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Report on Inspection of the Santa Barbara County Jail (*Conducted on April 2, 2015*)

EXECUTIVE SUMMARY

Disability Rights California (DRC) is the state and federally designated protection and advocacy agency charged with protecting the rights of people with disabilities in California. DRC has the authority to inspect and monitor conditions in any facility that holds people with disabilities. Pursuant to this authority, DRC is conducting inspections of conditions in six county correctional facilities in 2015. One of these facilities is the Santa Barbara County Jail ("Jail"). On April 2, 2015, three DRC attorneys and our authorized agent Kelly Knapp of the Prison Law Office, inspected the Jail. We appreciate that Sheriff Bill Brown met with us personally and that Sheriff Department staff was helpful and cooperative during our inspection.

We observed positive practices and programs during our inspection. Sheriff Brown is forward-looking, recognizes the physical limitations in the current jail facility, and has obtained funding and approval for construction of new jail in North County. The Department emphasizes the Sheriff's Treatment and Re-entry (STAR) Program for prisoners.

However, we also found evidence of the following violations of the rights of prisoners with disabilities:

- (a) Undue and excessive isolation and solitary confinement;
- (b) Inadequate mental health care; and
- (c) Denial of rights under the Americans with Disabilities Act (ADA).

Pursuant to our authority under 42 U.S.C. §10805(a)(1) and 29 U.S.C. § 794(f)(3) and as a result of this initial inspection, we find

there is probable cause to conclude that prisoners with disabilities are subjected to neglect in the Santa Barbara County [Jail](#).¹ We will continue to work with you regarding these findings and the next steps in our investigation.

Background

The Santa Barbara County Jail houses pretrial detainees as well as sentenced inmates, and both male and female offenders. The Main Jail facility has 815 beds and a rated capacity of 627 [prisoners](#).² The adjacent Medium Security Facility has 285 beds and a rated capacity of 160 prisoners.

The Jail has a long history of overcrowding, with multiple court orders intended to set population caps. The Sheriff's Department has added to the Main Jail in an effort to keep up with overcrowding. According to the Santa Barbara County Grand Jury, "[t]he central part of the Main Jail opened in 1971 with additions in 1988, 1992, and 1999, with a current bed capacity of 618. In 2006 an adjacent honor farm was reconfigured as a medium security facility to provide an additional 161 [beds](#)."³ Recently, two conference rooms in the basement of the Main Jail were converted to dorms with 120 [beds](#).⁴

In response to chronic jail overcrowding, Sheriff Bill Brown convened a Blue Ribbon Commission of experts and local leaders,

¹ Under DRC's authorizing statute, 42 U.S.C. § 10802(5), "[t]he term 'neglect' means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff." ["Return to Main Document"](#)

² California Board of State and Community Corrections ("BSCC"), Biennial Inspection Report of the Santa Barbara Jail, January 8, 2015, Attachment # 11. ["Return to Main Document"](#)

³ Report of the Santa Barbara County Grand Jury, 2010-2011, page 1, available from <http://www.sbcgj.org/2010/JailOvercrowding.pdf>. ["Return to Main Document"](#)

⁴ Report of the Santa Barbara Grand Jury Report, 2014-2015, page 2, available from http://www.sbcgj.org/2015/Detention_Facilities_020615.pdf. ["Return to Main Document"](#)

which issued a report and recommendations in [2008](#).⁵ The Commission recommended that the County build a new 300 bed jail facility and develop a program of community corrections as an alternative to housing prisoners in the jail.

Today, the Department has funding and approval for an even larger, 600 bed correctional facility in Santa Maria, to be completed in 2018. The new facility will be a two-tier modular design with a “state of the art” medical clinic. After the new North Jail opens, the Department still plans to operate parts of the Main Jail but with a reduced census of 600 prisoners. The Department will close the medium security facility adjacent to the Main Jail.

One important recommendation of the Blue Ribbon Commission was to reduce the jail population by developing more pre-trial alternatives. Blue Ribbon Report, pps. 21-23. At that time, pre-trial detainees made up 70% of the jail population. Blue Ribbon Report, p. 15. Since then, pre-trial detainees have not decreased and to the contrary, have increased to make up 73% of the jail [population](#).⁶ This is significantly above the average in other counties, which is [62%](#).⁷ Some counties have been successful in affirmatively reducing their pre-trial population. For example, Sonoma County worked with consultants to reduce pre-trial detainees to 50% of the jail population by implementing a robust array of alternatives to detention, such as day reporting and electronic monitoring.

Like other jails, Santa Barbara must now house prisoners who are sentenced to the Jail for years at a time, following the implementation of AB 109 in [2011](#).⁸ The 2015 Grand Jury reported that “[p]rior to AB 109, the average length of stay in the Jail was 20 days. It has now increased to over one year due to the incarceration of serious long-term

⁵ Final Report and Recommendations of the Blue Ribbon Commission on Jail Overcrowding, page 14, available from <http://www.sbsheriff.org/BRCReport>. [“Return to Main Document”](#)

⁶ BSCC Jail Profile Study, Attachment # 10, page 6. [“Return to Main Document”](#)

⁷ BSCC Jail Profile Study, Attachment # 10, page 6. [“Return to Main Document”](#)

⁸ Public Policy Institute of California, “California’s County Jails,” available from http://www.ppic.org/main/publication_show.asp?i=1061. [“Return to Main Document”](#)

[offenders.](#)⁹ The increasing length of stay makes adequacy of jail conditions even more pressing than in years past.

Corizon Health Care has provided physical health care services in the Jail for many years. Until recently, mental health services were provided by County Behavioral Health. In 2009, the Sheriff's Department terminated the contract with County Behavioral Health and contracted with Corizon to provide mental health care in the Jail.

FINDINGS RE: ABUSE AND/OR NEGLECT OF PRISONERS WITH DISABILITIES

Based on our monitoring visit on April 2, 2015, interviews with prisoners, their families and attorneys and on our review of public documents and prisoner medical [records](#),¹⁰ we found the following evidence of abuse and neglect in Santa Barbara County Jail.

1. Excessive Use of Isolation and Solitary Confinement

Isolation and solitary confinement in correctional facilities are generally considered to be situations in which prisoners are held in their cells, alone or with a cellmate, for 22 to 24 hours per [day](#).¹¹ In most jails, prisoners are held in isolation because they are classified as maximum security, are in administrative segregation or protective custody, or subject to short-term discipline. In contrast, prisoners in general population in most correctional facilities typically are housed in

⁹ Grand Jury Report, 2014-2015, footnote 4, page 2. [“Return to Main Document”](#)

¹⁰ The findings in this report are based in part on a review of the medical records for five prisoners, which we obtained these reports through signed releases from prisoners whom we interviewed and from their family members and attorneys; the records were not obtained through use of our access authority under 42 U.S.C. §10805(a)(1) and 29 U.S.C. § 794(f)(3). We have provided a copy of these records to the Sheriff's Department along with this report. [“Return to Main Document”](#)

¹¹ For support for this accepted definition of isolation, see, e.g., U.S. Department of Justice, Investigation of State Correctional Institution at Cresson, May 13, 2013, Attachment #7, p. 5, available at http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf (“terms ‘isolation’ or ‘solitary confinement’ mean the state of being confined to one’s cell for approximately 22 hours per day or more, alone or with other prisoners, that limits contact with others. ... An isolation unit means a unit where either all or most of those housed in the unit are subjected to isolation.”); *Wilkinson v. Austin*, 545 U.S. 209, 214, 224 (2005) (describing solitary confinement as limiting human contact for 23 hours per day); *Tillery v. Owens*, 907 F.2d 418, 422 (3d Cir. 1990) (21 to 22 hours per day). [“Return to Main Document”](#)

dormitories, or are locked in their cells only during sleeping hours, and are in dayrooms, activities or recreation areas during waking hours.

Even a short stay in conditions of extreme isolation is likely to worsen prisoners' mental health symptoms, causing them "to lapse in and out of a mindless state" or "semi-fatuous condition" at a heightened risk for suicide. See *Davis v. Ayala*, 576 U.S. ____, No. 13-1428, 2015 WL 2473373, at *20 (U.S. June 18, 2015) (Kennedy, J., concurring). Consequently, correctional facilities should place prisoners in isolation only when security conditions permit no [alternative](#).¹² Prisoners with mental health problems are especially harmed by prolonged isolation (defined as a duration of more than three to four [weeks](#)).¹³ Many state correctional systems, including those in California, Illinois, Massachusetts, Ohio and Pennsylvania, have adopted policies to ensure that prisoners with mental illness are excluded from isolation and solitary [confinement](#).¹⁴

We found widespread overuse of prolonged isolation and segregation in the Santa Barbara Jail. Many prisoners were locked in small cells for 22 to 24 hours per day and are not permitted to have radios or televisions. The primary exception is low to medium security prisoners, who are housed in dormitories.

Many parts of the Main Jail are old and built with a linear design, which limits access to dayrooms. However, increased out-of-cell time is possible even in this environment, especially since the jail census is

¹² Metzner J.L., Fellner J., "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *J Am Acad Psychiatry Law* 38:104–8, 2010, Attachment #2. ["Return to Main Document"](#)

¹³ American Psychiatric Association, Position statement on segregation of prisoners with mental illness (2012), Attachment #4, available from <http://www.psychiatry.org/File%20Library/Learn/Archives/Position-2012-Prisoners-Segregation.pdf>. Accord, Society for Correctional Physicians, "Restricted Housing of Mentally Ill Inmates, Position Statement," July 9, 2013, Attachment #5, available from <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates> ("prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment.") ["Return to Main Document"](#)

¹⁴ Metzner J.L., Dvoskin J.A., "An Overview of Correctional Psychiatry," *Psychiatr Clin North Am* 29:761–72 (2006), Attachment #1. See also, U.S. Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, Attachment #8, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf. ["Return to Main Document"](#)

lower than in past years. Nevertheless, custody staff did not describe any particular efforts or initiatives to increase out-of-cell time.

Extended Placement in Isolation in Safety Cells

We found that prisoners are held in safety cells in the Santa Barbara Jail for many days at a time, on a repeated basis, with no access to mental health treatment. Safety cells are small, windowless rooms, with rubberized walls, a pit toilet in the floor, and no furniture, bedding or source of water. Prisoners are not permitted normal clothing and are typically given only a blanket or “suicide smock.” They are not provided with regular access to showers, telephones, outdoor recreation, visitation or indeed, any out-of-cell time whatsoever.

California Code of Regulations, title 15, Section 1055, states that safety cells “shall be used to hold only those inmates who display behavior which results in the destruction of property or reveals an intent to cause physical harm to self or others. ... In no case shall the safety cell be used for punishment or as a substitute for treatment.” Section 1055 also requires documented monitoring, twice every 30 minutes. Typically, in most jails, prisoners remain in safety cells for a few hours at a time.

Courts have ruled that safety cells may be used as a “temporary measure” to control violent or suicidal prisoners “until they ‘cooled down’ sufficiently to be released from those cells.” *Anderson v. County of Kern*, 45 F.3d 1310, 1314 (9th Cir. 1995). In the *Anderson* case, the federal court of appeal ruled that because “the inmates were confined to the safety cell only for short periods of time,” their constitutional rights were not violated. *Id.* In the *Anderson* case, one prisoner was held in the safety cell for 90 minutes, another was held there for 3 hours and a third was held overnight. 45 F.3d at 1313. The *Anderson* court contrasted this temporary use of safety cells in the Kern County Jail with other cases in which extended placement in safety cells for 48 hours or more resulted in significant constitutional violations.

In the Santa Barbara Jail, custody staff were quite clear that placement in safety cells was not temporary, and stated unequivocally that prisoners could be in a safety cell “for days.”

Medical records and prisoner interviews confirmed that prisoners with mental illness and behavioral problems are housed in safety cells for three days at a time on a repeated [basis](#).¹⁵ For example, medical records from Prisoner C., show that over an 8 week period from February 7, 2015 to April 6, 2015, he was placed in a safety cell three times, each time for a duration of three to four days. Prisoners D. and E. were also subjected to repeated safety cell placement. Placing prisoners with mental illness in safety cells for days at a time without mental health treatment constitutes abuse and/or neglect, is inconsistent with minimum standards of care and violates constitutional guarantees.

Even in the small sample of medical records to which we had access, we noted that prisoners were kept in safety cells long after their behavior ceased to pose any risk to themselves or others. Corizon's suicide watch forms confirm that on multiple occasions, Prisoner C. denied any suicidal intent after a few hours in a safety cell, but remained there for up to three additional days. An even more troubling example is Prisoner D. On two separate occasions, he was placed in a safety cell and after several days, was seen by a mental health counselor who concluded he was stable and could be released. Both times, the mental health counselor left him in the safety cell to be released "at classification's discretion," or "custody discretion." This practice subjects prisoners to needless emotional distress and physical discomfort, and cannot be justified. As noted above, prisoners in a safety cell have no bed, toilet or regular clothing, and no source of water in their cell, which is small, absolutely barren and completely isolated.

The Jail's monitoring of safety cell placements was also deficient. To comply with the requirement for documented monitoring twice every thirty minutes, custody staff clip a sheet to the door of the cell and log their observations as they occur. The safety cells have a solid door with a small Plexiglas window that is normally covered, so staff must open the window to observe the prisoner inside. During our inspection of the Main Jail, we observed one such "monitoring." As we passed Safety Cell #1, we noted that it was occupied. From the log, we saw that a prisoner had been placed there the night before. Staff observations

¹⁵ According to Jail policy and practices, mental health staff evaluate prisoners in safety cells twice each day. In the records we reviewed, we did not see notes that confirmed that this practice was being carried out. ["Return to Main Document"](#)

were terse, with notes such as “breathing,” and “awake.” As we watched, a custody officer stepped up to the clip board, made a notation and stepped away without opening the window to the cell to observe the prisoner. The supervisor escorting us had to remind the officer to look in on the prisoner, which would not have occurred had we not been present.

Corizon mental health staff are only on-site during normal business hours; if incidents that require placement in a safety cell occur after hours or on weekends, custody staff stated that they do not contact Corizon mental health staff before safety call placement unless there is an emergency. This policy prevents mental health staff from providing necessary treatment and advice to inmates placed because of psychiatric reasons. Further, Custody staff stated their policy was that they waited until Corizon mental health staff assessed prisoners to determine when they get out of a safety cell placement, which will lead to extended stays in safety cells for prisoners who are calm and can return to their regular housing, simply because Corizon is not on site. In addition, even when Corizon staff does assess, prisoners are held longer than necessary, as noted above with Prisoner D., who was to be released at the discretion of classification, not mental health.

In interviews, other prisoners described the absence of any mental health treatment following their release from a safety cell placement for suicidality. One prisoner explained that he had been in the Jail for two months, had been on Effexor and Risperdal in the community and in prison, and had submitted requests to Corizon for mental health medications (his most recent request was almost a month earlier) and had been placed in a safety cell four to five times in the past month. Despite this history, at the time of our inspection, he told us that he still had not seen a mental health practitioner nor had he received a response to his medication request.

It is important to note that even a short stay in a safety cell can be extremely counter-therapeutic. One expert states unequivocally: “No one should be housed in segregation while they are acutely psychotic, suicidal or otherwise in the midst of a psychiatric [crisis.](#)”¹⁶ Yet this is precisely what the Santa Barbara Jail does with prisoners who are

¹⁶ Metzner and Dvoskin, footnote 16, page 2. [“Return to Main Document”](#)

suicidal and in crisis. According to another noted expert, “placing suicidal prisoners in barren observation cells ... ‘is counter-therapeutic in that no therapeutic relationship is formed and the prisoner learns it’s better to keep suicidal thoughts and plans to him or herself. In jails and prisons isolation ‘safety cells’ are used instead of doing what is essential in the treatment of anyone seriously contemplating suicide: talk to them. Thorough evaluation, continuity of contact with mental health clinicians, establishment of a trusting therapeutic relationship — these are the things that prevent suicides and assure the effectiveness of treatment — not fifteen minute checks on a prisoner in an observation/safety [cell.](#)”¹⁷

Leaving Prisoners on Psychiatric Holds under WIC § 5150 in Safety Cells without Mental Health Treatment.

One of the worst practices we observed from the medical records was the Jail’s failure to provide treatment for prisoners who have been placed on a psychiatric hold under Welf. & Inst. Code § 5150, and instead keeping them in a safety cell for the entire 72-hour duration of the hold. Attorneys who represent defendants reported that this happens repeatedly to their clients.

Under Section 5150, an individual may be detained for assessment, evaluation, crisis intervention and treatment if they are found to be a danger to self, danger to others or gravely disabled. In other jails, prisoners are typically transferred from the jail to an inpatient psychiatric hospital for treatment when they meet 5150 criteria. In Santa Barbara, the only LPS designated facility in the county is the county-owned psychiatric health facility, and Jail staff report difficulties locating an available bed there. However, if no beds are available, the alternatives are to transfer the prisoner to an LPS designated facility in another county, such as Vista Del Mar or Hillmont in Ventura County. If no beds are available there, the Department must provide intensive mental health treatment in the Jail itself.

When a prisoner is awaiting transfer to an inpatient facility, or when a bed cannot be located, Corizon does not appear to provide mental health treatment to prisoners who are placed on a §5150 hold. For

¹⁷ Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (2003), p. 183, quoting Dr. Terry Kupers, available <https://www.hrw.org/reports/2003/usa1003/usa1003.pdf> [“Return to Main Document”](#)

example, Prisoner C. was placed on a § 5150 hold while in a safety cell; apart from a daily status check, Corizon staff provided no mental health treatment. After three days, the 5150 hold expired and he remained in the safety cell, still without any mental health intervention. This practice violates state statute and subjects prisoners to abuse and neglect.

Placing Prisoners with Mental Illness in Isolation

Because of the damaging impact of isolation on prisoners with mental illness, the recommended practice is that these prisoners be excluded from [isolation](#).¹⁸ Santa Barbara does not follow this guideline, and prisoners with mental illness are routinely placed in prolonged isolation, even apart from the excessive use of safety cells noted above.

In the Main Jail, prisoners in single cells are effectively held in isolation if they are designated as maximum classification, administrative segregation, or protective custody. Conditions in segregation cells are characterized by inadequate exercise and extreme social isolation. Prisoners are offered three hours of outdoor recreation as required by Title 15 of the state regulations, usually as 1.5 hours twice per week, and a few minutes of shower time every other day. This leaves prisoners locked in their cells for 24 hours per day for five days per week, and 22.5 hours per day on the days when they have outdoor recreation. This amounts to solitary confinement for a large portion of the Jail population.

The mental health housing unit, known as 100, consists of cells in which prisoners are held alone, although they were designed for double occupancy. Consequently, prisoners in the mental health unit are held in conditions as isolating as maximum security housing. We interviewed prisoners with severe mental illness in dorms who said that, as difficult as their current housing was, the mental health unit was far worse because of the isolation conditions. Custody staff told us that prisoners get out-of-cell time for 1.5 hours twice per week in which to use the

¹⁸ See, Metzner J.L., Dvoskin J.A., “An Overview of Correctional Psychiatry,” Attachment #1. A recent agreement between the Department of Justice and a county jail in Georgia provides that segregation “shall be presumed contraindicated” for inmates with serious mental illness. If an inmate has a “serious mental illness” or other acute mental health contraindications to segregation, that inmate “shall not remain in segregation absent extraordinary and exceptional circumstances.” MOA Between the U.S. Department of Justice and Columbus, Georgia Regarding the Muscogee County Jail, January 16, 2015, Attachment #9, available from http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf. [“Return to Main Document”](#)

outdoor yard and shower, which meets the state regulations but still constitutes extreme, prolonged isolation.

Accepted treatment standards require mental health staff to take affirmative steps to ameliorate the harsh impact of isolation and segregation on prisoners with serious mental illness, assuming that the physical constraints of the facility and/or the security status of the prisoner do not allow alternative housing. The minimum standard of care for a segregated mental health unit is the following: “For prisoners with a serious mental illness [in segregation], the specialized mental health program should offer at least 10 to 15 hours per week of out-of-cell structured therapeutic activities in addition to at least another 10 hours per week of unstructured exercise or [recreation](#).”¹⁹ A recent settlement agreement between the U.S. Department of Justice and a county jail in Georgia describes a program consistent with these minimum standards. There, the jail agreed that prisoners housed in its secure mental health unit “would be offered a minimum of:

- i. At least 10 hours of out-of-cell structured time each week, with every effort made to provide two scheduled out-of-cell sessions of structured individual or group therapeutic treatment and programming Monday through Friday and one session on Saturdays, with each session lasting approximately one hour, with appropriate duration to be determined by a qualified mental health professional and detailed in that inmates individual treatment plan, and
- ii. At least two hours of unstructured out of cell recreation with other inmates each day, including exercise, dining and other leisure activities that provide opportunities for socializing, for a

¹⁹ Metzner and Dvoskin, footnote 19, Attachment #1, page 3. See also, American Psychiatric Association (“APA”) Position Statement on Segregation of Prisoners with Mental Illness,” Attachment #4 (“If an inmate with serious mental illness is placed in segregation, out of cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out of cell time should be permitted.”); Society of Correctional Physicians, “Position Statement: Restricted Housing of Mentally Ill Inmates,” Attachment #5, page 1 (if inmates with serious mental illness cannot be excluded from prolonged segregation, “the conditions of their confinement should be modified in a manner that allows for adequate out-of-cell structured therapeutic activities.”). [“Return to Main Document”](#)

total of at least 14 hours of out of cell unstructured time each [week.](#)²⁰

The manner in which the mental health unit is operated and the services provided by Corizon in this unit fail to meet these minimum standards of care, deny prisoners with mental illness needed treatment, subject them to abuse and neglect and violate their constitutional rights.

We note that some prisoners with serious mental illness are offered even less out-of-cell time than that reportedly provided in the mental health unit and segregation cells. We reviewed records from Prisoner E., a mentally ill prisoner who was in the Jail for four months until he was finally transferred to the County psychiatric health facility. Prisoner E. was held on a misdemeanor charge and had been declared incompetent to stand trial based on his mental illness. Custody staff wrote to his family stating that he was out of his single cell for only two hours per week, rather than the three hours per week required by Title 15. This is extreme isolation, and had a damaging impact on this prisoner's already fragile mental health.

Corizon does appear to conduct regular rounds of prisoners in isolation, which is a positive and important practice. However, the rounds consist of brief cell-front contact, with words exchanged through the small gap on the side of the solid metal door front. This cell front contact is no substitute for actual counseling and therapeutic contact, which Corizon does not provide.

2. Inadequate Mental Health Care

Under the U.S. Constitution, there are “six basic, essentially common sense, components of a minimally adequate prison mental health care delivery system.” *Coleman v. Brown*, 938 F. Supp.2d 955, 970 (E.D. Cal. 2013). The components are: screening, staffing, recordkeeping, medication, suicide prevention, and “a treatment program that involves more than segregation and close supervision of mentally ill inmates.” *Id.* at 970 n. 24; *Balla v. Idaho State Board of Corrections*, 595 F. Supp. 1558, 1577 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D.Tex.1980). The Jail must address the negative effects of housing in harsh segregated environments (*Coleman*, 938 F. Supp.2d at

²⁰ Muscogee Jail Agreement, footnote 19, Attachment #9, page 13. [“Return to Main Document”](#)

979–80), and provide “treat[ment] in an individualized manner” for mental disorders. *Id.* at 984. Treatment must have the goal of “stabilization and symptom management.” *Madrid v. Gomez*, 889 F. Supp. 1146, 1222 (N.D. Cal. 1995).

Absence of Group or Individual Out-of-Cell Therapeutic Activities

Outpatient mental health care in the Santa Barbara Jail appears consists solely of sporadic medication management and brief, cell-front interviews. Corizon staff do not conduct mental health groups or provide more extended therapeutic contacts apart from assessments and cell-front checks. For example, one prisoner we interviewed was housed in a dorm, reported a history of significant mental health treatment and said that he had been “suicidal” the previous night. He said that he wants medication but only if he can also speak to a mental health professional for ongoing therapy, which he had been told was not possible in the Jail.

The absence of any group or individual therapy, or other structured out-of-cell therapeutic activities violates minimum standards of care for prisoners with serious mental illness. For example, the National Commission on Correctional Health Care has adopted a standard 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.” *Standards for Health Services in Jails* (2014), Standard J-G-04, Attachment #3.

As discussed in the previous section, the Jail has a designated mental health unit for prisoners with serious mental illness. Custody keeps these prisoners in their cells for between 23 and 24 hours per day. As we noted above, Corizon staff do not provide the recommended out-of-cell structured therapeutic activities necessary to compensate for the impact of these isolation conditions on prisoners with mental illness.

We observed some positive practices. As noted above, Corizon mental health staff conduct regular isolation rounds. The Jail will provide 7 days of follow-up medications at release, and sometimes as much as 30 days. The Sheriff’s Department has a full time discharge planner.

Inadequate Screening, Poor Medication Continuity

Prisoners we interviewed had many complaints about their inability to continue the medications they had been on in the community. More than a dozen people reported that they had gone for weeks and months without the mental health medications they had been taking in the

community, despite disclosing this need during their initial screening and in later requests. By report, the lack of medication continuity extended to medications for physical health care conditions, and the medical records we reviewed confirmed these reports.

For example, Prisoner A. was taking medication for PTSD, anxiety and seizures before he was arrested. After booking, he was denied access to his anti-seizure medication, Dilantin. After four days, he had a grand mal seizure. The next day, staff started him back on Dilantin but did not address his need for medication for anxiety and PTSD. He had to wait more than two months after booking before he was seen by a Corizon psychiatrist who finally prescribed medication for his PTSD.

Some of the problems with medication continuity can be attributed to poor initial screening. For example, when Prisoner B. was booked into the Jail, he brought a bag with all his VA-issued medications, including medication for anxiety and PTSD. He was screened a week after booking by a therapist who listed all the medications prescribed by his VA doctors in the community, but failed to order any bridge medications for his physical or mental health needs or to refer him to a psychiatrist for further evaluation. He had to wait an additional two months before he was seen by a Corizon psychiatrist, who still did not prescribe the only medication that the VA had found effective in treating his PTSD.

Poor screening may also explain why Corizon reports that so few prisoners have serious mental illness in the Santa Barbara Jail. Corizon mental health staff told us that 13-16% of the jail population is identified with mental illness, and that 90 people are on psychotropic medications, which is roughly 11% of the prisoner population. Eight years earlier, the Blue Ribbon Commission had reported a mental illness rate of 29%, noting that this “understates the true picture, since it only counts those who agree to treatment and take jail-issued [medication](#).”²¹ The difference between the reported rates of mental illness in 2007 and 2015 could be attributable to a change in mental health providers in the jail. When the Blue Ribbon Commission issued its report, mental health services were provided by County Behavioral Health. Corizon Health Care, which is a for-profit provider, took over the contract to provide mental health

²¹ Blue Ribbon Commission Report, footnote 7, page 18. [“Return to Main Document”](#)

services in the Jail in 2009. Corizon's report that 11% of prisoners are on mental health medication is half the rate reported by the Blue Ribbon Commission, and well below the expected prevalence rate based on reports of national [experts](#).²² We are concerned that Corizon could be overlooking or under-treating prisoners with mental illness through inadequate screening or other practices discussed in this report.

Untimely Response to Requests for Mental Health Medication and Services

In brief interviews in one dormitory, five prisoners complained that they had submitted multiple requests over several months to be seen by mental health staff, with no response. Other prisoners whom we interviewed at greater length and whose records we obtained had the same complaint. Significantly, none of the records we reviewed included copies of prisoners' requests for medical and mental health care, so we could not verify their reports, but the consistency of the complaints suggests a problem.

We asked Corizon mental health staff about delays in responding to requests. Their reply was that they closely monitor requests, that urgent requests are answered immediately and that it may be two to three weeks to get a response to non-urgent requests. However, we are concerned that Corizon's reporting system may not be capturing all the sick call slips and psych line requests submitted by prisoners, especially because these requests are apparently not logged in the medical records. We plan to conduct further investigation to determine the extent of delays in responding to requests for mental health care.

We observed problems with medication management. From the records, we noted instances in which prisoners were placed on or discontinued from significant psychotropic medications with little monitoring. For example, Prisoner C. had been at a state hospital for six months, where he was restored to competence on a regime that included seven psychotropic medications, including several long-acting injectable anti-psychotic medications. A month after his return, the Jail psychiatrist abruptly discontinued all but two of these seven medications

²² Metzner, "Overview of Correction Psychiatry," Attachment #1 (prevalence rate of 20% for serious mental illness); Metzner and Fellner, Attachment # 2 (same, plus an additional 15 to 20% require mental health intervention, including medication). ["Return to Main Document"](#)

without tapering or transition; two days later, Prisoner C. attempted suicide. In another example, Prisoner D. was diagnosed with psychosis, but was prescribed Wellbutrin, an anti-depressant that can cause agitation. Two months later, after a cell extraction and assault on a deputy, a different Corizon psychiatrist terminated the order for Wellbutrin with a note that “this medication can worsen these [assaultive] behaviors.”

We noted a high number of suicide attempts in the medical records we reviewed. Custody staff informed us that the Jail had only one completed suicide in the last four years, but there have been 35 to 40 attempts. Corizon’s suicide prevention program appears to consist primarily of extended safety cell placement, which, as noted above, is not a substitute for mental health treatment and can also deter prisoners from reporting suicidal ideation.

We also failed to find any evidence in the medical records of a functioning behavior management program. Corizon’s form for monitoring prisoners on suicide watch is comprehensive and includes box that can be checked if a behavior management plan is being developed. However, this box was blank in every form we examined, and no prisoner records included a behavior management plan. Apparently Corizon staff do not develop written behavior management plans even for individuals such as Prisoner C., who made a suicide attempt and reported auditory hallucinations commanding him to commit suicide, or for Prisoner E., who was described as the “most difficult” prisoner in the Jail and had also attempted suicide by hanging. A template for a behavior management plans used in the San Francisco Jail are included as Attachment #12 to this report.

3. Denial of Rights under the Americans with Disabilities Act

Title II of the Americans with Disabilities Act (“ADA”) provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132. Jails and prisons are subject to the prohibitions and protections in Title II. *Pierce v. County of Orange*, 526 F.3d 1190, 1214 (9th Cir. 2008) (citing *Pa. Dep’t of Corr. v. Yeskey*, 524 U.S. 206, 209-10 (1998)). In correctional settings, the ADA requires that prisoners with disabilities be ensured equal access to jail programs, services and activities, including the ability to safely use personal hygiene services such as toilets and showers, to engage in

activities such as ambulation and exercise, and participate in programs such as visitation, educational classes, religious services, and inmate worker programs on the same basis as non-disabled prisoners.

Accessible Cells and Housing.

In 2010, the Department of Justice issued a new regulation specifically addressing the “nondiscrimination and program access obligations” of a correctional facility. 28 C.F.R. § 35.152, effective March 15, [2011](#).²³ This regulation provides in part that “[p]ublic entities shall implement reasonable policies, including physical modifications to additional cells in accordance with the 2010 Standards, so as to ensure that each inmate with a disability is housed in a cell with the accessible elements necessary to afford the inmate access to safe, appropriate housing.” 42 C.F.R. § 35.152(b)(3). Justice Department commentary on this regulation makes clear that it concerns the *program access* obligations of a correctional facility, which do not depend on the date of construction, as opposed to requirements for architectural accessibility, which are tied to the date of construction or [modification](#).²⁴

The Department houses most prisoners with disabilities in the Main Jail in South Dorm 25. This dorm contains double bunks with lower and upper levels. The Jail assigns prisoners to a lower bunk in this dorm if they have mobility impairments or another condition such as epilepsy. There is apparently no formal policy to monitor and enforce lower bunk orders. We observed a number of people sleeping on the floor in this dorm, with deputies looking on. Prisoners we interviewed stated that others had already taken all the lower bunks, and that they had no choice but to sleep on the floor. For example, Prisoner A. was in South Dorm 25 because he has epilepsy. He reported that he slept on the floor because he could not get a lower bunk and was afraid that he would be injured if he fell off an upper bunk during a seizure. In fact, because the Jail failed to provide him with his epilepsy medication, he had a grand mal seizure in his first few days in the Jail. Prisoner A. stated that he

²³ U.S. Department of Justice, Notice re: Final Regulations implementing Title II of the ADA, 75 Fed. Reg. 56164, 56218-56223 (2010), Attachment #6, also available at http://www.ada.gov/regs2010/titleII_2010/titleII_2010_regulations.htm#a2010guidance. [“Return to Main Document”](#)

²⁴ DOJ Regulations, 75 Fed. Reg. at 56218-56223, Attachment #6. [“Return to Main Document”](#)

had made multiple requests for a “boat,” which is a temporary plastic sleep surface that rests directly on the floor and on which prisoners can place a mattress. Floor sleeping was so common in this dorm that Prisoner A stated that those who get “boats” were the “lucky ones.”

During our inspection, custody staff ignored the floor sleepers and made no effort to enforce lower bunk orders, although it was obvious that these were being disregarded, or that the number of lower bunks was insufficient to meet the need. This is a blatant denial of one of the most basic accommodations for prisoners with – an accessible bed. The Jail apparently has no policy or practice to ensure that lower bunk orders are issued, honored and enforced.

Surprising, although prisoners with mobility impairments are concentrated in the South Dorm, the toilet and shower areas do not meet architectural standards for wheelchair use, and lack properly placed grab bars, shower heads, [etc.](#)²⁵ Medical records for Prisoner A, for example, note that he fell in the shower. During our inspection, we asked custody staff whether there was housing that complied with the ADA. Custody staff showed us a cell in a different area of the Jail that was supposedly ADA compliant. However, the toilet would be completely inaccessible to anyone in a wheelchair – the seat was far too low and there were no grab bars installed.

We also note that the Jail has carried out alterations to its facilities, such as the renovation of the honor farm in 2006 to add 161 medium security beds and the conversion of basement conference rooms to dormitories in 2013. The ADA applies to alterations to existing buildings after January 26, 1992, the effective date of the ADA. 28 C.F.R. § 35.151 (b). Consequently, these portions of the Jail must conform to the ADA’s architectural access standards, which are more comprehensive than the program access requirements discussed above. See, Uniform Federal Accessibility Standards on www.ada.gov.

²⁵ We are able to provide you with copies of DOJ publications on accessibility standards for correctional facilities, which can also be obtained online: ADA/Section 504 Design Guide: Accessible Cells in Correctional Facilities, available from <http://www.ada.gov/accessiblecells.htm> and the ADA standards for Accessible Design that specify the requirements for an accessible shower, §§ 603.1 to 610.4; acceptable reach ranges for fixtures, § 308, and accessible faucet and handle types, § 309.4. <http://www.ada.gov/regs2010/2010ADAStandards/2010ADAstandards.htm#sec805>. [“Return to Main Document”](#)

Denial of Accommodations

Prisoners complained to us about the Jail's failure to provide accommodations for their disabilities, in addition to the problem noted above regarding access to lower bunks. One prisoner with low vision reported that the Jail would not help him with reading and writing. Prisoner B., who uses a wheelchair, reported multiple falls because of untrained custody staff and accessibility barriers. When booked, the Jail took away his personal wheelchair and gave him another that had faulty brakes and was too large to pass through doorways. According to his records, he was injured in a fall off the transport bus in October 2014; was injured again in March 2015 when he attempted to transfer from his wheelchair to his bunk, and again in April 2015 when he fell in the shower, which did not have any grab bars. Prisoner B. reported that he has filed multiple grievances, to no effect.

Discrimination against Prisoners with Serious Mental Illness

The ADA regulations require public entities such as the Sheriff's Department to "administer programs, services and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d); 28 C.F.R. § 152(b)(2) (requiring correctional facilities to house prisoners with disabilities in the most integrated setting appropriate). In a recent investigation, the Department of Justice found that a Pennsylvania prison violated these provisions by automatically placing prisoners with mental illness in segregation and isolation [conditions](#).²⁶ The prison was required to "ensure that qualified prisoners with serious mental illness ... have as equal an opportunity as other prisoners to participate in and benefit from its housing and classification services, programs and activities, and the benefits that flow from them, such as out-of-cell time, interaction with other prisoners and movement outside of confined [environments](#)."²⁷

The Department discriminates against prisoners with serious mental illness by housing them in isolation conditions in the mental health unit, regardless of their classification level, and by failing to

²⁶ US DOJ, Cresson Investigation, Attachment #7, page 32. See also, US DOJ Investigation of Pennsylvania DOC, Attachment #8, pages 17-22. ["Return to Main Document"](#)

²⁷ US DOJ, Cresson Investigation, Attachment #7, page 34. ["Return to Main Document"](#)

provide them with support and accommodations to enable them to function in an integrated setting.

ADA Coordinator

The ADA regulations require the Jail to have an ADA coordinator. 42 C.F.R. § 35.106. The coordinator's role is "to ensure that individuals dealing with large agencies [such as the Sheriff's Department] are able to easily find a responsible person who is familiar with the requirements of the [ADA and the DOJ regulations] and can communicate those requirements to other individuals in the agency who may be unaware of their responsibilities." *Appendix A to Part 35, 28 C.F.R.* at page 568.

The Department does not appear to have an ADA coordinator for the Jail. When questioned, staff were unaware of such a position and could not identify any particular individual responsible for arranging accommodations. We conclude that the Jail is violating this requirement.

Notice of Rights and Complaint Procedure

The Jail also has an obligation to provide notice to prisoners of their rights under the ADA (28 C.F.R. § 35.106), and must have an ADA complaint procedure by which prisoners with disabilities may contest any disability-based discrimination or violation of the ADA. 28 C.F.R. § 35.107(b). The complaint procedure must provide for "*prompt and equitable* resolution of complaints alleging any action that would be prohibited by [the ADA regulations]." § 35.107(b) (emphasis added). The Jail's designated ADA coordinator is responsible for investigating complaints submitted through this process. § 35.107(a).

In interviews, prisoners with disabilities had complaints about their inability to obtain accommodations but were unfamiliar with any procedure for requesting accommodations for their disabilities, or appealing the denial of accommodations. This violates the notice requirement in 28 C.F.R. § 35.106. The Jail does not have an ADA complaint system, and the existing grievance system cannot substitute because it does not meet the ADA requirements listed above.

We did not have an opportunity to review the Jail's informing materials or substantive policies regarding prisoners with disabilities. However, the ADA regulations require the Sheriff's Department to conduct a self-evaluation of its services, policies and practices to determine whether they meet the requirements of the ADA. 28 C.F.R. § 35.105(a). Since the Jail has more than 50 employees, it was also

required to complete a Transition Plan by July 1993, detailing the steps and timeline it will take to achieve compliance with the ADA. Although the deadline to complete a self-evaluation and transition plan is long past, this is a continuing obligation and public entities that missed this deadline are not exempt from compliance. Reviewing policies and procedures is one part of the self-evaluation required by §35.105(a).

4. Other Areas of Concern, Including Medical and Dental Care

a. Floor sleeping and Overcrowding

The Jail has had a problem with floor sleepers due to overcrowding. Custody staff informed us that they had no floor sleepers at the time of our inspections, and had not had floor sleepers for the past four months. However, we observed several prisoners who were sleeping on mattresses on the floor especially in the medical unit (South) and among the inmates in protective custody. Custody staff stated they had the most problems with overcrowding with this classification group.

Other problems were excessive crowding in the dormitories and multi-man cells, which exceed rated capacity according to the BSCC. Attachment #11, pages 3-4.

Prisoner B., who has a collapsed lung and asthma, complained about the mold and dust in the Jail, which aggravated his asthma breathing problems. We observed that the air quality and ventilation in the converted basement dormitories was especially poor and several prisoners housed there complained about breathing problems.

b. Jail Design and Prisoner Safety

We observed one housing area with 14 inmates in multi-man cells with bars on the front; these cells open onto a small day room area and bathroom. The central control booth for these cells is down a hallway, so deputies have no direct line of sight into the housing area. There are cameras and a call button in the hallway, but prisoners cannot access these. We were told that deputies walk the hallways, but in between these patrols, prisoners have no means to report man down, and deputies cannot observe prisoners. Prisoners are at risk of attack, injury or rape from others in this setting, which is contrary to the requirements of the Prison Rape Elimination Act (PREA). The converted basement dorms also raise PREA concerns, since they are large and essentially unmonitored, with no line of sight from custody.

c. Medical Care for Chronic Conditions and Disabilities

In interviews, prisoners complained about poor care for asthma, diabetes and other chronic conditions.

INITIAL RECOMMENDATIONS

1. Isolation (defined as being locked down in a cell for at least 22 hours per day).

- a. Increase out-of-cell time and ameliorate isolation conditions in administrative segregation, protective custody, maximum security and mental health housing.
- b. Ensure that prisoners in single cells in the Main Jail are provided with a minimum of 4 hours per day of out-of-cell time.
- c. Develop procedures to exclude prisoners with serious mental illness from isolation and segregation absent extraordinary or exceptional circumstances.
- d. Develop new protocols for the outpatient mental health housing unit, so that prisoners are offered structured and unstructured out-of-cell time consistent with minimum standards outlined in this report.
- e. Ensure that Custody and Corizon mental health staff develop and implement behavior management plans for inmates with serious mental illness who engage in dangerous or disruptive behaviors with the goal of preventing their placements, or shortening the amount of time spent, in isolation conditions.

2. Safety Cells

- a. Inmates placed in safety cells as a result of behaviors related to mental health symptoms should not be housed there for longer than 12 hours at a time. If the facility administrator, in cooperation with licensed mental health staff, determines that there is no less restrictive housing appropriate after 12 hours, the inmate should be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and Section 4011.6 of the Penal Code.
- b. Inmates who are released from mental health related safety cell placements, or who return from treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and Section 4011.6 of the Penal Code, should be evaluated

by a mental health clinician in a confidential, out-of-cell setting, the next working day and then again within three to seven days depending on their clinical status.

3. Mental Health Treatment

- a. Establish a screening protocol at booking that (i) identifies all prisoners who are on mental health medication or otherwise in need of mental health treatment, and (ii) ensures that these prisoners are assessed and either provided with bridge medications, or if a determination is made not to provide requested medications, documenting the basis for the denial of medication and informing the prisoner in writing of how to file a grievance regarding this denial.
- b. Respond to prisoner requests in a timely manner. Qualified mental health staff should triage health needs request forms that seek mental health treatment the same day they are collected by the health care staff. The forms should be date-stamped at the time they are triaged, and noted in the prisoner's medical record. When qualified mental health staff determines clinician follow-up is necessary for diagnosis and treatment of an inmate's condition, the inmate should be referred to a clinician for a face-to-face evaluation that takes place immediately for emergent concerns, within 24 hours for urgent concerns, and within 14 calendar days for non-emergent or non-urgent concerns. Corizon should and report on monitor times to respond to requests
- c. For prisoners housed in the mental health housing unit, provide individual and/or group treatment, structured recreation, and rehabilitation services (e.g., psycho-education, supervised Activities of Daily Living and cell cleaning). They should receive ten to fifteen hours of out-of-cell-unstructured time each week (solo progressing to group) and ten to fifteen hours of out-of-cell structured activities with staff.

4. ADA

- a. Modify existing cells to offer wheelchair-accessible cells in different classification and housing areas, including medium and minimum security dormitory housing. This requirement applies to all areas in the Main Jail as needed to achieve program access, and to the basement dormitories in the Main Jail and the Medium Security facility adjacent to the Main Jail.
- b. Develop policies and procedures to assign and enforce orders for lower bunks and other disability-related accommodations, and monitor compliance with these orders on a regular basis.
- c. Ensure that prisoners with physical, sensory and mental health disabilities have access to the full range of Jail programs and activities and are not categorically assigned to more restricted housing than other prisoners.
- d. Appoint an ADA coordinator, establish an effective ADA complaint system, conduct a self-evaluation and develop a Transition Plan to achieve ADA compliance.
- e. Develop informational materials for prisoners with disabilities about how to request accommodations and file ADA grievances and complaints.

ATTACHMENTS

1. Metzner J.L., Dvoskin J.A., “An Overview of Correctional Psychiatry,” *Psychiatr Clin North Am* 29:761–72 (2006).
2. Metzner J.L., Fellner J., “Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics,” *J Am Acad Psychiatry Law* 38:104–8, 2010.
3. National Commission on Correctional Health Care, Standards for Health Services in Jails (2014), Standards J-E-09 and J-G-04.
4. American Psychiatric Association, Position statement on segregation of prisoners with mental illness (2012), <http://www.psychiatry.org/File%20Library/Learn/Archives/Position-2012-Prisoners-Segregation.pdf>
5. Society for Correctional Physicians, “Restricted Housing of Mentally Ill Inmates, Position Statement,” July 9, 2013, available from <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates>.
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7. U.S. Department of Justice, Investigation of State Correctional Institution at Cresson, May 13, 2013 at 5, available at http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf
8. U.S. Department of Justice, “Investigation of the Pennsylvania Department of Corrections’ Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities,” February 24, 2014, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf
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10. [California Board of State and Community Corrections \(“BSCC”\) Jail Profile Study, First Quarter of 2015, available from http://www.bscc.ca.gov/downloads/2015_1st_Qtr_JPS_Full_Report.pdf.](http://www.bscc.ca.gov/downloads/2015_1st_Qtr_JPS_Full_Report.pdf)
11. [BSCC Biennial Inspection report of the Santa Barbara Jail, January 8, 2015.](#)
12. [Jail Psychiatric Services, San Francisco Jail, Template for Behavior Management Plan.](#)

(Attachments are available upon request, please contact: Richard Diaz, richard.diaz@disabilityrightsca.org or call 213-213-8000)

[Read Santa Barbara County Sheriff’s Office response to DRC final report on inspection of Santa Barbara County Jail](#)

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