needs:

1. Ensure a robust community mental health system that supports people with mental illness in ways that keep them out of the criminal justice system in the first place.
2. Divert individuals with mental illness who come into contact with law enforcement away from jail and into appropriate placements with services.
3. Help individuals with mental illness safely and successfully reenter their communities after being incarcerated, with effective continuity-of-care and services to assist with housing, food, and other basic needs.

available beds in the state hospital system and resulting delays in providing court-ordered treatment to the IST population.

The County has not, however, taken similar steps to create capacity for a community-based restoration of competency program. Jail-based programs are compromised by their non-therapeutic carceral setting, and can themselves be dangerous places.²² In contrast, community-based programs offer a cost-efficient, effective means of restoring IST patients to competency, while reducing unnecessary incarceration and improving mental health outcomes.²³

Historically, San Diego County's efforts with respect to community-based mental health services have fallen short. The County failed to invest available state funding for mental health services, including over \$100 million of Mental Health Services Act (MHSA) funding in 2017, with an additional \$42 million in reserves.²⁴

In June 2016, a Grand Jury documented the County's under-utilization of MHSA monies. The Grand Jury recommended that the County "appropriate a larger percentage of MHSA funds each year in order to improve services to a larger number of seriously mentally ill and at-risk county residents."²⁵

The last few months have shown some reason for optimism, with the County taking steps to substantially increase investment. In October 2017, the County approved its Mental Health Services Act Three-Year Program and Expenditure Plan: Fiscal Years 2017-18 through 2019-20 ("San Diego MHSA Plan").²⁶ This plan would represent a major investment, nearly \$570 million, in community-based mental health services and housing.²⁷ It includes over \$33 million for mental health programs targeted to help youth and adults entangled in the criminal justice system.²⁸ The plan marks an important step toward addressing the overrepresentation of people with mental health needs in the criminal justice system and subjected to incarceration.

The San Diego MHSA Plan provides for increased outreach to people with mental health needs in jail and links to community-based services, including Full Service Partnership (FSP)²⁹ and Assertive Community Treatment (ACT)³⁰ programs, mental health and substance abuse treatment, health care, and housing. Additional programs are aimed at diversion from jail, reducing recidivism, and court-sponsored alternatives to incarceration. Examples include the Collaborative Behavioral Health Court and ACT program, the Psychiatric Emergency Response Team (PERT), the Serial Inebriate Program (SIP), and Courage to Call, a veteran peer support program.³¹

The County appears to be exploring other programs to decrease the number of people with mental health needs in jail. In July 2017, the Board funded an alternative custody and community transition pilot program designed for people with mental health needs and co-occurring substance abuse disorders incarcerated for non-violent misdemeanor offenses. The program is designed to link participants with community-based mental health

treatment and reentry services, with the goal of reducing recidivism. The pilot program is funded to serve 24 individuals at a time.³²

The County's plans also recognize the importance of better data collection and outcome-based program evaluation. For example, the County recently passed a resolution supporting *Stepping Up: A National Initiative to Reduce the Number of People with Mental Illness in Jails*, which encourages development of a data-driven plan to achieve reductions in the number of people with mental illness in jail.³³

Implementation of the *Stepping Up* Initiative and programs included in the MHSA Plan remain in the early stages, and should move forward expeditiously. These efforts will require sustained funding in the months and years to come, adequate transparency, and self-critical analysis of progress and of where additional resources may be needed.

RECOMMENDATIONS

Ending Over-Incarceration of People with Mental Illness and Strengthening Community-Based Mental Health Services

Recommendation 1. Fully implement the County's three-year Mental Health Services Act (MHSA) Plan, with adequate transparency as to spending and program outcomes.

Recommendation 2. Focus investment on community-based services and treatment programming that help individuals with mental health needs to thrive and to avoid incarceration and entanglement with the criminal justice system.

Recommendation 3. Develop capacity for community-based competency restoration programs for individuals found Incompetent to Stand Trial (IST), so they can receive treatment in the least restrictive setting appropriate and do not languish unnecessarily in jail.

Recommendation 4. Strengthen reentry programming for individuals with disabilities to ensure continuity of care, including with respect to medication and other treatment, and access to job opportunities, housing, food, and other basic needs for successful reintegration into the community.

Recommendation 5. Ensure that the County's mental health programs are subject to rigorous data collection and self-critical analysis of progress and where additional resources may be needed.

B. San Diego County Should Address Systemic Deficiencies Illustrated by the High Rate of Inmate Suicides.

The DRC Experts, Dr. Higgins and Dr. Canning, reviewed jail policies as well as individual records for all suicides that occurred between December 2014 and the end of 2016. They identified twenty-four (24) “Key Deficiencies” in San Diego County Jail’s system, covering nine (9) components of an effective correctional suicide prevention program. They provide forty-six (46) Recommendations to improve the County’s suicide prevention and related mental health treatment delivery efforts. Their full Report is attached as Appendix A.

The DRC Experts found that San Diego County must improve its Jail Suicide Prevention efforts in nine (9) areas:

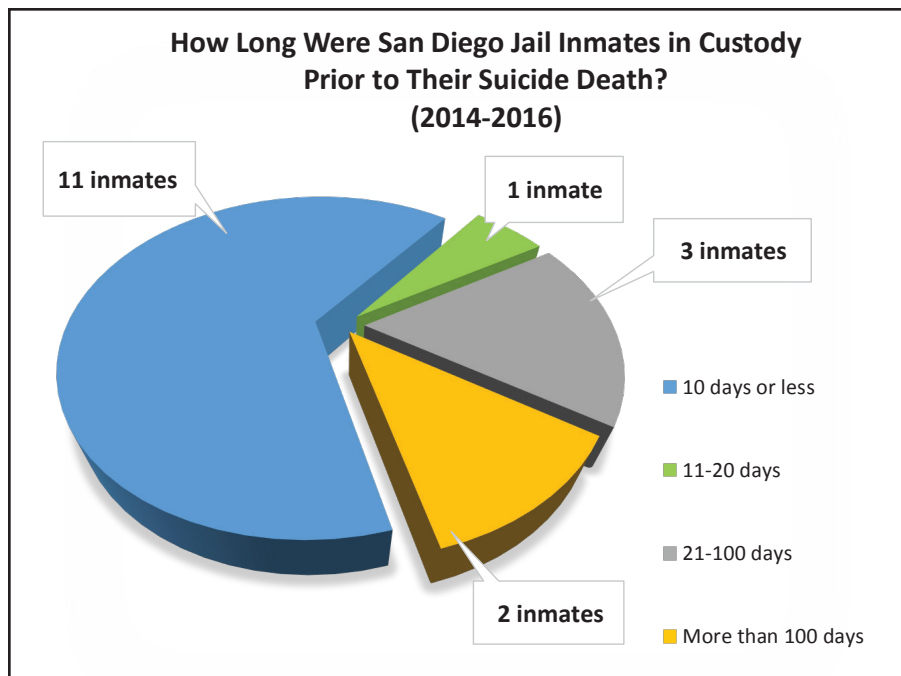
1. Screening for Suicide Risk and Related Mental Health Needs
2. Clinical Assessment and Intervention
3. Staff Communication
4. Addressing the Heightened Risks of Restrictive Housing
5. Supervision of At-Risk Inmates
6. Timely Emergency Response
7. Suicide Prevention Training
8. Internal Review of Inmate Suicides
9. Quality Improvement Program

The DRC Experts commended the County for some of its recent efforts to revamp its mental health and suicide prevention policies and practices. They have encouraged the County to continue to strengthen those efforts, while taking steps to address the identified Key Deficiencies, summarized here.

1. Screening for Suicide Risk and Related Mental Health Needs

Screening for suicide risk and related mental health needs is a critically important part of any suicide prevention program. Effective screening to determine if a person might be at risk of suicide is essential at the time of jail booking, as the initial period of detention carries heightened risk of suicide. Screening is also necessary at particular high-risk moments during a person’s incarceration.

The DRC Experts identified problems with the County’s suicide risk screening procedures at booking, at key transition events that carry elevated risk (e.g., placement in solitary confinement), and at other high-stress, high-risk moments (e.g., inmates receiving “bad news” about their criminal court case, moving to prison, or being extradited).



In one tragic and illustrative case reviewed by the DRC experts, an inmate arrived at the jail with symptoms of florid psychosis and mania. He was not referred for admission to the Psychiatric Security Unit. He was instead placed in an Administrative Segregation unit. He died by suicide a few days later without receiving an adequate screening for suicide risk.

2. Clinical Assessment and Intervention

Jails must effectively identify and monitor inmates' mental health needs and timely provide clinically indicated treatment, both in the event of an acute psychiatric episode and on an ongoing basis.

The DRC Experts identified several deficiencies in San Diego County's clinical referral and evaluation practices.

The experts also found that San Diego County Jail inmates do not receive an adequate individualized mental health treatment plan, a violation of state law³⁴, and do not have access to care that can prevent decompensation and reduce the risk of suicidal thinking and behavior.

3. Staff Communication

Communication between and among custodial staff and health care professionals working in the jail is another important aspect of suicide prevention. The DRC Experts found that San Diego County has lacked an effective system for custodial staff, mental health staff, and other health care staff to communicate about an inmate's decompensating condition, potential risk of suicide or self-harm, and mental health treatment needs.

In one case, a man died by suicide the day before his transfer to another state to face criminal charges. The DRC Experts found that custody staff knew he had made a credible suicide attempt a few weeks earlier, and that he was experiencing considerable stress about being extradited. Yet the inmate's treatment record did not reflect any sense of heightened risk requiring closer observation, monitoring, and clinical follow-up. The DRC Experts determined that this suicide death may have been preventable had there been better communication among custody and mental health staff about the inmate's situation.

4. Addressing the Heightened Risks of Restrictive Housing

The placement of inmates, particularly those with mental health needs, in segregated or restrictive housing increases the risk of suicidal and self-harming behavior, isolates individuals, and impedes normal interpersonal interactions that are essential to psychological health and adequate treatment.³⁵ At least six (6) inmates who died by suicide in the last four years were housed in designated solitary confinement units in San Diego County Jail, and several more were housed in units with solitary confinement conditions.



Segregation Cell Door (Las Colinas)



Housing Unit for Prisoners with Mental Illness (Central)

The experts found that San Diego County Jail lacks an adequate process to screen inmates for increased suicide risk prior to and during placement in solitary confinement. This means that jail staff may be placing inmates who are at greatest risk of suicide in solitary confinement without identifying and considering those risks.

In one case, an inmate was housed in Administrative Segregation for over four months. The DRC Experts found that this inmate appeared to suffer the ill effects of prolonged isolation and had significant symptoms of mental illness that were not detected by staff. After a series of emergency placements in the jail's "Safety Cell," the inmate was again placed in Administrative Segregation, where he spent the last six weeks of his life before hanging himself.

The DRC Experts also identified problems with custodial practices in monitoring inmates in solitary confinement to ensure that those inmates are safe and not engaging in self-harming behavior. They found failures to monitor inmates' safety and cases of malfunctioning communication equipment in the segregation units. In some cases, the result was delays in discovering and responding to inmates' ultimately fatal suicide attempts.

DRC observed video footage of one troubling suicide attempt in an Enhanced Observation Housing (EOH) Unit, which houses inmates at risk of suicide with solitary confinement conditions (as discussed in Section IV.C.4). Inmates are monitored by overhead video camera and per Department policy, should receive in-person checks at least once every 15 minutes. The video shows the inmate standing naked on the cell's desk, praying and preparing to jump, for over 14 minutes. He then dove head-first onto the floor. Four more minutes passed before custody staff appeared and summoned emergency medical care. Had the policy regarding in-person checks been followed, or the surveillance video been monitored, staff could have intervened prior to the inmate's jumping, and there would likely have been a more timely discovery and emergency response.

The extreme isolation and deprivations of solitary confinement increase suicidal ideation and self-harming behavior. Records indicate that such conditions contributed to inmates attempting suicide. In one suicide case, an inmate housed alone in Administrative Segregation was allowed just one hour out of his cell every 48 hours. He requested psychiatric services but two days later, he still had not been seen by mental health staff. He asked a deputy through the cell's intercom when he would get out of his cell and into the dayroom. He was told that he must remain in his cell. Forty-five minutes later, he was found hanging in his cell. Prior to hanging himself, he had urinated on the floor, stuck food and feces on the ceiling, and scrawled a suicide note on the cell walls using his own blood.

5. Supervision of At-Risk Inmates

When an inmate has suicidal thoughts, or engages in suicidal or self-harming behavior, staff must adequately supervise the inmate to ensure that the individual is safe.

The DRC Experts found several deficiencies regarding supervision of such inmates. For example, the experts found problematic the County's policies directing that custodial staff, rather than clinical staff, have final decision-making authority about where to house inmates identified as at risk of suicide.

Custody staff too often interfere with clinical decision-making regarding inmates with acute mental health needs. In one case, an inmate was booked while having acutely manic and psychotic symptoms. He had been hospitalized twice shortly before his incarceration and had been off his medications for several days prior to arrest. There was a two-day delay before he received a psychiatric evaluation and medications. The inmate made repeated statements about hurting himself, and he refused to take medications when they were finally ordered. A nurse practitioner recommended that the inmate be placed in a Safety Cell based on his condition. However, a sergeant refused to move him. He remained in an Administrative Segregation cell, where he died by suicide that evening.

6. Timely Emergency Response

When an inmate engages in a serious suicide attempt, the facility staff's emergency response will often determine if the person lives or dies. The DRC Experts found, in nearly half the emergency responses to lethal suicide attempts they reviewed, poor coordination of lifesaving efforts, delays in starting CPR, and/or malfunctioning medical equipment. They cited several troubling examples among recent suicide deaths.

In one case, medical staff were unable to initiate life-saving efforts due to malfunctioning automated external defibrillator (AED) equipment.

In a second suicide case, deputies waited seven minutes after discovering an inmate hanging in his cell, and then prevented nursing staff from evaluating the inmate's condition or using the AED.

In yet another case, the DRC Experts observed video of approximately 11 deputies standing at the scene of a suicide attempt for several minutes without initiating life-saving measures.

The DRC Experts also found that San Diego County Jail lacks an adequate program of drills for medical emergencies, including those stemming from serious suicide attempts.

7. Suicide Prevention Training

Custodial, medical, nursing, and mental health staff need strong training on the signs of mental illness and suicide risk, and on responding to inmates who are potentially at risk of suicide.

While the County has in recent months taken affirmative steps to enhance its suicide prevention training program in the wake of the Grand Jury's 2017 findings, the DRC Experts found that the County's training program is not well coordinated, tracked, or evaluated.

The DRC Experts found additional deficiencies with respect to the training of mental health clinicians. For example, records indicate that clinicians frequently use "contracts for safety," which ask patients to agree verbally or in writing that they will not engage in self-harm. According to suicide prevention experts, this practice has not been shown to decrease the risk of suicide attempts or to provide protection for clinicians. In fact, San Diego County Jail clinicians used these "contracts for safety" with multiple inmates who subsequently died by suicide while in custody.

8. Internal Review of Inmate Suicides

All inmate suicide deaths and medically serious suicide attempts should be subject to a rigorous review process, with the objective of identifying necessary improvements that can be made to enhance suicide prevention and inmate safety moving forward.

The DRC Experts found that the County's internal suicide review process, including as proposed in its recently revised Suicide Prevention Policy, is inadequate. They found that the policy does not sufficiently outline an internal

review process, and that it fails to identify how findings and corrective action plans will be acted upon.

It is problematic that the Sheriff's Department Critical Incident Review Board does not conduct a formal review of all serious suicide attempts. This is a missed opportunity to learn from experience and to strengthen policy, procedure, and training moving forward.

The DRC Experts also expressed concerns about the San Diego County Citizens' Law Enforcement Review Board (CLERB), finding that it does not serve a meaningful or sufficient role in the provision of external, independent oversight with respect to suicide prevention. (We strongly agree with this finding, and recommend a new model of independent oversight. See Section IV.D.)

9. Quality Improvement Program

Jail systems with a robust continuous quality improvement (CQI) program will be in the best position to identify problems and implement effective solutions, including with respect to suicide prevention. The DRC Experts found that the County has begun to take positive steps in this area, but that important work remains.

RECOMMENDATIONS

Improving Suicide Prevention in Jails

Recommendation 6. Develop a plan for timely implementation of the DRC Experts' forty-six (46) Recommendations to address deficiencies in San Diego County Jail's suicide prevention policies, practices, and training.

Recommendation 7. Strengthen the County's internal review process and quality improvement program to ensure implementation of necessary changes to enhance suicide prevention and inmate safety.

C. San Diego County Should Provide Adequate Treatment and Services to Inmates with Mental Health Needs.

Our investigation found that there are a large number of San Diego County Jail inmates with significant mental health needs. With few exceptions, enhanced mental health treatment programming is provided only to those with critically acute needs. In many cases, inmates remain in harsh, non-therapeutic settings without adequate treatment until their condition deteriorates. Only when they reach the point of engaging in acts of self-harm or having an acute breakdown do they receive an enhanced level of care. Such a system is cruel and counterproductive, and does not meet constitutional and legal requirements.

The County must take reasonable steps to ensure that it safeguards the rights of inmates with mental illness under the United States Constitution, the Americans with Disabilities Act, and other relevant laws. The County's compliance with state regulations – including Title 15 of the California Code of Regulations regarding jail operations – is important, but it does not demonstrate compliance with Constitutional and other legal requirements.³⁶

1. Overview of San Diego County's Jail Mental Health System

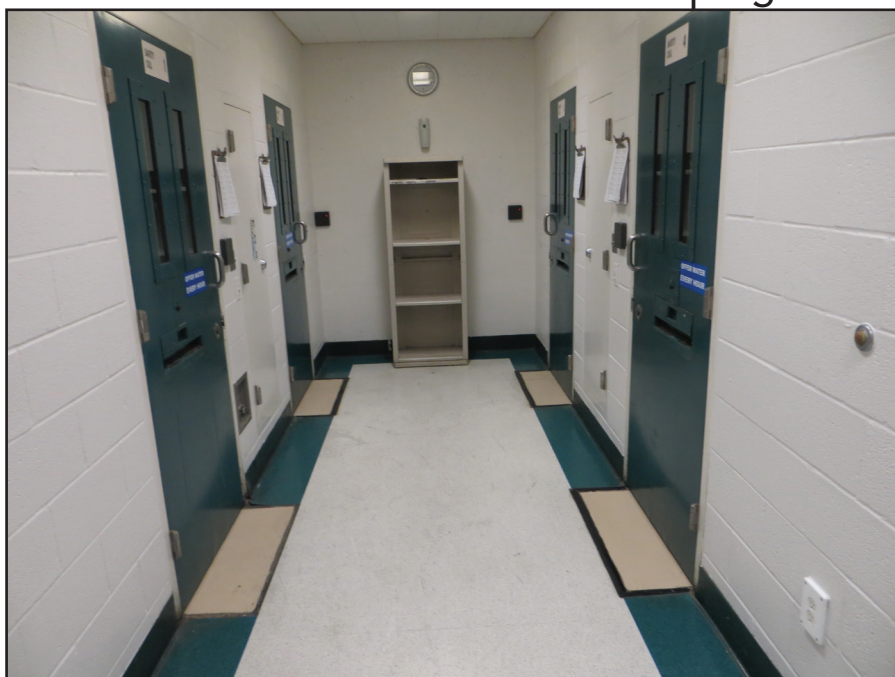
The Sheriff's Department utilizes a partnership of County staff and contract health professionals to provide mental health services. Liberty Healthcare Corporation, a private contractor, assists in the hiring of staff and management of the mental health programs. Of course, it remains the County's responsibility to ensure that inmates are provided adequate care based on individual clinical needs.

The jail system has two units, called Psychiatric Security Units, that have on-site mental health clinicians and daily treatment programming, serving up to thirty (30) men and thirty-two (32) women with the most critically acute mental health conditions.

The County's jails also rely heavily on Safety Cells and Enhanced Observation Housing (EOH) units to manage inmates identified as acting out or at risk of self-harm or suicide. These are severe and punitive-feeling placements, without meaningful treatment. They raise serious concerns.

There are other designated mental health "cluster" units that house people with mental illness. In general, these units do not provide meaningful treatment programming.

A Jail-Based Mental Competency Program, a 25-bed program at the Central Jail for inmates deemed Incompetent to Stand Trial (IST), opened in March 2017. DRC did not tour or assess this program.



Safety Cell Doors and Barren Cell Interior, with Grate in Floor Serving as Inmate's Toilet (Central Jail)

2. Safety Cells

We have significant concerns about the County's placement of large numbers of inmates in the jails' "Safety Cells."

By policy, Safety Cells are used for people who: (1) verbalize suicidal ideation or make suicidal gestures and are belligerent or intoxicated; (2) are combative or violent to a point that they may injure themselves, other patients or staff; or (3) are unable to function in the regular or specialized housing areas due to behavior which jeopardizes their safety.

These Safety Cells are extraordinarily harsh settings. They are small, windowless rooms with rubberized walls. There is no furniture or bedding, leaving the individual to sit or lie on the floor. Safety Cell doors contain a food slot and a small viewing window that faces a hallway. Cells have a ceiling light that is illuminated 24/7, and a camera for remote observation by custody staff.

The cells are completely barren, with no sink, toilet, or running water. Inmates defecate and urinate in a grate on the ground. In June 2017, a Grand Jury evaluation of jail conditions found a "very strong" smell of urine surrounding the Safety Cells.³⁷

Inmates placed in these Safety Cells are stripped naked and given only a "safety smock" made from heavy tear-free material fastened with straps or Velcro. The garment is open at the bottom, and no underwear is provided. Inmates receive no books or any other personal property while in a Safety Cell.

Placements in a Safety Cell are approved by the Watch Commander, in consultation with medical staff. An initial medical assessment must be done within 30 minutes after medical staff is notified. Department policies require observation of inmates placed in Safety Cells by custody staff at least twice every 30-minute period and by medical staff every four (4) hours. The jail's policy is for a mental health consultation to occur within 12 hours of placement, and a medical evaluation every 24 hours.

There is no time limit for how long an inmate may be kept in a Safety Cell. Record reviews show that many inmates are held in Safety Cells for much longer than 24 hours, and in some cases up to four days. Many inmates cycle in and out of Safety Cell placement multiple times. In 2017, inmates were placed in a Safety Cell more than 6,700 times.

3. Psychiatric Security Units (PSU)

The County has two jail-based inpatient mental health units, known as Psychiatric Security Units (PSU), at the Central Jail (30 beds for men, including four beds in "observation cells") and at the Las Colinas Detention and Reentry Facility (32 beds for women, plus six nearby beds in "observation cells"). Strikingly, these two units make the Sheriff's Department the County's largest provider of inpatient psychiatric services.

We observed a high level of acuity among the patients in these inpatient units, with some placed in troubling solitary confinement conditions.

At the same time, we found that the PSUs do have some positive treatment programming. For example, at Central Jail, the PSU has clinical staff on-site, along with deputy staff that receive specialized mental health training. The PSU has operated weekly “Love on a Leash” therapeutic programs with specially trained dogs.

At Las Colinas, the PSU has considerable treatment and programming space. Therapeutic programming has included yoga and arts/crafts. Patients receive weekly multi-disciplinary treatment group meetings and regular clinical contact.

The County Jail’s PSUs are the only units we observed that provide enhanced mental health treatment to inmates. They are available only to inmates demonstrating an extremely high level of acuity.



Men's Psychiatric Security Unit (Central Jail)



Women's Psychiatric Security Unit Cells (Las Colinas)

A deeply problematic practice impacting access to treatment in the PSU is the inappropriate influence of custody staff, often contrary to mental health providers’ clinical recommendations. For example, we received multiple reports that custody staff unilaterally place patients in the PSU’s “observation units,” which amount to a solitary confinement setting without access to the PSU’s treatment programming. Inmates in these cells have been observed, by us and by others, smearing food, feces, and urine on the walls and floor.

Custody staff have in some cases prevented PSU patients from having social visits or accessing the outdoor area for recreational activity, overruling clinicians’ judgment as to what is safe and clinically appropriate based on the



*Psychiatric Security Unit Observation Cells
(Las Colinas)*



*Psychiatric Security Unit Observation Cells
(Central Jail)*

patient's individual circumstances. Such disregard of clinical judgment is deeply counterproductive to treatment efforts.

The DRC Experts also found problematic the number of inmates in mental health crisis who are not referred for placement in the PSU. There are large numbers of inmates cycling in and out of Safety Cells, many remaining in those cells for extended periods of time. But Safety Cells are harsh, barren, and isolating. They are not designed to provide clinical evaluation or treatment.

Inmates exhibiting suicidal or self-harming behavior, or other manifestations of acute mental illness, should be timely assessed for placement in the PSUs. The County should ensure that these units are being fully and appropriately utilized, and that all patients in the PSU receive meaningful, clinically-driven treatment.

4. Enhanced Observation Housing (EOH) Units

With the County's development of the Inmate Safety Program in 2015 came the creation of Enhanced Observation Housing (EOH) units. These units, located at four jail facilities (Central, Las Colinas, George Bailey, Vista), are designated for observation and assessment of inmates who may be at elevated risk for suicide. Even though EOH inmates, in contrast to inmates in Safety Cells, generally have access to a toilet, they too endure conditions of extreme isolation and deprivation.

We observed and met with several inmates in EOH units. Consistent with County policy, all clothes and underwear are taken away, and inmates receive a safety smock, two blankets, and shower shoes. However, we reviewed multiple records documenting that EOH inmates were left naked, with no safety smock, and in some cases not even provided a blanket. Some are forced to sleep on a thin mat placed on the floor. Many inmates complained about being cold, even with the smock and blankets.

Inmates have no access to personal property, television, recreation yard time, or visits from family. Inmates in the EOH units eat from paper trays and

a paper safety spoon, and in some cases are restricted to eating without any utensil.

Inmates in the EOH units with individual cells complained about extremely limited time outside their cell and excessive isolation.



Women's EOH Cell in Medical Isolation (Las Colinas)

Mental health staff appear to recognize the extreme conditions in the EOH units. In one inmate's chart we reviewed, a psychiatrist recommended that the facility "discontinue EOH as the isolation is inhumane and likely to compromise [this inmate] psychologically." We learned that some inmates deny having suicidal thoughts so they can get out of the EOH unit, or avoid placement there, given the harsh conditions.

The number of inmates who pass through the EOH unit, with all its deprivations, is remarkable and far beyond what we have observed in other jails. In 2016, the County logged 5,269 EOH placements. The rate was similar in 2017, based on partial data provided to us. In hundreds of cases, the inmate spent three days or more in the EOH unit, including a substantial number with lengths of stay of one week or more.

Inmates in EOH units are given a risk designation of either "high" or "low." When we toured the facility in November 2016, mental health clinicians evaluated inmates every 24 hours if they were designated as "low" risk. We were alarmed to see that for inmates designated as "high" risk, clinicians would evaluate them only every 48 hours, on the purported basis that they needed more time to "cool down." We understand that the Department recently updated their policies to ensure that all inmates are seen at least every 24 hours.

Still, there is no limit as to how long an inmate can be held in EOH housing. Frequently, the inmate charts we reviewed simply noted "Continue to Observe (CTO)," with no clinical justification or plan for treatment. Mental health staff who cover the EOH units spend their time evaluating and re-evaluating potential suicide risk, but little to no time engaging with inmates to reduce that risk.

We are well aware of the County's important objective to prevent inmate suicide deaths, and that removal of clothing, property, and privileges can reduce the opportunities that an inmate may have to engage in self-harming behavior. That being said, we found extremely disturbing the levels of deprivation and isolation for so many individuals, without access to any therapeutic or recreational activities. These individuals, remember, have been specifically identified as having potential mental health needs. They require

frequent assessment and sustained therapeutic intervention. While the County has taken steps to better assess inmates' suicide risk, more must be done to provide necessary treatment.

5. Lack of Mental Health Treatment Programs

Through our investigation, a major theme that emerged was that inmates do not have timely access to adequate mental health care, including counseling, psychiatric medications, and other treatment programming.

The County has recently created designated mental health "cluster" units, which seem to provide some benefit to inmates with mental health needs who may be vulnerable to abuse or exploitation in general population units.

However, these designated mental health units lack formal treatment programming. Written guidelines for the largest such unit, at Central Jail, confirmed these limitations, stating that it "had no additional staff, doesn't provide additional treatment, or different follow-up guidelines. . . . [The unit] is simply psychiatric housing where inmates are less subjected to stigma if acting in a manner that would reveal their thought process impairments."

Mental health staff leadership shared with us that increased access to structured individual and group treatment activities would be beneficial to their patients, but that there is insufficient mental health staffing and related resources to deliver such a program.

Access to mental health treatment remains extremely limited outside the inpatient PSUs. It generally consists of medication management and brief, non-confidential "check-ins" with mental health staff, often through a cell door. Non-confidential clinical contacts undermine treatment, as prisoners are reluctant to disclose sensitive information about their mental health history or current situation. What is more, effective communication through the thick metal cell doors is extremely difficult – people must speak very loudly to be heard at all. (We observed psychiatrists meeting with some patients privately outside of their cell, which is a positive practice.)

Many inmates on the jail's mental health caseload expressed to us an interest in group or individual out-of-cell therapeutic activities. In one case, a patient's record documented that he requested to discontinue his antidepressant medication and try counseling. Instead, mental health staff increased his medication dosage and ignored his request for counseling.

The lack of access to mental health treatment activities and appropriate levels of care violates minimum standards of care for inmates with mental health needs.³⁸ The National Commission on Correctional Health Care has adopted a standard requiring that "[r]egardless of facility size or type, basic on-site outpatient [mental health] services include, at a minimum, individual counseling, group counseling and psychosocial/psychoeducational programs."³⁹

The County has reported that the jail system has recently increased mental health staffing. Any increase is a step in the right direction. It is clear that a significant increase in staffing and related resources is necessary to deliver meaningful treatment, including structured individual and group treatment programming, to the approximately 2,000 people with mental health needs inside the jails.

The Veterans Moving Forward Program

One notable exception to the lack of mental health programming in the San Diego County jails is the Veterans Moving Forward Program at Vista. The unit is decorated with artwork and displays flags representing each branch of service. Up to 64 inmates who are veterans participate in the program, which covers substance abuse, stress management, yoga, career planning, mentoring, financial planning, and journalism. A counselor from the Veterans Administration is assigned to the unit.

The Veterans Moving Forward Program excludes inmates with serious medical conditions and non-veterans. Many inmates, both veterans and non-veterans, would benefit from this sort of program but are unable to participate due to the lack of capacity and restrictive criteria.

We also found that inmates have faced significant delays in receiving prescribed psychiatric medications. Such delays can be dangerous and lead to mental health decompensation. The jail adopted a new pharmacy system in the summer of 2017. We received reports, confirmed by the County, of problematic delays between prescription and arrival of a medication for patients. The County has indicated that such problems have been addressed through the use of local pharmacies, particularly for urgent prescriptions. However, we continue to receive reports that medications are delayed.

Overall, the DRC Experts found that the County's jail mental health program "remains fragmented and without good continuity of care." They recommend development of a consolidated mental health treatment program that offers an appropriate spectrum of levels of care.

Specifically, the DRC Experts recommend creation of an "intermediate" level of mental health care, with sufficient capacity to ensure timely access for those individuals who need enhanced treatment programming. The program would serve patients "stepping down" from Safety Cell, EOH, or PSU admissions, as well as patients with a mental health condition that makes it difficult for them to function in a general population jail setting. The program would require a substantial increase in mental health clinician staffing to provide a structured treatment program that includes individual and group therapy to meet the clinical needs of the inmate population. Treatment must be provided pursuant

to individualized treatment plans, as required by Title 15 of the California Code of Regulations (Section 1210). The DRC Experts found the jail's treatment plans to be consistently inadequate. This was consistent with our review of dozens of inmates' jail mental health records.

DRC strongly encourages the County to implement an enhanced and structured outpatient treatment program. It would have enormous benefit with respect to the safety and well-being of inmates, jail operations, and reentry efforts. The Intensive Outpatient Program at Sacramento County Jail offers one useful model.⁴⁰

6. Undue and Excessive Solitary Confinement

Our investigation uncovered significant problems regarding the use of solitary confinement, particularly for inmates with mental health needs. Solitary confinement is generally defined as a placement in which inmates are held in their cells, alone or with a cellmate, for 22 to 24 hours per day.⁴¹ San Diego County Jail inmates may be held in these conditions, for example, in maximum security units, Administrative Segregation units, "Keep Separate All" units, EOH units, or disciplinary units.

There is growing consensus that the isolation of prisoners with mental illness should be avoided due to serious psychological and physical risks of harm.⁴² Solitary confinement is an extremely dangerous place for someone with mental health needs. At least six (6) jail inmates died by suicide in segregation units in recent years, a group that includes individuals with a known history of mental illness and suicide attempts. Several other inmates died in units with solitary confinement conditions.

Jail staff report that their goal is to meet the requirements of Title 15, a state regulation that mandates at least three (3) hours per week of exercise time in a space designed for recreation.⁴³ Segregated inmates are also typically scheduled to receive 50-60 minutes per day out of their cells to shower and use the phone. They spend the remaining 1,380-1,390 minutes of their days inside their cell. This is an extreme level of isolation.

We found that "lockdowns" are remarkably common in San Diego County's jails. During lockdowns, inmates in an entire unit or portion of a facility can be confined to their cells. The number of inmates reporting extended periods of cell confinement during lockdowns was astonishing. We saw multiple records showing inmates subjected to long-term lockdown conditions.

The Experience of Being on “Lockdown”

One inmate filed a grievance after her unit faced the tenth lockdown in two weeks. She wrote:

This treatment is worse than people treat . . . animals. You guys are messing with our mental state . . . We are on lockdown with no explanation as to why. We barely get to come out as is and to be completely locked away and ignored by officers is unnerving. Being locked in jail inside a box inside of another box can do things to a person’s mental state.

We also received information regarding a problematic practice that staff referred to as “Bypass.” Under this practice, jail staff would not document the lockdown of individual inmates – including many with mental illness. In other words, people outside of designated segregation units were held in solitary confinement conditions without it being tracked anywhere in the system. The County has indicated that this practice has been ended.

One positive practice we learned about was a segregation placement email alert system, which notifies mental health staff when any inmate is placed in a segregation unit or individual cell lockdown. We urge the County to build on this practice, which started in September 2017. There should be a documented process for mental health staff to recommend against segregation placements for inmates at risk of psychological harm or suicide in such conditions, and for such a recommendation to be followed absent a specific security risk. Jail leadership has indicated that such a process occurs on an *ad hoc* basis, and that they would consider formalizing it with proper documentation.

Jail leadership shared with us their perspective that the creation of the mental health “cluster” units has helped to reduce the number of people with mental illness in segregation units. We have not seen data to support this statement. And we remain deeply concerned about the lack of treatment, recreation, and other programming provided to inmates in the mental health “cluster” units.

We urge the County to continue to take affirmative steps to reduce the use of solitary confinement, and to eliminate the practice for inmates with mental illness. The County should track and analyze data on segregation placements, lengths of stay, and outcomes for inmates – particularly those with mental illness.

RECOMMENDATIONS

Improving Mental Health Treatment and Ending Harmful Use of Solitary Confinement

Recommendation 8. Substantially increase mental health staffing and related resources to ensure that individuals with mental illness in the jail receive clinically indicated treatment.

Recommendation 9. Ensure that the inpatient Psychiatric Security Units (PSUs) are fully and appropriately utilized, and that all patients in the PSU receive meaningful, clinically-driven treatment.

Recommendation 10. Greatly reduce the use of “Safety Cells” for individuals with mental health needs. Inmates placed in Safety Cells as a result of behaviors related to mental health symptoms should not be housed there for longer than six (6) hours. At that point, if there is no less restrictive housing appropriate, they should be considered for placement in inpatient care (including the PSU).

Recommendation 11. Revise policies and practices for the Enhanced Observation Housing (EOH) units to make them less harsh and inhumane, with a greater focus on delivery of treatment designed to reduce the risk of suicide and mental health decompensation.

Recommendation 12. Revise policies to allow individuals in EOH to have access to social visits, increased out-of-cell time, and recreational activities, and to possess clothes and certain personal property, based on individualized clinical assessments of their condition and safety needs.

Recommendation 13. Implement a consolidated mental health treatment program that offers a spectrum of levels of care. The program should include the creation of an “intermediate” level of mental health care for individuals who need enhanced treatment programming. The Intensive Outpatient Program at Sacramento County Jail offers one useful model.

Recommendation 14. Provide a written individualized treatment plan for each person requiring mental health services at the jail, as required by Title 15, Section 1210 of the California Code of Regulations. Ensure that clinically indicated treatment prescribed in the treatment plan is provided.

Recommendation 15. Reduce the use of solitary confinement segregation housing, and take affirmative steps to eliminate solitary confinement placements for individuals with mental illness at risk of harm in such a setting, absent exceptional and exigent circumstances.

Recommendation 16. Track and analyze data on all segregation housing placements and lockdowns, including lengths of stay and outcomes for inmates – particularly those with mental illness. Take corrective action to eliminate unnecessary segregation placements and lockdowns as part of ongoing quality improvement efforts.

Recommendation 17. Reduce the harsh isolation conditions in segregation and other restrictive housing units. Provide individuals in such units a minimum of four (4) hours per day of out-of-cell time, along with access to treatment, recreation, and other activities necessary to ensure their health and well-being.

D. San Diego County Should Establish Meaningful Independent Oversight of Jail Conditions and Treatment of Inmates.

The time has come for San Diego County to create a meaningful, professional, and independent oversight entity to monitor and report on jail conditions, including as to mental health care and suicide prevention.

Even as San Diego County has begun to tackle the challenges of reducing the number of suicides in its jails and addressing the mental health treatment of people in the community and those who end up in jail, such efforts are unlikely to lead to a durable solution on their own.

The need for stronger independent oversight is clear.

First, the sheer number of people dying in San Diego jails demands better oversight. The County's recent track record includes an extraordinarily high number of deaths – more than 30 inmate suicides since 2010, and many other inmate deaths. Several inmate deaths (suicide and non-suicide) have led to lawsuits costing the County millions of dollars. The situation has led to a lack of trust in the jail system across the community.⁴⁴

Second, even with the efforts by Dr. Joshua and others in the Sheriff's Department, there remain significant challenges regarding jail suicide prevention and mental health care. Among those challenges, the DRC Experts found that the County's internal suicide review process is undeveloped. Independent oversight can play an important and complementary role in strengthening internal review efforts, identifying the Department's need for additional resources, and helping the County achieve and solidify progress.

Third, the County's Citizens' Law Enforcement Review Board (CLERB) does not provide adequate or effective oversight. The County's citizenry has long recognized the value of independent oversight of the jail system. The public voted to establish the Citizens' Law Enforcement Review Board (CLERB) in 1990 to independently investigate citizen complaints against Sheriff's deputies and probation officers, as well as deaths of jail inmates.⁴⁵

But the CLERB has proven ineffective. The CLERB is sparsely staffed, with just three employees: an executive officer, an investigator, and an administrative assistant.⁴⁶ The CLERB is composed of eleven volunteers, who are not required to have previous special training or experience in investigations or other relevant topics.⁴⁷ The CLERB does not control its budget. It cannot hire additional investigative staff itself, even if needed to complete its work.

The CLERB has failed to keep up with the demands of its mission. Despite its authority to "annually inspect county adult detention facilities and annually file a report of such visitations together with pertinent recommendations" on issues that include "detention, care, custody, training, and treatment" of inmates,⁴⁸ the CLERB has *never* inspected the County's jail facilities in its more than 25 years.

The CLERB has also proven unable to complete its individual case investigations. At the beginning of 2011, the CLERB had six open death investigations.⁴⁹ That number grew to 19 by the end of 2014,⁵⁰ then to 35 in December 2015,⁵¹ and to 46 by the end of 2016.⁵² By October 2017, the CLERB had 59 open death investigations – including one dating back six years. Many of these long-delayed and unfinished death investigations are inmate suicides.

Given its tremendous backlog, the CLERB announced on November 11, 2017, that it was summarily dismissing eight (8) suicide death cases and fourteen (14) other cases of people dying in detention or while being taken into custody. The CLERB's stated reason for this action was that the investigation was not completed within the statutory one-year time limitation for imposing officer discipline for misconduct.⁵³ The CLERB asserted that this meant it lacked jurisdiction and could not complete its investigation.⁵⁴ (Oddly, the County's own web site for CLERB states that "death cases and other complex investigations often take more than one year to complete."⁵⁵)

In any event, CLERB's failure to complete its investigations means that these deaths will not face independent scrutiny.

The community response has been one of severe disapproval. One local editorial board called the CLERB's decision to summarily dismiss these cases "outrageous" and "insulting to victims' family members," noting that it "only reduces the likelihood of improved responses and practices" in the future.⁵⁶

Even with the reported addition of a newly funded CLERB Investigator position as of March 2018, it is DRC's assessment that the CLERB will not be able to adequately fulfill its mission as the County Jail system's sole oversight entity.

Benefits of Effective Independent Oversight:

- *Public identification of problems with conditions and operations and timely solutions, resulting in jail facilities that are safer, operated in conformance with the Constitution, other laws, and up-to-date correctional practices.*
- *Early detection of issues that may have been overlooked inside jail facilities before they become major problems.*
- *Cost-effective and proactive means to avert lawsuits challenging the legality of conditions of confinement or the treatment of prisoners.*
- *Independent input on the need for funds requested by Sheriff's Department and other public officials.*
- *Better-informed policy decisions.*⁵⁷

California counties like Los Angeles, Santa Clara, and Sonoma, the California State prison system, the City and County of Denver, and King County (Washington State) have implemented or are implementing a professional entity that provides independent oversight of jail operations. The Los Angeles County Office of Inspector General, created in 2014, provides an especially useful model.⁵⁸ Santa Clara County recently approved the creation

of a county Office of Correction and Law Enforcement Monitoring, along with an accompanying community advisory committee,⁵⁹ based on expert recommendations.⁶⁰

A professional, independent oversight entity would offer a critical benefit that CLERB has not – a proactive method to evaluate and improve systemwide practices in the County’s jails, going beyond a mere after-the-fact investigation of individual deaths.

It may be that the CLERB can play some positive and important role in monitoring the San Diego County Jail system moving forward. It can enhance the work of a professional oversight entity, similar to other systems like Denver’s, which provides for complementary roles by the Office of the Independent Monitor and a Citizen Oversight Board. But on its own, the CLERB cannot provide adequate oversight that ensures effectiveness, transparency, and accountability in the operation of San Diego County’s jails, or pave the way for necessary systemic improvements.

Meaningful, professional, and independent oversight would enhance the County’s efforts to address its historical weaknesses and challenges in its jails, help to achieve and solidify improvements, and strengthen the trust of the community through greater transparency. This, more than anything, may be the key to achieving a system that meets legal and constitutional standards, and that properly cares for people with mental health needs.

RECOMMENDATION

Meaningful, Independent Oversight of Jail System

Recommendation 18. The County should establish a professional independent oversight entity that has the authority and duty to monitor the treatment of inmates with mental health needs, suicide prevention, and other aspects of jail operations affecting inmates with disabilities, with periodic reporting to the Board of Supervisors and regular outreach to the public.

V. SUMMARY OF RECOMMENDATIONS

1. End Over-Incarceration of People with Mental Illness, Strengthen Community-Based Mental Health Services

Recommendation 1. Fully implement the County's three-year Mental Health Services Act (MHSA) Plan, with adequate transparency as to spending and program outcomes.

Recommendation 2. Focus investment on community-based services and treatment programming that help individuals with mental health needs to thrive and to avoid incarceration and entanglement with the criminal justice system.

Recommendation 3. Develop capacity for community-based competency restoration programs for individuals found Incompetent to Stand Trial (IST), so that they can receive treatment in the least restrictive setting appropriate and do not languish unnecessarily in jail.

Recommendation 4. Strengthen reentry programming for individuals with disabilities to ensure continuity of care, including with respect to medication and other treatment, and access to job opportunities, housing, food, and other basic needs for successful reintegration into the community.

Recommendation 5. Ensure that the County's mental health programs are subject to rigorous data collection and self-critical analysis of progress and where additional resources may be needed.

2. Improve Suicide Prevention Practices

Recommendation 6. Develop a plan for timely implementation of the DRC Experts' forty-six (46) Recommendations to address deficiencies in San Diego County Jail's suicide prevention policies, practices, and training.

Recommendation 7. Strengthen the County's internal review process and quality improvement program to ensure implementation of necessary changes to enhance suicide prevention and inmate safety.

3. Improve Mental Health Treatment, End the Harmful Use of Solitary Confinement

Recommendation 8. Substantially increase mental health staffing and related resources to ensure that individuals with mental illness in the jail receive clinically indicated treatment.

Recommendation 9. Ensure that the inpatient Psychiatric Security Units (PSUs) are fully and appropriately utilized, and that all patients in the PSU receive meaningful, clinically-driven treatment.

Recommendation 10. Greatly reduce the use of “Safety Cells” for individuals with mental health needs. Inmates placed in Safety Cells as a result of behaviors related to mental health symptoms should not be housed there for longer than six (6) hours. At that point, if there is no less restrictive housing appropriate, they should be considered for placement in inpatient care (including the PSU).

Recommendation 11. Revise policies and practices for the Enhanced Observation Housing (EOH) units to make them less harsh and inhumane, with a greater focus on delivery of treatment designed to reduce the risk of suicide and mental health decompensation.

Recommendation 12. Revise policies to allow individuals in EOH to have access to social visits, increased out-of-cell time, and recreational activities, and to possess clothes and certain personal property, based on individualized clinical assessments of their condition and safety needs.

Recommendation 13. Implement a consolidated mental health treatment program that offers a spectrum of levels of care. The program should include the creation of an “intermediate” level of mental health care for individuals who need enhanced treatment programming. The Intensive Outpatient Program at Sacramento County Jail offers one useful model.

Recommendation 14. Provide a written individualized treatment plan for each person requiring mental health services at the jail, as required by Title 15, Section 1210 of the California Code of Regulations. Ensure that clinically indicated treatment prescribed in the treatment plan is provided.

Recommendation 15. Reduce the use of solitary confinement segregation housing, and take affirmative steps to eliminate solitary confinement placements for individuals with mental illness at risk of harm in such a setting, absent exceptional and exigent circumstances.

Recommendation 16. Track and analyze data on all segregation housing placements and lockdowns, including lengths of stay and outcomes for inmates – particularly those with mental illness. Take corrective action to eliminate unnecessary segregation placements and lockdowns as part of ongoing quality improvement efforts.

Recommendation 17. Reduce the harsh isolation conditions in segregation and other restrictive housing units. Provide individuals in such units a minimum of four (4) hours per day of out-of-cell time, along with access to treatment, recreation, and other activities necessary to ensure their health and well-being.

4. Ensure Meaningful Independent Oversight of Jail System

Recommendation 18. The County should establish a professional independent oversight entity that has the authority and duty to monitor the treatment of inmates with mental health needs, suicide prevention, and other aspects of jail operations affecting inmates with disabilities, with periodic reporting to the Board of Supervisors and regular outreach to the public.

ENDNOTES

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Appendix A

DRC EXPERTS' FINDINGS AND RECOMMENDATIONS REGARDING SUICIDES IN SAN DIEGO COUNTY JAIL FACILITIES, MENTAL HEALTH AND SUICIDE PREVENTION POLICIES AND PROGRAMS

Karen Higgins, M.D.
Robert D. Canning, Ph.D., CCHP

I. INTRODUCTION

Suicide among persons held in correctional facilities is a significant public health problem which is complicated by the legal constraints placed upon correctional systems nationally. Although significant progress has been made in the last forty years, suicide remains the number one cause of death in American jails. Improvements in jail mental health service delivery systems continue to be needed to further decrease the rate of jail suicide deaths. In addition, changes in the conditions of confinement for inmates with mental health disabilities and needs, improved staff training, and facilities improvements can also contribute to reducing the suicide rate in jails.

DRC engaged us to review suicide deaths in the San Diego County Jail system from December 2014 through 2016, and to evaluate the adequacy of mental health services, emergency responses, and the system's overall suicide prevention program. Our review found that disjointed policies addressing suicidal inmates, lapses in continuity of mental health care, poor emergency response, inconsistent monitoring, and some physical plant issues contributed to the suicide deaths we reviewed.

Spurred by the high number of suicide deaths and the scrutiny they brought, the San Diego County Sheriff's Department ("Department") has made significant efforts to revamp its mental health policies and practices to allow consistency in treatment and better coordination between custodial and medical/mental health staff. These efforts should continue and be strengthened, to address the historically high number of inmates who make serious suicide attempts in the County's jails.

II. BACKGROUND

The San Diego County Jail system has seven facilities. From 2010 to the end of 2016, the average daily population of the jail system rose from 4,646 inmates to 5,362, an increase of 15 percent. The County's Grand Jury found that the jail system has had 46 inmate suicide deaths in the 12 years ending in 2016, with almost 50 percent occurring from 2013 through 2016. The recent spike in inmate suicide deaths has brought increased scrutiny to the jail system's procedures and particularly its mental health system. It is important to understand why rates have increased so dramatically over this period and to take proactive steps to prevent future suicides.

Taking a broad view, after the California legislature enacted Criminal Justice Realignment (AB109) in 2011, the state transferred jurisdiction for many inmates from state prisons to county jails. San Diego has seen a relatively small net increase in average daily population in its jail facilities: from 5,087 inmates in 2012, the first full year after AB109 took effect, to 5,362 inmates in 2016.

Jail suicide deaths typically occur soon after an individual's entry into the jail system. San Diego County Jail's experience appears to be no exception. Of the 17 suicides occurring in the San Diego Jail system from the beginning of 2014 through the end of 2016, 11 occurred within six days of the inmate's entry.

All suicide deaths since 2014 were of male inmates and occurred in three facilities: Central Jail (seven), Vista Detention Facility (six), and George Bailey Detention Facility (four). One inmate died by suffocation, three jumped from a second tier and died from massive head injuries, and the remaining 13 died of asphyxiation by ligature hanging. Eight of the inmates were housed in dormitories or multiple-person cells, and eight were housed in single cells. One inmate died in a holding cell.

Four inmates who died by suicide were housed in segregated housing (including one who was housed as psychiatric "overflow" in a segregated housing unit).

We understand that, as of this writing, there was one confirmed suicide death in San Diego County Jail facilities in 2017. This is a decrease from recent years, which is a positive development. Nevertheless, it is important for the system to engage in a meaningful analysis of its policies, to learn from the suicides that have occurred in recent years, and to continue to take proactive steps where necessary.

III. QUALIFICATION OF EXPERTS

Karen Higgins, M.D.

Dr. Higgins is a board-certified, General and Forensic psychiatrist who has been involved with correctional care services since 2001. From 2001 to 2004, she served as the lead psychiatrist for the Denver City and County jail systems. Within that time, she was a key participant in their mental health system, including suicide prevention. In addition, for more than six years, Dr. Higgins served as both the Statewide Senior Supervising Psychiatrist, and then the Statewide Chief Psychiatrist for the California Department of Corrections and Rehabilitation (CDCR). During this time, Dr. Higgins oversaw for program development at 33 prisons serving 150,000 inmates; acted as the subject matter expert for the Department on psychiatric and mental health related issues; played a key role in the development of Departmental policies and procedures related to mental health care and suicide prevention; was a member of the Departmental suicide prevention committee, which involved review of many psychological autopsies of inmate suicide deaths; worked with the California Attorney General on legal matters related to inmate care; and supported numerous Departmental quality of care improvement initiatives.

Robert D. Canning, Ph.D., CCHP

Dr. Canning has been involved in correctional suicide prevention work for more than 12 years. From 2005 to 2015, he was the suicide prevention coordinator for the CDCR. He was the Department's subject matter expert on correctional suicide prevention and in this role contributed to the Department's ongoing mental health litigation. He chaired the statewide suicide prevention committee, designed trainings for clinicians, wrote and oversaw the implementation of many policies and procedures about suicide prevention, and conducted quality improvement programs to improve screening of inmates. He re-designed the Department's suicide risk assessment documentation and designed and implemented a self-harm surveillance system that has received national attention. As

part of his work for CDCR, Dr. Canning has conducted over 35 psychological autopsies of inmate suicide deaths.

Dr. Canning has made presentations on suicide prevention in correctional settings at national meetings of the National Commission on Correctional Health Care (NCCHC) and the American Association of Suicidology (AAS). He recently co-authored a chapter on suicide prevention in correctional settings for the *Oxford Handbook of Prisons and Imprisonment*. He is an active member of the AAS and is one of five instructors of its two-day course on suicide risk assessment and management, entitled Recognizing and Responding to Suicide Risk (RRSR). Dr. Canning has taught the RRSR course to over 1,000 clinicians in both the U.S. and Canada. Finally, he has acted as a forensic expert on jail suicide to Los Angeles County.

Dr. Canning received his doctorate in Clinical Psychology in 1993 and completed a National Institute of Mental Health fellowship in psychiatric epidemiology in 1995. He has been licensed to practice in California since 1997 and prior to joining the CDCR worked for the Veterans Administration Northern California Health Care System and the U.C. Davis Medical Center.

IV. EXPERTS' ASSIGNMENT AND SCOPE OF REVIEW

DRC engaged us to review and analyze (1) individual suicide cases at the San Diego County Jail, with a focus on suicide deaths since December 2014, and (2) the jail's policies and procedures related to mental health care and suicide prevention. Our task was to prepare a report identifying systemic deficiencies in the provision of mental health care and suicide prevention, with recommendations for improvements.

We reviewed medical, mental health, and custodial records of all San Diego County Jail inmates who died by suicide since December 2014. Video of inmate housing units was viewed to observe the circumstances of the suicides, including emergency response and custodial welfare checks. Coroner reports, homicide investigation reports, and other documents (such as court proceedings and police reports for each inmate) were also reviewed. The suicide deaths served as an important starting point for our findings and recommendations throughout the report.

In addition to the records of the inmates who died by suicide during the review period, we reviewed policies and procedures of the Medical Services Division (MSD) and the Detention Services Bureau (DSB). Through DRC, we requested from the Sheriff's Department updated policies and procedures regarding mental health care and suicide prevention, and we have reviewed all materials that were provided. "Green sheets" (facility-specific procedures) were reviewed, as were a variety of training documents pertaining to suicide prevention. We have also reviewed relevant media reports, San Diego County Grand Jury reports (and the County's response), and Citizens' Law Enforcement Review Board (CLERB) reports.

On September 29, 2017, we participated in a two-hour conference call with custodial, mental health and medical staff from San Diego County (and its contractor Liberty Health), legal counsel for the County, and DRC, to discuss aspects of mental health care and suicide prevention in the jails and to clarify particular policies and practices. We did not conduct a site visit as part of this review.

All of the suicide deaths reviewed were of male inmates. Although the context of many findings and recommendations applies to issues identified in the male facilities, they should be applied equally to the treatment of female inmates in the San Diego County Jail system.

V. EXPERTS' ANALYSIS

Our findings and recommendations are based on materials received as of November 2017. Policy changes occurring after that date will not be reflected in our report.

Our analysis is divided into nine requisite components of a successful comprehensive correctional suicide prevention program,¹ and contains findings and recommendations to improve the Department's suicide prevention and mental health treatment delivery efforts. The components covered by this review are:

1. Screening for Suicide Risk and Related Mental Health Needs
2. Clinical Assessment and Interventions
3. Communication
4. Restrictive Housing and Monitoring of Inmates
5. Levels of Supervision of At-Risk Inmates
6. Emergency Response
7. Staff Training
8. Review of Suicide Deaths and Serious Suicide Attempts
9. Quality Improvement

Below, we provide our analysis. For each review component, we identify Key Deficiencies that were apparent through our review of suicides and relevant policies. We then provide specific Findings and Recommendations for systemic improvements addressing Key Deficiency areas.² In addition, we have completed two detailed individual reviews of recent suicides at the San Diego County Jail, to be provided directly to the County. These individual reviews may serve as models for the County's own quality improvement efforts moving forward.

¹ Hayes, Lindsay. (2017). *Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons*. National Commission on Correctional Health Care, <http://www.ncchc.org/other-resources>. Accessed October 21, 2017, and Canning, R.D. & Dvoskin, J.A. (2017). Preventing Suicide in Detention and Correctional Facilities. In J. Wooldredge and P. Smith (Eds.) *The Oxford Handbook of Prisons and Imprisonment*. New York City: Oxford University Press.

² Inmate names are not provided in this report. References to specific cases will be identified in a separate version of this report that is provided to the County.

1. SCREENING FOR SUICIDE RISK AND RELATED MENTAL HEALTH NEEDS

Screening for suicide risk and related mental health needs is an important part of any suicide prevention program. In jails, thorough screening upon entry (“booking”) is extremely important. Research shows that almost one-quarter of jail suicides occur in the first 24 hours of incarceration and an additional quarter within 14 days.³ Of the 12 suicide deaths that occurred at San Diego County Jail from December 2014 through 2016, eight (67%) occurred within 10 ten days of booking.

In addition to screening at the time of booking, screening should be administered for all inmates at important transition moments throughout their confinement. Screening should be administered by medical or mental health staff. (Trained custody staff can effectively administer appropriate initial booking screening with standard scoring that provide clear guidance for referral and further assessment.)

For many inmates, the initial period of incarceration is a period of extremely high risk. As time passes in jail, the risk of suicidal behavior tends to decrease but may rise quickly and suddenly due to transitions that inmates encounter – court dates, visits, receipt of bad news, transfers to other housing units or facilities, and placement in segregated settings. Thus, screening should occur at significant transition moments, the results of which should be available to clinical staff to track changes over time. A process for recurrent screening based on individual circumstances and events is important because research suggests that many individuals who die by suicide communicate their intent in the period before their deaths.⁴ That is to say, warning signs of suicide risk and related psychiatric distress are often identifiable with effective screening.

Screening should be systematic and use standardized questionnaires. They should be short, valid, and target psychological symptoms and risk factors most appropriate for the correctional settings in which they are used.⁵ Staff should be trained to ask questions clearly and uniformly, and forms should be available in English, Spanish, and other languages. Staff should not rely only on verbal responses, but should be trained to document contextual factors such as behavior and appearance, the inmate’s attention to the questions, information from arresting officers, family members, friends, or other individuals associated with the inmate, and other factors that provide important information about suicide risk. Finally, documentation of adequate screening is also legal documentation for the protection of both the facility and staff.

³ Hayes, Lindsay M. (2010). National study of jail suicide: 20 years later. *Journal of Correctional Health Care*, 18, 233-245.

⁴ Ibid.

⁵ Maloney, M.P., Dvoskin, J., and Metzner, J.L. (2015). Mental health screening and brief assessments. In R.L. Trestman, K.L. Appelbaum, and J.L. Metzner (Eds.) *Oxford Textbook of Correctional Psychiatry*. New York: Oxford University Press.

KEY DEFICIENCIES: SCREENING

1. The initial booking screening questions are poorly worded, are not designed in a way that effectively elicits important information, and lack important elements, such as inquiry regarding history of psychiatric hospitalization.
2. The system has lacked an adequate policy or procedure for conducting a suicide risk/ mental health screening for individuals at transition events that carry elevated risk, such as when they are placed in segregation or moved to a new facility.
3. The system has lacked an adequate procedure for screening inmates returning from court (where they may have received bad news), moving to prison, or being extradited. These are events that may elevate an inmate's risk of suicide.

FINDINGS AND RECOMMENDATIONS: SCREENING

FINDING 1.1. Of the twelve (12) San Diego County Jail inmates who died by suicide from December 2014 through 2016, we identified a number of problems with the initial suicide risk screening and referral process. For example, one had a 24-hour delay before his initial screening. Of the six inmates who screened positive for mental health problems during their initial screening, one had no referral for further evaluation.

Six inmates denied any mental health problems during their initial screening. Among this group, one inmate had indicators that would have warranted a mental health referral, yet we found no record of a referral being made.

One particularly troubling case stood out. The inmate had a diagnosis of bipolar disorder and was screened, but even though he demonstrated signs and symptoms of florid psychosis and mania, he was not referred for evaluation and admission to the Psychiatric Security Unit. He was placed in a Safety Cell, was later released to general population, and died on Day Six of his confinement while still floridly psychotic and manic, despite a request to custodial staff earlier in the day for safety cell placement. Jail staff did not complete a separate assessment of suicide risk despite this inmate's extreme mental state and need for evaluation and treatment. Individuals suffering from bipolar disorder have some of the highest rates of suicide compared to other mental disorders. The inmate's documented mental health history and his symptomology at the jail were such that he should have received urgent psychiatric attention and been referred for inpatient care.

RECOMMENDATION: *The Department should adopt a standardized screening measure such as the Brief Jail Mental Health Screen⁶ and augment it with a suicide risk screening measure such as the Columbia-Suicide Severity Rating Scale⁷ or a series of suicide-specific questions (current suicidality, past attempts, etc.).*

⁶ The screener can be obtained from: <https://www.prainc.com/?product=brief-jail-mental-health-screen>.

⁷ The C-SSRS can be obtained from <http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english>.

RECOMMENDATION: *Suicide prevention policies and procedures should contain a specific section devoted to screening – including guidance on measures, locations, and times. The section should explain when and who administers screening in the range of potential situations. This section will guide staff actions and decrease the number of “false negative” screenings, which are the ones most costly to a system.⁸ The policies should include a checklist with criteria that guides staff when to refer for evaluation by the jail’s designated “Gatekeeper” (generally, a Registered Nurse or mental health clinician) and guides Gatekeepers on when to refer for further evaluation by the mental health program.*

FINDING 1.2. We identified four suicide deaths for which the inmates screened positive for drug and/or alcohol withdrawal but were not targeted for a more comprehensive suicide risk assessment. There is evidence showing that such inmates are at increased risk of suicide and self-harm. These individuals should have been further assessed.⁹

RECOMMENDATION: *New arrivals withdrawing from alcohol and/or drugs should be specifically assessed for psychiatric disorders and suicide risk. While the Jail’s policy (MSD.S.10) lists “Intoxication/Withdrawal Symptoms” as among “Other Risk Factors That Could Cause Circumstantial Concerns,” review of the jail’s recent suicide deaths indicate the need for revision of this policy to ensure that such symptoms trigger a comprehensive suicide risk assessment.*

FINDING 1.3. The San Diego County Jail system lacks an effective quality improvement program with respect to mental health/suicide risk screening.

RECOMMENDATION: *Because mental health and suicide risk screening is a component of effective quality improvement programs in health care settings, procedures should be developed to track both when screening occurs and the results of the screening. Rates of screening and referrals should be a key indicator in the Department’s quality improvement program.*

⁸ In general, screening measures should err on the side of false positives since it is less costly to complete an extra evaluation than deal with the aftermath of a preventable suicide death. Canning, R.D. & Dvoskin, J.A. (2017). Preventing Suicide in Detention and Correctional Facilities. In J. Wooldredge and P. Smith (Eds.) *The Oxford Handbook of Prisons and Imprisonment*. New York City: Oxford University Press.

⁹ Rivlin, A., Ferris, R., Marzano, L., Fazel, S., and Hawton, K. (2013). A typology of male prisoners making near-lethal suicide attempts. *Crisis*, 13, 335-347.

2. CLINICAL ASSESSMENT AND INTERVENTION

Treatment planning and management of prisoners potentially at risk of suicide relies on effective clinical assessment. Effective clinical assessment of suicide risk requires clinicians to 1) gather data on risk and protective factors and warning signs; 2) perform a suicide inquiry in which they ascertain the extent of planning, intent, and the quality and character of suicidal ideation, if present; 3) come to a judgment of risk with a rationale for this level; and 4) develop a treatment plan for management of the suicidal patient. Each assessment (especially those conducted in response to a crisis evaluation) should include a short-term "safety plan" that emphasizes enhancement of protective factors, reduction of acute and/or modifiable risk factors (possibly housing issues or issues involving recent transfers), and treatment of current distress and agitation. These safety plans can be modeled after brief interventions used in emergency departments in the community¹⁰, but should be specifically tailored to correctional settings. Treatment planning should include specific timeframes for review and updating. Referrals for mental health treatment should have specific timeframes for response by mental health staff.

It is important for jail staff – custodial, mental health, and medical – to monitor and treat identified mental health problems. This requires staff to provide clinically indicated treatment and to respond quickly and effectively to crises as they arise. Even after an inmate's crisis subsides, there is a continued need to address mental health treatment needs. An inmate should be transitioned into a structured mental health program that addresses their level of symptoms and functioning in the correctional environment. In addition, if an inmate is assessed to be at elevated suicide risk, they should continue to be evaluated for this risk as they continue in confinement, with an individualized treatment plan and safety plan.

KEY DEFICIENCIES: CLINICAL ASSESSMENT AND INTERVENTION

1. Although inmates are often referred for further mental health and suicide risk evaluations after positive screening results, it is not clear from the records or the County's policies and procedures what (if any) criteria have been used or what timeframes have been required for referrals and evaluations.
2. The documentation of risk evaluations has been poor and inconsistent, hindering effective treatment and continuity of care among providers and between jail facilities.
3. Mental health staff do not adequately consider previous risk evaluations and changes to inmates' conditions during the course of confinement.
4. Inmates who have required mental health treatment and remained in custody for significant periods do not have individualized mental health treatment plans in their charts or access to an adequate level of mental health care programming.

¹⁰ Stanley, Barbara and Brown, Gregory K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice* 19. 256-264.

FINDINGS AND RECOMMENDATIONS: CLINICAL ASSESSMENT AND INTERVENTION

FINDING 2.1. The San Diego County Jail policies do not provide adequate guidance, including clear timelines, regarding the evaluation process for inmates who screen positive for mental health needs or suicide risk at booking. For example, in one case reviewed, the inmate was brought to the jail after a serious suicide attempt. Though he was seen for further evaluation after the initial screening, it was unclear who performed the evaluation or what the rationale for it was.

RECOMMENDATION: Policies and procedures should provide specific timelines for referral and completion of evaluations after referral. For instance, the policy should establish timelines for response to referrals – standard guidelines, for example, may be for evaluations that are “emergent” to be completed within four hours, “urgent” within 24 hours, and “routine” referrals within five business days. Data about these referral timelines and completion rates should be reviewed regularly to gauge access to care as part of a quality improvement program.

FINDING 2.2. The quality of suicide risk evaluations varied among the records reviewed. Although the policies provide criteria for categorizing an inmate as “High” risk for suicidal behavior, we found that risk factors were not adequately documented, even as several inmates had a clear history of suicidal behavior and/or a known psychiatric history.

RECOMMENDATION: To improve the quality of suicide risk evaluations, the Department should create a standardized suicide risk evaluation form or template in the electronic record. This would facilitate improved documentation by mental health clinicians with respect to their risk assessments. This form or template should include the following sections:

1. The reason for evaluation along with time, date, and location
2. Sources of information
3. Discrete sections for Warning Signs such as the AAS’ IS PATH WARM, and acute and chronic (or static) risk factors
4. Protective factors
5. Questions about planning or a desire for death
6. A mental status exam
7. Judgment of risk and a rationale for the judgment
8. A safety plan that addresses modifiable risk factors and warning signs.

FINDING 2.3. Mental health staff do not clearly or adequately document inmates' suicide risk levels. In some cases, the assigned suicide risk levels were problematic. For example, one inmate was incorrectly rated as "Low" risk just two days after a serious suicide attempt. In addition, the jail system's two-level stratification of risk ("High" or "Low" risk) is inconsistent with common practice. Many healthcare systems (e.g., California Department of Corrections and Rehabilitation, United States Department of Defense, U.S. Department of Veterans Affairs) use at least a three-level stratification – such as Low, Medium, High – or four-part – such as Low, Medium, High, Extreme.

RECOMMENDATION: *Because a judgment of risk drives treatment decisions (i.e. what to do), the County should utilize a three-level rating system that more realistically describes the continuum of risk and will allow clinicians to devise treatments that better fit the needs of the patient. The addition of a "Medium" risk level will alert other staff that a patient's risk for suicidal behavior is significant and requires more attention and alertness.*

FINDING 2.4. We could identify no standardized procedure for placing, monitoring, and releasing inmates from various levels of suicide monitoring. For instance, one inmate who died by suicide had four Safety Cell placements based on suicide risk over a period of four months. Each time, he was released without adequate documentation of the clinician's judgment of risk and the rationale for the decision. The situation for another inmate's two Safety Cell placements prior to his suicide was similar.

RECOMMENDATION: *The Department should ensure adequate and consistent documentation of suicide risk assessments when adjusting an inmate's level of observation.*

FINDING 2.5. The San Diego County Jail's policies for addressing inmate medication refusals are vague and inadequate. In at least one reviewed case, the inmate's refusal of psychiatric medication was not addressed in a timely fashion.

RECOMMENDATION: *The Department should implement procedures, with specific timelines, for when an inmate refuses prescribed psychiatric medications.*

FINDING 2.6. We identified deficiencies with the process and setting of clinical contacts for prisoners at risk of suicide. Although a number of inmates we reviewed were seen by mental health staff, it was unclear if there was a standard interval between mental health visits, or if they were done on an *ad hoc* basis, or if they were simply up to the individual clinician's discretion. A substantial number of mental health clinical visits appear to have been conducted inside the housing units, including at cell-front. This setting does not provide adequate auditory and visual privacy and confidentiality necessary for meaningful clinical interactions.

RECOMMENDATION: *The Department should establish standard intervals for mental health visits, which can be made more frequent pursuant to individual clinical need.*

RECOMMENDATION: *Because interviewing inmates at cell-front decreases the chance for a frank and open conversation with a patient, the Department should provide confidential treatment space for inmates being followed by mental health.*

FINDING 2.7. We have significant concern about the lack of required follow-up for prisoners identified as at risk of suicide after they are discharged from the San Diego County Jail's Inmate Safety Program (ISP), including from the Psychiatric Security Unit, Safety Cells, and Enhanced Observation Housing (EOH). The use of specific risk factors to determine follow-up processes for such inmates is questionable in our estimation. Although we understand the rationale, we believe that the program runs the risk of false negatives, which are much costlier than false positives when it comes to suicide attempts and deaths. Prisoners who have required placement in the Inmate Safety Program based on an identified risk of self-harm should, as a rule, be provided clinical follow-up and, as appropriate, clinically indicated treatment interventions.

RECOMMENDATION: *The ISP Follow Up Protocol should provide that all inmates released from EOH should be seen by a mental health clinician within 24 hours of release and have their safety plan reviewed and updated if necessary.*

RECOMMENDATION: *Decisions regarding clinical follow-up after release from the Inmate Safety Program (including EOH) should not be left to a "clinician's discretion." We believe a best practice is to have a specific follow-up schedule that all clinicians follow, e.g. daily clinical "check-ins" for five days after a housing change, followed by weekly check-ins for two weeks.*

RECOMMENDATION: *Inmates who are being followed by the mental health program after release from the Inmate Safety Program (including EOH) should have specific timeframes for clinical contacts outside the specific follow-up procedure. This would allow for a more in-depth interview to cover treatment plans and medication compliance, for instance.*

FINDING 2.8. Four inmates who died by suicide suffered differing levels of drug/alcohol withdrawal symptoms, but only two inmates were housed in Medical Observation Beds (MOB). The policy on MOB placement for patients "experiencing severe symptoms" of drug withdrawal does not mention concurrent treatment by psychiatry except in passing. The section notes that these inmates "should be considered a high risk for suicide" but notes only that nurses will round "once a shift" on the MOB. That is, there is a significant gap in the provision of mental health treatment and suicide prevention monitoring for prisoners at risk who are also experiencing withdrawal symptoms.

RECOMMENDATION: *We recommend a higher level of observation, including clinically indicated mental health treatment, for inmates experiencing both mental health problems and withdrawal symptoms.*

FINDING 2.9. The Inmate Safety Program policies lack sufficient direction regarding the timeframes for assessment and release from the Enhanced Observation Housing (EOH) units. It is essential that inmates placed in EOH be reviewed and transferred to less restrictive settings at the earliest time appropriate based on their condition.

RECOMMENDATION: Policies should give specific direction to staff about the criteria for placing and assessing inmates in EOH units. For instance, we believe this type of housing is appropriate for inmates voicing suicidal thoughts and deemed at medium or high risk of acting on these thoughts in the very short-term (minutes to hours). We recommend that the schedule for re-assessment of inmates in EOH should not be categorical, but based on evaluations conducted by mental health professionals at regular intervals. While we commend the Jail for recently modifying its policy to ensure that all EOH prisoners are re-assessed for suicide risk, at a minimum, at least once in each 24-hour period, when clinical presentation dictates closer monitoring, clinicians must make a judgment of current risk including any changes since the last assessment. Decisions to transfer an EOH inmate to either general population or a mental health housing unit must take into account past behavior, current symptoms, and the context of confinement (charges, court date, pending transfer, etc.), and must include a written safety plan.

RECOMMENDATION: Stays in the EOH should not exceed 48 hours. If the inmate is not stabilized within that time period, they should be evaluated for referral to inpatient psychiatric treatment (i.e., the Psychiatric Security Unit). However, if the placement in EOH housing extends beyond 48 hours, the withholding of out-of-cell time, personal property, social visits, and clothing should be based on individualized clinical assessment and safety concerns.

FINDING 2.10. Inmates who have required mental health treatment and remained in custody for significant periods did not have documented, individualized mental health treatment plans in their charts or access to an adequate level of mental health care programming.

The Department is making efforts to improve how inmates are evaluated and at elevated risk for suicide are monitored, but overall the mental health program remains fragmented and without good continuity of care, which can lead to poor outcomes. For instance, as noted above, it was unclear to us why some inmates would be placed in Safety Cells and some in EOH. Further, based on our experience with suicidal inmates in correctional settings, we did not understand why inmates deemed at high risk of suicide were not more often evaluated for placement in the Jail's inpatient level of care unit.

RECOMMENDATION: The Department should take steps towards development of a consolidated mental health treatment environment which combines the Safety Cell program, Enhanced Observation Housing, and an enhanced outpatient mental health program.

Many systems have adopted a "level of care" system to provide mental health services and to clarify hand-offs and treatment programs. The Department appears to have created categories of mental health needs, but without formalizing a system in policy and procedure that provides for an appropriate spectrum of levels of care. The PSU is the highest level of care. There are mental health "cluster" units, as on the sixth floor at the Central Jail, but without formal treatment programming. There is also the Detention Outpatient Psychiatric Services (DOPS), which appears to include the lion's share of inmates requiring some level of ongoing mental health attention.

It would be useful and important to create an “intermediate” level of care, located in enough San Diego County Jail facilities to ensure timely access for those with mental health needs that warrant enhanced treatment programming. The program would serve as a “step-down” for people with recent Safety Cell, EOH, or PSU admissions, as well as for people with a serious mental illness that makes it difficult for them to function in a general population jail setting. The program would have sufficient mental health staffing to provide a structured treatment program that includes individual and group therapy, guided by individualized treatment plans (as required by Title 15, Sec. 1210 of the California Code of Regulations) that identify mental health problems, treatment goals, and a plan to accomplish those goals.

3. COMMUNICATION

Communication between and among correctional staff and other professionals working in the jail environment is an important aspect of suicide prevention. Suicide prevention expert Lindsay Hayes lists three categories of communication: (1) getting information about the inmate’s behavior at the time of arrest and transport; (2) communication between correctional staff and clinical staff about changes in an inmate’s status and condition; and (3) communication between all staff and inmates who may be suicidal. Poor communication practices can result in poor outcomes. Hayes recommends a multidisciplinary approach to working with suicidal individuals that notes:

Poor communication between and among correctional, medical, and mental health personnel, as outside entities...is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts, and boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.¹¹

KEY DEFICIENCIES: COMMUNICATION

1. The San Diego County Jail system has lacked an effective way for custodial staff and mental health staff to communicate about important changes in an inmate’s status (e.g. results of court proceedings, “bad news,” impending transfers, etc.).
2. The lack of standardization in clinical documentation has hampered effective communication between treating clinicians and other health care staff.

¹¹ Hayes, L. (2017). *Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons*. National Commission on Correctional Health Care, <http://www.ncchc.org/other-resources>. Accessed October 21, 2017.

FINDINGS AND RECOMMENDATIONS: COMMUNICATION

FINDING 3.1. Several inmates who died by suicide in jail had significant events (“bad news”) during their incarceration that may have significantly increased their suicide risk. Inmates may have multiple court dates with mixed results and many are sentenced to terms either locally or in state prisons. These developments can have a significant impact on an inmate’s psychological state and contribute to elevated risk of suicide or self-harm. For instance, one hanged himself a few days before he was to transfer to state prison. Another committed suicide the day before his transfer to another state to face criminal charges. This case was particularly egregious because it was known among staff that he had made a credible suicide attempt in a similar manner just two weeks earlier, and that he was experiencing considerable stress about being extradited to another state to face criminal charges. Yet, as the date of his extradition approached, the clinical record did not reflect any sense that this could be a period of heightened risk requiring closer observation, monitoring, and clinical follow-up. From our review, this was a suicide death that with adequate communication was preventable. Our review of San Diego County Jail policies and procedures found no specific mechanism for communication in these kinds of situations.

RECOMMENDATION: *Communication and coordination among custodial staff and health care staff regarding inmates at risk of suicide and psychiatric decompensation need improvement. Custodial staff must maintain awareness, share information, and make appropriate referrals to mental health and medical staff. Multidisciplinary teams should meet on a regular basis to discuss the status of inmates with significant mental health needs or who demonstrate significant suicide risk factors.*

FINDING 3.2. Mention of significant events was scant in the treatment records we reviewed. Given the vulnerability to external events that many inmates experience (and their inability to control many of them), evaluations of risk should include information about such events and how they may impact the inmate’s risk.

RECOMMENDATION: *Treatment plans should include substantive discussion, including potentially a specific section, regarding significant events that could affect the inmate’s treatment needs and/or risk of suicide.*

4. RESTRICTIVE HOUSING AND MONITORING OF INMATES

The housing placement of inmates can have profound impacts on their mental well-being and produce changes in their risk of self-injury and suicide. Our experience with jail and prison facilities, along with extensive research, has shown that placement in segregated housing increases the risk of suicidal and self-harming behavior, isolates individuals, and impedes normal interpersonal interactions that are essential to psychological health and adequate treatment.

Policies and procedures should take this known risk into account and include mental health and suicide risk information when housing decisions are made. Housing inmates in isolated settings may increase their sense of hopelessness and desperation, increasing the potential for suicidal thinking and behavior. In addition, the housing of individuals with intellectual disabilities in such settings can trigger suicidal thoughts and behavior. Placing inmates with mental illness in solitary confinement-type housing (i.e. housing situations where an inmate is limited to a few hours of out-of-cell time or less per day, has reduced privileges, and has minimal opportunity for normal social interactions) can exacerbate symptoms and lead to

negative outcomes. The placement of inmates with mental illness or elevated suicide risk in solitary confinement settings should be avoided whenever possible. When such placements are deemed necessary, adequate monitoring and enhanced mental health treatment are essential.

In addition, the monitoring of inmates in housing units, particularly units with solitary confinement-type conditions, is a standard custodial practice. Adequate welfare and/or safety checks involve observing inmates and noting their status and welfare. Inmates housed in segregated housing are often monitored at more frequent intervals than those in general population settings.

The construction of jail cells in segregation units should account for the risk presented by attachment points – such as ventilation grates and bed frames – that are commonly used for hanging attempts.

KEY DEFICIENCIES: RESTRICTIVE HOUSING

1. San Diego County Jail lacks an adequate process to screen inmates for increased suicide risk prior to placement into Administrative Segregation (AdSeg) or Keep Separate All (KSA) housing.
2. Security/welfare checks of inmates in housing units were observed to be inadequate. In several cases, they were poorly performed and in others they were not completed in a timely fashion.
3. San Diego County Jail lacks an effective system to monitor and to provide necessary treatment of inmates on the mental health caseload who are housed in AdSeg or KSA housing, increasing the risk of suicide and psychological deterioration in these settings.

FINDINGS AND RECOMMENDATIONS: RESTRICTIVE HOUSING

FINDING 4.1. There is not an adequate process for mental health screening before inmates are placed into AdSeg or KSA housing, which are known to carry significant risks for people with mental illness.

RECOMMENDATION: *Given the harsh setting and restrictions inherent in restrictive housing units and the impact this may have on inmates, the Jail should institute screening of all inmates prior to their placement in such units. This screening could be included with a medical screening completed by nursing staff. The screening would ask simple questions addressing current distress and thoughts of suicide, and provide an opportunity for mental health staff to identify treatment needs and to provide input into housing decisions.*

FINDING 4.2. Inadequate security/welfare checks (also known as “proof of life checks”) were observed via video review in a number of cases in which inmates died by suicide. In at least one case, hourly safety checks were not completed pursuant to Jail policy during the time period the inmate died by suicide. In video and record reviews of at least three inmates who died, checks were completed inadequately – either not completed timely or in manner that failed to meaningfully assess the welfare of the inmate. For instance, in one case, the video showed two deputies enter the housing unit and separate to allow one to check the upper tier and one the lower. The deputies completed their checks of 40 cells in

17 seconds, far too quickly to complete meaningful checks. The deputy checking the upper tier did not stop except at the first cell and did not appear to take enough time to establish that the inmates in each cell were alive and safe.

RECOMMENDATION: *The Department should provide annual training for sworn staff that includes reminders about the requirement for assuring the welfare of inmates during security/welfare checks.*

RECOMMENDATION: *The Department should implement a method to track and audit the timeliness and adequacy of security/welfare checks, such as reviewing videos.*

FINDING 4.3. The San Diego County Jail lacks adequate policies or procedures for monitoring and treatment of inmates with mental illness in restrictive housing. Policies lack direction regarding how mental health information should be incorporated into housing decisions. For example, one inmate was housed in AdSeg for over four months, but his segregated housing status was not mentioned in his clinical documentation. This inmate, who appeared to suffer the ill effects of prolonged isolation, had significant symptoms of mental illness that were not detected by staff until he voiced suicidal ideation two months after his incarceration. After several more Safety Cell placements and adjudication of his criminal charges, he professed to have safety concerns and was housed in AdSeg for the last six weeks of his incarceration and life. He hanged himself several days before he was to be transferred to state prison.

RECOMMENDATION: *The Department should implement procedures that ensure appropriate monitoring of inmates in segregated housing units to timely identify inmates with deteriorating mental health, and implement a program that delivers necessary treatment for inmates on the mental health caseload in restrictive housing units.*

FINDING 4.4. The suicide death of one inmate revealed that monitoring panels in control booths were at times set to mute and staff did not adequately monitor alert lights in the control booths. In this case and others, such practices can result in staff missing emergencies and calls for help from inmates.

RECOMMENDATION: *The Jail should train all housing staff to properly maintain alert systems and monitors in housing unit control booths, and to respond appropriately when alerted.*

FINDING 4.5. Eight inmates died by hanging from December 2014 through 2016. In all of these cases, ligatures were attached to ventilation grills or looped around beds that had a separation from the cell wall.

RECOMMENDATION: *The Department should take affirmative steps to address the known risk of suicide attempts associated with the presence of attachment points in cells, particularly in segregated housing. This may include retrofitting cell ventilation grates and beds (so that the bed is flush against the cell wall) and avoiding attachment points in future construction, such that ligature material cannot be passed through gaps for suicide attempts by hanging.*

5. LEVELS OF SUPERVISION OF AT-RISK INMATES

Adequate monitoring of suicidal inmates is a crucial component of a comprehensive suicide prevention program. As the World Health Organization has recognized: "The level of monitoring should match the level of risk. Inmates judged to be actively suicidal require constant supervision. Inmates who have raised staff suspicions of suicide but who do not admit to being actively suicidal, may not require constant supervision but will need to be observed more frequently."¹²

KEY DEFICIENCIES: SUPERVISION

1. The Department's policies lack sufficient clarity about the levels of risk and the levels of observation specified for each level of risk. The policy should provide for constant observation of inmates at high risk whenever clinically indicated.
2. The Department's policies and procedures for monitoring inmates in Safety Cells and EOH are unclear and at times give conflicting guidance for staff, which can lead to poor decision-making and poor continuity of care for at-risk inmates.
3. Monitoring schedules for the County's jail facilities do not match the system-wide policies and procedures manual, which creates confusion and inconsistency in practices.
4. The Department's policy and practices do not ensure that health care staff have authority to determine the appropriate level of care and observation (absent clear and documented security concerns), with custodial staff primarily authorized to make such decisions. This is problematic. Decision-making regarding the level of suicide risk for inmates is the responsibility of the mental health and medical programs. Although safety and security need to be taken into account, the welfare of inmates is a top priority.

FINDINGS AND RECOMMENDATIONS: SUPERVISION

FINDING 5.1. The Department's policies lack sufficient clarity about the levels of risk and the levels of observation specified for each level of risk.

RECOMMENDATION: *Levels of observation for suicidal inmates should progress from the highest level of observation – constant, direct, visual observation (also called 1:1 or Suicide Watch) – and be stepped down from that level. Inmates requiring 1:1 observation are inmates who are currently attempting to harm themselves, or who express suicidal thoughts with a well-developed plan and available means, and continue to espouse the intent to carry out their plan. This most intense level of observation is reserved for those inmates who are at the gravest risk and need immediate psychiatric inpatient care (either in the PSU or offsite inpatient facility).*

¹² World Health Organization. (2007). Preventing Suicide in Jails and Prisons. World Health Organization & International Association for Suicide Prevention. Geneva, Switzerland.

RECOMMENDATION: Inmates requiring a less stringent level of observation are those inmates who may have stated suicidal thoughts and/or intentions but do not have the means or well-developed plan, but are agitated and in great distress. These inmates, still at high risk, should be placed on Suicide Precaution, which requires staggered 15-minute checks (rather than “twice in every 30 minute period” as appears to have been the practice at some San Diego County jail facilities).¹³ Staggered 15 minute checks means that an inmate must be observed at least once in every 15-minute interval and there should never be more than 15 minutes between observations. In practice, inmates housed in Safety Cells or the EOH for suicidal thinking or behavior should always be placed on Suicide Precaution status unless they are being evaluated for referral to the PSU, in which case they should be placed on continuous visual observation until transferred.

RECOMMENDATION: Decisions to move an inmate from a higher level of observation to a lower one should always require a clinical assessment of current risk and a justification by a mental health clinician.

FINDING 5.2. Recent proposed changes to the suicide prevention policy specifying three levels of Suicide Watch and certain frequencies of monitoring/observation represent a positive step by the Department. The policy should continue to be refined to provide adequate clarity regarding applicable criteria for the levels of risk and observation.

RECOMMENDATION: Policy should provide clear guidance regarding the criteria for levels of risk and observation. Policy should also provide for constant, visual observation (also called 1:1 observation) when clinically indicated. For instance, in the proposed policy we reviewed, the observation schedules for inmates identified as “Level I” is the same as that for inmates identified as “Level II,” and neither provide for constant visual observation. The policy should specify observation levels based on risk and housing (e.g., inmates who are voicing suicidal thoughts and intention to act, and are housed in Safety Cells, should be on 1:1 Observation, while inmates housed in EOH and having intermittent suicidal thoughts should be on Suicide Precaution).

RECOMMENDATION: Inmates placed in safety cells should be re-evaluated for stepdown or inpatient placement no more than 12 hours after placement.

FINDING 5.3. Individual facility policies regarding monitoring of inmates at elevated risk of suicide are in some cases inconsistent with the Department’s system-wide policies. For example, the Department’s policies specify that sworn staff will monitor inmates in Safety Cells a minimum of twice per 30 minutes, yet the “Green Sheets” for the Las Colinas Detention and Reentry Facility and the Vista Detention Facility do not.

RECOMMENDATION: *The Department must ensure that all facilities' Green Sheets are consistent with system-wide policies and procedures for monitoring inmates housed in Safety Cells and EOH.*

FINDING 5.4. The Department's policies do not provide health care staff a sufficient role in some decisions regarding release from EOH or Safety Cell Housing of inmates evaluated for increased risk of self-injury. DSB Policy Section J.1 states that "[e]very four hours, the watch commander or designee will evaluate the inmate for continued retention in a safety cell." In another section regarding removal of inmates from Safety Cells, the watch commander is to consult with a mental health provider "to determine whether the inmate, if removed from the safety cell, is likely to pose a threat to himself/herself or others." Additionally, Sections J.4 (Enhanced Observation Housing) and J.5 (Inmate Safety Program) note that *custodial* personnel make the decision about housing inmates in either setting – albeit with input from a Gatekeeper.

RECOMMENDATION: *Decisions regarding housing of inmates at elevated risk for suicidal behavior should primarily be the responsibility of medical and mental health staff, unless safety and security override these concerns (e.g., an agitated, violent, and suicidal patient). Where such safety and security concerns exist, custodial staff should consult with medical/mental health staff when making housing decisions.*

6. EMERGENCY RESPONSE

When a medical emergency occurs inside a jail, the level of training and response of custodial and medical staff will often determine if an inmate lives or dies. National correctional standards acknowledge that a facility's policy regarding intervention should be threefold. First, all staff who come in contact with inmates should be trained in standard first aid procedures and CPR. Second, any staff member who discovers an inmate attempting suicide should immediately survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR. Third, staff should never presume that the inmate is dead but rather should initiate and continue life-saving measures until relieved by medical personnel.¹³

KEY DEFICIENCIES: EMERGENCY RESPONSE

1. Almost half of the emergency responses to lethal suicide attempts from December 2014 through 2016 featured poor coordination of lifesaving efforts, delays in starting CPR, or malfunctioning equipment.
2. The Department does not appear to have a program of drills to improve readiness and response in the case of medical emergencies.

¹³ Hayes, L. (1995). *Prison Suicide: An Overview and Guide to Prevention*. United States Department of Justice, National Institute of Corrections. Washington, DC.

FINDINGS AND RECOMMENDATIONS: EMERGENCY RESPONSE

FINDING 6.1. Review of records and video footage of suicide deaths of seven inmates (58.3% of those reviewed) demonstrated serious problems with emergency response. In one case, health care staff were unable to utilize the automated electronic defibrillator (AED) due to malfunctioning equipment. In another case, there was a nearly seven-minute delay in using the AED prior to the arrival of the paramedics. Deputies discovered one inmate hanging in his cell but waited seven minutes to cut the inmate down and then prevented nursing staff from evaluating the inmate's condition or using the AED. There were two cases involving a delay in starting cardiopulmonary resuscitation (CPR), in one case for several minutes while approximately 11 deputies stood around without initiating life-saving measures.

Good coordination between custodial and medical staff is important because brain damage from asphyxiation can occur within 4 minutes, with death often resulting within 5-6 minutes. Timely initiation of effective life-saving measures can save lives. This did not occur in many San Diego jail suicide cases.

Our review found that not all staff understand their role in emergency responses to suicide attempts. Language in the Department's policies for Medical Emergencies is not clear. For example, it states that medical personnel "may assist or take over CPR responsibilities" (emphasis added). The policy language should be changed to give medical personnel the responsibility of emergency response when they arrive on scene.

RECOMMENDATION: *All staff should be thoroughly trained, including periodic refresher training, in their specific emergency response roles:*

- a. Sworn staff should not assume an inmate is dead, but should start lifesaving measures except in well-delineated circumstances (electrocution, etc.)
- b. Any staff member should sound the alarm and notify 911.
- c. Sworn staff should be trained on how to use emergency equipment such as AEDs and cut down tools.
- d. Sworn staff should continue lifesaving measures until relieved and/or directed by medical staff.
- e. Medical staff should assume control of the emergency response as soon as they arrive on the scene.
- f. Declaration of death is the responsibility of a licensed physician.

RECOMMENDATION: *Multi-disciplinary drills should be regularly conducted in housing units to assure that emergency response readiness is maintained and that staff understand their roles.*

RECOMMENDATION: *Emergency response equipment should be audited regularly and maintained in working condition.*

7. STAFF TRAINING

"The framework for a comprehensive suicide prevention program includes substantial staff training."¹⁴ All custodial, medical, nursing, and mental health staff should undergo systematic and ongoing training on the signs of mental illness and elevated suicide risk. All staff who have significant contact with inmates "should be trained to recognize verbal and behavioral cues that indicate potential suicide."¹⁵

We reviewed numerous San Diego County Jail materials related to suicide prevention, including PowerPoint presentations, handouts, brief trainings, scenarios, lesson plan, and booklets.

KEY DEFICIENCIES: STAFF TRAINING

1. The Department's training programs for custodial and medical/mental health staff is not well coordinated. It is not clear what the training schedule is, what the training requirements are, how training records are kept, and how trainings should be evaluated.
2. Training for mental health clinicians on principles of suicide risk assessment and treatment should adhere to accepted clinical standards, with reference to the professional literature about risk assessment and the treatment of suicidal patients.

FINDINGS AND RECOMMENDATIONS: STAFF TRAINING

FINDING 7.1. Currently there is no consolidated training program that encompasses all aspects of suicide prevention, including suicide warning sign awareness, how to work with inmates with mental illness, principles of suicide risk assessment, correctional suicide prevention, treatment of suicidal inmates, and emergency response.

RECOMMENDATION: *The Department should implement a training program that includes modules for custody cadets, custodial staff, and medical/mental health staff (including contract staff). Policies should be written that cover training for all staff and that includes timeframes, content requirements, and evaluation strategies. In addition, a system should be put in place that tracks trainings and ensures that all staff are current on required trainings.*

FINDING 7.2. Generally, the training materials we reviewed indicate that there are gaps in the training for medical and mental health staff, who must be prepared to assess suicide risk and identify appropriate interventions.

RECOMMENDATION: *The Department's training unit should be charged with developing a set of curricula covering all aspects of mental health treatment and suicide risk assessment and treatment.*

¹⁴ Metzner, J. and Hughes, K. (2015). Suicide risk management. In R.L. Trestman, K.L. Appelbaum, and J.L. Metzner (Eds.) *Oxford Textbook of Correctional Psychiatry*. New York: Oxford University Press.

¹⁵ Ibid.

RECOMMENDATION: All staff who have regular contact with inmates should be required to have standard first aid cardiopulmonary resuscitation (CPR) training and be trained in the use of various emergency equipment (cut down tools, automated external defibrillators (AEDs), etc.). This will help ensure that staff understand their roles in emergency response and can respond appropriately.

RECOMMENDATION: The Department should use a standardized and best practice training protocol for sworn staff, such as that developed by Lindsay Hayes.¹⁶

FINDING 7.3. Review of the suicides between December 2014 and 2016 revealed both strengths and weaknesses in clinical documentation, which could be improved with training and the use of guidelines for documentation. Risk assessments were often brief and did not include important information about the inmates, such as history of suicidal behavior or protective factors, and were often shortened to "Denies SI."

The records of multiple inmates revealed poor staff practices, such as the use of "contracting for safety." This practice has not been shown to decrease the risk of suicide attempts or to provide any protection for clinicians and should be discouraged by medical and mental health staff.

RECOMMENDATION: Mental health staff should have specific suicide risk assessment training that adopts best practices in training, such as the Recognizing and Responding to Suicide Risk course from the American Association for Suicidology.¹⁷ The training should be included in onboarding for new employees and should be required periodically for current staff.

¹⁶ Hayes, L. (2016). Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities. Available from the National Center on Institutions and Alternatives. <http://www.ncianet.org/criminal-justice-services/suicide-prevention-in-custody/publications/training-curriculum-and-program-guide-2016>.

¹⁷ See Recognizing and Responding to Suicide Risk for Correctional Clinicians. American Association for Suicidology. <http://www.suicidology.org/training-accreditation/rrsr-c>.

8. REVIEW OF SUICIDE DEATHS AND SERIOUS SUICIDE ATTEMPTS

All suicide deaths and medically serious suicide attempts should be subject to a rigorous review process to identify any improvements that can be made to suicide prevention and patient safety. Review should cover medical and custodial procedures, training protocols and records, and mental health treatment (if any), and should lead to recommendations for changes in policy, procedure, and training. The review should be grounded in the principles of a “just culture” – a review that “balances the need for an open and honest reporting environment with the end of a quality learning environment and culture... Just culture requires a change in focus from errors and outcomes to system design and management of the behavioral choices of all employees.”¹⁸

KEY DEFICIENCIES: REVIEW OF SUICIDES

1. The existing suicide review process as proposed in the recently developed Suicide Prevention Policy is incomplete and requires improvement.
2. The reports issued by the San Diego County Citizens’ Law Enforcement Review Board (CLERB) do not serve a meaningful or sufficient role in reviewing suicide deaths and serious suicide attempts at the Jail. The CLERB has a narrow mandate for investigation and can, at best, only provide limited insight to problems of patient care and emergency response.
3. We identified a number of problems with respect to the accuracy and quality of CLERB reports regarding suicide deaths at the Jail.

FINDINGS AND RECOMMENDATIONS: REVIEW OF SUICIDES

FINDING 8.1. The proposed suicide review process is inadequate. It does not address what elements of the death will be examined and by whom. In addition, although the proposal designates the organizational bodies who are to review the death, it does not identify how any findings and corrective action plans will be acted upon and how proposed corrective actions will be enforced.

RECOMMENDATION: *The suicide review process should be designed to include all stakeholders and fit within the Department’s quality improvement program. It should have a mechanism to make sure suggested improvements are completed, and lay out in detail the structure of the review (content, timeline for review, and approval).*

RECOMMENDATION: *The policy should lengthen the preliminary review period from 24 to 72 hours to provide sufficient opportunity to address the complexity of these incidents and the organization in which they occur.*

FINDING 8.2. The CLERB reports provide limited utility in reviewing suicide deaths and guiding corrective action to avoid repeated problems. The CLERB does not adequately address the appropriateness of mental health treatment and suicide prevention policy or practices. This is a role that the Department must take on itself.

¹⁸ Boysen, P.G. (2013). Just culture: A foundation for balanced accountability and patient safety. *The Ochsner Journal*, 13: 400-4006.

RECOMMENDATION: *The Department should implement a robust process for review of suicide deaths and serious suicide attempts that involves a generally accepted methodology (e.g. psychological autopsy or root cause analysis). Both the psychological autopsy and root cause analysis have substantial support for their use in quality improvement and as responses to suicide deaths in custody. (The Department has indicated that a psychological autopsy was completed for at least one recent suicide, but we were not provided a copy of that report.)*

9. QUALITY IMPROVEMENT

The purpose of continuous quality improvement (CQI) programs is to improve health care by identifying problems, implementing and monitoring corrective action, and studying its effectiveness. Key components of CQI include identification of key indicators and processes, a system to collect data about these components, an analytical strategy for the data, and a way to feed the findings back into everyday practice to improve care. The CQI program must be systematic and include all aspects of care.

KEY DEFICIENCIES: QUALITY IMPROVEMENT

1. The Department has taken some positive steps regarding quality improvement but does not yet have a fully functioning or effective quality improvement program.

FINDINGS AND RECOMMENDATIONS: QUALITY IMPROVEMENT

FINDING 9.1. The Department does not have a functioning quality improvement program. As discussed in this report, there is a need for improved quality improvement processes regarding mental health/suicide risk screening, clinical assessments, individual suicide and suicide attempt reviews, and other aspects of a correctional mental health care and suicide prevention program.

RECOMMENDATION: *The Department should ensure that it has an effective system to track clinical data within the mental health and medical systems in the jail system. In addition, the Department should develop a system to track important custodial indicators related to suicide prevention. This tracking should be part of a larger quality improvement program.¹⁹*

FINDING 9.2. We were encouraged to see that the Department is taking steps to implement and enhance its Suicide Prevention Response & Improvement Team (SPRIT) to monitor suicide attempts and also evaluate suicide deaths.

RECOMMENDATION: *The policy should describe the composition of the SPRIT and its responsibilities and reporting structure. The SPRIT should be part of the Department's larger quality improvement program and should have primary responsibility for the oversight of the Department's programs to prevent suicide.²⁰*

¹⁹ See Section IV.B.3 in Canning, R.D. & Dvoskin, J.A. (2017). Preventing Suicide in Detention and Correctional Facilities. In J. Wooldredge and P. Smith (Eds.) *The Oxford Handbook of Prisons and Imprisonment*. New York City: Oxford University Press.

²⁰ Ibid. Section IV.B.2.

10. CONCLUSION

The San Diego County Jail has made notable improvements in its suicide prevention program in the last two years. We believe the recommendations we have outlined will solidify these gains and go a long way to prevent more suicides in San Diego County Jail facilities.

Respectfully submitted,
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