



San Diego County Sheriff's Department

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William D. Gore, Sheriff

April 24, 2018

Aaron J. Fischer
Rebecca Cervenak
Kim Swain
Disability Rights California
Bay Area Regional Office
1130 Broadway, Suite #500
Oakland, CA 94621

Re: County of San Diego's Final Response to Disability Rights California's March 2018 Investigation Report: "SUICIDES AT SAN DIEGO COUNTY JAIL; A System Failing People With Mental Illness"

Dear Mr. Fischer, Ms. Cervenak, and Ms. Swain:

The County of San Diego and the San Diego County Sheriff's Department appreciate the opportunity to respond to the 2018 Disability Rights California (DRC) Investigation Report, "*SUICIDES AT SAN DIEGO COUNTY JAIL: A System Failing People with Mental Illness.*" The report followed the opening of an investigation by DRC into conditions at San Diego County Jails in 2015. During its investigation, DRC visited several San Diego County Sheriff's Department detention facilities and conducted interviews with jail inmates, jail staff and Sheriff's Department leadership. The report focused on suicide prevention and treatment of mentally ill inmates¹ in the detention facilities. Additionally, the report focuses on community response to the growing mental health crisis and a perceived lack of sufficient external, independent oversight with respect to suicide prevention in the jails by the San Diego County Citizens' Law Enforcement Review Board (CLERB).

It has long been and continues to be the goal of the County of San Diego and the Sheriff's Department to provide to those suffering from mental illness the best possible housing, treatment and care. The report recognizes "*the great advantage of committed mental health staff and a number of strong leaders within the Sheriff's Department*" (DRC report, page 2). In promoting the County of San Diego and the Sheriff's Department's position of openness and transparency, we recognize the benefit in utilizing independent review of our policies, procedures and operations.

¹ When DRC first contacted the San Diego County Sheriff's Department in 2015, the investigation appeared to focus on issues relating to accommodations for inmates with disabilities. But as DRC's staff attorney has stated, the focus of the investigation changed sometime during DRC's nearly two-year long period of contact with the Sheriff's Department.

Notwithstanding the DRC and Department's differences of opinion, the Department welcomes the feedback regarding the jail system and will continue to develop and improve our processes and procedures. As mutually agreed, DRC has allowed the Sheriff's Department the opportunity to provide feedback of perceived inaccuracies contained within the report. This document serves as our response to the provided DRC report.

Following review of the report, the Sheriff's Department has significant concerns relating to several recommendations, findings and characterizations of the mental health and oversight provided to individuals that are both in the community and incarcerated in San Diego. In essence, the report focuses on the following matters: the suicide rate of San Diego detention facilities, a perceived inadequacy in both community and detention facility inpatient psychiatric services, and a lack of oversight by CLERB with respect to suicide prevention.

The cornerstone of the report is the assertion that San Diego County jails have a suicide rate "many times higher" than is found in similarly sized county jail systems. To support this claim, DRC cites to a series of *San Diego CityBeat* articles from 2013-2014 that made the same assertion. The Sheriff's Department looked into these claims when the *CityBeat* articles were first published, and found them to be alarmist and misleading. However, because these misleading claims have since resurfaced in legal briefs filed by plaintiffs' attorneys seeking money judgments against the County, as well as in DRC's report, the County retained former San Diego State University Statistics Professor, Dr. Colleen Kelly to review the 2010-2017 jail suicide data from the ten largest California counties and create an appropriate, accurate comparison of the suicide rates. (The Kelly report is attached to this letter).

One of Dr. Kelly's key findings is that the DRC report, like the *CityBeat* articles before it, took a fundamentally flawed approach in comparing suicide data from different jail systems. DRC's report failed to take into account the significant diversity of jail systems, each having different size, demographics and most importantly different lengths of stay. To cite one key difference, San Diego had the highest percentage of white inmates of the ten largest jail systems in California (2010-2016). This is important because statistics show that white inmates are six times as likely to commit suicide compared to African American inmates and three times as likely to commit suicide compared to Hispanic inmates (Kelly Report, page 4.) To fairly compare these ten counties, the *Bureau of Justice Statistics* recommends standardizing each jail system's suicide rates to the average racial proportions of those ten counties.

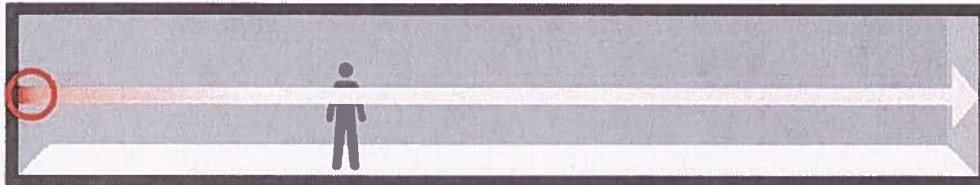
DRC's report further compounded its flawed methodology by utilizing what is commonly referred to as the Average Daily Population (ADP) method to calculate suicide rates. This practice has historically been used when other data was unavailable. In fact, the *Bureau of Justice Statistics Special Report on Suicide and Homicide in State Prisons and Local Jails* found that the methodology using ADP is less accurate than the approach using "inmates at risk" to calculate a suicide rate. (Kelly Report, page 3.) Consequently, Dr. Kelly used the more accurate "inmates at risk" approach.

QUANTIFYING SUICIDE RISK

Inmates at Risk

Cell in Facility A (prison)

Avg stay: 365 days



Inmates
at Risk: 1

Jan Feb Mar Apr Sep Oct Nov Dec

Most jail suicides happen
in the first two weeks

Cell in Facility B (jail)

Avg stay: 60 days



Inmates
at Risk: 6

The ADP method is calculated as the number of suicides per year divided by the ADP and multiplied by 100,000. The key flaw in this calculation is the use of the ADP denominator. The ADP represents how many inmates were, on average, within a jail on a daily basis. The number of inmates passing through San Diego County's detention facilities far exceeds the ADP. This is due to the transitory nature of a local detention facility. San Diego historically has a higher number of admissions (specific individuals booked into a detention facility) than similar sized systems in California. It can be concluded the more bookings in a system, the more inmates can be considered at-risk for suicide. The ADP suicide rate is also flawed when making comparisons across jail systems with different length of stay distributions. For comparison, San Diego reflected an average length of stay of 22 days versus Los Angeles' 56 days (2011-2017) for that same time period. The net result is more individuals moving through the jail system and subsequently at-risk for suicide.²

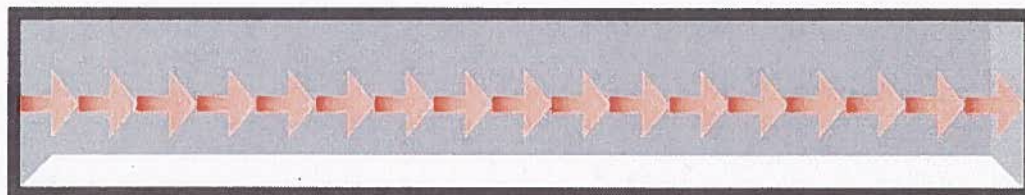
² Another major concern of the report is the timeframe chosen by DRC to compare inmate suicide deaths with other large California county jail systems. For this particular parameter DRC opted to use 2014-2016 numbers, the peak of the cycle relating to inmate suicide deaths. The very next year, 2017, San Diego's jail system had only one suicide. DRC's exclusion of the 2017 statistics from the selected timeframe further calls its methodology and conclusions into question.

SUICIDE RISK BASED ON INMATE TURNOVER

BSCC, 2011-2016

San Diego County jails

Avg stay: 22 days

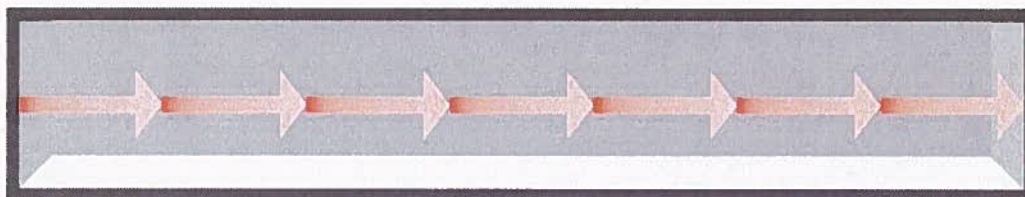


Inmates
at Risk: 17

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Los Angeles County jails

Avg stay: 56 days



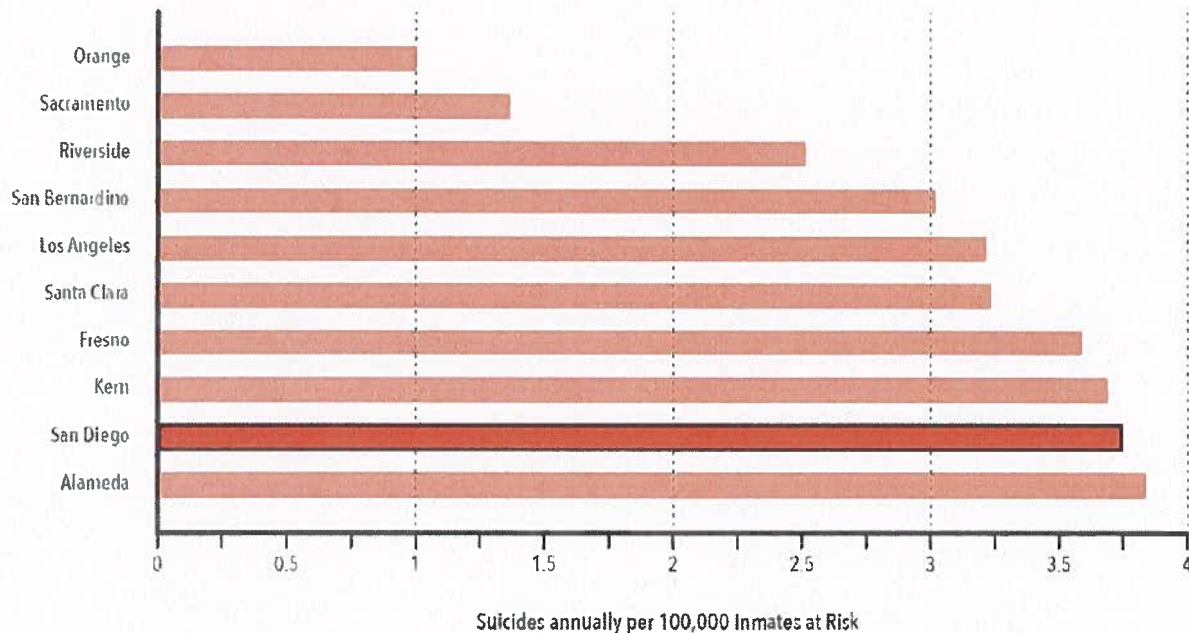
Inmates
at Risk: 7

Using a proper statistical model, Dr. Kelly's independent analysis shows that San Diego County jails do not have a higher suicide rate than all other large county jail systems. In fact, the suicide rate in San Diego County jails is very similar to the rates found in the jail systems of most other large California counties. (Kelly Report, page 2). Dr. Kelly's report also refutes DRC's claim that San Diego County jails have an annual rate of 107 suicides for every 100,000 inmates. In creating an "apples to apples" comparison and using the most appropriate rate calculation method recommended by the Federal Bureau of Justice Statistics Special Report, Dr. Kelly was able to show that DRC's claim is drastically inaccurate. The data gathered and analysis conducted by Dr. Kelly demonstrate that for the past several years on average fewer than 4 suicides per 100,000 inmates at risk have occurred in San Diego County jails³.

³ Dr. Kelly notes that the ADP suicide rates quoted in the DRC report "yield suicide numbers that are approximately 20 times larger than the actual number of suicides in those year and are more than three times larger than the number of suicides in the entire period 2010-2017 even though there were more than 700,000 inmates in the system during this period." (Kelly Report, page 3.)

INMATES AT RISK SUICIDE RATES

Standardized to the average racial distribution, 2010-2017



In the DRC's response to the Kelly report, which thoroughly refutes the alarmist notion that the San Diego County jails have a much higher than normal rate of suicides among California jails, DRC does not take issue with Dr. Kelly's analysis, nor do they argue that the "at risk" calculation is any way flawed. Instead, DRC asserts that San Diego County's higher population of "at risk" inmates (relative to other jail systems within California) "only adds urgency to the need for action." We agree that San Diego County's higher population of "at risk" inmates requires that suicide prevention be considered a top priority. The programs that have been implemented by the Sheriff's Department towards reduction of suicides have been highly successful, as evidenced by the reduction of suicides in the jails in 2017, to a single incident. What DRC, however, fails to acknowledge is that the Kelly report undermines and disproves the false premise that the suicide rate in the San Diego County jails constitutes a "crisis" that requires the oversight of DRC and their monitors.

None of this is intended to suggest that the Sheriff's Department's suicide prevention practices cannot be improved. The Sheriff's Department takes suicide prevention very seriously and has invested (and will continue to invest) significant resources to recruit and train jail staff, implement effective programs, and create an infrastructure conducive to preventing jail suicides. For example, in 2015, the Department implemented the Inmate Safety Program, in order to further reduce the number of inmate suicides.

DRC's report also makes several factually erroneous claims related to suicide attempts, the Inmate Safety Program, and inmate lawsuits. To wit:

- DRC's report claims that there were 73 suicide attempts and serious acts of self-harm from January to September 2017 in San Diego County jails. The number of suicide attempts during that period was 10. Implementation of the Inmate Safety Program has reduced the number of suicide attempts and self-harming gestures inside the detention facilities. In the full year of 2017, 15 suicide attempts were recorded. In making its misleading claim, it appears that DRC has combined *self-harming gestures* and *suicide attempts*. While *self-harming gestures* are important to recognize and address, they should not and must not be confused with actual *suicide attempts*. Moreover, not all incidents of *self-harming gestures* that are reported involve attempts at serious self-harm.

For example inmates will tell staff, in response to notification of a pending transfer, "I'm going to kill myself if you transfer me," in an attempt to avoid transfer. While these incidents appear to be more an attempt to manipulate the system, our recording practices are such that they may document these incidents as suicide attempts.

- On page 28 of its report, the DRC suggests that the County has paid "millions of dollars" due to medical and suicide-related lawsuits since 2010. This is misleading. The Office of County Counsel reports that the County has paid less than \$100,000 due to lawsuits involving suicides in County jail since 2010.
- Other dubious claims are made by DRC that are couched as characterizations rather than statements of fact, but nonetheless seem as though they are intended to be inflammatory rather than analytical. For example, DRC characterizes Enhanced Observation Housing (EOH) units as having "extreme conditions" and Inmate Safety Cells as "extraordinarily harsh settings." The Safety Cells are designed to keep suicidal inmates safe and prevent them from being able to harm themselves; they also provide for standardized assessments by qualified mental health providers.

DRC acknowledges that, per policy, safety cells are for inmates who are unable to function in the regular or socialized housing areas due to behavior which jeopardizes their safety. Yet DRC cites, in support of their characterization of the safety cells as being "extraordinarily harsh," the fact there are no windows, toilets or sinks. The reason those fixtures are not included in safety cells is that suicidal inmates could use them to harm themselves.

Similarly, the Enhanced Observation Housing unit cells are not intended to be harsh or inhumane. These cells were designed for suicide prevention. It logically follows that the lethal methods inmates typically use (hanging or jumping) to commit suicide must be removed from this environment. Again, the purpose of these cells is for assessment by mental health staff in a safe environment.

- There are a number of mental health-related examples in DRC's report that are either factually inaccurate and/or misleading as to the conditions inside the detention facilities.

Some of these incidents are the subject of litigation, and therefore, will not be the subject of specific comment. However, the Sheriff's Department can state that no inmate described in DRC's report who had verbalized suicidal thoughts or behavior was ignored or not evaluated for the Inmate Safety Program. Moreover, the inmates did receive a suicide assessment from a Psychiatrist who had the authority to exercise independent clinical judgement.

Finally, the Sheriff's Department disagrees with DRC's implication that our Citizen's Law Enforcement Review Board (CLERB) does not provide "meaningful, independent oversight" to the Sheriff's Department. In 2017, CLERB invested significant resources in personnel and streamlining operations to meet its mission of being an independent oversight for the Sheriff's Department. The authority and duty to monitor inmate treatment, suicide prevention, and jail operations should be performed by CLERB, the well-established, experienced existing independent oversight agency, as opposed to creating a new independent oversight entity.

The San Diego Sheriff's Department fully supports the funding and staffing of CLERB to ensure it is able to carry out its investigations as authorized by its Rules and Regulations with subsequent reporting to the Board of Supervisors and regular community outreach, which is consistent with its current complaint and death investigation practices. CLERB's inspections result in independent oversight of jail operations, the public identification of problems with conditions and operations, early detection of potential issues inside jail facilities, and better-informed policy decisions.

DETAILED RESPONSES TO DRC RECOMMENDATIONS 1-18

As noted above, the San Diego County Sheriff's Department facilitated and fully cooperated with DRC's inspection of several of our detention facilities. Despite DRC's criticisms of its jail system, San Diego detention facilities are in full compliance with California Code of Regulations, Title 15 Standards for Local Detention Facilities, as evidenced by inspections from the Board of State and Community Corrections. The Sheriff's Department continues to strive to improve operations, practices and policies.

Responses below are offered in the interest of recognizing and responding to DRC's observations, analysis and recommendations. Responses to Recommendations 1-5 were obtained from the County's Health and Human Services Agency, a partner with the Sheriff's Department in providing continuity of care for our inmate/patients. The response to Recommendation 18 was provided by CLERB, our independent oversight entity.

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

RESPONSE:

The County's comprehensive three-year MHSA Plan for fiscal year 2017-2018 through fiscal year 2019-2020 was approved by the County of San Diego Board of Supervisors on October 10, 2017. The Board will receive annual updates that include spending and program outcomes.

All posted reports can be found on the County of San Diego MHSA website at: <http://www.sandiego.camhsa.org/archive.aspx>

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.

RESPONSE:

The County agrees that community-based services that help those with mental health needs avoid incarceration are important. The County is working to continue previous efforts in this area. The County will continue to invest in community-based services and treatment programming that help individuals with mental health needs thrive and avoid incarceration and entanglement with the criminal justice system. Some examples of such efforts include the following:

- The County expanded the number of Psychiatric Emergency Response Teams (PERT) from twelve (12) prior to MHSA to fifty (50) teams today, with 50 % of individuals served having been stabilized and avoiding hospitalization or jail encounters.
- The County has continued development of Assertive Community Treatment/Full Service Partnership Programs (ACT/FSP) that served approximately 1000 individuals prior to 2016 with an array of housing supports. This past year, the County's Behavioral Health Services department introduced a new program for individuals in the justice system with serious mental illness who are transitioning from custody and in need of wraparound services to include treatment, housing, and stability in the community. This is in addition to another program already serving this population, Center Star ACT. Overall about 14% of ACT clients had contact with the justice system one year prior to entering the ACT program, and 56% of these clients avoided contact with the justice system following treatment.
- The County implemented the Behavioral Health Collaborative Court in 2009, which offers comprehensive ACT treatment as an alternative to custody for individuals with serious mental illness including those with a dual diagnosis.
- The County expanded long term capacity for individuals who are gravely disabled, of whom, 60% had contact with the criminal justice system in their past. This expansion increased the number of beds from 75 beds in 2014 to over 250 anticipated by this summer. This expansion does not involve MHSA funding.

- Beginning in 2010, the County has ensured that all of our outpatient mental health clinics have urgent care/walk in hours to help facilitate court referrals.
- In 2010, the County launched one of its largest community education and prevention campaigns, "It's Up to Us," enhancing community and family awareness of mental health issues while de-stigmatizing mental illness and helping individuals access needed care and resources. An increase in calls to our Access and Crisis line has been attributed to the campaign's success as the campaign works to bring attention to available programs and resources, with the hope that connecting someone to care earlier will lead to positive outcomes and prevent negative outcomes such as justice system involvement.
- The county implemented the In-Reach program, which was designed to facilitate appropriate prevention and early intervention services and aftercare linkages with a focus on African American and Latino individuals disproportionately represented in the jail system who may not have been connected to community-based care in the past.
- The County implemented the Courage to Call program which serves returning service men/women and veterans through peer navigation and early intervention, including services to help them connect to resources and avoid unnecessary contacts with the criminal justice system.
- The County implemented the In-Home Outreach Team (IHOT), which is a centralized program offering three mobile teams to provide in-home outreach to adults with serious mental illness who are reluctant or resistant to receiving mental health services. IHOT also provides support and education to family members and caretakers of IHOT participants. Teams serve the six regions of the County of San Diego. Eligible individuals may have a co-occurring substance abuse diagnosis, in addition to a diagnosis of a serious mental illness.

All of the programs offered by the County's Behavioral Health Services (BHS) department are listed on their website at: <http://sandiego.networkofcare.org/mh/services/content.aspx?id=6572>

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.

RESPONSE:

The County is aware that this issue is being examined at the state level and we will continue to research and monitor any developments.

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.

RESPONSE:

The Sheriff's Re-Entry Services Division has taken numerous steps to strengthen re-entry programming for individuals with mental health needs. The Sheriff's Department works with two contracted agencies that provide discharge planning services to our inmates with behavioral health disorders. Their focus is on severely mentally ill individuals. The contractors evaluate the individual, work with any family/community connections they have and prepare a discharge plan. While in custody, they will visit the inmate at least twice a month, establishing a relationship and preparing them for release.

Upon release, contract staff pick up the inmate, collect their discharge medications, and bring the individual either to a program if they were able to secure a bed in a residential treatment program, or to their home if they are returning home to family. Case managers and clinicians continue to work with the individual for 3 months post release to make sure that any problems that arise are addressed. The program structure for the discharge planners follows a successful contract already in place with our mainline inmates who have substance abuse issues. We anticipate expanding these services in the near future to include department staff working alongside these providers.

The Sheriff's Department also works collaboratively with community providers, criminal justice partners and community members to develop and implement reentry programs designed to provide ongoing support and stability to former inmates by cultivating positive and meaningful opportunities. Community engagement and coordination offers individuals in our custody an opportunity to build relationships with community based organizations prior to release. The goal is to enhance reentry services offered within our jail facilities while creating relationships and linkages to ongoing support upon reentry. Services provided include psych-social treatment, vocational training and employment connection, health and wellness, college education opportunities and creative arts. The direct links to services and ongoing support include employment, housing, system of care coordination, psycho-social interventions and general life skills.

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.

RESPONSE:

The County's behavioral health programs are already subject to rigorous data collection and self-critical analysis of progress to determine where additional resources may be needed. The

County's behavioral health programs utilize a wide variety of outcome tools to regularly track the clients' change in symptoms and functioning as well as progress towards recovery. The County's Behavioral Health Services (BHS) department works closely with the University of California – San Diego Research Centers to develop procedures that evaluate client outcomes on a quarterly, annual, and triennial basis. System-wide and program level reports are produced that specifically include client outcomes tracked via the outcome measures and other indicators (e.g., housing).

Additionally, all mental health programs are required to adhere to cultural competence standards which include assessments at the program and staff levels, as well as the completion of client satisfaction surveys that are administered twice a year. All data from these measures are analyzed and reported on as well.

BHS routinely develops and distributes "dashboards" (detailed, at-a-glance summaries) and reports to support the goals of providing safe, client centered, effective, timely, efficient, and equitable services. Data and reports are utilized for system and program monitoring in alignment with BHS' goal of continuous improvement and outcome driven guiding principles. Annual System of Care reports can be viewed at the following links:

Children, Youth & Families System of Care:
https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/TRL%20Section%206/CYFBHS%20SOC%20Report%202015-16_Final.pdf

Adult and Older Adult System of Care:

https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/TRL%20Section%206/AOABHS%20Annual%20Report%20FY%202015-16_FINAL.pdf

Recommendation 6. Develop a plan for timely implementation of the DRC Experts' 46 recommendations to address deficiencies in San Diego County Jails suicide prevention policies, practices, and training.

RESPONSE:

Although the Sheriff's Department agrees with some of the recommendations of the DRC experts, it disagrees with many of them and believes their analysis was incomplete. DRC Experts Dr. Karen Higgins and Dr. Robert D. Canning were provided reports from our department at a time when many of our processes were changing. Moreover, their experience regarding mental health care for inmates lies primarily with the California Department of Corrections and Rehabilitation and the prison system, not city and county jail systems. Further, Dr. Higgins and

Dr. Canning did not visit any of our jails or conduct interviews with any of the mental health staff, inmates, or leadership at any point in time. Thus, many of the recommendations were derived from second hand reports of what actually occurs inside the jails.

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

RESPONSE:

Continuous Quality Improvement (CQI) is already being done with respect to suicide prevention and inmate safety. A CQI process exists to identify problems and implement effective solutions, including suicide prevention. All in custody deaths are reviewed at monthly facility Patient Care Coordination Committee (PCCC) meetings. Suicide attempts are reviewed to address areas of improvement related to suicide prevention. The Sheriff's Department Critical Incident Review Board reviews in-custody deaths. We also began performing psychological autopsies on suicide deaths at the end of 2016.

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

RESPONSE:

The County agrees that increasing mental health staffing and related resources are important ways to ensure that mentally ill inmates receive appropriate treatment. The Sheriff's Department has substantially increased its mental health staffing. This includes 14 Full Time Equivalent (FTE) Sheriff's Detentions Licensed Mental Health Clinicians (a 133% increase in Mental Health clinician staffing in the past 3 years) as well as 6 full time licensed psychologists and the equivalent of 7 FTE board certified psychiatrists who are employed through our mental health provider. In addition, the County of San Diego approved an additional \$3 million annually for the recruitment of an additional 16 FTE Sheriff's Detentions Licensed Mental Health Clinicians to be able to staff the intake facilities 24 hours per day.

The Sheriff's Department recognizes the importance of mental health services and has over the past three years consistently increased its annual mental health budget to over \$14 million annually. The increase in staffing provides individuals with mental illness access to more psycho-social and therapeutic programs through both outpatient and inpatient services while in custody.

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

RESPONSE:

The Sheriff's Department believes that the Psychiatric Security Units are fully and appropriately utilized. The PSU is utilized for those acutely in need of psychiatric stabilization in order to

provide them with care including the administration of psychiatric medications, recreation therapy, milieu therapy, and implemented multi-disciplinarily treatment plans for each patient. Ensuring the PSU is fully and appropriately utilized is an ongoing priority for our clinical staff due to increasing needs.

A multidisciplinary team representing custody, classification, medical, mental health, and counseling regularly meet to discuss placement and treatment options. Each patient's treatment plan is reviewed and modified on a weekly basis. The PSU is for those inmates who meet the requirements of the Welfare and Institutions code Section 5150 (Danger to Self, Others, or Gravely Disabled) as well as Sections 5250 and 5270, (Temporary or Permanent Conservatorship). This process is governed in collaboration with the mental health clinical team and the Courts.

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 greater than 6 hours. At that point if there is no less restrictive housing appropriate, they should be considered placement in inpatient care including the PSU.

RESPONSE:

The Sheriff's Department is implementing strategies to reduce the number of safety cell placements and better utilize the enhanced observation housing cells for individuals who express suicidal ideation or behaviors. The Sheriff's Department is in the process of implementing and creating a Suicide Prevention Focused Response Team that will evaluate safety cell placements of individuals with mental health issues. The team will develop evidence-based and best practices for the handling and treatment of individuals placed into a safety cell. The safety cell length of stay will be based on the clinical assessment of the inmate by the mental health provider and the Team will develop practices that benefit the inmates with mental health conditions.

This Team will also evaluate our current policy in order to recommend other placement and housing options, including the PSU. The PSU is again for those inmates who meet the requirements of Welfare and Institutions code Section 5150 (Danger to Self, Others, or Gravely

Disabled) as well as Sections 5250 and 5270, (Temporary or Permanent Conservatorship). This process is governed in collaboration with the mental health clinical team and the Courts.

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.

RESPONSE:

The Sheriff's Department disagrees with the characterization of the enhanced observation units as harsh or inhumane. These cells were designed for suicide prevention so the lethal methods that inmates typically use (hanging or jumping) were removed from this environment. The purpose of these cells is for structured assessments by mental health staff in a safe environment.

The Suicide Prevention Focused Response Team that the Sheriff's Department will be creating will evaluate the current policy and make whatever changes are necessary to improve practices. The addition of mental health clinician staff will provide the department with more resources for the treatment of patients placed in EOH.

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.

RESPONSE:

The Sheriff's Department does not believe the EOH policies need to be revised at this time. The purpose of the enhanced observation housing units is to create a safe environment for an assessment by mental health staff. These units are not intended for long term housing. Further, articles such as clothes or other personal property may be used by inmates who are suicidal to attempt to harm themselves. Again, the Suicide Prevention Focused Response Team that the Sheriff's Department will be creating will evaluate and determine whether certain living restrictions can be modified. The department wants to be careful not to create a housing option that would encourage other inmates to manipulate the system for personal gain. We are strongly committed to suicide prevention and our efforts will be towards that end with respect to the use of these cells.

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.

RESPONSE:

The Sheriff's Department has already implemented a mental health treatment program that offers different levels of care. Sheriff's mental health care has progressed from mental health services that focused heavily on medication management and discharge planning to include more comprehensive services which include an "intermediate" level of care for non-medication related mental health issues. We have established a dedicated Step Down Unit. We are providing intermediate services in 6 of our jails, with plans to offer them in the 7th later in 2018. Expansion of our Licensed Mental Health Clinician staff has allowed us to expand the outreach of our services. Additionally, discharge planning efforts are now more extensive with the utilization of county contracts with Training Center and Project In Reach.

Recommendation 14. Provide a written individualized treatment plan for each person requiring mental health services in 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.

RESPONSE:

The Sheriff's Department already provides treatment planning for inmates with mental health needs. The Sheriff's Detention facilities have passed each Title 15 Health and Hygiene inspection and have satisfied this requirement annually. Treatment planning is embedded in our mental health staff documentation for our Licensed Mental Health Clinicians as it is a required section in all of our templates (mental health needs assessment, suicide risk assessment). The multidisciplinary groups at each facility serve as a forum where high risk inmate treatment plans are discussed. Multidisciplinary groups started at Vista Detention Facility in 2009 and gradually transitioned to the other detention facilities between 2011-2013.

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.

RESPONSE:

The Sheriff's Department acknowledges that the use of solitary confinement is an issue currently being discussed nationally across many types of correctional facilities. The Sheriff's Department has been proactive in reducing the number of administrative segregated housing placements. Multidisciplinary groups meet weekly (at the Vista Detention Facility) or biweekly (at San Diego

Central Jail, George Baily Detention Facility and Las Colinas Detention and Reentry Facility) to focus on trying to ensure care and minimize decompensation for those in segregated housing.

Licensed Mental Health Clinicians conduct and document weekly administrative segregation wellness checks to monitor and intervene in case of decompensation. The Clinicians also communicate weekly with the Jail Population Management Unit to share their impressions and concerns about inmates in segregated housing who have mental health needs. Additionally, system wide segregation emails are sent to the Clinicians informing them of restrictive housing placement for assessment within 24 hours. The Sheriff's Department will continue to focus on this issue going forward.

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.

RESPONSE:

The Sheriff's Department agrees that tracking and analyzing data with segregation is helpful to reduce unnecessary segregation placements and is currently working to that end. The Sheriff's Department processes noted in Recommendation 15 are part of a collaborative effort to eliminate unnecessary segregation placements and lockdowns. Tracking and analyzing data on segregated housing is not currently done but we appreciate the feedback and will explore in the future. The Department is currently in the initial stages of procuring a new Jail Information Management System. The procurement process offers the ability to customize the new system in a manner that may allow for additional tracking of pertinent administrative segregation information.

Recommendation 17. Reduce the harsh isolation conditions in segregation and other restrictive housing units. Provide individuals in such units a minimum of four 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.

RESPONSE:

The Sheriff's Department acknowledges that segregation can have adverse effects on inmates in prolonged isolation. The Sheriff's Department has taken proactive efforts to improve isolation conditions in restrictive housing units. In efforts to improve conditions in segregated housing, we have undertaken group dayroom projects, whereby the Jail Population Management Unit (JPMU) in collaboration with mental health and line staff attempt to pair up segregated inmates for lengthier and shared dayroom times to encourage socialization. This will be a continuous improvement process as in many national detention facilities.

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.

RESPONSE:

The County already has a professional, independent oversight entity in the Citizens Law Enforcement Review Board (CLERB). Pursuant to San Diego County Code of Administrative Ordinances Section 340, when CLERB was established in 1991 the purpose and intent of the

Board of Supervisors (BOS) was for CLERB to advise the BOS, the Sheriff, and Chief Probation Officer on matters related to the handling of citizen complaints which charge peace officers and custodial officers employed by the County's Sheriff's Department or Probation Department with misconduct arising out of the performance of their duties. CLERB was also established to receive and investigate specific citizen complaints and investigate deaths arising out of or in connection with the activities of peace officers and custodial officers employed by the County's Sheriff's Department or Probation Department.

CLERB's Rules and Regulations (R&R), which were adopted in 1992, detail other duties and responsibilities for which CLERB has authority. CLERB R&R Section 4.7 (d) indicates that CLERB shall have authority to:

Annually inspect county adult detention facilities and annually file a report of such visitations together with pertinent recommendations with the BOS, the Presiding Judge of the Superior Court, the Sheriff, the Board of Corrections, and Attorney General. Inspections shall be concerned with the conditions of inmate employment, detention, care, custody, training, and treatment on the basis of, but not limited to, the minimum standards established by the Board of Corrections. (Emphasis added.)

In the past, CLERB's focus has been limited to the investigation of complaints of misconduct and deaths arising out of or in connection with the activities of peace officers and custodial officers and making policy and procedure recommendations. Presumably due to staffing and/or funding issues, CLERB has never inspected the county's adult detention facilities. However, when receiving complaints about general conditions or operations not pertaining to the actions of peace officers, CLERB advises the Sheriff's Department of the nature of these complaints.

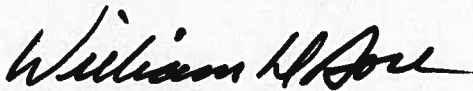
With the hiring of a new Executive Officer in June 2017 and the addition of a newly funded Investigator position as of March 16, 2018, several internal practices have been implemented to ensure that CLERB conducts timely investigations into complaints of misconduct and deaths. With its additional staffing, CLERB will be able to annually inspect county adult detention facilities for the purpose of documenting the conditions of detention, care, custody, training, and treatment as authorized by CLERB Rules and Regulations Section 4.7 (d). These inspections will

result in meaningful and sufficient monitoring of treatment of inmates with mental health needs, suicide prevention practices, and other aspects of jail operations affecting inmates with disabilities.

CONCLUSION

The Sheriff's Office and the County of San Diego appreciate DRC's insight and experience on the issues associated with those suffering mental illness in our detention facilities. The Sheriff's Department and the County of San Diego maintain a commitment to providing all inmates safe, secure housing in conjunction with the highest standard of medical and mental health services in all San Diego County jails.

Sincerely,

A handwritten signature in black ink, appearing to read "William D. Gore". The signature is fluid and cursive, written in a professional style.

William D. Gore, Sheriff

WDG:eds

Attachment: [Expert Report by Colleen Kelly, Ph.D.]